T'itq'et Community Multi-Year Health & Wellness Plan2019-2024

Approved March 18, 2019

Prepared by Tarbell Facilitation Network

Table of Contents

Executive Summary **4**

I. Introduction **6**

II. Health And Wellness Vision, Mission And Values **7**

III. T'it'q'et Community Health Priorities' Process **9**

IV. T'it'q'et Community Multi-Year Health & Wellness Plan – A Continuum of Delivery **14**

a. Continuum of Delivery - Spectrum of Care 17

b. Continuum of Delivery - First Nations Health Benefits 21

c. Continuum of Delivery - T'it'q'et Management Structure 23

V. Community Needs Assessment **25**

VI. Community Demographics & Context **29**

VII. Performance Measurement **31**

VIII. Conclusion **32**

APPENDIX A - 7.3 Healthy & Thriving Community **34**

APPENDIX B – Continuum Of Delivery **1**

Table of Figures

Figure 1 Health Plan Goal Alignment Table 12

Figure 2 P'egp'íg'lha Governance Structure 13

Figure 3 First Nations Authority: Funding Model Activity Structure 16

Figure 4 Spectrum of Care Table 19

Figure 5 Spectrum of Care Table (b) 20

Figure 6 First Nations Health Benefits Table 22

Figure 7: T'it'q'et Management Structure Table 24

Figure 8 First Nations Perspective on Health & Wellness 26

Figure 9 Process Acrostic 27

Figure 10 Map of Community ***Error! Bookmark not defined.***

Figure 11 Map of Community 30

Figure 12 Performance Measurement Process 32

Executive Summary

The T'it'q'et Multi-Year Community Health & Wellness Plan (MYHWP) 2019-2024 has been developed through a community engagement process whereby Elders, youth, men and women had opportunity to share their wealth of insights and increase awareness of current health needs.

This updated health plan outlines community goals and objectives and how they contribute to the Nation's broader vision of attaining optimal health for community members. The T'it'q'et community health priorities have been outlined in such a way that allows staff to see clear linkages to the First Nations Health Authority's (FNHA) Funding Model Activity Structure. This funding model activity structure that is also well supported by other health-related plans in the region, is not intended to be prescriptive or meant to infringe upon community governance systems. Instead, having an all-encompassing health plan will support T'it'q'et health staff situate themselves in their work and also assists the FNHA position their approach to funding within the *7 Directives.*

Community members reviewed the health goals, strategies and actions previously developed in the *T'it'q'et Comprehensive Community Plan: Healthy and Thriving Community Strategies (2014)*. Community members revised their nine (9) health priorities making social and health support services that meet the needs of all community members the top priority. Youth and Elder needs' are matched in importance given the population is proportionately young and growing as well as aging. Thus, building a strong, unified and safe community is also matched with promoting and supporting a drug and alcohol free community. Keeping with cultural traditions, this health plan aims to promote and provide opportunities to pursue healthy lifestyles, build food security and support family unity. Building a healthy, united community is built on values of taking personal responsibility and making contributions that support the individual and collective well-being of T'it'q'et members.

As part of this health plan, recommendations were made on how the health plan itself can be further strengthened. For example, creating an all-inclusive health plan requires the most up-to-date information. It is recommended that new information be gathered by carrying out a current health needs assessment that measures not only the health needs of individuals but of families. There are 14 families who have been named and are represented on the P'egp'íg'lha Traditional Council; these families have responsibilities and rights under the St'át'lmc P'egp'íg'lha Constitution. It would be valuable information to learn about the health status of these and other families and learn why some families may be thriving while others are not. For those families not thriving, identifying the gaps in services that could make a difference to improving their health status needs to be addressed.

RECOMMENDATIONS

- Develop a new Needs Assessment that will support the funding of appropriate health programs and services for the community of T'it'q'et.

- Dedicate funding to employ a researcher who will support capacity building of community members in training them to design surveys. These surveys will inform the development of the new Needs Assessment.

- Designate three (3) community liaison paid positions to support survey development.

- Build an evaluation in tandem with the Needs Assessment - Develop meaningful performance measurements based on the criteria of health, wellness and building capacity.

I. Introduction

Welcome to the T'it'q'et Community Multi-Year Health & Wellness Plan (MYHWP) for 2019-2024. This plan is designed to clarify how the T'it'q'et health department will be the health and wellness partner to its community, the FNHA and neighboring health and wellness agencies and initiatives.

To contextualize this current MYHWP, the earlier T'it'q'et Health Plan (2009-2010) was the outcome of work that begun in 2001 on a Pre-Health Transfer Planning Process. This process was part of the effort by the T'it'q'et Human Development Committee to secure greater management of health care services.[1] Therefore, the T'it'q'et Community MYHWP is a transitional document as a result of past efforts to transform the funding and health delivery process as a result of the transfer.

Excerpt from the Constitution, 2007:

Skw7ikwlacwkálha

Nilh ts7a skw7íkwlacws i P'egp'íg'lha úcwalmicw. Ts7as lhélta scwakwekwkálha i sqwal'útkálha. S7ats'xstsútkalh kelh múta7 s7ats'xstwál'. Cuz' hal'acítem ku tí7texw nt'ákmen i stsmal'tkálha. Xekantsútkalh kelh. Cuz' nkálstúm' ta tsuwa7lhkálha nt'ákmen xílem nelh skelkla7lhkálha múta7 cuz' xílem i ts7ása úcwalmicw.

(Translation: Rose Agnes Whitely).

The P'egp'ig'lha Clan Dream

Our words come from our hearts. We will look after ourselves and each other. We will make our own laws. We will follow our own way of life as did our ancestors and as will our future generations.

The community MYHWP is designed to respect the P'egp'íg'lha Constitution and guide how T'it'q'et manages the work of delivering health and wellness programs and services in a manner that:

- Responds to community needs and priorities;
- Aligns with FNHA, Interior Region and Northern St'at'imc planning goals; and
- Supports participation in FNHA and any other available funding agreements and processes.

This renewed community MYHWP has been prepared based on community engagement focus groups beginning in May 2018 and a review of available documentation. This includes the community's 2002 needs assessment, 2009 health plan and 2014 comprehensive community plan as well an analysis of relevant national, provincial, regional health plans.

As an active document, this renewed community MYHWP will continue to be developed, amended and evaluated by T'it'q'et health staff to ensure the health needs of the community members are being fulfilled.

[1] From Health Plan 2010, p. 5.

T'it'q'et Health Department Mission Statement

To empower the P'egp'íg'lha to improve their Health in a holistic manner individually within families and the larger community through, emotional, physical, spiritual and mental wellness.

We will achieve this by providing programs such as Medical Travel Support, Homecare, Nursing Services, Wellness and Addictions Clinical Counseling, Family Preservation and Traditional Wellness.

In fulfilling the P'egp'íg'lha Clan Dream, we look forward to working with all those interested in being a health and wellness partner to our members, communities and nation.[2]

II. Health And Wellness Vision, Mission And Values

It was heard clearly that community members wants all health services to be inclusive of ancestral teachings like the seven sacred ancestral values[3],[4] and cultural teachings as stated in the vision statement of the Pegp'ig7lha Clan:[5]

> *We are the Pegp'ig7lha Clan of the St'át'imc Nation. We live at T'ít'q'et, Qwíxwcen, Sk'wel'sút, Q'áq'peqw, Sk'emqín, Aku7 Ca7a, Txwín'ek, and Spēl'pl'ekw.*
>
> *The Creator has placed us here in this territory and that connection to our land can never be broken. The traditional ways, values and laws of our ancestors are held in the St'át'imc language and are written on the land.*
>
> *Our Elders have passed them down in the stories to the children and grandchildren since the beginning.*

T'it'q'et Council Mission Statement

Also guided by the P'egp'íg'lha Constitution, the mission of T'ít'q'et Council is to: provide a safe community; allow our community members the opportunity to reach their full potential; maintain unity; encourage self-sufficiency; and provide staff with a supportive and secure work place.

To achieve this mission, the T'ít'q'et Council will make informed decisions through: due diligence; hearing the voice of the people; being accountable and transparent; mutual respect; and focusing on meeting the needs of the community.

---

[2] As stated in the T'it'q'et Comprehensive Community Plan (2014).

[3] Sxeks Ta Nt'akmensa I P'egp'íg'lha Constitution – Traditional Laws of the P'egp'íg'lha (July 14, 2007) as stated in the Community Comprehensive Plan (2014).

[4] T'it'q'et Annual Report, 2016/17 p. 5.

[5] Sxeks Ta Nt'akmensa I P'egp'íg'lha Constitution – Traditional Laws of the P'egp'íg'lha (July 14, 2007) as stated in the Community Comprehensive Plan (2014).

We are committed to working together to build our community in a good way that is based on the teachings of our ancestors.

We will:

- *Show respect for the Creator and all of creation including ourselves.*
- *Live in harmony with all things.*
- *Learn and speak our St'át'imc language.*
- *Maintain, practice and teach our traditional ways to our children.*
- *Govern according to our traditional values and principles.*
- *Strive for self - sufficiency and independence for our community.*
- *Ratify our traditional values and principles in a written constitution.*

Approved and accepted by Membership on February 26, 2000.

In discussions with community/council members and staff during the engagement process, there emerged several health goals defined in three clusters of health, wellness and building capacity:

- Health
  - Cultural Identity and Traditional Health Practices
  - Personal and Family Health and Wellness Journeys (mental health, cancer, health benefits, addictions, etc.)
  - Healthy lifestyles/eating, activity
- Wellness
  - Holistic health and Social Determinants
  - Decolonization and Forgiveness
  - Addressing suppressive behaviours
  - Youth, Elder and Community interaction
- Building Capacity
  - Education, Staffing
  - Retirement preparedness
  - Working with others
    - Relationship with FNHA
    - Relationships with federal and provincial governments

Seven Sacred Ancestral Values

"We will, to the best of our ability, adhere to and obey the seven sacred values provided to us by the Creator:

- Health
- Generations
- Pity/Compassion
- Quietness
- Happiness
- Generosity
- Power

These sacred values are the fundamental basis for all other laws, policies and actions. They are our guide to maintaining balance on our land, and in our community, allowing us to live in harmony with all other nations and creation as relatives." (CCP, 2014, Sec 6.3).

Those who participated in the engagement process also wanted to seek creative ways to strengthen community unity. A recurring theme for example was the importance of involving youth and Elders separately and together in health and wellness activities and community life. One way this could be realized was by building a multi-purpose, multi-community facility. Then, in a collective sense, community is healthier as they thrive emotionally, mentally, physically, spiritually, and socially.

III. T'it'q'et Community Health Priorities' Process

Part of the process in developing the T'it'q'et Community MYHWP, was to review the health priorities. In order to do this, the process involved review of all available health planning documents: *T'it'q'et Comprehensive Community Plan: Healthy and Thriving Community Strategies* (2014), the 2009 Health Plan, the 2002 Health Needs Assessment as well regional and provincial health plans.

During the Community Comprehensive Plan consultation process (2014), six overall goals and objectives were identified to address community health priorities:

- **Self-Sustaining:** To have a diversified economy and fulfilling employment for members.
- **Language, Culture & Heritage:** To strengthen our language and culture with the wisdom of our Elders and the energy of our youth.
- **Healthy & Thriving Community:** To be a strong, healthy, unified community with services that support economic independence and healthy individuals and families.
- **Healthy Environment:** To provide a clean, safe, healthy place to live for all our members.
- **Governance:** To have a strong stable government, guided by our traditions and supported by responsive administration and staff.
- **Community Service:** To ensure that services provided to the community are of the highest standard

Within the Healthy and Thriving Community goal (Section 7.3 in CCP, 2014) there were 9 strategies along with corresponding actions identified. The May 2018 engagement sessions provided community youth, men, women and Elders an opportunity to share their wealth of insights and increase awareness of current health needs. Community members participated in

an exercise to 'prioritize' the range of health goals, strategies and actions previously developed from the community engagement that resulted in the development of the CCP, 2014.[6]

The revised order of priority for the 9 strategies and the related actions contained in the CCP (2014) have been incorporated into this iteration of the community MYHP:

1. Provide social and health support services that meet the needs of all of our members (on and off reserve). (21 Actions)

2. Provide support, guidance and opportunities for youth to ensure they possess the skills, self esteem and capacity to live as powerful members of the community (8 Actions)

3. Build a strong, unified, safe community (11 Actions)

4. Ensure the Elders' needs are being identified and met on an ongoing basis (9 Actions)

5. Promote and support a drug and alcohol free community (11 Actions)

6. Promote and provide opportunities to pursue healthy lifestyles (10 Actions)

7. Build T'it'q'et's food security (10 Actions)

8. Support Family Unity (7 Actions)

9. To build a healthy, united community that values personal responsibility and contribution (9 Actions)

A Health Plan Goal Alignment Table was developed (see next page) to show how the community's revised priorities further our community goals from the earlier health plan (2009). This table provides a review of the various priorities and goals expressed in health planning processes at the FNHA province wide and interior region level, at the provincial health authority level, at the northern St'at'imc territorial/6 community level, as well as at the T'it'q'et community level. There is an obvious direct correlation with the 7 Directives (2011) and with the priorities/goals of health partners: First Nations Health Authority (FNHA) and Interior Health.

There is also an opportunity to coordinate the T'it'q'et community health plan with, and to inform these other plans and processes as part of the strategy to better meet identified

[6] This answers question #2 on the FNHA 21 point checklist

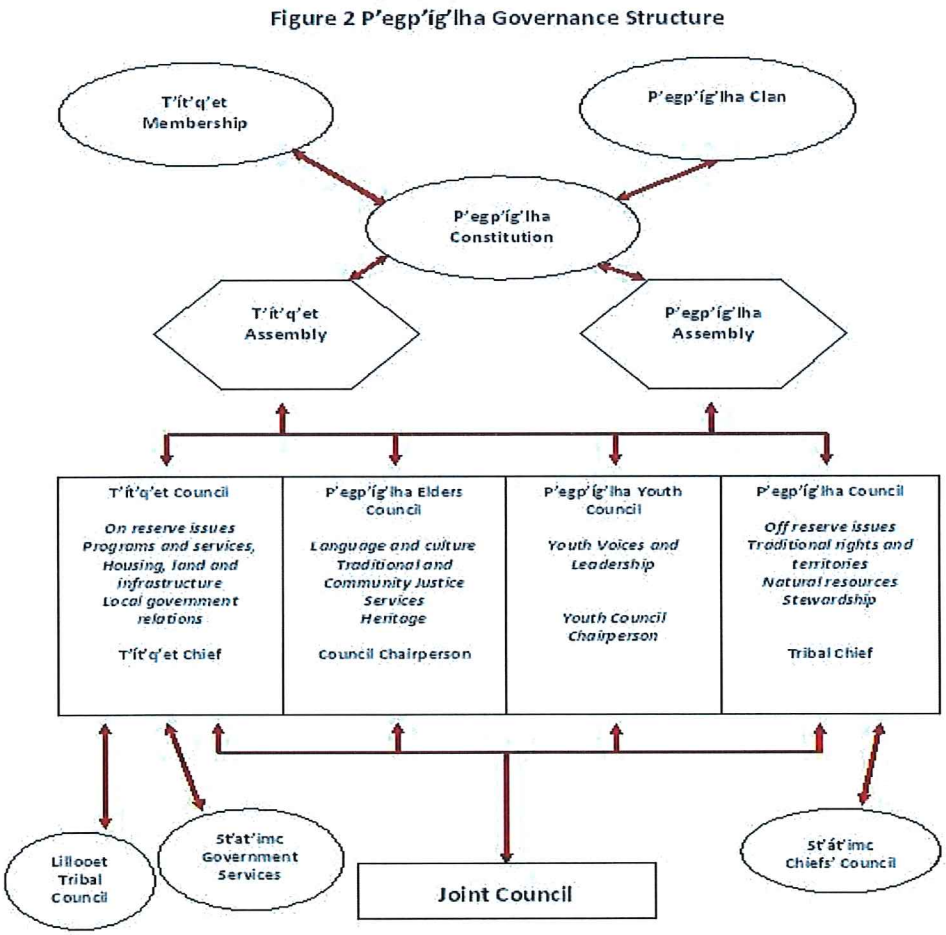
community health and wellness needs, priorities and goal "To be a strong, healthy, unified community with services that support individuals and families." (Section 7.3 in CCP, 2014).

T'it'q̓et Comprehensive Community Plan: Healthy and Thriving Community Strategies (2014)	T'it'q̓et Community Health Plan (2009)	Interim Northern St'at'imc Health Plan	7 Directives (2011)	FNHA Interim Interior Regional Health & Wellness (2014)	FNHA Renewed MYHP 2016-2021	Interior Health Authority Strategy Map – January 2018	Interior Health Authority - Aboriginal Health & Wellness Strategy 2015-2019
1. Provide social and health support services that meet the needs of all of our members (on and off reserve) (21 Actions) 2. Provide support, guidance and opportunities for youth to ensure they possess the skills, self esteem and capacity to live as powerful members of the community (8 Actions) 3. Build a strong, unified, safe community (11 Actions) 4. Ensure the Elders' needs are being identified and met on an ongoing basis (9 Actions) 5. Promote and support a drug and alcohol free community (11 Actions) 6. Promote and provide opportunities to pursue healthy lifestyles (10 Actions) 7. Build T'it'q̓et's food security (10 Actions) 8. Support Family Unity (7 Actions) 9. To build a healthy, united community that values personal responsibility and contribution (9 Actions)	1. Promotion of self care and independence 2. Assure safety and comfort by providing a focal point for community healing through delivery of defined services 3. Maintain dignity and self respect to promote community healing through the mobilization of community and cultural resources in a holistic, culturally based manner to support community members and, 4. Maintain stability by promoting and developing work schedules to address reliability and dependency.	#1: Northern St'at'imc Health Governance and Shared Health Services Structure #2: Traditional Wellness Framework #3: Mental Wellness and Substance Use #4: Primary Health Care Integrated Services #5: Families: Children and Youth #6: Families: Elders and Vulnerable Adults	Directive #1: Community-driven, Nation-based Directive #2: Increase First Nations Decision-making and Control Directive #3: Improve Services Directive #4: Foster meaningful Collaboration Directive #5: Develop human and economic capacity Directive #6: Be without prejudice to First Nations' interests Directive #7: Function at a high operational standard	Goal 1: Design strong, sustainable health and wellness services that support community capacities Goal 2: Improve health and wellness programs and services to better meet the needs of the Interior Nations Goal 3: Align First Nations Health Authority and Interior Health Authority planning and investments with the Interior Regional Health and Wellness Plan Goal 4: Improve access to high quality health services and infrastructure	1. Enhance First Nations Health Governance 2. Champion the BC First Nations Perspective on Health & Wellness 3. Advance Excellence in Programs/Services 4. Operate as an Efficient, Effective & Excellent First Nation Health Organization	Goal 1: Improve Health & Wellness Goal 2: Deliver High Quality Care Goal 3: Ensure Sustainable Health Care by Improving Innovation, Productivity, and Efficiency Goal 4: Cultivate an Engaged Workforce and a Healthy Workplace	Priority 1:Advance Cultural Competency & Safety. Goal: "...to provide culturally safe and relevant care for Aboriginal people." Priority 2: Ensure Meaningful Participation. Goal: "To ensure health care planning and services are co-developed with our Aboriginal partners..." Priority 3: Improve Health Equity. Goal: "To improve equitable access to health care services for Aboriginal persons at the time they need them and where they need them. Priority 4: Improve Mental Wellness. Goal: "To improve the mental wellness of Aboriginal people within Interior Health."

Figure 1 Health Plan Goal Alignment Table

This current health plan was also validated with further engagement with the community health staff and Band Program Directors. The T'it'q'et community MYHWP was then put forward and recommended to Chief and Council for their approval. The approval process can be seen with the review of the P'egp'ig'lha Governance Structure as seen below in Figure 2.

Figure 2 P'egp'íg'lha Governance Structure



IV. T'it'q'et Community Multi-Year Health & Wellness Plan – A Continuum of Delivery

The different financial methods to deliver funding for the administration and management of community health programs and services are explained here. These financial methods support the T'it'q'et Community Multi-Year Health and Wellness Plan (MYHWP). Each funding model whether it is the Set, Flexible or Block Funding offered through contribution agreements vary "in terms of level of control, flexibility, authority, reporting requirements and accountability." The different funding models offer First Nation communities a choice in the level of control they have over their health services based on their "eligibility, interests, needs and capacity."[7]

The funding models are as follows:

- **Set Funding Model (Agreements are up to three (3) years)**
    - The programs are pre-designed. However, communities, with the written approval of the Minister, can redirect funding resources within the same sub-sub activity. Interim and year-end reports are required.
- **Flexible Funding Model (Agreements are two (2) to five (5) years)**
    - Communities must develop a Multi-Year Work Plan that also includes a health management structure. Within this funding model, there is flexibility to reallocate funds within the same Program Authority. With the written permission from the Minister, communities may carry forward program funding for reinvestment in the next fiscal year. It is mandatory to submit an annual report as well as a year-end audit report.
- **Block Funding Model (Agreements are five (5) to ten (10) years).**
    - In this funding model, communities must determine their health priorities; develop a health plan, as well as a health management structure. Funds may be reallocated across all authorities and any surpluses may be retained for reinvestment in priorities, which are listed in their health plan. It is mandatory to submit annual reports and year-end audit reports as well as an evaluation report every five (5) years.

---

[7] Retrieved September 1, 2018 from: https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/funding/contribution-agreements.html

Below, the funding models that are considered for the development of the T'it'q'et Community MYHWP are explained as well as the First Nation Authority's Funding Model Activity Structure.

The T'it'qet Community MYHWP brings the health goals of the community together with the First Nations Authority's Funding Model Activity Structure (see Figure 2 below). The FNHA model is comprised of three Activity Level Authorities, namely: *Primary Health Care, Supplementary Health Benefits* and *the Health Infrastructure Support*. These are the categories reflected in Block Funding Agreements. These three main funding categories are further detailed in five sub-activity levels and 13 sub-sub Activity Levels. These are the categories reflected in Flexible Funding Agreements. This is followed by an array of nearly fifty (50) program and services, thirty-two (32) of which are considered primary care, eight (8) in the Supplementary Health Benefits and nine (9) under the Health Infrastructure Supports category.

Under this new health delivery system, the FNHA Funding Model Activity Structure allows flexibility in how communities designate their health and wellness priorities. Thus, the community is enabled to move towards developing an integrated health system based on our own holistic understanding of health and wellness as defined by our T'it'q'et Council Mission Statement[8] and the T'it'q'et Health Department Mission Statement.

For more information regarding reporting requirements and a description of programs and services within the FNHA's Funding Model Activity Structure please see the guide at: http://www.fnha.ca/Documents/FNHA-Reporting-Requirements-Guide.pdf.

[8] Sxeks Ta Nt'akmensa I P'egp'íg'lha Constitution – Traditional Laws of the P'egp'íg'lha (July 14, 2007) as stated in the Community Comprehensive Plan (2014).

Figure 3 First Nations Authority: Funding Model Activity Structure

It is important to note that what is presented in the FNHA Funding Model Activity Structure below are only examples of how community priorities can be organized. At present they do not specifically represent T'it'q'et priorities and goals as this will be an activity completed in collaboration with T'it'q'et staff and approved by Chief and Council.

The FNHA Funding Model Activity Structure has been employed for purposes of guiding the development of a new T'it'q'et Community Multi-Year Health and Wellness Plan. From the community's perspective this particular funding model activity structure describes a **Continuum of Delivery** and its three main categories correspond to: *a Spectrum of Care*, *First Nations Health Benefits* and *T'it'q'et's Management Structure* and their related sub-activities and program clusters. T'it'q'et's Community Multi-Year Health and Wellness Plan is built around defined goals at the appropriate level based on the type of funding agreement in place (in this case a flexible agreement). This is intended to provide T'it'q'et with both a clear road map for its health and wellness priorities over a five-year period (broken down by each year) and an understanding of how this relates to FNHA's funding and reporting requirements.

Following, each component of the Continuum of Delivery will be explained separately.

a. Continuum of Delivery - Spectrum of Care

The spectrum of care is the first third of the FNHA Funding Model Activity Structure and it focuses on the available program and services in the primary health care categories. It is important to note that there are four programs that are considered mandatory as stated by the FNHA, and they are: Home and Community Care, Nursing, Immunization and Drinking Water Safety.

These four programs represent core activities that need to be performed within a holder's agreement if a community is receiving funding for these programs. A good example is the Drinking Water Program: sampling needs to be completed based on the schedule provided and staff need to be trained to understand their role in identifying water issues. In many communities this program funding is transferred to the maintenance departments and those staff complete the sampling and maintain a good relationship with FNHA Environmental Health Officers (EHO) but report to the health director any issues that maybe occurring. If this is the case the health plan would identify that relationship and how the structure is within the organization.

In some cases, a community may not get Home and Community Care funding but this service is provided for from FNHA staff nursing. In this example, the community would not be responsible for providing the service as they do not receive funding for it.[9]

[9] The two explanations regarding Drinking Water Program and the HCC funding was provided by an FNHA representative, August, 2018.

As you will see in the FNHA Funding Model Activity Structure, mandatory programs are highlighted with an '(m)'. The Spectrum of Care includes: Health Promotion & Disease Prevention; Public Health; and Primary Care.

Under the Health Promotion & Disease Prevention funding category, there are three program clusters with seven programs and services divided between them:

- Healthy Child Development (includes two programs: Healthy Development, and Oral Health programs);
- Mental Wellness (includes two programs: Mental Health & Suicide Prevention, and Substance Abuse Prevention & Treatment programs); and
- Healthy Living (includes three programs: Chronic Disease, Injury Prevention and Health & Aging).

Under the Public Health funding category, there are two program clusters with seven programs and services divided between them:

- Communicable Diseases (includes five programs: Disease Control, Blood Borne & Sexually Transmitted, Respiratory, Emergencies, and Community Nursing); and
- Environment (includes 2 programs: Environmental Health, and Research).

Under the Primary Care funding category, there are two program clusters, which in this case, are also programs and services:

- Clinical Care; and
- Home and Community Care (which are also programs).

Funding Category	Health Promotion & Disease Prevention						
Program Clusters	Healthy Child Development Goal:		Mental Wellness Goal:		Healthy Living Goal: Promote well-being of the individual in all aspects: mentally, physically, emotionally, spiritually; Prevent disease and morbidities.		
Programs & Services	Healthy Development	Oral Health	Mental Health & Suicide Prevention	Substance Abuse Prevention & Treatment	Chronic Disease	Injury Prevention	Health & Aging
Goals from T'it'g'et 2018 CHP Workplan Goals from the Health Plan 2010-2015	Maternal and Child Health (infant to preschool): To enhance maternal reproductive & infant health through programs & services dealing with provisions of healthcare, access to appropriate treatment services, counseling, and health education CPNP: To improve, include & capture families; providing information of nutrition, health, wellness and safety HeadStart: To offer early intervention strategies for preschool children and their families as an opportunity for learning and future education. Maternal & Child Health: To promote and offer programs for healthy mothers and children Make every mother and child count.		Brighter Futures: To provide wellness programs to the community to improve the wellbeing of children, families, and the community.	NNADAP: To address & reduce the use of substance abuse Youth & Solvent Abuse: To reduce the use of solvent substance for youth & to educate youth and community of the lasting effects this has on an individual. FASD: To provide a best practices approach to effectively address FASD in the community.	To improve quality of life Diabetes: To ensure access of prevention and promotion programs that emphasize healthy lifestyles		School Age Health (elementary & teens): Promote healthy lifestyle practices and self-care. Elder Care: To maximize health for the elderly and minimize need for institutionalized care

Figure 4 Spectrum of Care Table

Public Health							Primary Care	
Communicable Diseases					Environment		Clinical Care	HCC
Control & Management	Blood Borne and Sexually Transmit-ted	Respiratory	Emergency	Community Nursing	Environ-mental Health	Research		
To decrease the incidence of morbidity and mortality through the control and prevention of communicable disease by such measures as surveillance, immunization, education, treatment, isolation, and to eradicate the sources of infection.	HIV-AIDS: To promote aware-ness of HIV/AIDS					Safe Drinking Water: To ensure the community has access to safe drinking water and a backup plan if the water is compromised.		To respond to the unique health and social needs of elders, and people with disabilities who live in the community.

Figure 5 Spectrum of Care Table (b)

b. Continuum of Delivery - First Nations Health Benefits

The First Nations Health Benefits is the middle third of the FNHA Funding Model Activity Structure and it is unique in many ways. It is considered in tandem to be a funding category, a program cluster, and contains nine program and services, which the model describes as 'exceptions':

- First Nations Health Benefits
- Medical Transportation
- Mental Health Counselling & Crisis Intervention
- Dental Care
- Pharmacy
- Supplies & Equipment
- Vision Care
- Community Dental
- Visiting Health Care Professionals

The First Nations Health Benefits are managed in a less flexible way than the other programs. They are more defined and have set amounts allocated to the community based on information from Health Canada. However, unique to this program is that if a community has a deficit at the end of a fiscal period and the costs are within program guidelines, the community will be reimbursed for those costs.[10]

[10] As stated in correspondence with the FNHA Representative, August, 2018

Figure 6 First Nations Health Benefits Table

Funding Category	First Nations Health Benefits								
Program Clusters	First Nations Health Benefits								
Programs & Services	First Nations Health Benefits	Medical Transportation	Mental Health Counseling & Crisis Intervention	Dental Care	Pharmacy	Supplies & Equipment	Vision Care	Community Dental	Visiting Health Care Professionals
Community Goals Taken from the 2010-2015 T'it'q'et Health Plan	To provide financial assistance to members in need, to attend medical appointments outside of the community.	To provide financial assistance to members in need, to attend medical appointments outside of the community.	Building Healthy Communities: To provide a quality, safe and community based mental health program to the community						

c. Continuum of Delivery - T'it'q'et Management Structure

The T'it'q'et Management Structure makes up the last third of the FNHA Funding Model Activity Structure: There are two funding categories under Health System Infrastructure relating to Health System Capacity and Health System Transformation.

Under Health System Capacity, there are three program clusters and seven (7) programs and services between them:

- Planning & Quality (Management, Accreditation, Consultation & Liaison)
- Human Resources (Staffing, Careers)
- Facilities (Capital Operations & Management, Security Services)

Under Health System Transformation there are three program clusters and five programs and services:

- Systems Integration (the program cluster is also a program and service: Systems Integration)
- E-Health Info-structure (Solutions, Coordinator)
- Nursing Innovation (the program cluster is also a program and service: Nursing Innovation)

T'it'q'et Management Structure

Funding Category	**Capacity**							**Transformation**				
Program Clusters	Planning & Quality Goal:			Human Resources Goal:		Facilities Goal:		Systems Integration Goal:	e-Health Goal:			Nursing Innovation Goal:
Programs and Services	Management	Accreditation	Consultation & Liaison	Staffing	Careers	Capital O&M	Security Services		Info-structure	Solutions	Coordinator	
Community Goals **Year 1** Taken from the T'it'q'et 2010-2015 Health Plan			Update community health needs assessment to inform on-going & future health planning. See attached BN.			Capital Project: Health Centre - To continue to prepare the proposal towards the construction on a health centre by 2024.						
Year 2												
Year 3												
Year 4												
Year 5												

Figure 7: T'it'q'et Management Structure Table

Creating an all-inclusive health and wellness plan requires information from many sources as well as the most up-to-date information. As previously mentioned, several documents were reviewed as well as an analysis of relevant national, provincial, regional health plans. However, it is strongly recommended that updated information regarding individuals, families and community infrastructure health needs be gathered by carrying out a current health needs assessment. It would be valuable information to learn about the current health status of the 14 traditional family groupings and other parts of the community in order to identify any gaps in services that could be addressed to make a difference to improving health status.

The next section examines what is already known from the last health needs assessment, identifies gaps and explains further the importance of updating this type of information, which is intended to strengthen the community health plan.

V. Community Needs Assessment

The 2002 Community Health Needs Assessment appears to have been focused more on what the community felt about priorities amongst the program and services available from Health Canada at that time. This is reflective of the design of community health plans of the day.

The findings of the 2002 assessment were then reviewed and updated as part of the 2009 health plan. As noted the health and wellness environment that T'it'q'et operates within has shifted significantly since those times particularly given the creation of the First Nations Health Council, Health Authority, Health Directors Association and the agreements with federal, provincial governments as well as provincial and regional health authorities and related agencies. As part of the engagement process for this health plan, community participants also identified the necessity to update the 2002 community health needs assessment in order to reflect current needs of the community.

The following information is intended to provide a framework through which the community can design, develop and conduct a more robust community health and wellness needs assessment. An updated needs assessment is required as part of the implementation of this renewed community health plan, as it will support continuous improvement of health services over the next 5 years.

A community health and wellness assessment is the critical step to determining the state of health and wellness in a community and/or in developing health and wellness programs, services and projects. It is a part of health planning that supports the identification of health

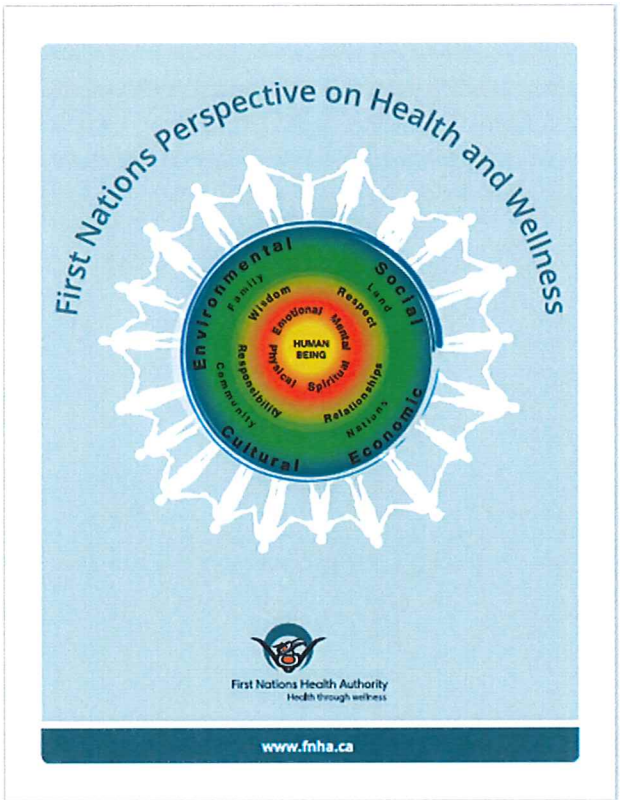


Figure 8 First Nations Perspective on Health & Wellness

and wellness service needs, the setting of measurable goals, the distribution of health and human service resources, the development of policy and the design of evaluation.

The assessment process can also serve as a foundation for improving communication and cooperation within a community and the building of collaborative relationships with external partners.

The process is holistic in that it includes physical, psychological, social, environmental and economic aspects of life. It is built on a shared understanding of how health and wellness are defined: "...Wellness refers to a general satisfaction in all areas of life including aesthetic, cultural, educational, emotional, environmental, mental, relational and spiritual."[11] Health is defined as ' a state of complete physical, mental and social wellness and not merely the absence of disease or infirmity" (World Health Organization, 2001). This is consistent with Model on "First Nations perspectives on health and wellness",[12] which starts in the centre with individuals taking responsibility for their own health and wellness and their unique journey for nurturing and finding balance in their mental, emotional, spiritual and physical realities. For First Nations people this operates within collectively held values, relationships to family, community, nation and territory and to the Indigenous determinants of health. Through this holistic approach First Nations are returning to a state of being "healthy, self-determining and vibrant BC First Nations children, families and communities" (FNHA Vision statement).

There are a number of conceptual frameworks that can help to shape how to direct an assessment, identify pertinent issues and determine which data sources to use. These models include:

---

[11] Community Health and Wellness Needs Assessment: A Step by Step Guide, Edited by Deena Alleria Nardi and Josy M. Petr, 2003, Thomson Delmar Learning, ISBN 0-7668-3498-0

[12] http://www.fnha.ca/wellnessContent/Wellness/FNHA-First-Nations-Perspective-on-Health-and-Wellness-Poster.pdf

- The community as partner - including a core group and 8 'systems' within the community: physical environment; community safety; transportation; health and human services; economics; education; policies and government; and recreation;
- Ecological - the individual, interpersonal, organizational, community and public policy influences;
- Behavioural - health service use determined by perceptions about threats to health, benefits of using services, and triggers for seeking services; and
- Beliefs - the relationship between the consumer's use of health services and beliefs about whether the health behaviours and practices get them the desired result (efficacy).

The steps of a community health and wellness assessment generally include: Obtaining informed consent → Defining and describing the problem → Determining what information is required→ Gathering Information; and Analyzing the selected data. The following PROCESS acrostic provides initial insight into how these steps are applied:

Figure 9 Process Acrostic

P	Purpose/Problem - Determine the purpose of the assessment and define/describe the problem
R	Refine - Formulate and refine the primary questions and all associated questions of the study
O	Organize - The coalition to identify, retrieve, and categorize data
C	Compare - The information against the selected benchmarks/goals which provide a standard for measurement of quality health care
E	Evaluate - The outcomes of existing health and wellness services to actual health and wellness outcomes
S	Summarize - Findings and make recommendations
S	Submit - The report

The methods used identify, gather, examine and analyze data on health and wellness needs include: Focus groups with specific constituencies; Interviews with experienced and/or expert key informants; Survey methodologies; Secondary analysis of existing data; and Geographic information systems to map and layer information (GIS). Each method's validity needs to be assessed relative to what information is being sought and there must be a level of rigour in the methodology through which the technique is used.

It is also important to be able to assess the resulting findings on needs in terms of whether they highlight different kinds of needs:

- Normative needs are the benchmarks or recognized standards for health outcomes for population groups collectively
- Comparative needs are the identified determinants of health for a specific population that are compared to the health behaviours outcome data for a specific population
- Expressed needs are already identified by users and providers of health care and community services in a community
- Felt needs are expressed needs that are subjectively experienced by a person or population. They are experienced as lacking or desired and are shaped by perceptions about the health indicator or access to services.

It is recommended that funding be dedicated to employ a researcher who will support capacity building of community members in training them to design surveys that will be carried out over the year. These few community members will be designated as community liaisons, who in their paid positions actively engage community members to participate.

In doing research that encourages community involvement, the surveys will identify specific community health needs as they become evident, since the dynamics of the community is ever-changing.

The researcher's task is to train these community liaisons and to ensure the survey development informs the design of the needs assessment. The researcher will initially analyze the information gathered in order to ensure the needs assessment is asking the proper questions. This process will continue over the year as the survey questions evolve. This evolution is considered an iterative process that will support the funding of appropriate health services and programming that meet the health goals of T'it'q'et community members.

The T'it'q'et Community MYHWP will undoubtedly have elements that continue to work towards the goals contained with the earlier health plans of 2002 and 2009. For example, the 2002 plan focused on: 1) promot(ing) self-care and independence, 2) assur(ing) safety and comfort, 3) maintain(ing) dignity and self-respect, and 4) provid(ing) stability.

In addition, the FNHA's newly streamlined Funding Model Activity Structure has four mandatory health services and programming of: Community Nursing, Home and Community Care, Immunization, and Safe Drinking Water.[13] The community health plan will also focus on three main areas:

- Health and Management Structure
- Management and Delivery of Mandatory Programs
- Management and Delivery of Community Health Programs

[13] See also checklist Question #19

Thus, the T'it'q'et Community MYHWP will be used as a guide for the T'it'q'et health program and services. All community and FNHA policies and programs will be provided parameters in which to develop goals and outcomes of each program via a newly created tool and checklist that will be used to evaluate the T'it'q'et Community MYHWP under the FNHA Funding Arrangements Agreement.

VI. Community Demographics & Context[14]

It is important to understand the demographics of the T'it'q'et community in order to address the context of health needs. Demographics consider social statistics such as: environment, population, age, sex, income, education, employment, economic development, health, religion, marital status, and births and deaths. Context in this case, refers to the interrelated environmental and historical circumstances and conditions that form the basis of health for community.

The First Nation of T'it'q'et (formerly known as the Lillooet Indian Band) consists of 7 reserves lands: Kilchult 3, Lillooet 1, Lillooet 1A, McCartney's Flat 4, Riley Creek 1B, Seton Lake 5 and Towinock 2. The total recognized reserve area of 1497.5 hectares equates to 5.78 square miles situated within the larger traditional territory of 11,000 square miles. T'it'q'et is located approximately 254 kilometres northeast of Vancouver, BC on Highway 99.[15] The housing list for T'it'q'et identifies a total of 120 homes, however, only 91 are currently occupied.[16]

According to Indigenous Services Canada's (formerly INAC) Indian Registry, as of May, 2018, there are a total of 427 registered status band members. On-reserve members make up 43.8% (or 186 members out of 427) with off-reserve members making up 56.4% (or 241 members) of the total community membership. The total male population (50.6% or 216 members) is nearly balanced with the female population (49.4% or 211 members).

However, it is important to note that the 2016 Census Data also shows that the population of T'it'q'et (named in the census as the Lillooet Indian Band)[17] slightly differs from numbers seen in the Indian Registry. The total band members number at a rate 30% greater, than was seen in the Indian registry, with 243 members. The census data shows that the community growth is strong as those members age 0-14 years of age (60/243 members) make up 25% of the total population. At the same time, T'it'q'et has an aging population. Members aged between 65 and

---

[14] Question 3 of the 21 point checklist

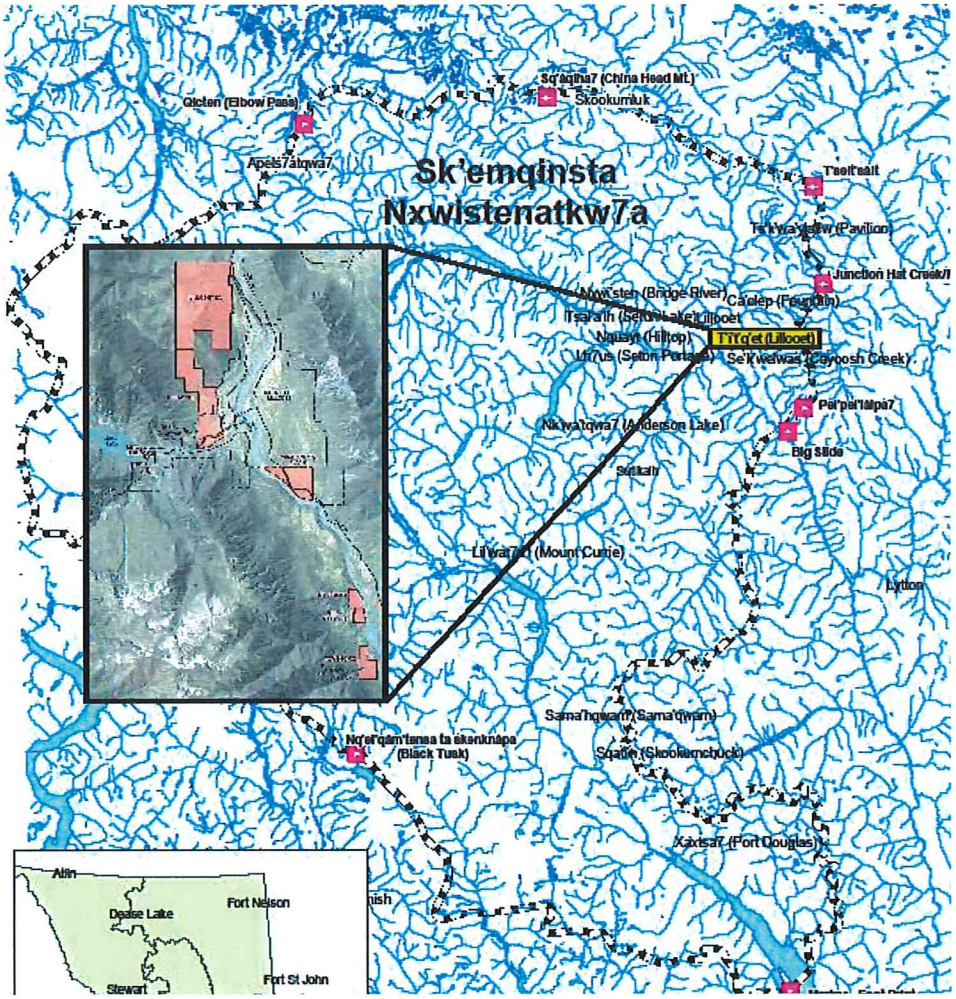
[15] From the *T'it'q'et Council Strategic Plan 2018-2023*, p. 8.

[16] As reported by Acting Health Director, S.S., June, 2018.

[17] https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=5931821&Geo2=PR&Code2=59&Data=Count&SearchText=Lillooet%201&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=5931821&TABID=1

85 years also make up 25% of the total population (60/243 members) suggesting that currently, T'it'q'et has an equally young and aging population.

Figure 10 Map of Community



The median age of T'it'q'et members is 33 years compared to the BC median age of 40.8 years.[18] Yet, there is a lowered life expectancy for residents of Lillooet according to the Local Health Area Profile (LHA, October, 2007).[19] The T'it'q'et population is included in Lillooet key health statistics thus, residents of Lillooet LHA have an expected life expectancy of 77.9 years compared to the Interior Health Region as a whole at 80.0 years.

Unfortunately, the unemployment rate for T'it'q'et residents is 30.4% compared to the BC average of 6%, according to the INAC statistics (2006).

From a community health plan perspective, it is important to understand who comprises the target population. In T'it'q'et, like most communities, it is a complex and mixed data set of categories. For example, it is important to know of community members, who are:

---

[18] From *T'it'q'et Council Strategic Plan 2018-2023*, p. 8.

[19] From the *T'it'q'et Council Strategic Plan 2018-2023*, p. 9.

- status band members,
- non-status band members,
- non-First Nation members and,
- (other) community members.

Community Health Planning and Wellness Needs Assessments require clear understanding of the target population as well as the changing trends found within the population. These trends would clarify the profile of the current population but also the population's expected growth over the next ten to twenty years. Finding specific trends has been difficult to uncover even after examining the numbers seen in the Indian Registry and the 2016 Census. Therefore, based upon data currently available and the scope of the project to update the community health plan, it was concluded that additional research is required. This additional work is important in order to not only plan for the growth in the population but more specifically, to assess community needs and meet those needs with appropriate service

VII. Performance Measurement

This renewed Community Multi-year Health and Wellness Plan will reflect the streamlining of cultural services. The revised health plan builds on the work of past years through our learning from both the successes and limitations of the past Health Canada funding agreement and existing programs. The development of this new plan will also take into account what is expected under the FNHA Funding Agreement Framework and the current needs of our community members.

At the same time as finalizing the goals within the community MYHWP, it is imperative to consider how the community will measure continuous improvement of health services and programming. How will the community know when they have successfully reached their health goals? Designing meaningful measures can be part of the overall discussion and review of the community MYHWP.

The chart provided below offers eight (8) steps in the performance measurement process. These steps offer guidance when considering the best possible data, analysis and reporting requirements for each of the measures. The outcome of the performance measurement process has the greatest impact when measurements are created alongside the development of the Needs Assessment. The concurrent creation of both performance measurements and surveys/questions allow a more meaningful process to occur. Each influence the other with short-term outcomes that result in the gathering of more targeted data and lessens the risk of over-collecting information that is not useful and may cause survey fatigue of community members. A draft performance measurement table has been included as part of the Continuum of Delivery. It is recommended that a researcher who has experience doing evaluation, support the community to further the development of meaningful performance measurements based on the criteria of health, wellness and building capacity. These criteria

came from the community's review of what makes a "Healthy and Thriving Community" (Sec 7.3 CCP, 2014).

Performance Measurement Process

Figure 10 Performance Measurement Process

VIII. Conclusion

The Continuum of Delivery is what organizes the T'it'q'et community strategic planning for the next five years. The Continuum of Delivery takes into account the traditional laws of the P'egp'íg'lha Nation and the sacred relationship with the land that provides the inherent right to live and thrive as a distinct People (St'at'lmc P'egp'íg'lha Constitution).

The T'it'q'et strategic planning model via the *Continuum of Delivery* is first and foremost inclusive of ancestral knowledge and values, as demonstrated by the seven sacred values, which are deemed fundamental to all other laws, policies and actions undertaken in the community.

The seven (7) sacred values focus on: balancing **health** (in four dimensions of spiritual, emotional, physical and mental), creating **happiness**, consideration of **future generations,** helping one another through **generosity**, demonstrating **pity/compassion,** utilizing our **power** to extend honour and respect at the same time as being equally responsible and accountable to ourselves and to our families/community, holding the virtue of **quietness**, that we listen to each other, to Creator, and to our Spirit Guides.

To that end, these seven (7) sacred values are embedded into the Continuum of Delivery at all levels of the health management activities and is cross-cutting with the indicators of success via the performance measurement.

Through the various levels of activities, the Continuum of Delivery will be used to: Set community priorities; organize goals for the short and long term; focus the planning and funding resources required to carry out the health plan; and strengthen the operations by ensuring clarity of annual goals, and health staff roles and responsibilities.

In addition, the Continuum of Delivery can be used to assess – and when required, used to adjust community priorities in response to the changing environment. Thus, the Continuum of Delivery is flexible; it can be adjusted accordingly to accommodate for reductions in funding and/or infusion of new monies. Furthermore, the Continuum of Delivery can adjust to new fiscal realities in health such as a young growing population in tandem with an aging population as well as recognizing when the indicators of success have been reached.

Finally, sharing community data with health authorities and governments creates synergy and establishes a more informed and strategic approach to community health and development. More importantly, community is collaborating and actively involved in achieving their own successful health outcomes. This dynamic is supportive of Nation-building and sovereignty.

APPENDIX A - 7.3 Healthy & Thriving Community

GOAL: To be a strong, healthy, unified community with services that support individuals and families.

(7.3) STRATEGY 1: Provide social and health support services that meet the needs of all of our members (on and off reserve).

Actions:

- Carry out a health needs assessment and develop service delivery strategies in consultation with community
- Incorporate the principles of the First Nations Health Authority into the P'egp'íg'lha health plan.
- Meet the needs of elders and people with disabilities
- Deliver health care workshops
- Incorporate alternative health and traditional healing practices
- Integrate traditional and contemporary approaches to health care
- Promote healthy lifestyles (ie encourage healthy diets and proper nutrition)
- Provide appropriate and specialized counselling services to community members
- Ensure health care is responsive to members' needs
- Align Health Department job descriptions to ensure that service delivery is responsive to the needs of the community
- Develop and Implement an Advocacy Plan
  (ie. ensure clients have access to necessary health services.)
- Establish health board for community involvement in keeping with the P'egp'íg'lha Governance structure
- Work with external agencies and the First Nations Health Authority to ensure programming and service delivery to the community remains consistent or is enhanced
- Establish professional Health services at new Health Centre open 7 days a week with access to medical services(emergency and clinic)
- Workshops
- Weight loss
- Healthy eating
- Health Staff needs to be available to community members and elders
- Address transportation needs to the extent possible for participation in community events
- Support members with mobility issues by seeking out funding sources for the purchase of medical equipment e.g., wheelchairs, crutches to enable those with mobility problems opportunities to engage in exercise
- Work toward a holistic approach to healing and self-reliance through inter-program coordination of services and facilities

(7.3) STRATEGY 2: Provide support, guidance and opportunities for youth to ensure they possess the skills, self esteem and capacity to live as powerful members of the community.

Actions:

- Provide youth the resources to build self-esteem and confidence
- Encourage and support positive role models and mentors for/by youth
- Provide opportunities for youth to participate in community events and activities in a leadership capacity
- Provide opportunities for youth to socialize and strengthen relationships with elders
- Support the youth strategic plan for addressing youth needs in the community including key issues and challenges
- Provide training and mentoring opportunities
- Provide youth council with the mandate and support necessary to initiate youth specific programming
- Promote programs and services that increase reading competencies

(7.3) STRATEGY 3: Build a strong, unified, safe community.

Actions:

- Holistically and comprehensively address health and social issues such as drug and alcohol abuse, violence, sexual abuse and suicide.
- Foster physical spiritual mental wellbeing
- Support treatment services for substance abuse
- Provide support services and programs to resolve and mediate conflict
- Celebrate success and accomplishments that builds self esteem and self worth (recognition)
- Promote respect and care for each other
- Support antiviolence programs and services in the community and workplace
- Address abuse issues (physical, mental, emotional, financial)
- More sharing /generosity/helping each other in the community
- Encourage and support members who feel isolated
- Support the community justice initiatives

(7.3) STRATEGY 4: Ensure that Elders' needs are being identified and met on an on-going basis.

Actions:

- Elders have proper care and the ability to live with health and dignity within the community. The wisdom and voice of the elders is protected and supported with the community and articulated within the governance of the community
- Involve Elders Council in health service planning
- Ensure Elders have a voice and role in the governance and social life of the community
- Ensure Elder's needs are understood and addressed within the community
- Ensure that Elders have the opportunity to express and pass their knowledge, wisdom and experience onto the younger generations
- Provide health care in keeping with Elders needs
- Support social activities and inclusion
- Implement specialized housing and assisted living to remain within the community and family
- Provide respite care to support families providing elder care and other families requiring this service

(7.3) STRATEGY 5: Promote and support a drug and alcohol free community.

Actions:

- Develop and Implement a community based detox program
- Provide support systems for people detoxing or transitioning from drug and alcohol treatment back into community
- Welcoming and honoring back community members that have returned from treatment
- Support programs for organizing sober activities
- Incorporate culturally appropriate treatment services
- Conduct a feasibility of a treatment facility (ie Regional Cooperative FNHA to spear-head)
- Provide transitional programs, services & activities
- Support families to attend treatment
- Encourage and support youth initiatives in addressing chemical dependencies
- Provide education programs on issues such as co-dependency and drug use amongst youth,
- Develop strategies by and for youth addressing the problem of drug abuse within the community

(7.3) STRATEGY 6: Promote and provide opportunities to pursue healthy lifestyles.

Actions:

- Develop a recreation plan that clearly identifies recreational needs and a strategic plan for pursuing the development of appropriate programming and infrastructure
- Educate community membership regarding the importance of living healthy active lives
- Encourage the development and implementation of traditional cultural activities and sports
- Provide support and encouragement for community members, particularly youth to participate in sports and activities, including team and individual sports Identify and pursue funding opportunities to support athletic interests of community members
- Provide opportunities in the community for activities and transportation such as trails interconnecting homes and facilities with lighting
- Recognize and celebrate community members who experience accomplishments in sports and active living
- Organize and support youth sports tournaments and competitions in the community
- Organize age appropriate exercise and fitness classes with tailored programs to match the physical abilities of the individual
- Support youth led opportunities for recreation such as outdoor playing fields, and Basketball courts (develop outdoor sports facilities)
- Search funding sources for the purchase of additional Fitness equipment, e.g. fitness equipment & weight

(7.3) STRATEGY 7: Build T'ít'q'et's food security.

Actions:

- Consult with community for the development of plans for T'ít'q'et agricultural production for local food consumption as well as local agricultural markets
- Enhance T'ít'q'et capacity for food production
- Position T'ít'q'et as a stakeholder in the local agricultural market
- Undertake an agricultural resources assessment to determine the viability and options food and produce production in the community
- Develop and implement an agriculture and food security strategy for the community
- Provide opportunities for training community members in gardening, horticulture and agriculture
- Undertake a feasibility assessment for providing produce and niche agricultural products to the local and regional market

- Examine options for the development of food co-ops for local community members
- Explore options for developing greenhouses to extend the growing production season and the products available to the community
- Continue to enhance the use and production of existing community gardens

(7.3) STRATEGY 8: Support Family Unity.

Action:

- Continue to strengthen the participation of families within the community
- Support community events to build camaraderie and understanding between families and strengthen community relationships
- Engage parents/caregivers in discussions and plans to keep children with their families
- Focus on parenting (providing programs for parenting skills and support services or develop programs to support parents)
- Ensure financial support for families/children -to keep families together – and ensure that a financial burden does not fall on those with limited or fixed income ie grand-parents
- Ensure availability of appropriate counselling services for children and families in the reunification process
- Seek political alliances for improved child and families services

(7.3) STRATEGY 9: To build a healthy, united community that values personal responsibility and contribution.

Actions:

- Work with other communities to build a Wellness Centre for the benefit of the Upper St'át'imc.
- Explore ways to integrate the proposed Wellness Centre with other/future developments (e.g. an apartment development).
- Develop and maintain Terms of Reference, Policy and Guidelines for all T'ít'q'et human development programs and services.
- Provide policy development training for members.
- Provide support services for those returning to the community.
- Acknowledge new members and those returning to the community by potlatching or ceremony.
- Explore opportunities to partner with other communities to build a Transition House.
- Take control of Child Welfare Services
- Promote and support greater parent and community participation in the education school age children

APPENDIX B – Continuum Of Delivery

CONTINUUM OF DELIVERY FOR THE COMMUNITY OF T'IT'Q'ET 2019-2024

(to be completed in collaboration with community staff)

Spectrum of Care

Funding Category	Health Promotion & Disease Prevention							Public Health							Primary Care	
Program Clusters	Healthy Child Development Goal:		Mental Wellness Goal:		Healthy Living Goal: Promote well-being of the individual in all aspects mentally, physically, emotionally, and spiritually and prevent disease and morbidities			Communicable Diseases Goal:					Environment: Safe Drinking Water (**m**) Goal:		Clinical Care Goal:	Home & Community Care (**m**) Goal:
Programs & Services	Healthy Development:	Oral Health	Mental Health & Suicide Prevention	Substance Abuse Prevention & Treatment	Chronic Disease	Injury Prevention	Health & Aging	Disease Control & Management - Immunization (**m**)	Blood borne & sexually transmitted	Respiratory	Emergency	Community Nursing (**m**)	Environmental Health	Research		HCC
Community Goals **Year 1**							Elder Care: Maximize health for elderly and Minimize need for institutionalized care									
Year 2																
Year 3																
Year 4																
Year 5							Elder's access to									

							new Facility									

First Nations Health Benefits

Funding Category	First Nations Health Benefits								
Program Clusters	First Nations Health Benefits Goal:								
Programs & Services	First Nations Health Benefits	Medical Transportation	Mental Health Counseling & Crisis Intervention	Dental Care	Pharmacy	Supplies & Equipment	Vision Care	Community Dental	Visiting Health Care Professionals
Community Goals Year 1 *Taken from the 2010-2015 T'it'q'et Health Plan		To provide financial assistance to members in need, to attend medical appointments outside of the community.	Building Healthy Communities: To provide a quality, safe and community based mental health program to the community						
Year 2									
Year 3									
Year 4									
Year 5									

T'it'q'et Management Structure

Funding Category	**Capacity**							**Transformation**				
Program Clusters	Planning & Quality Goal:			Human Resources Goal:		Facilities Goal:		Systems Integration Goal:	e-Health Goal:			Nursing Innovation Goal:
Programs and Services	Management	Accreditation	Consultation & Liaison	Staffing	Careers	Capital O&M	Security Services		Info-structure	Solutions	Coordinator	
Community Goals **Year 1** Taken from the T'it'q'et 2010-2015 Health Plan			Update community health needs assessment to inform on-going & future health planning. See attached BN.			Capital Project: Health Centre, Prepare proposal for the construction of health centre by 2024.						
Year 2												
Year 3												

Year 4												
Year 5												

PURPOSE: HEALTH PERFORMANCE MANAGEMENT MEASURES CHART ***Have We Achieved Health?***				
	CULTURAL IDENTITY STRENGTHENED	TRADITIONAL HEALTH PRACTICES INCORPORATED	PERSONAL AND FAMILY HEALTH AND WELLNESS JOURNEYS	HEALTHY LIFESTYLES EATING AND ACTIVITIES
HEALTHY LIVING GOAL : (T'it'q'et decides what this is)				
WHAT ACTIVITIES AND OUTPUT?				
HOW?				
RESOURCES?				
WHO?				
REACH?				
SHORT TERM MEASURES AND OUTCOMES				

LONG TERM MEASURES AND OUTCOMES				
RESULTS				

PURPOSE: WELLNESS PERFORMANCE MANAGEMENT MEASURES CHART *Have We Achieved Wellness?*				
	HOLISTIC HEALTH AND SOCIAL DETERMINANTS	DECOLONIZATION AND FORGIVENESS	ADDRESSING SUPPRESSIVE BEHAVIOURS	YOUTH, ELDER AND COMMUNITY INTERACTION
WELLNESS GOAL : (T'it'q'et decides what this is)				
WHAT ACTIVITIES AND OUTPUT?				
HOW?				
RESOURCES?				
WHO?				
REACH?				
SHORT TERM MEASURES AND OUTCOMES				

LONG TERM MEASURES AND OUTCOMES				
RESULTS				

PURPOSE: BUILDING CAPACITY PERFORMANCE MANAGEMENT MEASURES CHART ***Have we achieved what we want with respect to building capacity?***				
	EDUCATION AND STAFFING	RETIREMENT PREPAREDNESS	WORKING WITH OTHERS RELATIONSHIP WITH FNHA	BUILDING RELATIONSHIPS WITH FEDERAL & PROVINCIAL GOVERNMENTS
BUILDING CAPACITY GOAL : (T'it'q'et decides what this is)				
WHAT ACTIVITIES AND OUTPUT?				
HOW?				
RESOURCES?				
WHO?				
REACH?				
SHORT TERM MEASURES AND OUTCOMES				

LONG TERM MEASURES AND OUTCOMES				
RESULTS				