Bonaparte Indian Band
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COMMUNITY HEALTH PLAN

Bonaparte Indian Band
2610 Perry Rd.,Hwy 97N
Box 669 Cache Creek, B.C.
V0K 1H0

Presented by:

June
2012

Section 1: Overview

Vision Statement:

Mission Statement:

The mission of the Bonaparte Indian Band health Department is to work with our health service partners to provide, maintain, coordinate, monitor and evaluate the best possible health programs for our community members.

Purpose and Goals:

1. Ensure that health programs and activities are responsive to the needs of individuals, families and our community as a whole.
2. Develop enhanced partnerships and networks to increase our ability to get the best services for the most people possible.
3. Exercise leadership to ensure a proactive and comprehensive approach to healthy service delivery.
4. Work to challenge established methods and approaches to delivery of health services and advocate for changes and innovations.
5. Conduct an ongoing search for the best human resources to support our health service provision.
6. Promote the professional, technical and educational development of our health team. Support, monitor and evaluate their capacity and competence.
7. Work closely to integrate health care services with other sectors of the federal, provincial and municipal governments. Build capacity through integrated services.
8. Maximize the efficiency and effectiveness of human and financial resources. Review and reallocate resources to address priority needs and respond to emergent demands.
9. Provide liaison with provincial health programs, regional health boards, community partners and other First Nations Community Health Departments. Facilitate working agreements to support these relationships.
10. Encourage and facilitate the ongoing collection of data to ensure updated research to support fact based decisions on allocation of resources.
11. Develop technical and information systems to support our health service provision.
12. Continue to advocate for increased funding to address increased workloads, demands and expectations.

Bonaparte Indian Band Health Committee

The Health Committee is made up of:

- Health Director
- 2 members of Chief and Council
- 1 elder
- 1 youth member
- Band Administrator
- 2 communities members at large

The Health Committee will meet quarterly.

Role and Approach of the Health Committee:

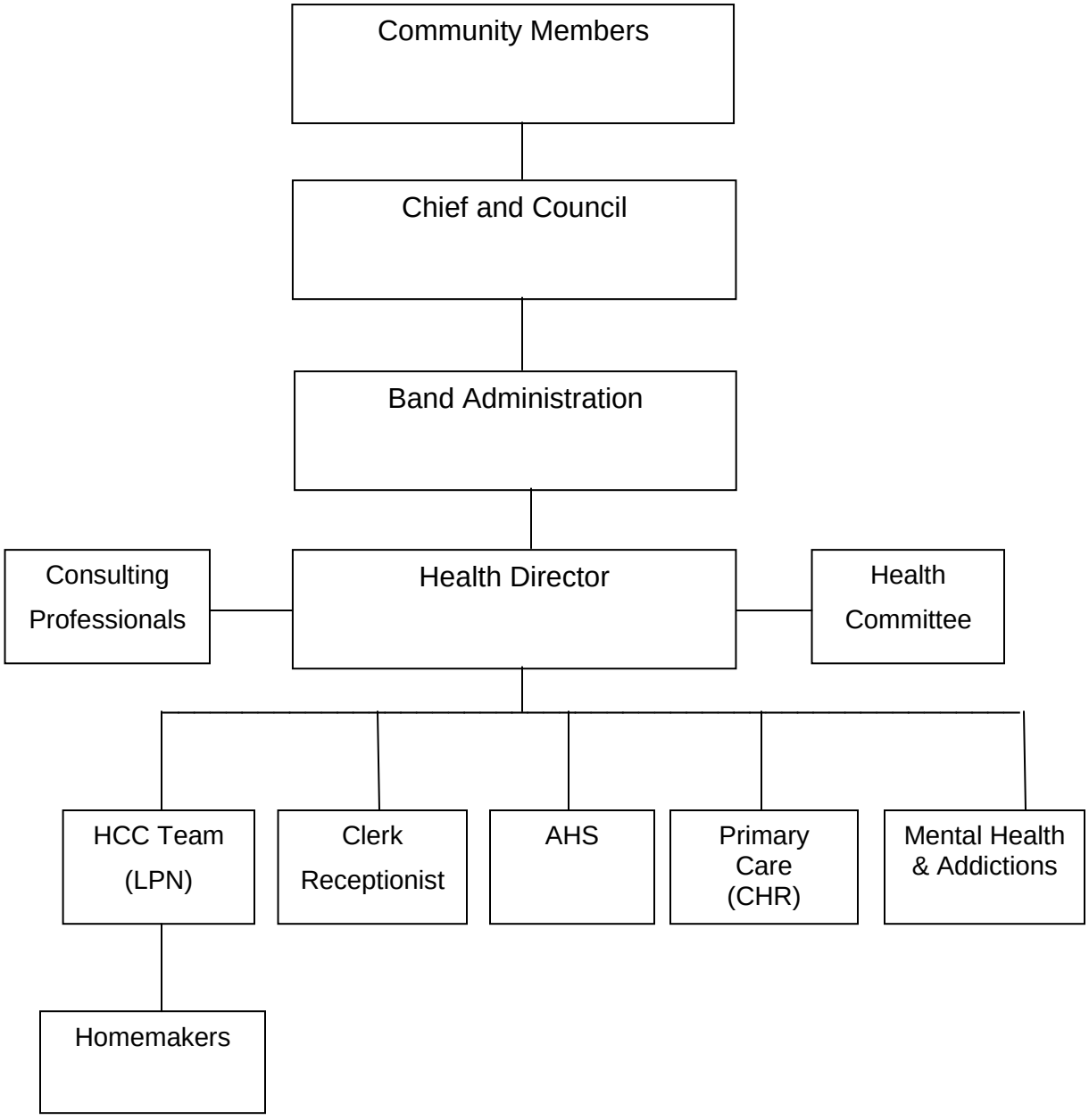
1. To support the Health Department and Health Team efforts to provide quality and responsiveness services.
2. To provide written community support for funding and program applications and proposals.
3. To ensure a community voice in the planning, review and facilitation of health programs and services.
4. To role model healthy choices and lifestyles that support the goals of the health department.
5. To participate in meetings with neighbouring communities, health partners and other boards and committees.
6. To ensure the consideration of cultural and traditional practices in health department planning and programming.
7. To remind the health department of the balance between the past, the present and the future for the Bonaparte Indian Band.
8. To provide support and promote health activities by “getting the word out” and facilitating communication with community members.
9. To support health promotion by being involved in health related activities in the community.
10. To facilitate health education by distributing information in formal and informal ways. To ensure the information being shared in the community is accurate and up to date.

Responsibilities of the Health Committee:

The Health Committee is an advisory committee. It is responsible for collecting, sharing and distributing health updates, research and health promotion information.

Governance follows the chart on the following page.

Health Management Structure



Philosophy of the Bonaparte Health Committee and the Health Department

Our philosophy is based on building healthy individuals, healthy families and a healthy community.

Our health care services must ensure accessibility and equality.

Our health Department wants to ensure responsibility and accountability.

Development of short term and long term plans is based on community needs.

Partnerships are the key to our success. We will work to build positive, constructive partnerships.

Health Needs Assessment and Resource Assessment

Our health planning process is based on community identified needs.

We have collected data by a community needs assessment.

We are working hard to ensure that our plan is responsive and in keeping with the standards of excellence in health services.

Demographics of our community

Demographics	**2012**
Band Members living on reserve	237
Other status Indians living on reserve	14
Band Members living off reserve (Receiving health services on reserve)	43
Non Band Members living on reserve (Receiving health services)	17
Total	**311**
Our transient population is approximately	23

(See CWIS statistics in appendix)

BONAPARTE INDIAN BAND

About our community as a whole

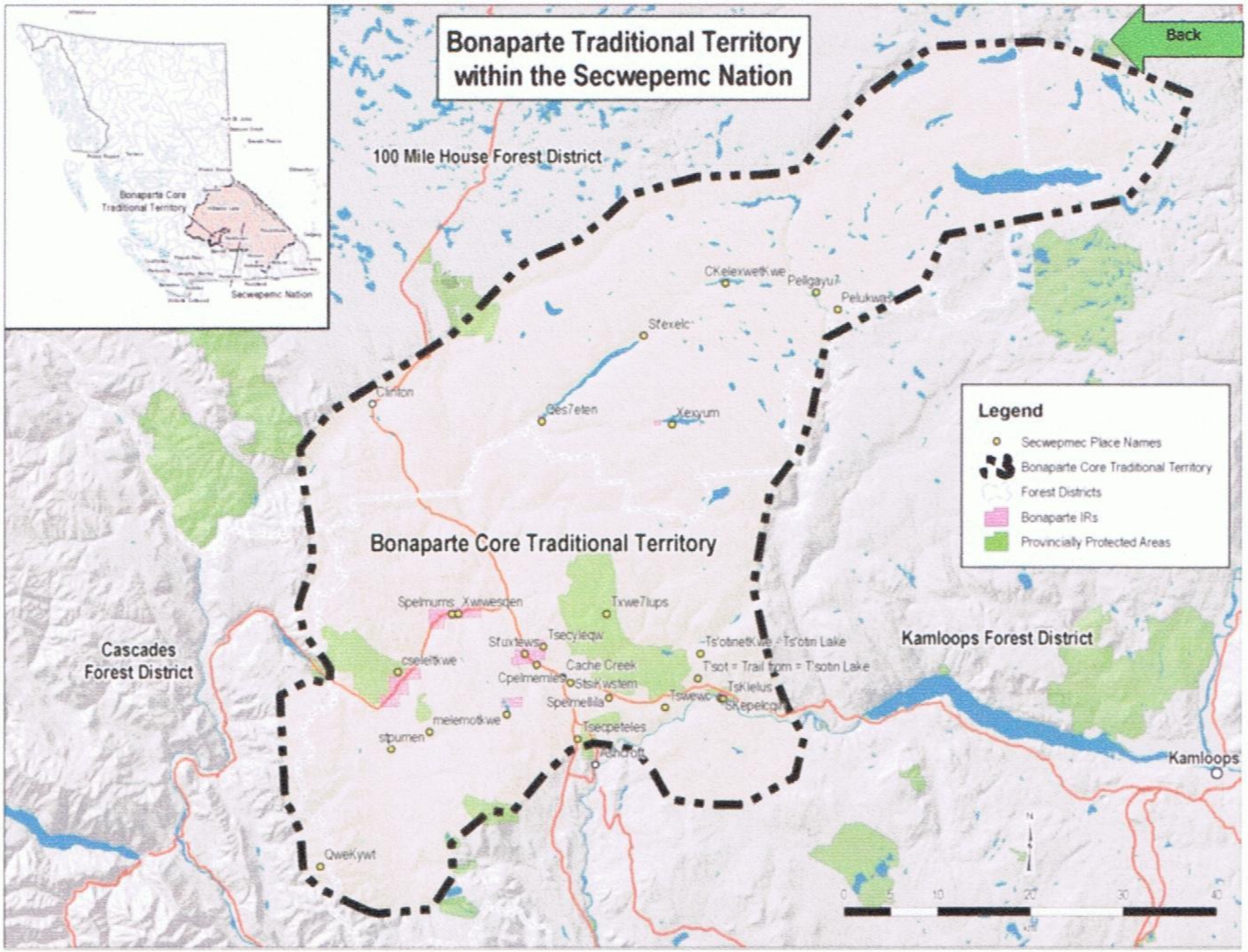
Bonaparte Indian Band is part of the Secwepemc Nation. It is approximately 10 kilometers west of Cache Creek on about 1878 hectares of land in the interior of B.C. The Bonaparte people have existed and prospered within their traditional territory since time immemorial. The Band is separated into nine sections, and has a membership of 1011. Approximately one quarter of the Band members live on reserve.

Bonaparte is governed by an elected chief and eight council members elected under the Indian Act (1985) election system. Council terms are two years with the last election taking place in March of 2011.

The Bonaparte Indian Band provides governance to and on behalf of its members both on and off reserve. The Band provides a number of programs and services that impact almost all facets of band and community member's lives including: membership, health and social development, education, housing and infrastructure, land management, natural resource management and preservation of language and culture. The Bonaparte Indian Band also facilitates economic development through an economic development corporation and provides political and intergovernmental representation.

Bonaparte's mission is to provide the best possible quality of life for its community members by:

- Delivering programs and services in a fair and equitable manner.
- Facilitating economic development and new employment opportunities.
- Protecting, conserving and enhancing the natural environment.
- Respecting and preserving Bonaparte's culture and traditional values.


Bonaparte Traditional Territory
within the Secwepemc Nation
Back
100 Mile House Forest District
Bonaparte Core Traditional Territory
Cascades
Forest District
Kamloops Forest District
Kamloops
Clinton
Cache Creek
Legend
Secwepmec Place Names
Bonaparte Core Traditional Territory
Forest Districts
Bonaparte IRs
Provincially Protected Areas
Secwepemc Nation

Our nearest active treatment hospitals are in Kamloops, Lilloet, and 100 Mile House. There is also a small treatment and assessment centre in Ashcroft. One of the continuing challenges for our community members is the ability to deal consistently with a family doctor.

This challenging situation means increased patient travel and increased frustration as people wait for service and deal with referrals with unknown doctors and professionals. The time and energy required to organize, coordinate and support our community members is extensive. Lack of housing in our community results in many community members living off reserve and yet returning for services in their home community.

As a result of these challenges and because of our community demographics we are required to address a number of issues:

1. Cutbacks in services are forcing people to return to reserve to receive services. This is particularly prevalent with young families.

2. Over 50% of the First Nations population is under 23. The evidence shows that First Nations youth begin parenting at a younger age and have more children then youth in the mainstream.

3. New legislation – Bill C3 will affect Band membership. We have a number of people awaiting resolution.

4. We have an aging population of baby boomers who are moving into the age of increased health needs. They are also predicted to have greater longevity contributing to a longer need for services.

5. We have an increasing birth rate and an increase in the number of parents staying on reserve to receive services. Maternal/child health needs are greater than the rest of the population.

6. The loss of traditional lifestyles continues to contribute to poorer health status for all First Nations people and is evidenced in our community. Changes such as nutrition, smoking, alcohol, poverty and social services and programs of support enhance the challenges our community members face.

7. First Nations people experience higher rates of injury and death from motor vehicle accidents, suicides and violent crime than the mainstream society. This results in higher rates of hospitalization and enhanced need for follow up services once the victim/patient returns to the community.

8. Our improved availability and affordability of housing on reserve has resulted in a trend of young families returning to the community. The affordability issue also means extended families choosing to live together. This results in increased numbers and increased demand for services.

9. Our aging population is experiencing the manifestation of health problems and challenges that resulted from residential school treatment and trauma. The lack of health data from that era and the extent of the impact of the treatment survivors received compromises their health in their later years.

10. The most significant portion of our population (young people) are adversely impacted by the lack of employment opportunities on reserve and in the surrounding area. The lack of employment income contributes too many of the determinants of health problems and concerns.

11. The lack of employment opportunities combined with cutbacks in education and social programs has resulted in more young people staying home longer. This trend is predicted to continue.

12. Our aging population means provision of services to an increasing number of people with long term health problems. Our data tells us that:

    6% have some form of arthritis
    7% have high blood pressure
    6% have heart disease
    11% have diabetes
    6% have respiratory problems
    11% have mental health concerns

13. Through changing social values, our population has increased awareness and has become more demanding and have higher expectations for health service and service quality.

14. There is an ongoing challenge to ensure clear and accurate data information collection. We still maintain paper files only. We need to explore technical support and resources.

15. Although we have a new health centre it requires the addition of appropriate furniture and supplies.

The Bonaparte Indian Band Response to Changing Issues

- Construction of the new Band office/Health Centre
- Employment for health care workers
- Clarification of job descriptions and positions
- Efforts to enhance community services available
- Work to increase service partners
- Exploration of program funding
- Increase in communication with community members
- Ongoing efforts to ensure equitable access to services.

Health Needs Priorities

Our priorities will always be the overall wellness of our community.

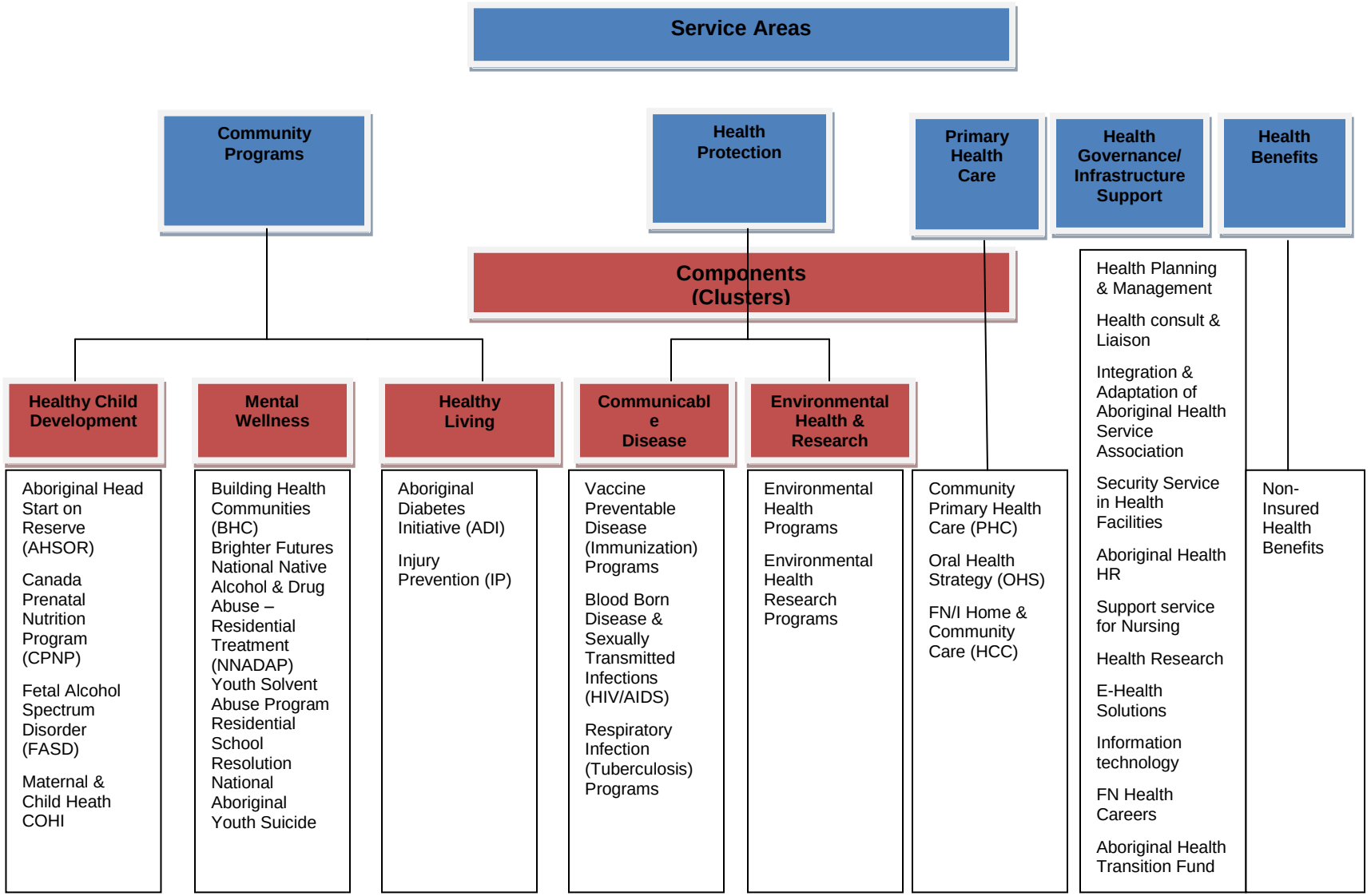
For the next five years our priorities will be improving and enhancing health services for the Bonaparte Indian Band community.

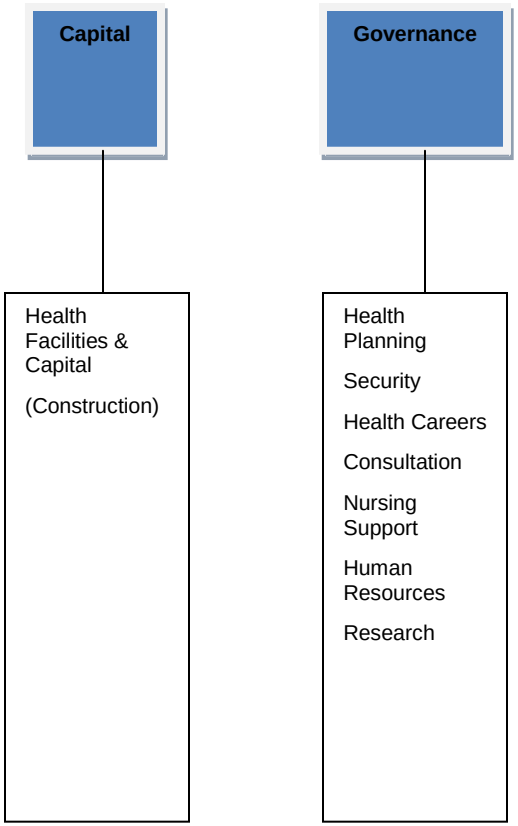
Our process for setting priorities is in response to the community needs that have been identified.

Needs Assessment

In March 2011 the Knucwentivecw Corporation completed a Comprehensive Community Plan outline for the Bonaparte Indian Band. A significant part of this community assessment included Community Wellness. These findings will be used to support ongoing research and strategic planning for health service provision in our community.

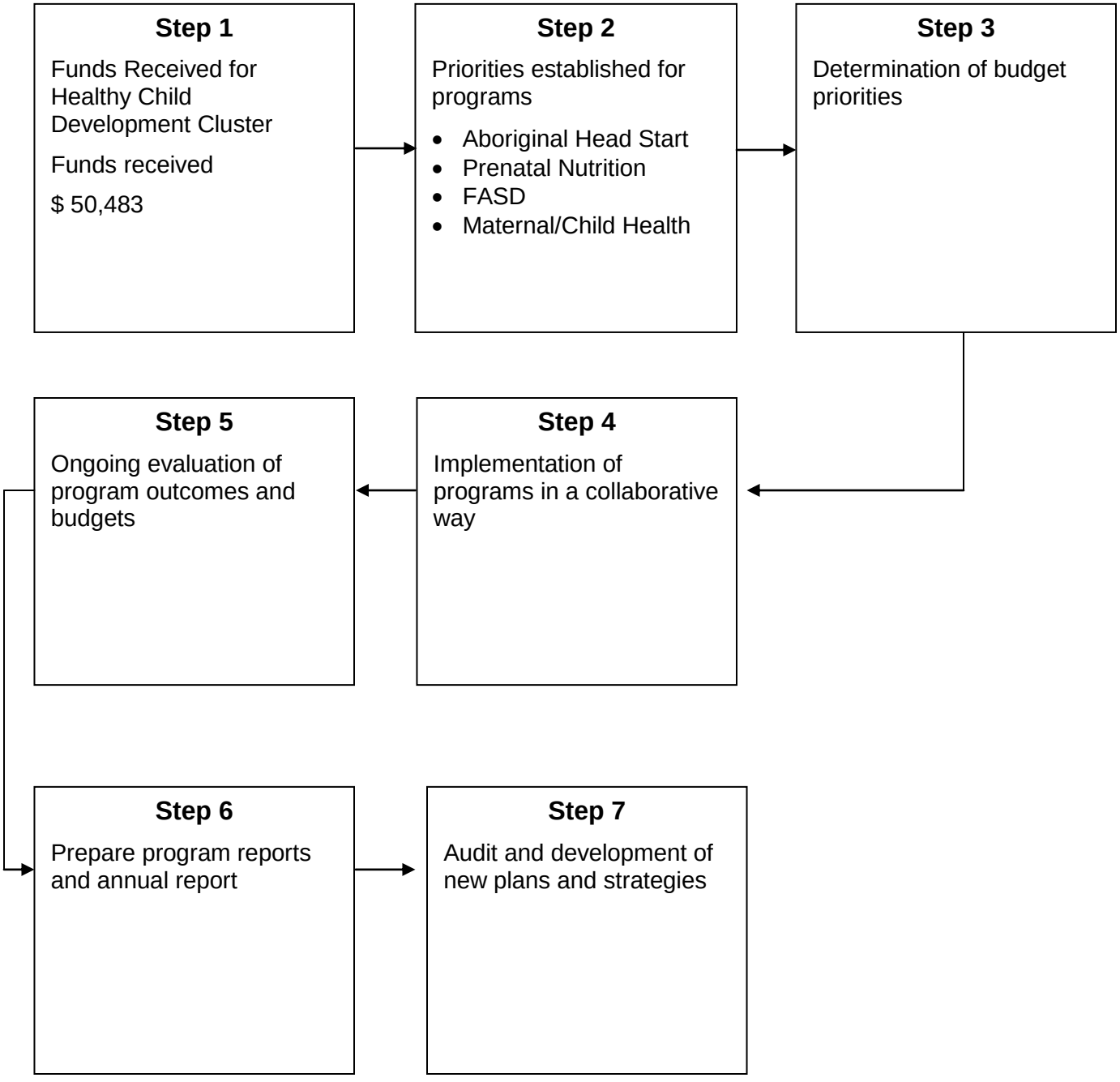
BONAPATE INDIAN BAND PROGRAM STRUCTURE




Capital
Health Facilities & Capital
(Construction)
Governance
Health Planning
Security
Health Careers
Consultation
Nursing Support
Human Resources
Research

Section 2:

Healthy Child Development Cluster



Aboriginal Head Start on Reserve

Goal:

To enhance early childhood development, school readiness and overall family health and wellness for children from birth to 6 years old in our community.

Objectives:

- To enrol 100% of our eligible children in our Head Start Program.
- To utilize our resources to facilitate Head Start at both of our health centres.
- To use our resources to ensure outreach services for children who do not attend the Head Start Program.
- To build capacity in our community by developing partnerships with other children's services including our daycare and community school.
- To provide developments screening at key stages from birth to 6 years.
- To support the building of confidence, self esteem and resilience for children and families in our community.
- To provide referrals for children and parents to address specific concerns.

Activities:

- Providing one on one screening at 6 months, 1 year, 2 years, 4 years and 5 years.
- Developing programming to address the six mandatory components of the Aboriginal Head Start program
    1. Culture and Language:
        - → Providing children with a positive sense of who they are and where they belong.
        - → Building knowledge of the Secwepemc language and the culture and traditions of the community.
        - → Engaging our language speakers.
    2. Education and School Readiness:
        - → Ensuring school readiness
        - → Building partnerships with schools and other education partners.
        - → Ensuring early intervention referrals for vision, hearing, speech, communication and social wellness.
        - → Developing networks for referrals and enhanced resources.

3. Health Promotion:
    - → Increasing awareness for parents and families on healthy choices and activities.
    - → Gathering commitment for healthy practices such as car seats, helmets, and lifejackets.
    - → Practicing safety at home and at play.
    - → Informing, reminding and reinforcing health teachings such as hand washing, teeth brushing, health snacks and drinks.

    We believe children will teach parents and grandparents too!
4. Nutrition:
    - → Sharing food planning and preparation ideas.
    - → Role modeling healthy eating.
    - → Providing only nutritious snacks and drinks.
    - → Practicing new “food talk” in our settings.
    - → Including traditional foods in our head start programs.
    - → Building and sharing recipes and food planning guides.
5. Social Support:
    - → Providing social activities for families.
    - → Including extended families in program activities.
    - → Sharing resources for children and families.
    - → Ensuring that head start is a place for parents and grandparents to meet each other.
    - → Giving children new opportunities to meet and play – this extends to families.
    - → Providing referrals to professionals and outside agencies.
6. Parental and Family Involvement:
    - → Involving parents in program planning and day to day activities.
    - → Including extended families in activities, events and outings.
    - → Engaging parents and grandparents in meaningful ways.
    - → Using outreach to extend information and involvement.

Outcome Measures:

- All eligible children are enrolled or received outreach services from Aboriginal Head Start.
- All parents are given opportunities to be included and involved in head start planning and provision of the program.
- All six mandatory components are addressed in our program planning and activities.
- Feedback from schools and daycare indicate improved and enhanced readiness.
- Interaction with partners such as schools, daycares and outside agencies are maintained and increased.
- Partnerships and resources continue to be developed and improved.
- Families, parents and grandparents continue their involvement with education and health after their children leave head start.

Service Providers:

- ECE Facilitators
- CHR
- Child Care Workers
- Daycare Workers
- Community Health Nurse
- Volunteers

Partnerships:

- Schools
- Daycares
- Professional child care service providers
- Speech therapist
- Dental therapists and dentists
- Developmental specialists
- Hearing specialists
- Interior Health

Timeframe for activities in our community:

Our Aboriginal Head Start Program presently has 6 children involved. Within 2 years we will increase to 15. Within 5 years we will have all eligible children involved.

Canadian Prenatal Nutrition Program (CPNP)

Goal:

- To help our community to promote public health and provide support to improve the well being of pregnant women, new moms and their babies.

Objectives:

- To decrease the rate of unhealthy birth weights.
- To increase the rate of breastfeeding initiation.
- To increase the length of time moms continue to breastfeed.
- To provide support and resources for all of our breastfeeding moms.
- To provide information to support longer investment in breastfeeding.
- To help pregnant women and new moms develop nutritional practices that support their own well being and the well being of their babies.

Activities:

- Nutrition gift certificates for new parents.
- Monthly baby circle meetings.
- Resources for breast feeding and infant nutrition.
- “Good food” boxes for families.
- Food planning and menu planning information.
- Education and information sharing for parents and extended families.
- Inclusion of traditional practices for food preparation and food choices.
- Development of support groups for parents and families.
- Referrals for additional support and resources.

Service Providers:

- CHN
- CHR
- Volunteers

Partnerships:

→ Interior Health
→ Nutritionists
→ Physicians
→ Medical specialists

Timeframe for activities in our community:

5 years.

Maternal/Child Health

Goal:

- To contribute to improved health for pregnant women, mothers and infants in our community by focusing on prevention and early intervention.

Objectives:

- To positively impact behaviours and practices of mothers during pregnancy.
- To provide education and support to pregnant women to improve maternal health outcomes.
- To reduce infant and maternal mortality.
- To improve maternal education and pregnancy/birth preparation.
- To provide prenatal delivery and post natal support and education for moms and infants/children (0 – 6 years.)
- To provide resources for pregnant moms, dads and their extended families.

Activities:

- Prenatal and post natal classes.
- Baby circle.
- Sewing circle.
- Community kitchens.
- Menu preparation
- Healthy babies updates
- Breast feeding support and education
- Infant development
- Resource sharing
- Referrals
- Home visits
- Support group meetings
- Child restraint seat education provision and assistance
- Safety in home sessions
- Safe play sessions
- Ages and stages assessment and support
- Collaboration with our daycare, Aboriginal Head Start and school programs

- Family activities and events as well as cultural and traditional activities
- Regular contact with pregnant moms, new moms and their babies and families
- Weight and measures at:
  2weeks, 1 month, 3 months, 6 months, 1 year, 18 months and 2 years
- Maintenance of baby feeding charts to include:
  - → Length of breastfeeding
  - → Introduction of formula and Introduction of solid foods

Outcome Measures:

- All pregnant mothers in our community participating in our pre and post natal programs.
- Reduction in the number of mothers smoking during pregnancy and/or the amount of smoking during pregnancy.
- Reduction in the number of mothers consuming alcohol during pregnancy.
- Increase in requested resources by moms and dads during pregnancy and for 0 – 6 years.
- Reduction in infant and maternal mortality.
- Reduction in the number of “at risk” babies born in our community.
- Increase in breast feeding initiation and length of breastfeeding.
- Reduction in the number of incidents of “not thriving” infants and toddlers.
- Increase in participation in our “healthy child development” programs and services.

Service Providers:

- CHN.
- CHR

Partnerships:

- Interior Health.
- Medical Professionals and Specialists.

Timeframe for activities in our community:

5 years.

Fetal Alcohol Spectrum Disorder (FASD)

Goal:

- To continue our efforts and education to prevent FASD and support individuals and families affected by it.

Objective:

- To decrease the number of babies born with symptoms or manifestations of FASD.
- To improve awareness of the dangers and impacts of alcohol consumption during pregnancy.
- To provide awareness of the resources and referrals available to those affected by FASD.
- To build partnerships and collaborative relationships with agencies, professionals and service providers who work with the challenges of FASD.
- To build capacity within our own communities through training, resource collections, information sharing and best practices to support our ability to provide enhanced services and activities.

Activities:

- Prenatal education.
- Health promotion activities:
  - → Brochures
  - → Posters
  - → Reminders
  - → Youth promotional activities to support awareness
  - → Availability of resource information
- Baby circle discussions
- Maternal/child health support
- Shared activities with regional, provincial and Health Canada partners.
- Youth group involvement.
- Support groups.
- Referrals and follow up.
- Knowledge contests.
- Head Start curriculum.
- Guest speakers and presenters.

- Workshops and training sessions.
- Parenting skills sessions and support group activities.
- Maternal/child health information sessions.

Outcome Measures:

- A decrease in babies born with symptoms or manifestations of FASD.
- All pregnant and breastfeeding moms receive information and resources on FASD.
- Proactive and preventive information is provided to all young people of child bearing age.
- An increase in partnerships to support services available in our community for those impacted by FASD.
- An increase in training to support our healthcare service providers as they work in our community.
- Increased resources to build capacity and a strong knowledge base in our health centre to be available to our community.

Service Providers:

- CHN
- CHR
- Mental Health and Addictions Worker

Partnerships:

- Professional agencies
- Physicians
- Physiologists
- Psychiatrists
- Schools, Daycares, Child Care Agencies

Timeframe for activities in our community:

2 - 5 years.

Children's Oral Health Initiative

Goal:

To reduce early childhood tooth decay and develop understanding of long term dental health.

Objectives:

- To enrol all of our eligible children (ages 0 – 7) in our COHI program.
- To ensure that all children receive screening and fluoride application as required.
- To provide information and resources to pregnant women, parents, caregivers and childcare service providers to support oral health
- To build partnerships with other agencies and programs to reach more children with oral health services and information.
- To include oral health messages and role model oral health at all community functions and activities.
- To increase the referral and resource information available to us.

Activities:

- Enrol children in COHI on an ongoing basis.
- Screening according to COHI protocol.
- Application of fluoride varnish.
- One on one oral health instruction for children ages 0 – 7 and their parents and caregivers (including pregnant women.)
- Bring oral health information to community and school events.
- Maintain dental health records and data.
- Provide resources and referrals as needed.

Outcome Measures:

- All eligible children enrolled in COHI and receiving services.
- All pregnant women receiving oral health instruction at least once during pregnancy.
- Reduction in early childhood tooth decay.
- Reduction in need for referral for dental treatment under general anaesthetic.
- Increase in teeth brushing, flossing and "talk" about oral health.
- COHI information shared in all childhood settings.
- Increased inquiries for information and referrals for oral health.

Service Providers:

- Dental Hygienist (contract)
- COHI Aide.
- Administrative support.
- Dentist (visits)
- CHR

Partnerships:

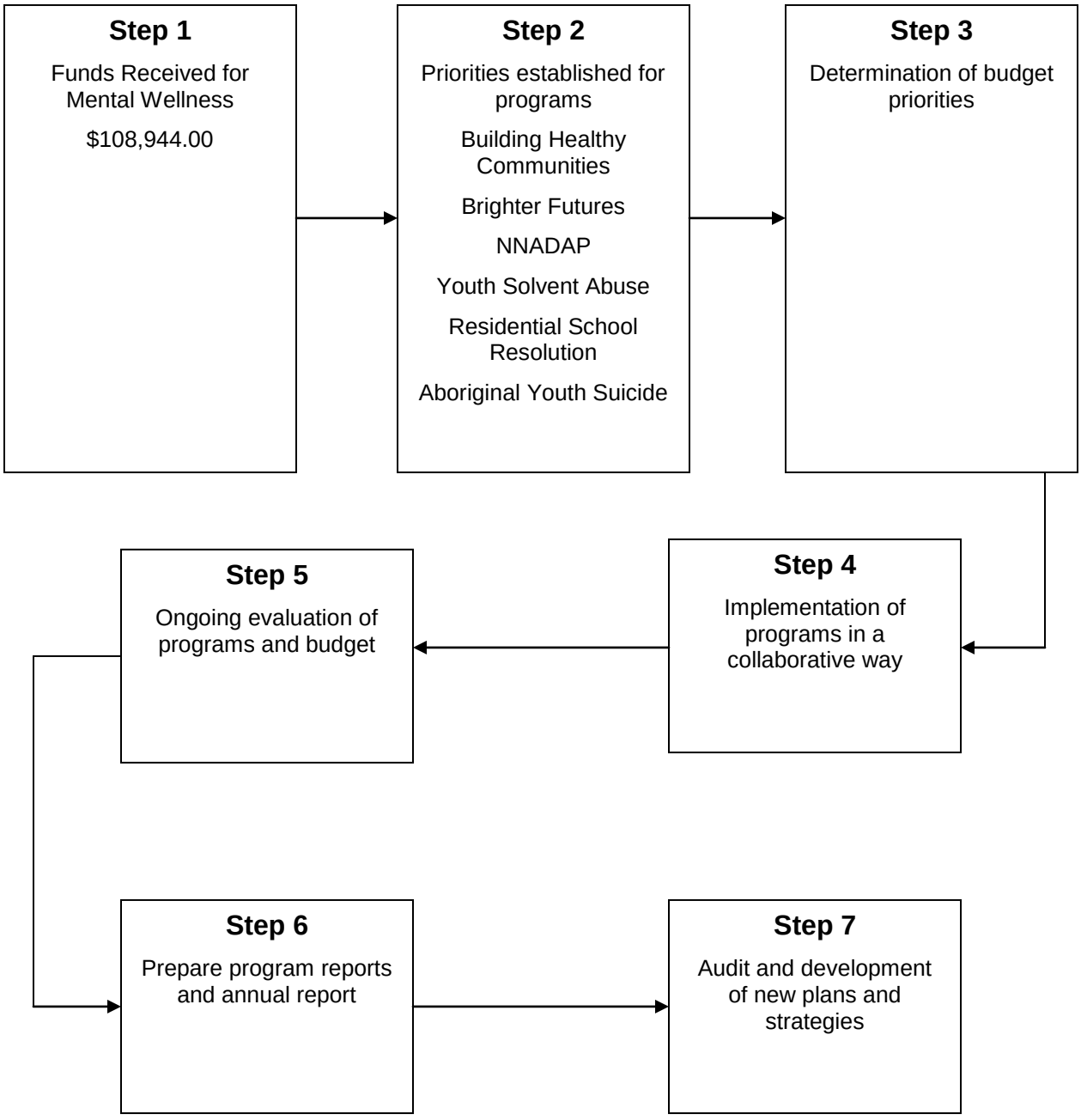
- Interior Health
- Professional Referral Agencies.
- Dentists

Timeframe for activities in our community:

5 years.

Section 3:

Mental Wellness Cluster



Brighter Futures

Goal:

- Our goal is to build community resilience and sustainability through health promotion and prevention focusing on learning related activities and to increase awareness, change attitudes, build knowledge and enhance skills. The goal encompasses five components: Mental Health, Child Development, Parenting, Healthy Babies and Injury Prevention.

Objectives:

Mental Health:

- Providing information and awareness activity around mental health issues and concerns.
- Providing basic counselling services for individuals and families to support mental wellness.
- Setting up wellness activities for families and groups to build positive mental well being.
- Responding to mental health community crisis in proactive and intervening ways.

Child Development:

- Providing before and after school programs to help support healthy learning environments.
- Providing community based programs and activities for children, youth and families.
- Supporting healthy families with information, resources, programs and activities.
- Promoting skill development and supporting the value of education.

Parenting:

- Promoting Stuctwewsemc culturally sensitive, positive, supportive parenting.
- Providing support groups for parents.
- Providing resources and referrals for parents and families.

Healthy Babies:

- Improving the health and well being of moms and babies (0 – 18 months.)
- Providing education and support for pre and post natal care and wellness.
- Supporting pregnancy, birthing and parenting with information and activities.

Injury Prevention:

- Providing CPR, First Responder and First Aid Training for staff and community members.
- Providing bike, skateboard, swimming, boating and travel safety courses and follow up.
- Promoting seatbelt and car seat use.
- Promoting safe community environments.

Activities:

- Safety workshops
- Guest presenters
- Health promotion campaigns
- Community awareness programs.
- Parenting courses.
- Family violence workshops.
- Support groups.
- Resource development.
- ATV safety.
- Water sports safety.
- Girl Power programs
- Team support programs
- Youth activities

Outcome Measures:

- Increasing attendance at parenting programs and workshops.
- Certification for 5 community members, in First Aid, CPR, and First Responder Training each year.
- Certification for 5 staff members in First Aid, CPR, First Responder and Mental Health Training each year.
- Increased availability of requested resources for parents and families.
- 100 % children using car seats, safety equipment and safe play practices.
- Increasing partnerships and linkages for families and youth in our community.
- No children riding in the back of trucks. No children riding in boats without life jackets.

Service Providers:

- Mental Health and Addictions Worker.
- CHR
- Youth Worker

Partnerships:

- Mental Health Agencies.
- Interior Health
- Professional Referrals.

Timeframe:

We presently run 4 - 6 programs. We will add 6 programs at the end of five years.

Building Healthy Communities

Goal:

- Developing the capacity and support to assist communities in developing programs to address Mental Wellness with a focus on youth solvent abuse and mental health crisis.

Objectives:

- Reducing the solvent use and abuse by youth in our community.
- Providing updated training for our staff to ensure their readiness to provide prevention and intervention services.
- Building partnerships and linkages for resources, referrals and service options.
- Providing crisis intervention training and services for crisis intervention follow up.

Activities:

- Workshops and guest presenters on:
    - → Suicide prevention
    - → Solvent abuse awareness
    - → Healthy lifestyles for youth
    - → Family communication
    - → Solvent abuse awareness and prevention
- Youth field trips and activities.
- Family support and follow up.
- Family events and activities.
- Training in mental health initial response and follow up.
- Parenting teens workshop and referrals
- Family & community mediation.

Outcome Measures:

- A reduction in reported incidents of solvent abuse by youth.
- An overall increase in awareness regarding the problem of youth solvent abuse.
- An increase in the number of trained staff in mental health, first aid, solvent abuse prevention and intervention, suicide prevention and crisis intervention.
- Increased attendance at healthy community activities and events for youth and families.
- Participation in activities for parents and teens.

Service Providers:

- Mental Health and Addictions Worker.
- CHR
- NNADAP Worker.

Partnerships:

- Mental Health Agencies.
- Treatment Centres
- Interior Health
- Mental Health Professionals and Specialists.

Timeframes:

We presently provide referral services for solvent abuse and mental health. In 2 years we will have 2 FTE's in place and in 5 years we will all of these activities in place with response service staff to provide the services.

National Native Alcohol and Drug Abuse Program

Goal:

- Providing programs and services aimed at reducing high levels of alcohol, drug and solvent abuse.

Objectives:

- Provide programs in keeping with the most recent models for response to alcohol and drug abuse.
- Providing staff training to support client and community needs.
- Understanding the culture and traditional responses to alcohol and drug abuse.
- Developing strong partnerships to facilitate resource and referral support.
- Continue to provide intake assessment, referrals and support
- Incorporate traditional practices in our programming plans.

Activities:

Our activities will be set up in keeping with the recently developed six elements of response to alcohol and drug abuse.

The six key elements include:

Element 1: Community Development, Prevention and Health Promotion

- Family awareness promotion
- Developing support networks
- Information sharing
- Awareness and education campaigns
- Development of age appropriate information

Element 2: Early Identification, Intervention and Aftercare

These services are designed to address the needs of people with at least moderate levels of risk from their alcohol and drug use.

- Review of options.
- Referrals
- Support groups
- Information sharing
- Resource development
- Partnership development
- Follow up activities

Element 3: Secondary Risk Reduction

These services and supports are for people at high risk for substance abuse related dangers.

- Active outreach
- Risk management activities
- Awareness of treatment options
- Support groups
- FASD diagnosis and support

Element 4: Active Treatment

These services are more complex and beyond the scope of services of an intake or support worker.

- Referral to detox
- Referral to specific counselling
- Mental health referrals
- Preparation for residential treatment

Element 5: Specialized Treatment

This is for people with highly complex or service substance abuse. These services include:

- Support services
- Medical detox
- Psychiatric services

- Advanced counselling services.
- Acute mental health services

Element 6: Care Facilitation

These services are for individuals and families who need help to access a range of services and support to meet their complex and broader needs.

- Formal mental health services
- Addictions counselling
- Formal treatment services
- Cultural supports

Care facilitation is the active effort to stay connected to clients, their families and their community in a holistic and client driven approach. It ensures continuum of care. It is the new facilitative approach to addictions and mental health. vIt requires extensive partnership development and outreach programs. It means working closely with professional referrals and outside agencies.

Outcome Measures:

- Overall increased awareness of services provided by NNADAP.
- Feedback from clients indicating satisfaction with services offered.
- Increase in length of time people refrain from abusing drugs and alcohol.
- Increase in numbers of people seeking information and resources from service providers.
- Increased training for staff and service providers.

Service Providers:

- Intake Worker
- Mental Health and Addictions Worker
- CHR

Partnerships:

- Treatment centres
- Professional counselling services
- Interior Health
- Primary care health service providers

We presently provide basic intake services and referrals for more extended service. In the next 2 years we will extend our services to include all elements of the NNADAP program.

Tobacco Control Strategies:

Goal:

- Our goal is to establish community based “best practices” for tobacco control.

Objectives:

- To reduce the number of smokers who are:
  - → Starting to smoke
  - → Continuing to smoke
  - → Being exposed to second hand smoke
  - → Starting or continuing to chew tobacco
- To develop resources for increased awareness, education and support for “quitters.”

Activities:

- Developing a community plan to address tobacco control.
- Facilitate effective support groups.
- Facilitate prevention workshops in schools and other community events.
- Provide resources and referrals for follow up support.

Outcome Measures:

- The reduction of smoking at community events and in community facilities.
- An increase in requests for resources, referrals and support.
- A reduction in the number of smokers in our community.

Service Providers:

- CHR
- Volunteer support

Partnerships:

- Health Canada
- Interior Health

Time frame:

During the first year, we will continue to offer resources and referrals for tobacco control. Each year, we will add programs and activities to support our overall achievements. Within five years we will have a fully involved tobacco reduction and control program.

Aboriginal Youth Suicide

Goal:

- Increase awareness of the risk and symptoms of youth suicide and reduce the number of youth suicides and suicide attempts in our community

Objectives:

- Providing resources and information to youth, parents, youth workers and community members about youth suicide.
- Building of partnerships with other agencies and professionals to support our youth suicide program.
- Increasing resource and referral options for youth at risk of suicide.
- Providing referrals for youth and parents when suicide is a risk.
- Opening discussions about suicide and suicide prevention to open doors and avenues for access to resources.

Activities:

- Workshops for youth, parents, educators and youth workers.
- Development of age appropriate resources on suicide and suicide prevention.
- Support groups.
- Poster contest.
- Video presentations.
- Community meetings to increase awareness about youth suicide.
- Referrals for individual and family counselling.
- Referrals for treatment services and for addiction issues.

Outcome Measures:

- All youth and parents have access to resources and referrals.
- Increased inquiries for information and support.
- Reduction in the number of suicides and attempted suicides in our youth.
- Increased attendance and participation in workshops and other events.

Service Providers:

- Addictions Worker.
- CHN

Partnerships:

- Treatment centres.
- Interior Health.
- Professional Counselling Agencies.
- Schools and youth centres.

Timeframe for Activities in Our Community:

We presently offer referrals for youth and families. In 1 year we will implement development of resources and community meetings. Within 5 years we will extend to include all additional activities in the NNADAP program.

Youth Solvent Abuse Program

Goal:

- The increase of awareness about Youth Solvent Abuse and reduce the occurrence of solvent abuse in our community.

Objectives:

- The provision of referrals for parents and youth to address solvent abuse.
- Providing resource information to support the reduction of youth solvent abuse.
- Providing information to support parents and youth workers to work positively to reduce solvent abuse.
- The building of partnerships to enhance our response to youth solvent abuse.

Activities:

- Collection of all available resource materials (videos, books, websites)
- Guest speakers at appropriate functions.
- Education seminars and health promotion events.

Outcome Measures:

- Reducing the number of reports of solvent abuse by youth in our community.
- An increase in inquiries for information to enhance understanding of solvent abuse.
- Increasing partnerships to support addressing solvent abuse by our youth.

Service Providers:

- CHR
- Mental Health and Addictions Workers.

Partnerships:

- Mental Health Agencies.
- Treatment centres.
- Interior Health.
- Professional referrals.

Timeframe:

We presently provide resources and referrals. Over the next 5 years we will expand availability and include more education and health promotion.

Indian Residential School Resolution Health Support Program

Goal:

- Providing mental health and emotional support services for Indian Residential School students and their families before, during and after settlement processes.

Objectives:

- Providing mental health and emotional support to survivors and their families.
- Make referrals for mental health crisis related to the residential school experience.

Activities:

- Distribution of resource materials
- Encouraging support groups.
- Mental health referrals for individuals and families.

Outcome Measures:

- Attendance at support group.
- Requests for information.
- Increased resource materials.

Service Providers:

- Mental Health and Addictions Worker.
- CHR
- Volunteers.

. **Partnerships:**

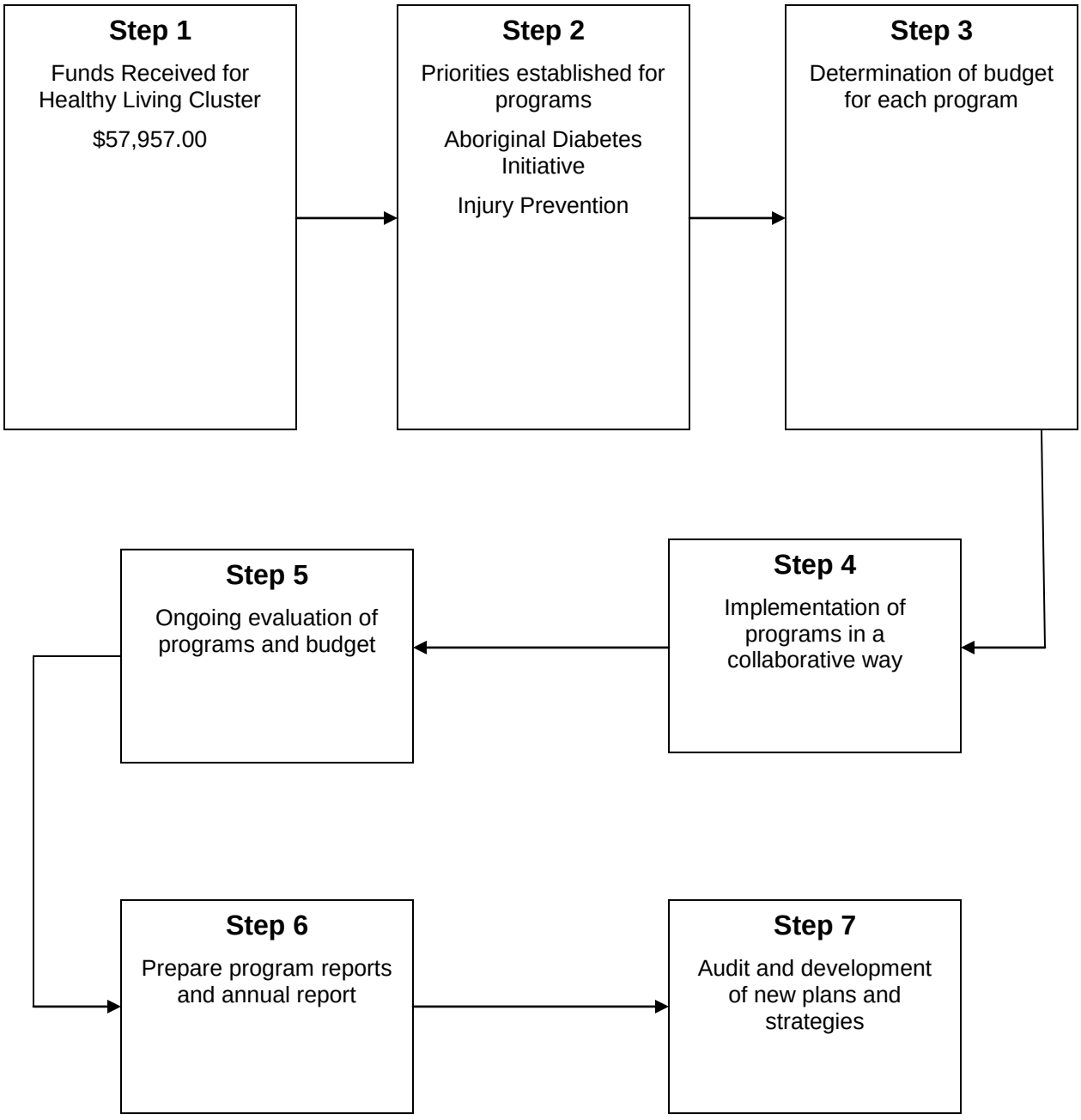
- Legal agency referrals.
- Professional counselling referral agencies.
- Provincial and Federal Indian Residential School Reconciliation Groups.

Timeframe:

Our referrals already take place. In the next five years we will continue to increase availability and accessibility of resources. We will need to address the funding issues concerning service for Residential School survivors and those who are intergenerationally impacted.

Section 4:

Healthy Living Cluster



Aboriginal Diabetes Initiative

Goal:

- Raising awareness of diabetes and its risk factors.
- Supporting healthy lifestyle choices that includes prevention and ongoing care for diabetes.

Objectives:

- Increase awareness of the symptoms and risk factors of diabetes.
- Support culturally appropriate approaches to prevention and treatment of diabetes.
- Increase partnerships and resources to enhance care and treatment options.
- To include diabetes awareness at community functions and events
- To decrease the rates and severity of diabetes complications and resulting hospitalizations.
- To increase awareness and reduce the incidence of youth obesity - a known risk factor for diabetes.

Activities:

- Support group.
- Education and information sessions.
- Support for menu planning and food preparation to address diabetes.
- Diabetic lunches.
- Attendance at conferences.
- Distribution of brochures and information booklets.
- Obesity workshops.

Outcome Measures:

- Increase in attendance at diabetes presentations and support group activities.
- Increase in requests for resource materials, info sheets and brochures.
- Improved early detection and reporting of diabetes.
- Improved access for care and treatment of diabetes.
- Increased resources and referral information.

- A decrease in the severity of complications and hospitalizations for diabetes related incidents.
- Development of stronger partnerships to improve care options.

Service Providers:

- CHR
- CHN (visiting)
- Dietician (visiting)
- Nutritionist (visiting)

Partnerships:

- Canadian Diabetes Association.
- Interior Health
- Professional Referral Agencies.
- Physicians and Nurse Practitioners.
- Dietician (visiting)
- Nutritionist (visiting)

Timeframes:

We are presently dealing with 16 diabetics in our community. We are providing referrals and resources. In the next two years we will work to develop a support group and to promote awareness. In five years we will have an active comprehensive program for diabetics.

Injury Prevention

Goal:

- The raising of awareness of injury prevention (unintentional and intentional) and reduction of injuries by developing activities, programs and environments that will prevent and reduce the impact of injuries.

Objectives:

- Promoting safety in all community settings.
- Providing education and resources and activities to prevent and reduce injuries.
- Increase in partnerships to promote injury prevention.
- Provision of CPR, First Responder, and First Aid training for staff and community members.

Activities:

Workshops on:

- ATV safety.
- Safety in and out of the water.
- Increased road safety.
- Motorbike and scooter safety.
- Roller blade and skate board safety.
- Bike safety.

Other Activities:

- Assessment of play safe equipment.
- Provision of safe grounds.
- Safety from bullying.
- Safe from vandalism.
- Safe homes and houses.
- Safe facilities.
- Seatbelts and child restraint seats. (Car seat lending service)
- Workplace safety. (WCB regulations)
- Infant and child safety.
- Safe equipment.
- Safe environments for the elderly.

Outcome Measures:

- 100% of children using child restraint seats and seatbelts.
- 100% of adults using seatbelts.
- 100% of children using helmets.
- No children riding in the back of trucks.
- Reduction in reported accidents at play.
- Reduction in reported workplace injuries.
- Reduction in reported injuries in the home.
- Reduction in reported injuries in community facilities.

Service providers:

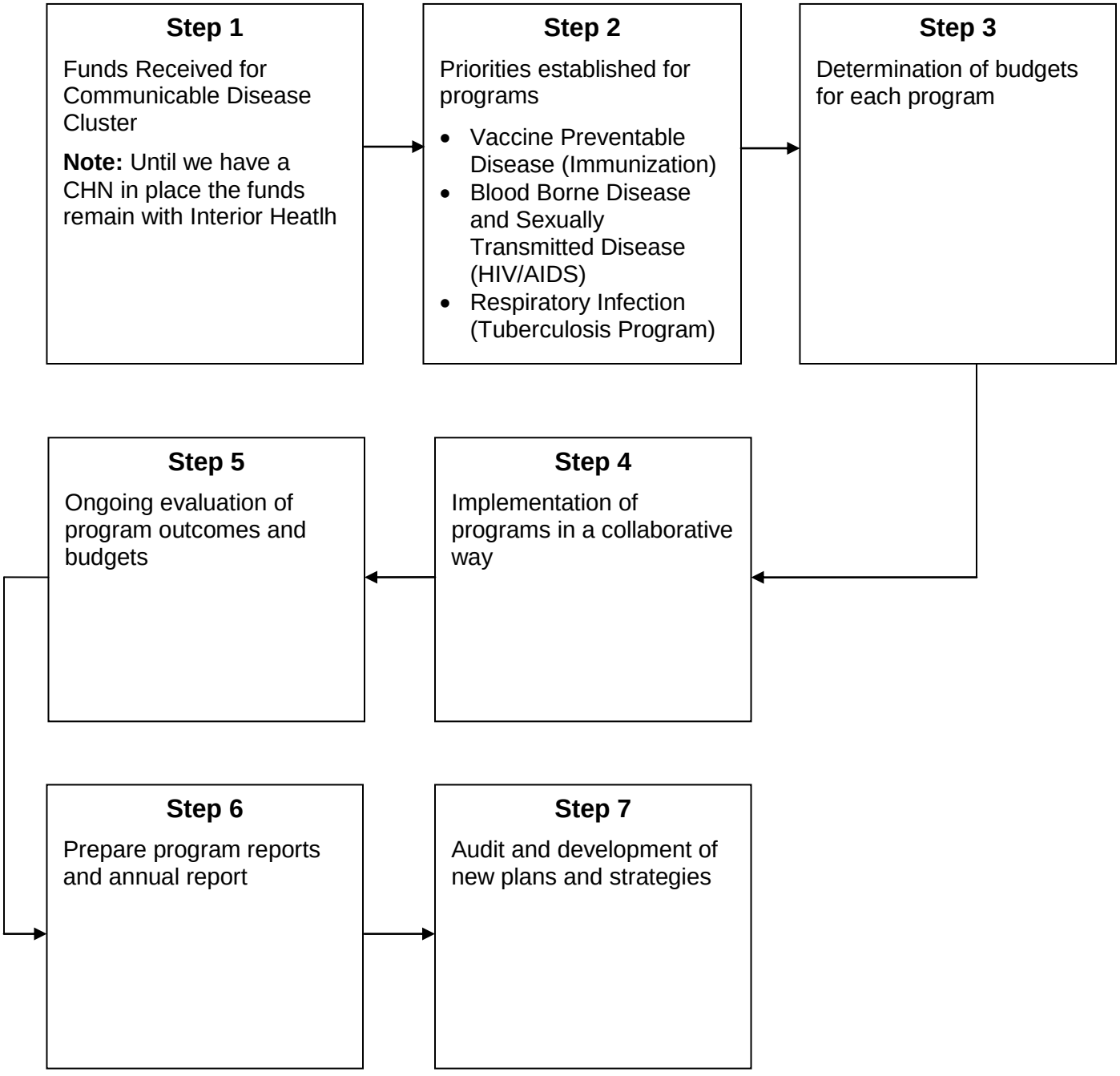
- Schools and daycares.
- RCMP
- Physicians and professional therapists.
- CHR
- Community Volunteers

Timeframes:

We presently promote injury prevention with resources and safety events. In the next five years, our plan is to develop a fully comprehensive injury prevention program and activities.

Section 5:

Communicable Disease Cluster



A CDC protocol is in effect between the Secwepmc First Nations, IH and FNIH. This has been designed to reduce risks that may arrive from jurisdictional confusion.

Vaccine Preventable Disease

Goal:

- To introduce an immunization strategy which reduces incidents of vaccine preventable diseases and their resulting health challenges.

Objectives:

- Improve immunization rates aiming for a target rate of 95% of children under 6.
- Improve immunization rates for vaccine preventable diseases in children over 6, youth and adults aiming for a target rate of 95%.
- Implement newly recommended vaccines.
- Improve data collection and information sharing about immunization and prevention of vaccine preventable diseases.
- Improve and increase resources contributing to education and prevention of communicable diseases.

Activities:

- Immunization clinics.
- Education and health promotion activities.
- Data collection.
- Sharing resources.
- Referrals.

Outcome measures:

- Increased immunizations of children under 6. (95%)
- Increased immunizations for children over 6, youth and adults. (95%)
- Reduction in reports of vaccine preventable diseases.
- Increased use of resources for vaccine preventable diseases.

Service Providers:

- CHN.(visiting)
- CHR

Partnerships:

- Communicable Disease Control. (CDC)
- Schools.
- Day Cares.
- Interior Health

Timeframe:

This service is presently provided by a visiting Health Canada nurse. In one year we will have a Community Health nurse in place and this will allow us to continue to enhance community based services over the next five years.

Blood Borne Disease and Sexually Transmitted Infections (HIV/AIDS)

Goal:

- To work in partnership with other health providers to provide HIV/Aids education, prevention and support services.

Objectives:

- Providing referrals for individuals and families dealing with HIV/Aids.
- Providing education, support and referrals for individuals with sexually transmitted diseases.
- Increasing awareness and reduce the stigma attached to HIV/Aids.
- Promote testing, access to prevention, education and resources for individuals and families dealing with HIV/Aids.

Activities:

- Collection of available resource materials.
- Inclusion of available information at health and wellness events in schools and in the community.
- Health promotion activities.

Outcome measures:

- Attendance at events where information is shared.
- Increased inquiries for resource information.
- Decrease in reported cases of sexually transmitted diseases and HIV/Aids.

Service Providers:	**Partnerships:**
• CHN	→ AIDS Network.
• Health and Human Service Workers	→ Feather of Hope.
• Youth Worker	→ Interior Health.
• Health Management Team	→ HIV/AIDS Support Group

Timeframe:

We presently provide referrals and resources in this area. In the first two years we will be able to enhance service provision with a CHN in place. In five years we will be able to actively provide all services outlined in our plan.

Respiratory Infection (Tuberculoses Programs)

Goal:

- To support TB reduction in our community with a target of 3.6 per 100,000 by 2015. (Global stop TB rate)

Objectives:

- To achieve lifetime control of TB for TB infected individuals.
- To prevent further occurrences of TB disease and infection.
- To provide support, resources and referrals for individuals and families dealing with TB.
- To develop and maintain partnerships to support our TB strategies.

Activities:

- Case finding, case holding and contact tracing.
- Education and health promotion.
- Ongoing surveillance.
- Developing partnerships.

Outcome Measures:

- Reduction in reported cases.
- Enhanced and increased partnerships.
- Increased use of research and resource information.

Service Providers:

- CHR

Partnerships:

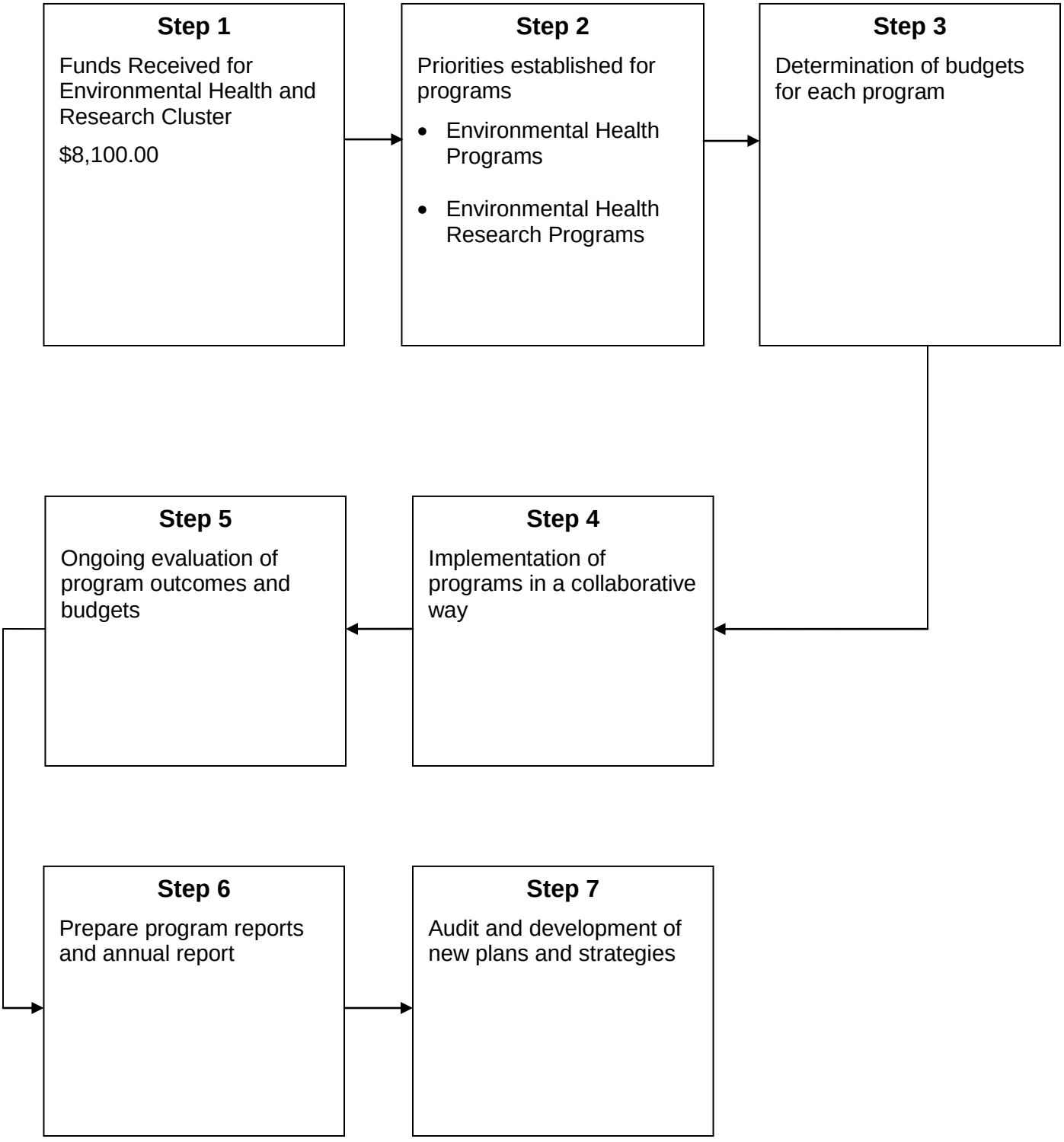
- Schools
- Interior Health
- Communicable Disease Control
- Tuberculoses Support Network.

Timeframe:

We presently provide surveillance, referrals and resource information. In the next year, with a nurse in place we will be able to ensure programs to increase awareness, ensure prevention and provide support. Our promotion activities will increase over the next five years.

Section 6:

Environmental Health and Research Cluster



Environmental Health Programs

Goal:

To work in partnership with other agencies to identify and prevent environmental public health risks that could impact the residents of our community. When risks are identified our community will work closely with the Environmental Health Officer to be certain all possible steps are taken to reduce the risk.

Objectives:

- To ensure a working Memorandum of Agreement to achieve services of the Environmental Health Officer.
- To access the following services from the EHO:
  - → Advice
  - → Education
  - → Public health inspections
  - → Risk management
  - → Reporting

Safe Drinking Water:

- To develop a “communication” strategy regarding drinking water safety.
- To provide training for safe drinking water practices.
- To monitor drinking water, interpret results and take necessary action.
- To review new and upgraded community water systems to ensure safe drinking water.
- To provide education about safe drinking water.

Food Safety:

- To work with the EHO who will inspect public food service facilities for community gatherings and events.
- To encourage attendance and participation for certification at “Food Safe” training provided by the EHO.
- To provide shared information, resources and support to ensure safe food handling in the home.

Healthy Homes:

- To work with the EHO in public/social housing to identify risks such as:
  - → Air quality
  - → Containments
  - → Pest control
  - → Water supply
  - → Solid and liquid waste disposal
  - → General safety
  - → Overcrowding

Wastewater:

- To identify existing and potential hazards with wastewater disposal.
- To initiate inspections of new and existing sewage disposal to ensure safe practices.
- To provide public education on wastewater management.

Solid Waste Disposal:

- To review, assess, evaluate and identify risks in solid waste collection and disposal practices.
- To provide resource information for recycling and reducing waste and disposal of hazardous waste.

Facilities Inspections:

- To ensure routine inspections of public facilities and additional inspections for specific purposes.

Communicable Disease Control:

- To provide surveillance, investigations, training and educational activities and data collection to address environmental health communicable diseases such as:
    - → Food borne
    - → Water borne (E. coli)
    - → Vector borne (West Nile)

Emergency Preparedness Response:

- To develop and maintain Emergency Preparedness and Response Plans.
- To provide public education, resources and reminders for emergency response.

Environmental Contaminants, Research and Risk Assessment:

- To provide public education and resource information on environmental contaminants and research.

Activities:

- Working closely with the Environmental Health Officer.
- Water monitoring.
- Training, education and safety activities.
- Collecting and sharing resource material.
- Environmental health inspections by the EHO of:
    - → Homes
    - → Facilities
    - → Food handling
    - → Water handling
    - → Containments
    - → Waste handling

Outcome Measures:

- Reduction in reports of environmental diseases.
- Reduction in reports of Communicable diseases that are water borne, food borne or vector borne.
- Increased awareness and education about environmental health issues and concerns.
- Increase participation in training and education sessions such as:
    - → Food safe
    - → Drinking water safety
    - → Environmental safety in homes
    - → Environmental safety in communities
    - → Facility safety
    - → Water borne, food borne or vector borne diseases
- A fully updated Emergency Response Plan

Service Providers:

- CHR.
- Emergency Response Workers .

Partnerships:

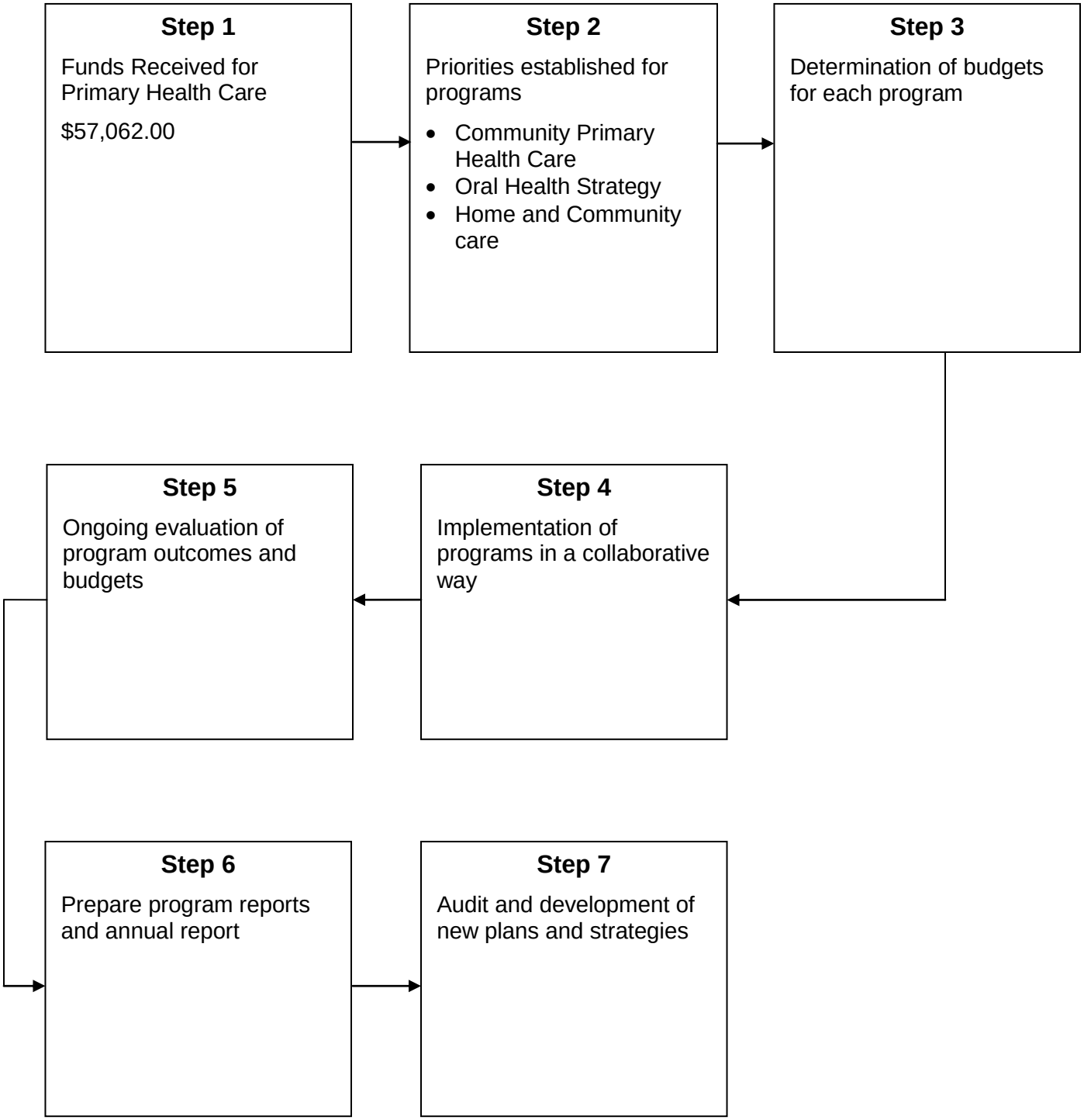
- Municipal District.
- Village of Cache Creek.
- Village of Ashcroft
- Interior Health

Timeframe:

We presently conduct all required testing. In the next year we will begin to address other services when we complete required training. In five years we will have a comprehensive environmental program in place.

Section 7:

Primary Health Care Cluster



Community Primary Health Care

Goal:

- Providing quality nursing practice, which is evidence informed, respectful of tradition, culture and build the overall health of our community members.

Objectives:

- Providing nursing services that are community based, culturally appropriate and responsible to community needs.
- Plan and implement primary care programs.
- Conduct health promotion and health education for the community.
- Implement disease prevention and illness management strategies.
- Conduct immunization clinics and promote vaccine preventable disease management.
- Ensure updated, standardized primary health care on reserve.

Activities:

- Building partnerships to support primary health care.
- Visiting new parents.
- Facilitating new baby care.
- Immunization clinics.
- Providing primary care services.
- Facilitating community health education.
- Supporting healthy lifestyles and wellness activities.
- Visiting schools, daycares, and aboriginal head start.
- Providing resources and referrals for primary health care needs.
- Supporting health promotion activities.

Outcome Measures:

- Achievement of immunization goals/targets.
- Increased participation in wellness activities, education and health.
- Maintenance of the established promotion events.
- Increased requests for resource information and referrals.

Service Providers:

- CHN
- CHR

Partnerships:

Health Canada

Interior Health

Health Facilities

Nurse Practitioners

Physicians

Timeframe:

Our first step in the first year is to hire a community health nurse for 4 - 5 days per week. Over the next 2 years we will build partnerships to support our CHN and develop a fully qualified primary health care team.

Oral Health Strategy

Goal:

- Reducing the health risk of tooth decay and encourage long term oral health in our community.

Objectives:

- Increasing referral and resource information available for dental health.
- Providing dental health education and promotion.
- Building partnerships to enhance dental health.
- Including dental health information and role model dental health at community functions and events.

Activities:

- Providing resources on dental health in our health centre and at community functions.
- Bringing dental health information to community events, schools and health fairs.
- Promoting dental health at community events.
- Providing referrals on request.

Outcome Measures:

- Reduction in emergencies and/or hospitalization resulting from poor dental health.
- Increased participation in dental health activities (brushing, flossing, dental visits.)
- Increased inquiries for dental health resource information and referrals.
- Increased partnerships to support dental health.

Service Providers:

- CHR

Partnerships:

- Dentists
- Interior Health
- Dental Therapist

Home and Community Care

Goal:

- Providing homecare services which are respectful of culture and tradition and supportive to family and community involvement. Also providing services which will allow family members to stay in their homes and community longer and with more safety.

Objectives:

- Reducing length of hospitalization and need for return to the hospital by providing better homecare in our community.
- Allowing clients to stay in their homes and communities longer and avoid extended and personal care settings away from their community.
- Building capacity in our communities and families to provide homecare services equivalent to those in the mainstream population.
- Providing homecare services in keeping with traditional and cultural practices in our community.
- Ensuring service needs assessments that are objective, effective and lead to the development of a comprehensive care plan.
- Updating assessments and care plans based on changing needs.
- Assisting community members living with chronic and acute illness in maintaining optimum health, well being and independence in their homes and community.
- Providing training to support families and caregivers in providing homecare services.
- Building partnerships with other health agencies to support and enhance our healthcare services.
- Developing community and family support services through provision of resources, updating of equipment and technology and the maintenance of information systems.
- Including support homecare patients in community activities, health promotion events and support settings.
- Collecting resource materials and referral information for home care patients.

Activities:

- Building partnerships for improved and enhanced homecare services.
- Needs assessment and development of care plans.
- Provision of homecare services.

- Training workshops and seminars.
- Working with families and caregivers to provide in-home training and service updates.
- Collection of resource materials.
- Support groups.

Outcome Measures:

- The reduction in the length of hospitalization.
- The reduction in the numbers of returning to hospitals after surgeries or illness.
- To fully update assessments and care plans once per year in response to changing needs.
- Allowing more seniors being able to stay in their homes and communities.
- Increased involvement of family and community members in the provision of homecare.
- Attendance and participation in workshops, seminars and training events.
- Participation of homecare patients in community events and activities.
- Enhanced staff training in homecare service provision.
- Increased inquiries for resource information and referral support.

Service Providers:

- CHN.
- HCN
- Health and Human Service Worker.
- Health Management Team.

Partnerships:

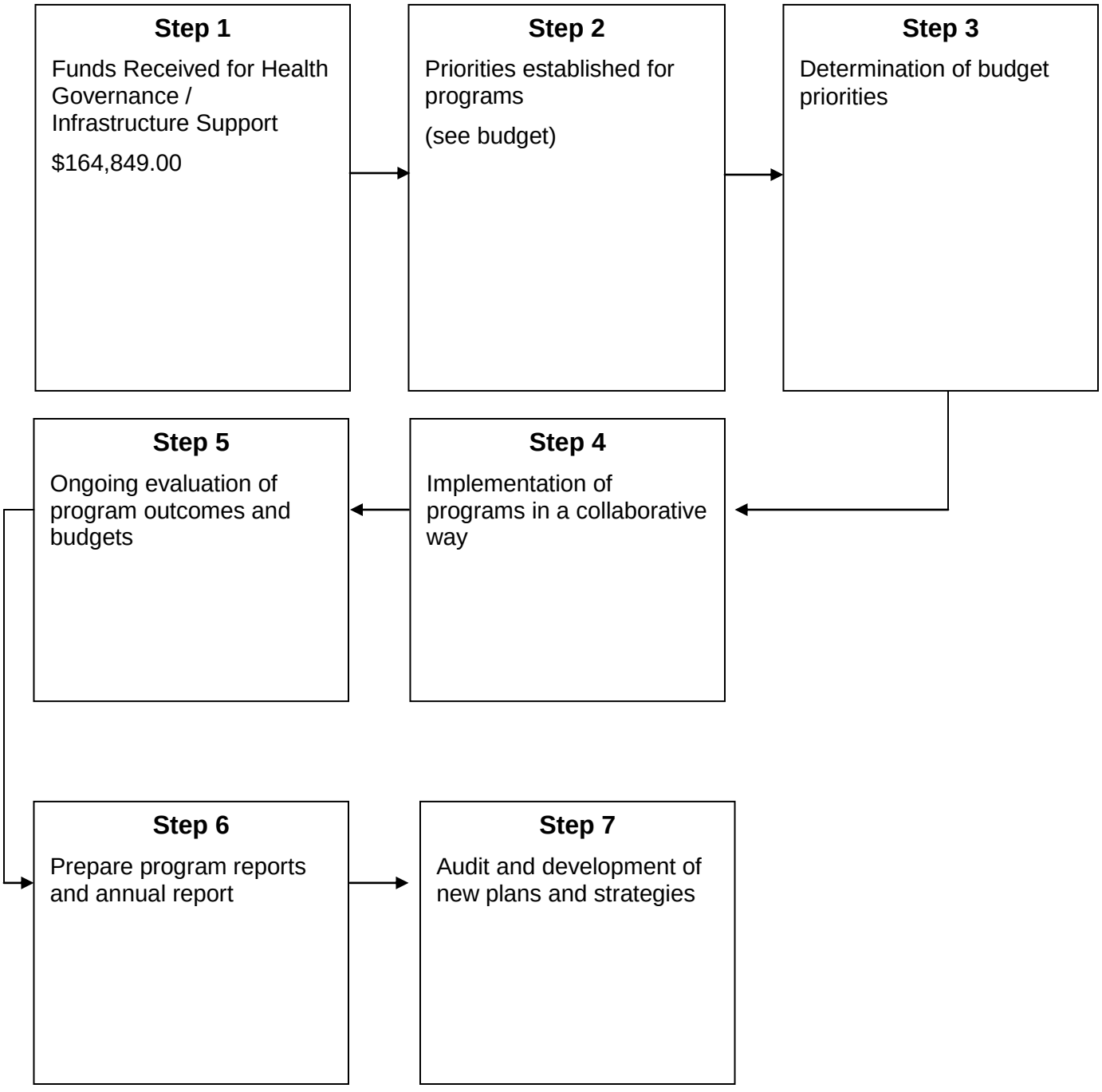
- Interior Health
- Hospitals
- Extended care facilities.
- Chronic Disease Support.
- Seniors Programs.
- Programs for persons with disabilities.

Timeframe:

We presently provide Home and Community Care services to 17 members. In our first year we will complete assessments to determine how many other community members qualify. In year 2 we will begin training for staff, family and volunteers. By year 5 we will have a fully comprehensive Home and Community Care plan in place.

Section 8:

Governance and Infrastructure Support



Health Planning and Management

Goal:

- Providing quality preventative health care services in our community by effective health planning and efficient management of our resources.

Objectives:

- Building a competent health care team.
- Providing a positive working environment for our staff.
- To complete needs analysis and health evaluation to support our health planning and management.
- To manage our resources in the most efficient, effective and economical ways.
- To continue to advocate for adequate resources.
- To manage our health care services in a positive, proactive manner.
- To work closely with our Chief and Council and our administrative staff to ensure excellence in the management of our resources.
- To provide the quality of health care service our community deserves.
- To engage all stakeholders in our health service planning and health service resource management.

Activities:

- Day to day operation of the Bonaparte Health Centre and the programs and services for the community.
- Administrative support.
- Management support.
- Recruitment and retention of staff.
- Support for nurses.
- Training and development of staff and management team.
- Risk management – insurance leeway etc.
- Minor capital investments.
- Planning meetings.

Outcome Measures:

- Access to adequate resources to support programs and services.
- Updated and ongoing needs analysis.
- Accurate data available to support programs and services.
- A collaborative, cooperative community based approach to health service provision.
- Service provision that meets and/or exceeds established standards.

Service Providers:

- Chief and Council
- Administrators

Partnerships:

- Health Canada Regional Support.
- Bonaparte Chief and Council.
- Community membership.

Timeframe:

In the first year we will focus on moving into our new health centre and hiring a nurse and needed support staff. We will also offer training to our CHR and develop partnerships for service support. Over the next five years we will add all of the governance activities in our plan and be fully responsible for the success of our efforts.

Health Consult and Liaison

Goal:

- To provide support for the Health Care Staff through effective consulting and liaison.

Objectives:

- Enhancing our ability to provide quality service through consultation with knowledgeable and experienced consultants.
- Strengthen our service delivery by consulting with other professionals and liaison with similar health care organizations and agencies.
- Building partnerships through mutual consulting and liaison.
- Ensuring updated information and current application of standards of practice.

Activities:

- Develop mentoring and training relationships with consultants.
- Attend conferences and workshops.
- Contact consultants for specific activities.
- Meet with partner agencies.
- Maintain professional affiliations.
- Develop consulting and liaison relationships.

Outcome Measures:

- Increased capacity of staff and management.
- Increased partnerships.
- Increased resources to support ongoing learning and development.
- Updated practices and enhanced quality and standards of practice.

Service Providers:

- Health Care Staff
- Administrators
- Health Coordinator

Partnerships:

- Professional consultants.
- Professional associations.
- Professional referral agencies
- Content experts.

Timeframe:

When a nurse is hired (in year one) we will require a health consultant to support her. We will continue for the next five years to contract specific consulting services on a “as needed” basis.

Integration and Adaption of Aboriginal Health Service Association

Goal:

- The integration the guidelines of the Aboriginal Health Service Association to ensure and support our provision of health services.

Objectives:

- Maintain the standards of service as outlined as required.
- Update MOU's and MOA's to ensure the best possible support.
- Ensure a safe, secure working environment for our staff and community members who use our facilities

Activities:

- Staff meetings
- Partnership meetings
- Regional meetings
- Partnership visits
- Review of agreements, plans and strategies.

Service Providers:

- All Health Care Services Staff.

Partnerships:

- Health Canada
- Regional partners.
- Provincial partners
- Chief and Council

Timeframe:

Within two years we will have a health coordinator or director in place who will be responsible for the integration and adaption. By the end of the first 5 years this will be an enhanced reality in our community.

Security Services in Health Facilities

Goal:

- Ensuring the safety and security of health facilities in our community.

Objectives:

- Ensuring confidentiality for staff and community members in our health facility.
- Providing a safe environment for staff working in health facilities.
- Ensuring secure storage of all products in health facilities.
- Ensuring secure storage of health information and health data in our record keeping.
- Providing security to ensure a safe, encouraging facility for provision of health care services.

Activities:

- Oath of confidentiality.
- Secure process for keeping and sharing data collected.
- Installation of security and alarm systems to ensure a safe environment.
- Secure storage of all medical products and equipment.
- Yearly security assessments.
- Reporting of any security or safe concerns.
- Working in partnership with band security and the RCMP.

Outcome Measures:

- Positive security assessments.
- Follow up on security concerns.
- Secure processes are followed for storage of all products and equipment.
- Confidentiality is respected and the oath is adhered to.
- Reduction in reports of security breaches in health facilities.

Service Providers:

- All Health Care Staff

Partnerships:

- Chief and Council
- RCMP
- Band Security Staff

Timeframe:

All of our security measures will be put in place as soon as we are in our new health facility. As we hire staff and increase our services, we will complete our other security activities.

Aboriginal Health Human Resources

Goal:

- To build a strong Aboriginal human resource base to support provision of health care services in aboriginal communities.

Objectives:

- To increase the number of aboriginal people working in health careers.
- To adapt health care educational curricula to support development the cultural competencies.
- To develop educational opportunities that bridges the gaps and breaks the barriers facing aboriginal students.
- To improve the retention of health care workers in aboriginal communities.

Activities:

- Participation in educational committees and advisory groups.
- Contributing to educations and career development research.
- Developing partnerships to facilitate educational and career opportunities.
- Ongoing efforts to recruit and retain aboriginal health care workers.
- Ongoing efforts to develop encouraging and supportive environments for aboriginal workers in the health care field.

Outcome Measures:

- Increased numbers of Aboriginal health care workers.
- Adaption of health care curricula to include culture, tradition and community specific learning.
- Improved retention of aboriginal workers.

Service Providers:

- Health staff.
- Administrators

Partnerships:

- Health Canada
- Interior Health
- Colleges and Universities
- Service Canada

Timeframe:

This will be an ongoing investment over the next five years.

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Health Governance Infrastructure Support

E-Health Solutions and Information Technology

Goal:

- The use of technology to increase information sharing and collection of data to support health service delivery in our community.
- The collection of effective data to support service delivery, reporting and program planning.

Objectives:

- Support, educate, update and inform our health care providers using technology and tools and ehealth partnerships.
- Enhance access to current information needed to provide quality of health care in communities.
- Improve collaboration in service delivery by improving the ease of contact with ehealth partners.
- Support clients at a community level in seeking better and more information to support responsible health care.

Activities:

- Telehealth awareness training.
- Increased health information resources and sharing that information with staff, management and community members.
- Maintaining a Health Information System with daily activities and statistics.
- Using the Health Information System to support our planning and decision making.

Outcome Measures:

- Increased use of ehealth to share information with professional partners and community members.
- Updated, accurate statistics available.
- Increased use of ehealth resources to support service delivery.
- Attendance at information sessions.

Service Providers:

- Health Administration Team.
- CHN
- Mental Health and Addictions Workers.
- Aboriginal Head Start Workers.
- Information Technology Department.

Partnerships:

- Health Canada
- Interior Health
- First Nations Health Council

Timeframe:

We will begin as soon as we move into the new health centre. Step 1 will be to initiate the technology support to facilitate health solutions. Step 2 will be to seek a Health Information System to be compatible with other public health information systems. Step 3 will be to train staff to work with the technology. By the end of year one we will be up and running. By the end of year 5 it will be a fully functioning part of our health programs and activities.

First Nations Health Careers

Goal:

- Increasing our resources by building a strong and stable health care work force.

Objectives:

- Providing training opportunities for existing staff to build knowledge and experience in health related careers.
- To interest aboriginal people in entering careers in health care.
- Providing information and resources to support aboriginal students to enter health care careers.

Activities:

- Career fair participation.
- Health career camps, workshops and presentations.
- Collection of resources such as videos, brochures, career workbooks, colouring books and info sheets.
- Practicum student supervision.

Outcome Measures:

- Increased requests for information.
- Increased applications for positions.
- Increased stability and longevity of employees.
- Increased numbers of aboriginal people in health care positions.
- Increased requests for practicum placements in health care roles.

Service Providers:

- All health staff

Partnerships:

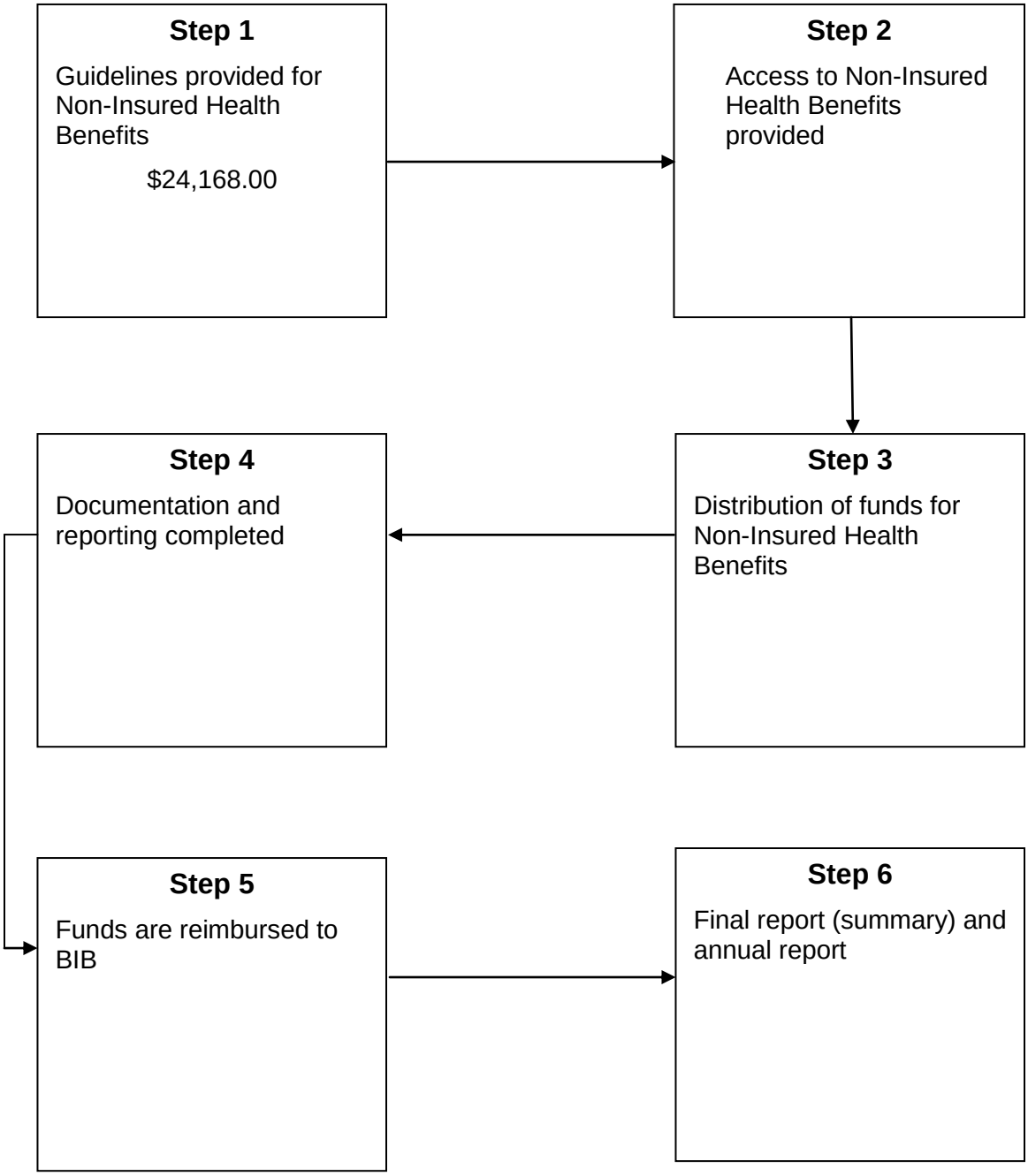
- Colleges and Universities
- Schools
- Mentors/Practicum Supervisors
- First Nations Health Council

Timeframe:

We will begin in year one with resources and referrals. We will continue to develop and enhance the program over the program over the next five years.

Section 9

Health Benefits (Non-Insured)



Note: We are presently administering this program. The guidelines for non insured health benefits are in the appendix.

Non-Insured Health Benefits

Goal:

- Administration of the Health Canada Non-Insured Benefits Program. To ensure that our community members are able to access necessary patient transportation services when they are not covered by other health programs and/or insurance. (It is important to administer this program with objectivity and provide fair and equitable benefits.)

Objectives:

- Using the benefits criteria to determine eligibility for NIHB.
- Collecting information from clients and submit claims to the NIHB program for reimbursement.
- Providing resource and referral information in response to inquiries and clarity.
- Explaining the criteria for NIHB and the processes involved in order to receive benefits.
- Collecting necessary documentation to ensure efficient processing and appropriate reimbursement. All receipts muct be included.

Activities:

- Processing forms.
- Clarifying information.
- Support for applications and appeals processing.
- Providing resource information and referral for more information and clarification.
- Providing direction and advice for applicants and recipients.

Outcome Measures:

- Successful applications.
- Accurate applications including documentation.
- Ability to answer questions.
- Positive feedback from applicants and recipients indicating satisfaction with process and support.
- Reduction in follow up information requested by funding program.
- Fewer complaints from community members about not understanding the program.

Service Providers:

- Health Canada Admin Staff.
- NIHB clerk
- Accounting staff

Partnerships:

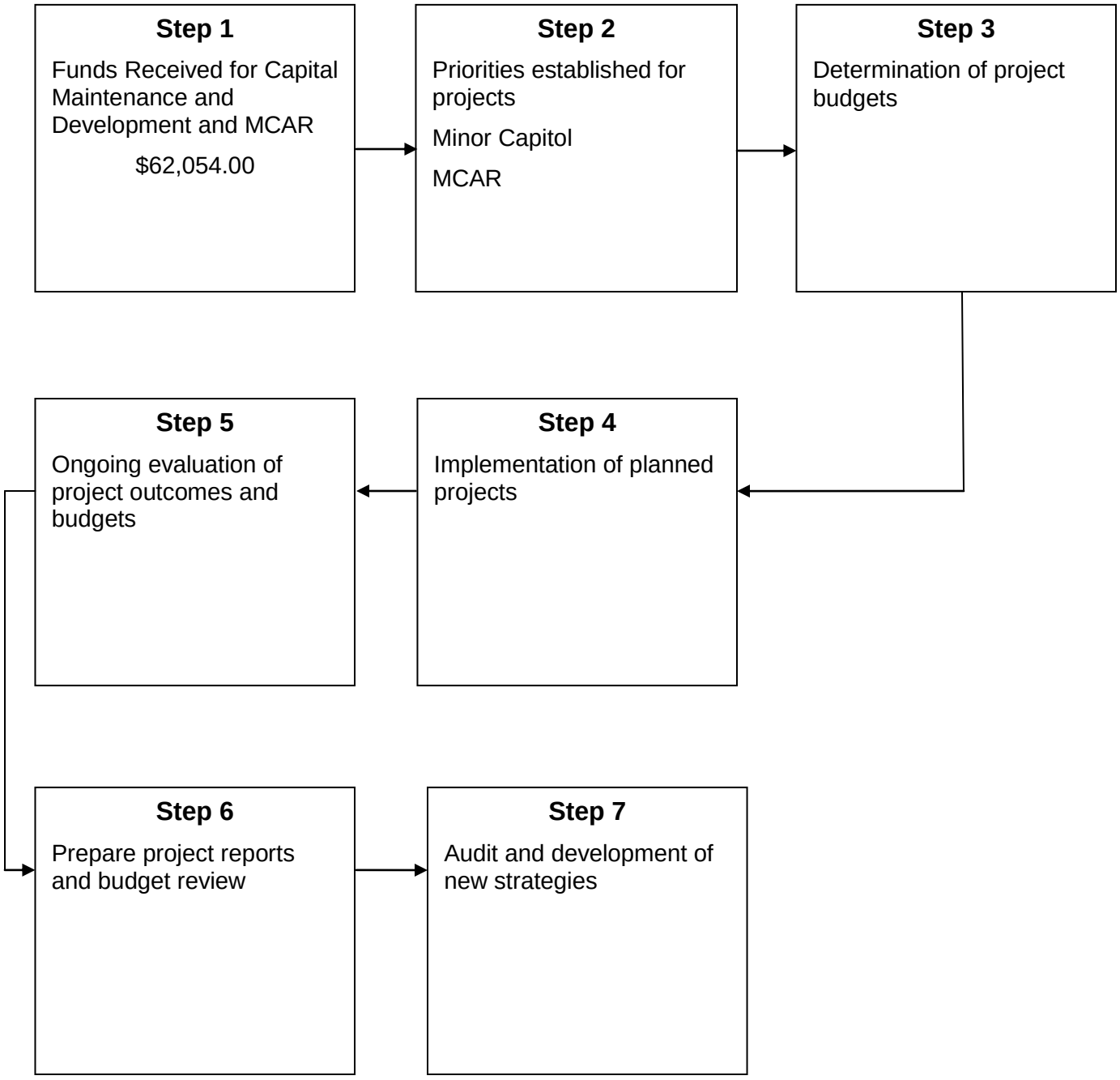
- Health Canada
- Referral agencies

Timeframe:

We are presently administering this program. Over the next year we will clarify guidelines and offer fair and equitable practices. We will continue over the next five years to improve the efficiency and effectiveness of administering this program.

Section 10

Capital Maintenance and Development Moveable Capital Assets Reserve and Depreciation



Capital (Maintenance and Development)

Goal:

- Maintaining and developing appropriate facilities and equipment with which to provide health services and programs.

Objectives:

- Increase the longevity of facilities and equipment by effective maintenance.
- Maintain and develop appropriate, serviceable and functional (practical) facilities for our community health care.
- Maintain facilities and equipment to ensure maximum usage and accessibility.
- Ensure a safe, secure, comfortable work environment in health facilities.

Activities:

- Needs assessment.
- Effective planning
- Facility inspections.
- Repair and maintenance.
- Regular review of facilities and equipment.
- To update electronic equipment and software.
- Maintaining an accurate inventory list.

Outcome Measures:

- Longer and more productive use of facilities and equipment.

Service Providers:

- Adminstration
- Health Team
- Facility workers

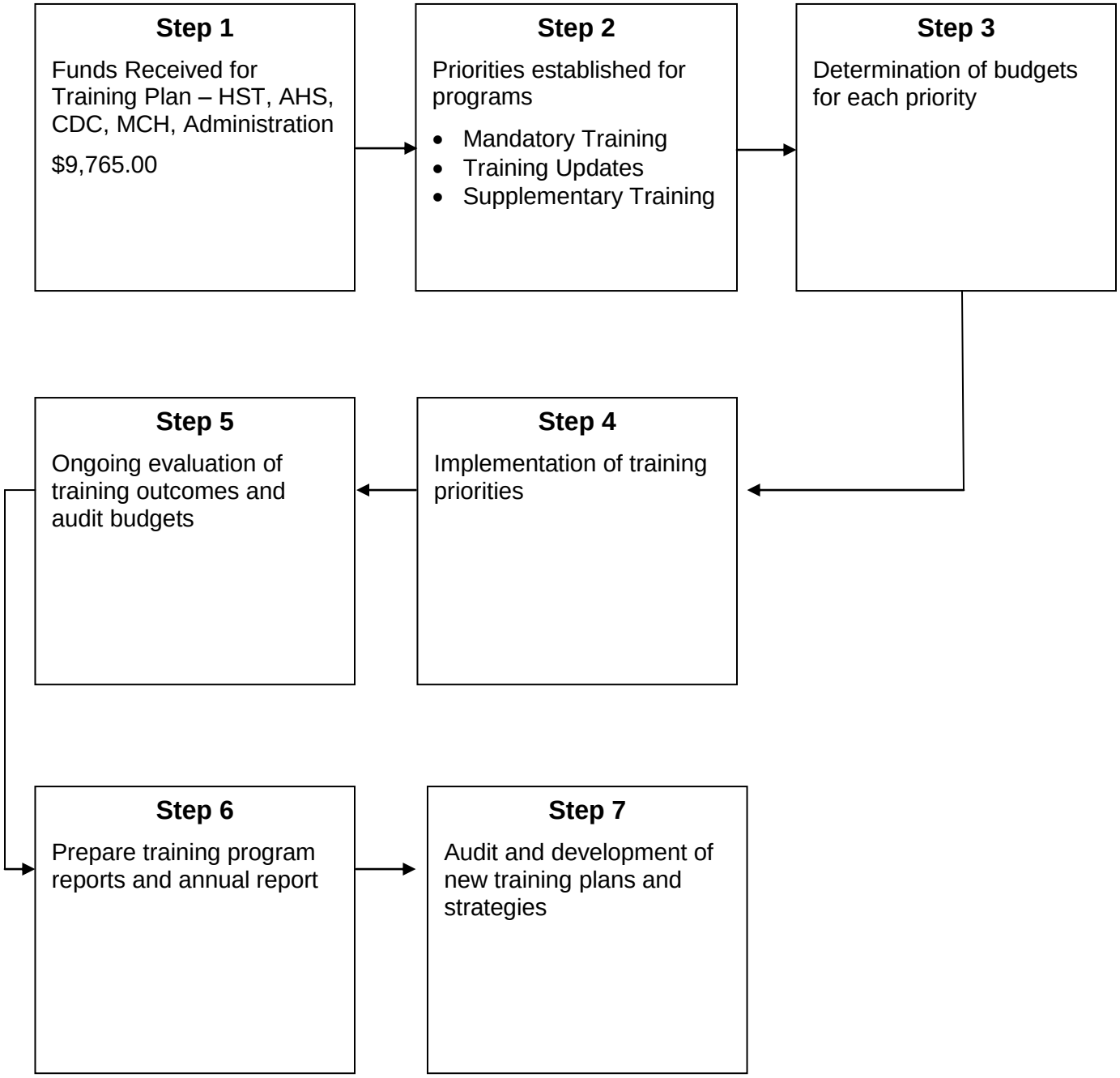
Partnerships:

- Trades contractors
- Housing and Maintenance

Timeframe:

This will be ongoing over the next 5 years. We will document inventories and respond to needs and requirements each year.

Section 11:
Training Plan



Training Plan:

Our training plan for the next 5 years will be based on addressing three levels of training needs.

1. Mandatory Training – training required to maintain certification and to meet health service standards.
2. Training Updates – training to update qualifications and include new research and approaches,
3. Supplementary Training – training to enhance skills and expand abilities on the job.

Training Priorities:

- Training to maintain standards of certification for our CHN/HCCN/MCHN.
- Training for emergency responders to maintain certification for an emergency operations centre during a disaster or emergency.
- Training for Home and Community Care workers to maintain certification and enhance service skills (foot care, bathing, post surgery, lifting and movement.)
- Basic first aid training as required for staff and community members.
- Food safe training for staff and community members involved in food preparation or food services.
- Updating computer skills, information technology skills, and training for the Health Information System.
- Updated training for Aboriginal Head Start and Early Childhood workers.
- Teambuilding and positive working skills training for staff and management.
- Training to support understanding of the new Mental Health/Addictions approach and methodologies.
- Updated training on drugs and drug addictions for staff and interested community members.
- Support training for families providing home care to family members.
- Respite worker/caregiver training for provision of respite services for families.
- Strategic planning training for staff and management.

Bonaparte Health Centre

Furniture and Equipment – MAR

Bonaparte Health & Community Services Building – Floor Plans

Accreditation:

We will be carefully considering the process of accreditation over the next five years. When we are in our new Health Centre and we have a CHN and a Health Director in place, we will be ready to explore the process of accreditation.

By the end of our 5 year operation schedule we will be ready to make a decision on accreditation.

Section12

Liability and Malpractice Insurance

Our Health Centre Staff and our Community Health Committee must have general liability insurance which includes professional liability.

Our liability insurance is with HUB International. We have insurance coverage from 2,000.000.00 (two million) to 8,000,000.00 (eight million). Our insurance is updated yearly to ensure any new and changing liability.

Our liability is in keeping with the professional standards outline for our professional staff and all service providers.

A copy of our liability insurance policy is included in our Community Health Plan Appendix.

Section 13

Accountability and Reporting

All of our health services are community based and community driven. Our accountability is always first to our community members. We are, of course, also accountable to our staff and volunteers as well as our professional and performance measures.

We have established a number of checks and balances to ensure our accountability in the following ways:

- ☐ Recognition of FOIP and confidentiality agreements.
- ☐ Degree of responsiveness to the identified needs as demonstrated by the community members.
- ☐ Response to feedback gathered from program participant and service uses.
- ☐ Maintenance of staffing, training and resources to ensure professional standards of service provision.
- ☐ Recording, documenting and maintaining of our Health Information System to support strategic planning and budgeting.
- ☐ Use of best practices only.
- ☐ Updating of service agreements, memorandums of understanding and working agreements to ensure the best professional support.
- ☐ Ongoing development and maintenance of partnerships to support health and program services.

Our accountability will be addressed through:

- ☐ Signing authority:
- ☐ Agreements and contracts.
- ☐ BCR: Chief and Council (Quorum)
- ☐ Monitoring
- ☐ Evaluating
- ☐ Documenting
- ☐ Reporting

The following reports are keys to accountability:

1. Comprehensive Audit and Annual Report.
    - Financial audit.
    - Program audit.
    - Outcomes of programs and services.
    - Service review with recommendations.

Completion date: yearly by June 30.

2. Communicable Disease Control Reports.
    - Documentation of all communicable disease occurrences.
    - Documentation of all immunizations.
    - Reporting of outcomes of immunizations.

Completion date: Monthly and yearly reports.

3. Environmental Health Reports.
    - Reporting of all facility inspections and outcomes.
    - Reporting of environmental hazards or risks and actions taken.
    - Reporting of environmental activities or incidents and recommendations.
    - Reporting of environmental education and information sharing at the community level.

Completion date: Within 14 days of the inspection and/or incident and Included in the annual report.

4. Service Response Reports.
    - Reporting of intakes and service directions.
    - Recording of contacts and interactions
    - Documenting participation and attendance at health activities and events.
    - Data collection for planning.

Completion date: Monthly and for inclusion in the annual report.

5. Program Reports.
    - Recording of logistics for program activities.
    - Documenting objectives and outcomes.
    - Collection of feedback from participants.
    - Recording expenditures and relating to budgets.

Completion date: Monthly reports for inclusion in the annual report.

6. Emergency Response Reports.
    - Description of emergency.
    - Description of response.
    - Documentation of involvement.
    - Documentation of mutual aid/partnership response.

Completion date: Within 14 days of the emergency and included in the annual report.

7. Employee Appraisal Reports.
    - Performance appraisals.
    - Attendance.
    - Retention activities
    - Training activities
    - Recommendations for ongoing development.

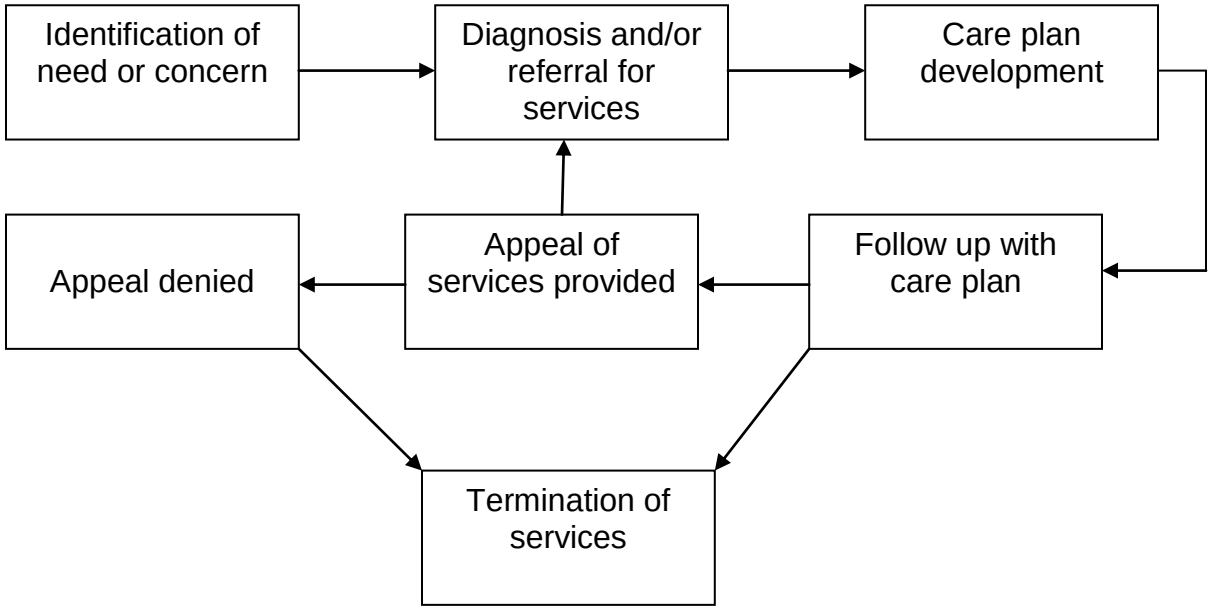
Annually within one month of anniversary date. After 6 months for new employees.

8. Security Report.
    - Documentation of risks, concerns or hazards.
    - Reporting of security breaches.
    - Reporting security activities.

Completion date: Monthly reports for inclusion in the annual report.

Service Appeals Procedures:

Community members and service users always have the right to appeal the services or service level received. The following chart demonstrates the appeal process. Appeals are part of being accountable for the quality and accessibility of services.



- Appeal must be addressed within 14 days.
- Each appeal may be heard a maximum of 3 times.
- An appeal may result in the same diagnosis and/or referral.
- An appeal may follow the lines in the organizational chart in effort to achieve resolution.

Surplus and Deficits:

To ensure accountability and responsibility we will take steps to manage all surplus and deficits as outlined in our accountability framework. Deficits will be the responsibility of the band. We will use the flexible transfer funding model to invest our surplus in health priorities as outlined in our Community Health Plan. We will address priority programs first and follow with support for secondary programs such as information technology and emergency resources.

Accounting Services:

A percentage of our administrative dollars go to the Bonaparte finance department. They provide the services of receivables, payables, payroll, budgets, bank reconciliation and all other financial functions required by the health department.

They have a fully qualified accountant and finance team. They handle all of the steps of the accounting process including preparing for the auditors and the final audit.

Our accountant's resume` and letter of service agreement is in the appendix. It clearly outlines the accountant's role in the health plan implementation and financial management.

Section 14

Confidentiality and FOIP

Due to the sensitive nature of health information, we have taken the following steps to ensure confidentiality and Freedom of Information and Protection of Privacy in our Health Department.

The following steps provide a framework for ensuring confidentiality and adherence to FOIP:

- ☐ Security for our Health Information System and data collections.
- ☐ Updating of forms and data collection tools to ensure only required information is collected.
- ☐ Updating addresses and names to eliminate stereotypical and/or judgmental addresses.
- ☐ Eliminating identifying information from documents and publications.
- ☐ Collection and sharing of data that is non-personal and non-identifying.
- ☐ Ensuring that information is secured and only accessible by qualified personnel.
- ☐ Requirement that all staff take the oath of confidentiality and understand the application of the oath.
- ☐ Security for shredded materials and storage of data.
- ☐ Passwords for computer security and access to files.
- ☐ Security regarding removal of files from the Health Centre and other facilities.
- ☐ Care and attention is paid to determine what information is published or displayed in our Health Centre or in the media.
- ☐ Removal of names and other identifying information from our community health plan and other reports which are sent outside of our community
- ☐ Attention is paid to security and confidentiality in electronic communication.

The oath of confidentiality and all policies regarding security of information and FOIP are included in our band policy package in the appendix.

Section 15

Safe Storage and Disposal of Supplies and Sharps

Program Objectives:

- To store and transport all vaccine so that the cold chain is maintained to minimize spoilage or waste.
- To safely dispose of all contaminated and dangerous materials (eg, needles, condoms.)

Operational Objectives:

- To ensure all staff are adequately trained in safe disposal of hazardous materials.
- To increase community awareness about safe disposal of condoms and needles by providing information and community education.
- To ensure that all dangerous surpluses are picked up and disposed of effectively.

Procedures Regarding Drugs and Medical Supplies:

- Vaccines are ordered by CHN's from IHA Health Units in Kamloops, Ashcroft and 100 Mile House.
- Vaccines are stored and transported according to provincial guidelines specified by BCCDC by one of the CHN's.
- Storage and outdates are monitored by the CHN.
- All vaccines and allergy medications are secured.
- All vaccines are stored following the guidelines of the manufactures and Health Canada.

Evaluation:

Data collection tools include the CHN monthly report, annual immunization status report and CDC outbreak reports.

Data collection will measure the following:

- Occurrence and frequency: if the program occurred and within what timeframe.
- Participation: attendance at each program or number of people contacted – e.g., through mail out.
- Satisfaction: evaluative data such as satisfaction surveys.
- Review of annual statistics – e.g., immunization rates.
- Activity reports from "sharps" disposal service provider.

Timeframe:

This is presently documented and taken care of by a visiting nurse. When we hire a nurse the responsibility will transfer to her. Over the next 5 year period we will have our best practices fully in place

Section 16

Nursing Consultation and Professional Support

Nursing Consultation is a mandatory requirement for all practicing nurses in B.C. Nursing Consultation is the supervision of and consultation to nurses for their professional practices.

This service is currently provided by a senior level nurse who acts in a nursing supervision role.

Informal consultation is also provided by the FNIH Regional Nursing Consultant. The Band's CHN/HCCN/MCHN participates in the FNIH quarterly meetings of nurses and seeks information and advice from the FNIH Nursing Consultant as needed.

The core activities of Professional Nursing Consultant are:

- Consultation and support for nursing services to the community through contact with the Community Health Nurse and the Health Director (as needed.)
- Orientation and verification of appropriate professional registration and qualifications.
- Consultation on the professional practice of the Community Health Nurse.
- Consultation to support quality community health nursing practices.
- Consultation to facilitate meeting health goals and objectives by nursing services.

Additional activities include:

- Assistance with the recruitment and hiring of the Community Health Nurse.
- Provision of ongoing assistance to ensure nursing standards are maintained through annual chart audits and program reviews.
- Provision of updates on all relevant changes to nursing practices.
- Provision of reference materials and updates on communicable disease control.
- Assistance to the Band in the investigation and resolution of complaints regarding nursing practice.
- Support with the evaluation of programs and services.

Timeframe:

Nursing consultation and professional support will be required as soon as we hire a nurse. We will continue to expand as our program expands.

Section 17

Fixed Capital Assets

Goal:

- To effectively address the need for increased service capacity by providing increased service capacity. Our new health centre will soon be full and more space will be required.

Objectives:

- To provide space for our special programs, a visiting dentist, a visiting doctor and adequate office space

Activities:

- Possible feasibility study to determine actual space needs.

Outcome Measures:

- Adequate space for programs, services and service providers.
- Updated service space.

Service Providers:

- Health Coordinator (TBA)
- Chief and Council
- Health Committee
- Health Staff

Partnerships:

- Chief and Council
- Interior Health Authority
- FNIHB
- Partner Agencies and Services