Enhanced Primary Health Services in the Regional Municipality of Wood Buffalo

A proposal to the Aboriginal Health Transition Fund

28 April 2008

version for posting to website

January 2009

1. General Information

1.1 Project Title

Planning for Enhanced Primary Care Services for the First Nations' People within the Regional Municipality of Wood Buffalo

1.2 Identification

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1.3 Project Partners

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1.4 Amount Requested from the AHTF

Funding Requested from AHTF	$844,720
Other Funding Sources and Amounts:	
• First Nations & Inuit Health	In-kind – technical assessment for telehealth requirements, committee membership, attendance at meetings, teleconference/videoconference links Ongoing health human resources costs
• Northern Lights Health Authority	In-kind – Committee membership, attendance at meetings, teleconference/ videoconference links Ongoing health human resources costs
• ATC	In-kind – people in community working closely with region, office space for the Partnership Liaison Consultant, etc
• Treaty 8 Canada Health Infoway Telehealth Change Management Project	As yet undetermined resources to be available. Support could include funding for a telehealth liaison for ATC.
Total Project Cost	$ 844,720 plus in-kind contributions

1.5 Duration of the Project

July 2008 to March 31, 2010

1.6 Overall Objectives of the Project

To better adapt and integrate health service provision to First Nations people in the Regional Municipality of Wood Buffalo.

To implement an action plan for increasing access to Primary Health Services for the First Nations people of the Regional Municipality of Wood Buffalo.

The project will bring together the key organizations (the Athabasca Tribal Council, the Northern Lights Health Region, the First Nations and Inuit Health) to: further facilitate the partnership between these organizations, and others as required in order to improve integration, coordination, and collaboration of health services for First Nations people in north eastern Alberta; provide opportunity for continuing community consultation and participation; prioritize

the needs identified in Phase I; develop program plans for providing health service delivery to meet the needs; and evaluate the overall initiative.

2. Project Information

2.1 Executive Summary

ATC and its partner organizations (Northern Lights Health Region, and First Nations & Inuit Health) have entered into a partnership arrangement to work towards enhanced primary care health services for the First Nations people in the Regional Municipality of Wood Buffalo.

In Phase I of this project, the Partners (i) clarified the overall roles and responsibilities of each organization in providing primary care through a signed Memorandum of Intent, (ii) set up the Terms of Reference for the Steering Committee, and (iii) involved the communities in identifying primary health care service needs.

Although the Partners recognize that there are continuing jurisdictional and organizational barriers to be addressed, Phase I has made important inroads in identifying the roles of the partners and in identifying the health service needs of the First Nations Communities. The partners are prepared to work collaboratively on an ongoing basis to identify innovative means of bridging the barriers in order to reach the goal of enhanced primary health services for First Nations communities.

Phase II of the project is expected to take 21 months. Phase II will build on the work of Phase I and will be based on a participatory model, which will offer the Partners and the First Nations communities the opportunity to participate and contribute throughout the project.

From the initial Memorandum of Intent, the partners will develop and sign a formal Memorandum of Understanding to further shape the roles and responsibilities each organization has in delivering primary care in the Regional Municipality of Wood Buffalo. These roles and responsibilities will be specified in service level agreements developed and signed as a result of the consultative process with First Nations communities to identify health service gaps, prioritize the health service needs for each community, and establish plans for best meeting those needs.

Phase II will increase access to primary health care service by focusing on i) increasing access to health professionals and primary care services, and ii) building resource capacity with the First Nations communities, both in terms of health human resources and skill/knowledge level of the communities. Specifically, the project will target enhanced primary health care service delivery in the following eight areas:

1. increased training of locals for health related positions
2. enhanced telehealth equipment and capabilities
3. increased clinical telehealth programming
4. increased primary health prevention and promotion services, including increased human resource capacity
5. increased access to mental health services
6. increased access to dental services
7. increased access to nurse and nurse practitioner services
8. increased access to physician services

Change management activities will be undertaken with the First Nations communities, the regional staff, and other health professionals, in order to prepare them for new and innovative models of primary care service delivery in the region.

External evaluators will work with the Partners and communities in a participatory manner, to try and ensure project objectives are met in a timely and appropriate manner.

2.2 Recipient and Partner Profiles

2.2.1 Athabasca Tribal Council Profile

The Athabasca Tribal Council (ATC), established in 1987, represents the interests of the five First Nations of North Eastern Alberta with a vision of "*working in unity together we will continue to realize our true value as healthy, productive and proud Cree and Dene people*". The ATC includes the Athabasca Chipewyan First Nation, Chipewyan Prairie First Nation, Fort McKay First Nation, Fort McMurray No. 468 First Nation, and Mikisew Cree First Nation, which are comprised of more than 2,500 native Cree and Chipewyan people.

A board of directors consisting of the five First Nations Chiefs heads the ATC. A Chief Executive Officer oversees the day to day running of the ATC. The Board had identified the following goals:

- Enhance and promote the general well being of our people by providing programs, services, and opportunities;
- Foster growth, prosperity and development of First Nations communities through capacity building;
- Maintain and protect out Treaty Rights and Freedoms;
- Promote, maintain and protect the integrity of our relationship with Mother Earth, the Land, water, ice, air, and resources;
- Promote and protect our origins, territories, environment, culture, customs, history and languages as First Nations' peoples;
- Work together in harmony and unity, supporting each other politically, socially, economically and culturally; and
- Develop meaningful and productive relationships with our stakeholders.

In order to achieve the vision and the goals, the ATC works closely with their member groups and with economic, educational, and health partners in the region. The ATC has specialized programs in the fields of education, training, health, social services, and the environment.

The ATC Department of Health works with member First Nations in promoting initiatives in the matters of Health and Child Care. Initiatives include the establishment of effective Community Day Cares, the initiation of Community Health Needs Assessments, participation in Regional Health Surveys conducted by the Northern Lights Regional Health, and the establishment of a Regional Prescription Drug Abuse Strategy Committee to combat prescription drug abuse in this area. A major focus is being placed on identifying and implementing means to increase access to primary health services for the First Nations communities.

The ATC was incorporated in 1987, and has served the First Nations communities for 19 years. ATC has worked across many jurisdictions, including municipal, provincial and federal governments. At present, the ATC is in partnership with Northern Lights Health Region (NLHR) in providing an Aboriginal Liaison who works to insure seamless health care services for individuals coming in from outlying and remote areas. Furthermore, the ATC and the NLHR has engaged in informal relationship building over the last decade in the form of discussions and informal collaborations to provide better health care services such as Primary Health, Mental Health, and other health services. Major issues are discussed and resolved through the informal mechanisms and structures that we have developed.

2.2.2 Partner Profiles

The Northern Lights Health Region is the largest of nine regional health regions in Alberta. It is also the region with the fewest number of people, although it serves over 20 communities across the great expanse of Northern Alberta. From the provincial boundaries of B.C., Saskatchewan and the N.W.T. this health region serves the remote and rural communities of northern Alberta by providing public health care, acute health care, emergency and trauma care, mental health care, and allied health services. The authority's over 1000 professionals are dedicated to delivering the highest possible standard of care to the people living in these communities.

The NLHR is committed to achieving its vision through a committed focus to its mission and by living its values in how it operates and works with its stakeholders and communities.

Vision: Work together for a healthier future.

Mission: Improve health and promote wellness.

The NHLR faces some unique challenges in providing health services:

- The region is split into two physically distinct areas – the western half (High Level and Ft. Vermillion area) and the eastern half (Regional Municipality of Wood Buffalo area).;
- Fort McMurray (approximately 435 km north of Edmonton) is home to almost 65,000 people[1] and is one of Canada's youngest and fastest growing communities. The majority of the region's population live in Fort McMurray itself.
- The smaller, more remote communities in the Regional Municipality of Wood Buffalo have a total population of about 15,000[2].
- The region has the highest percentage of aboriginal population in the province. Within the Regional Municipality of Wood Buffalo, 12% of the population is aboriginal[3].
- NLHR has a shortage of health professionals within the region as a whole.

[1] Regional Municipality of Wood Buffalo. Municipal Census. 2006. p12.
[2] Ibid. p 12.
[3] Ibid. p 26.

The Northern Lights Health Region is committed to working with the ATC and its partners to improve access to primary health services for the First Nations people in the region.

The Wood Buffalo Primary Care Network (WBPCN) is involved in the project through its alliance with the NLHR. The NLHR makes up one-half of the governance structure for the WBPCN (the local physicians making up the other half of the governance). As such, they are not a separate partner, but are included in the discussion and may be referenced throughout the document either with the NLHR, or separately, as appropriate. Their profile is shown here as well.

"Achieving excellence in primary care through team-based practice"

The Wood Buffalo Primary Care Network (PCN) is the result of a formal arrangement between Fort McMurray Family Physicians and the Northern Lights Health Region. Through this collaboration the PCN proposes to increase access to primary care services while improving on the coordination of comprehensive care available for the region of Wood Buffalo.

The PCN is a specialized primary care clinic focusing on diabetes, heart disease, geriatric care, palliative care, and women's health. The PCN brings together an interdisciplinary team of health professionals who provide comprehensive, coordinated care for patients referred by their family physician. The PCN provides community linkages to: specialists, health care professionals and community services and assist patients in navigating through the system.

Key Priorities:

Presently the PCN has chosen to focus on specific gaps identified by the physicians and RHA representatives and will augment the services provided by Primary Care Physicians and the Northern Lights Health Region through:

- Extended coordinated care in the areas of:
  - Chronic Disease Management
    - Diabetes
    - Heart Disease
  - Geriatric Care
  - Palliative Care
  - Women's Health
- Coordinated next day physicians' appointments for patients referred through Health Link
- Linking unattached patients with physicians with open practices
- Encouraging Chronic Disease Self Management
- Supporting health promotion activities in the related areas

Health Canada Mission and Vision:

Helping the people of Canada maintain and improve their health.

Health Canada is committed to improving the lives of all of Canada's people and to making this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system.

First Nations and Inuit Health Mandate:

Ensure the availability of, or access to, health services for First Nations and Inuit communities.

Assist First Nations and Inuit communities address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations.

Build strong partnerships with First Nations and Inuit to improve the health system.

FNIH enables the best possible outcomes in promoting, improving, and preserving the health status of First Nations and their communities by: facilitating access to health services according to identified health needs; providing access to health information; building capacity and promoting self-reliance; and demonstrating accountability in the effective use of resources.

2.2.3 Partners' Responsibilities

FNIH has a major fiduciary role in providing health services to the First Nations communities. While they currently meet this obligation, they, and their Partner organizations, have a desire to enhance the existing level of service to the First Nations communities in the Regional Municipality of Wood Buffalo. This project will examine options for ensuring FNIH is able to meet this objective though partnership with the NLHR, ATC, and others.

Partnership Development and Engagement: The partners agree to participate in the project and to develop a clear understanding of roles and responsibilities. The partnership will not reduce FNIHs fiduciary responsibilities, but will explore creative means of ensuring FNIH fulfill their responsibilities to the highest level possible. The first step will be through the development and signing of a Memo of Understanding (MOU). The MOU will provide jurisdiction clarity (federal, provincial, public health acts, RHA, First Nations), and set accountability structures that will preserve unique roles and responsibility of all partners. The linkages that will be created will be of great benefit to the stakeholders as they jointly advance agendas of common and mutual interest.

Program Delivery: The partners will discuss issues related to program delivery and identify potential solutions to the issues. The partners recognize that some issues may not be resolved during the project, but that they will attempt to work around any such challenges.

Change Management: Change management will occur at several levels: general administration, staff education, and telehealth program-specific. The partners will ensure appropriate staff education and training, client awareness of programs, cultural awareness, and traditional knowledge sharing (cross-cultural sharing of information). The partners will review and implement common policies and procedures to ensure equitable access for First Nations peoples to primary health services.

Communication and Dissemination: The partners will develop communication and dissemination plans to insure that all stakeholders are informed of progress and decision-making.

Evaluation Activities: The partners will ensure the hiring of an external evaluator, who will develop and implement a comprehensive evaluation of the project.

2.3 Project Description

2.3.1 Statement of Purpose

To continue to build and formalize a partnership to better adapt and integrate health service provision to First Nations people in the Regional Municipality of Wood Buffalo.

To develop and implement an action plan for increasing access to Primary Health Services for the First Nations people of the Regional Municipality of Wood Buffalo.

Background: The project began in 2007 with the submission of a proposal to the Aboriginal Health Transition Fund (AHTF) for the developmental phase of planning enhanced primary health services. In Phase I of the project, the project team has i) established a project Steering Committee; ii) approved Terms of Reference for the Steering Committee; iii) developed and approved a Memorandum of Intent (MOI) as the first phase in the formalization of the partnership; iv) held an official signing ceremony of the MOI; and v) involved the First Nations communities in a process to determine the gaps in health services and the priority primary health service needs within each community.

The MOI is found in Attachment 1; the Terms of Reference is found in Attachment 6.

Target population: Within the Regional Municipality of Wood Buffalo there are five First Nations communities. Table 1 shows the population for each area.

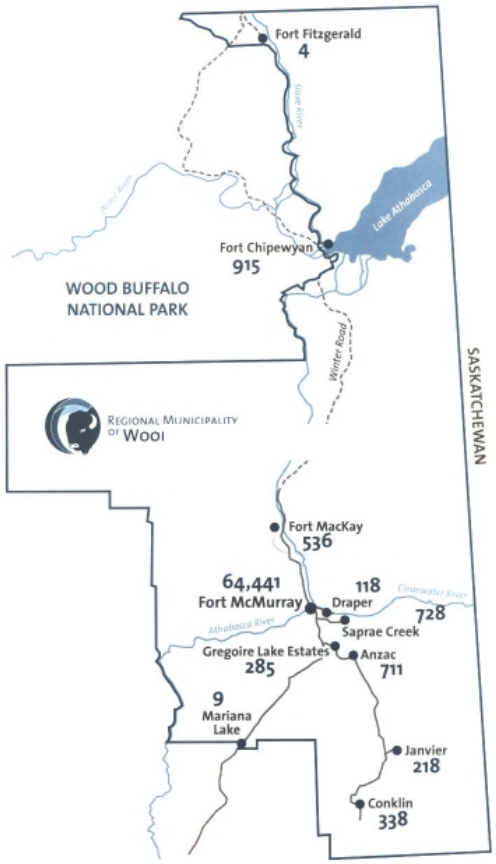
Table 1 Population of First Nations Communities in the Regional Municipality of Wood Buffalo[4]

Community	Population
Fort Chipewyan	1200[5]
Mikisew Cree (Ft. Chip)	2434
Athabasca Chipewyan (Ft. Chip)	828
Fort McKay	614
Fort McMurray (Gregoire Lakes area)	597
Chipewyan Prairie (Janvier area)	682

The NLHR provides health services to its population and struggles with on-going shortages in health human resources in all disciplines. Service delivery is further complicated by the geographic location of the region (located in the far north-east corner of Alberta); the rapidly expanding population of the region; and the remoteness of many of its communities. The First Nations population in NLHR, specifically within the Regional Municipality of Wood Buffalo, make up the majority of the population living in the remote communities. The map below shows the location of the communities within the Regional Municipality of Wood Buffalo. The First Nations population reside primarily in the communities of Fort Chipewyan, Fort MacKay, Janvier, and the Gregoire Lakes area.

[4] Population figures provided by First Nations & Inuit Health. 3 Apr 07.
[5] Revised 10 Apr 08. D.Cyprien, Health Director, Nunee Health Board.

First Nation and Inuit Health provide nursing services to the First Nation community health centres within the Regional Municipality of Wood Buffalo. As well FNIH provides funding, support, and advice to Fort Chipewyan (a transferred community) and to Fort McKay. FNIH provides funding through contribution agreements for comprehensive preventative health programs. However, most health services are available only in Fort McMurray, not within the communities. The distance from Fort McMurray presents difficulties in receiving services, for instance, while the Gregoire Lakes area and Fort MacKay are within reasonable driving distance, a vehicle is necessary for the travel and is not always an option.



Fort Chipewyan is Alberta's oldest continuous European settlement dating back to 1788 when the North West Company established an outpost there. Two First Nations communities – the Miksew Cree First Nation and the Athabasca Chipewyan First Nation, surround it. The only vehicle access to Fort Chipewyan is via a winter road from Fort Smith, 140 kilometers to the north or from Fort McMurray, 303 kilometers to the south. Fort Chipewyan has a paved all weather, lighted airstrip. Scheduled air service from Fort McMurray and Edmonton provides residents with food, clothing and all supplies. Air Mikisew provides the air service six days per week.

The health of residents in the Fort Chipewyan area is taken care of by the Nunee Health Board Society. The Society has taken control and responsibility of health and wellness services through a transfer agreement with FNIH. It provides funding for primary health service through its nursing station with only the most serious or specialized case being flown south to Fort McMurray or Edmonton and preventative programs through additional funds.

Residents of First Nations communities in the Regional Municipality of Wood Buffalo must endure a large travel burden, dangerous driving conditions, long waits, lack of public transportation and mounting travel costs in order to receive primary health services such as prescriptions, referrals, lab tests, consultation, diagnosis, diagnostic tests and pharmacy. FNIHB does provide funds through the Non-Insured Health Benefit Program for medical transportation, transporting residents from the communities to medical services off reserve.

Health service needs of the First Nations Communities in Wood Buffalo: In a needs assessment conducted in 2001 researchers found:

"They [First Nations people of the Regional Municipality of Wood Buffalo] gave the health system an overall rating from poor to excellent. Most of the respondents indicated that it was good (42%) to fair (33%). A small portion of the respondents (5%) said it was excellent and 19% said it was poor. These results were mostly different than other Albertans, where 15% gave the system an excellent rating, 53% gave it a good rating, 26% gave it a fair rating and 7% gave it a

poor rating. From these results, the ATC respondents considered the health care system in their region to be worse than those of other Albertans."[6]

Unfortunately there is nothing to indicate that the situation has improved since the 2001 study. As part of Phase 1 of this project, an informal needs assessment was conducted. The consultant met with various individuals from Janvier, Gregoire Lakes area, Fort MacKay, and Fort Chipewyan including, health professionals; personnel from band and/or health administration; and residents of the communities.

The following table shows the health services currently available within each of the First Nations communities. More specific community information is shown below the table; some details of the need assessment are shown in Attachment 7, while more information is available separately.

Table 2 Health services currently provided, by community

Service	Fort Chipewyan	Fort MacKay	Gregoire Lakes*[7]	Janvier
Physician	✓ (visiting basis only)	✓ (telehealth & visiting basis only)	X	X
Community Health Representatives (CHR)	✓	✓	vacant	✓
Community Health Nurse (CHN)	✓ 2CHNs	✓	vacant	✓
Nurse Practitioner (NP)	✓	X	X	X
Health educator	✓ PHN does this work	✓ CHN/CHR do this work	X	✓ CHN/CHR do this work
Pharmacist	X	X	X	X
Mental Health Worker	✓	X	X	X
NNADAP worker	✓	✓	vacant	✓
Home Care Nurse (HCN)	✓	✓	vacant	vacant

[6] Population Research Laboratory. A Comprehensive Needs Assessment in the First Nations Communities of the Athabasca Tribal Council. University of Alberta. August 2001.

[7] At the time of writing, Gregoire Lakes has no health services; the health centre is closed and the telephone is no longer in service. However, as of May 2008 a CHN will be starting in Janvier and Gregoire Lakes (2:3 days/week).

Service	Fort Chipewyan	Fort MacKay	Gregoire Lakes*[7]	Janvier
Home Care Assistant	✓	X	X	X
Psychologists	✓ (visiting basis only)	✓ (visiting basis only)	X	✓ (visiting basis only)
Dentist	✓ (visiting basis only)	X	X	X
Dental hygienist	✓ (school visits only)	✓ (school visits only)	✓ (school visits only)	✓ (school visits only)
Physiotherapist	✓ (visiting basis only)	X	X	X
Physiotherapy Assistant	✓	X	X	X
Clinical telehealth services	✓ (very limited)	✓ (limited)	X	X

While each community has its own specific priorities, overall the health needs of the communities are many. Not all of the needs can be met by this project, however they are identified for future study. For instance, priority items that cannot be addressed in this project include:

- Improved housing – At least three of the communities have serious problems related to old, unrepaired houses riddled with mould. This presents serious health risks, particularly in terms of respiratory illnesses. Improved housing on the reserves is a necessity for proper health of First Nations people.
- Lack of adequate and affordable food – Three of the communities do not have grocery stores on in the community; the fourth (Fort Chipewyan) has a store, but the cost of shipping makes the cost of food prohibitive for many. Consideration should be given to options such as Band or community run/sponsored stores with nutritious, affordable food available. Lack of proper food and nutrition can lead to illnesses, and worsen existing illnesses, such as diabetes. Consideration should also be given to projects such as green houses powered by renewable energy sources such as wind power, to grow a consistent supply of affordable vegetables.
- Substance abuse within the communities – All communities indicated that substance abuse was a major issue within their population. All communities have some resources and programming targeted towards this, but it is not sufficient. Additional resources are necessary to deal with this growing problem.

Primary health care needs to be addressed in this project:

The project will include the development and integration of the following:

1. increased training of locals for health related positions
2. enhanced telehealth equipment and capabilities
3. increased clinical telehealth programming
4. increased primary health prevention and promotion services, including increased human resource capacity
5. increased access to mental health services
6. increased access to dental services
7. increased access to nurse and nurse practitioner services
8. increased access to physician services

Other project components:

The project will also include the following aspects:

9. continued development and facilitation of partnership
10. continued community consultation and participation in the planning and delivery of appropriate primary health services
11. implemented change management
12. evaluation

Although all partners will play important roles in the project, the majority of the on-going activities will be done by the ATC Health Director and the Partnership Liaison Consultant. In order to ensure the ATC Health Director is able to commit the necessary time to the project, an Assistant to the Health Director will be hired for the 21-month time period. Additionally, since a primary focus will be on training and change management activities in the communities, an individual will be hired to coordinate and provide some of the training and change management activities to the First Nations communities. The role of the trainer will be facilitated by the placement of basic video-teleconferencing equipment into the ATC offices. There is no point trying to encourage the First Nations communities to increase their use of videoconferencing if ATC cannot communicate directly with the communities.

Summary of Project Components:

Increased training of locals for health-related positions

There is a chronic shortage of people to fill health-related positions in the First Nations communities. This includes administrative and non-professional positions, as well as professional positions. Lack of information/knowledge about the roles, as well as lack of training for the positions prevents the communities from having sufficient interest from local people. Existing staff require upgrading on an on-going basis, and/or retraining for additional roles.

a. *Increase information to health-related roles through health fairs/job fairs* – While an in-person 'fair' with multiple health organizations in attendance will be planned, ongoing information can also be provided regularly to communities via videoconferencing.

b. *Increase access to distance education programs* – The project will enter into discussions with organizations such as Norquest and Keyano College to increase access to distance education programs for professions such as LPN, health records administration, home care workers, and health educators. Initially one computer per health centre will be set up to provide access to computer-based distance education programs.

Enhanced telehealth equipment and capabilities

All sites have basic telehealth equipment, however only Fort MacKay is using their equipment on a regular basis for clinical purposes and for educational purposes. Sites need to adequate equipment to do clinical programming (e.g. upgraded, hand-held cameras). The staff needs support and training to use the equipment. Proper and adequate connectivity is important; two sites have equipment sitting unused because it is not connected.

c. *Change management* - Link with the Treaty 8 Canada Health Infoway Telehealth Project to provide human and financial resources to conduct change management activities in the communities and to teach the sites how to use their equipment.

d. *Ensure proper equipment, physical location of equipment, and connectivity of equipment* – Work with the communities and with FNIH to physically locate the equipment in suitable rooms, whenever possible. Currently the placement of some equipment limits the ability to use it.

e. *Staff and community education* – Use the telehealth equipment for administrative and educational purposes. For example, access the University of Alberta's Lunch and Learn programs on Wednesday (Ft. Chip already doing so). Establish regular linkages from the Wood Buffalo Primary Care Network to the communities. The ATC trainer will either prepare and deliver community education courses, or arrange for them to be delivered.

Increased clinical telehealth programming

Only one site (Fort MacKay) is using their equipment for regular clinical telehealth purposes. They currently have a ½ day clinic with a family physician on a weekly basis. Although they have had a positive community reaction to using telehealth for clinical services, they have not sought to increase their service offerings.

Another site (Fort Chipewyan) has tested clinical services, but has not continued providing clinical service on a regular basis.

f. *Establish regular clinical telehealth services to each community based on need* – These services will focus on basic primary care (i.e. family physician, nurse practitioner services) on a regular basis, as well as services specific to the needs of the community (i.e. TB monitoring in Janvier). The project will work with NLHR, WBPCN, and Capital Health to determine which programs can be offered and in which communities.

Increased primary health prevention and promotion services, including increased human resource capacity

Although all communities, except for Gregoire Lakes, have some health prevention and promotion services, there is a general need for more, and for additional trained resources to provide it.

This initiative will tie in closely with the increased telehealth capabilities, as much of the training and programming can be done via videoconferencing.

g. *Provision of health prevention/promotion programs* - There are community-specific needs for health prevention and promotion activities, however there are also general community needs. The project will focus on these to begin with. The services will not be limited to, but will focus initially on, the following:

    - Nutrition information
    - Chronic disease information

h. *Development of appropriate literature* - Although there is literature available, not all of it is language, culture, and education level appropriate. Also, there are costs associated with some sources. The project will contract individuals to prepare materials and then prepare them for distribution to the communities.

Increased access to mental health services

Although all communities, with the exception of Gregoire Lakes, have NNADP workers, and access to mental health therapist/psychologists, the need for these services is very large. Existing resources are stretched due to the high levels of substance abuse and violence in the communities. As well, only Fort Chipewyan has access to mental health therapist/psychologists of both genders. Due to the sensitive nature of some of the cases, gender-specific therapists are needed.

i. *Identify ways to increase mental health services to the communities* - The project will attempt to augment existing resources. A subcommittee will identify and implement ways to increase access. Some increase might be found through telehealth programming.

Increased access to dental services

The lack of dental treatment is a major issue for the communities. Fort Chipewyan has a dentist who flies in on a regular basis. They currently do not have access to a dental hygienist, although they previously did. Janvier has a full dental suite in the health centre – unused for the past six years. There is at least a month waiting time for dentist appointments in Fort McMurray.

There is, however, a preventative dental program through the Public Health Division of NLHR. The program is partially funded through FNIH (Nunee in the case of Fort Chipeywan). The focus of the prevention is on school-aged children, primarily kindergarten to grade 6. The program also provides services to the Aboriginal Headstart Program sites.

j. *Establish ongoing access to dentists in the First Nations communities* - The project will work with the Dental Officer for NLHR and the Regional Dental Officer for FNIH to develop a program providing access to dentists in Janvier, Ft. MacKay, and Gregoire Lakes.

k. *Expand the scope of the existing dental prevention program* - The project will work with the Dental Officer for NLHR and the Regional Dental Officer for FNIH to develop a program for regular service from dental hygienists to all communities, not just for school children. The scope will be expanded to include young mothers, elders, and other high priority target groups

Increased access to nurse and nurse practitioner services

Fort Chipewyan has a nurse practitioner; the other communities do not have a nurse practitioner. All of the communities experience ongoing on-going nursing shortages. These shortages can create issues accessing other health services in the First Nations communities. For instance, without a home care nurse, a community cannot access funding through FNIH for the home care program.

l. *Increase recruitment activity for a nurse practitioner and plan for an integrated program with the WBPCN* – FNIH has committed partial funding for a nurse practitioner, the NLHR has agreed to help maintain a nurse practitioner. However, recruitment has been unsuccessful. The Partners will increase recruitment activities. They will also develop a regional nurse practitioner program through the WBPCN that will allow for increased support of all nurse practitioners within the region, regardless of location.

m. *Increased recruitment of nurses (PHN and HCN) for continuity and relief* – There is a shortage of nurses in the communities, particularly Home Care Nurses. The project will implement ways of increasing the supply of nurses within the region in order to ensure back-up and support for nurses within the First Nations communities.

n. *Increase networking and education opportunities for nurses* – In addition to the Partners developing approaches for on-going recruitment of nurses, they will develop a regional network support program to provide on-going education through in-services and videoconferencing, and ways to provide nurse back-up to the communities.

The project will integrate nurse/nurse practitioner services with nursing professionals within the region, thereby increasing the local capacity and job satisfaction.

Increased access to physician services

Fort Chipewyan has a family physician who flies in every second week for five days. Fort McKay has a family physician available by telehealth every Monday afternoon; once every six weeks the physician is on site for two clinic days. (It should be noted however, that the physician is located in Nova Scotia and is not a local physician.) Neither Janvier nor Gregoire Lakes area has physician services on site.

o. *Establish ongoing physician access to the First Nations communities* - The project will work with the University of Alberta, Faculty of Medicine and Dentistry, Office of the Associate Dean of Rural and Regional Health, to develop a program based on Ontario's Sioux Lookout Zone[8].

The project will integrate physician services with medical professionals in Fort McMurray, thereby increasing the local capacity through support from the University.

[8] Originally funded by First Nations and Inuit Health as Health Integration Initiative project.

Continued development and facilitation of partnership

In Phase I a Memorandum of Intent was signed between the Partners. The Partners will now continuing to formalize the partnership in Phase II.

p. *Development of the Memorandum of Understanding (MOU)* - The MOU will provide jurisdiction clarity (federal, provincial, public health acts, RHA, First Nations), and set accountability structures that will preserve unique roles and responsibility of all partners.

q. *Service level agreements for specific service delivery* – As service programming is finalized, detailed service level agreements will be developed and signed by the Partners (and by other external groups that may be involved in specific initiatives). These agreements will specify expectations, roles, and responsibilities for each group involved.

Continued community consultation and participation in the planning and delivery of appropriate primary health services

Continued community participation will ensure that the delivery of primary health services are appropriate for the community, and will identify emerging needs that can then be addressed by the Partners.

r. *Quarterly meetings of the Health Directors* – The Health Directors from the First Nations communities will play a key role in identifying issues and keeping implementation appropriate.

s. *Semi-annual community visits* – On-going visits to the communities will allow health professionals, administration, and community representatives to keep informed of changes, and to identify new issues.

Implemented Change Management

Change can be difficult and challenging for many people. Without proper identification of what change in processes and behaviours are necessary, implementing new and innovative technology becomes more problematic. Change management is a structured process that helps individuals and organizations in preparing, managing, and reinforcing change. In a project of this nature, where long standing processes of different organizations and individuals will be affected, it is important to ensure change management activities are developed and provided.

t. *Change Management in general* – A number of activities will be undertaken. Details will be developed as the planning process proceeds. The change management activities will include staff education and training as required. The First Nations Communities will need specific activities developed to help build the capacity within each community to provide or support certain services. One key challenge will be in the area of aligning policies and procedures the introduction of new service delivery models or the collaboration of the partners when the project is operational. The project will provide supports to the PCN, the RHA, and the First Nations communities to help in aligning and integrating the necessary policies and procedures.

u. *Change Management specific to Telehealth* - Provision of clinical services by telehealth is significantly different than providing services within a traditional clinical setting. It requires shifts in behaviour and attitudes of staff, patients and providers in terms of scheduling appointments, delivering the services, interpersonal communications, and time management. Staff and providers must also learn to operate new technology and to

feel comfortable using the technology for clinical service delivery. Change Management activities can facilitate the implementation and adoption of telehealth services by both providers and patients through participatory methodology. This means that change management will be collaboratively facilitated with the participation of each of the health centres within the First Nation communities at the decision-makers' level and at the level of the healthcare staff. This application recognizes that policymakers and healthcare staff each have vested interests to implement telehealth to best serve First Nation communities.

Change management activities will include, but not be limited to, (i) collaboratively creating an awareness campaign within the communities (ii) collaboratively identifying non-telehealth service provision workflows and documenting how these workflows need to change to accommodate telehealth; (iii) providing assistance to the physicians in Fort McMurray to practice and learn the new ways of providing services; (iv) linking the nurse practitioners to other nurses or nurse practitioners who provide services by telehealth. This may be a temporary or long-term support; and (v) identifying other physicians who provide services by telehealth and linking them to the Fort McMurray physicians on a temporary or long-term basis.

For telehealth-specific change management, the project will rely on the Treaty 8 Canada Health Infoway Telehealth Project to assist in providing resources and direction.

Evaluation

The evaluation plan follows a Participatory Action Research (PAR) model, to empower First Nations people, the healthcare staff, and the stakeholders in managing, controlling, and enabling all their health resources for a beneficial mutual partnership. According to many researchers, PAR, best reflects Indigenous ways of understanding and completing evaluation and research.[9] This evaluation process will involve decision-makers and healthcare staff to improve healthcare services. The evaluation will focus both on the processes used to establish the partnership and the outcomes achieved as a result of the partnership.

Consistency with AHTF objectives: The objectives for the Aboriginal Health Transition Fund are:

- improved integration of federal, provincial, territorial (F/P/T) funded health systems;
- improved access to health services;
- health programs and services that are better suited to Aboriginal peoples; and
- increased participation of Aboriginal peoples in the design, delivery, and evaluation of health programs and services.

The partnership between ATC, FNIH, and NLHR will increase both the level of health services provided to First Nations communities, and the level of integration between the various health

[9] Balcazar, F. E. etal. Participatory Action Research: General Principles and a Study with a Chronic Health Condition, 2004.
Minore, Bruce, et al. "Addressing the Realities of Health Care in Northern Aboriginal Communities through Participatory Action Research." Journal of Interprofessional Care 18.4 (2004): 360-69.
Smith, Linda Tuhiwai. Decolonizing Methodologies. 2004.

providers. The Partners are committed to working together to resolve jurisdictional and organizational barriers using innovative means. The Partners plan on bridging the gaps created by the jurisdictional and organizational barriers.

The on-going consultation and participation of the First Nations communities in identifying gaps in health service delivery, in setting health service priorities, and in planning for appropriate health service delivery to the communities, will provide the fundamental groundwork for establishing programs appropriate for the First Nations communities in the Regional Municipality of Wood Buffalo.

Challenges: The key challenges will be to align policies and procedures, aligning jurisdictions (F/P) and partnership development. These challenges will be addressed in this project by engaging in processes leading to the development and signing of an MOU, relationship and trust building, development of accountability structures, transparency, and new ways of delivering programs and services. However, the objectives of this project are aligned with the mandate of each organization and the Partners are committed to this process, and to working together to overcome any potential organizational and resource barriers. There is senior level commitment from each organization for the project.

The existing scarcity of health human resources, not only in NLHR but also across Alberta, will be a challenge for the implementation of some aspects of the project.

3.3.2 Work Plan

Project Title: Enhancing Primary Care Services for the First Nations' People within the Regional Municipality of Wood Buffalo

Organization: Athabasca Tribal Council

Overall Objective: To develop and implement an action plan for increasing access to Primary Health Services for the First Nations people of the Regional Municipality of Wood Buffalo.

Specific Objectives	Activities	Expected Outcomes	Timelines
Continued development and facilitation of the partnership between the Athabasca Tribal Council, the Northern Lights Health Region	Contract with consultant to provide research, professional advice, communications support, and supportive systems that will improve the partnership over time.	Building on the signed Memorandum of Intent, formalize the partnership between the key partners (the Athabasca Tribal Council, the Northern Lights Health Region), with a signed Memorandum of Understanding	July 2008 – June 2009
		Based on the eight broad areas identified in the needs assessment, refine a plan that outlines how best to improve integration of services from the various health care provider organizations; how to modify existing services; and how to develop further services	July 2008 – March 2009
		Signed service agreement between partners outlining specifics of program delivery	January 2009 and ongoing as required

Specific Objectives	Activities	Expected Outcomes	Timelines
		Enhanced working relationships between the partners and the First Nations communities	Ongoing
	Identification of new partnership opportunities to enhance service delivery to First Nations people	Provision for inclusion of other provider organizations (e.g. Capital Health, CIHI, University of Alberta) as required	Ongoing
Continued community consultation and participation	Ongoing communication and participation with communities	Increased participation of First Nations communities in determining how best to provide needed services	Ongoing
		Established formal mechanism for ensuring community participation in establishing health service needs	January 2009
Implemented change management	Review and align policies and procedures within the region between the organizations	Increased collaboration and consistency of expectations and outcomes	December 2008 – ongoing
	Change management activities to support the incorporation of new service delivery models	Acceptance by First Nations communities of new service delivery models	November 2008 – ongoing
		Acceptance of Regional staff and health professionals of new service delivery	November 2008 – ongoing
		Increased capacity within the First Nations communities to support health services	November 2008 – ongoing
		Regional staff and health professionals appropriately trained to provide health services to the First Nations communities	November 2008 – ongoing
		Seamless incorporation of new service delivery into the routines of Regional staff and health professionals	Ongoing
Ongoing evaluation of the initiative	Contract external evaluators to	Selection of external evaluators	September 2008

Specific Objectives	Activities	Expected Outcomes	Timelines
	develop and implement an appropriate evaluation of the initiative	Refinement of the evaluation framework	November 2008
		Interim results leading to refinement of process, as necessary	Ongoing
		Completed evaluation	June 2010 (final evaluation report due after completion of project)
Development and implementation of program delivery			
Increased training of locals for health related positions	Establish a sub-committee to develop health fairs for the communities	Implemented plan for providing information to the communities	January 2009 - ongoing
		Increased awareness amongst the First Nations people as to what options there are for health-related careers	January 2009 - ongoing
	Formalize discussions with educational institutions regarding distance education programs	Implemented plan for making distance education programs available to the First Nations communities	January 2009 - ongoing
		Increased number of First Nations people training for health related careers	January 2009 - ongoing
Enhanced telehealth equipment and capabilities	Ensure proper equipment and physical location of equipment	Review of technical and physical requirements for telehealth	July – October 2008
		Installation of upgraded telehealth equipment in identified communities	July – December 2008
	Change management activities	Work with the Treaty 8 Canada Health Infoway Telehealth Project to identify and allocate resources for the Regional Municipality of Wood Buffalo	September – December 2008

Specific Objectives	Activities	Expected Outcomes	Timelines
		Change management activities for staff/health professionals involved in telehealth	November 2008 - ongoing
		Development and implementation of a public communication and change management process to properly orient the First Nations communities in consultation with communities	November 2008 – July 2009
	Establish regular staff and community education programming	Establish an education program roster	March 2009
		Identify education provider	January – March 2009
		Implement telehealth education programming (note: this outcome will be related to Increased Primary Health prevention and Promotion services objective)	April 2009 - ongoing
Increased clinical telehealth programming	Establish regular telehealth clinical service delivery in each community	Identification of service delivery to be provided by telehealth	January – March 2009
		Identification of clinical service deliverer	February – April 2009
		Development of implementation plan for service delivery	February – April 2009
		Implemented clinical telehealth service delivery	June 2009 – ongoing
	Develop a plan for provision of other identified health services to the communities	Appropriate and timely health services specific for the needs of the First Nations communities	Ongoing
		Improved integration of regional services in the First Nations communities	Ongoing
Increased primary health prevention and promotion services	Identify resources to develop programming in nutrition education	Increased knowledge of nutrition and its importance to health in the First Nations communities	January 2009 - ongoing
	Identify resources to develop programming in chronic disease education	Increased knowledge amongst the First Nations people on how to prevent and/or treat chronic diseases	January 2009 - ongoing

Specific Objectives	Activities	Expected Outcomes	Timelines
	Preparation, printing, distribution of age, education, language appropriate health materials	Increased awareness and knowledge in the First Nations communities	January – December 2009
Increased access to mental health services	Formalize a sub-committee to examine the issue of increasing the number of mental health workers within the region	Development of a plan to increase access to mental health workers on a continuous basis.	January – April 2009
	Develop a program for enhanced access to mental health services	Recruitment of mental health providers, whether in-person or via telehealth services	May 2009 - ongoing
		Increased access to mental health workers in all communities	May 2009 - ongoing
Increased access to dental services	Formalize a dental recruitment program	Increased access to dental treatment services in First Nations communities	January – December 2009
	Expand the scope of the preventative dental program offered through NLHR and FNIH	Increased preventative dental programming for First Nations communities	January – December 2009
Increased access to nurse and nurse practitioner services	Develop a plan for implementing a NP program within the region to serve the First Nations communities	Develop a clear mandate addressing the responsibility and scope of the services to the ATC communities, with first focus on Janvier and Gregoire Lakes.	November 2008 – March 2009
		Identification of how the funds for an ongoing NP program will be obtained	November 2008 – March 2009
		Integrate NP services into the WBPCN	November 2008 – March 2009
		Actively recruit for a NP	January 2009
	Develop a program for increased recruitment of	Active recruitment campaign for additional PHNs and HCNs to work in and support the First Nations communities	January 2009 - ongoing

Specific Objectives	Activities	Expected Outcomes	Timelines
	nurses (PHN and HCN) for continuity and relief	Enhanced nursing services in all of the First Nations communities	June 2009 - ongoing
	Develop a program for networking and education opportunities for nurses	Increased job-satisfaction and reduced stress amongst nurses in the First Nations communities	July 2009 - ongoing
Increased access to physician services	Formalize a working group with the University of Alberta, Faculty of Medicine and Dentistry	Implemented plan for provision of physician services to the First Nations communities, with possible benefit to the physicians in Fort McMurray	November 2008 – March 2010

3.3.3 Budget

1. Personnel
    - Partnership Liaison Consultant
    - Administrative support – Assistant to the ATC Health Director
    - Telehealth change management support – contribution of Treaty 8 Canada Health Infoway Telehealth Change Management Project

2. Supplies and Services
    - Long distance telephone and fax
    - Photocopying/printing
    - Minor office supplies (paper, etc)
    - Annual financial audit reports
    - ATC administration
    - Teleconferencing – in-kind contribution by NLHR and FNIH

3. Travel and Accommodation
    - Semi-annual meeting of the five chiefs and the CEOs
    - Quarterly meeting of the five Health Directors
    - Quarterly meeting of the partners in Fort McMurray – FNIH to fly up – in-kind contribution
    - Monthly travel and accommodation for the Partnership Liaison Consultant
    - Vehicle rental for the Partnership Liaison Consultant

- Monthly travel costs for the ATC-based trainer
- Travel costs for community representatives to attend formal Signing Ceremony
- Regular travel for evaluation purposes – accounted for under evaluation

4. Equipment and Office Rental
   - Videoconference unit for ATC
   - One computer per health centre (Janvier, Gregoire Lakes, Fort Chipewyan) for on-line training
   - All other equipment and office use will be in-kind contributions from the partners

5. Communication and Dissemination
   - Community consultation (including hosting)
   - Partnership meeting expenses
   - Reporting to the Aboriginal Health Transition Fund
   - Participation in provincial primary care activities and other conferences
   - Formal signing ceremony for Memorandum of Intent

6. Training and Staff Development - includes change management activities

7. Evaluation
   - External evaluation team

8. Capital Costs
   - None anticipated

9. Other
   - Preparation, printing of age, education, language appropriate health materials
   - Purchase of training materials for distance education courses
   - Health/job fair activities
   - Subcommittees for physician, nurse and dental recruitment and sustainability planning

4. Attachments

Attachment 1 - Letters of support

Signed Memorandum of Intent between Athabasca Tribal Council, First Nations and Inuit Health, and Northern Lights Health Region

Attachment 2 - Letter of incorporation

1. Athabasca Tribal Council

Attachment 1 – Memorandum of Intent

Memorandum of Intent

Between

Athabasca Tribal Council

and

Health Canada, First Nations and Inuit Health

and

Northern Lights Health Region

PREAMBLE

The Athabasca Tribal Council (ATC), Health Canada, First Nations and Inuit Health (FNIH), and Northern Lights Health Region (NLHR), (collectively "the Participants") recognize the importance of closing the health gaps between First Nations and other Albertans, and of establishing a new working relationship between the Participants based on mutual respect and recognition.

The Participants acknowledge that the status quo will not close the health gaps between First Nations and other Albertans and that improvement of current health programs and services is required. It is also recognized that the health care needs of First Nations people encompass the physical, spiritual, mental, economic, emotional, environmental, social and cultural wellness of the individual, family and community and require a holistic approach.

DEFINITIONS

For the purpose of this Memorandum of Intent, the following definitions are used:

First Nations people – specifically the First Nations people residing within the boundaries of the Regional Municipality of Wood Buffalo. These include the Athabasca Chipewyan First Nation, Chipewyan Prairie First Nation, Fort McKay First Nation, Fort McMurray No. 468 First Nation, and Mikisew Cree First Nation.

Participants – the Participants of this Memorandum are:

- Athabasca Tribal Council [9206 McCormick Drive, Fort McMurray, AB T9H 1C7. Telephone – (780) 791-6538, Facsimile – (780) 788-1764]
- Health Canada, First Nations and Inuit Health [Suite 730, 9700 Jasper Avenue, Edmonton, AB T5J 4C3. Telephone – (780) 495-2703, Facsimile – (780) 495-2687]
- Northern Lights Health Region [7 Hospital Street, Fort McMurray, AB T9H 1P2. Telephone – (780) 791-6161, Facsimile – (780) 791-6029]

Primary Health Care - is the first level of contact with the health system to promote health, prevent illness, care for common illnesses, and manage ongoing health problems. It is socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. It includes the following: health promotion, illness prevention, care of the sick, advocacy, and community development.

Primary Health Care Services – the means of providing the appropriate primary health care.

1. PURPOSE

The purpose of this Memorandum of Intent is to develop a collaborative and coordinated approach to the improvement of the primary health care services to First Nations people within the Regional Municipality of Wood Buffalo.

2. ROLES AND RESPONSIBILITIES

2.1 The Participants acknowledge and respect that there are established jurisdictional and fiduciary relationships and responsibilities, but will work to actively remove impediments to progress by establishing effective working relationships among the Participants.

2.2 First Nations recognize their responsibility and leadership role in improving the health of First Nations individuals, families and communities.

2.3 The Participants recognize the importance of engaging the expertise of First Nations communities and of health care professionals in the design and delivery of health programs and services to First Nations.

2.4 The Participants acknowledge that their active participation is required in order to improve First Nation's health outcomes.

3. PRIORITIES AND ACTIONS

3.1 The Participants will explore opportunities to improve access to primary health care services that meet the needs of First Nations communities.

3.2 The Participants may also discuss other priorities that may be identified from time to time, including new initiatives that bring together First Nations communities, governments, other health organizations, and private sector to work on a common goal of improved health outcomes.

3.3 The Participants further intend to discuss changes to programs and services that might impact the other Participants and to address where possible.

4. SERVICE CONTRACTS

4.1 Any and all service contracts that are entered into between NLHR, FNIH, and a First Nations organization must include appropriate mechanisms for monitoring by ATC, to ensure that full service is provided on behalf of the First Nations. This does not include individual contracts made directly between FNIH and a First nations organization.

5. CONFIDENTIALITY

5.1 The Participants expect that information exchanged under this Memorandum of Intent will be provided in a form appropriate for public dissemination under applicable laws and the policies, procedures, rules or regulations of the transmitting Participants. Information that is not appropriate for public dissemination should be shared according to the policies, procedures, rules or regulations of each Participant as permitted by the laws of their respective jurisdictions.

6. DURATION

6.1 Each Participant may request that the Memorandum of Intent be reviewed, amended or replaced by providing ninety (90) days written notice to the other Participants.

6.2 Upon receipt of such notice by all Participants, the requesting participant shall call a meeting of the Participants to discuss and establish a process to review, amend or replace this Memorandum of Intent within a time frame to be agreed upon by the Participants.

6.3 Any Participant may terminate its participation in the arrangement proposed in this Memorandum of Intent for any reason, in its sole discretion, upon ninety (90) days written notice to the other Participants.

6.4 Any notice to be given under terms of this agreement shall be deemed given to the other parties if in writing and personally delivered, sent by prepaid registered mail, or sent by facsimile, addressed to the organizational addresses provided above.

7. LEGAL EFFECT OF MEMORANDUM OF INTENT

7.1 This Memorandum of Intent sets out the general terms of the Participants' intent. Notwithstanding the intent of each Participant to proceed with the initiatives contemplated herein, this Memorandum of Intent is not intended to, nor does it, constitute a binding and enforceable agreement.

7.2 Nothing in this Memorandum of Intent shall:

(a) be construed to diminish, derogate from, or prejudice any treaty or Aboriginal rights of the First Nation;

(b) prejudice whatsoever any applications, negotiations or settlements with respect to land claims or land entitlements between Canada and the First Nation;

(c) prejudice whatsoever the implementation of the inherent right to self-government nor prejudice in any way negotiations with respect to self-government involving the First Nation, or;

(d) be construed as modifying Treaty No 8 or creating a new treaty within the meaning of the *Constitution Act, 1982.*

8. SPECIFIC PROGRAMS AND SERVICES

8.1 The Participants acknowledge and agree that any specific programs or services to be provided by one or more of the Participants as a result of the discussions and consideration contemplated in this Memorandum of Intent, shall be subject to the negotiation and execution of a separate agreement reflecting the terms and provisions as negotiated and agreed upon by the Participants.

9. SIGNATURES

HEALTH CANADA, FIRST NATIONS AND INUIT HEALTH	Herman Wierenga Regional Director, First Nations and Inuit Health, Alberta Region	_____
NORTHERN LIGHTS HEALTH REGION	Bernie Blais Chief Executive Officer	_____
ATHABASCA TRIBAL COUNCIL	Chief Allen Adam Health Portfolio, Athabasca Tribal Council	_____

Memorandum of Intent

Between

Health Canada, First Nations and Inuit Health

and

Northern Lights Health Region

and

Athabasca Tribal Council

Health Canada / Santé Canada

Herman Wierenga
Regional Director, First Nations Inuit Health, Alberta Region

Northern Lights Health Region

Bernie Blais
Chief Executive Officer

Athabasca Tribal Council

Chief Allen Adam
Health Portfolio, Athabasca Tribal Council

Date: March 26, 2008

Attachment 2 - Letter of Incorporation for ATC

CORPORATE ACCESS NUMBER

20379068

Alberta
GOVERNMENT OF ALBERTA

BUSINESS CORPORATIONS ACT

CERTIFICATE
OF
AMENDMENT

ATHABASCA TRIBAL CORPORATION
CHANGED ITS NAME TO **ATHABASCA TRIBAL COUNCIL LTD.** ON
MAY 16, 1997.

REGISTRIES
GOVERNMENT OF ALBERTA

Registrar of Corporations

REG 3068 (96/01)

Attachment 3 - Communication Plan

Reporting to Partners

Representatives of the Partner organizations will formally communicate on no less than a monthly basis. During the initial stages of the project communication will be more frequent. Communication will include emails, telephone conversations, videoconferencing, and face-to-face meetings.

The Partnership Liaison Consultant will ensure all reports and committee minutes will be posted on the Onehealth portal for easy access by all Partners.

The Partnership Liaison Consultant/Project Coordinator will prepare monthly project reports for the ATC Health Director to circulate to the other partners.

Reporting to AHTF

The Partnership Liaison Consultant/Project Coordinator will prepare quarterly activity reports for the ATC Health Director to submit to the AHTF.

A final report, including a separate evaluation report, will be produced at the end of the project.

Reporting to Community members

The community members will be actively engaged throughout the course of the project. Participation will occur at different levels of the community. The Tribal Chiefs and Health Directors will play an important role in guiding the ATC through the process, and in ensuring information exchange within the communities.

The Partners will use existing mechanisms to share information with the communities, e.g. Health centres, community newsletters.

Reporting to/Partnering with other organizations

The ATC Health Director and the Partnership Liaison Consultant/Project Coordinator will take the lead roles in contacting other organizations to discuss potential working relationships and involvement in additional activities to enhance primary health services in the Regional Municipality of Wood Buffalo.

The ATC Health Director and the FNIH Clinical Telehealth Lead will use their roles on the Treaty 8 Canada Health Infoway Telehealth Project to a) update on the status of this project, and b) to influence the overall direction of clinical telehealth support for First Nations communities in the north.

The ATC Health Director, the FNIH Clinical Telehealth Lead and the Partnership Liaison Consultant/Project Coordinator will actively work with existing clinical telehealth programs and to bring focus to the primary health service needs of the First Nations Communities in the Regional Municipality of Wood Buffalo.

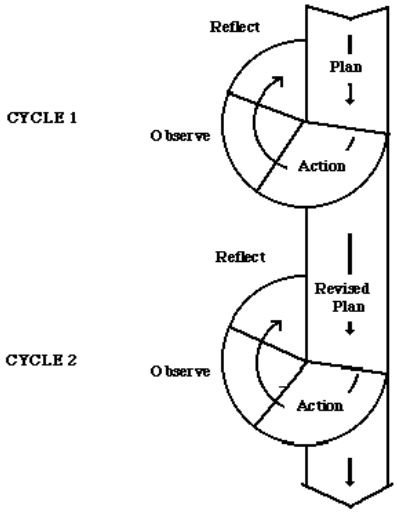
Reporting to the Media

The Partners will work together to have a common message for media events, such as at the formal Signing Ceremony for the Memorandum of Understanding.

Attachment 4 – Evaluation Plan

One method of participatory evaluation is sometimes referred to as 'action research' or 'action evaluation'. Action evaluation is generally considered to be a family of methodologies that pursue action (or change) and research (or understanding) at the same time. In most of its forms it does this by using a cyclic process that alternates between action and critical reflection and in the later cycles, continuously refining methods, data and interpretation in the light of the understanding developed in the earlier cycles. The following diagram shows this cycle of planning, action, observing and reflecting[10].

Figure 1 – Participatory action evaluation cycles



Thus action evaluation is an emergent process that takes shape as understanding increases. It tends to be an iterative process focused towards better understanding what happens. In most of its forms it is also participative (since change is usually easier to achieve when those affected by the change are involved) and qualitative. Action evaluation is best used in 'real' life situations, rather than in controlled, experimental studies, since its primary focus is on solving real problems and generating genuine and sustained improvements. This makes it an ideal approach for the evaluation of the Enhancing Health Services in the *Regional Municipality of Wood Buffalo Project*.

An Evaluation Team will be asked to develop their methodology in order to capture the information in a meaningful, but cost-effective manner. Specifically, the methodology should provide the following:

- Ensure there are sufficient opportunities for the Partnership Liaison Consultant and the Evaluation Steering Committee to provide direction at critical points in the project;
- Ensure that there are sufficient opportunities for feedback and reflection with the Partnership Liaison Consultant and Evaluation Steering Committee;

[10] Hopkins, D. (1985). A teacher's guide to classroom research. Philadelphia: Open University Press.

- Establish opportunities for a variety of stakeholders (service providers, patients, families, and others) to provide information and comments; and
- Provide sound, clearly articulated findings and recommendations to the project partners, and to Health Canada.

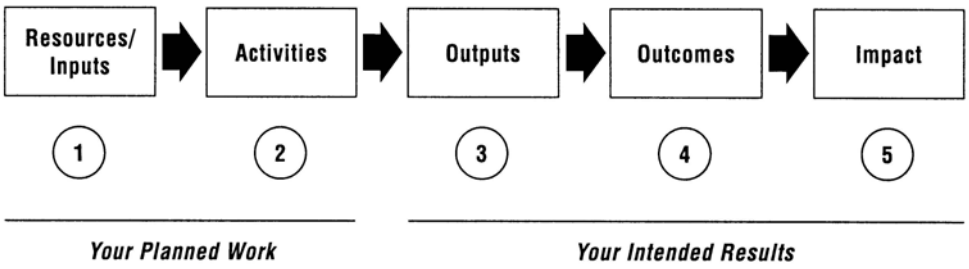
The methodology should provide ample opportunity for the Evaluation Team and the Partnership Liaison Consultant and the Project Team to discuss observations and their implications in order to address barriers and challenges as they are identified.

As indicated previously, the Evaluation Team will be expected to incorporate an action oriented evaluation approach. Although the evaluation will use both qualitative and quantitative data, particular emphasis is placed on the qualitative data. A variety of means will be used for data collection including review and analysis of administrative and clinical documentation, surveys, interviews and focus groups.

Logic Model and Evaluation Framework

An Evaluation Logic Model is a visual, systematic approach to defining the relationships amongst the resources available to the program, the activities that will be undertaken, and the intended results from the program. A basic schematic of a logic model is displayed below.

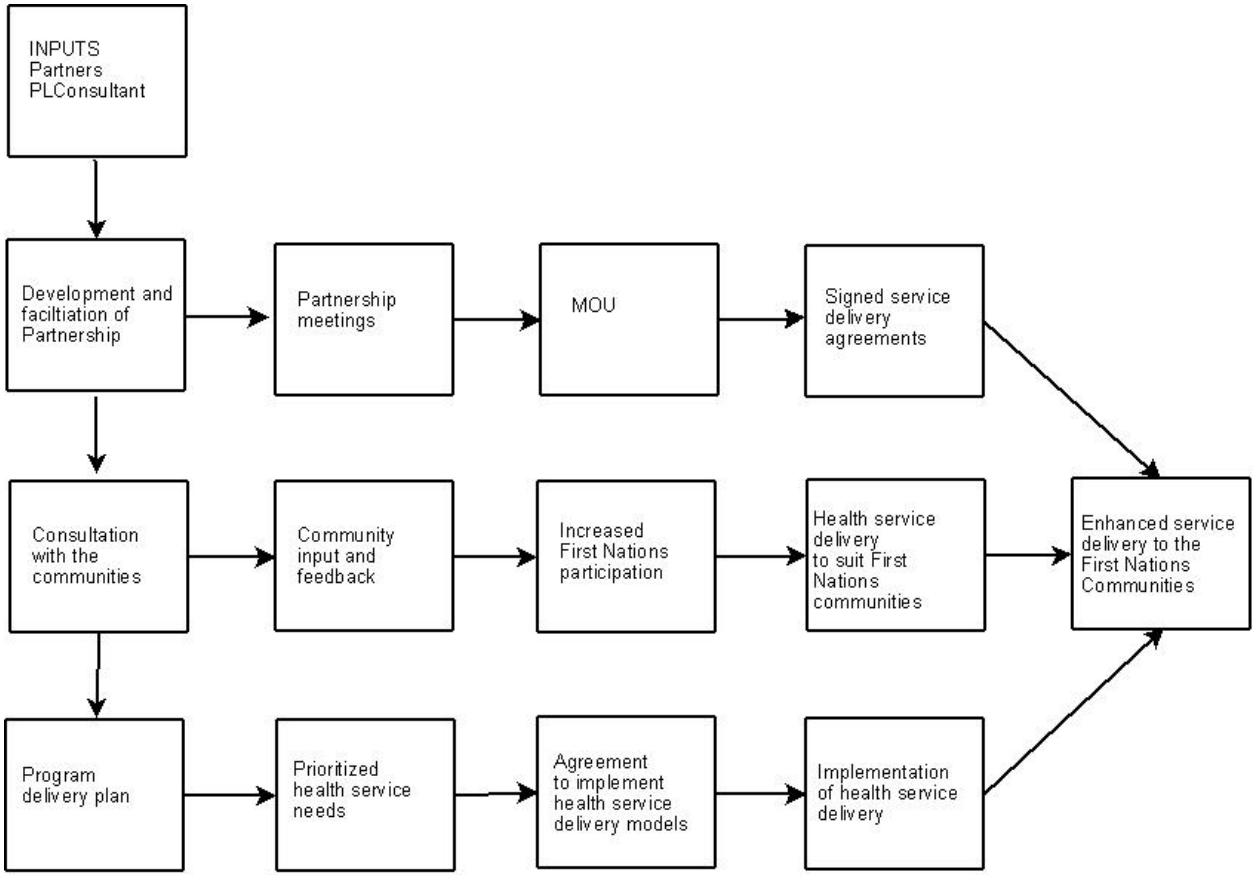
Figure 2 Basic Logic Model Schematic[11]



The following is a draft of the logic model for the project. Once the External Evaluators are contracted, the logic model will be refined and an evaluation framework developed.

[11] WK Kellogg Foundation. (2001) Logic Model Development Guide. www.wkkf.org/pubs/Pub3669.pdf

Figure 3 Draft Logic Model



Ethical Considerations

It is expected that the evaluation be conducted in accordance with standard ethical practices and guidelines. It is unlikely that the Evaluation Team will require formal ethical approval. However, if required, the Partnership Liaison Consultant will work with the evaluators to obtain any necessary ethical approval.

ATC will be overseeing both the project and the evaluation. ATC will ensure that cultural sensitivities are recognized and respected.

Attachment 5 – Sustainability Plan

The main focal point of sustainability is the Memorandum of Intent that was developed and signed during Phase I of the project.

The project is focused on developing and implementing appropriate primary health service delivery for First Nations communities in the Regional Municipality of Wood Buffalo, based on the needs of the individual communities. The needs have been identified through the participation of the communities. The project will continue to develop the First Nations communities' participation as the Partners proceed into the service delivery phase.

The major Partners, and their senior organizational managers have been identified and have begun the process of collaborating and formalizing the partnership. The Partners are committed to working with each other to enhance primary health services in the Regional Municipality of Wood Buffalo and are intent on delivering high quality, appropriate health services to the First Nations communities.

The Partners will take the time, up-front, to identify appropriate resources for the project and set up a governance structure that will not only manage the project, but continue on to govern the joint service delivery agreements.

Each Partner will bring in additional resources, as required, to support the project and the ongoing service delivery. They recognize that in-kind contributions from each organization will be necessary. Although there are currently some budgetary items that have no final answers (e.g. full funding for a Nurse Practitioner), the Partners have the intent and goodwill to continue moving forward to resolve these issues in a timely manner.

FNIH is committed to increasing telehealth capability in First Nations communities across Alberta. They have funding for connectivity and equipment. This aspect of health service delivery will occur regardless of the *Planning for Enhanced Primary Health Services in the Regional Municipality of Wood Buffalo*. However, by incorporating it into the larger project, and ensuring that health service needs are appropriately defined, the end service delivery will be better integrated into the operations of the NLHR and Wood Buffalo PCN and will provide better service to the First Nations communities.

FNIH has also committed funding towards a Nurse Practitioner. By including the planning of the Nurse Practitioner service delivery in this project, the Nurse Practitioner will be fully integrated into the Wood Buffalo PCN, which will provide her with supports and resources that would not otherwise be accessible.

The ATC will provide in-kind support during the project by providing office space and administrative support to the Partnership Liaison Consultant. The active involvement of ATC has the support and commitment of its senior management.

Attachment 6 – Terms of Reference for the Joint ATC/FNIH/NLHR Steering Committee

PURPOSE:

To oversee the development and implementation of the appropriate primary health care service delivery to the First Nations communities in the Regional Municipality of Wood Buffalo through improved integration, coordination, and collaboration between the partner organizations.

ACCOUNTABILITY and AUTHORITY

In order to develop an effective working partnership between the organizations, the Steering Committee has the authority to develop the partnership framework and to ensure that they are acceptable and beneficial to the sponsoring organizations; to develop and conduct a process to identify the primary care needs of the First Nations communities within the Regional Municipality of Wood Buffalo; to develop a proposal for the Aboriginal Health Transition Fund; and to make decisions related to the development and implementation of primary health care service delivery.

The Steering Committee is accountable to:

(a) Health Canada – Aboriginal Health Transition Fund (project funder) – The Steering Committee will provide accurate written documentation and accounting of the project as specified by the grant.

(b) Athabasca Tribal Council – The Steering Committee will be accountable to the Athabasca Tribal Council Chiefs.

(c) Northern Lights Health Region – The Steering Committee will provide timely and accurate documentation to the Regional CEO in order for the Northern Lights Health Region to plan and allocate appropriate and adequate resources.

(d) Health Canada – First Nations and Inuit Health - The Steering Committee will provide timely and accurate documentation to the Department in order for Health Canada to plan and allocate appropriate and adequate resources.

COMMITTEE APPOINTMENT & COMPOSITION:

Organization	Representative	Alternative Representative(s)
Athabasca Tribal Council	Director of Health (Patrick Mercredi)	Donna Cyprien, Health Director, Nunee Health Board
Northern Lights Health Region	Chief Integration, Liaison and Emergency Preparedness Officer (Mike Linn)	Madge Aplin, VP Community Services
Health Canada	Program Liaison Officer –	Levina Ewasiuk/Deborah

Organization	Representative	Alternative Representative(s)
	Treaty 8 – Aaron McEwan	Greyeyes Christopher Sarin

TERM:

The committee will meet for an indefinite period of time.

MEETINGS:

For the initial development and implementation phase of the project (October 2007 – June 2008), Steering Committee meetings will be scheduled every 4-6 weeks. During the implementation phase of the project (July 2008 onwards), meetings may be scheduled every 8-10 weeks, or at the call of the Chair.

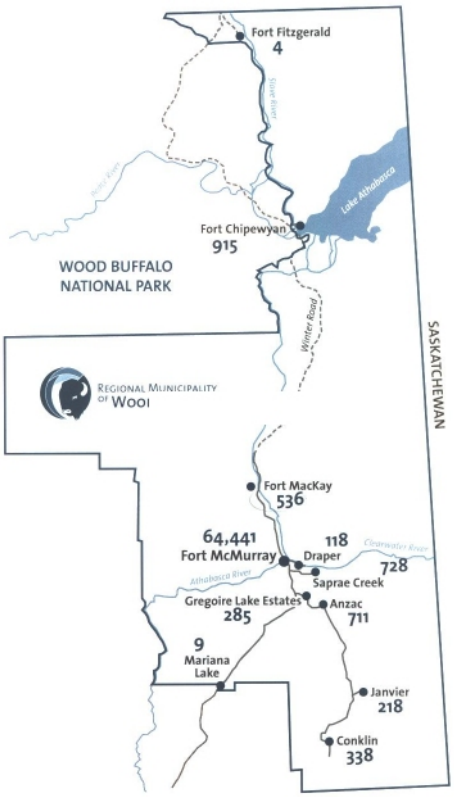
Although the Steering Committee will meet regularly, decisions will also be made based on electronic communication. Steering Committee members are expected to reply to electronic communications in a timely and appropriate manner.

QUORUM:

One member from each organization, whether representative or alternative representative, must be involved in the decision-making. Decisions can be submitted electronically before a meeting if a member is unable to attend in person.

Attachment 7 – Summary of Community Needs Assessment

The community data shown here is very general. Health Canada, Statistics Canada, and Indian and Northern Affairs were unable to provide any more specific information other than what it is available in publications. Any additional community information would have to come directly from the community.



1.1 Table: Population in the Regional Municipality of Wood Buffalo by Area from 1999 to 2007

Fort McMurray1	36,452	42,156	47,240	56,111	60,983	61,366	65,400
Anzac	397	446	548	647	685	711	714
Conklin	215	219	213	210	242	338	299
Draper	47	60	84	141	148	118	185
Fort Chipewyan	1,020	1,036	1,012	1,146	744	915	1,007
Fort Fitzgerald			30	4	12	4	2
Fort MacKay	262	399	186	218	104	536	737
Gregoire Lake Estates	163	206	184	206	180	285	248
Janvier	207	185	143	112	141	218	178
Mariana Lake	7	15	11	8	5	9	9
Saprae Creek	509	659	603	624	754	728	737
Hinterland2		122				47	43
First Nations Reserves3						1,018	1,036
Shadow Population:4							
- Project Accomodation5,6	3,568	5,903	8,063	7,678	9,178	10,442	18,572
Total	**42,847**	**51,406**	**58,317**	**67,105**	**73,176**	**76,735**	**89,167**

1 The work camp, hotel/motel and campground population residing in Fort McMurray are included in the total.

2 "Hinterland" means sparsely populated region outside of Urban and Rural Service Areas, and does not include First Nations Reserves, Work Camps and Campgrounds.3 Source: Department of Indian Affairs and Northern Development, First Nations Profiles Population Data as of June 2007.4 "Shadow Population" means temporary residents of a municipality who are employed or will be employed by an industrial or commercial establishment in the municipality for a minimum of 30 days. 5 Maximum project accommodation capacity permitted as of Aug 30 2007 in the RMWB was 26,417 beds (Source: RMWB). 6 Source: Regional Issues Working Group (RIWG).

Source: Regional Municipality of Wood Buffalo. Municipal census 2007.

Wood Buffalo
Alberta
(Regional municipality)

Alberta
(Province)

Aboriginal population	Wood Buffalo, Regional municipality			Alberta		
	Total	Male	Female	Total	Male	Female
Total Aboriginal and non-Aboriginal identity population[44]	51,410	27,610	23,800	3,256,360	1,630,870	1,625,485
Aboriginal identity population[45]	5,365	2,830	2,530	188,365	91,740	96,625
Non-Aboriginal identity population	46,045	24,780	21,265	3,067,990	1,539,125	1,528,865

Notes:

1. 2006 and 2001 population based on 100% data

Source: http://www12.statcan.ca/english/census06/data/profiles/community/ Last accessed 11 April 2008

Janvier - Chipewyan Prairie

Roads – Janvier is located 97 km. South of Fort McMurray.

Source:
http://www.aboriginalcanada.gc.ca/abdt/apps/connectivitysurvey.nsf/vAllCProfile_en/881.html last accessed 11 April 2008

Air Services

There is a gravel runway for small aircraft but there are no scheduled flights.

Source: http://www.atc97.org/cpfn.html last accessed 11 April 1008

Highest priority needs as identified in the community:

1. Substance abuse
2. Mold in houses
3. Communicable diseases
4. Family physician services
5. Dental services
6. Recreational activities and recreational director
7. Social programming e.g. for elders, young mothers, etc.
8. Affordable groceries/grocery store
9. Skilled human resources to do health related positions

Fort MacKay – First McKay First Nations

Economic Base

Suncor and Syncrude employ some residents. Seasonal work in the forest industry, such as fire fighting and slashing provide another source of employment. Hunting and trapping are used by some to supplement income.

Roads

Fort McKay is approximately 65 kms from Fort McMurray. Highway 63 from Fort McKay to Fort McMurray is paved.

Air Services

The nearest airstrip is 3 kms south at Mildred Lake. There is a paved and lighted airport at Fort McMurray.

Railway

The nearest depot is in Fort McMurray.

Bus Service

Daily service to and from Fort McMurray.

Source: http://www.atc97.org/ftmckayfn.html last accessed 11 April 08

Highest priority needs as identified in the community:

1. Dental services
2. Physical therapy services
3. Dietetic services
4. Nursing services
5. Counselling services – particularly gender specific
6. Chronic diseases
7. Skilled human resources to do health related positions

Gregoire Lakes Area - Fort McMurray First Nations

Economic Base

The Band does some contract pallet manufacturing for some of the oil companies. Other sources of employment have been the Syncrude, Suncor, Petro-Canada and Amoco sites.

Other sources of seasonal employment can be found in the forest industry with fire fighting, reforestation, and slashing activities.

Hunting and trapping is used mainly as a supplementary income.

Roads

The Gregoire Lake Reserve is approximately 50 kms from Fort McMurray. The paved road consists of approximately 33 kms along Highway #63 and 18 kms along secondary Highway #868.

Air Services

There is a private grass airstrip near the community. The nearest paved and lighted airport is Fort McMurray.

Railway

No passenger service.

Bus Service

Flag stop bus service is available at Anzac corner, which is at the junction of Highway #63 and secondary Highway #868. This flag stop is approximately 18 kms away from Anzac.

Source: http://www.atc97.org/ftmcmurrayfn.html last accessed 11 April 2008

Highest priority needs as identified in the community:

1. Mold in houses
2. Overcrowding in houses/shortage of houses
3. Substances abuse
4. Communicable diseases
5. Nursing services
6. Physician services
7. Dental services
8. Chronic diseases
9. Medical transportation system – needs improving
10. Social support groups, e.g. young moms, etc.
11. Water testing in homes
12. Parenting skills courses

Fort Chipewyan - Mikisew Cree and Athabasca Chipewyan

Athabasca Chipewyan First Nations reserve is across the lake from the hamlet of Fort Chipewyan in the southwestern tip of Lake Athabasca.

Fort Chipewyan is approximately 200 air kms north of Fort McMurray and 600 kms northeast of Edmonton.

Economic Base

The three major resource base activities in the Fort Chipewyan area was trapping, fishing and lumbering. Today, commercial fishing generates some revenue. Seasonal fire fighting opportunities supplement some member's income. Many members work in government and business service positions in Fort Chipewyan. Other sources of employment have been with Syncrude, Suncor and other oil sands related companies.

Roads

The only vehicle access to Fort Chipewyan is via a winter road from Fort Smith, 140 kilometers to the north or from Fort McMurray, 303 kilometers.

Air Services

Fort Chipewyan has a paved all weather, lighted airstrip. Scheduled air service from Fort McMurray and Edmonton provides residents with food, clothing and all supplies. Mikisew's Contact Airlines provides the air service six days per week. In addition a number of air charter services are available from Fort McMurray.

River Barge Service

Although there is no passenger service via the river barge they are used during the summer to transport goods to the community.

Railway

No rail service to this community.

Bus Service

There is a weekly bus service from Fort McMurray to Fort Chipewyan when the winter road is open.

Source: http://www.atc97.org/acfn.html last accessed 11 April 2008


MAXIMUM
5
km/h
STOP

Highest priority needs as identified in the community:

1. Augmentation of existing services – medical, nursing, dental, allied health
2. Skilled human resources to do health related positions
3. Additional resource materials for target populations