

Tab 6: TEMAGAMI FIRST NATION (TFN) FIVE-YEAR WORKPLAN 2020-2025

Contents

EARLY CHILDHOOD DEVELOPMENT: ABORIGINAL HEAD START ON-RESERVE (AHSOR) 1

CANADIAN PRENATAL NUTRITION PROGRAM (CPNP) FETAL ALCOHOL SYNDROME 4

BRIGHTER FUTURES (BF)..... 6

BUILDING HEALTHY COMMUNITIES (BHC) 9

CLINICAL AND CLIENT CARE – NURSING, COMMUNITY HEALTH REPRESENTATIVE, CLERICAL (NURSING, CHR, CLERICAL) ERROR! BOOKMARK NOT DEFINED.

HEALTHY LIVING – COMMUNITY HEALTH PROMOTION AND INJURY PREVENTION - COMMUNITY HEALTH REPRESENTATIVE ERROR! BOOKMARK NOT DEFINED.

COMMUNICABLE DISEASE CONTROL AND MANAGEMENT (NURSING, CHR, CLERICAL)..... ERROR! BOOKMARK NOT DEFINED.

BLOOD BORNE DISEASE AND SEXUALLY TRANSMITTED INFECTIONS – HIV / AIDS (NURSING, CHR, CLERICAL) ERROR! BOOKMARK NOT DEFINED.

NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM (NNADAP) 11

CHRONIC DISEASE PREVENTION AND MANAGEMENT – ABORIGINAL DIABETES INITIATIVE (ADI)..... 13

FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE (H&CC) ERROR! BOOKMARK NOT DEFINED.

NON-INSURED HEALTH BENEFITS (NIHB) 15

HEALTH PLANNING AND QUALITY MANAGEMENT (HPM) 16

OPERATIONS AND MAINTENANCE (O&M) 18

Early Childhood Development: Aboriginal Head Start On-Reserve (AHSOR)

Outcome: To provide centre-based programming that is designed and delivered by TFN to support the health and developmental needs of First Nations children from birth to age six and their families. AHSOR will encourage and support the wellbeing of children, individuals and families through community interaction and approaches. The centre based program includes the six program components listed below and is designed to encourage each child to enjoy life long learn and support the spiritual, emotional, intellectual and physical growth of children residing in TFN.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
Strengthen children’s development through educational activities, and programs (Education).	<ul style="list-style-type: none"> - Facilitate early literacy skills - Encourage age appropriate motor development and cognitive skills occur through each stage of development - ECE workers develop fine and gross motor development activities - ECE workers incorporate Fine and gross motor development activities (e.g. The Hoop-and-Stick game, regalia making) - Activities for children will be in-group or circle format and shall allow for daily <ul style="list-style-type: none"> ▪ Individual and small group activity ▪ Large and small muscle activity ▪ Cognitive, language and social activity ▪ Child initiated and adult initiated activities 	RECE Program Supervisor RECE/AHS Worker	Record in PathDMS the following: <ul style="list-style-type: none"> • Attendance of children • Daily attendance of staff • Child Assessment and Screening Test • Appropriate documentation in children’s files • Number of AHSOR children who have been diagnosed with special needs • Number of AHSOR children screened/assessed for special needs • Number of AHSOR children referred to other community resources (e.g., Nurses, doctors, specialists, etc.) for special needs support or diagnosis • Number of AHSOR children on a wait list for special needs diagnostic • Assessment

<p>Promote culturally appropriate parenting skills and involvement in their child's learning (Parenting Skills)</p>	<ul style="list-style-type: none"> - Empower parents/caregivers to understand and support their child's growth and development - Reinforce parents/caregivers in their role as the primary teachers of the children. - Encouraging parents and guardians to read with their children and participate in cultural / family activities - Encourage parents to use the resource library - Distribute monthly parenting magazine - Facilitate family events (e.g. Easter Egg Hunt) - Provide parent and family support activities - Safety education and awareness activities (e.g., playground safety, car seat technician training, car seat use, seat belt use, bike safety, etc.) - Encourage participation in parent advisory council 	<p>RECE Program Supervisor</p> <p>RECE/AHS Worker</p>	<p>Frequency of Parent/Family Participation: track the total number of adult parent and family participants involved and the frequency of their involvement (i.e., daily, weekly, monthly or special occasions) and report monthly and in the CBRT.</p> <p>Record in PathDMS the following:</p> <p>Number of parent advisory council sessions.</p> <p>Parent satisfaction feedback.</p> <p>Number of families involved in AHS activities</p>
<p>Promote traditional culture and language through various learning activities and workshops with parents and their children (Culture and Language).</p>	<ul style="list-style-type: none"> - Elders teach children their First Nation language using Anishinaabemowin resources (e.g. "What's this Name?" signs posted around buildings, language classes) - Workshops on traditional crafts and regalia - Ceremonies conducted by Elders 	<p>RECE Program Supervisor</p> <p>RECE/AHS Worker</p> <p>ELDERS</p>	<p>Record in PathDMS the following:</p> <p>Number of Traditional based Activities</p> <p>Number of participants</p> <p>Number of families</p>
<p>Improve the physical and mental health and well-being of children and parents. (Health Promotion / Nutrition)</p>	<ul style="list-style-type: none"> - Awareness of healthy personal hygiene and dental habits are promoted by AHSOR staff - Appropriate levels of physical activity are integrated into the curriculum - Visits from health professionals for education and awareness in accordance with policies and procedures - Teach, model and encourage parents the basic tools that contribute to 	<p>RECE Program Supervisor</p> <p>RECE/AHS Worker</p>	<p>Number of professional visits</p> <p>Number of audio or dental screenings</p> <p>Number of other health related screenings</p> <p>TFN AHSOR Program policies and procedures are followed and documented</p> <p>Nutritional guidelines are followed</p> <p>Number of times nutritional</p>

	<p>the holistic health needs for the children</p> <ul style="list-style-type: none"> - Providing healthy foods during Centre based activities including two snacks and a lunch for children. - Assist families in meeting each child’s nutritional needs and in establishing healthy eating habits that will nurture healthy development and promote health throughout the child’s life. - 		<p>tips/recipes/handouts are shared with parents/caregivers</p> <p>TFN AHSOR Program policies and procedures are followed and documented</p>
Provide social support and improve social health and well-being of children and parents (Social Support)	<ul style="list-style-type: none"> - Enable linkages and cooperation with other community programs and services to enhance the effectiveness of the growth and social development of both children and caregivers 	<p>RECE Program Supervisor</p> <p>RECE/AHS Worker</p>	<p>Record in PathDMS the following:</p> <p>Number of referrals to other programs and services</p> <p>Number of meetings</p>

Canadian Prenatal Nutrition Program (CPNP) / Maternal Child Health (MCH) / FASD

Outcome: To promote healthy pregnancies and the health of infants and young children by supporting the improvement of maternal and infant nutritional health.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
CPNP: To provide nutrition screening, education and counseling for pregnant women and mothers as required	<ol style="list-style-type: none"> 1. Assess needs of the expecting mother(s) 2. Register pregnant women/women with infants of 12 months or less into the CPNP program 3. Provide one-to-one education, awareness and support on healthy pregnancy (including nutrition and Fetal Alcohol Spectrum Disorder) 4. Provide prenatal classes 	Healthy Babies Health Children Worker CHN CHR	The following indicators tracked using PathDMS <ul style="list-style-type: none"> • Number of clients • Number of Activities • Number of Participants • Number of families involved in activities Age of Participants • CBRT indicators • Number of outcomes and lessons learned (reviewed quarterly) • FNIHB Healthy Child Development indicators
CPNP: Breastfeeding promotion, education and support will be provided to encourage women to breastfeed. The education and support will teach women and their families about benefits of breastfeeding, nutrition, etc. Supportive activities will help women access nutritional programming through transportation and childcare.	<ol style="list-style-type: none"> 5. Plan and conduct one-to-one or group prenatal classes as appropriate 6. Breastfeeding support through consultations, support for use of breast pumps as required 	Healthy Babies Health Children Worker CHN	The following indicators tracked using PathDMS: <ul style="list-style-type: none"> • Number of Participants, clients, and activities • Number of families involved in activities • Age of Participants • CBRT indicators • Number of outcomes and lessons learned (reviewed quarterly) • FNIHB Healthy Child Development indicators
MCH: Maternal nourishment activities including providing healthy foods to pregnant or breastfeeding	<ol style="list-style-type: none"> 7. Dispense bi-monthly food vouchers 8. Document as required 	Healthy Babies Health Children Worker	The following indicators tracked on PathDMS: <ul style="list-style-type: none"> • Number of clients • Number of Activities

<p>women. Women will be given healthy food in educational workshops or food hampers/vouchers.</p>	<p>9. Advocate as required</p>		<ul style="list-style-type: none"> • Number of Participants • Number of families involved in activities • Age of Participants • CBRT indicators • Number of outcomes and lessons learned (reviewed quarterly) • FNIHB Healthy Child Development indicators
<p>FASD: Implement culturally appropriate and evidence based prevention and early intervention programs related to FASD.</p>	<p>10. Provide Prenatal addictions awareness workshops to increase awareness of risks and support on healthy pregnancy (including Fetal Alcohol Spectrum Disorder</p>	<p>Healthy Babies Health Children Worker CHN</p>	<p>The following indicators tracked on PathDMS:</p> <ul style="list-style-type: none"> • Number of Activities • Number of Participants • Number of families involved in activities • Age of Participants • CBRT indicators

Brighter Futures (BF)

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

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
Improve the quality of, and access to, culturally appropriate mental health services at the community level (Mental Health);	Offer regularly scheduled mental health awareness sessions which promote and educate on Healthy Lifestyle dynamics and protective health factors to encourage and support the Mental, Physical, Emotional wellbeing of the Children, Youth and Community in conjunction with the BHC program.	Community Health Representative	Record in PathDMS the following: Number of Activities Number of Participants Number of families involved in activities Age of Participants CBRT indicators
Strengthen the existing child development network of social, health, medical, educational and cultural services (Child Development)	Address issues affecting the health of infants, toddlers, and preschool children	Healthy Babies Healthy Children Worker Native Child Welfare Prevention Worker	

<p>Reduce death and acute and long-term disability due to childhood injuries (Injury Prevention)</p>	<p>Public education through workshops, newsletters and social media including the following: Road Safety – Rate of Injuries associated to First Nations people, Motor Vehicle Safety, Car Seats Use/Safety, and Evidence Based Best Practices Fires – Rates of Injuries associated to First Nations People, House Fires, Fire Safety, Best Practices Injuries Prevention – Rates of Injuries associated to First Nations people, Intentional Injuries (Self harm, VIOLENCE)</p> <p>Knowledge development and training of TFN staff (e.g. Food Handler’s Safety courses)</p>	<p>Community Health Representative</p>	
<p>Improve the physical, mental and social health and well-being of mothers and infants (Healthy Babies)</p>	<p>Involve parents and professionals in improving the outlook of children, youth, families, and community as a whole.</p> <p>Undertake intervention and prevention activities to assist children and parents to develop positive and satisfying attitudes, values and skills which are rooted in cultural heritage</p>	<p>Healthy Babies Healthy Children Worker</p>	
<p>Promote culturally appropriate parenting skills and involvement in their child’s learning (Parenting Skills)</p>	<p>Offer workshops and resource materials for parents such as: Positive Parenting Dynamics / Best Practices, Traditional Parenting Dynamics / Best Practices.</p> <p>Empower parents / caregivers to understand and support their child’s growth and development.</p> <p>Reinforce parents / caregivers in their role as the primary teachers of the children.</p>	<p>Healthy Babies Healthy Children Worker</p> <p>Native Child Welfare Prevention Worker</p>	

	<p>Encouraging parents and guardians to read with their children and participate in cultural / family activities.</p> <p>Facilitate family events (e.g. Easter Egg Hunt).</p> <p>Safety education and awareness activities (e.g., playground safety, car seat use, seat belt use, bike safety, etc.)</p>		
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Building Healthy Communities (BHC)

Outcome: To assist in preparing for and managing mental health crises (e.g. suicide and substance abuse)

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
<p>To support the community well-being through mental wellness promotion and the implementation of traditional programming as follows:</p> <p>Primary Program Area: HEALTHY LIFESTYLES PROMOTION: Promote and educate on Healthy Lifestyle dynamics and protective health factors to encourage and support the Mental, Physical, Emotional well being of the Children, Youth and Community</p>	<p>PPA 1: Promotion (Presentations) of age appropriate Healthy Lifestyle topics in the areas of; <i>Mental Health, Nutrition, Physical Activity, Injury Prevention, Childhood/Adolescent Development, Positive Parenting and Youth Suicide</i></p> <p>Priority Topics include: <u>Nutrition</u> Healthy Eating, Fueling Your Body for Mental Health, Impacts (Disease/Chronic Conditions) of Negative Nutrition, <u>Physical Activity</u> Managing your Health and Body, Implementing manageable Physical Activity in your Life, Impacts (Disease/Chronic Conditions) of the Lack of Physical Activity <u>Youth/Adolescent Development</u> Biological (Physical) Body Changes, Adolescent Development Mental, Biological/Psychological Changes</p> <p>PPA 2: Participate in annual Youth Gatherings /Conferences/Forums within and outside the community to encourage peer to peer engagement, participation and exposure within and outside community</p>	<p>Community Health Representative</p> <p>Native Child Welfare Prevention Worker</p>	<p>Record in PathDMS the following:</p> <p>Number of clients Number of Activities Number of Participants Number of families involved in activities Age of Participants CBRT indicators Number of outcomes and lessons learned (reviewed quarterly)</p>

	PPA 3: Ongoing research and participation in relevant Trainings, Facilitator Trainings as well as relevant Regional working group(s), Task Force(s) in the region, outside and within the community		
Secondary Program Area: Deliver/create age appropriate AWARENESS on priority risk factors in the community in the areas of: Mental Health, Youth Suicide, Injury Prevention, Child Adolescent development, relevant to the needs of Children Youth and Community	SPA 1: Awareness (Presentations) of age appropriate priority “risk factors” within the community, delivered in areas such as; Mental Health, Nutrition, Physical Activity, Injury Prevention, Childhood/Adolescent Development, Positive Parenting and Youth Suicide	Community Health Representative	Record in PathDMS the following: Number of Activities Number of Participants Number of families involved in activities Age of Participants CBRT indicators Number of outcomes and lessons learned (reviewed quarterly)
	Offer/ Implement Focus Group sessions for “target audience(s)” on specific program topics and or priority risk factor(s) within and outside of the community for example: Mental Disorders, Decreasing the Stigma, Stress management, Coping Skills, Depression, Anxiety, Self Esteem/worth, Identity, Safe Talk – Youth Suicide, Decreasing the Stigma, Peer to Peer Support, Creating Awareness, Building on Resiliency with Individuals,	Native Child Welfare Prevention Worker	
	Ongoing relevant program research, development for new resources, linkages, networks that support the ongoing delivery of program		
Tertiary Program Action: Program Resources/Accessibility: Support all relevant health/community based programs to broaden the scope of promotion and awareness deliverables of Brighter Futures, Building Healthy Communities, NNADAP and solvent abuse programs by implementing or developing accessible community oriented resources suitable to the children, youth and community needs	TPA 1: Utilize interactive BFI/BHC YOUTH “Facebook” page, Health Newsletter for (accessible) Program Resource Dissemination that is supplementary to program information delivered.	Community Health Representative	Record in PathDMS the following: Number of Activities Number of Participants Number of families involved in activities Age of Participants CBRT indicators Number of outcomes and lessons learned (reviewed quarterly)
	Utilize PathDMS software to strategically deliver program objective(s) throughout the year towards target audience.		

National Native Alcohol and Drug Abuse Program (NNADAP)

Outcome: Support the community to reduce the levels of alcohol and other substance abuse within among TFN citizens

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
To provide community based prevention and treatment programming and interventions aimed at reducing and preventing alcohol, drug and solvent abuse for Temagami First Nation(TFN) citizens and supporting	<p>Promotional Activities to strengthen protective factors and minimize risk factors for substance abuse and addiction within individuals, families and the community by preventing substance use and/or abuse, avoiding high-risk substance use and delaying age of first substance use.</p> <p>Prevention Activities To prevent and reduce the incidence of alcohol and substance abuse in the community through health promotion aimed at changing the underlying social, cultural and environmental determinants of health (i.e. fishing, traditional crafts, dance, media, group work and such)</p>	NNADAP Worker	<p>Record in PathDMS the following:</p> <p>Number of Activities</p> <p>Number of Participants</p> <p>Age of Participants</p> <p>CBRT indicators</p> <p>The following client-based indicators will be captured in PathDMS:</p> <ul style="list-style-type: none"> • Brief interventions (e.g. Supportive discussions including personalized feedback, identification of supportive networks/ resources, goal setting on substance use behaviours). • Interventions with youth at risk for suicide (e.g. Counselling, assessments) • Interventions with individuals or those affected after an attempted suicide (e.g. Support, counselling, treatment planning) • Interventions after a death by suicide with those

<p>overall community wellness.</p> <p>Culture and land based activities may be integrated into all these continuum of care activities.</p>			<p>affected</p> <ul style="list-style-type: none"> • Treatment Planning • Aftercare Planning and Support • Addictions recovery support • Solvent abuse awareness and education • Identify and strengthen protective factors for client (minimize risk factors) • Direct Counselling • Referrals
	<p>Early Identification and Intervention: Provide “brief service” as initial point of contact for individuals at risk for or who have already developed a substance abuse problem.</p>		<p>Record in PathDMS the following:</p> <p>Number of clients CBRT indicators</p>
	<p>Screening, Assessment and Referral: Is provided to identify individuals at elevated risk for substance abuse, collect the information required to refer the client to the appropriate course of treatment (such as outpatient, day or evening treatment, or a residential treatment centre) and identify any additional services that might be required (such as detoxification, job support services, mental health treatment).</p>		<p>Record in PathDMS the following:</p> <p>Number of clients CBRT indicators</p>
	<p>Treatment: To provide support to individuals and families in crisis, and/or with problems of at least a moderate severity or complexity. To provide counselling (one to one, traditional healing).</p>		<p>Record in PathDMS the following:</p> <p>Number of clients Number of Activities Number of Participants Age of Participants CBRT indicators</p>
	<p>Discharge Planning and Aftercare: Provide after care to clients (such as ongoing, one-on-one counselling, referring to appropriate support services, maintain a link with the treatment centre concerning client care and programs) as well as provide access to off-reserve resources for post-treatment support</p>		<p>Record in PathDMS the following:</p> <p>Number of clients CBRT indicators</p>

Chronic Disease Prevention and Management – Aboriginal Diabetes Initiative (ADI)

Outcome: To improve the health status of community members through actions designed to contribute to the promotion of healthy living and supportive environments, and are specifically aimed at reducing prevalence and incidence of diabetes and its risk factors

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
Increase awareness of diabetes, diabetes risk factors and complications as well as ways to prevent diabetes	To increase awareness of diabetes , risk factors and complications as a prevention measure by providing and/or participating in educational workshops /events open to all community members living with or at risk of diabetes (e.g. summer picnic, fall feasts, annual health fair, cultural based activities)	Health Promotion Worker	Record in PathDMS the following: Number of Activities Number of Participants Age of Participants CBRT indicators
Support activities targeted at healthy eating and food security.	Healthy Eating/Food Security activities to provide opportunities for community members to develop skills to practice healthy living lifestyles (e.g., workshops, grocery store tours, community garden, food preservation, cooking skills programs with children, youth, pregnant women, adults; school milk program)		Record in PathDMS the following: Number of Activities Number of Participants Age of Participants CBRT indicators
Increase physical activity as a healthy living practice.	Increased Physical Activity: Promote physical activity as a healthy living practice for all community members living with or at risk of diabetes (e.g. leading physical activities in the community school twice a month;		Record in PathDMS the following:

	implementing a community walking club; children swimming; encouraging/signing up people to use TFN exercise equipment).		Number of Activities Number of Participants Age of Participants CBRT indicators
Increase the early detection and screening for complications of diabetes in TFN	Early detection/screening of diabetes through the provision of community based screening processes (including coordinating and implementing: the DIP program; HA1C tests between visiting professionals and community members at the health centre and in schools) resulting in more immediate follow-up and referrals to specialists as required.		Record in PathDMS the following: Number of Activities Number of Participants Age of Participants CBRT indicators Lessons Learned Outcomes Emerging Priorities
Increase capacity to prevent and manage diabetes.	Increase capacity to prevent and manage diabetes and/or secondary complications by increasing awareness of neuropathy through the provision of foot care clinics (support coordination, encourage at risk community members participation etc.) Plan and conduct monthly diabetes activities that consist of educational presentations and luncheons based on Canada Food Guides.	Health Promotion Worker	Record in PathDMS the following: Number of Activities Number of Participants Age of Participants CBRT indicators
Increase knowledge development and information-sharing to inform community-led evidence-based activities.	Knowledge Development and information sharing: To enable Health Staff to have subject matter knowledge in the area of diabetes through the provision of in-service training Knowledge Development and information sharing: Monitor trends in food insecurity experienced in the community and develop appropriate strategies as required.		Record in PathDMS the following: Number of Activities Number of Participants Age of Participants CBRT indicators

TEMAGAMI FIRST NATION (TFN) Workplan 2021/20-2029-30
Activity Level: Supplemental Health Benefits

Non-Insured Health Benefits (NIHB)

Outcome: To improve access to local health care providers.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
<p>To provide local medical transportation to appointments as a benefit coverage for Temagami First Nation(TFN) individuals</p> <p>To provide coordination services, support/ advocacy or information and awareness of NIHB or other benefit programs for registered band members, community members and/ or health services providers.</p>	<p>Provide medical transportation services and/ or service coordination to:</p> <ul style="list-style-type: none"> • All registered members of TFN living on reserve • All registered band members (regardless of their band affiliation) living in TFN where feasible within existing resources; • All other registered band members as deemed feasible, on an exception basis and within existing resources <p>TFN will record all claims data and submit electronically to FNIH as per reporting schedule identified in agreement. Required indemnification documents for Medical Transportation Drivers maintained submitted to FNIH upon request.</p> <p>Coordination and support/ advocacy to access other NIHB offered to registered band members as per client request.</p> <p>Provide information to community members and/ or service providers on NIHB implementing appropriate consent processes as required.</p>	<p>Medical Transportation Coordinator</p> <p>Medical Transportation Driver(s)</p>	<p>Number of clients transported (when and where)</p>

Health Planning and Quality Management (HPM)

Outcome: To design and manage the delivery of health programs and services.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
Health Planning and Quality Management: to design health programs, develop health plans, establish services and/or allocate funds according to Temagami First Nation's(TFN) identified health priorities	<ol style="list-style-type: none"> 1. Design health programs, develop health program plans, and administration, which/and/or allocate funds according to their identified health priorities 2. Optimize flexibility for health programming and services for recipients. 3. In-service training 4. Orientation plans 5. Effective communication with other First Nation, partners and affiliates 	Health Services Manager Office Manager	Number of meetings
Support Operational Plans: Strengthen and enhance the accountability of Temagami First Nation(TFN) regarding the management and the delivery of quality health programs and services	<ol style="list-style-type: none"> 6. Effectively manage and assist in every day operations of the health and social services unit 7. To assist in the development of/and approve annual activity plans 8. Annual review of pandemic plan 9. Annual review of Emergency Preparedness Plan 		Up to date Pandemic Plan Up to date Emergency Preparedness Plan
Administration	<ol style="list-style-type: none"> 10. Quarterly/annual reports, CBRT, narrative reports, electronic medical records 11. Financial accountability including expenditure reports, budgeting, audit, bi-annual reallocations, surplus/deficit management 		Timely submission of FNIH reporting requirements

Ongoing health system improvement by embedding quality improvement activities	12. Oversee ongoing timely implementation of PathDMS, an application to track all participant based activities that will improve administrative reporting, enhance communication with community members and populate the CBRT		<p>Monthly reports generated</p> <p>Review progress with Health Staff</p>
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Operations and Maintenance (O&M)

Outcome: To undertake proper maintenance, operations and custodial functions for all capital facilities housed by TFN personnel.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
To undertake proper maintenance, operations and custodial functions for all capital facilities	<ol style="list-style-type: none"> 1. General cleaning and sanitary services, daily, both indoor and outdoor. 2. Minor maintenance activities. 3. Undertake operation and maintenance activities for safety and security purposes on a priority basis, using materials and supplies as provided by the First Nation with the view to maintaining the capital facilities as safe and secure for occupants and visitors. 4. Maintain and test safety, emergency, fire detection and protection equipment's. <p>NOTE SEE OPERATIONS AND MAINTENANCE MANUAL FOR DETAILS</p>	Janitor	Daily Checklist Log

REQUIREMENT #4:

Mandatory Programs Workplans for 2020(21)-2029(30)

Contents

CLINICAL AND CLIENT CARE – NURSING, COMMUNITY HEALTH REPRESENTATIVE, CLERICAL (NURSING, CHR, CLERICAL)	1
HEALTHY LIVING – COMMUNITY HEALTH PROMOTION AND INJURY PREVENTION-COMMUNITY HEALTH REPRESENTATIVE	2
COMMUNICABLE DISEASE CONTROL AND MANAGEMENT (NURSING, CHR, CLERICAL)	4
BLOOD BORNE DISEASE AND SEXUALLY TRANSMITTED INFECTIONS – HIV / AIDS (NURSING, CHR, CLERICAL).....	7
FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE (H&CC)	8
DRINKING WATER SAFETY PROGRAM (EPH/DWSP)	9

Clinical and Client Care – Nursing, Community Health Representative, Clerical (Nursing, CHR, Clerical)

Outcome: To provide essential health care services directed towards First Nation citizens which enable them to receive the clinical care they need in their home communities.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
Access to Treatment: Immediate assessment of a seriously injured or ill client to determine the severity of the condition and the type of care needed. (Urgent and Non Urgent Care)	<ol style="list-style-type: none"> 1. Provide access to urgent and non-urgent health services to community members. 2. All clients will have access to medical transportation services as per community resources. Referral to professional service on and off the reserve. 3. Referrals to medical transportation clerk 4. Emergency services to be provided by ambulance 	<p>CHN</p> <p>CHR</p>	<p>Client charts</p> <p>Number of Clinical Client Care (CCC) service encounters during the reporting year for urgent and non-urgent clinical services reported on CBRT</p> <p>Number of encounters during reporting year by CBRT classification</p>
Coordination and Case Management: Linkages with other services may include other health, social and education programs available both within the community and outside of the community	<ol style="list-style-type: none"> 5. Provide access to coordination and consultation services with other appropriate health care providers and/or institutions as indicated by client needs (both internal and external to TFN) 6. liaise with appropriate provincial/regional public health authorities 	<p>CHN</p> <p>CHR</p>	<p>Number of referrals to outside healthcare providers</p>
Provision of and access to medical equipment, supplies and pharmaceuticals to provide clinical and client care (Access to Medical Equipment, Supplies and Pharmaceuticals)	<ol style="list-style-type: none"> 7. Ensure that expendable first aid supplies and equipment shall be distributed as per policy implemented by TFN in accordance with the ISC community health nurse's scope of practice. 	<p>CHN</p>	<p>Guidelines for first aid supplies and equipment are followed</p>
A System of Record Keeping and Data Collection	<ol style="list-style-type: none"> 8. Maintain a client record 9. Maintain an information system that enables program monitoring, ongoing planning, reporting and evaluation activities (e.g. PathDMS) 	<p>CHN</p>	<p>Annual spot check of client records</p> <p>Quarterly and Annual PathDMS reporting</p>
A Continuous Quality Improvement Process	<ol style="list-style-type: none"> 10. Capacity to review and continuously improve the delivery of clinical and client care in a safe and effective manner. 	<p>CHN</p>	<p>Ongoing review with Health Services Manager</p>

TEMAGAMI FIRST NATION (TFN) Workplan 2020(21)-2029(30)

Activity Level: Primary Health Care

Sub Activity Level: Health Promotion and Disease Prevention

Sub Sub Activity Level: Healthy Living

Healthy Living – Community Health Promotion and Injury Prevention-Community Health Representative

Outcome: To provide essential health care services directed towards First Nation citizens which enable them to receive the clinical care they need in their home communities.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
Community Health Promotion and Injury Prevention #1 - to provide culturally relevant community based programs to reduce the rate of all chronic diseases and improve health outcomes associated with chronic diseases and injuries among TFN citizens	<p>Health Promotion and Primary Prevention: Provide culturally relevant health promotion and disease prevention activities to reduce or prevent chronic diseases such as heart disease, stroke, cancer, arthritis</p> <p>To increase awareness of the impact of lifestyle upon individual health outcome (healthy lifestyles promotion To deliver educational, prevention, intervention and treatment services in mandated areas under the program i.e. blood pressure clinic at lunch and learns.</p> <p>Provide support to the Community Health Nurse</p> <p>Liaise between health professionals and community members, provide translation, ensure client understanding of medical professional</p>	CHR CHN	Record in PathDMS the following: Number of clients Number of Activities Number of Participants Number of families involved in activities Age of Participants CBRT indicators Number of outcomes and lessons learned (reviewed quarterly) Number of referrals made The following indicators will be tracked in PathDMS: <ul style="list-style-type: none"> • Education and awareness to reduce or prevent chronic diseases such as heart disease, stroke, cancer, arthritis • Diabetes non diagnostic Screening • Diabetes Diagnostic Screening • To increase awareness of healthy behaviour such as healthy food, eating and

	communications, and appropriate follow up		<p>physical activity</p> <ul style="list-style-type: none"> • To increase awareness of diabetes, risk factors and complications • To increase capacity to manage diabetes (maintain health after diagnosis) • To increase awareness of the impact of lifestyle on health outcomes • Client based chronic disease awareness and prevention information (handouts) • To provide education prevention and treatment for bug borne communicable diseases including lice, bites and scabies, • To provide education, prevention and treatment information for Sexually Transmitted Infections, HIV/AIDs • To provide education, prevention and treatment information for viruses and bacteria. • Foot Care
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TEMAGAMI FIRST NATION (TFN) Workplan 2020(21)- 2029(30)

Activity Level: Primary Health Care

Sub Activity Level: Public Health Protection

Sub Sub Activity Level: Communicable Disease Control and Management

Communicable Disease Control and Management (Nursing, CHR, Clerical)

Outcome: To reduce the incidence, spread and human health effects of communicable diseases, as well as improve health through prevention and health promotion activities. The immunization program focuses on increasing uptake of routine infant series and preschool immunization as well as routine immunization across the lifespan. The overall expected outcomes are to improve coverage rates for routine immunizations, reduce Vaccine Preventable Disease (VPD) incidence and outbreaks, and the development of an enhanced immunization surveillance system.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
To provide primary prevention through provision of immunization against vaccine-preventable diseases	Provide immunization to infants, children, and adults or clients of the TFN's community, according to provincial routine immunization schedules and FNIH policies/guidelines where appropriate;	CHN	90% of 2 year old infants will be up-to-date with immunizations
To monitor communicable disease cases reported by physicians, hospitals, and other health care agencies;	Conduct regular tracking of the incidence of disease in the TFN's community to assist in the early identification of potential outbreaks and emerging trends;		95% of eligible preschoolers will receive MMRV, Tdap-IPV upon school entry
To collect routine immunization coverage rates according to provincial/territorial routine immunization schedules;	Keep records of all communicable disease control activities, including mandatory reporting forms, client records, immunization coverage rates and detailed documentation of how cases and outbreaks are managed;		95% of eligible Grade 7 students will receive Hepatitis B, Gardasil9 (HPV9) and Meningococcal vaccine (Men-C-ACYW). 95% of eligible grade 8 students will have completed the Hep B series
To provide interventions, including counseling, treatment, therapy, referral, follow-up, inspection, infection control and outbreak management in relation to	Provide educational information on communicable disease control and immunization to individual clients, community leaders and other community health workers and support the development of community based education and awareness materials;	CHR	95% of eligible students will have completed the Gardasil series and Meningococcal vaccine by the end of grade 12. 95% of all eligible Grade 7 students will receive gardasil. Catch up will be offered until Grade 12. 95% of 14-16 year olds will receive Tdap immunization.

communicable diseases;	<p>Communicable disease control contact tracing and follow-up as per CDC manual.</p> <p>All outbreak situations will be reported to the Environmental Health Officer, FNIHB Nursing Coordinator, and the Medical Officer of Health as required. The school and the daycare will also be notified if needed. Vaccinations will be given accordingly.</p> <p>Confidentiality will be maintained at all times. All clients requesting counseling and screening are forwarded to appropriate individuals as indicated, and follow-up done to ensure above is received.</p> <p>Support the implementation of vaccine cold chain management processes</p>		<p>95% of adolescents will catch up with 2 doses of varicella if born after Jan 1, 2000.</p> <p>All adults offered Td booster. Verbal refusals will be noted on client files. Tdap to be offered as 1st dose in adulthood if not previously received.</p> <p>75% of eligible clients at risk will receive flu and be recorded on client files. Priority target populations include: pregnant women, elderly over 65 years old and children under 2 years of age.</p> <p>75% of high-risk clients will receive pneumococcal vaccination.</p> <p>All immunizations will be recorded on client files and MIMS.</p> <p>Immunization coverage reporting to be submitted with annual reporting in accordance with the terms and conditions of the Contribution Agreement.</p> <p>All immunizations provided are in accordance with the PFISO.</p>
To provide screening and follow-up services where appropriate;	To provide screening and follow-up services where appropriate	CHN	Number of client services
To provide professional consultation and continuing education to physicians, nurse practitioners and other community base workers	Provide and support education and training to nursing personnel and other health care professionals to maintain knowledge and competence in communicable disease control and management		<p>Number of professional consultations</p> <p>Number of training(s) held</p>
To encourage and enable research that will contribute to reduction of communicable diseases among First Nations and Inuit communities in Canada.	Liaise with appropriate provincial/regional public health authorities		Number of research projects undertaken

<p>To enable health workers and communities to prevent and control TB at the community level, by increasing awareness and understanding of the disease</p>	<p>Provide education to individuals such as health professionals and community members to help control and prevent TB in TFN's community</p>		<p>Number of education session(s) held</p>
<p>To facilitate the testing and ongoing revision of the community-level Emergency Response and Pandemic Plans</p>	<p>Documented work plan to describe the delivery of the CDC program which is available at all times. The plan must describe the ongoing method of delivering: (a) immunizations; (b) outbreak management; (c) surveillance; and (d) education.</p> <p>Liaise with appropriate provincial/territorial/regional public health authorities; Integrate TFN's community-level pandemic plan into the community's Emergency Management Plan; Implement TFN's community-level pandemic plan when the situation warrants</p>		<p>Success will be measured in the event of an emergency situation at the community level. Following and Emergency situation, the response will be evaluated and modified if required. Any changes will be added to the existing Emergency Response Plan.</p>

TEMAGAMI FIRST NATION (TFN) Workplan 2020(21)- 2029(30)

Activity Level: Primary Health Care

Sub Activity Level: Public Health Protection

Sub Sub Activity Level: Communicable Disease Control and Management

Blood Borne Disease and Sexually Transmitted Infections – HIV / AIDS (Nursing, CHR, Clerical)

Outcome: To reduce the incidence, spread and human health effects of communicable diseases, as well as improve health through prevention and health promotion activities. The immunization program focuses on increasing uptake of routine infant series and preschool immunization as well as routine immunization across the lifespan. The overall expected outcomes are to improve coverage rates for routine immunizations, reduce Vaccine Preventable Disease (VPD) incidence and outbreaks, and the development of an enhanced immunization surveillance system.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
Communicable disease control contact tracing and follow-up as per CDC manual.	All outbreak situations will be reported to the Environmental Health Officer, Tribal Nursing Coordinator, and the Medical Officer of Health. The school and the daycare will also be notified if needed. Vaccinations will be given accordingly.	CHN CHR	100% of CDC cases actioned as per CDC protocol.
HIV pre/post test counseling information provided when requested.	HIV pre/post test counseling information provided when requested.		Communicable disease cases/numbers will be reported to the Health Services Manager (as needed)
HIV Testing is not provided at the community level.	HIV Testing is not provided at the community level.		All identified target groups will be immunized.
Confidentiality will be maintained at all times. All clients requesting counseling and screening are forwarded to appropriate individuals as indicated, and follow-up done to ensure above is received.	Confidentiality will be maintained at all times. All clients requesting counseling and screening are forwarded to appropriate individuals as indicated, and follow-up done to ensure above is received.		Follow-up, refer and educate.
Community youth and adult are informed of the risks of obtaining HIV.	Health promotion and prevention activities specific to HIV will be held at least twice a year and more frequently in combination with other communicable disease activities.	CHR	Reporting in PathDMS

TEMAGAMI FIRST NATION (TFN) Workplan 2020(21)- 2029(30)

Activity Level: Primary Health Care

Sub Activity Level: Primary Care

Sub Sub Activity Level: Home and Community Care

First Nations and Inuit Home and Community Care (H&CC)

Outcome: To improve longevity and the quality of life for seniors, frail, elderly and disabled TFN citizens.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
To enable TFN citizens of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their homes and communities.	Build the capacity within TFN to plan, develop and deliver comprehensive, culturally sensitive, accessible and effective home care services.	Home and Community Care Coordinator	Number of clients tracked in E-SDRT Record in PathDMS the following: Number of Home Visits Number of Activities Number of Participants Age of Participants
	Assist community members with chronic and acute illness in maintaining optimum health and a healthy lifestyle, well-being and independence in their homes and communities	Homemaker	
	Facilitate the effective use of home care resources through a structured, culturally defined and sensitive assessment process to determine service needs of clients and the development of a care plan	Home Maintenance Worker	
	Ensure that all clients with an assessed need for home care services have access to a comprehensive continuum of services within the community, where possible	Elder’s Support Worker	
	Assist clients in participating in the development and implementation of the client’s care plan to the fullest extent and to utilize available community support services where available and appropriate in the care of clients	Community Health Nurse	
	Build the capacity within First Nation communities to support the delivery of quality client centered home care services promoting safety.		

TEMAGAMI FIRST NATION (TFN) Workplan 2020(21)- 2029(30)

Activity Level: Primary Health Care

Sub Activity Level: Public Health Protection

Sub Sub Activity Level: Environmental Health

Drinking Water Safety Program (EPH/DWSP)

Outcome: Identify and prevent environmental public health risks that could affect the health of community residents.

Objective(s): (Program Goal)	Activities: (Action taken by the community to achieve the Program Goal)	Data Collection: (Identify who is responsible for data collection)	Outcome Measures / Indicators: (How will I be able to measure the impact of the action undertaken)
Sample and test drinking water supplies for <i>E. coli</i> , total coliforms, and chlorine residuals in distribution systems greater than five (5) connections, cisterns and community wells.	Sample and test drinking water in distribution systems greater than five (5) connections for <i>E. coli</i> , total coliforms, and chlorine residuals once per week, with a minimum of two samples from different locations in the distribution system	Water Treatment Officer	Results of bacteriological and chlorine residual testing results reported to EHO monthly Notify the EHO for interpretation of results and further action immediately upon results exceeding health limits
Reduce the possibility of waterborne disease outbreaks by increasing and improving the monitoring of and reporting on community drinking water supplies	Perform quality assurance tests according to the quality assurance plan developed in collaboration with the EHO		Ongoing reporting of the quality assurance plan
Build capacity through community-based drinking water quality monitoring programs	Participate in the development and implementation of community emergency response plans pertaining to the water system		Number of education sessions held