NORTHERN INTER-TRIBAL HEALTH AUTHORITY

2012/2013

Annual Report

Celebrating our Youth Leaders for a Brighter Future

Contents

Our Vision, Mission, and Principles

Vision

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

Mission

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

Principles

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

NORTHERN INTER-TRIBAL HEALTH AUTHORITY

About NITHA

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

What is Third Level?

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

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

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

Services NITHA Provides

Public Health

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

Community Services

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

The Partnership

Prince Albert Grand Council
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Prince Albert, SK
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Tel: (306) 953-7200
Fax: (306) 764-6272

Meadow Lake Tribal Council
8002 Flying Dust Reserve
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S9X 1T8
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Fax: (306) 236-6485

Lac La Ronge Indian Band
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Tel: (306) 425-3600
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Peter Ballantyne Cree Nation
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Prince Albert, SK
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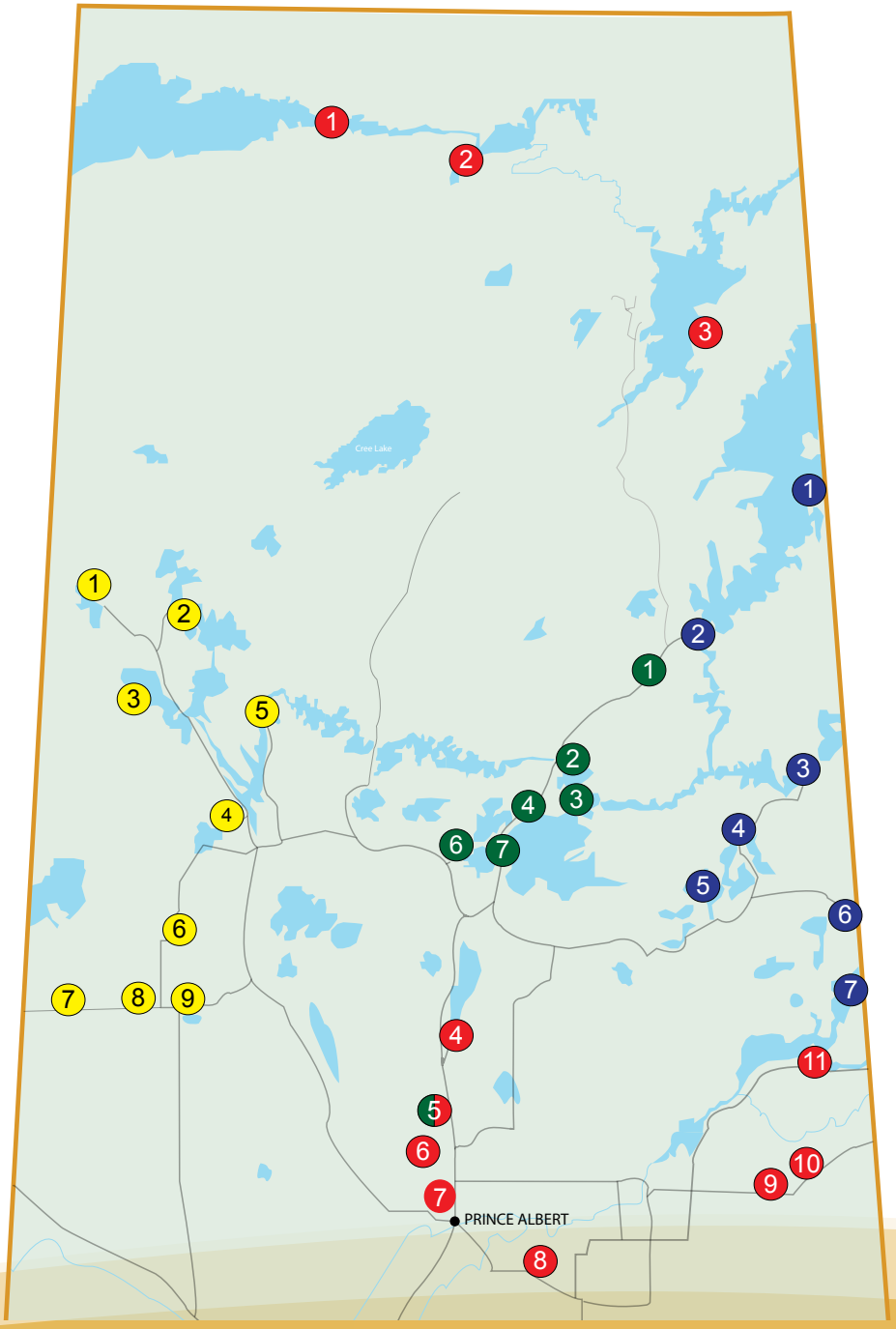
Fax: (306) 922-4979

Partnership Communities



Peter Ballantyne Cree Nation

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

Meadow Lake Tribal Council

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

Prince Albert Grand Council

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

Lac La Ronge Indian Band

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

Board of Chiefs

CHAIRPERSON
GRAND CHIEF
RON MICHEL
Prince Albert
Grand Council

TRIBAL CHIEF
ERIC SYLVESTRE
Meadow Lake
Tribal Council

VICE CHAIR
CHIEF TAMMY
COOK-SEARSON
Lac La Ronge
Indian Band

CHIEF
DARREL MCCALLUM
Peter Ballantyne
Cree Nation

Executive Council

AL DUCHARME
Prince Albert
Grand Council

FLORA FIDDLER
Meadow Lake
Tribal Council

MARY CARLSON
Lac La Ronge
Indian Band

ARNETTE WEBER-BEEDS
Peter Ballantyne
Cree Nation

Guided by Our Elders

ELDER
VITALINE READ

ELDER
GERTIE MONTGRAND

ELDER
JOHN MORIN

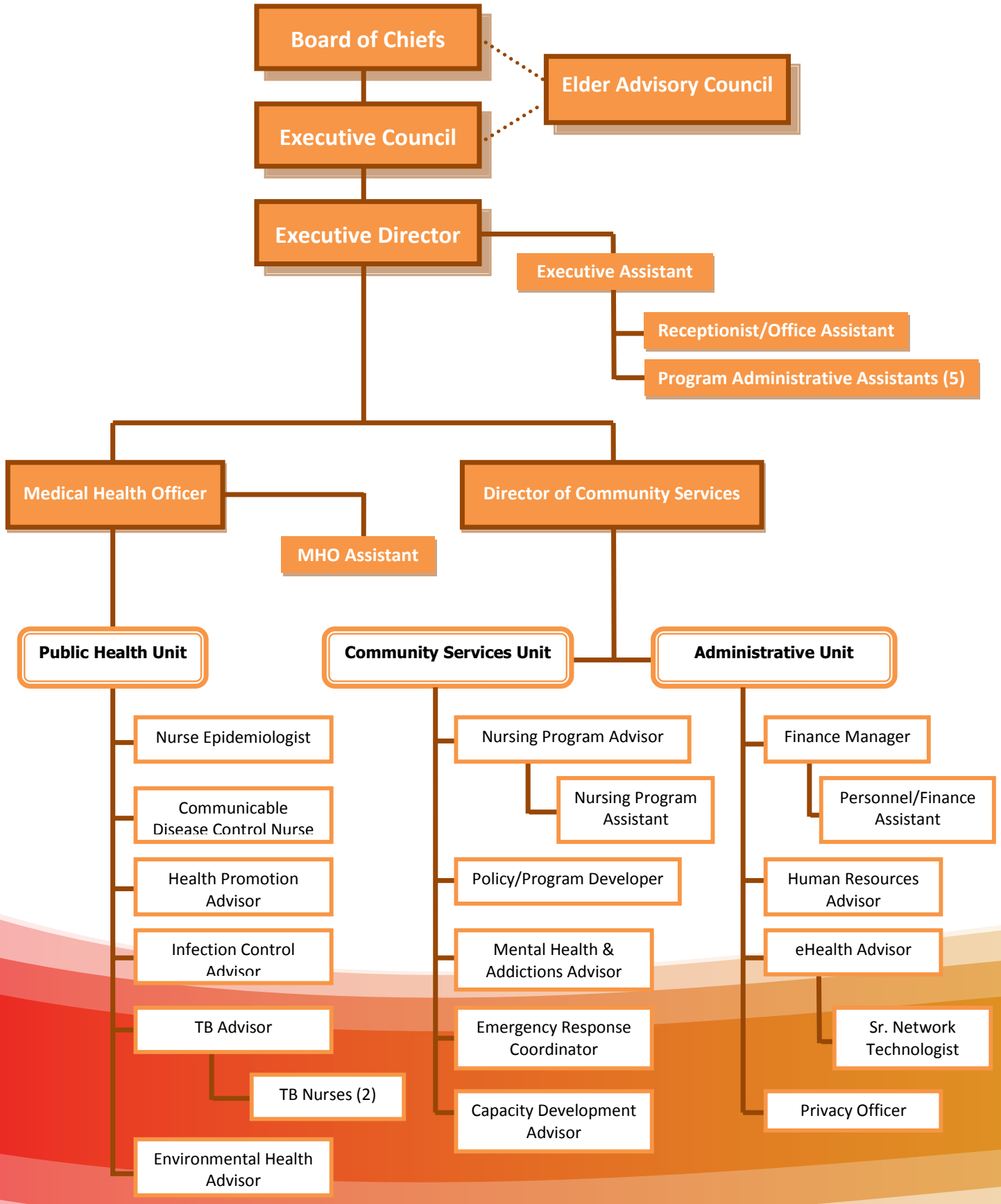
ELDER
MIKE DANIELS

ELDER
ROSE DANIELS

ELDER
KATE HAMILTON

NITHA's primary identity is a First Nations health organization empowered by each Partners' traditional languages, diverse cultures, values and knowledge. Our Elders represent the four partners, and support NITHA through providing advice, making recommendation, ensuring the respecting of cultural values and providing wisdom to our many groups throughout the organization. It is through the elder representation that NITHA remains a grounded in First Nation identity of our diverse partnership.

Organizational Chart



Message from the Chair

Tansi, Edlanet'e,

I am honoured to present the 2012-13 Annual Report for the Northern Inter-Tribal Health Authority. The theme of this year's report is "Celebrating Our Youth – Leaders for a Brighter Future". We believe in investing in our young people and recognizing and promoting those youth who make the choice to be a positive role model. This past year, NITHA created a Role Model Calendar in which youth from the Partnership communities were identified and celebrated for their accomplishments. As well the NITHA Scholarship Program recognized the academic achievements of our young people who are enrolled in a health related post secondary education program.

The Board of Chiefs and Executive Council continues to provide leadership, guidance and support which has translated into the implementation of new and innovative approaches to supporting our Partners. The Leadership reviews the long term goals and risk management strategies of the organization and provides the road map for NITHA's future. This important work will continue throughout the year as we finalize our Organizational Heath Plan which will take us through the next 5 years. Despite the local effects of ongoing, global economic challenges, we're especially pleased that NITHA has kept a strong financial footing; this has allowed us to provide quality professional support to our Partners.

Essential to NITHA's success is of course the complement of caring and committed staff whom are passionate about their work and continually strive to improve the overall health and wellbeing of our people in the North through a wide variety of programs, tools and training opportunities.

As we look to the future, we are certain there will be challenges and hurdles to overcome -- that is the nature of our world -- but we are also confident NITHA will meet and overcome those Challenges. On behalf of the Board of Chiefs I dedicate this years annual report to the future leaders, our youth, who will lead us to a brighter future.

Grand Chief Ron Michel
NITHA Chairperson

Executive Director Address

This annual report provides the Northern Inter-Tribal Health Authorities activities for the fiscal year ending March 31st, 2013. It attempts to report on the accomplishments in each program area according to the identified strategic priorities. The report provides the organization with an opportunity to give an overview of each position in the organization, the accomplishments and challenges in the year and the plans for the next fiscal year.

The 2012-2013 year was an exciting and rewarding year. We began the development of the NITHA 5 year Operational Plan for 2013 – 2018, and we needed to obtain an extension as the plan could not be completed. The plan which is now due in September of 2013 is in the process of being completed, the program leads, working with their Partner working groups, drafted program plans that meet the identified strategic priorities. The plans will go through a review first by our Executive Council and approval from our Board of Chiefs. The entire plan will be submitted to Health Canada in October of 2013, for final approval and hopefully a new transfer agreement for the 2014-2019 fiscal years.

We were required to complete the evaluation report for 2005-2012, which was contracted to Hanson and Associates of Whitehorse, Yukon the main evaluator was Gaye Hanson. The full document was disseminated to the four Partners, and is available upon request. The document recommended 5 major areas of improvement, which were as follows: Foundations for the future, Strengthening Accountability and Relationships, Program Management and Technology, Finance and Human Resources Management and Monitoring, Evaluation and Knowledge Management. In each of these main areas there was three to six recommendations, which will be address in our operational plan.

As well NITHA completed a Health Status Report, contracted to researchers based at the University of Saskatchewan, specifically Robert Nesdole, Debora J. Voigts and Rein Lepnurm. This document will be review by the NITHA Executive Council, and if approved by the Board of Chiefs the recommendations will be included in the operational plan.

The coming year of 2013-2014 will be the finalization of our Operational Plan, and the revision of our strategic Priorities. We look forward to working with our partners to work towards achieving our Vision and Mission.

Executive Assistant
Heather Gunville

Mary Carlson
Executive Director

Community Services Unit

Director of Community Services
Bev Peel

Program Overview

The Community Services Unit provides program support and knowledge in the areas of nursing education/training, capacity development, mental health and addictions, and emergency preparedness. The Unit partially reduces the residual role for FNIH in a post-transfer environment while maintaining working relationships through open communications and mutual respect. The Unit is tasked with providing up-dated information on the availability or shortfall of the regional or national programs and ensuring coordination of support to assist the Partners in the development of financial proposals.

The Unit staff organizes working groups of which all communities within the four partners are encouraged to send a member. These working groups offer an opportunity for the partner organizations to have input into the work that occurs at NITHA for the Partnership.

The Director of Community Services handles the day to day management of programs and operations, as well as supervision of employees in the Community Services Unit and the Administration Unit. The focus is on directing and supporting the planning, negotiations, proposal writing and implementation of programs within both units.

Program Administrative Assistant
Maxine Ballantyne

Program Administrative Assistant - Term
Jacqueline Natomagan

NURSE PROGRAM ADVISOR

Achievements

Nurse Program Advisor
Fay Michayluk

The Nurse Program Advisor position was filled in October 2012, with the first task to being drafted, an annual work plan and beginning to work on the 5 year Organizational Health Plan. The Organizational Health Plan on the NITHA Strategic Initiatives directed toward the formalizing of a process to deal with the Transfer of Medical Function, nurses certification, scope of practice and licensing that is negotiated with and approved by all stakeholders. In ongoing discussions , meetings and teleconferences with the NITHA Nurse Managers and the Saskatchewan Registered Nurses Association (SRNA) NITHA has been and will continue to be very involved in the SRNA Bylaw changes and ongoing development of the Educational Program and the Prior Learning Assessment Reviews as it directly affects the provision of nursing in the north.

Achievements

The SRNA Annual Meeting and Conference planned for May 2013 will provide a forum for NITHA Nurse Managers and nurses to voice their opinions and to vote on the proposed Bylaw changes which will bring about changes respecting the roles and responsibilities of nurses working in the north. NITHA plans to support several representatives from the Partner organizations to attend the meeting and to have their say in the proposed changes. If the Bylaw changes are passed SRNA will begin work on the Prior Learning Assessment Reviews and changes to the Registered Nurse roles and responsibilities in the four categories, General Practice, RN with Additional Authorized Practice (northern nursing), RN Speciality Nursing Practice and the RN(NP).

The Orientation Skills Training (OST) which usually occurs three times a year, is determined by the number of new nursing hires in the Partnership. In 2012 the following sessions were held:

- June - 8 Participants
- July - 7 Participants
- December - 7 Participants

The Program also provides a refresher and audit review of all nursing personnel at the request of the Partner Organizations. NITHA contracted 2 - RN(NP)s that provide the training and mentoring of this program. Currently all teaching materials have been reviewed, revised and updated to meet best practice guidelines. NITHA also contracts a physician Dr. Leo Lanoie, who has worked with the organization for many years, he provides medical reviews and clinical support for nurses in the field.

The NITHA Strategic Initiative respecting *development of options for long term and special care throughout the NITHA Region*, will involve working closely with the Partner Organizations to focus on the completion of an environmental scan, a needs assessment and feasibility study. The work will begin in mid 2013 with input from the NITHA Home Care Working Group and the NITHA Nurse Managers Working Group.

Hosted regular meetings and teleconferences with the NITHA Nurse Managers Working Group and the NITHA Home Care Working Group have occurred over the past several months.

NITHA was invited and then submitted proposals to FNIHB to host three major workshops in early 2013. These three workshops were funded by FNIHB and facilitated and hosted by NITHA.

- January 18th, Saskatoon - FSIN Regional Home Care Working Group Workshop on HIV and Home Care. Ten presenters from those living with HIV to physicians providing HIV care and treatment in First Nations Communities to a nurse who works in BC to provide treatment and care to those who are HIV positive and those living with AIDS. This workshop was very well received by those attending the two day workshop. We had a total of 42 attend from the Partnership.

- February 12th, the introduction to the Re Act Tool Kit (Elder Abuse in First Nations Communities). The presenter represented the National Office and introduced the Tool Kit and the participants worked in small groups to discuss implementation in their home communities. NITHA facilitated and chaired the meeting, we had 131 register, and 103 attend from the Partnership.

- March 5th, 6th, in Saskatoon - Chronic Disease Prevention Management Model Project, Regional Engagement Session. The meeting objective was for the National Office to gather input and information from participants to inform the development of a Chronic Disease Prevention and Management Framework. Sask. Region was the first of National meetings which will conclude in early 2014. NITHA facilitated and chaired the two days of meetings, we had 38 representatives from across Saskatchewan Region, as well as invited guests from the province and other Chronic Disease programs.

The Nurse Program Advisor was involved in sub committees of the Home Care Working Group regarding on going plans for training and program development regarding HIV in the Home Care Program and the development of the Home Health Aid Manual.

Challenges

The dissolution of the Transfer of Medical Function, the SRNA Bylaw changes and the concerns regarding nursing service delivery in the northern stations brought about the need for ongoing explanations, discussion and involvement both internally and externally. This is necessary to ensure NITHA and the northern nursing program is clearly involved and well informed of pending changes. This work will be ongoing pending the results of the May 2013 SRNA Bylaw votes.

The increasing numbers of positive HIV and other blood borne disease in First Nations communities and the increased number of client choosing to remain in their home communities to receive care and treatment has added stress to Home Care Programs. The need to develop clear Policies and Procedures respecting the delivery and standardization of Home Care and Community Health Care for HIV clients is essential.

Palliative Care is not a program currently funded by FNIHB. Palliative Care within the Partner Organizations is an increasing service requirement as more community members choose to spend their last days within the comfort of their home communities and with their family and friends. The frustration here is the provincial program does not provide consistent service to on reserve populations. Over the past few months serious dialogue has begun regarding the need for the development of a strong First Nation funded and directed Palliative Care Program to serve the Partner organizations. NITHA ongoing involvement in these discussions is critical.

There is a need to discuss and plan the Community Nursing and Public Health Unit Working Groups and consider if and how there is an overlap in the organization of these two programs. Considering the intense work carried on regarding HIV within the FSIN Regional Home Care Working Group and the Public Health Unit CDC program, communication and sharing of program training and development requires an open forum for discussions. Many of the community health programs and primary health care programs intersect for example the infant, children and school immunizations programs. Prenatal, postnatal and wellness clinics require ongoing interaction and information sharing. The importance of all aspects of a nursing service delivery must be open and strive for a collaborative team approach to the provision of nursing care.

Priorities

1. Internally aspire to open discussion regarding formation of a collaborative team approach within the Nursing Program including Home Care and the Public Health Unit.
2. Continue to support the Orientation Skills Training with the intention to support all NITHA Partner organizations to ensure all northern nurses have current Transfer of Medical Function in place and are in a position to apply for the Prior Learning Assessment Review and the RN Additional Authorized Practice certification.
3. Continue to work closely with the Partner organizations, the FSIN Home Care Working Group and the FNIHB in the development of clear direction for the delivery of Home Care Services relating to HIV.
4. Continue to work with FNIHB and represent the partners in the development of Policies and Procedures relating to the provision of Palliative Care in First Nations communities.
5. Initiate discussions, review current needs and develop a plan to address the long term and special care needs within NITHA Partner organizations.

CAPACITY DEVELOPMENT ADVISOR

Capacity Development Advisor
Linda Nosbush

Program Overview

The NITHA Executive Council decided to focus its capacity development efforts on certified professional training in the Health Sector. In order to make this happen, barriers to access need to be addressed, and innovative ways to deliver programs explored.

The strategic priorities for 2012-13 were to strengthen the capacity of First Nations to deliver quality health services at the community level and strengthen leadership and management functions.

The focus was on certified programs that lead to national credentials in these priority areas:

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

Furthermore, NITHA envisioned that Career Paths would be developed that:

- Recognize Prior Learning and Experience;
- Support existing employees to upskill while maintaining full time employment;
- Enable employees to build career ladders that allow them to step 'on' and 'off' training ladders in ways that maximize transfer of credits and acknowledge essential skills across all health careers which, in turn, enable them to work Interprofessionally as a health team;
- Enable those working toward certification with the First Nations Health Managers' Association to ladder this training into a Saskatchewan Post-Secondary Training Programs; and
- Facilitate access to training through a blended distance model.

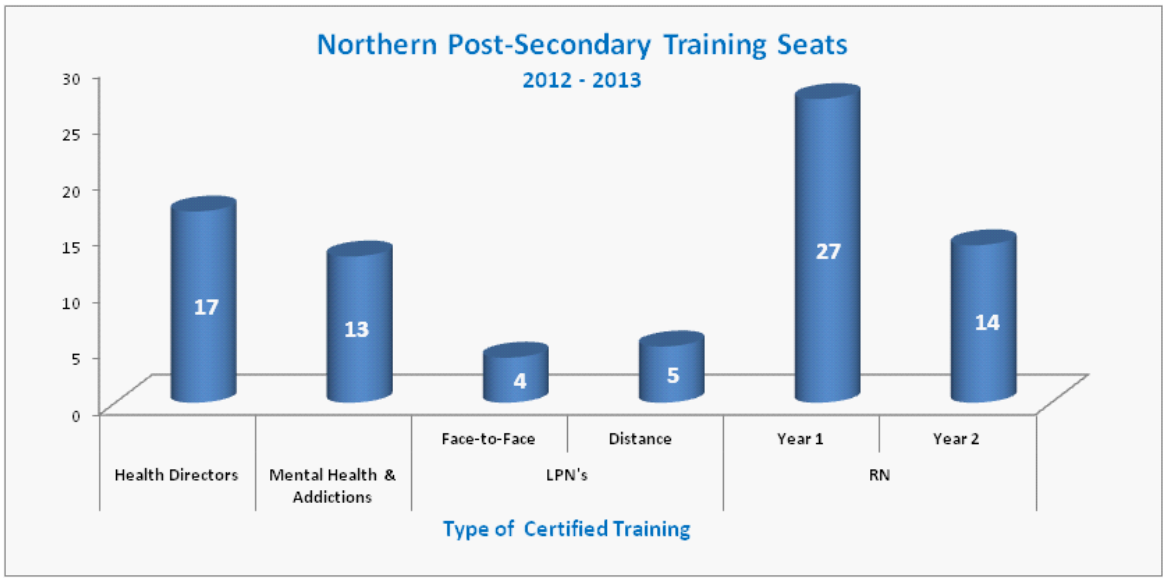
Achievements

Thompson's Report on a *Northern Health Human Resources Data collection (2012)* found that the following six positions would have the greatest demand for new hires (estimated at 293 per year or 24% of the Northern Health Sector Labour Force) over the next five years:

- Social and community service workers,
- Registered Nurses,
- Nurse aides,
- Early childhood educators,
- Licensed Practical Nurses, and
- There is also an increased demand for Director/Manager/Coordinator skills and training but since there has been a reorganization of the occupational code, system comparisons are difficult.

The labour market information in this report will continue to inform priority development within NITHA and the NLMHSTS.

The past year has been very productive for the joint ventures of the NITHA AHHRI Partners and the Northern Labour Market Health Sector Training Subcommittee (NLMHSTS).



Post-Secondary Training involved 80 students this year in four certified programs:

Health Directors/Managers/Coordinators – Seventeen Health Directors/Coordinators are in the Certified Health/ Manager Program through the First Nations Health Managers Association (FNHMA). The courses are based on the National consultation. Present students have completed two of the five courses required for this national certification. The other 3 courses will be completed in the 2013-2014 fiscal year.

Presently, meetings are occurring that will enable NITHA Health Directors to transfer their FNHMA credits into an existing Saskatchewan Post-Secondary Program.

Mental Health and Addictions - Thirteen students completed Part B of the Preparatory Program and four additional courses in their program this year. They will be one-third of the way through the new integrated Mental Health and Addictions Worker Certificate Program through SIAST by the end of June 2013 and will also have attained Level II the Community Development Certification. This program employs a blended distance delivery model and, is called 'upskilling' since all students work full time and attend classes part time. They meet in Prince Albert for an Intensive Week of Instruction at the beginning of each term (May

and September, 2012; January, April, and June, 2013) and then meet online once per week for three hours. This training will provide National Certification through CACCF (Canadian Addiction Counsellors Certification Federation). The certification of the 13 students will be complete in June 2017.

Nursing (RN) -The Distributed Learning BScN was initiated in 2011-12. This year the following students are enrolled:

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

The Program is offered through the University of Saskatchewan and is utilizing patient robots as part of the instructional methodology in order to provide more 'hands-on' meaningful learning under the supervision of university instructors.

Practical Nursing - Both face-to-face and blended distance programs have been offered:

- Face-to-Face - 5 students finished April 30, 2013
- Blended Distance - 4 students will finish December 2013

The 15 previous graduates are living and working in the North; five more will be available in May and an additional four will be available by January 2014. In total, this initiative will have provided 24 LPNs for the Northern Labour Market.

Community Development - We have been working with Flo Frank, an international authority in community development, to develop a certification process at four levels. A Train the Trainer module will also be developed, at the request of the participants. Core competencies have been developed and agreed upon by SIAST's Mental Health and Addictions Program Head. The four levels are:

- Level 1 - Community Development - The Basics: History, Process and Action Planning
- Level 2 - Community Engagement and Partnerships - Communication
- Level 3 - Supporting Strategies and Advocacy - Career Development and Self Care
- Level 4 - Systems and Change - Personal, Organizational, Community, and Sector

In the 21st century, it is not only important to have initial training but also to have the opportunity to build on previous training, even to the point of changing career paths. This requires a broader look at Health Sector Training Programs, one that explores how various health careers are interrelated and how expertise can be built within and across career paths over time in order to be responsive to the needs of individuals and communities. The following have received attention this year.

- **The Mental Health and Addictions Studies Career Path** has developed across five post-secondary institutions, is an example of how one might build a career path from the Prep level to the Post Graduate Diploma level. This year the new courses in the Certificate Program were developed and the Diploma course development is now underway. FNUC/University of Regina are developing the Holistic Health and Healing Degree.

- The work on the **Health Director Career Ladder** has progressed this year. We've had a number of meetings with Saskatchewan Post-Secondary Institutions to explore how the First Nations Health Managers Association Certification can transfer into a Certificate Program to enable further development of a Career Ladder responsive to the needs of First Nations Health Managers and Directors.

While many presentations occur during a year, some have the potential for greater impact. Two stand out this year:

- **Joint Task Force on Improving Education and Employment Outcomes for First Nations and Métis People**, January 25, 2013 – Partners from Northlands College, SIAST, NLMHSTS, NITHA, FNHMA from Ottawa, and a Community Health Director joined us for the presentation; and students from the Mental Health and Addictions Certificate Worker Program made a short five-minute DVD to share with the Task Force. The Task Force was most receptive to our presentation and particularly valued the testimonials from students. Their concluding comments included, "While everyone else is suggesting what needs to be done to increase engagement with Post-Secondary Training and the Labour Force, NITHA and her partners in the NLMHSTS are actually doing what everyone is just talking about it!"

- **Northern Labour Market**, March 7, 2013 - This committee comprises many partners, who were very supportive of the work being done to provide Health Sector Certified Training in response to Labour Market needs. As a result of this presentation, we have begun to work with the Career Development Subcommittee of the Northern Labour Market, and have contracted KCDC (Keewatin Career Development Corporation) to work with us on a Cultural Competency set of modules.

Priorities

The **priorities** for next year will be:

- Mental Health and Addictions
- Health Director/Manager
- Community Health Representatives/Developers
- Completion of the LPN and RN Programs

While many barriers are being removed, challenges still remain in the planning, managing, and organizing of program services within the partnership. They include: communication practices, travel costs that consume major portions of budgets, capacity to respond to the broad range of community worker skills needed, and the lack of alignment between academic training years and budget years. While the funding streams are stabilizing provincially, the precarious nature of federal funding (two streams of AHHRI are sun setting March 31, 2014 and the final stream is sun setting March 31, 2015) is threatening our partnership and the leveraging capacity that has enabled our work.

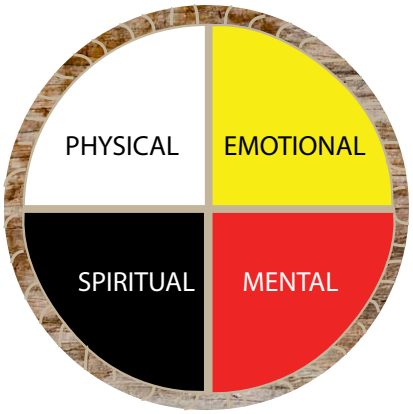
MENTAL HEALTH AND ADDICTIONS ADVISOR

Mental Health & Addictions Advisor
Cyndy Lee

Program Overview

The Mental Health and Addictions Advisor position was filled in September 2012. This began the process of defining the role, determining the responsibilities and, most importantly, creating connections with the Partners. The Advisor went out to Meadow Lake Tribal Council, Lac La Ronge Indian Band, Peter Ballantyne Cree Nation and Prince Albert Grand Council offices to meet staff working in the area of mental health and addictions. These meetings were very productive and began the process of building meaningful working relationships and gathering direction on what services the Advisor could provide that were important to them.

The Mental Health & Addictions Advisor assists the second level service providers to plan, develop, implement and evaluate Mental Health & Addictions program strategies. In consultation with the four NITHA Partners, the goal of the program is to develop a comprehensive framework including a model of service delivery encompassing prevention, assessment, education, intervention, treatment and aftercare in the mental health & addictions area. This framework will reflect the incorporation of models drawn from research literature that are culturally appropriate and create an environment of cultural responsiveness within which healing can occur. The Partner communities will develop their own distinctive, home-grown programs and service delivery systems.



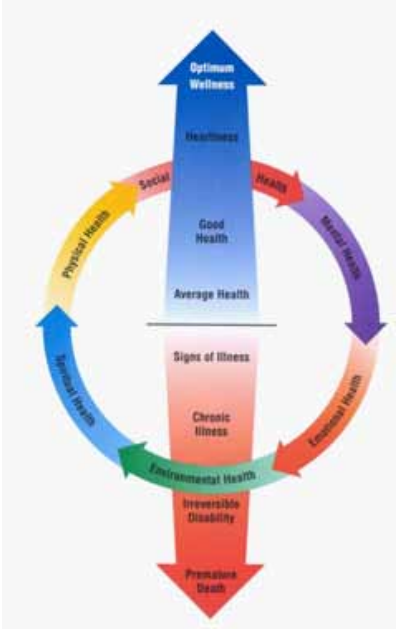
- NITHA's goal is to support Partnership needs in Mental Wellness
- Strengthen the capacity of First Nations to deliver culturally appropriate and responsive services

Achievements

A significant amount of research into mental and health and addictions issues has been done and an electronic resource library has been established. Three major text books have been purchased and appropriate research papers and articles have been catalogued and saved by topic for easy access and dissemination.

The Mental Health & Addictions Working group has been established with representatives from the four Partners. Meetings were held in February and May to fulfill the mandate of quarterly meetings.

The MHA Advisor coordinated a "Good Grief" workshop on March 14 & 15th in Prince Albert for participants from the Partner communities. The Good Grief workshop is a activity based workshop that provides therapy for grief and loss. It utilizes volunteers and community members and needs only one trained



facilitator. The Good Grief workshop format can be used with different populations and to address grief specific to suicide. This program has been offered for fifteen years and is well-researched and proven effective. It was offered in a "train the trainer" format with the partners sending several staff (if possible) from the community to take the training and then roll it out as a team. The training consisted of one day of theory and establishing a knowledge/skill base and a second day of explanation of the "Good Grief" workshop and applying the theory in a practical manner to the components of the workshop. The workshop was attended by 67 participants and 2 students observers. Evaluations of the workshop were very positive, with a noted increase in knowledge of the topic area. The Good Grief workshops have been facilitated in several communities with positive outcomes.

Lac La Ronge Indian Band, Community Corrections and the MHA Advisor worked collaboratively to develop a responsive treatment program for offenders to be delivered to members of LLRIB who have been mandated for treatment. This is currently being delivered in La Ronge.

Challenges

Certainly one of the major challenges of this position is the complexity of the organizations, the Partners and other stakeholders. As well, despite mental health and addictions services being fairly well-staffed, the level of need in this area is so overwhelming. This makes shifting from crisis intervention to prevention very difficult. Another significant challenge is to find a model of intervention that supports the Crisis Response teams at the second level. Crisis Response teams are heavily used and support for the second level staff are scarce. Ways to provide debriefing and support services at the second level is crucial to the ongoing management of crisis in the Partner communities.

A major challenge continues to be the cost of providing training to staff that work and live in remote and isolated communities. Alternate methods such as teleconferencing need to be reviewed for their usefulness and appropriateness for some of the communities.

Priorities

a. Developing external partnerships with local, regional, provincial and national organizations and sectors.
b. Continuing development of a resource library that highlights research based programs that are culturally responsive and reflect promising practices.
c. Support training initiatives that build community capacity and increase the skills and applied knowledge of staff.
d. Respond to requests for specific programs and/or interventions as needed.
e. Contribute to the development and implementation of a Mental Health and Addictions section of a Child and Youth Strategy for the NITHA Partners.

Mental Health and Addictions is an area of health care that has become a priority for many levels of government and community agencies. This creates the potential for significant growth and development in knowledge, understanding and services. NITHA mental health and addictions program will continue to support Partners and work together toward the development of a comprehensive and inclusive continuum of care within a framework of culturally responsive mental health services. The focus will be on removing the stigma and barriers for those with mental health concerns and improving outcomes for those living in the NITHA communities.

EMERGENCY RESPONSE COORDINATOR

Program Overview

The Emergency Response Coordinator (ERC) works with the Partnership to support and advise on emergency response and preparedness issues. The position is evolving and beginning to encompass past initiatives such as community emergency response planning, pandemic planning, public access to defibrillation, First Aid/CPR training and First Responder capacity development. The NITHA ERC is poised to assist the Partnership in any regard relating to the emergency response.

Emergency Response Coordinator
Patrick Hassler

Achievements

The assessment of the state of emergency preparedness and capacity is ongoing and is achieved by meeting with community members and leaders, stakeholders, second level personnel, Regional Health Authorities as well as Provincial and Federal regulators. It was noted quite early that the community leaders are very engaged on this topic and are open to self-identify the need for more education/orientation on emergency response matters and processes.

NITHA communities` Emergency Response Plans and Emergency Preparedness has been supported with the NITHA Annual Review Policy and Procedures Guide as well as with ongoing community risk assessments. An annual review of Emergency Response Plans is an industry standard that will be more achievable using the Annual Policy and Procedure as assistance. The NITHA Policy and Procedures Guide also assists in the safe storage of updated plans by providing for storage options through NITHA. NITHA continues to advocate for funding of full time permanent Emergency Response positions at the 2nd level, in order to support policy and procedure implementation.

We continue to support First Responder initiatives through stakeholder coordination, and advice and support regarding operational policies and procedures. NITHA has endeavoured to bring this training "in house". The process has begun with training First Aid and CPR instructors throughout the Partnership that will lead to the upgrade of this instructor level to the First Responder Level when the two year instructor experience prerequisite is met. To date this initiative has seen 6 people trained to instruct First Aid and CPR, approximately 50 people trained in First Aid and CPR and approximately 26 First Responders trained throughout the Partnership with a 2/3rd reduction in cost of training. We have also seen the creation of the Sturgeon Lake First Responder Group who will begin responding to 911 calls this summer. It remains the desire of NITHA to increase the number and utilization of First Responders. The importance of First Responders and their impacts on a community cannot be understated and NITHA will endeavour to support and advise communities in the implementation and sustainability of First Responder groups.

Training opportunities for Partner communities will continue to be a priority for the NITHA ERC. Many courses are available to communities to improve their state of emergency preparedness. Many communities have had training in the past (eg. Basic Emergency Management). This training should be repeated and built upon to ensure the information and skill set delivered is current and relevant.

Challenges

Training challenges have been identified within the Partnership. The standard course for orienting communities to the emergency response has been the Basic Emergency Management (BEM) program offered by Corrections and Public Safety. The challenge with this program is that currently there is no expiry date to the training. This presents a problem to the Partnership due to the funding procedures at Aboriginal Affairs and Northern Development Canada (AANDC). The current stand point is that once this training is delivered within a community that it will not be financially supported again. This approach does not take into consideration that persons change job titles, move or simply no longer employed by the community. The NITHA ERC is attempting to see changes in this government policy. The program is delivered by Corrections and Public Safety continues to be offered to communities free of charge for classes of 10-12 seats. Travel expenses for community members will remain the responsibility of their respective community.

NITHA funded full time Emergency Response Positions at the 2nd Level for the four partners, in a one year term to assist in the process of update and teaching the policies and procedures.

Manpower in the area of Emergency Response and Preparedness has been a significant challenge. 2nd level and community manpower is needed to conduct Risk Assessments, update emergency response plans, build contingency plans, as well as to prepare communities for unique contingencies for their communities (such as evacuations). Without dedicated full time positions in these areas progress will remain problematic and sluggish.

Priorities

As the industry standard has changed in regards to emergency response plans, the NITHA ERC continues to be committed to ensuring partner communities are aware of and compliant with the changes. The change has been in taking an "all hazards" approach to community ERPs. The "all Hazards" approach is evidence based and is a sound approach to emergency planning. The current step in coming in line with this approach is to conduct community risk assessments.

Many organizations are mobilized during a large emergency response such as evacuations. The NITHA ERC will continue to engage these organizations and ensure that the Partner community voices and concerns are heard and addressed. Northern communities are very unique and require a tailored approach during emergent events that differs in many ways from First Nations communities in the South. The NITHA ERC will continue to ensure that the "North" is not made to fit in the "Southern" box in regards to emergency response.

First Responder groups are an extremely important part of the community response and pre hospital treatment on reserve. The NITHA Partnership in many cases finds themselves many hours from definitive care and pre hospital emergency medical services. Functioning First Responder groups can help shorten this window in getting basic life support care to their community much faster than outside agencies. NITHA ERC will continue to support and assist communities in the development and sustainability of First Responder initiatives through initiatives that bring the training "in house" as well as by engaging stake holders and Regional Health Authorities.

Public Health Unit (PHU)

Program Overview

The Public Health Unit provides direct services and support to NITHA Partnership communities in the areas of communicable disease requiring public health follow-up and immunization, environmental health services, emergency preparedness, health promotion and infection control. The PHU unit has a broad goal of improving the health and wellbeing of the NITHA population through increased health promotion and primary prevention. The PHU works towards preventing disease or ill health from occurring rather than having to deal with ill health once the condition has developed. This approach of prevention is vital to having healthier individuals, families and communities.

The Medical Health Officer (MHO) position is vacant with Dr. Mandiangu Nsungu providing MHO services on a contractual basis. NITHA is working on recruiting a full time MHO.

The Public Health Working Group, with representation from all partners continues to meet regularly. This group provides direction and guidance to the unit in moving public health issues forward. Provincial and National work is reviewed and reworked to be appropriate for the NITHA partnership. The NITHA PHU working group is working to align the NITHA Public Health Strategy with the provincial Saskatchewan Population Health Council (SPHC) and their focus areas of Healthy Communities, Communicable Disease, Safe Environments and Public Health Infrastructure. NITHA has been involved with various provincial strategies within these four areas that will improve the health of NITHA populations. Tuberculosis, HIV and Sexually Transmitted Infections are areas where considerable work has been done and further involvement with the strategy development and interventions continue. These will be expanded further in later sections.

The PHU provides individual and group educational presentations as well as provides an annual communicable disease conference for nurses in the partnership. Presently NITHA uses a system called iPHIS for electronic data collection of notifiable disease information. NITHA receives notification of notifiable diseases from the Saskatchewan Disease Control Laboratory via the Regional Health Authorities. In the future the Ministry of Health will be replacing iPHIS with the public health system, Panorama. Even with the use of electronic systems there are still 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).

Program Administrative Assistant
Linda Rogozinski

Program Administrative Assistant
Deanna Brown

Program Administrative Assistant
Cindy Sewap

NURSE EPIDEMIOLOGIST

Program Overview

Nurse Epidemiologist
Shirley Woods

This position 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.

Achievements

The vaccine used in our communities is purchased by the Saskatchewan Ministry of Health and we receive close to $500,000 worth of vaccine to distribute to the NITHA partnership communities.

The Nurse Epidemiologist participates in a number of working groups related to Panorama. These groups consist of the First Nations Change Management Group, the Provincial SPRINT (Saskatchewan Panorama Redesign, Implementation & Networking Team) and SPRINTER(Configuration work groups for Immunization and Family Health) Working Groups as well as the Panorama Deployment Information Sharing Group. Much of the work in these groups is to ensure the system will meet the needs of First Nation individuals, families and communities.

In February 2009, NITHA became aware of the opportunity to submit proposals for "Innovation Funds" for nursing stations. Funding was received for the personal data assistants (PDA) and this funding will end this year.

PDAs are used for ongoing education, education resource, client teaching and many medical and nursing applications. This project has been well received by nurses in the field, a baseline survey has been completed by all nurses receiving the ipods and additional evaluation is presently being completed.

Immunization

This Immunization continues to be the best protective intervention for the prevention of vaccine-preventable diseases. This year brought a change in the Prevnar schedule with the reduction of one dose at the 6 month age for healthy children. It also brought a new vaccine, rotavirus, which was implemented November, 2012. This program targets infants from 6 weeks to 8 months of age and is offered at the regular 2 month and 4 month Child Health Clinic (CHC) visits.

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 2012. Influenza statistics are collected on a fiscal year or flu season. The other statistics are collected on a school year and will reflect the 2011-12 school year.

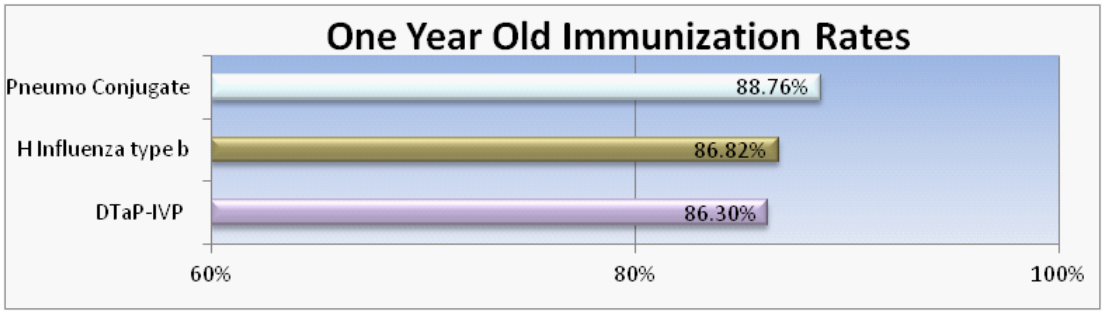
Presently data is collected manually from most communities, except in AHA and James Smith First Nation who are using the Saskatchewan Immunization Management System (SIMS) and are able to run electronic reports. This is the paperless client immunization record system used by the provincial health system. SIMS is a legacy system that has worked well but being replaced by Panorama. For those communities using SIMS their data

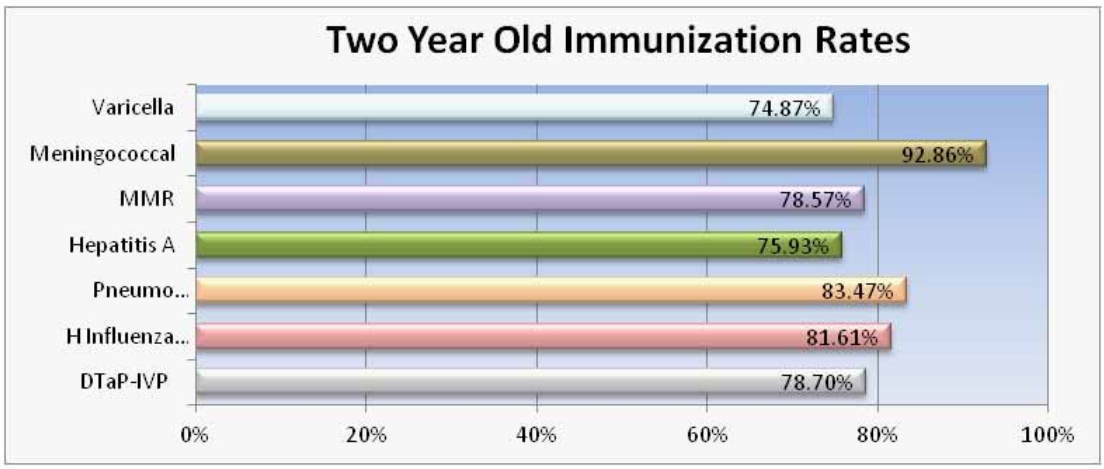
will be moved to Panorama. Other communities in the partnership are able to join SIMS until December 31, 2013. After this the province will not support as they are focussing resources on Panorama deployment.

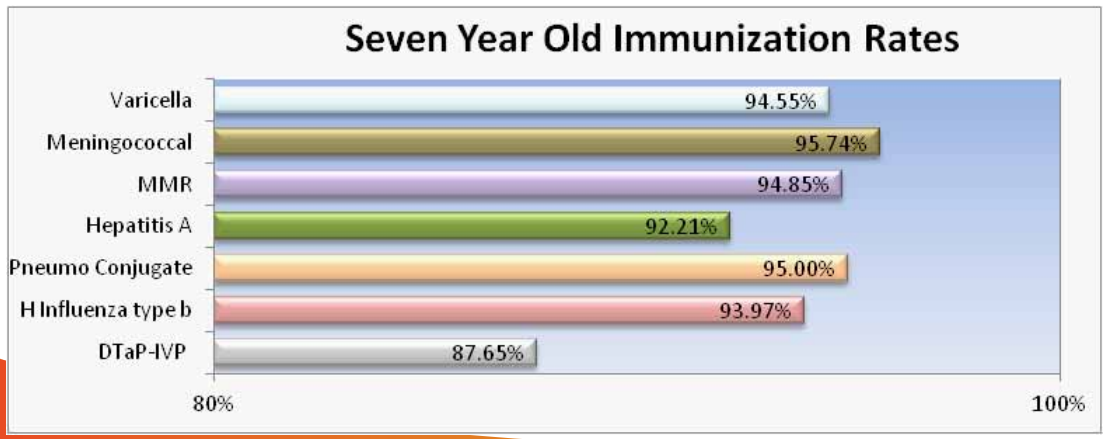
The preschool program is for Infants at two months of age with Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae B (DTaP-IPV-Hib) and Pneumococcal (13 serotypes). The DTaP-IPV-Hib is provided in 1 needle at 2, 4, 6, and 18 months. The Prevnar is given at 2, 4, and 12 months of age. The rates of immunization for this age ranged from 44% to 100% in some communities. Once a child reaches one year of age they receive 4 injections, Prevnar, Measles, Mumps, German Measles (Rubella), and Varicella (Chicken Pox) (MMRV), Meningococcal, and Hepatitis A. 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 MMRV and Hepatitis A. They do not receive a Prevnar at this age.

Immunization rates for 2 year olds in individual communities ranged from 22% to 100%. The range for immunization rates in the 7 year olds was 40-100%. The national goal for immunization rates is 95-97 percent.

In 2012, 77% of infants received immunization during their 2nd month of life. This is the same as last year. Unfortunately, by 7 months, less than half of children (42%) had received the required 3 doses. This was down by 5% from the previous year.







Human Papillomavirus (HPV) was launched in September 2008 for grade 6 girls, a 3 doses series. There were 262 students eligible with 258 (98%) receiving their first dose and 189 (72%) received a third dose.

Grade 6 students also receive meningococcal, of which 90% of eligible students received, varicella (chicken pox), 269 students were eligible and 199 (74%) received it, and hepatitis B vaccine, 2 dose series, with 398 (73%) receiving the 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 412 eligible students with 310 (75%) receiving the Tdap immunization. There is an MMR catch-up program for grade 8 and grade 12 and this group saw 87% and 71% respectively immunized.

For most adult immunizations statistics are not collected.

In the 2012/13 influenza season vaccine was again 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.

Statistics were collected on those under the age of 5 and those over and under the age of 65. The numbers this year were down by 42% for those under the age of 65 for a total of 2760 doses and down 16% for those over 65 for a total of 439 doses provided. There were also 551 doses of vaccine given to those under the age of 5. The lower numbers may have been influenced by the temporary suspension of influenza clinics while further investigation into the product occurred. As a result of the investigation the vaccine was found to be safe and effective but this may have impacted the public's perception of the safety of the vaccine.

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

Immunization is considered a special nursing procedure. NITHA provides the education and theory while the Partners provide the experience needed to perform the procedures. This year 56 inoculist exams were received and processed. 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. New nurses participate in education program to prepare for working in nursing stations and all of these nurses receive an inservice on immunization.

NITHA continues to work towards minimizing costs related to cold chain breaks (periods of time in which the vaccine is not stored between 2 and 8 degrees Celsius). Each year NITHA coordinates the servicing of all biological refrigerators, purchases new refrigerators as well as repairs of existing equipment. This year we have began to replace fridges with a fridge that can maintain appropriate temperature for 5 days. Additional coolers, warm mark, cold mark monitors and thermometers have been purchased. There were a total of 1380 wasted doses reported to NITHA and an additional 2844 doses lost due to cold chain. 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.

COMMUNICABLE DISEASE CONTROL NURSE (CDC)

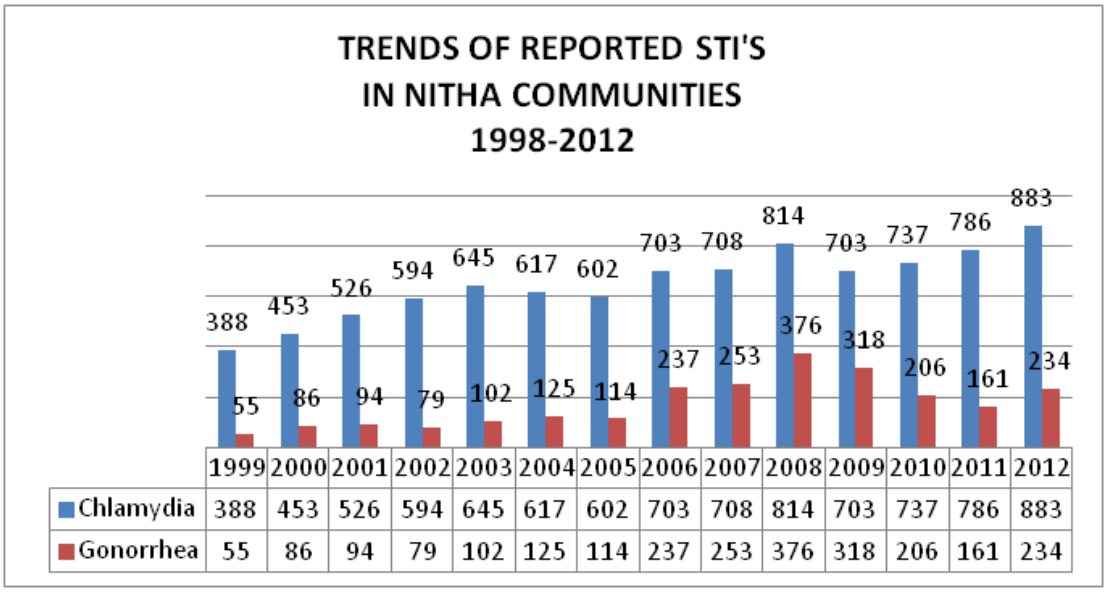
Program Overview

This position was created with the re-vamping of the Public Health Unit and filled in April 2012. The first order of business was to develop the annual work plan and the 5 year operational plan. The position responds to requests and inquiries from the partnership by and offering interventions when concerns are identified and provides support by the timely reporting of Communicable Diseases in the Partnership. As well provides direct support to frontline health workers.

Communicable Disease Control Nurse
James Piad

Achievements

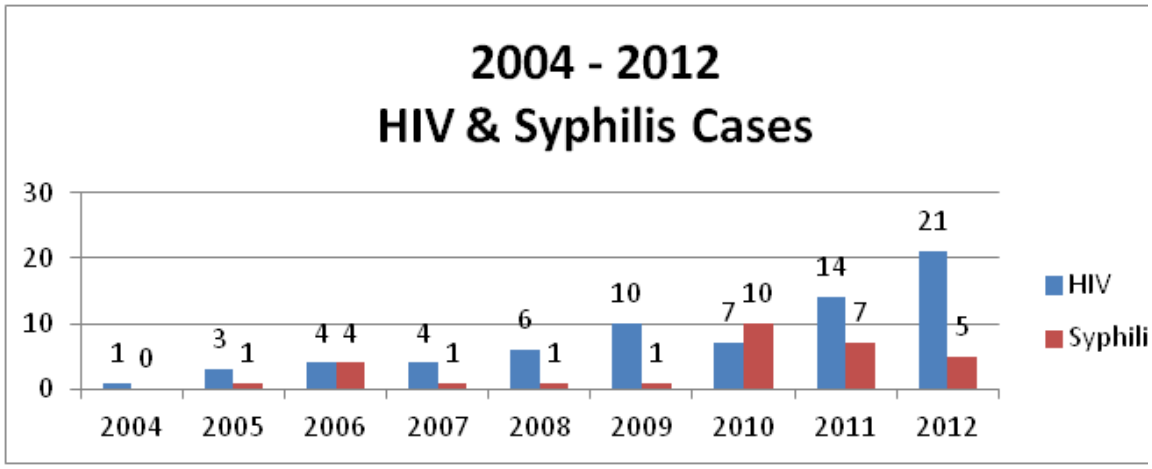
This year the number of STD (sexually transmitted disease) reported has increased by 12.3% for chlamydia and 45.43% for gonorrhea. In 2009, there was a decrease of 13.1% for chlamydia and 15.42% for gonorrhea but in 2010 and 2011 slight increases were noted for each year. This year, saw the highest increase in the number of STD reported since 2007. A parallel increase may be observed in other STD's since the risky behavioral factors are the same for all.



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Chlamydia	388	453	526	594	645	617	602	703	708	814	703	737	786	883
Gonorrhea	55	86	94	79	102	125	114	237	253	376	318	206	161	234

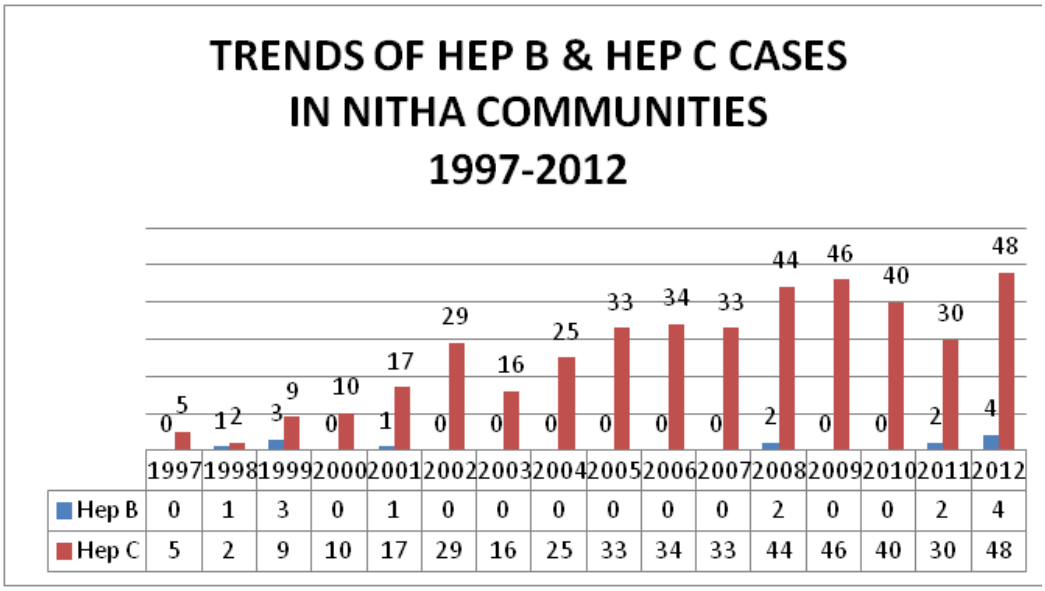
Aggregate rates for NITHA Communities are still above the provincial and national levels and reasons are still poorly understood.

Syphilis has fluctuated over the last 8 years, with the highest number of cases in 2010 of 10. We had a total of 5 cases again this year, this disease is highly preventable and treatable yet has the potential for fatal complications.



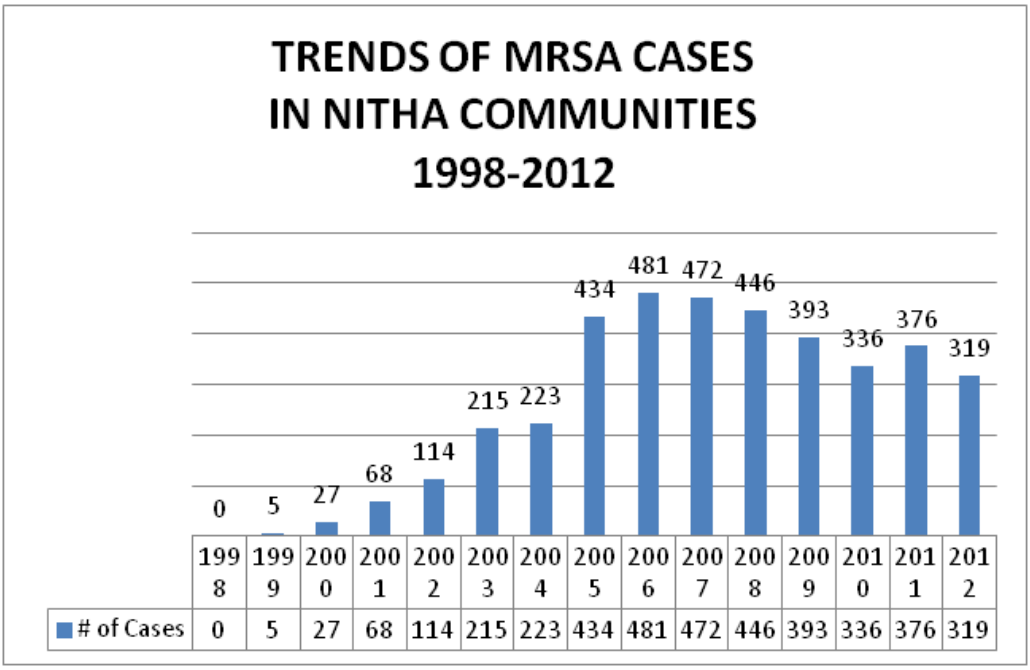
This year saw the highest number of reported HIV cases in NITHA. In 2011, there were 14 registered as against the present of 21. Since 2004 to 2012, NITHA has a total number of 70 reported cases not including those residing in other health regions. Only one case was reported to have developed AIDS. Currently, Saskatchewan STD Strategy is being developed by STD Working Group for the province. This will be an excellent resource material which could be used by NITHA and the partners for future STD program plans.

This year Hepatitis C increased by 84.62% in comparison to the number reported last year. Compared to the 5 year average, the increase is 29.73%. Intravenous drug users who are either current or past users comprise most of the Hep C cases and comes commonly as a co-infection with HIV.



There was 4 cases of Hepatitis B throughout the partnership in 2012, although this is a low number it is a 50% increase from 2011 and 100% increase from 2010, see above graph.

Methicillin Resistant Staphylococcus Aureus (MRSA) numbers reported started to decline in 2007, against the 5-year average, the decrease is 21%. In 2011 we had 376 cases and 319 cases in 2012, therefore a decrease of 15%.



Cases of other communicable diseases have occurred sporadically in NITHA communities and the numbers for this year have not gone above the usual occurrence every year. Influenza (flu), a vaccine preventable infection had 18 reported cases. Pertussis, another vaccine preventable infection had one reported case which was a baby below one year old. Invasive types infection, reported for Group A Streptococcal Disease was four and Pneumococcal Disease, seven.

ENVIRONMENTAL HEALTH ADVISOR

Program Overview

Environmental Health Advisor
Brenda Ziegler

The Environmental Public Health Program (EPHP) in the NITHA Partnership works to identify and prevent environmental public health risks that could impact the health of community residents. This program is delivered by Environmental Health Officers (EHO's) working for Meadow Lake Tribal Council, and Prince Albert Grand Council.

The Environmental Health Advisor (EHA) position is a member of NITHA's Public Health Unit, and works under the supervision of the Medical Health Officer.

The major role/responsibility is to provide internal and external support to the Environmental Health Officers in the development and delivery of Environmental Public Health Programs (EPHP) within their communities, and act as consultant to the NITHA Medical Health Officer and NITHA Executive Council on environmental health issues.

Achievements

The EHA participates in a number of meetings, both internal and external. 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. Participation in these meetings also provides the opportunity to network with Federal, Provincial, Municipal and non-government agencies. 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 has also provided coverage within the partnership when EHO's are away, or in emergency situations.

The EHA 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.

The EHA continues to participate on the Saskatchewan Biomonitoring Study Steering Committee overlooking the on-going project to gather baseline data on the prevalence of contaminants in the population residing in areas of future oil-sands development in Northern Saskatchewan. At this point in the project sample collection is wrapping up from Northern Saskatchewan and being prepared for analysis, which will continue into the Spring/Summer of 2013.

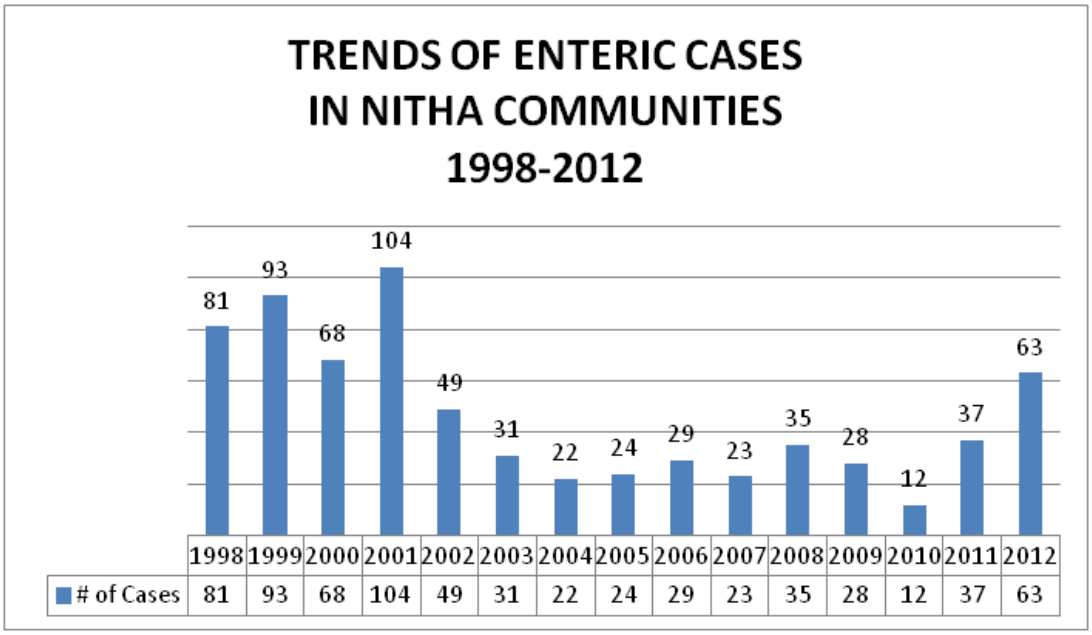
In the past NITHA, and our partner EHO's had participated in an Annual Joint Water Meeting. This annual meeting had provided a forum for sharing information on drinking water and sewage disposal systems, discussing issues and solutions, with the common goal of providing safe drinking water and safe disposal of waste. Some of the systems within the NITHA partnership are shared with neighbouring communities. This annual joint meeting was cancelled for this year. The Ministry of Environment was experiencing some staffing and program changes, due to the formation of the Water Security Agency.

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

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

NITHA continues to provide education, support and assistance on timely reporting and follow up of enteric diseases to community health nurses. The NITHA Epidemiologist and the Environmental Health Advisor participate on the provincial working group tasked with updating the Provincial Communicable Disease Control Manual. Work is progressing on updating the NITHA Enteric Disease Notification Forms and information handouts to reflect the updates and changes to the Provincial Communicable Disease Control Manual.

Enteric diseases continue to be the least notifiable communicable disease reported in NITHA communities. Sixty-three confirmed enteric cases were reported for 2012.

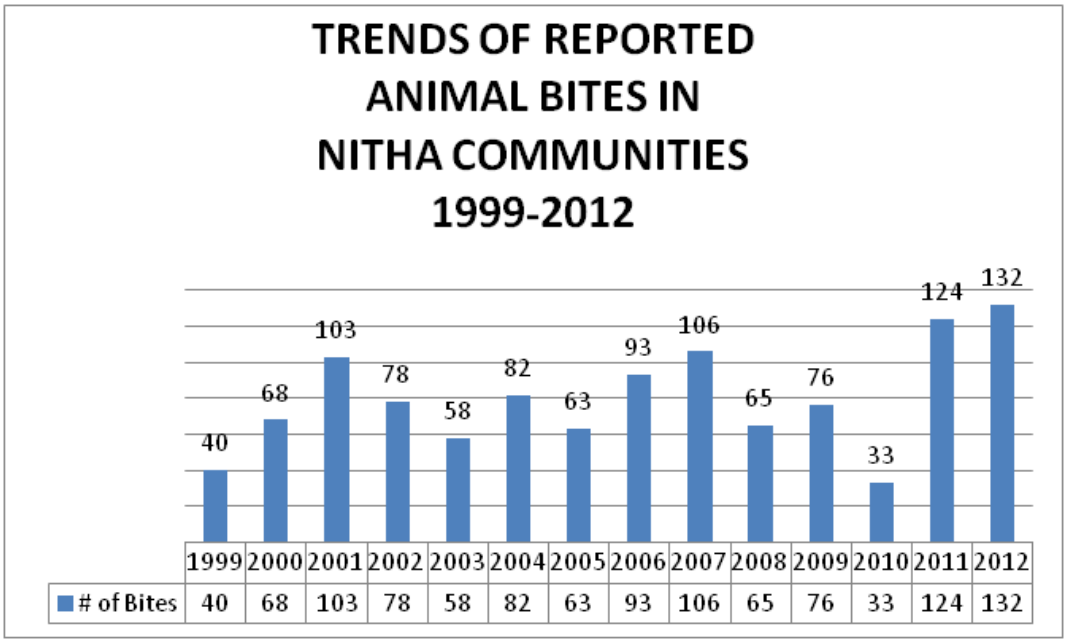


*Communicable disease statistics are collected for calendar year

Three of our partner communities experienced an outbreak of Shigellosis; two of which were outbreaks that had begun at the end of last year's reporting period and carried over to the first months of this years' reporting period. Of the reported enterics, 62% were *Shigella sonnei*.

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

The NITHA partnership received a total of 132 reports of bite incidents during the 2012 year, which required follow-up. Dogs were involved in 128 of the reported bite incidents and in 7.9% of these incidents the bite was to the facial area. Children under 10 years of age were involved in 24% of the bites. Three patients required Rabies Post-Exposure Prophylaxis.



HEALTH PROMOTION ADVISOR

Program Overview

Health Promotion Advisor
Linda Gilmour Kessler

The goal of the Health Promotion Advisor (HPA) is to provide comprehensive support to the NITHA partners in the area of Health Promotion. This includes working with the NITHA partners and other partners to develop health promotion strategies, Mentor and collaborate to identify and plan capacity building opportunities to build the health promotion skills required to deliver health promotion programs, Provide support, guidance, and advice regarding health promotion, develop partnerships at the local, provincial and federal levels to ensure evidence based health promotion practice and to effectively deliver health promotion programs.

One of the NITHA Strategic Objectives is to develop a Children and Youth Health Strategy. The Health Promotion Advisor is taking the lead on this and working with the Public Health Unit, NITHA staff, the Public Health Working Group and other stakeholders. NITHA is in the process of developing a plan to work with our NITHA partners to fully develop and implement this strategy.

The HPA co-chairs the **Northern Early Years Coalition (NEYC)**, which focuses on the four key areas of action: Awareness, Advocacy, Capacity Development and Growing and Expanding the Coalition. A Northern series of early childhood brain development workshops were held in the spring of 2013. A Northern Children's Charter was developed and will be released in November 2013 for National Child Day. The NEYC is also working on a Northern Early Childhood background paper which will be used to inform the development of a child and family provincial/federal strategy.

The HPA **is a member of the Saskatchewan Population Health Council's (SPHC) – Child Health Clinic" Resource task group**. The purpose of this task group is to review and develop handouts to be using in the Child Health Clinics. Standardizing resources is important for the implementation of Panorama (Family Health module).

The HPA and NITHA partners are involved in the Northern Healthy Community Partnership (NHCP) and teams which include **Healthy Eating, Active Living, Books Babies and Bonding, Positive Child/Youth Development (40 Developmental Assets), Northern Tobacco Strategy and Promotions and Promotions/Media**.

The HPA is a member of the NHCP core group which provides the overall coordination of the NHCP and health promotion initiatives in northern communities. Work is underway to strengthen the NHCP partnership with NITHA and the partners. The HPA has the opportunity to become a co-facilitator of the NHCP which will mean that NITHA and the partners will have a strong and equal voice.

Child & Youth Health and Well-Being

The HPA has assisted several NITHA partner's communities to implement 40 Developmental Asset survey. As well the HPA sits on the Provincial Youth Surveillance Survey steering committee.

The HPA also attends the **Saskatchewan Alliance for Youth and Community Well-being (SAYCW) steering committee**. One of the key activities of the SAYCW is to develop a provincial youth surveillance survey for use in Saskatchewan schools. The SAYCW has recently received $700,000 to work on this project in the next year.

In conjunction with other staff we developed the **NITHA 2013 Youth Calendar** which profiled youth role models from the NITHA communities.

The Northern Tobacco Strategy (NTS) is co-chaired by the HPA and has representation from the NITHA partner's. Several northern resources have been developed and planning is underway for training frontline health and education workers to use these resources. A North-wide "Let's Talk Tobacco" campaign was launched on Weedless Wednesday (Jan. 23rd). NITHA schools received a campaign package and were encouraged to participate. A Capacity Development Event (Traditional Tobacco) held Feb. 13th for members of the NTS. This event had Cree, Dene and Metis elders share the use of traditional tobacco. As well we are active in the Saskatchewan Tobacco Reduction Coalition and attends quarterly meetings. A provincial "Best Practices for Tobacco Reduction" report was developed and released on Weedless Wednesday, Jan. 23rd.

The HPA is a member of the **NHCP Promotions and Media task group**. Activities include monthly radio spots, monthly health promotion posters and the development of the NHCP website (soon to be launched). The NITHA HPA and MH/Addictions Advisor participate in several meetings of a provincial **Positive Mental Health Campaign committee**. This campaign will dovetail into NHCP radio spots via the NHCP promotions and media team.

Several capacity development initiatives have included developing Health Promotion core competencies. The Health Promotion Advisor has also worked with several of the NITHA partners to develop the health promotion component of their work plans and assisted in the development of health promotion related proposals. Ongoing support and guidance is provided to NITHA partners.

The HPA is a member of the **Provincial Population Health Promotion Practitioners Council – Health Promotion Foundations Subcommittee.** This subcommittee is developing Health Promotion Framework documents.

The HPA is a member of the Provincial Food Costing Task Group. Work included researching First Nation stats on Food Security and interpretation of the FN data. The HPA had the lead role in writing the First Nation section of the Food Costing Report.

As well, the HPA has participated in the **CDA Aboriginal Diabetes Gathering** planning committee to be held May 15th in Prince Albert and attended the **Public Health Nutrition Research Day** providing input and advocating for First Nations nutrition research priorities which included food security, infant and child nutrition and chronic diseases and attended the **FNIHB Chronic Disease Prevention and Management** consultations and provided input from a prevention and nutrition/chronic disease management perspective.

Challenges

The Health Promotion Adviser has encountered several challenges in the past year:

- Several of the NITHA partner health promotion and other key positions were vacant. This limited the ability of the NITHA HPWG to meet and plan collaborative health promotion initiatives. It has also limited the ability for the NITHA partners to have representation on other health promotion committees/task groups.

- Continued resistance from the Saskatchewan Population Health Council to having the NITHA HPA involved in the Healthy Communities task group and related strategies. The NITHA CEO and Nurse Epidemiologist have worked on behalf of the HPA Advisor to attempt to resolve this issue.

Priorities

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

Future activities will include:

- Continuing to target health promotion strategies at children and youth who will be the leaders of the future. Many of the current health promotion initiatives focus on "Healthy Children, Healthy Families and Healthy Communities".

- Continuing to aligning health promotion initiatives with Saskatchewan Population Health Council, Healthy Communities task group, while considering the unique needs of the NITHA partner First Nations communities.

- Explore interest with the NITHA partners and other key stakeholders in developing a Northern injury prevention strategy.

- Building health promotion capacity of the NITHA second level partners and other NITHA staff to plan, implement and evaluate health promotion initiatives.

- Working with and providing guidance and support to NITHA second level partners and NITHA staff for health promotion initiatives.

INFECTION CONTROL ADVISOR

Program Overview

Infection Control Advisor
Ivan Serunkuma

The Infection Control Advisor (ICA) position was filled in June 2012 during the re-vamping of the Public Health Unit to work in the area of development of policies and practices that minimize the risk of spreading infections in health care settings. Several activities have been accomplished through objectives and goals formulated after careful identification of priority areas which are summarized in the figure below.

Achievements

The Infection Control working group was set up, they meet every 2- 3 months and are working on infection prevention and control policies and procedures. The policies and procedures developed during the year include; Safe handling of sharps, respiratory hygiene and cough etiquette, how to deal with spills (blood and body substances), reprocessing of patient care equipment, biomedical waste management.

Infection Prevention and Control priority areas

Several education sessions have been provided mainly via video conference with the following topics covered: Adherence to proper hand hygiene practices, introduction to cleaning, disinfection and sterilization, enteric food borne infections and several others.

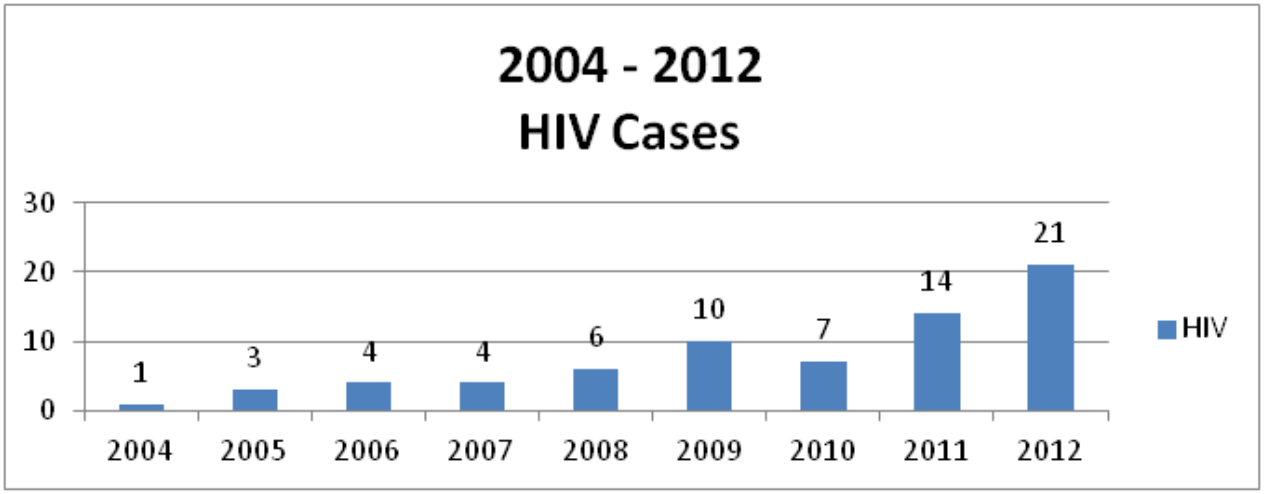
The advisor also assists with the evaluation of products and procedures used while performing various infection control practices like environmental cleaning, hand hygiene, equipment disinfection and sterilization.

Other roles of the advisor during the past year have been advice concerning Health Care facility design, providing infection control advice during construction, participating in development of guidelines in the health region and province whose policies will subsequently have an impact on the health of our clients as they access services in the health facilities. The ICA works closely with the Public Health Working group to advise on infection control issues identified by the Partners.

The IPC Advisor and the Communicable Diseases (CD) Control nurse co- lead the HIV program with valuable input from the Nurse Epidemiologist. The HIV program aims to develop a coordinated and progressive response to the increasing HIV rates in NITHA communities.

The Saskatchewan Provincial rate for positive HIV test reports for persons above 15yrs for 2011 was 19.6 per 100,000 population. This was more than double the national average (7.6) in the same year. (Public Health Agency of Canada [PHAC], AT a Glance – *HIV and AIDS in Canada: Surveillance Report to December 31st, 2011*). According to the Northern Saskatchewan Health Indicator Report 2011, the northern HIV incidence rate was almost equal to the provincial rate. First nation communities have a disproportionate number of reported HIV cases in the province.

As shown in the graph below, there was a steady increase in the absolute number of HIV in the NITHA communities between 2004 and 2012.



The epidemiology of HIV in Saskatchewan is different from the rest of Canada in that new cases are mainly associated with injection drug use. It should however be noted that the number of cases resulting from un protected sexual contact is also on the rise. Almost half of the positive HIV cases in 2011 had concurrent Hepatitis C and all had a past Sexually Transmitted Infection (STI).

Working with the NITHA partnership to advance HIV/AIDS related initiatives, the HIV program focuses on:

- Developing and sustaining an HIV strategy that benefits and meets the needs of the partnership.
- Supporting NITHA Partners in the development of capacity in HIV/AIDS case management, early detection, and management of comorbidities and opportunistic infections.
- Develop strategies aimed at preventing the acquisition of HIV/AIDS, facilitate early detection of the disease and reduce the impact of an already established disease including HIV stigma.
- Analysis and interpretation of HIV/AIDS data for use in planning, implementation and evaluation of best practice.

The Saskatchewan HIV strategy can be utilized as a resource by the collaboration between NITHA and partner organizations to achieve a reduction in the rates of HIV acquisition and improve the quality of Life of persons living with HIV.

Challenges

Simultaneous priorities like housing and infrastructure, child welfare, other medical conditions like diabetes and hypertension plus many other priorities when added to HIV can be overwhelming. This challenge can be overcome by demonstrating how improvements in social determinants of health can reduce the vulnerability of First Nation communities to HIV.

Stigma has a strong negative impact on HIV positive clients. It may lead to different degrees of involvement by individuals and various communities in the HIV/AIDS related initiatives. Educational and awareness campaigns can be used to reduce stigma.

Fatigue: HIV has been a major public health issue for over 25 years globally. With the step up in the awareness campaign, the result may be immunity to public health messages and lack of fear of becoming infected due to the hope given by treatment.

TB ADVISOR

Program Overview

TB Advisor
Sheila Hourigan

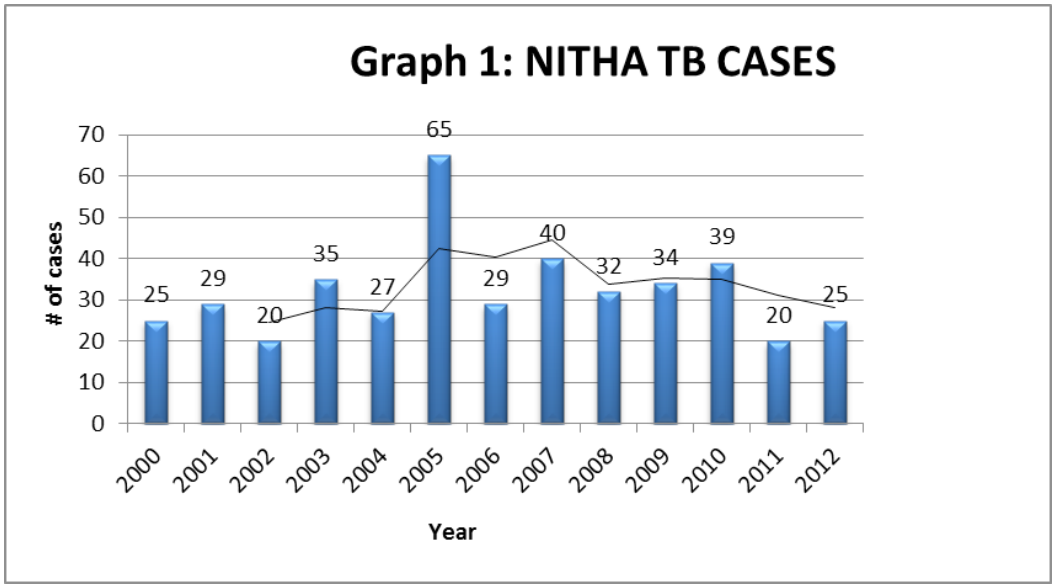
The *Saskatchewan Provincial TB Strategy, 2013-2018,* was developed in consultation with all TB stakeholders including NITHA over the course of 2012/2013 and will be officially announced June 2013. The major highlight of the provincial strategy as it relates to NITHA is the sub *Strategy for Tuberculosis Management in High Incidence Communities*. Two or three NITHA Communities will be piloting this strategy which principles are to first ensure we are meeting the current TB control program recommendations well and then to enhance the program through various strategies depending on the specific needs and issues of that community.

The NITHA TB program has continued its emphasis on contact tracing, support of preschool screening and outbreak management this year. The workload remains heavy with a total of 38 community visits by the NITHA TB nurses and another 7 by contracted nurses. More than 1000 hours were spent working in the communities. The additional resources were required to support the outbreak management in one community and the enhanced preschool screening program in high incidence communities. These needs were supported by NITHA.

Achievements

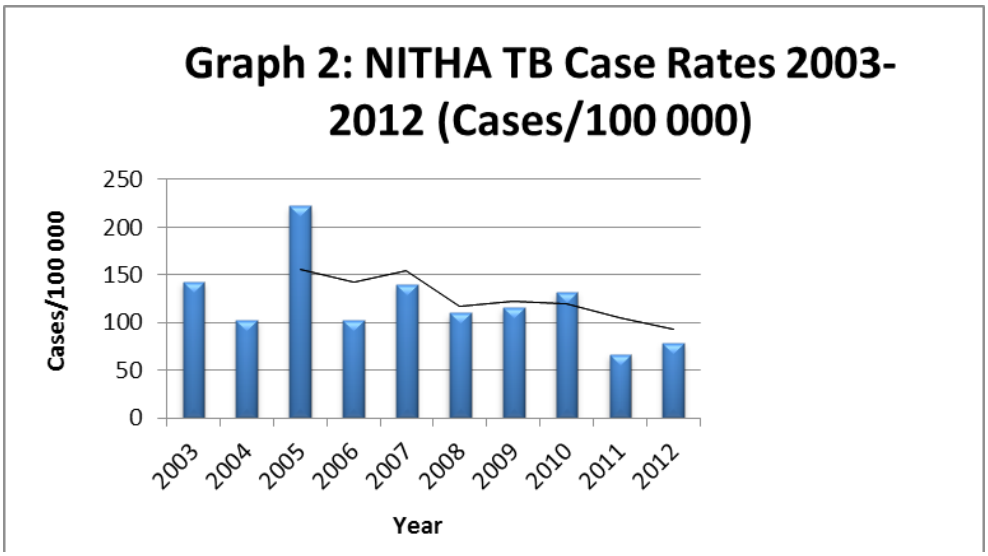
In 2012 there were 25 cases of active Tuberculosis in NITHA communities. This is a 25% increase from last year's 20 cases. 10 of these cases were in a community that was experiencing an outbreak that was identified at the end of last year. Our highest incidence communities had quiet years with only one or two cases each.

TB Nurse
Eileen Oliveri



TB Nurse
Janine Arnold

Case rates are shown in Graph 2 below.



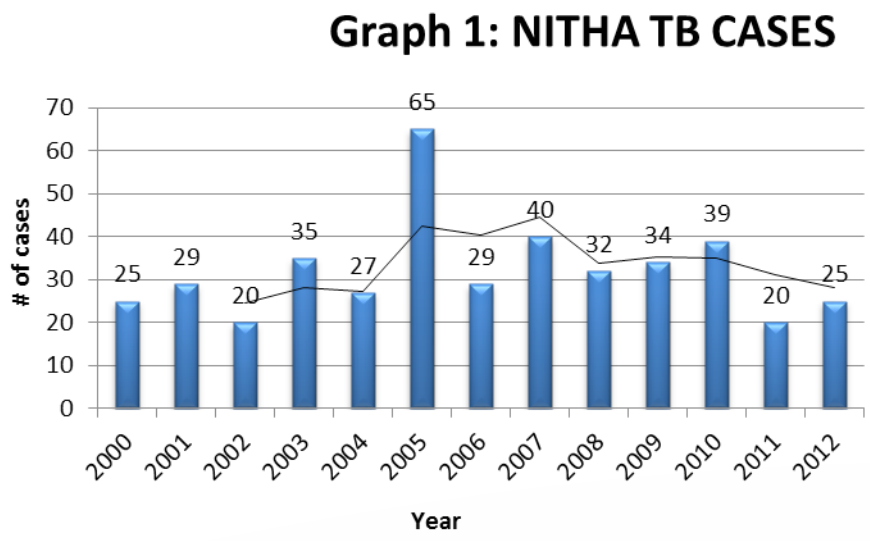
*Based on CWIS population figures

The age distribution of 2012 Active Tuberculosis cases is highlighted in Table 1 below.

Table 1-Age Breakdown of 2012 Active Cases of Tuberculosis

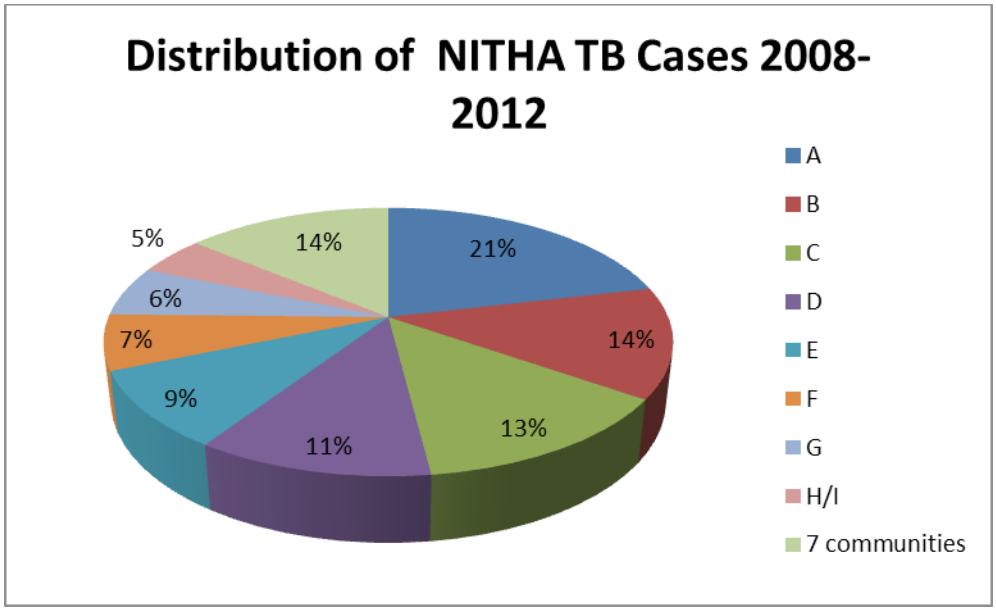
Age	
0-4 yrs	3
5-14 yrs	0
15-24 yrs	4
25-34 yrs	5
35-64 yrs	12
65+ yrs	1
Total	**25**

The number of cases in the 15-24 year old age group, which has had the highest numbers for the past 6 years, had lower numbers again this year. The age group contributing the greatest number of cases again this year was the middle age group, age 35-64. This age group also dominated the outbreak community's cases. Cases in this age group frequently had significant risk factors for progression to disease including recent exposure, alcohol and drug abuse and smoking.



Graph 4 below shows that since between 2008 and 2012, 86% of all TB Cases were contained in 9 communities with 1 community contributing more than 20% of all NITHA TB cases. Focusing additional resources in these communities has the potential to reduce the burden of disease significantly.

Graph 4:



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	7	11	3	0
Child 0-14	0	4	0	0

There were 7 smear positive cases, able to transmit the disease to others, in 2012 which is 28 % of all cases. Early detection is a key to reducing the incidence of infectious disease and NITHA has implemented a number of strategies to increase early detection, especially in regards to educating nurses. However, it is clear that more efforts are needed in this area, most notably in terms of enhancing community awareness. This has been identified as important activity for the additional resources that may be focused on the high incidence communities.

Education and Support

Community Health Nursing

The NITHA TB nurses oriented 18 nurses at the community level to the TB program this year. 22 nurses attending the Orientation and Skills Training program participated in a presentation on early detection and treatment of TB.

Telephone consultation continues to be an important means of supporting nurses as they struggle with the day to day challenges presented by the TB program and their clients. The NITHA nurses took the lead role in conducting all the screening in the preschool age group in the 13 communities reaching the threshold for enhanced screening (3 year average annual rate of smear positive TB > 15/ 100 000). The age groups for this screening were reduced from 2 groups to one this year. However, this year most children had not had prior vaccination with BCG and so were eligible to be screened making the total number of children eligible for testing similar to last year. The community health nurses were asked to conduct the school entry TST screening on all eligible (no prior BCG vaccination, nor previous positive TST) children in all NITHA communities.

While the NITHA TB nurses continue to take the lead role in contact tracing the community health nurses are frequently called upon to begin compiling the list of contacts when a smear positive case is diagnosed and also to ensure that any children under age 5 are skin tested immediately if the NITHA nurse cannot be in the community within a week of the diagnosis of the index case. Any contacts that the NITHA TB nurses are unable to test or to conduct a symptom inquiry on are also followed by the CHN. Thus community health nurse has an integral role in managing contact tracing and their support is invaluable. The NITHA TB nurses visited communities to assist with contact tracing on 17 occasions this year, similar to the number of visits last year.

TB Program Workers:

23 TB program workers were newly trained or received an update to their training this year suggesting ongoing instability in this workforce.

Training TB workers, which focuses on the Direct Observed Therapy program is the most important way NITHA supports TB workers in the communities. There was a provincial TB worker workshop held in September with 21 workers from NITHA communities participating.

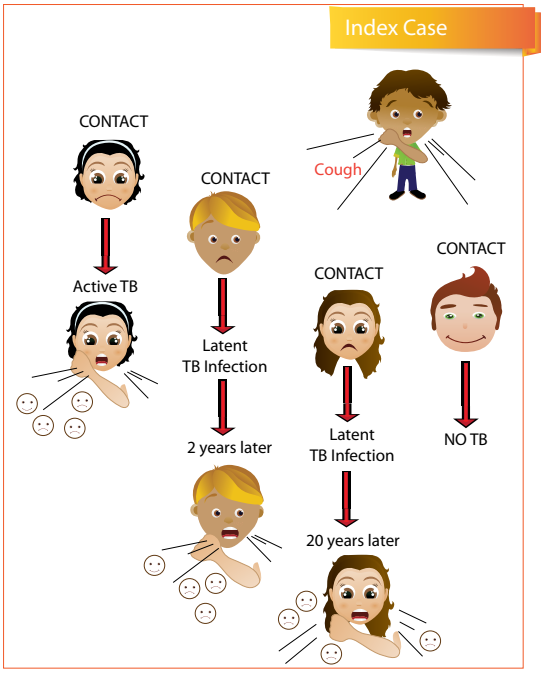
Case management issues were supported on a 19 occasions for a total of 40 hours while NITHA Nurse visited the communities. In all case management issues we work closely with TB control as they manage client care from the clinical perspective.

There have been some changes with the FNIHB payment system for TB workers this year resulting in some significant delays in the workers being paid. The workers have been very patient while FNIHB works to rectify these issues. NITHA is frequently called upon to assist the workers in addressing these delays.

Contact Tracing:

Supporting contact tracing has become the primary emphasis of the NITHA TB program as it is the most valuable means of interrupting the cycle of transmission (Figure 1), detecting cases early and by preventing active disease.

Figure 1- Tuberculosis Cycle of Transmission



There were 11 contact traces (for cases that were diagnosed both on and off reserve) required in NITHA partner communities in 2012, 10 infectious traces looking for spread and 1 primary trace looking for a source. Between April 1, 2012 and March 31st 2013, NITHA Nurses made 22 community visits to conduct contact tracing. The NITHA TB nurses did more than 300 Tuberculin skin tests (TST) and 500 symptom inquires and 100 sputum collections during these visits. There were 30 new positive skin tests and 50 referrals to TB Control. The majority of contact follow-up occurs through a community based approach where people are visited in their homes. It is estimated that more than 1000 home visits were conducted by the NITHA TB nurses in the course of contact tracing. This includes activities such as skin testing and reading, symptom inquiries, sputum collection, appointment notifications and client education.

This year the TB program developed a contact investigation worksheet which has the added dimension of assessment of risk factors. The assessment by the TB nurses of contact's risk factors was not done previously. While this has added considerably to the workload of contact tracing there is considerable benefit to this approach.

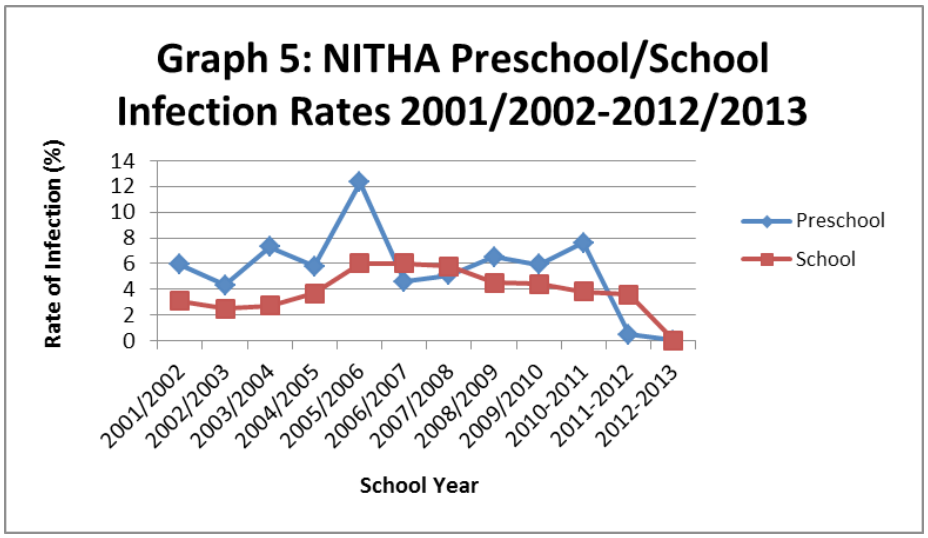
The NITHA TB nurses with the support of the CHN's in the communities have been successful in meeting the contact tracing timeline targets that have been identified by the NITHA TB program and which are supported by the provincial TB program and the National TB standards. Specifically all contact lists were compiled within one week of the diagnosis of the index cases, children under 5 years of age skin were tested and referred to TB

control within 1 week and more than 80 % of the remaining contacts were tested within 2 weeks. We are currently working with our other provincial stakeholders to achieve other contact tracing targets such as assessment and institution of treatment or preventive therapy within 30 days.

Childhood Screening Program:

The enhanced childhood screening program for all communities with a 3 year average annual incidence of smear positive TB greater than 15/100 000 was changed again this year to only 2 year olds from 1 and 2 year olds. The NITHA nurses took the lead role in conducting this screening to ensure timely completion and good coverage. The nurses visited the 13 communities meeting these criteria on 22 occasions to prepare for and/or conduct screening. 111 of 131 eligible children were screened in this age group. None had a positive skin test for an infection rate of 0%. (See Graph 5 below) The coverage rate of the number of children tested on time, out of the number eligible was 85%. Those children that were caught up at a later time are not included in this coverage rate.

For the most part the CHN's were asked to be responsible for the testing of children at school entry. This year only children at school entry who had not had BCG vaccination were tested. Eighteen on reserve schools in partner communities conducted tuberculin skin testing of students at school entry (age 4 or kindergarten depending on the community's preference). 147 students were tested in all none had a significant skin test, for a rate of infection of 0%. Previous rates, when children who had BCG vaccination were also included in the screening, averaged around 5%.



Surveillance:

Collecting and analyzing TB data to identify disease and infection trends as well as monitoring program activities are important to ongoing tuberculosis program planning and evaluation. Data analysis this year was focused on the outbreak community as well as significant trends in some of the high incidence communities.

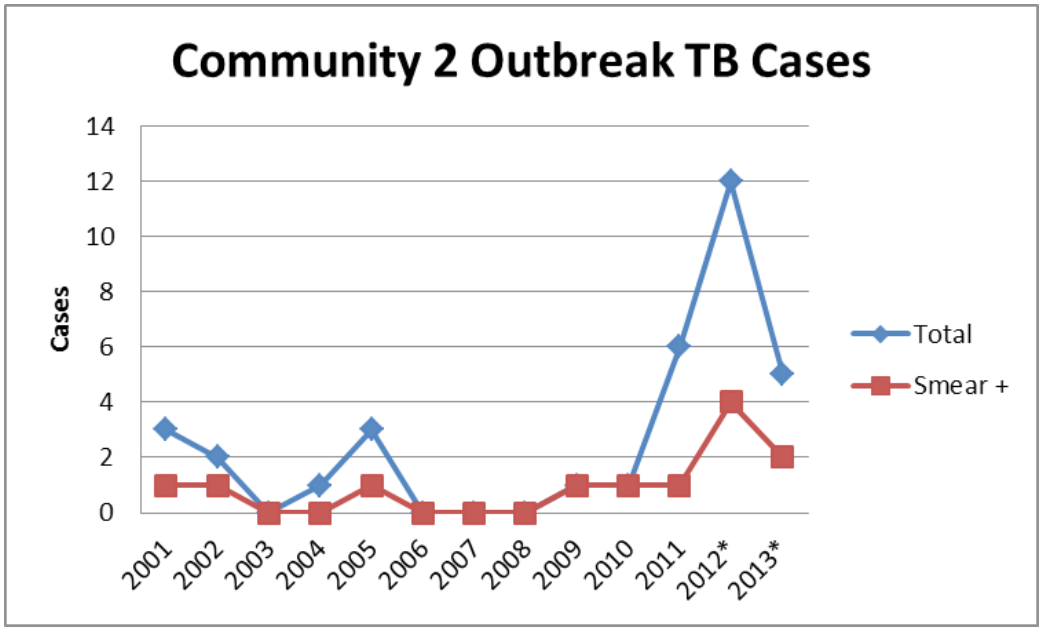
Outbreak/ High Incidence Community Management

Community 1

This community who experienced an outbreak of TB associated with HIV in 2011 has had no further cases in 2012.

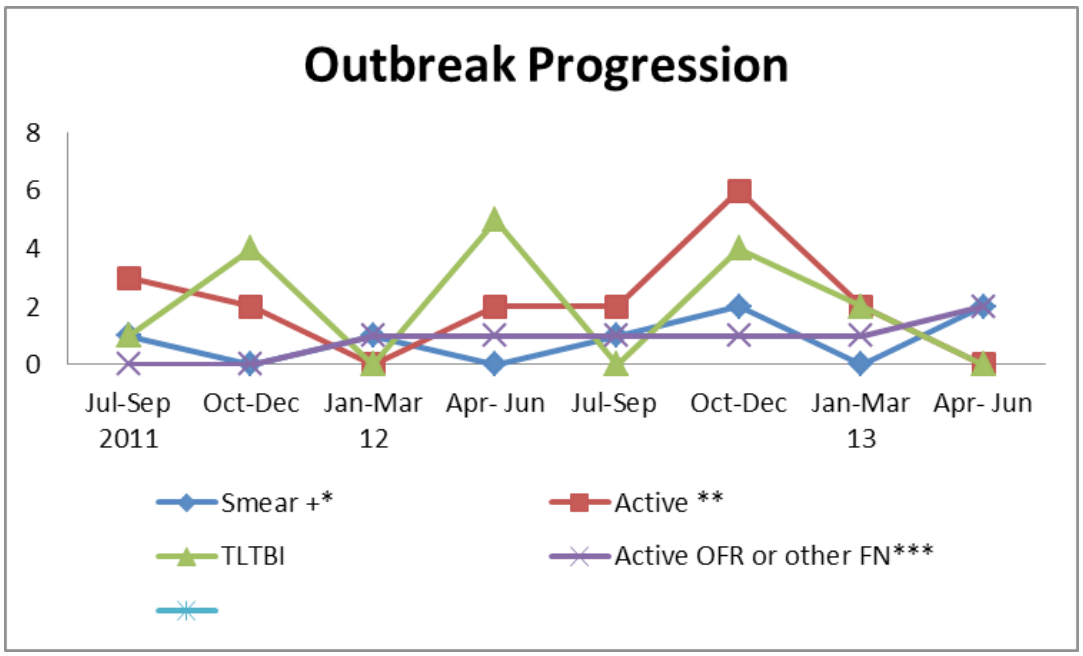
Community 2

This community, who had 6 cases reported in 2011 went forward with an outbreak management plan in April 2012 to support the ongoing efforts required to control the TB transmission that was occurring. In 2012, the community had 10 cases on reserve and there were 2 additional cases, both smear positive, who were diagnosed off reserve, but who lived on the community prior to their diagnosis and transmitted the disease to a number of contacts in the community. In 2013 there have been 2 new cases in the community and 3 cases in other First Nation communities epidemiologically linked to this outbreak. There have been no new cases in the community since February of 2013 at the time of writing this report (June 2013).

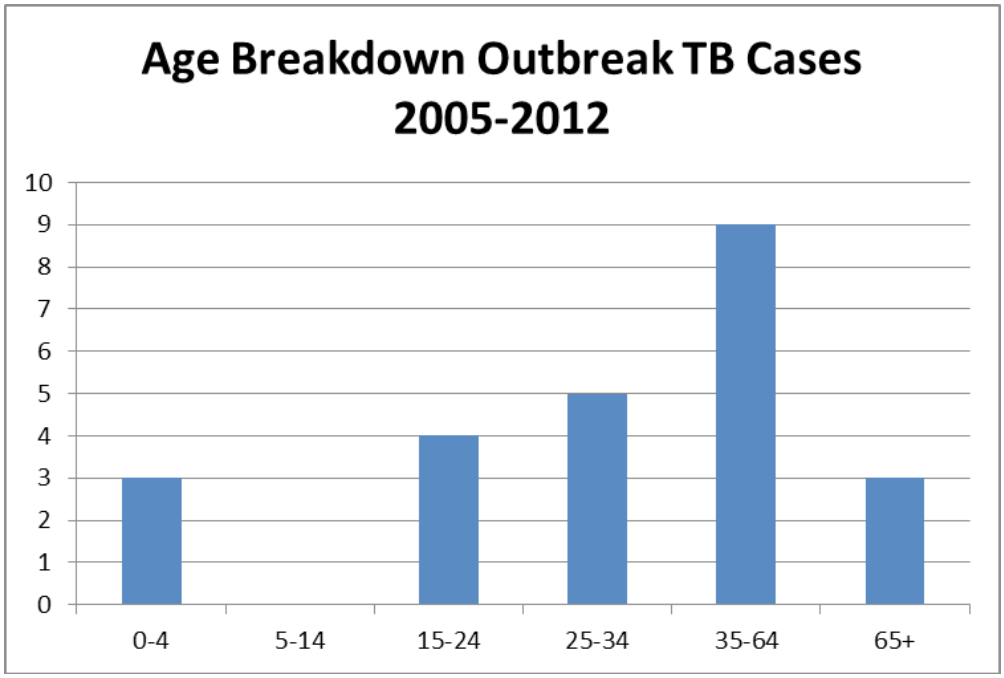


2012* includes 2 off reserve smear + cases, but not smear - cases
2013* includes epidemiologically linked case in other FN

The graph below shows the progression of the outbreak beginning in June 2011. In total there have been 24 cases associated with this outbreak, which involve multiple FN communities as well as some off reserve communities.



* includes 4 off reserve smear + cases
** smear + on reserve included in the total
***OFR- off Reserve- may be other cases that we are not aware of. 4/6 OFR have been smear +



The graph above shows the age breakdown of the cases in the primary community from 2005-2012. It is evident that nearly all age group are affected with Middle age adults being the most prominent.

Outbreak Activities:

Contact Tracing

The priority activity during any outbreak is contact tracing. There were 5 smear + cases who required contract tracing in the period April 2012 until March 31, 2013. More than 180 contacts were identified, 10 of these contacts had active TB and another 31 were newly diagnosed with Latent TB infection (LTBI). 16 of those with LTBI were started on preventative treatment. More than 300 home visits were made in the course of contact tracing. All contacts were assessed for risk factors for the progression to TB disease. In addition, TB Control identified a number of individuals who were at increased risk because of multiple exposures to TB. The majority of these were not recent contacts. 28 individuals were located and interviewed. There were a number of challenges to the contact tracing such as the index cases not being available for interview to identify contacts and contacts not attending follow up appointment with TB Control. The NITHA TB nurses visited this community on 10 occasions (more than 40 days) during this period.

Community Awareness

A number of activities designed to raise community awareness about tuberculosis and its signs and symptoms were implemented during the course of the outbreak. All clients' presenting to the health centre for any reason were given information by the community nurses about TB and the problem in the community and interviewed regarding symptoms using a one page tool developed for this purpose. There was a poster campaign initiated in the health centre and in the general community. There were a number of radio announcements made, as well as information provided in 2 community newsletters. A door to door campaign was initiated early on in the outbreak to ensure all community members knew the situation. Changing in staffing meant that this couldn't continue so a CD about TB was developed and left at people's homes being visited in course of contact or was available for anyone to take home form the health centre. A fridge magnet about the signs and symptoms of TB was placed in everyone's mailbox. Finally, displays about Tuberculosis were set up at Treaty days as well as other community events. All of these activities had a significant impact on raising community awareness. Many people presented to the community health staff asking for more information and to be tested. Two active cases were identified in this manner.

Health Care Provider Awareness

There were a number of initiatives implemented to assist the health staff in the follow-up of individuals at risk or with suspected disease. These included a TB investigation protocol that was posted in the pharmacy and each exam room, an ALERT form placed in client charts who required contact follow- up or who should be watched on an ongoing basis for symptoms of TB. A sputum tracking form was developed to assist nurses in remembering which clients they had asked to bring sputum samples and whether they had complied. The NITHA TB nurse maintained close liaison with the community health nurses and nurse in charge throughout the outbreak. These individuals in turn kept the leadership informed about the outbreak.

Monitoring of the Outbreak

A multi stakeholder outbreak management working group included participants from NITHA, the Community, TB control and FNIB. Meetings were conducted by teleconference on a monthly and then bimonthly basis to review the situation and decide on strategy moving forward.

Administrative Unit

Program Overview

The Administration unit is responsible for the on-going daily operations of the organization as a whole. Personnel include an Executive Director, Finance Manager, eHealth Advisor, Informatics Technologist, Privacy Officer, Executive Assistant, Human Resource Advisor, Finance Manager, and a Receptionist. Besides the need to have effective internal communication and coordination mechanisms, NITHA functions in a multi-jurisdictional environment that makes communication and coordination with different stakeholders an extremely important part of our activities. These stakeholders include among others the NITHA Partners, Regional Health Authorities, FNIHB and Saskatchewan Health.

Receptionist/Office Assistant
Tricia Morin

HUMAN RESOURCE ADVISOR

Human Resource Manager
Tolu Babalola

During the fiscal year 2012/13, NITHA's Human Resources Advisor has been able to ensure that the Human Resources activities compliment the goals and objectives of NITHA. These activities were carried out via the following functions – Collaborative support between NITHA and the Partnerships, Human Resources Strategic Planning, Recruitment and Selection, Human Resources Training and Development, Compensation, Employee Benefits, Employee Relations, Employment Legislation Compliance Responsibilities, Performance Management, Human Resources Policies and Procedures, Occupational Health and Safety and Employee Wellness. We have worked together with our Partners in achieving success and supporting their needs.

Achievements

Collaborative Support between NITHA and the Partnerships – HR at NITHA has supported the partnerships in the following areas:

- Providing advisory services and information on HR issues including job descriptions, HR policies and procedures, interview questions for positions and compensation issues.
- Providing information on Occupational Health and Safety for implementation at Partnership level.
- Supporting representatives from the partnerships to jointly participate with NITHA staff in relevant training activities.

The Partnerships continues to support NITHA in having their representatives actively participate in our resume screening meetings and recruitment interviews.

HR Strategic Planning and Recruitment – During the last fiscal year, the HR initiatives complemented the recruitment and retention strategic objectives of NITHA. HR was able to roll out different recruitment strategies for hard to fill positions.

The following key positions were filled during the fiscal year:

POSITION FILLED	DATE FILLED
Communicable Disease Control Nurse	April 2012
Infection Control Advisor	April 2012
Tuberculosis Nurse	July 2012
Privacy Officer	August 2012
Mental Health and Addictions Advisor	September 2012
Nursing Program Advisor	October 2012

Professional Development - At NITHA we engage in a continuous stream of necessary actions to maintain or enhance people's skills and competency. We have constantly ensured that employee skills are updated through our employee professional development program. Our training activities during the year has included the following:

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

We spent a considerable amount of time this year revising the existing Personnel Manual which has not been revised since 2002, this will have to be approved by the NEC and the Board of Chiefs before it is implemented. This will hopefully occur in early next fiscal year.

During the fiscal year, the Occupational Health and Safety (OH&S) Committee agreed to the adoption of the Occupational Health and Safety Intervention Model for the Occupational Health and Safety Program at NITHA. Basically, this is a collaborative approach to health & safety in our workplace where the Occupational Health and Safety Committee members at NITHA work with the Health & Safety Officer (Federal Representative) to improve the OH&S program, which builds up our internal system to better identify, prevent and resolve issues and hazards, with less intervention from the regulatory authorities. NITHA has taken the lead in establishing the Occupational Health and Safety Program. It is our desire to support the Partnerships with establishing similar programs.

CBRT - During the fiscal year, NITHA developed the Community-Based Reporting Template (CBRT) to support the work of Contribution Agreement recipients (including NITHA) in meeting the reporting requirements of their Agreements. HR participated in this program by providing data input for Health Workers on primary activity area of the health workers, certification type, and licensing and training information as indicated. This data base is being developed for the use of health workers at NITHA and the partnerships.

Challenges

The health industry continues to be plagued with the shortages in Certified Health Care providers, NITHA and the Partnerships are no exception. The demand for skills needed in the health industry is yet to be met by supply creating a competition between provinces and organizations for these professionals.

NITHA, the Partnerships and other health organizations continue to experience insufficient Physician services in both the northwest and the northeast districts of North Saskatchewan. This is putting more pressure on community nursing services and will likely lead to demand for Nurse Practitioners in the North.

Graduates who stay and complete the training and remain to work within Northern Saskatchewan.

The other issues that need to be tackled to bring about the success of NITHA and the Partnerships in eliminating the challenges of recruitment and retention are as follows:

1. Document and Implement HR strategies that reduce turnover of staff.
2. Provide funding for HR initiatives that will create and manage the changes required.

Retaining our employees is crucial to our success at NITHA. Finding quality people is difficult and replacement is costly. Turnover rate remained at 13% as at March 2013 which was the same as at end of 2011/12 fiscal year.

Priorities For Next Year and the Future

- Development and implementation of Human Resources Working Group in collaboration with the Partners.
- To utilize collective effort in identifying shared strategic HR goals and objectives between NITHA and the Partnerships.
- Capture, document and implement successful recruitment and retention strategies for NITHA and the Partnerships
- Maintain up to date HR policies and procedures and ensure that the policies and procedures are in compliance with legislation.
- Continue to identify training needs for staff and enhance service delivery to the partnerships.

eHEALTH PLANNING & DESIGN

Program Overview

eHealth Advisor
Charles Bighead

eHealth Advisor works to engage stakeholders and coordinates efforts to develop operations in support of common goals for eHealth initiatives and IT services, with particular emphasis on integration with provincial eHealth networks. Examples of eHealth solutions are:

- Panorama which is an electronic public health surveillance system
- Telehealth for visual communications over a distance. Useful for administrative, education and clinical application
- Microsoft Office for word processing, spreadsheets, and managing emails
- Internet access for research, social networking, and online collaboration

One of the more interesting eHealth solutions is an Electronic Medical Record (EMR) system. An EMR is a comprehensive health information system designed to improve client care and clinical processes. Secondary uses of the information in the EMR would help support evidence based decision making. An EMR is costly and complex to implement though and requires a long term plan with proper supports and resources.

The NITHA eHealth Working Group consists of representatives from the NITHA Partners. The purpose of the group is to act in an advisory capacity and to make recommendations to the NITHA Executive Council with regards to eHealth issues.

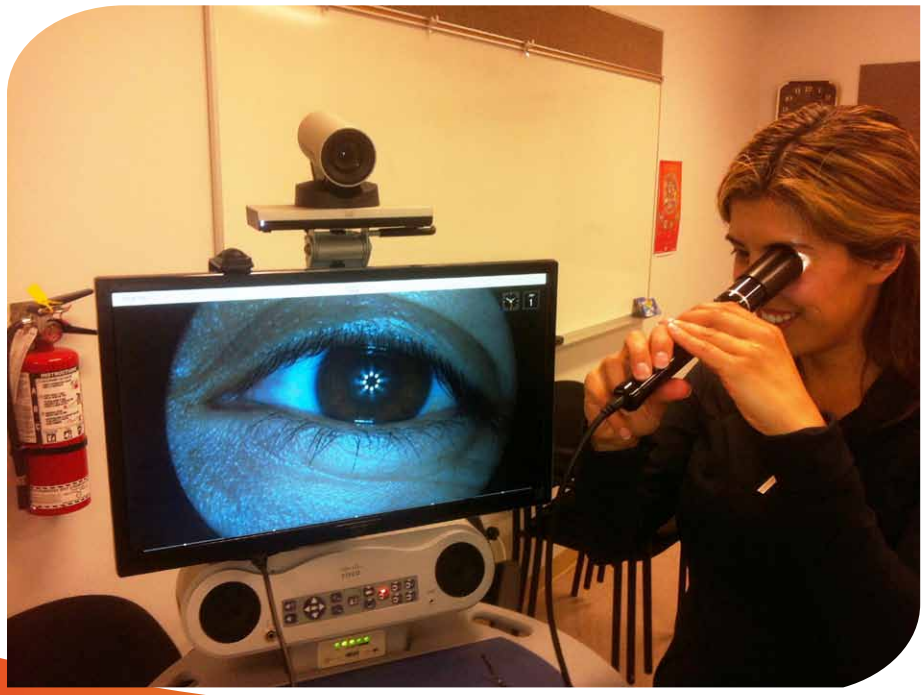
Achievements

NITHA was successful in the submission of two proposals to FNIHB one for eHealth solutions and on for Panorama. This funding provided the opportunity to complete the activities below as NITHA has no funding in the Transfer agreement for eHealth solutions. NITHA also provided the partners with $75,000.00 each to support IT services at the 2nd level, we are working towards obtaining this funding on a full time basis from FNIHB.

This year NITHA developed a web-based tool to assist communities with their CBRT reporting obligations. The tool was designed to make the data collection that is necessary to produce the year end CBRT report as easy and convenient as possible.

Much effort was put into ensuring the system is works properly, is secured and is user friendly. The NITHA Partners and FNIH were involved in the testing and quality assurance phase of the project. The tool is particularly useful for the more onerous data collection requirements such as those in Clinical and Client Care section of the CBRT.

The tool was based on the CBRT version 2011-2012. FNIH has indicated there will be no changes to this version of the CBRT for at least two more fiscal years (2013-2014 and 2014-2015) therefore no modifications will be needed to the eCBRT tool for a while.



The administrative uses of Telehealth continue to be beneficial because it reduces travel costs and provides an option for individuals who would otherwise not be available in-person. NITHA and the Partners routinely use the technology for meetings and staff recruitment to name a few examples. Northern First Nations have connected with province sites and with sites outside the province and the country.

This year's goal was to begin adding First Nations Telehealth sites to the Saskatchewan Telehealth Network (STN) in order to attain "official" Saskatchewan Telehealth site status. Official site status is necessary for remote access to provincial services such as clinical consults with medical specialists and to partake in the numerous educational opportunities.

In order to become an official Telehealth site, First Nations must have compatible and up-to-date telehealth equipment, and must have high speed *CommunityNet* network connections. Presently only a few First Nations Telehealth sites meet all these requirements. As high speed Fiber based network services become available in 2013, effort will be put into upgrading all First Nations Telehealth CommunityNet connections and getting all First Nations telehealth locations official site status.

NITHA has been supporting MLTC with development of their "tele-medicine" program. This entails community capacity development, dedicated telehealth personnel, integration with the province and remote access to physicians and medical specialists.

The NITHA eHealth Advisor continues to be a First Nations representative on the Panorama *Information Governance Working Group (IGWG)* and the Panorama *Information Technology Working Group (ITWG)*. These are working groups taking direction from and reporting to the tripartite *First Nations Deployment of Panorama in Saskatchewan (FNDPS) Steering Committee*.

Panorama is a shared public health information system that will be hosted by the Province. A few important principles developed by the IGWG with regards to health information are:

- The primary purposes of Panorama are to support the care of individuals and to support public health surveillance.
- The collection, use or disclosure of information must have a clear purpose and be restricted to that purpose. Secondary purposes of the information such as program evaluation or research will require the agreement of the community.
- Communities intending to use Panorama should have in place organizational policies and procedures that support good privacy practices.
- Information will be housed centrally in Regina and mechanisms to control and prevent the unauthorized use of information will be put in place.

With regards to IT support requirements for Panorama, NITHA is advocating a First Nations managed (and funded) Support Service model. This entails capacity throughout the NITHA Partnership.

There is still opportunity for First Nations to utilize the Saskatchewan Immunization Management Systems (SIMS). Although the long term plan is for Panorama to replace SIMS, it will be sometime before the immunization management component of Panorama is available for use. Note that any data entered into SIMS will be transferred to Panorama so that data re-entry will not be necessary.

The Northern Medical Services (NMS) have begun using the Electronic Medical Record (EMR) system by *MedAccess* to manage client health information and clinical processes. The NMS met with NITHA to promote use of the EMR on-reserve but the Leadership want the "data trusteeship" issues addressed. The intent is to ensure First Nations data is not used inappropriately and that there are proper controls with respect to who owns the data and who are permitted to access it. Addressing and resolving this information governance issue is a priority for 2013-14.

NITHA's Health Transfer Agreement is up for renewal and for the first time NITHA is proposing to include eHealth. Under this arrangement the most notable advantage will be the ability to support long term planning and sustainability for eHealth initiatives such as an EMR implementation in the North.

During the summer the NITHA eHealth Working Group drafted a long term eHealth plan and identified the following goals:

- Protect First Nations health information in a shared health information environment
- Provide specific IT services such as management of the telecommunications service (i.e. CommunityNet)
- Form meaningful partnerships with the Federal and Provincial governments to support First Nations eHealth initiatives
- Access and utilize Provincial eHealth services (ex. Saskatchewan Telehealth Network, SIMS/Panorama, EMR, EHR, etc.)
- Develop custom database solutions in the absence of "off-the-shelf" solutions

The eHealth plan is preliminary and has been reviewed by the NITHA Executive Council and FNIH.

NITHA continues to provide advanced IT support to the NITHA Partners when requested. Help is usually limited to resolving complex IT problems or supporting complex IT installations.

NITHA implemented a new local server design this year and applied the latest technologies such as Windows Server 2012 and virtualization. These technologies will improve the remote access experience for mobile staff and will help ensure the server is reliable and robust. One of the other purposes of applying the latest technologies was to demonstrate best practices to the Partners and to share lessons learned.

Senior Network Technologist
Eric Xue

FSIN and the Federal and Provincial governments continue to address regional eHealth issues through the *MOU: First Nations Health & Wellbeing and its Health Information Working Group*. The main accomplishment this year was to conduct an environmental assessment of First Nations health information holdings including the electronic systems that hold that data.

There have been preliminary discussions to consolidate various eHealth committees and working groups (ex. FSIN eHealth Working Group, NITHA eHealth MOU, and FNIH eRAG) into a single First Nations regional advisory group.

In November, KCDC sponsored the first annual First Nations *Informatics, Connectivity and Technology (ICT)* conference and in February Battleford Tribal Council sponsored a 2-day regional eHealth workshop. At both events NITHA made presentations on Privacy and on First Nations managed eHealth services.

Priorities

The priorities for the New Year are to;

1. Support communities who are interested in using the eCBRT tool
2. Continuing adding First Nations telehealth sites to the Saskatchewan Telehealth Network
3. Facilitate Healthcare workers interested in participating in educational events via telehealth
4. Address the Information Governance issues around a shared EMR
5. Continue readying First Nations for Panorama
6. Influence an effective inter-governance process for advancing First Nations eHealth systems

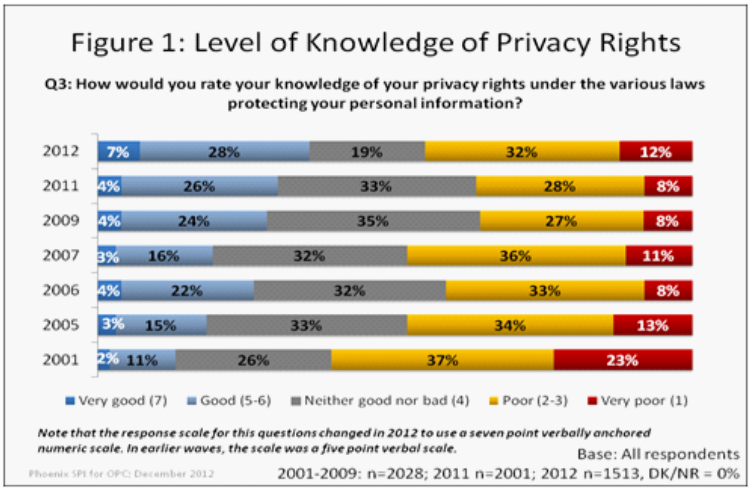
PRIVACY OFFICER

Program Overview

Privacy Officer
Robert Hunt

In August of 2012 the Privacy Officer position was filled on a one-year term based on a proposal submitted to FNIHB. The goal of this position is to oversee the development, implementation, maintenance and adherence to NITHA's privacy and access to information policies and procedures as required by applicable laws, professional ethics and agreements. The privacy officer works with the NITHA staff and Privacy working group to develop and implement privacy policies and procedures based on the Canadian Standards Association (CSA) Ten Privacy Principles.

Regardless of where clients receive health services all health care providers have a legal and ethical obligation to respect the privacy rights of clients and to protect their information from inappropriate use or disclosure. One way that this can be done is by informing clients of their "Privacy Rights". As reflected in a recent privacy survey commissioned by the Office of the Privacy Commissioner of Canada[1]. In 2012, only 35% of respondents rated their knowledge of their legal privacy rights as good to very good. In the same survey 66% of respondents expressed a significant level of concern over their personal privacy.



[1]http://www.priv.gc.ca/information/por-rop/2013/por_2013_01_e.asp

Achievements

In September of 2012 a preliminary privacy assessment was commenced using the CSA Ten Privacy Principles to determine NITHA's capacity to protect client information and client privacy rights. In summary the main activities were as follows.

- Determine the legal, ethical and contractual requirements to protect client privacy.
- Review of documented and leadership approved privacy policies and procedures.
- Determine privacy gaps by documenting issues that require further attention.
- Conduct a privacy survey to determine NITHA's awareness of privacy principals.
- Develop or attain relevant privacy tools to address the privacy work to be done.

[1]http://www.priv.gc.ca/information/por-rop/2013/por_2013_01_e.asp

Challenges

Though there has been some success in interacting within the NITHA Partnership it is an area that will require further efforts. A key limiting factor in this area is that although FNIHB has an expectation that privacy requirements will be meet, they historically have not provide specific funding or training resources to the NITHA Partnership.

Another key challenge is in regards to dispelling "privacy myths". As an example, it is not uncommon for health care professionals to assume that the ethics training they received 20 years ago meets the privacy requirements of regulated health care professionals today.

Priorities

The three main privacy activities planned for next year are a result of the privacy assessment and the eHealth needs of the NITHA Partnership. As mentioned privacy policies and procedures need to be documented and then approval by leadership as ultimately it is leadership that is responsible for protecting client information and client privacy rights. To achieve this it is imperative that a NITHA Partnership Privacy Working Group be established with representation from all Partners. Once policies have been developed by the group and ratified by leadership; privacy awareness and training can begin in earnest. The final activity planned is the continued collaborative work with the eHealth advisor to identify and implement appropriate client privacy controls for proposed eHealth initiatives.

FINANCE MANAGER

Program Overview

Finance Manager
Lisa Lepine

In the 2012/2013 fiscal year, NITHA entered the 3rd year of the 3 year extension of the transfer agreement and which expired in March 31st, 2013. Health Canada granted an extension for the existing agreement until March 31, 2014.

The majority of NITHA's funding comes from its transfer agreement with Health Canada. The amount was $2,609,929 for this fiscal year. The Transfer Agreement funds are used to support the Public Health Unit (PHU), the Community Services Unit (CSU) and NITHA Administration.

Transfer Funding	$2,520,916
Environmental Health	199,772
TOTAL TRANSFER FUNDING	$2,630,688

Personnel & Finance Assistant
Glenna Thomas

SET Agreement funding is provided by Health Canada and is targeted towards specific programs and service needs of the Partner communities. These targeted programs are portrayed below.

TB Initiative	396,550
Home Care	169,557
Nursing Innovation Investments	12,815
Targeted Immunization Strategy	70,000
NAYSPS	53,500
Nursing Education	15,000
Aboriginal Human Resource	418,906
E-Health Solutions	294,707
Panorama	169,025
TOTAL 2012-2013 SET FUNDING	$1,600,060

Achievements

Each year an operational budget is developed and submitted to the NITHA Executive Council for recommendation to the Board of Chiefs for approval. The detailed budgeted financial statements are presented and reviewed by the NEC, on a quarterly basis and submitted to the Board of Chiefs for approval. As well the program leads are provided information on a regular basis to monitor budgets.

Every year NITHA's interest revenue is allocated to a Scholarship Fund. In this current fiscal year NITHA distributed $17,250 to twelve scholarship recipients who are pursuing a health career. The next call for scholarship submission is September 2013, information on how to apply can be accessed through the website.

The Board of Chiefs selected Deloitte LLP, this selection is done every three years and will be up for renewal in 2014. They provide a independent audit of the financial statements and have stated a fair presentation in all material respects.

NITHA also this year underwent a Ministerial Audit performed by FNIHB auditors, there was four recommendations that have been reviewed and implemented within the organization.

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.

FINANCIAL STATEMENTS

MARCH 31, 2013

Deloitte.

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

Tel: (306) 763-7411
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INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of Northern Inter-Tribal Health Authority Inc., which comprise the statements of financial position as at March 31, 2013, March 31, 2012 and April 1, 2011 and the statements of revenue, expenses and changes in fund balances and cash flows for the years ended March 31, 2013 and March 31, 2012, and a summary of significant accounting policies and other explanatory information.

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

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits 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 in our audits 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, 2013, March 31, 2012 and April 1, 2011, and the results of its operations and its cash flows for the years ended March 31, 2013 and March 31, 2012 in accordance with Canadian public sector accounting standards for government not-for-profit organizations.

Deloitte LLP

Chartered Accountants

August 20, 2013
Prince Albert, Saskatchewan

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENTS OF REVENUE, EXPENSES AND CHANGES IN FUND BALANCES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	Operating Fund (Schedule 1)	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2013**	Total 2012 (Note 2)
REVENUE							
Contributions, transfers and projects							
Health Canada - transfer agreements	$ 2,603,929	$ 2,630,688	$ -	$ -	$ -	$ **2,630,688**	$ 2,640,175
Health Canada - contribution agreements	2,190,351	1,600,060	-	-	-	**1,600,060**	2,135,289
Administration fees (Note 9)	134,054	56,418	-	-	-	**56,418**	84,600
Expense recoveries	1,000	99,325	-	-	-	**99,325**	22,661
Gain on sale of capital assets	-	-	-	-	10,261	**10,261**	-
Interest	-	-	-	62,109	-	**62,109**	55,393
Transfer from deferred revenue	30,500	420,631	-	-	-	**420,631**	-
Transfer to deferred revenue	-	(336,929)	-	-	-	**(336,929)**	(444,869)
	4,959,834	4,470,193	-	62,109	10,261	**4,542,563**	4,493,249
EXPENSES							
Health Canada programs	5,374,305	4,123,948	-	17,250	-	**4,141,198**	3,857,490
Expenses funded by appropriated surplus	-	-	683,676	-	-	**683,676**	415,249
Amortization of capital assets	-	-	-	-	257,723	**257,723**	335,012
	5,374,305	4,123,948	683,676	17,250	257,723	**5,082,597**	4,607,751
NET (DEFICIT) SURPLUS	$ (414,471)	346,245	(683,676)	44,859	(247,462)	**(540,034)**	(114,502)
FUND BALANCES, BEGINNING OF YEAR		200,305	4,041,040	399,367	492,416	**5,133,128**	5,247,630
TRANSFER TO SURPLUS APPROPRIATED FOR SCHOLARSHIPS		-	-	-	-	**-**	(42,393)
TRANSFER TO CAPITAL FUND		(188,678)	-	-	-	**(188,678)**	(53,888)
TRANSFER FROM OPERATING FUND		-	744,062	-	188,678	**932,740**	1,814,648
TRANSFER TO APPROPRIATED SURPLUS		(744,062)	-	-	-	**(744,062)**	(1,718,367)
FUND BALANCES, END OF YEAR		$ (386,190)	$ 4,101,426	$ 444,226	$ 433,632	$ **4,593,094**	$ 5,133,128

See accompanying notes

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENTS OF FINANCIAL POSITION
as at March 31, 2013 and 2012 and April 1, 2011

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**March 31, 2013**	March 31, 2012 (Note 2)	April 1, 2011 (Note 2)
CURRENT ASSETS							
Cash and cash equivalent	$ 433,571	$ 4,101,426	$ 444,226	$ -	$ **4,979,223**	$ 6,031,069	$ 5,282,940
Accounts receivable	85,311	-	-	-	**85,311**	15,671	385,929
Prepaid expenses	12,095	-	-	-	**12,095**	5,783	5,130
	530,977	4,101,426	444,226	-	**5,076,629**	6,052,523	5,673,999
CAPITAL ASSETS (Note 5)	-	-	-	433,632	**433,632**	492,416	773,540
	$ 530,977	$ 4,101,426	$ 444,226	$ 433,632	$ **5,510,261**	$ 6,544,939	$ 6,447,539
CURRENT LIABILITIES							
Accounts payable and accrued charges	$ 570,238	$ -	$ -	$ -	$ **570,238**	$ 956,942	$ 1,189,909
Deferred revenue (Note 6)	346,929	-	-	-	**346,929**	454,869	10,000
	917,167	-	-	-	**917,167**	1,411,811	1,199,909
FUND BALANCES							
Unappropriated (deficit) surplus	(386,190)	-	-	-	**(386,190)**	200,305	1,379,194
Appropriated surplus (Note 7)	-	4,101,426	-	-	**4,101,426**	4,041,040	2,737,922
Surplus appropriated for scholarships (Note 8)	-	-	444,226	-	**444,226**	399,367	356,974
Equity in capital assets	-	-	-	433,632	**433,632**	492,416	773,540
	(386,190)	4,101,426	444,226	433,632	**4,593,094**	5,133,128	5,247,630
	$ 530,977	$ 4,101,426	$ 444,226	$ 433,632	$ **5,510,261**	$ 6,544,939	$ 6,447,539

See accompanying notes

SIGNED ON BEHALF OF THE BOARD:

Chair

Board Member

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENTS OF CASH FLOWS
years ended March 31, 2013 and 2012

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2013**	Total 2012 (Note 2)
CASH FLOWS FROM (USED IN) OPERATING ACTIVITIES						
Net (deficit) surplus	$ 346,245	$ (683,676)	$ 44,859	$ (247,462)	**$ (540,034)**	$ (101,088)
Adjust items not affecting cash						
Gain on sale of capital assets	-	-	-	(10,261)	**(10,261)**	-
Amortization of capital assets	-	-	-	257,723	**257,723**	335,012
	346,245	(683,676)	44,859	-	**(292,572)**	233,924
Changes in non-cash working capital						
Accounts receivable	(69,640)	-	-	-	**(69,640)**	370,258
Prepaid expenses	(6,312)	-	-	-	**(6,312)**	(653)
Accounts payable and accrued charges	(386,704)	-	-	-	**(386,704)**	(246,381)
Deferred revenue	(107,940)	-	-	-	**(107,940)**	444,869
	(224,351)	(683,676)	44,859	-	**(863,168)**	802,017
CASH FLOWS FROM (USED IN) CAPITAL ACTIVITIES						
Purchase of capital assets	-	-	-	(198,939)	**(198,939)**	(53,888)
Proceeds from disposal of capital assets	-	-	-	10,261	**10,261**	-
	-	-	-	(188,678)	**(188,678)**	(53,888)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(224,351)	(683,676)	44,859	(188,678)	**(1,051,846)**	748,129
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	1,590,662	4,041,040	399,367	-	**6,031,069**	5,282,940
TRANSFER TO SURPLUS APPROPRIATED FOR SCHOLARSHIPS	-	-	-	-	-	(42,393)
TRANSFER TO CAPITAL FUND	(188,678)	-	-	-	**(188,678)**	(53,888)
TRANSFER FROM OPERATING FUND	-	744,062	-	188,678	**932,740**	1,814,648
TRANSFER (TO) FROM APPROPRIATED SURPLUS	(744,062)	-	-	-	**(744,062)**	(1,718,367)
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 433,571	$ 4,101,426	$ 444,226	$ -	**$ 4,979,223**	$ 6,031,069
CASH AND CASH EQUIVALENTS CONSISTS OF:						
Cash					**$ 498,282**	$ 804,818
Short-term investments					**4,480,941**	5,226,251
Cash and cash equivalents					**$ 4,979,223**	$ 6,031,069

See accompanying notes

1. DESCRIPTION OF BUSINESS

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

2. ADOPTION OF A NEW ACCOUNTING FRAMEWORK

These financial statements have been prepared in accordance with Canadian public sector accounting (PSA) standards, issued by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants (CICA). The Authority has adopted the standards for government not-for-profit organizations, set forth at PSA Handbook section PS 4200 to PS 4270. As these are the Authority's first financial statements prepared in accordance with PSA standards, Section PS 2125, First-time Adoption by Government Corporations, has been applied. The Authority has also adopted Section PS3450, Financial Instruments.

In accordance with the requirements of Section PS 2125, the accounting policies set out in Note 3 have been consistently applied to all years presented and adjustments resulting from the adoption of the new standards have been applied retrospectively excluding cases where optional exemptions available under Section PS 2125 have been applied. The Authority has not elected to use any of the optional exemptions.

The financial statements were previously prepared in accordance with Canadian generally accepted accounting principles, as set forth in Part V of the CICA Handbook.

Impact of the adoption of the new standards as at April 1, 2011

The impact of the adoption of the new standards on the statement of financial position as at April 1, 2011 is summarized as follows:

2. ADOPTION OF NEW ACCOUNTING FRAMEWORK (continued)

	Balance as previously reported March 31, 2011	Adjustment	Reference	Balance as adjusted as at April 1, 2011
Liabilities				
Accounts payable and accrued charges	$ 1,146,902	$ 43,007	(a)	$ 1,189,909
Fund balances				
Unappropriated (deficit) surplus	$ 1,422,201	$ (43,007)	(a)	$ 1,379,194
Appropriated surplus	2,737,922	-		2,737,922
Surplus appropriated for scholarships	356,974	-		356,974
Equity in capital assets	773,540	-		773,540
	$ 5,290,637	$ (43,007)		$ 5,247,630

Impact of the adoption of the new standards on the statement of revenue, expenses and changes in fund balances for the year ended March 31, 2012 is summarized as follows:

	Balance as previously reported March 31, 2012	Adjustment	Reference	Balance as adjusted March 31, 2012
Expenses				
Health Canada Programs	$ 3,844,076	$ 13,414	(a)	3,857,490
Net surplus (deficit)	$ (101,088)	$ (13,414)	(a)	$ (114,502)

Explanation of adjustments

a. Accumulated sick leave

The Authority made an adjustment to the 2011 financial statements with respect to the accounting for employee future benefits. Specifically, this adjustment related to accounting policy differences under public sector accounting standards with respect to the determination of the obligation for accumulated sick leave. In aggregate, the resulting increase in accumulated non-vesting sick leave liability at April 1, 2011 was $43,007. Health Canada programs expense for the year ended March 31, 2012 increased by $13,414.

2. ADOPTION OF NEW ACCOUNTING FRAMEWORK (continued)

Explanation of adjustments (continued)

b. Financial Instruments

Effective April 1, 2012 the Authority adopted the PSA standards for Financial Instruments (PSA Handbook Section PS 3450). Section PS 3450 establishes standards on how to account for and report all types of financial instruments, including derivatives. Section PS 3450 has been applied prospectively, in accordance with the transitional provisions of the Section.

Upon adoption of Section PS 3450 the Authority was required to assign its financial instruments to one of two measurement categories: fair value; or cost or amortized cost. Cash and cash equivalents, accounts receivable and accounts payable and accrued charges are classified in amortized cost category. The adoption of Section PS 3450 had no impact on the recognition and measurement of financial instruments reported in these financial statements.

3. SIGNIFICANT ACCOUNTING POLICIES

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

Fund Accounting

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

i) The Operating Fund accounts for the Authority's administrative and program delivery activities,

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

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

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

Cash and cash equivalents

Cash and cash equivalents consists of bank balances held with financial institutions and money market funds with maturities less than 90 days.

3. 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
Software	3 years
Equipment and furniture	5 years
Leasehold improvements	5 years
Vehicles	5 years

Impairment of Capital Assets

When an item in capital assets no longer has any long-term service potential to the Authority, the excess of its net carrying amount over any residual value is recognized as an expense in the statement of revenue, expenses and changes in fund balances. Write-downs are not reversed.

Accumulated Sick Leave Benefit Liability

The Authority provides sick leave benefits for employees that accumulate but do not vest. The Authority recognizes sick leave benefit liability and an expense in the period in which employees render services in return for the benefits. The value of the accumulated sick leave reflects the present value of the liability of future employees' earnings.

Revenue Recognition

The Authority follows the deferral method of accounting for contributions. Restricted grants are recognized as revenue in the year in which the related expenses are incurred. Unrestricted grants are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Financial Instruments

Cash and cash equivalents, accounts receivable and accounts payable and accrued charges are classified as amortized cost. The carrying value of these financial instruments approximates their fair value due to their short term nature.

Use of Estimates

The preparation of the financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Key components of the financial statements requiring management to make estimates includes allowance for doubtful accounts, the useful lives of capital assets and accrual for accumulated sick leave. Actual results could differ from these estimates.

4. ECONOMIC DEPENDENCE

The Authority receives the major portion of its revenues pursuant to various funding agreements with the First Nations and Inuit Health Branch of Health Canada. The most significant agreement undertaken was a 5-year health transfer agreement, which expired September 30, 2011. An extension of this transfer agreement was granted, which now expires March 31, 2014.

5. CAPITAL ASSETS

	Cost	Accumulated Amortization	Net Book Value **March 31, 2013**	Net Book Value March 31, 2012	Net Book Value April 1, 2011
Computers	$ 992,309	$ 858,964	**$ 133,345**	$ 232,082	$ 446,753
Software	68,081	11,347	**56,734**	-	-
Equipment and furniture	356,045	253,480	**102,565**	99,368	101,730
Leasehold improvements	407,156	356,428	**50,728**	53,037	57,963
Vehicles	278,964	188,704	**90,260**	107,929	167,094
	$ 2,102,555	$ 1,668,923	**$ 433,632**	$ 492,416	$ 773,540

6. DEFERRED REVENUE

	March 31, 2013	March 31, 2012	April 1, 2011
Community Health Plan	**$ -**	$ 30,500	$ -
Aboriginal Human Resources	**336,929**	390,131	-
Telehealth - HSIF	**-**	13,934	-
CASET - HSIF	**-**	10,304	-
Glaxosmith Kline Project	**10,000**	10,000	10,000
	$ 346,929	$ 454,869	$ 10,000

7. APPROPRIATED SURPLUS

The Authority maintains an Appropriated Surplus Fund to fund program initiatives. The Board of Directors of the Authority authorized the transfer of balances to and from the Appropriated Surplus Fund during the 2013 fiscal year. Funds have been allocated within the Appropriated Surplus Fund for future expenditures as follows:

7. APPROPRIATED SURPLUS (continued)

	March 31, 2012 Opening Balance	Transfers In (Out)	Expenses	**March 31, 2013 Ending Balance**
Capacity development iniatives	$ 435,660	$ (106,396)	$ 28,456	$ **300,808**
Capital projects	841,000	-	-	**841,000**
E-Health solutions	510,000	147,437	317,437	**340,000**
Human resource iniatives	34,000	(30,308)	3,692	-
Nursing support	329,300	(329,300)	-	-
Special projects	1,602,866	(928,046)	314,820	**360,000**
Strategic planning and long-term planning	288,214	1,990,675	19,271	**2,259,618**
	$ 4,041,040	$ 744,062	$ 683,676	$ **4,101,426**

8. SURPLUS APPROPRIATED FOR SCHOLARSHIPS

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

	Amount
2003	$ 5,555
2004	22,140
2005	17,180
2006	22,658
2007	34,843
2008	116,065
2009	82,997
2010	16,793
2011	38,743
2012	55,393
Scholarships 2012	(13,000)
2013	62,109
Scholarships 2013	(17,250)
	$ 444,226

9. ADMINISTRATION FEES

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

	Schedule	**March 31, 2013**	March 31, 2012
TB Initiative	5	**$ -**	$ 14,810
Home Care	6	**12,143**	5,965
Communicable Disease Control / CDHE	7	**-**	7,359
Nursing Innovation Investments	8	**1,165**	-
Targeted Immunization Strategy	9	**-**	1,672
National Aboriginal Youth Suicide Prevention Strategy	10	**2,913**	3,953
Nursing Education - CHPC / NEPD	11	**1,246**	2,967
Aboriginal Human Resource	12	**-**	1,000
E-Health Solutions	13	**23,405**	24,979
HIV / STI Conference	14	**-**	15,317
Panorama	15	**15,546**	6,152
Other administrative amounts recorded		**-**	426
		$ 56,418	$ 84,600

10. RELATED PARTY TRANSACTIONS

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

	March 31, 2013	March 31, 2012
Prince Albert Grand Council	**$ 161,270**	$ 131,082
Meadow Lake Tribal Council	**$ 229,644**	$ 232,265
Peter Ballantyne Cree Nation	**$ 208,130**	$ 158,853
Lac La Ronge Indian Band	**$ 178,708**	$ 125,138

At March 31, 2013, there was $61,842 (2012- $61,379 2011- $573) of receivables and $60,706 (2012- $61,501 2011 – $197,327) of payables with the Authority's partners listed above. These transactions were made in the normal course of business and have been recorded at the exchanged amounts.

11. FINANCIAL INSTRUMENTS

Credit Risk

The Authority is exposed to credit risk from the potential non-payment of accounts receivable. The risk is reduced since 80% of the accounts receivable is due from Canada Revenue Agency and Meadow Lake Tribal Council.

Interest Rate Risk

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

Liquidity Risk

Liquidity risk is the risk of being unable to meet cash requirements or fund obligations as they become due. The Authority manages its liquidity risk by constantly monitoring forecasted and actual cash flows and financial liability maturities, and by holding cash and assets that can be readily converted into cash. Accounts payable and accrued charges are generally repaid within 30 days.

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
SUMMARY OF OPERATING FUND REVENUE, EXPENSES AND SURPLUS FROM PROGRAMS PRIOR TO INTERFUND TRANSFERS
years ended March 31, 2013 and 2012

	Schedule	Health Canada Transfer	Health Canada Contributions	Other Revenue	Administration Fees	Transfer From Deferred Revenue	Total Revenue	Expenses	Surplus (Deficit) 2013	Surplus (Deficit) 2012
TRANSFER AGREEMENTS										
Public Health Unit	2	$ 782,169	$ -	$ 6,108	$ -	$ -	$ 788,277	$ 703,428	$ 84,849	$ 337,261
Administration	3	1,219,118	-	87,436	56,418	30,500	1,393,472	1,213,776	179,696	94,351
Community Services Unit	4	629,401	-	1,605	-	-	631,006	535,839	95,167	142,065
SET AGREEMENTS										
TB Initiative	5	-	396,550	185	-	-	396,735	435,010	(38,275)	(2,106)
Home Care	6	-	169,557	1,183	-	-	170,740	170,740	-	-
Communicable Disease Control / CDHE	7	-	-	-	-	-	-	-	-	5,380
Nursing Innovation Investments	8	-	12,815	-	-	-	12,815	12,815	-	-
Targeted Immunization Strategy	9	-	70,000	-	-	-	70,000	34,418	35,582	16,995
NAYSPS	10	-	53,500	-	-	-	53,500	53,500	-	-
Nursing Education	11	-	15,000	-	-	-	15,000	15,000	-	(118)
Aboriginal Human Resource	12	-	418,906	-	-	53,202	472,108	472,164	(56)	-
E-Health Solutions	13	-	294,707	-	-	-	294,707	259,707	35,000	-
HIV/STI	14	-	-	-	-	-	-	40,351	(40,351)	-
Panorama	15	-	169,025	2,808	-	-	171,833	170,781	1,052	(461)
CASET - HSIF	16	-	-	-	-	-	-	6,418	(6,418)	-
TOTAL		2,630,688	$ 1,600,060	$ 99,325	$ 56,418	$ 83,702	$ 4,470,193	$ 4,123,948	$ 346,245	$ 593,367

Schedule 2

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
PUBLIC HEALTH UNIT
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - transfer agreement	$ 755,410	$ 782,169	$ 975,127
Expense recoveries	500	6,108	2,494
	755,910	788,277	977,621
EXPENSES			
Meetings and workshops	6,500	2,928	2,200
Personnel	749,523	670,150	577,572
Professional Fees	4,000	-	400
Telephone and supplies	19,500	14,539	10,662
Travel and vehicle	31,500	15,811	17,018
West Nile Virus Reduction program	-	-	32,508
	811,023	703,428	640,360
(DEFICIT) SURPLUS	$ (55,113)	$ 84,849	$ 337,261

Schedule 3

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ADMINISTRATION
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - transfer agreement	$ 1,219,118	$ 1,219,118	$ 1,229,805
Administration fees	134,054	56,418	84,600
Expense recoveries	500	87,436	638
Transfer (to) from deferred revenue	30,500	30,500	(30,500)
	1,384,172	1,393,472	1,284,543
EXPENSES			
Bank charges	3,000	4,003	1,821
Equipment lease and maintenance	45,700	34,064	20,263
Facility costs	140,021	126,443	129,170
Meetings and workshops	159,573	80,941	123,733
Personnel	837,221	746,734	744,778
Professional services	63,200	81,012	40,042
Community Health Plan	30,500	30,000	-
Telephone and supplies	115,000	83,287	106,335
Travel and vehicle	40,109	27,292	24,050
	1,434,324	1,213,776	1,190,192
(DEFICIT) SURPLUS	(50,152)	179,696	94,351
NET TRANSFER TO CAPITAL FUND	-	(125,240)	(31,514)
	$ (50,152)	$ 54,456	$ 62,837

Schedule 4

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
COMMUNITY SERVICES UNIT
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - transfer agreement	$ 629,401	$ 629,401	$ 435,243
Expense recoveries	-	1,605	-
	629,401	631,006	435,243
EXPENSES			
Meetings and workshops	8,750	1,897	1,798
Personnel	652,087	435,621	224,214
Professional services	12,000	12,000	12,000
Program costs	92,000	74,755	51,989
Telephone and supplies	7,000	2,185	-
Travel and vehicle	27,000	9,381	3,177
	798,837	535,839	293,178
(DEFICIT) SURPLUS	$ (169,436)	$ 95,167	$ 142,065

Schedule 5

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TB INITIATIVE
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada	$ 396,550	$ 396,550	$ 396,550
Health Canada - TST Funding	-	-	52,486
Health Canada - TB Community Based ED	-		2,730
Expense recoveries	-	185	-
	396,550	396,735	451,766
EXPENSES			
Administration fees	-	-	14,810
Equipment lease and maintenance	310	341	310
Facility costs	1,575	1,538	1,538
Meetings and workshops	500	-	165
Personnel	397,635	363,606	350,911
Program costs	60,000	-	55,215
Program incentives	5,300	3,429	6,793
Outbreak services	40,000	29,116	-
Telephone and supplies	8,500	8,776	8,420
Travel and vehicle	22,500	28,204	15,710
	536,320	435,010	453,872
DEFICIT	$ (139,770)	$ (38,275)	$ (2,106)

Schedule 6

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HOME CARE
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - contribution agreement	$ 169,557	$ 169,557	$ 67,531
Expense recoveries	-	1,183	-
	169,557	170,740	67,531
EXPENSES			
Administration fees	16,956	12,143	5,965
Meetings and workshops	13,434	1,036	44
Personnel	28,887	55,900	2,028
Program costs	98,000	81,713	58,558
Telephone and supplies	8,780	17,903	
Travel and vehicle	3,500	2,045	936
	169,557	170,740	67,531
SURPLUS	$ -	$ -	$ -

Schedule 7

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
COMMUNICABLE DISEASE CONTROL / CDHE
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - contribution agreement	$ -	$ -	$ 91,000
EXPENSES			
Administration fees	-	-	7,359
Personnel	-	-	45,689
Program costs	-	-	32,572
	-	-	85,620
SURPLUS	-	-	5,380
NET TRANSFER TO CAPITAL FUND	-	-	(5,380)
	$ -	$ -	$ -

Schedule 8

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING INNOVATION INVESTMENTS
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - contribution agreement	$ 24,000	$ 12,815	$ 18,395
EXPENSES			
Administration Fees	2,054	1,165	1,672
Personnel	2,946	1,676	1,762
Professional fees	3,000	-	-
Telephone and supplies	16,000	9,974	14,961
	24,000	12,815	18,395
SURPLUS	$ -	$ -	$ -

Schedule 9

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TARGETED IMMUNIZATION STRATEGY
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - contribution agreement	$ 70,000	$ 70,000	$ 60,000
EXPENSES			
Administration fees	6,000	-	3,953
Equipment lease and maintenance	39,300	4,550	24,718
Program costs	4,000	3,933	921
Telephone and supplies	10,000	336	12,784
Travel and vehicle	200	-	168
Meetings and workshops	10,500	25,599	461
	70,000	34,418	43,005
SURPLUS	-	35,582	16,995
TRANSFER TO CAPITAL FUND	-	(37,214)	(16,995)
DEFICIT	$ -	$ (1,632)	$ -

Schedule 10

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NATIONAL ABORIGINAL YOUTH SUICIDE PREVENTION STRATEGY
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - contribution agreement	$ **53,500**	$ **53,500**	$ 53,500
EXPENSES			
Administration fees	**3,500**	**2,913**	2,967
Meetings and workshops (recovery)	**10,000**	**721**	7,452
Program costs	**40,000**	**49,866**	42,132
Travel and vehicle	**-**	**-**	949
	53,500	**53,500**	53,500
SURPLUS	$ **-**	$ **-**	$ -

Schedule 11

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING EDUCATION
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - contribution agreement	$ 15,000	$ 15,000	$ 15,000
EXPENSES			
Administration fees	-	1,246	-
Personnel	9,000	6,287	5,225
Program costs	-	5,415	8,155
Telephone and supplies	4,600	2,052	1,155
Travel and vehicle	1,400	-	583
	15,000	15,000	15,118
SURPLUS	$ -	$ -	$ (118)

Schedule 12

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ABORIGINAL HUMAN RESOURCE
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - contribution agreement	$ 418,906	$ 418,906	$ 823,727
Expense recoveries	-	-	19,530
Transfer from (to) deferred revenue	390,131	53,202	(390,131)
	809,037	472,108	453,126
EXPENSES			
Administration fees	-	-	1,000
Meetings and workshops	33,192	18,488	13,526
Professional fees	61,300	32,663	34,584
Program costs	665,941	418,910	384,702
NLMHSTS		-	18,530
Telephone and supplies	48,604	2,103	784
	809,037	472,164	453,126
DEFICIT	$ -	$ (56)	$ -

Schedule 13

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
E-HEALTH SOLUTIONS
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada	$ 294,707	$ 294,707	$ 273,704
Health Canada - HSIF	-	-	15,000
Transfer from (to) deferred revenue	-	-	(13,934)
	294,707	294,707	274,770
EXPENSES			
Administration fees	28,207	23,405	24,979
Meetings and workshops	-	-	1,092
Professional fees	-	-	11,853
Personnel	-	5,674	17,155
Program costs	213,500	230,012	218,613
Travel and vehicle	1,000	616	1,078
	242,707	259,707	274,770
SURPLUS	$ 52,000	$ 35,000	$ -
TRANSFER TO CAPITAL FUND	(52,000)	(35,000)	-
	$ -	$ -	$ -

Schedule 14

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HIV / STI CONFERENCE
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - contribution agreement	$ **183,000**	$ -	$ 183,000
EXPENSES			
Administration fee	**8,300**	-	15,317
Meetings and workshops	-	**375**	9,361
Personnel	**71,758**	**37,057**	39,320
Program costs	**100,000**	-	112,131
Telephone and supplies	**800**	**1,617**	445
Travel and vehicle	**2,142**	**1,302**	6,426
	183,000	**40,351**	183,000
DEFICIT	$ -	$ **(40,351)**	$ 0

Schedule 15

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
PANORAMA
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - contribution agreement	$ 175,000	$ 169,025	$ 67,666
Expense recoveries	-	2,808	
	175,000	171,833	67,666
EXPENSES			
Administration fees	16,500	15,546	6,152
Meetings and workshops	1,806	5,038	1,834
Personnel	128,694	122,300	55,642
Professional fees	22,500	18,798	-
Program costs	-	2,139	-
Telephone and supplies	-	2,372	-
Travel and vehicle	5,500	4,588	4,499
	175,000	170,781	68,127
SURPLUS	-	1,052	(461)
TRANSFER TO CAPITAL FUND	-	(1,486)	-
	$ -	$ (434)	$ (461)

Schedule 16

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
CASET - HSIF
SCHEDULE OF REVENUE AND EXPENSES
years ended March 31, 2013 and 2012

	Budget 2013 (Unaudited)	2013	2012 (Note 2)
REVENUE			
Health Canada - HSIF	$ -	$ -	$ 15,000
Transfer from (to) deferred revenue	-	-	(10,304)
	-	-	4,696
EXPENSES			
Administration fee	-	-	427
Travel and vehicle	-	6,418	4,269
	-	6,418	4,696
DEFICIT	$ -	$ (6,418)	$ -

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NORTHERN INTER-TRIBAL HEALTH AUTHORITY

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