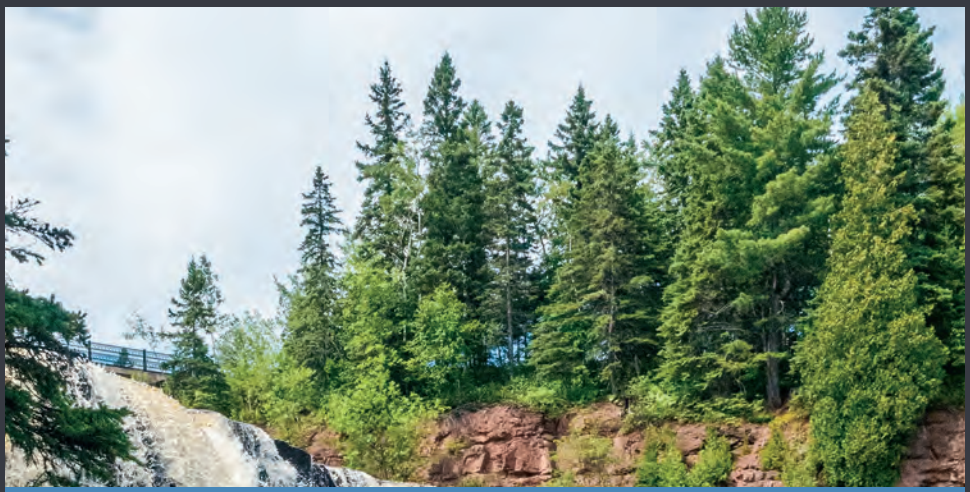

FIRST NATIONS IN QUEBEC HEALTH AND SOCIAL SERVICES GOVERNANCE PROJECT

SUMMARY REPORT
PRE-AGA OF THE FNQLHSSC
JULY 8, 2015

Report produced by the First Nations of Quebec and Labrador
Health and Social Services Commission

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1
INTRODUCTION

Kahnawake elder Charlie Patton said the opening prayer and wished all the participants an excellent day of sharing and discussion.

Mr. Malik Kistabish thanked Mr. Patton for the prayer that he gave and said that the project is one calling for the different nations to speak with one voice and to bring about a better future for our children. Mr. Kistabish thanked the FNQLHSSC for organizing this day and all those who accepted the invitation to take part in the sharing and discussion planned as part of the day's activities.

Ms. Marjolaine Siouï noted the work that was done by the FNQLHSSC Board of Directors in preparing the meeting. She said she hoped this day would provide an opportunity to advance a bit further in the project and allow everyone to see how the project is progressing.

Chief Salomée McKenzie thanked all the participants for attending this meeting. She expressed her gratitude for the work done by the FNQLHSSC and for the efforts that everyone is making in their respective communities. She added that we are united by our values and that a great many efforts will be necessary to make our vision a reality. Mobilizing themselves is among the strengths of the First Nations and we must be proud of who we are.

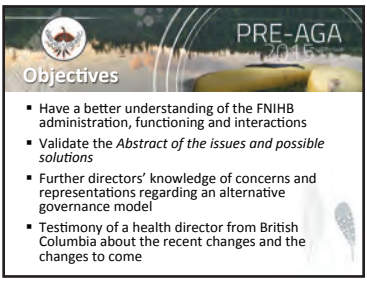
1.1
ABOUT THIS MEETING: ACTIVITIES, OBJECTIVES AND INFORMATION TO BE GIVEN

As the meeting's facilitator, Mr. Dan Gaspé presented the three objectives of the meeting:

1. Learn more about the functions of First Nations and Inuit Health Branch (FNIHB) of Health Canada.
2. Validate the summary of the issues and solutions.
3. Give everyone an opportunity

2
PROJECT UPDATE

Patrice Lacasse, Governance Advisor, FNQLHSSC



The objective of the presentation by Mr. Patrice Lacasse was to go over the project and the work accomplished on it to date. Mr. Lacasse gave a brief summary of the federal policies and strategic directions that have had an influence on the communities' takeover of health services.

To date, numerous activities have been carried out under the project: produce a portrait of the situation; define the values, principles and vision statement to guide the project; determine a common definition of the concept of governance; and identify the issues encountered in the administration and delivery of services in the communities. Updates on the project have also been regularly given to the AFNQL Chiefs and other groups. Mr. Lacasse said that all this work has served to prepare for the meeting of February 2016 at which a framework model will be presented to the Chiefs for their approval.

Mr. Lacasse went over the meeting's objectives. The first objective is to improve our understanding of how FNIHB works. It is important to know what is being done in Montreal and Ottawa from the perspective of a partial or total takeover by the communities. In the fall, this same exercise may be done concerning Aboriginal Affairs and Northern Development Canada (AANDC). The second objective is to validate the summary of issues and solutions[1]. A workshop has been prepared so that the people present today can validate and improve the document. There is also the matter of discussing whether or not a takeover by the community will allow these challenges to be met. The third objective is to broaden the knowledge of the directors and to get their opinions. The final objective is to learn more about the experience of First Nations in British Columbia via a presentation by a health director for a community in that province.

Mr. Lacasse spoke about upcoming meetings. In October, the directors will attend a regional meeting at which the concepts related to the governance model will be discussed. They will also learn more about the functions of AANDC and FNIHB, if a need in that regard is seen. The directors will also meet in the winter of 2016 to select one or several models. This same exercise will then be repeated with the Chiefs.

[1] The summary of issues refers to an exercise carried out with the health directors during a regional meeting in January 2015.

Planning will have to be carried out regarding the post-project steps, i.e., those steps to be taken after March 2016. Once a framework model has been selected, it will be necessary to detail each component, begin negotiations with governments, and produce a transition plan and a strategic plan for purposes of developing programs that meet our needs. It will be necessary to define the process for allowing the communities to carry out these mandates.

Numerous documents have been produced as part of the project. Mr. Lacasse invited the participants to distribute these documents in their communities. He also told the participants that the website for the project is being reworked and that all the documents which have been produced will be put up at the website for consultation.

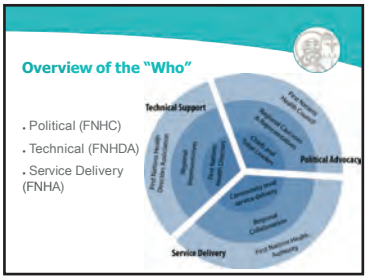
3
FNIHB INTERNAL FUNCTIONS

FNIHB Deputy Minister Valerie Gideon gave the objectives of her presentation, which were to provide information on: the processes for defining priorities; funding sources; and the different governance models for First Nations in Canada.

Following is some of the information obtained from the presentation by Ms. Gideon:

- Each region is required to implement a discussion process with First Nations and must document the efforts made to bring this participation about;
- In recent years, these has been a decrease in the proportion of the FNIHB budget allocated for administration and salaries and an increase in the budgets that go directly to the communities;
- The architecture of the program's authorities is considered as permanent. However, a process for requesting changes is possible;
- For any policy change or for the creation of new funding, the Minister must write to the Prime Minister to request authorization for the expenditure. Requests to renew existing funding are sent directly to Treasury Board;
- Treasury Board is under no legal obligation to fund FNIHB. The budget granted to FNIHB is voted on each year. Thus, the federal government does not tie the 1979 Indian health policy in with the Constitution. The *Canada Health Act* does not describe the federal role concerning the health of Indians;
- The envelope received by FNIHB increases by 3% annually and the funding for NIHB increases by 5% annually;
- Following the public service cuts in 2012, the emphasis has been put on the capacity of the regional offices;
- FNIHB in Quebec region has 135 employees, including eight nurses working in the communities;
- Governance models elsewhere in Canada: diversity is seen between the provinces regarding the federal responsibilities that were returned to the First Nations and regarding relations between First Nations and provincial governments.

4
GOVERNANCE MODEL FOR FIRST NATIONS IN BRITISH COLUMBIA



M. Keith Marshall, Health Director of the Hailika'as Heiltsuk Health Centre in Bella Bella, British Columbia, is Vice-President of the First Nations Health Directors Association (FNHDA). The two objectives of the presentation were to demonstrate the progress of convey information on the First Nations Health Directors Association.

Mr. Marshall first presented the major steps that led to the transfer of responsibilities of the FNIHB to First Nations in British Columbia. The talks in BC began in 2000, when the chiefs discussed the possibility of taking responsibility for health services. In the following years, various studies led to the drafting of a health plan for First Nations in negotiations with the federal and provincial governments and the establishment of First Nations organizations. Discussions with governments led to the signing of a tripartite agreement outlining the basic health care responsibilities taken on by First Nations.

The three main organizations described in this Agreement are the First Nations Health Council, which plays a political role, the First Nations Health Directors Association, which plays a technical role, and the First Nations Health Authority, whose responsibility lies in the delivery of services.

He then addressed the issue of the FNHDA, which is the first association of its kind in Canada. This association is dedicated to the support of health directors and managers who work in First Nations communities in British Columbia. Its activities include providing training as well as advice and recommendations for the improvement of health services to health managers.

Mr. Marshall ended his presentation by outlining some changes that have occurred in his community since it has taken on increased responsibility in health care. "Sometimes it's not that we need more money, but sometimes, we need more flexibility to do what we want with the money," he said. As such, the community now offers a new telehealth service for the detection of retinal diseases and it also hired a physiotherapist and a dentist to provide services directly to its territory. These additions provide better health care services to patients and allow the community to save on transport costs.

5
RESULTS OF THE DISCUSSIONS AND EXCHANGES

During the day, two workshops were held for the participants: the first one dealt with the functions of FNIHB and the second one dealt with issues related to the delivery of health and social services in the communities.

5.1
FNIHB FUNCTIONS

The first workshop included a review of the presentation by Ms. Gideon. The participants then discussed their understanding of the roles and functions of FNIHB, the aspects they would like to cover in greater depth at a future meeting, and the opportunities and challenges stemming from a partial or total takeover of FNIHB functions. At the end of the workshop, each group was asked to share its thoughts.

Sections 5.1.1 to 5.1.5 summarize the participants' opinions and questions.

5.1.1
General impressions and learnings

Several participants noted that FNIHB (national and regional) is an immense bureaucracy, with burdensome and complicated administrative procedures, as seen by the presentation by Ms. Gideon on the credits/authorities request process. The process is rigorous and strewn with red tape, but not unchangeable. It can be modified to meet needs or reflect the philosophy behind its management by successive governments.

Several participants deplored all the bureaucratic red tape. Given the many steps and validation processes involved, some feared that it distorts the initial intentions, which are to ensure the implementation of adequate programs and services for First Nations.

The presentation of the budgetary aspect of the national and regional offices was also appreciated. This gives a better idea of the funding that goes to FNIHB and the communities. However, there remain other areas to cover, such as costs unaccompanied by specified amounts and institutional services estimates.

The participants appreciated the succinct distinction made between FNIHB functions and responsibilities at the regional and national levels. They indicated they would like to know more about these functions and the related human resources and activities. In having a better idea of these respective responsibilities, they all agreed on the need to know more about institutional services.

5.1.2
In-depth information

Ms. Gideon's presentation was very clear and extremely interesting. All the information presented led to many questions and thoughts about the current situation, in terms of jurisdiction, the national and regional functions of FNIHB, and programs and funding.

Jurisdiction

The subject of federal vs. provincial responsibility quickly came up as the first topic. Several questions still need answers in this regard. For example, what is the role of FNIHB vs. the role of the province? In a case of jurisdictional conflict, who is responsible for First Nations' needs? Who is responsible for supporting the services provided to First Nations' members in the communities, especially in specific cases (e.g., dialysis, emergency pre-hospital care, etc.)? It seems necessary to have a presentation by the province so that we can know more about the way they function and thus be able to deal with the topic from the perspective of responsibility.

Functions, roles and responsibilities

At several times, participants expressed the need to fully distinguish between FNIHB roles and functions at the national level vs. the regional level. It is clear that these roles are complementary, but we still need an overall portrait. It may be useful to know whether being able to access the operational plan would facilitate understanding of the roles.

Development of programs

The participants said they would like concrete knowledge about the process for developing programs. For example, how does FNIHB at the national level develop programs? How is the voice of First Nations heard and taken into account? According to what basis and approach or school of thought are programs developed?

Non-Insured Health Benefits (NIHB)

Considering the scope and immensity of the Non-Insured Health Benefits (NIHB) program, its functioning should be more closely understood. Many resources (human, financial and material) are allocated to NIHB and the quality of its management has important impacts on individuals.

Funding of current programs

The participants had many questions about the mechanism for allocating funding and for managing the growth of this funding. What are the principles and mechanisms serving to adjust the indexation rate or increases? Why was there a 5% increase for NIHB but not for the other programs? How are the federal departments taking account of the McIvor decision, considering that it entails a population increase? How are budgets prioritized and what indicators are used? Does some funding go unused and does it go back into consolidated funding?

Several participants commented on the well-known fact that the indexation rate of programs is 3%. However, if we combine this with the indexation rate for the Canada Health Transfer, does the province of Quebec benefit from the same indexation rate? Beyond the question of federal vs. provincial jurisdiction, what are the amounts paid to the Quebec government? What do these amounts refer to? How are these amounts put into the health and social services system? The participants would like to know more regarding these aspects.

5.1.3 Concerns about a new governance model

The presentation led to certain concerns expressed from the perspective of a partial or total takeover of FNIHB responsibilities.

Programs and the power to act

The main concern has to do with the First Nations' capacity for transforming strategies and programs so that they better correspond to their conception of well-being.

A takeover of authorities would make it possible to determine the necessary interventions for each community. The participants were wondering what possible room for manoeuvre there would be. Would the obligations be the same or would they be subject to important modifications? To what extent could standards and criteria be transformed? For example, could we target topics that are not traditionally considered as part of health and social services (e.g., housing, education, etc.)? Also, in terms of minimal progress, what essential services could not be replaced?

At present, the programs are handled by a segmented approach. People are wondering how flexible this segmentation is at the regional and local levels. We need to know how it might be possible to transform these categories, because we must remember that our main interest lies in restoring to the communities the capacity for developing their services according to their realities.

Accessible financial resources

The concerns related to funding deal primarily with the involvement of the First Nations. Looking at British Columbia, did the First Nations there have to submit a request to the Treasury Board? With what First Nations was the tripartite agreement negotiated?

Following negotiation of the agreement, how would representations on behalf of the First Nations take place if the funding was deemed to be inadequate? Would the First Nations have to justify their requests to the Treasury Board? In the event that the government considered it necessary to cut expenses, how would they be able to maintain services and ensure the effectiveness of those services?

From a more pragmatic perspective, several people had questions about the possibilities of funding reserved today at FNIHB. For example, could the First Nations access amounts for departmental services and for services that would no longer be given by FNIHB at the national level?

Accountability

Beyond accountability developed and agreed on by everyone, the participants had questions about the type of accountability which would continue to be shown to the federal government. For example, who would take charge of compliance? What type of compliance towards FNIHB would be required? Would money be allocated to ensure this compliance? What would be the obligations associated with showing accountability?

Change management

Some questions were raised concerning what is to be done to ensure follow-up on the project. If we refer to the development of partnerships in the presentation by Ms. Gideon (see slide 10 attached), what are the prerequisites? Will it be necessary to have an institutional policy? Further to getting First Nations' support at the political level, are there any other necessary obligations?

Another aspect of concern to the participants involves the transfer of federal and provincial government operations to the First Nations. How can this transition take place? Further to the applicable federal and provincial laws, would there be any obligations to which the First Nations might be subjected? These concerns deal primarily with human and material resources.

5.1.4
Challenges in taking over authorities and responsibilities

An eventual takeover (partial or total) requires a great deal of planning. The participants were asked to share their concerns regarding the risks from the perspective of preventing or mitigating those risks.

We felt it would be better to put the elements dealing with opportunities in a different section. They are thus in section 5.1.5 ('Opportunities for renewed governance').

Relations with federal and provincial partners

There is the risk that a takeover by the First Nations will lead to a reduction and/or freezing of the available budgetary envelopes. The First Nations could then have difficulty convincing the federal government to re-open the agreement in order to allow adjustments of the funding necessary for meeting the needs.

There is reason to have questions concerning the impacts on fairness of services to be given in the case of a takeover by the First Nations. Will we receive the full cooperation of the federal and provincial governments to implement a joint organization and effective coordination mechanisms to ensure the continuing quality of services?

Considering the responsibilities that the First Nations could have, it is seen as necessary to ensure that the provincial system does not disengage to any further extent its responsibility at the clinical and financial levels. We must also make sure that any major change does not further poison the current situation presenting unresolved jurisdictional conflicts between the federal and provincial levels.

Financial resources

We need to be realistic and to consider the fact that the major desired changes will not necessarily bring a major additional amount of financial resources. We cannot adequately meet all the needs with the funding that is currently available. On the other hand, the First Nations will have control of the resources and will be able to decide among themselves how best to meet the needs.

Informational resources

Information and data form the basis of any effective decision-making process. They are thus needed for directing our efforts in an objective manner. The federal and provincial governments have a good deal of data concerning the First Nations. With the First Nations having responsibility, getting hold of all this information will become more urgent and important for making sure that well-informed decisions are made.

Mobilizing people to adhere to the project

The method used to achieve the ultimate objective involves repatriating powers to the communities. However, some activities and responsibilities will require regional and national coordination to ensure that they are collectively exercised. We must make sure that the communities feel at ease with this dynamic concerning the devolution of powers, which does not take control away from them. The idea is that we must make sure that the First Nations governments feel their autonomy is being respected. At the same time, an agreement between the First Nations and the federal government must include a clause recognizing the fiduciary responsibility of the federal government, all in order to prevent the agreement from doing any kind of harm to the First Nations.

It was noted that it is important for the Chiefs to be aware of the fact that the health and social services directors are in agreement among themselves and that no-one must lose light of the final goal, which is to improve the well-being of our people. Things will play out at the political level seeing that the Chiefs represent the final authority, in their communities and as part of the Chiefs' Assembly. It is essential that the values and principles adopted at the start of the project guide everyone's thinking in this matter.

5.1.5
Opportunities for renewed governance

Many of the elements brought up by the participants had to do with their vision and their expectations vis-à-vis a new governance model, primarily in terms of supplementary capacities and principles to be taken into account.

These elements are grouped together under different headings: power of joint action; solidarity; jurisdictional clarification; human resources & economic development; culture; and accountability.

Power of joint action – Determination of approaches and programs

The takeover of responsibilities held by federal departments would allow First Nations to determine their health and social services programs. This in turn would allow flexibility in operationalizing actions to be determined by the specific realities in the communities. All this would be supported by approaches and strategies chosen by the First Nations.

We must ensure that the communities have the power to develop their programs and establish their standards. We must get beyond the 1989 Health Services Transfer Policy. This means truly going past the stage of operationalizing or administering services. And it entails giving particular attention to respect of populations and their traditions and cultures.

Targeted response

Some participants felt it was obvious to consider that the takeover of programs will allow better directed responses. It is reasonable to believe that taking charge of NIHB will allow savings by implementing alternative and less expensive care better adapted to patients' needs.

Solidarity

Some participants said that the First Nations must come together as one. This unity will make greater strength and support possible when needed. At the same time, the desire was expressed to ensure a system of relations and interrelations at different levels. All of this must appear and be made explicit in the model that is chosen.

Further to this strength and mutual support, the pooling of resources could bring about economies of scale. The sharing and management of resources could benefit all the communities. In that regard, some participants stressed the importance of sharing some responsibilities at the regional level, similar to what is being done by the First Nations Health Authority (FNHA) in British Columbia, in order to coordinate this pooling.

Regional authority

Further to the idea of designating what renewed governance should look like, some participants identified what they would like to avoid seeing. Concerning the presence of a regional authority, such a body must not adopt too technical and administrative a role which puts the emphasis solely on accountability and nothing more. It must be based more on the objectives of the programs. In short, it must be closer to the needs at ground level.

In the case of a takeover, it would be a good idea to clarify the role of the First Nations' organization responsible for the regional plan vs. the roles of FNIHB, Quebec and other partners regarding responsibilities for decision-making, management, operationalization, services to be provided, etc. The idea is to foster the most effective interactions possible, thereby avoiding problems due to any mistaken interpretation of roles and responsibilities.

Several participants emphasized the educational role that a regional authority should play. The existing recognition between the First Nations and non-Aboriginals often creates obstacles when it comes time to develop initiatives for integrating services. Unfortunately, business relations are still too often conditioned by the presence or absence of people's prejudices. This situation has impacts on the mobilization of stakeholders for making modifications to improve services and collaborations.

Relations with the province

The participants stressed the importance of integrating their services with the province's services. To do so, the participants said they would like to see Quebec sign on to the project with the desire to get actively involved by implementing structures and mechanisms for promoting interactions between the First Nations and the federal and provincial governments. The idea is to create a favourable environment for addressing the challenges that persist.

Relations between the First Nations and the province are going well on several fronts. It was suggested that we capitalize on the positive experiences as a way of tackling the elements that present challenges. For example, establishing continuums of services in mental health could be further facilitated. Some participants brought up the idea of intensifying the exchange of information about users of services in order to ensure better follow-up and support at the same time.

Human resources & economic resources development

Recruitment and retention of human resources is already a difficulty that several communities must face. A takeover of resources could allow the implementation of solutions that are not applicable at present. We must ensure the establishment of an environment which works more to encourage young people to get an education and return to the community.

Integration of culture

If a new governance model is to be effective, the chosen model must include and respect the different cultures in the communities. The participants affirmed on several occasions that the objective is to avoid reproducing what is currently being done. The idea is to obtain the authority needed to develop strategies, programs and services, all in coherence with First Nations' conceptions of health and well-being.

Accountability

Participants wanted to ensure that with the chosen model, the First Nations would be first and foremost accountable to their populations. It is the people to whom the authorities must account for their actions regarding resources and powers. It is not normal, right now, for this accountability apply just to governments and their various apparatuses.

The exercise of this accountability needs to be thoroughly reviewed. We must ensure that these activities can meet the needs of communities and governments, and at the same time simplify its operationalization.

5.2 ISSUES AND CHALLENGES

The second workshop took the form of an adaptation of *World Café*. The participants formed small groups to consider seven issues taken from the *Abstract of health and social services issues*, a document that was produced following the discussions held at the joint meeting in January 2015. The participants thus studied the opportunities offered by a new governance model in terms of these issues as follows: funding, decisionmaking, access to human and material resources, access to services, relations with the provincial system, information management, and integration of culture.

The questions put to the participants to guide their reflections were:

- How will having supplementary authorities allow you to exert more influence on the issues and challenges that you have identified? What becomes possible with a new governance structure? What is the added value?
- Can you identify other solutions further to the proposed ones? Do they allow for influence over the issues and challenges that you have identified?

5.2.1 Issue – Funding

The participants raised the possibility of establishing a funding distribution mechanism that would be more equitable as based on indicators that they themselves would determine. The mechanism would be more legitimate considering the recognition of the expertise held by the First Nations, i.e., expertise based on knowledge of the realities in the communities.

The legitimacy of a process for distributing funding would also stem from the fact that it would be developed and approved by the First Nations. The distribution process and its mechanisms would take greater account of the specific characteristics of the communities. It would also be possible to develop reciprocal mechanisms between the communities in order to offer services to First Nations members not living in their original community.

The participants stressed that funding agreements would have flexibility seeing that they would collectively determine the nature of the agreements, while also ensuring that the amounts would be administered with rigour and according to adequate rules.

Another important point has to do with the possible impact on partners. Seeing that a takeover of responsibilities could signify control of financial resources and solidarity among the Nations, it is highly possible that relations will improve with provincial bodies.

In connection with the points that were raised, some discussions focused on access to financial resources. In a context where some communities are having difficulties regarding funding of programs, it could at times become necessary to establish mechanisms for ensuring the integrity of the health and social services budgets.

5.2.2
Issue – Decision-making

A partial or total takeover of the authorities and responsibilities held by FNIHB and AANDC would allow the First Nations to define their own criteria and rules for defining services and operating procedures. This would also allow more room for being creative with regard to the ways of delivering services.

It was suggested that a common foundation for supporting strategies and framework programs be established; this would also permit the management of specific programs at the local level. It would be in a decentralized form that would recognize authority and expertise at the local level.

The adoption of a community approach moving up to the regional level would allow the development of more adequate strategies. Decisions would thus be made on the basis of consultations of the involved stakeholders. This way of doing things would represent a break with the current method which involves the use of directives coming from a national structure.

Another possibility that was raised involved offering services to people living in the communities as well as to those not living in them. This would ensure compliance with the principle mentioned numerous times by the Chiefs, namely that the band councils are still responsible towards their populations, regardless of place of residence.

It was suggested that powers be repatriated to the communities. This would be accompanied by a delegation of powers to one or more regional authorities, depending on which of the options would be judged to be the most appropriate one.

5.2.3
Issue – Access to human and material resources

With a takeover of responsibilities, the First Nations would be able to define certain standards of greater flexibility, thus allowing the application of specific solutions. Indeed, the current rules of the federal government lack flexibility; this hinders the carrying out of innovative initiatives. For example, little funding is available for implementing incentive measures adapted to the needs of communities in distant or remote regions, as means of ensuring employee retention.

It would be appropriate to develop a regional strategy for human resources development. With authority and control in this area, the First Nations could reach agreement concerning their strategic directions and priorities. The idea here is to define the human resources needs for each community that will correspond to their realities. Collectively, we could envisage doing placement activities at the regional level in order to mitigate certain challenges that the communities encounter.

This takeover could also provide the opportunity to review the issue of access to certain health professionals. For example, Health Canada pays for psychological services, but not for the psychologists themselves. Another aspect could be to identify and implement other strategies for encourage First Nations youths to study in areas allowing them to remain in their communities; this would also reinforce retention of existing personnel. It was thus suggested that we promote occupations and professions in health and social services and that we establish partnerships with different educational institutions.

A need was expressed regarding the professionalization of some functions. Making use of certification will also meet the needs to increase the capacities of human resources, recognize their expertise and experience, and ensure quality of services.

5.2.4
Issue – Access to services

It will be necessary to get the province to recognize the communities' capacity and legitimacy for exercising full autonomy in defining and organizing their services. By having control over resources and planning of services, we presume it will be easier to look again at certain topics with the province, such as service corridors, linkages between organizations, services offered in English, etc. To do so, it will be necessary to obtain all the information required in this regard from federal and provincial partners.

5.2.5
Issue – Relations with the provincial system

Some participants feel that a collective takeover by the First Nations can only improve interactions and relations with the province. With the creation of a regional First Nations organization to ensure coordination of the devolved authorities and the inherent responsibilities, the province would have no choice but to actively collaborate. It is presumed that there would be more consultation of First Nations ahead of provincial legislative changes, allowing them to react and share their concerns. The First Nations would thus enjoy greater influence.

It was asked whether improving relations with the province could entail the creation of more inclusive initiatives, i.e., the implementation of services that would not necessarily make any difference between First Nations and non-Aboriginal people.

It was suggested by the participants that we identify ways to ensure a First Nations' presence with provincial health and social services institutions.

5.2.6
Issue – Information management

The participants generally acknowledged that information management forms the basis of everything; it is the first step towards effective management. It would be wise to provide better support of research activities in order to obtain data that assists in the development and determination of the communities' needs and priorities. Participants wondered about the possibility of repatriating or accessing the data held by the province.

It was recommended that we create an integrated information system and a single database. We must also develop expertise in data analysis and interpretation, along with skills in transmitting knowledge to the communities.

5.2.7
Issue – Integration of culture

One of the observations mentioned was that integration of the cultural aspect will take place naturally and gradually. In having control, the First Nations will instill the specific nature of what is intrinsically theirs into the process. Seeing that the framework will be determined by the First Nations, the resulting framework will necessarily reflect their identity. They will do all this at their own pace.

Even though culture naturally integrates actions and products, we must still give particular attention to culture and implement mechanisms for ensuring its presence. For example, it was noted that we could integrate traditional medicine and ceremonies. We must also ensure respect of traditional ways of doing things (when to turn to formal authorities, when to use circles for bringing people together, etc.).

One of the positive results would be that it would no longer be necessary to justify using certain traditional medical practices, such as sweat lodges, forest outings, hunting and fishing practices, etc.

Another relevant aspect concerns the specific cultural aspect that can at times be an obstacle to good relations, if it is accompanied by misunderstanding or fear. To counter this aspect, it would be better to ensure the availability of tools to combat prejudices and bridge the gaps between peoples. Greater control would give the First Nations the possibility of better informing their partners. The human resources who provide services to the First Nations must be culturally competent.

It was suggested by the participants that we document traditional practices through research on models of practice. This would bring about better understanding of what is being done in the communities.

The participants also recommended establishing a cultural committee to promote better integration of culture.

6
CONCLUSION OF THE MEETING

Marjolaine Siouï thanked the participants for the work accomplished this day. The objectives that had been set were. The information that was obtained during the meeting will be put into a report for distribution. Mme Siouï mentioned that the meeting in October will allow us to see how the new governance model can be constructed. She told the participants that the members of the FNQLHSSC Board of Directors will be holding strategic work sessions on the governance project.

Ms. Siouï thanked the facilitators of the workshops and Mr. Patrice Lacasse for organizing the meeting.

Charlie Patton, who is an elder from Kahnawake, said the closing prayer.

7 NEXT STEPS

The presentations and discussions held at the Pre-AGA allowed us to continue our reflections for purposes of guiding the development of a new model for renewed governance.

Some information will be necessary for constructing the model framework that is eventually chosen. Some activities will have to be carried out to guide the development of a model, and a decision will have to be made for its application.

- Write up a brief describing the project and write up a business plan
- Prepare studies on the impact of an eventual takeover of programs;
- Study the impacts of new interactions among the different involved stakeholders at the national, regional and local levels;
- Prepare a risk assessment related to change management;
- Schematize the decision-making mechanisms of FNIHB and AANDC;
- Analyze the human resources and budgetary allocation mechanisms;
- Develop different transition scenarios.

These elements will then be made part of the planning for the continuation of the project. These activities will also be carried out from the perspective of an eventual takeover of responsibilities of FNIHB (national and regional) and AANDC (with regard to programs involving social development).

With regard to meetings, three will be held in the coming months:

- Health Directors Network, September 2015
- Regional meeting – October 20-21, 2015
- Chiefs Special Assembly – March 2016

8
APPENDICES

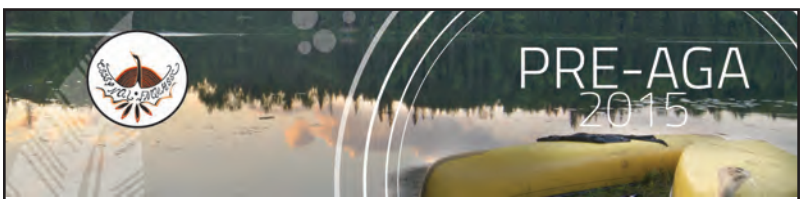
- **A** Agenda
- **B** PowerPoint — Patrice Lacasse
- **C** PowerPoint — Valerie Gideon
- **D** PowerPoint — Keith Marshall

APPENDIX A
Agenda

PRE-AGA JULY 8, 2015

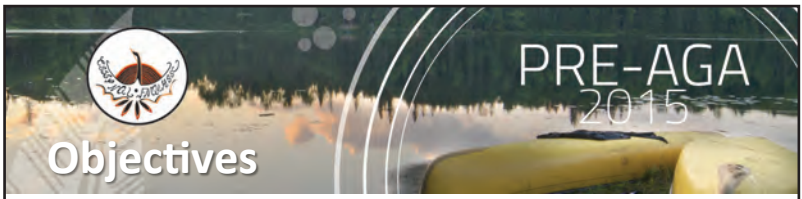
7:30 a.m.	Welcome and registration	
8:30 a.m.	Opening	Charlie Patton
8:45 a.m.	Words of welcome	Malik Kistabish Marjolaine Siouï Chef Salomée McKenzie
9:00 a.m.	Approach, objectives and information	Dan Gaspé
9:05 a.m.	Health and social services governance project	Patrice Lacasse
9:20 a.m.	Internal functional analysis of the First Nations & Inuit Health Branch (FNIHB)	Valerie Gideon
10:15 a.m.	Break	
10:30 a.m.	Workshops	All participants
11:30 a.m.	Pooling of information	Dan Gaspé
11:50 a.m.	Lunch	
1:00 p.m.	Presentation of the Compendium and facts sheets	Patrice Lacasse
1:15 p.m.	Health and social services directors' workshop	All participants
2:30 p.m.	Pooling of information	Dan Gaspé
2:50 p.m.	Break	
3:05 p.m.	Vision of a health director from British Columbia	Keith Marshall
4:15 p.m.	Summary of the day and concluding remarks	Dan Gaspé Marjolaine Siouï
4:25 p.m.	Closing ceremony	Charlie Patton

APPENDIX B
PowerPoint — Patrice Lacasse

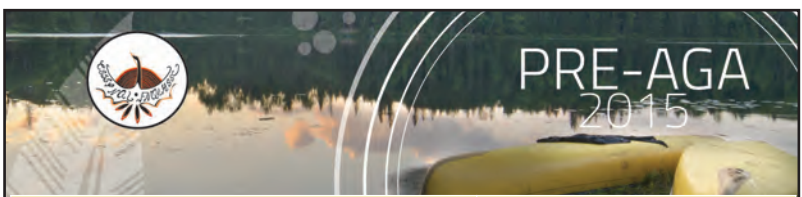


Improve First Nations' health

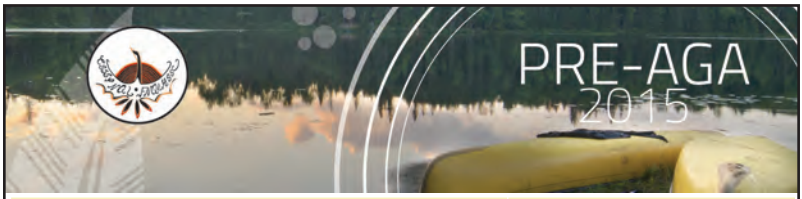
- Increased powers for communities
- Increased self-determination
- Programs and services based on the approaches we will have chosen
- Review the relationships we have with the federal and provincial governments
- Engage in a different model



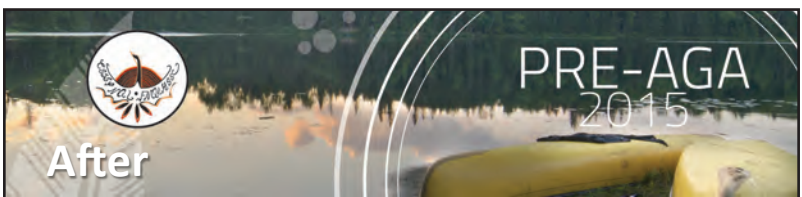
- Have a better understanding of the FNIHB administration, functioning and interactions
- Validate the *Abstract of the issues and possible solutions*
- Further directors' knowledge of concerns and representations regarding an alternative governance model
- Testimony of a health director from British Columbia about the recent changes and the changes to come



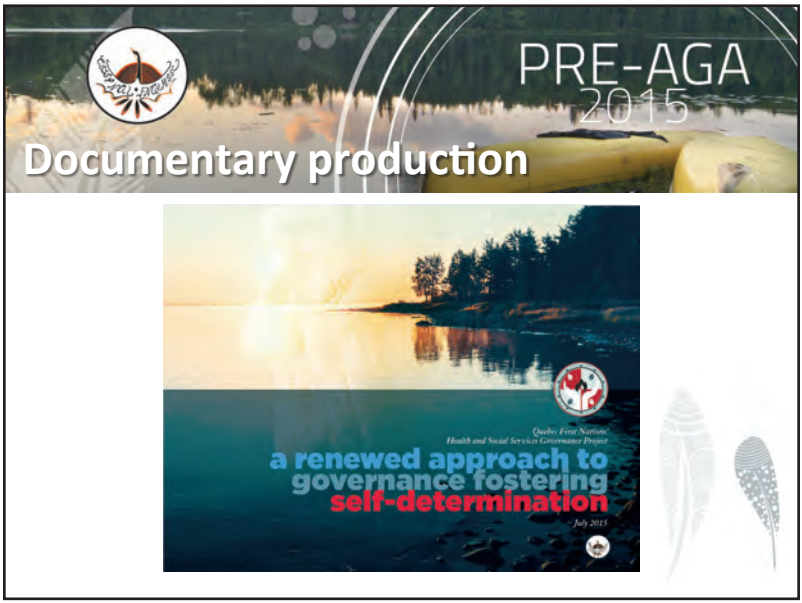
		Completed activities
Portrait of the situation **2014**	The FNQLHSSC has identified and analyzed the health and social services governance change processes that have occurred in the world in the past years.	• Creation of new partnerships • Inventory of existing models • Analysis of the legal situation of Quebec First Nations
Your opinion **2014-2015**	Community decision-makers were asked to express their opinion on the current governance structure.	Meetings: • February 2014 • July 2014 • January 2015 • July 2015 — Development of the vision, values and principles guiding the project.



		Upcoming activities
The options **Fall 2015**	One or several governance models will be developed based on the information collected. The Chiefs, local managers, health and stakeholders will be consulted during the development of models.	Development of model proposals and meeting with health and social services directors.
The choice **Winter 2016**	First Nations will give their opinions on the models developed. First Nations will choose, in their own way and according to their needs, the most appropriate governance model.	Finalize the chosen model and meeting with the Chiefs for the possible adoption of the model.



- Agree on a process to identify the components of a new model (Business Plan)
- Preliminary negotiations with Health Canada and AANDC
- Develop the implementation and transition plans
- Develop a regional strategic plan


PRE-AGA
2015
Documentary production
Quebec First Nations'
Health and Social Services Governance Project
a renewed approach to
governance fostering
self-determination
July 2015


PRE-AGA
2015
FIRST NATIONS IN QUEBEC
HEALTH AND SOCIAL SERVICES
GOVERNANCE PROJECT
REVIEW OF HEALTH AND SOCIAL SERVICES
PROVIDED TO QUEBEC FIRST NATIONS AND INUIT
FIRST NATIONS IN QUEBEC
HEALTH AND SOCIAL SERVICES
GOVERNANCE PROJECT
INDIGENOUS GOVERNANCE MODELS
AND INITIATIVES ACROSS CANADA
FIRST NATIONS IN QUEBEC
HEALTH AND SOCIAL SERVICES
GOVERNANCE PROJECT
BETTER GOVERNANCE,
GREATER WELLBEING


PRE-AGA
2015
FIRST NATIONS IN QUEBEC
HEALTH AND SOCIAL SERVICES
GOVERNANCE PROJECT
SUMMARY REPORT
PRE-AGA OF THE FNQLHSSC
JULY 8, 2015
FIRST NATIONS IN QUEBEC
HEALTH AND SOCIAL SERVICES
GOVERNANCE PROJECT
SUMMARY REPORT
JOINT MEETING OF THE AFNQL-FNQLHSSC
JANUARY 27 AND 28, 2015
FIRST NATIONS IN QUEBEC
HEALTH AND SOCIAL SERVICES
GOVERNANCE PROJECT
DESCRIPTIVE OF THE PROJECT


First Nations of Quebec and Labrador
Health and Social Services Commission
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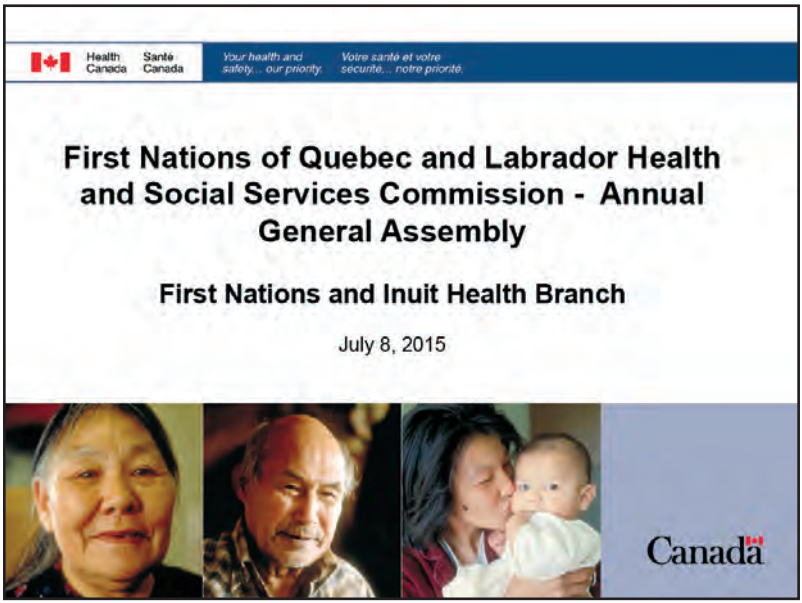
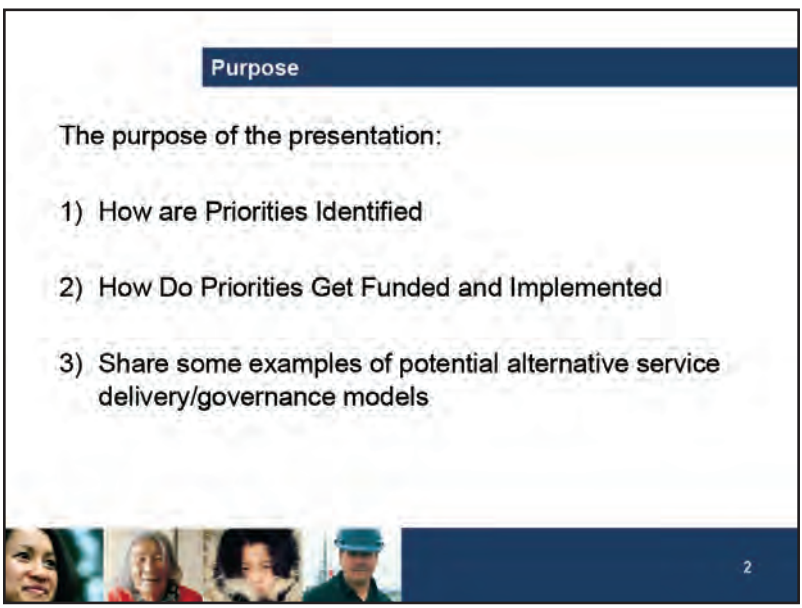
NEWS AND MEDIA
AREAS OF INTERVENTION
HUMAN RESOURCES
PUBLICATIONS
Health and Social Services Governance
WORKING TOGETHER FOR THE WELL-BEING OF THE FIRST NATIONS
Governance Project on Health and Social Services
Governance in the area of health and social services
A COLLECTIVE REFLECTION FOR THE WELL-BEING OF THE FIRST NATIONS OF QUEBEC
The reflective process on governance in the area of health and social services aims to strengthen the power to take action of the First Nations of Quebec.
The ultimate objective is to create a governance model that will eventually contribute to improving access to the health and social services that are offered to First Nations.
Why focus on governance?
Currently, the guidelines and programs implemented by the federal and provincial authorities are not sufficient to reduce the persistent gap between the living conditions of Canadians and those of First Nations.
Our publications
2007-2017 Blueprint
2014-2017 Strategic Plan of the FNQLHSSC
Joint meeting of the AFNQL-FNQLHSSC, January 27 & 28, 2015 – Summary report
Other publications developed as part of this project
Health and Social Services Governance : Working Together for the Well-being of the First Nations
External links
Big Stone
British Columbia's First Nations Health Authority
Centre for First Nations Governance
FNIHB's Strategic Plan
Aboriginal Affairs and Northern Development Canada's Strategic Plan

APPENDIX C
PowerPoint — Valerie Gideon





How are government priorities identified

Speech from the Throne:

- outlines Government priorities and reveals the work it proposes for the upcoming session of Parliament.

The Federal Budget:

- outlines the government's fiscal, social and economic policies and priorities.

Main Estimates

- outline the pre-approved and annual budget requirements of each federal department and provide the basic funding for departments to continue their current activities.

3

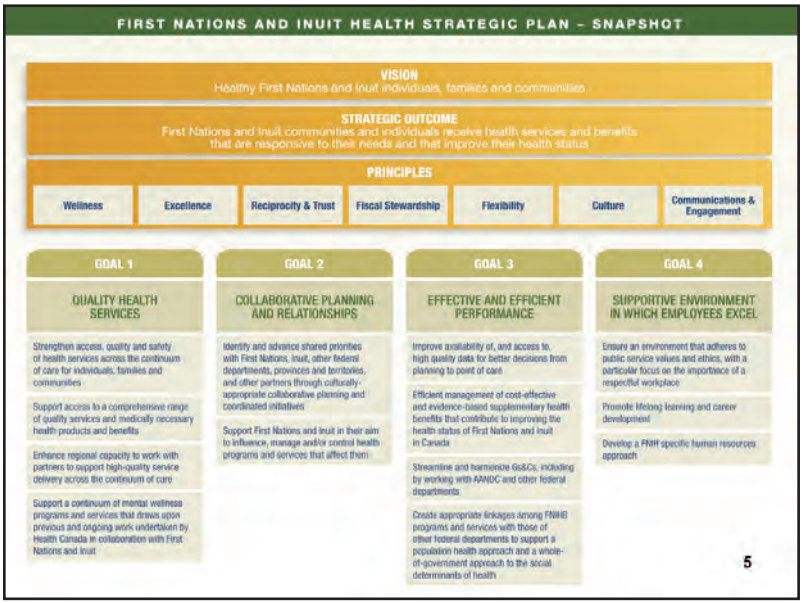
How are FNIHB priorities identified

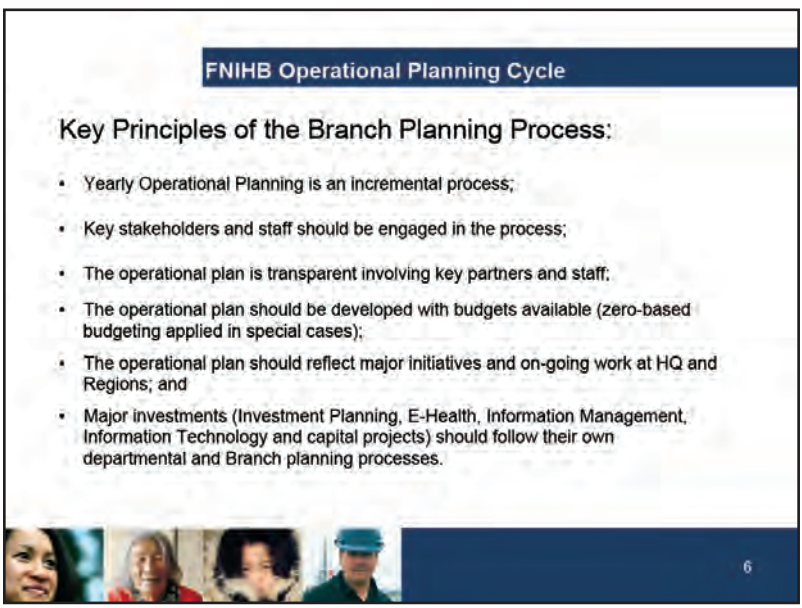
FNIHB mandate derived from the 1979 Indian Health Policy

- Builds on Constitutional division of powers, *Department of Health Act*, and historical practices in First Nations and Inuit health;
- To ensure that First Nation and Inuit (FNI) communities have access to health services;
- Help FNI communities overcome health barriers, to deal with the threats of disease, and to reach a level of health comparable to that of other Canadians living in similar areas; and
- Build strong partnerships with communities to improve the FNI health systems.

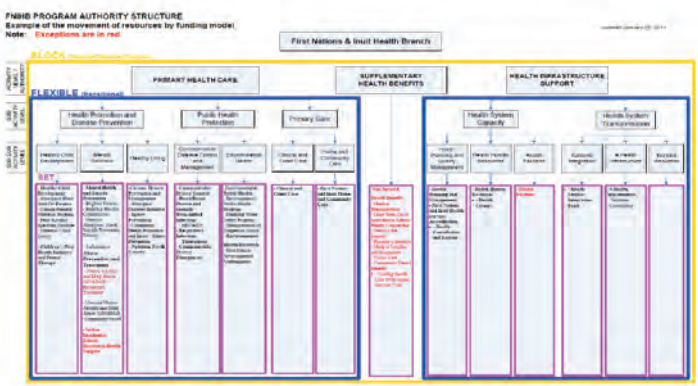
The FNIHB Strategic Plan is the driving force towards renewal and enhancement of the way in which the FNIHB responds to the needs of First Nations and Inuit individuals, families and communities.

4

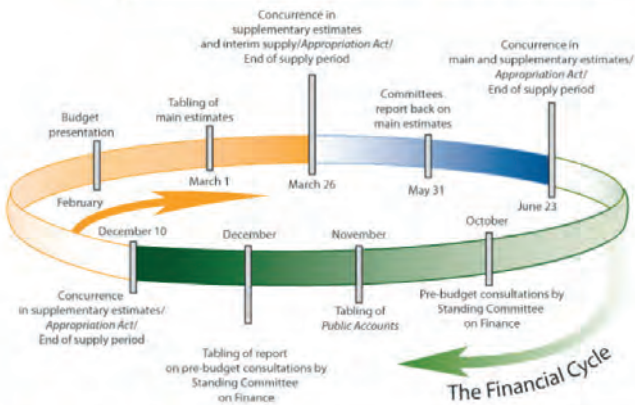

FIRST NATIONS AND INUIT HEALTH STRATEGIC PLAN – SNAPSHOT
VISION
Healthy First Nations and Inuit individuals, families and communities
STRATEGIC OUTCOME
First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs and that improve their health status
PRINCIPLES
Wellness
Excellence
Reciprocity & Trust
Fiscal Stewardship
Flexibility
Culture
Communications & Engagement
GOAL 1
QUALITY HEALTH SERVICES
Strengthen access, quality and safety of health services across the continuum of care for individuals, families and communities
Support access to a comprehensive range of quality services and medically necessary health products and benefits
Enhance regional capacity to work with partners to support high-quality service delivery across the continuum of care
Support a continuum of mental wellness programs and services that draws upon previous and ongoing work undertaken by Health Canada in collaboration with First Nations and Inuit
GOAL 2
COLLABORATIVE PLANNING AND RELATIONSHIPS
Identify and advance shared priorities with First Nations, Inuit, other federal departments, provinces and territories, and other partners through culturally-appropriate collaborative planning and coordinated initiatives
Support First Nations and Inuit in their aim to influence, manage and/or control health programs and services that affect them
GOAL 3
EFFECTIVE AND EFFICIENT PERFORMANCE
Improve availability of, and access to, high quality data for better decisions from planning to point of care
Efficient management of cost-effective and evidence-based supplementary health benefits that contribute to improving the health status of First Nations and Inuit in Canada
Streamline and harmonize Gs&Cs, including by working with AANDC and other federal departments
Create appropriate linkages among FNIHB programs and services with those of other federal departments to support a population health approach and a whole-of-government approach to the social determinants of health
GOAL 4
SUPPORTIVE ENVIRONMENT IN WHICH EMPLOYEES EXCEL
Ensure an environment that adheres to public service values and ethics, with a particular focus on the importance of a respectful workplace
Promote lifelong learning and career development
Develop a FNIH specific human resources approach
5


FNIHB Operational Planning Cycle
Key Principles of the Branch Planning Process:
• Yearly Operational Planning is an incremental process;
• Key stakeholders and staff should be engaged in the process;
• The operational plan is transparent involving key partners and staff;
• The operational plan should be developed with budgets available (zero-based budgeting applied in special cases);
• The operational plan should reflect major initiatives and on-going work at HQ and Regions; and
• Major investments (Investment Planning, E-Health, Information Management, Information Technology and capital projects) should follow their own departmental and Branch planning processes.
6

FNIHB Program Authority Structure



Parliamentary Process (The Financial Cycle)



Government Spending - "Business of Supply"

- In most cases, departments/agencies require authority from Parliament to initiate/continue spending on programs and initiatives.
- Spending authority presented in the form of the Estimates
  Main Estimates - a statute authorizing spending of money for a specific purpose; and
  Supplementary Estimates - spending requirements not developed in time for inclusion in Main Estimates.
- In order for spending to be included in a bill to go before Parliament, needs to be approved by Cabinet and/or Treasury Board.

9

What Policy Instruments are required

Memorandum to Cabinet (MC):

- Broad policy document presented by a Minister to seek Cabinet's approval on new/substantive changes to current policy, programming and/or planned spending; and
- Explains the "what & why" rather than the "how", conveying overall policy idea, options and key considerations (e.g. legal, communications, horizontal/ international impacts, and how it fits within the federal government's broader agenda).

Treasury Board Submission (TB Sub):

- Document addressing implementation of Minister's idea or proposal (i.e. the "how, rather than the "what"); and
- Purpose of a TB Sub: allow Ministers to take a decision on whether to undertake activities outside of its existing delegated authorities.

10

The FNIHB 'Envelope'

- FNIHB's funding falls under three categories – Indian Envelope and Non-Indian Evelope and Special Purpose Alllotments
- Indian Envelope created in 1993/1994 at the same time as AANDC's Indian and Inuit Funding Envelope and Claims Envelope
- Included resources for all Medical Services Branch (now FNIHB) programs
- Base amount was established at 1993-94 reference levels with a 3% annual growth
- All new funding since 1994 is **outside** envelope and not subject to growth (ie Aboriginal Headstart, upstream programs, First Nations and Inuit Home and Community Care, telehealth, capital, water)

11

The FNIHB 'Envelope » Cont'd

- Special Purpose Allotment -A special purpose allotment is used to set apart a portion of an organization's voted appropriation for a **specific initiative or item**. Such an allotment is established when the Board wishes to impose special expenditure controls.
- Funds left unspent in an SPA must lapse to the Consolidated Revenue Fund (CRF) and cannot be reallocated for other purposes.
- FNIHB SPAs now include: Indian Residential Schools, NIHB, NIHB – Qalipu, and NIHB – McIvor.
- NIHB SPAs level determined by previous years expenditures + up to 5%

12

FNIHB Funding Allocations 2015-16

$M	Operating (Vote 1)	Capital (Vote 5)	G&Cs (Vote 10)	Total
FNI Primary Health Care	217.3	2.4	570.9	790.6
Supplementary Health Benefits for FNI	920.2	0.0	202.5	1,122.7
Health Infrastructure Support for FNI	32.8	1.8	598.2	632.8
Total	1,170.3	4.2	1,371.6	**2,546.1**

13

First Nations and Inuit Drive Implementation

First Nations and Inuit are significantly involved in the provision of health services in a number of ways:

Direct Service Delivery:

- 76% of First Nations and Inuit communities have assumed greater responsibility for their health care resources through a Block or Flexible Funding approach *.
- 36% of First Nation communities have taken responsibility for clinical and client care services provided in nursing stations in remote and isolated communities.
- First Nations and Inuit have also included health authority and/or funds within AANDC led Comprehensive Claims and Self-Government Agreements.

Policy and Program Development:

- National organizations are consulted regularly and the two main national associations representing First Nations and Inuit are part of the FNIHB's senior management table.
- Participation on national and regional program Advisory Committees.
- Regional First Nations and Inuit organizations involved in program development and implementation.
- Co-management committees or joint work plans in some regions.

Block funding approach refers to Block / Flexible / Flexible-Transfer / Transfer. Flexible funding approach refers to Flexible (T) / Transitional. Does not include Set funding models)

14

Defining FNIHB Roles to Support Implementation

FNIHB HQ and Regional offices have structures and core functions that support each other as set out in the FNIHB Accountability Framework.

National Core Functions	Regional Core Functions
Interprofessional practice Management & Support	Professional services/practice advisors
Program Policy Development and Support	Program Management and Support
Program Operational Support	Service Delivery Quality Improvement/Accreditation Grants and Contributions Management/ Community Liaison Community capacity development and support to community health planning
Non-Insured Health Benefits	Strategic initiatives and special projects
Strategic and Horizontal Policy	Strategic Planning and Policy
Partnership Development and Management	Intra/Intergovernmental and First Nations/ Inuit relations
Strategic and Operational Planning	Health Planning
Health Information Management	Data & Surveillance
Performance Measurement, Evaluation and Audit	Performance Measurement i.e. Community Based Reporting Template
Internal Services	Operations

15

FNIHB – Quebec Region

- Approximately 135 employees, 7 main sectors.
- More than 30 programs and services offered to First Nation and Inuit

16

FTE's: FNIHB Quebec Region

Regional Branch Office			6.46
Governance and Operations	Planning, Analysis, Policies and Information Unit		6.01
	Liaison Unit		8.88
	Financing, Administration and, Management Systems		26.49
		Total	41.39
Professional Services	Professional services		16.47
	Pharmacy		3.29
	Dental		6.05
		Total	25.81
Community-Based Programs			14.09
Indian Residential School			3.02
Nursing Services	Regional Nurses		8.63
	Nurses in communities		7.67
		Total	16.30
Non-Insured Health Benefits			25.03
		Total	132.10

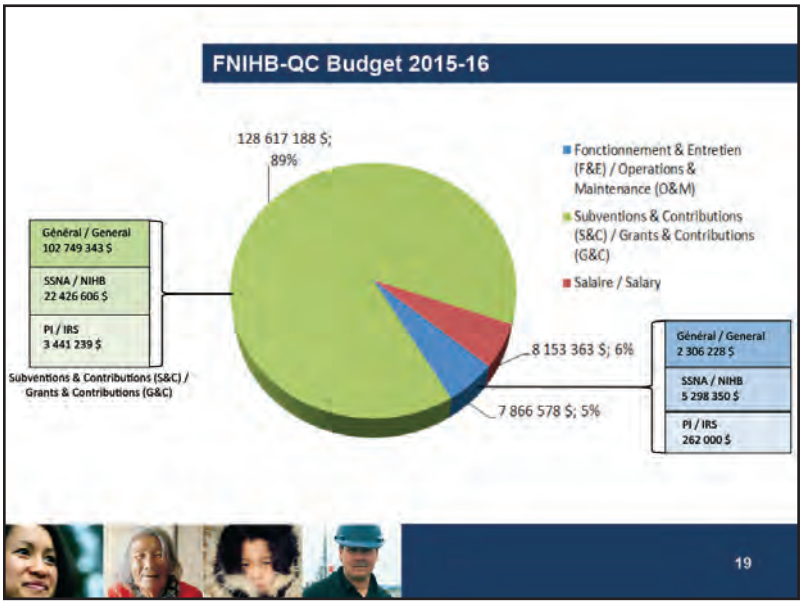
These amounts do not include maternity leave, leave without pay, secondments and various services / support from HQ. Total can change during the year.

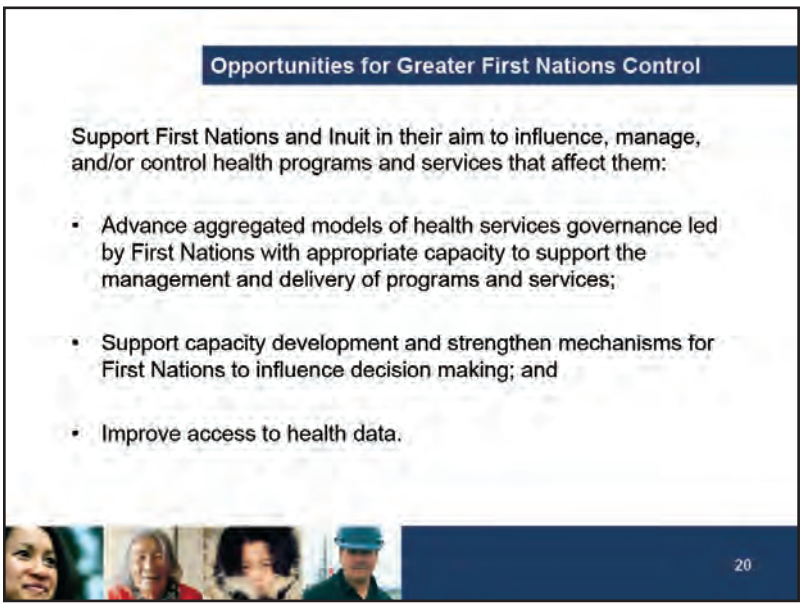
17

Regional Corporate Supports

- The FNIHB-QC region relies on a number of corporate services which include:
  - Access to Information and Privacy;
  - Information Technology;
  - Human Resources;
  - Real Property;
  - Information Management; and
  - Financial Management.
- Corporate services often have 'hidden costs', with levies applied at the departmental level before funds are allocated to the branches/regions.
- These services are essential to ensure accountability and efficient and effective operations.

18


FNIHB-QC Budget 2015-16
128 617 188 $; 89%
Fonctionnement & Entretien (F&E) / Operations & Maintenance (O&M)
Subventions & Contributions (S&C) / Grants & Contributions (G&C)
Salaire / Salary
Général / General 102 749 343 $
SSNA / NIHB 22 426 606 $
PI / IRS 3 441 239 $
Subventions & Contributions (S&C) / Grants & Contributions (G&C)
8 153 363 $; 6%
7 866 578 $; 5%
Général / General 2 306 228 $
SSNA / NIHB 5 298 350 $
PI / IRS 262 000 $
19


Opportunities for Greater First Nations Control
Support First Nations and Inuit in their aim to influence, manage, and/or control health programs and services that affect them:
• Advance aggregated models of health services governance led by First Nations with appropriate capacity to support the management and delivery of programs and services;
• Support capacity development and strengthen mechanisms for First Nations to influence decision making; and
• Improve access to health data.
20

Existing Models: Different paths to increased control

- Transfer of higher-level Regional functions to aggregates of FN communities in a sub-region of a province, e.g. the Northern Inter-Tribal Health Authority (NITHA) in Saskatchewan
- Co-management agreements (e.g. Atlantic, Alberta)
- British Columbia Tripartite Framework Agreement on First Nation Health Governance
- Self-government or land claim agreements that include health (e.g. James Bay and Northern Quebec Agreement, Nis'ga, Nunatsiavut)
- Non Insured Health Benefits (e.g. Bigstone, Akwesasne)

21

Discussion

What types of models are right for you

How do you organize to advance your collective goals

How do you define success in the short, medium and long terms

22

Annex A

FNIHB OPERATIONAL ROAD MAP

23

Annex B

FNIHB OPERATIONAL ROAD MAP - LEGEND

Annual Reference Level Update (ARLU)	ARLU is the formal process for updating the cost of previously approved operations / programs in order to provide a base for the development of the Main Estimates, which is submitted to Parliament to receive new-year funding.
Public Accounts	The Public Accounts of Canada is the report of the Government of Canada prepared annually by the Receiver General, as required by section 64 of the Financial Administration Act. It covers the fiscal year of the Government, which ends on March 31. The information contained in the report originates from two sources of data: :: the summarized financial transactions presented in the Accounts of Canada, maintained by the Receiver General; and :: the detailed records, maintained by departments and agencies.
Federal Budget	The Federal Budget is presented annually (typically February or March) to identify planned government spending, expected government revenue, and forecast economic conditions for the upcoming fiscal year.
Interim Supply	Interim Supply refers to the funds required by the Government to conduct its activities from April 1, the beginning of the fiscal year, to the final Supply day in the period ending June 23, when the House votes on the Main Estimates for the year.
Full	Full refers to the remainder of the funds from Interim Supply being approved in Main Estimates by the House for the fiscal year.
Main Estimates	The Main Estimates are expressed as a series of "Votes", or resolutions, which summarize the estimated financial requirements for a federal department or agency in a particular expenditure category, such as operations, capital or grants. Each budgetary item, or Vote, has two essential components: an amount of money and a destination (a description of what the money will be used for). The Main Estimates outline spending for departments, agencies and programs and contain the proposed wording of the conditions governing spending that Parliament will be asked to approve.

24

Annex B

FNIHB OPERATIONAL ROAD MAP - LEGEND

Supplementary Estimates (Supps A,B,C)	Supplementary Estimates ensure that previously planned government initiatives receive the necessary funding to move them forward. They present information to Parliament on the Government of Canada's spending requirements that were not sufficiently developed in time for inclusion in the Main Estimates, and will from time to time include urgent but unforeseen expenditures, such as natural disasters (an ice storm, H1N1, etc.). :: Supplementary Estimates (A) are tabled in May and the associated appropriation act is granted royal assent and becomes law in June. These provide federal organizations with the funding they need early in the year. :: Supplementary Estimates (B) are tabled in late October or early November and the associated appropriation act is granted royal assent in December. :: Supplementary Estimates (C) are tabled in February and the associated appropriation act is granted royal assent in March.
Reports on Plans and Priorities (RPP)	The Reports on Plans and Priorities (RPP) are annual expenditure plans that provide information on departmental strategic outcomes and program activities, plans and priorities, expected results, performance indicators and resource requirements on three-year basis.
Departmental Performance Report (DPR)	Departmental Performance Reports (DPR) are individual departmental and agency accounts of the results that they achieved against the expected results that they identified in their corresponding Report on Plans and Priorities (RPPs).
Management Operational Plan (MOP)	The Management Operational Plan (MOP) is a detailed operational plan for each Directorate and Region with deliverables and required budget. It is reported on quarterly, and accountability is between Regional Executives / Director Generals and the Assistant Deputy Minister (ADM).

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Annex B

FNIHB OPERATIONAL ROAD MAP - LEGEND

Branch Operational Plan (BOP)	The Branch Operational Plan (BOP) highlights branch priorities, key deliverables, milestones, performance indicators, targets, and expected results. It is used as the basis for reporting at the corporate level at Mid Year Review and Year End Review, and the accountability is between the ADM and Deputy Minister (DM).
Corporate Overview of Operational Plans (COOP)	The Corporate Overview of Operational Plans (COOP) is an internal departmental document that sets the initial planning baseline for the operating year ahead and serves as an information bridge between detailed Branch plans and strategic departmental commitments identified in the RPP. It outlines key initiatives and activities that are planned to be undertaken over the next fiscal year along with the resources required to support them.
Corporate Risk Profile	Corporate risks are those that may impact across branches and could affect the achievement of the Department's mandate as well as the strategic plans identified in the annual Report on Plan and Priorities (RPP). These risks are identified and managed trough Health Canada's Corporate Risk Profile (CRP).
Branch Risk Registry	FNIHB's Branch Risk Registry is a management tool used in organizational risk assessment and is a central repository for all risks identified by the Branch. Each risk includes information about the environment, probability, impact, treatment, response and accountability, etc. Risk management has been integrated within FNIHB's planning and reporting cycle. This has been facilitated by integrating risks in the planning cycle template, which in turn, facilitates the reporting of planned activities against branch level risks which allowing us to effectively demonstrate results.

26

APPENDIX D
PowerPoint — Keith Marshall

First Nations Health
Directors Association

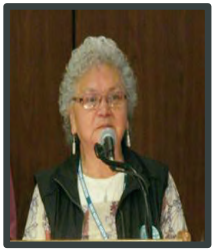
Sharing experience for community wellness

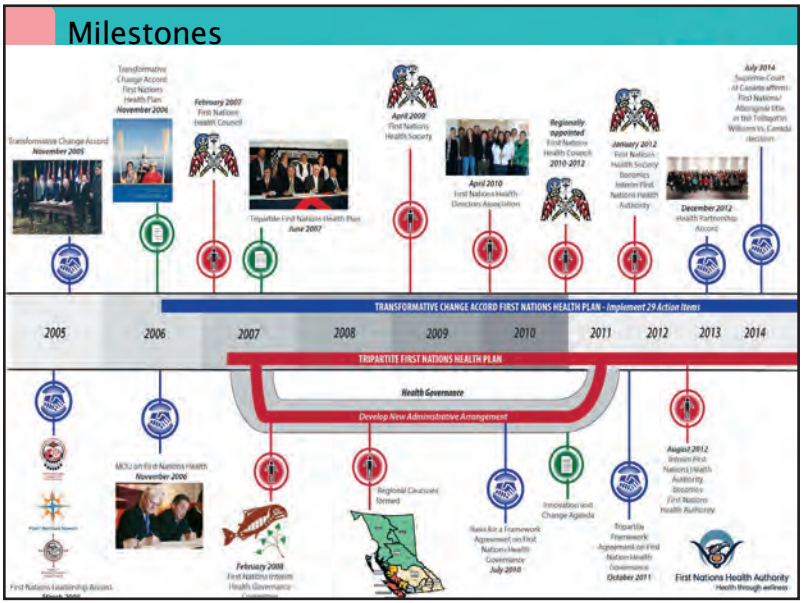
First Nations of Quebec and Labrador
Health and Social Services Commission

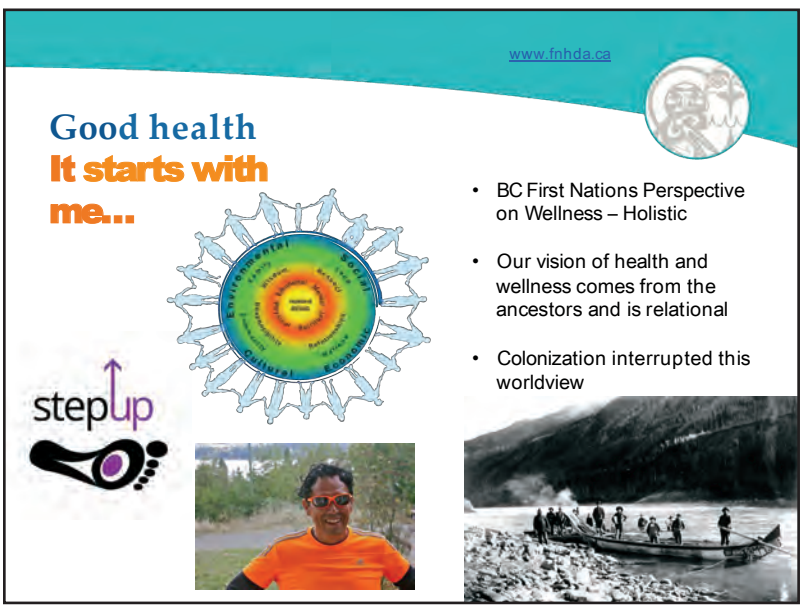
Keith Marshall, Vice-President, FNHDA
Montréal, Quebec
July 8, 2015

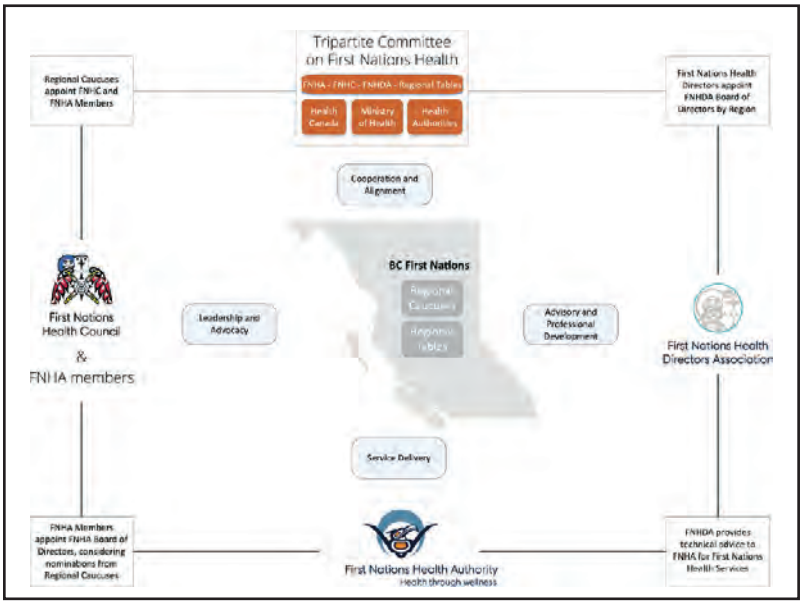
Outline

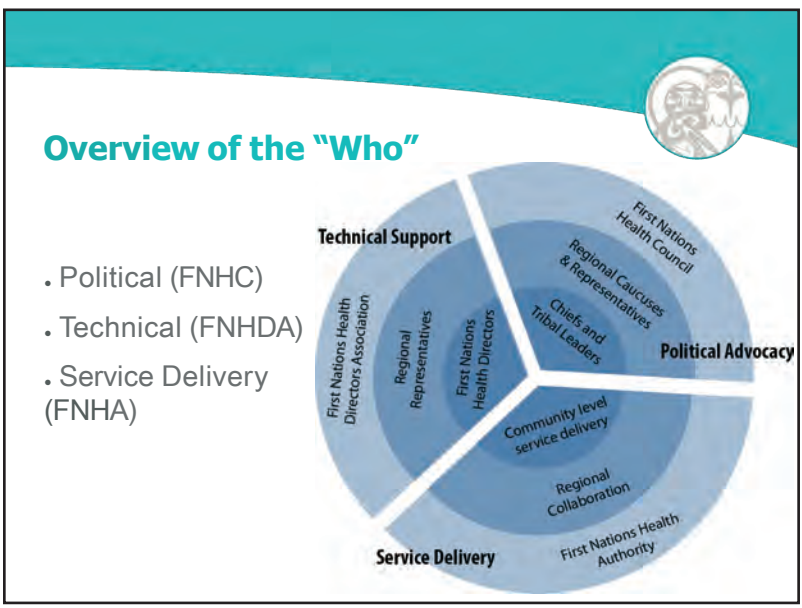
- Three Pillars: Health Governance Journey
- First Nations Health Directors Association: Our Story
- Hailika'as Heitsuk Health Centre Society

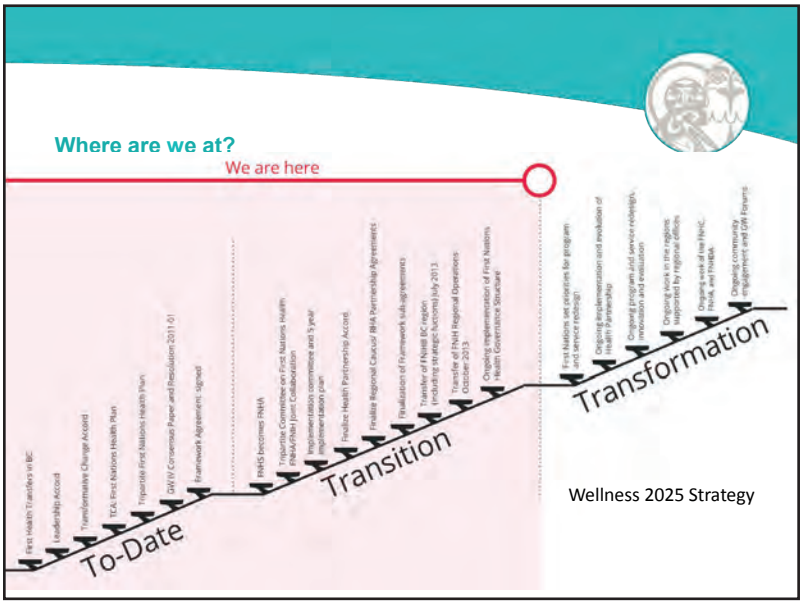



Milestones
Transformative Change Accord First Nations Health Plan November 2006
Transformative Change Accord November 2005
February 2007 First Nations Health Council
Tripartite First Nations Health Plan June 2007
April 2008 First Nations Health Society
April 2010 First Nations Health Directors Association
Regionally appointed First Nations Health Council 2010-2012
January 2012 First Nations Health Society Secretariat Interim First Nations Health Authority
December 2012 Health Partnership Accord
July 2014 Supreme Court of Canada affirms First Nations/ Aboriginal title in Tsilhqot'in Nation v. British Columbia decision
TRANSFORMATIVE CHANGE ACCORD FIRST NATIONS HEALTH PLAN - Implement 29 Action Items
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
TRIPARTITE FIRST NATIONS HEALTH PLAN
Health Governance
Develop New Administrative Arrangement
First Nations Leadership Accord
MOU on First Nations Health November 2006
February 2008 First Nations Health Governance
Regional Caucuses formed
Innovation and Change Agenda
Basis for a Framework Agreement on First Nations Health Governance July 2010
Tripartite Framework Agreement on First Nation Health Governance October 2011
August 2012 Interim First Nations Health Authority becomes First Nations Health Authority
First Nations Health Authority Health through wellness


www.fnhda.ca
Good health
It starts with me...
Environmental
Social
Cultural
Economic
stepup
• BC First Nations Perspective on Wellness – Holistic
• Our vision of health and wellness comes from the ancestors and is relational
• Colonization interrupted this worldview


Tripartite Committee on First Nations Health
FNHA - FNHC - FNHDA - Regional Tables
Health Canada
Ministry of Health
Health Authorities
Regional Caucuses appoint FNHC and FNHA Members
First Nations Health Directors appoint FNHDA Board of Directors by Region
Cooperation and Alignment
BC First Nations
Regional Caucuses
Regional Tables
First Nations Health Council
&
FNHA members
Leadership and Advocacy
Advisory and Professional Development
First Nations Health Directors Association
Service Delivery
FNHA Members appoint FNHA Board of Directors, considering nominations from Regional Caucuses
First Nations Health Authority
Health through wellness
FNHDA provides technical advice to FNHA for First Nations Health Services


Overview of the "Who"
• Political (FNHC)
• Technical (FNHDA)
• Service Delivery (FNHA)
Technical Support
First Nations Health Directors Association
Regional Representatives
First Nations Health Directors
First Nations Health Council
Regional Caucuses & Representatives
Chiefs and Tribal Leaders
Political Advocacy
Community level service delivery
Regional Collaboration
First Nations Health Authority
Service Delivery



The Framework Agreement

The Framework Agreement is a legal agreement that sets out basic funding and other commitments and requirements for the new health governance arrangement:

- Assume administrative responsibility of Health Canada First Nations Inuit Health Branch **Pacific Region** health programs and services
- Establish a First Nations Health Authority
- New Partnerships with Province of BC and each Regional Health Authority (6 total)

"A BC First Nations Health Authority is the heart of the new structure, and through this authority, programs and services will designed, delivered and managed by First Nations people for First Nations people and in a way that best meets the First Nation's needs."

The Honourable
Leona Aglukkaq
Federal Minister of
Health (2008-2013)

Gathering Wisdom for a Shared Journey V

Another significant step forward in creating a more effective and culturally-responsive health service system for BC First Nations.

+800 delegates

94% of BC First Nation Chiefs and Proxies in attendance

The 2012 Consensus Paper mandates transition from the interim First Nations Health Authority into a permanent form and begins planning for the establishment of Regional Offices to support health and wellness engagement with First Nations and Health Authorities at the regional level.

After Gathering Wisdom for a Shared Journey V

Continue with Engagement & Approval Pathway

Start strategic discussions on services and transformation

Our Approach to Good Governance

Approach: Setting Standards, Setting Stages, Setting Structure, Upholding Our Commitments

We have developed our own tools of good governance: 7 Directives, Corporate Governance Requirements, Mandates & Activities of Regions, FNHC, FNHA, FNHDA, Reciprocal Accountability Principles & Processes

We come together at quarterly Sub Regional and Regional Caucuses and annually at Gathering Wisdom for a Shared Journey to develop and adopt tools of good governance

The First Nations Health Directors Association: Our Story

- A few years ago, several First Nations Health Directors began the journey towards creating their own professional association.
- In the works for over a decade, the First Nations Health Directors Association was created *by* Health Directors, *for* Health Directors.

Region	FNHDA Board Representative Member
Interior	Shelly Lampreau Colleen LeBourdais Teresa Johnni
Vancouver Island	Vanessa Charlong Judith Gohn Georgia Cook
Fraser	Kelowa Edel Virginia Peters Peter John
North	Verne Tom Patricia Hoard Lauren Brown
Vancouver Coastal	Rachel Andrew Nelson Kim Brooks Keith Marshall

Our Shared Vision Statement

The FNHDA shares a common vision statement with our other First Nations health governance entities in BC, the FNHC and FNHA:

"Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities"

Our Mission

The FNHDA works with First Nations Health Directors in BC to:

Promote culturally strong, experienced, professionally trained First Nations Health Directors;

Provide technical advice on research, policy, program planning and design; and

Support the implementation of community Health Plans.

The FNHDA: Our Purpose

We are a membership-based professional organization dedicated to supporting Health Directors and managers working in First Nations communities across British Columbia.

Value of Health Directors

We are connected to our communities.

Through our members, we are in the community; everything we do is dedicated to improving the health and well being of community members, helping our partners understand the needs and challenges of the individuals and families with whom we work.

Our Association acts as a conduit to our peers.

The role of a Health Director is multi-faceted

- Health Directors work in demanding and complex community and organizational environments
- Health Directors bring a wealth of real-world experience to their role of managing health services for individuals and families
- We are advisors and partners in First Nations healthcare

What we offer

- We are a flexible and practical resource for our members. As an Association, we support our members in their role a First Nations Health Directors.
- We are connected to our communities.
- Through our members, we are in the community; everything we do is dedicated to improving the health and wellbeing of community members, helping our partners understand the needs and challenges of the people and families with whom we work.

Strategic Plan 2015-2018
recently developed

- Three-year guide for implementing FNHDA's mandate
- Overview of FNHDA's mandate, vision, mission, goals, and objectives

Our FNHDA Strategic Plan has three goals:

Goal 1:

Provide professional development, training, networking and support services for Health Directors, supporting their well-being and success in their community roles, and enabling their participation in the improvement of the broader health system.

FNHDA Strategic Plan continued…

Goal 2:

Support Transformation through effective participation of the FNHDA in the First Nations health governance structure and providing quality and timely technical advice.

Goal 3:

Uphold high operational standards and seek to continuously improve, grow and evolve the FNHDA.

Training Plan 2015-2018 – *what is it?*

- List of FNHDA's training priorities
- The Training Plan serves as a guide for creating annual FNHDA training workplans

Training Plan 2015-2018

Health Director training priority areas

1) Community Health & Wellness Planning
2) Community Health Services & Programs, Health Knowledge, and Wellness
3) Cultural Competency and Cultural Safety
4) Communication
5) Financial Management
6) Human Resources
7) Governance, Transformation, and Community Health Leadership

Future FNHDA activities

- Continued development of annual FNHDA Training and Development Strategies and Workplan
- New training support programs based on member feedback and identified priorities
- Continued gathering of Health Director Technical Advice for solution-development and recommendations for improved health services

Any questions so far?

Let's shift focus to the community level…

Heiltsuk Health Board
Hailika'as Heiltsuk Health Centre Society

Nĭnuáğailas

"Haikilaxs Sasmaqvs"

2015

"take care of your children"

Hailika'as Heiltsuk Health Centre Society - Organization Chart *(May 12, 2014)*

Heiltsuk Community → Heiltsuk Tribal Council → Hailika'as Heiltsuk Health Centre Society → Health Director

Administration	Patient Transportation Program	Home & Community Care Program	Community Wellness Program	Healthy Families Program
Team Leader: IT Department Manager	Team Leader: Program Manager	Team Leader: Program Manager	Team Leader: Counsellor 1	Sasum House Team Leader: Head Start Program Coordinator Dental Team Leader: Dental Program Manager
• **Finance Manager (Finance Team Leader)** • **Office Manager/Accreditation Coordinator** • **Receptionist** • **Office Assistant/Visiting Professional Liaison** • **Finance Assistant** • **Finance Clerk (PT)** • **Community Telemedicine Coordinator (PT)** • **Janitor** • **Maintenance Worker**	• Patient Clerk (PT)	• Home & Community Care Nurse • Licensed Practical Nurse • Personal Care Attendant 1 • Personal Care Attendant 2 • Cook • Elders Van Driver • Janitor/Equipment Manager • Elders Advocate (PT) (Mat Leave)	• Child/Youth Program Coordinator • Counsellor 2 • Fitness Centre Supervisor • Fitness Centre Worker (PT) • Youth Worker 1 • Youth Worker 2	• AHS ECE Assistant 1 • AHS ECE Assistant 2 • AHS ECE Assistant 3 • Community Health Nurse (CDC) • Diabetes Prevention Worker (vacant) • Diabetes/Chronic Disease Nurse (vacant) • Maternal Child Health Hnis'u 1 • Maternal Child Health Hnis'u 2 • Maternal Child Health Nurse (PT) • Sasum House & Youth Centre Janitor (PT)

Mandate and Role of the Hailika'as Heiltsuk Health Centre Society

Administration
To be efficient and effective in providing the best possible support services to the Health Centre.

Community Wellness
Non- legislated voluntary program.

Healthy Families
To offer and promote well being of community members through the implementation of holistic healthy families programs.

Home & Community Care
Services will promote independence and respect by providing a safe environment, which reflects the Heiltsuk culture, which is to maintain holistic health and well-being for all.

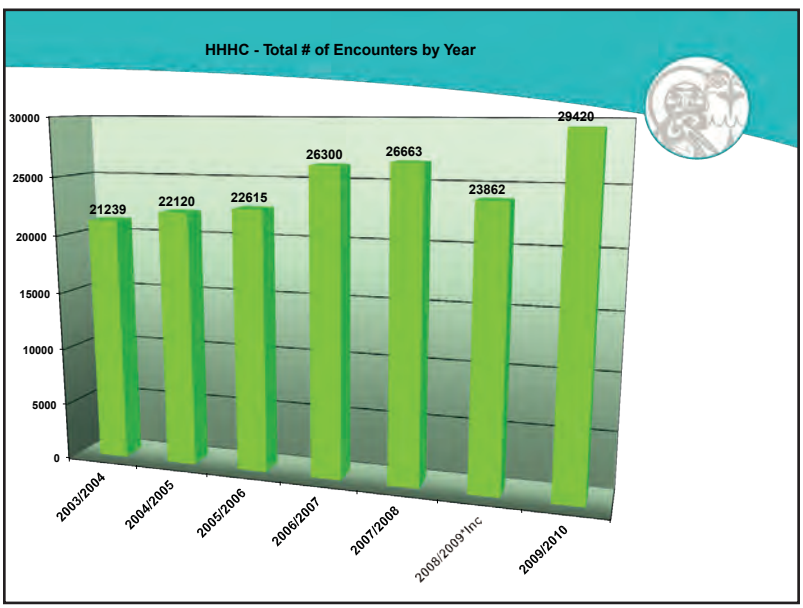
Patient Travel
Provide medical transportation benefits to access medically required health services to the nearest appropriate facility to the clients in accordance with the NIHB General Program Directive, NIHB Medical Transportation Directive, NIHB Medical Transportation Policy Framework and regional guidelines.

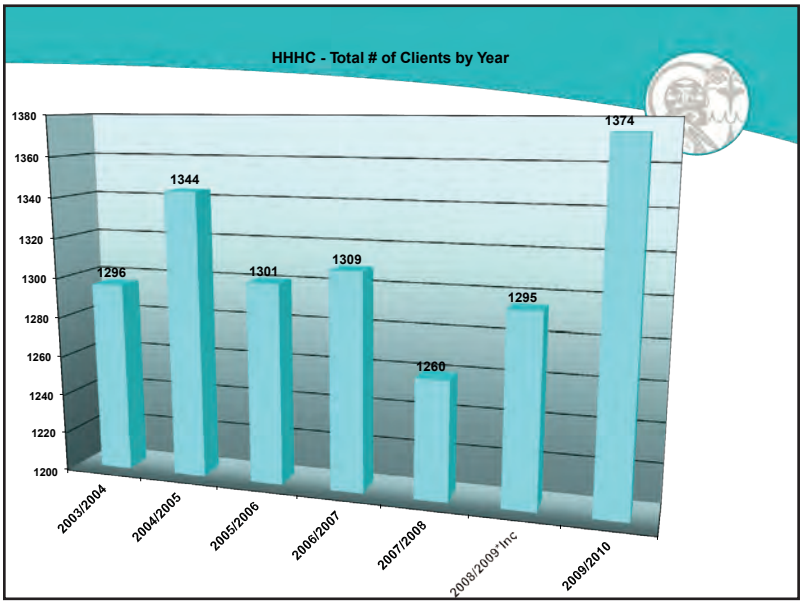
Fully accredited through Accreditation Canada (since 2009)

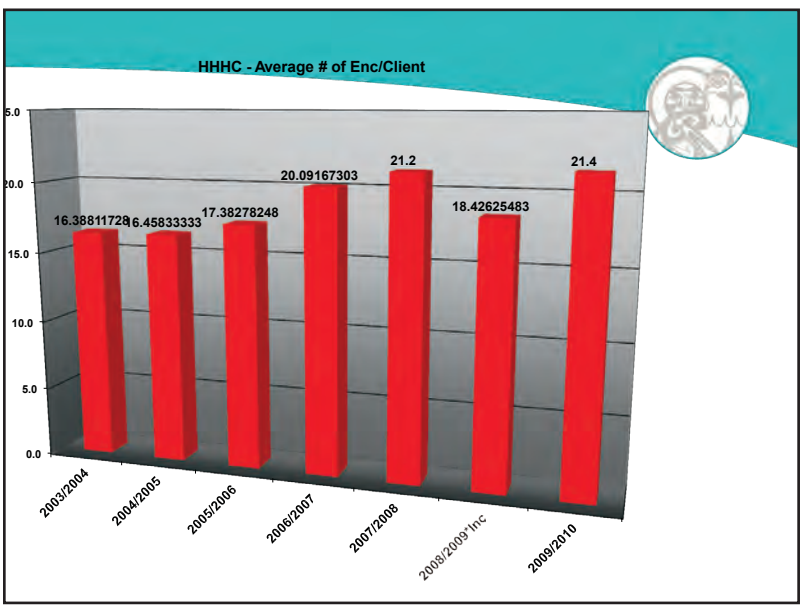
Hailika'as Heiltsuk Health Centre

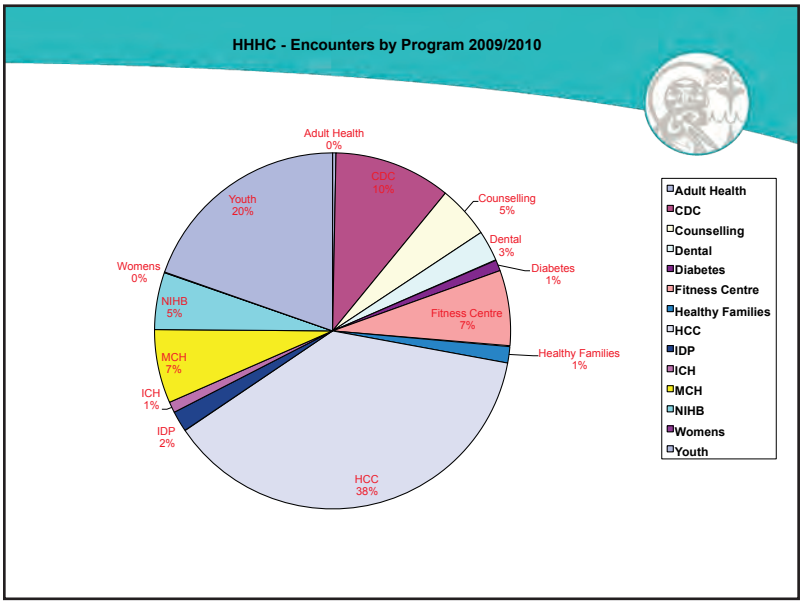
What are the services provided to Heiltsuk?

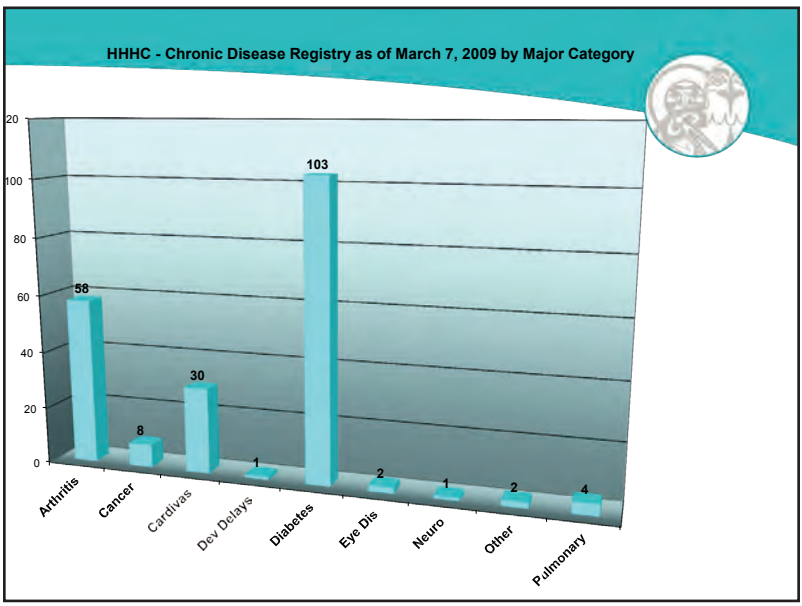
- Administration
- Patient Transportation
  - Non-Insured Health Benefits – non-transferred
- Home & Community Care
  - Nursing
  - Personal Care Attendant/Home Support Workers
  - Occupational Therapy
  - Physio Therapy
  - Elders Advocate
  - Drop ins, Luncheons, Breakfast Club, Meals on Wheels
- Healthy Families
  - Aboriginal Head Start – center based model
  - Maternal Child Health – family home visiting
  - Pre/Post Natal
  - Heiltsuk Language Nest Program
  - Dental
  - Communicable Disease Control – Public Health Nursing – Immunizations
  - Environmental Health – Water Samples, Food Safe
  - HIV/AIDS
  - Aboriginal Diabetes Initiative




HHHC - Total # of Clients by Year
1380
1360
1340
1320
1300
1280
1260
1240
1220
1200
1296
1344
1301
1309
1260
1295
1374
2003/2004
2004/2005
2005/2006
2006/2007
2007/2008
2008/2009*Inc
2009/2010


HHHC - Average # of Enc/Client
5.0
20.0
15.0
10.0
5.0
0.0
16.38811728
16.45833333
17.38278248
20.09167303
21.2
18.42625483
21.4
2003/2004
2004/2005
2005/2006
2006/2007
2007/2008
2008/2009*Inc
2009/2010


HHHC - Encounters by Program 2009/2010
Adult Health 0%
CDC 10%
Counselling 5%
Dental 3%
Diabetes 1%
Fitness Centre 7%
Healthy Families 1%
HCC 38%
IDP 2%
ICH 1%
MCH 7%
NIHB 5%
Womens 0%
Youth 20%
Adult Health
CDC
Counselling
Dental
Diabetes
Fitness Centre
Healthy Families
HCC
IDP
ICH
MCH
NIHB
Womens
Youth


HHHC - Chronic Disease Registry as of March 7, 2009 by Major Category
120
100
80
60
40
20
0
58
8
30
1
103
2
1
2
4
Arthritis
Cancer
Cardivas
Dev Delays
Diabetes
Eye Dis
Neuro
Other
Pulmonary

Working together our collective efforts will result in improvements at the individual, community, region, and population health levels in all wellness determinant areas.

Thank you

Contact Us

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