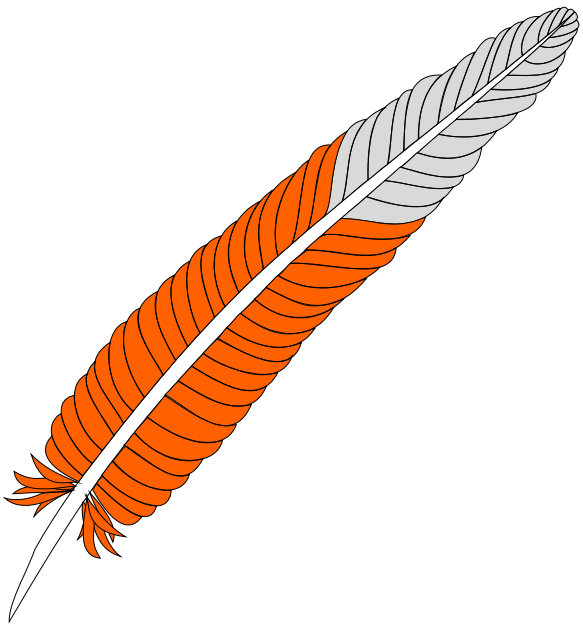
Health Canada Santé Canada

Transfer of Health Programs to First Nations and Inuit Communities

Handbook 2
The Health Services Transfer



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Business Planning and Management Directorate
First Nations and Inuit Health Branch
Health Canada

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About This Handbook

Purpose

This Handbook is the second of three handbooks that provide information about the transfer of control of Indian and Inuit health programs from the federal government to First Nations and Inuit communities. This handbook provides details about Health Services Transfer for Band Councils, Tribal Councils, and other First Nation and Inuit organizations, as well as for managers and transfer officers in the First Nations and Inuit Health Branch of Health Canada.

This handbook describes the components of the Community Health Plan (CHP) and the process, procedures and policies for Transfer. The information in this handbook will be useful to Band and Tribal Councils and other First Nation or Inuit organizations which have decided to proceed with Transfer.

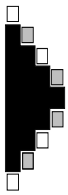
The CHP is the key document for discussions between the community and FNIHB working toward a Transfer Agreement. The CHP provides details about the community, its identified health needs, and all aspects of how the community will deliver health services and programs under a Transfer Agreement.

Is Transfer Appropriate for My Community?

If you are not sure if the Transfer approach is appropriate for your community, and need more information on community and program eligibility, read *Handbook 1 - An Introduction to Three Approaches*. Handbook 1 provides an overview of three options for the delivery of health services:

- the Health Services Transfer approach
- Integrated Community-Based Health Services approach
- Self-Government.

Using This Handbook



This handbook describes transfer of control of health programs to First Nations and Inuit communities south of the 60th parallel.

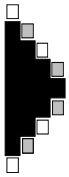
Use this handbook as the primary source document for completing the Community Health Plan. Read it from cover to cover or choose the sections from the Table of Contents that you want to know more about. Use the references in each section to find other documents that have more details on specific topics. Some regional variations may exist such as regulations governing certain health professionals and environmental protection under provincial jurisdiction.

Additional Information You Will Need – Handbooks 1 and 3

The first handbook, *Transferring Control of Health Programs to First Nations and Inuit Communities: Handbook 1 - An Introduction to Three Approaches,* provides an introduction to the approaches for transfer of control of health programs and summarizes First Nations and Inuit Health Branch (FNIHB) policies concerning control of health programs by First Nations and Inuit communities across Canada. Handbook 1 contains information you will need before using Handbook 2. The third handbook, *Transferring Control of Health Programs to First Nations and Inuit Communities: Handbook 3 - After the Transfer—the New Environment,* explains what happens during implementation of Transfer.

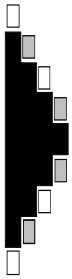
Keeping Up to Date

The three Handbooks together update earlier FNIHB documents on transferring health programs to First Nations and Inuit control.



If there are any other handbooks or documents providing policy statements that conflict with the contents of these Handbooks, the policies in these Handbooks are the ones to follow.

The relationship between the federal government and Aboriginal people across Canada is evolving. FNIHB regularly reviews its policies on transfer of control of health programs to make sure they support this renewed relationship.



To ensure that you have the most current version of Handbook 1, 2, or 3, contact the Regional Office of FNIHB or go to the FNIHB website:

http://www.hc-sc.gc.ca/fnihb

Handbooks 1, 2 and 3 can be downloaded from the FNIHB website. Changes which affect the Handbooks will be posted regularly on the website.

The Three Phases of Transfer

1

What Are the Major Steps Involved in the Health Services Transfer Approach?

- **Pre-Transfer Planning Phase:** During this phase, communities initiate the process, enter into discussions with FNIHB, begin planning, obtain pre-transfer funding and complete the first four components of their Community Health Plan (CHP). This phase takes about 12 months to complete.
- **Bridging Phase:** In this phase, planning continues. The next eight components of the CHP are completed. Representatives from the community work with regional staff from FNIHB to establish a Memorandum of Understanding (MOU) based on the research done in preparing the CHP. The Bridging Phase usually takes nine months to complete.
- **Implementation Phase:** This phase begins when the community and FNIHB sign the Health Services Transfer Agreement. During this phase, the community manages its own health programs in accordance with the signed Transfer Agreement and the CHP. The last three components of the CHP must be completed within the first year of this phase. (The community may choose to complete two of these last three components, the Training Plan and Emergency Preparedness Plan, in the Bridging Phase.)

Figure 1 lists the phases of Transfer and the fifteen components of the CHP.

Figure 2 provides a broader overview of the Framework for Transfer.

Criteria for Pre-Transfer Planning

To be eligible to begin the planning process for the Transfer approach, a community must provide:

- a mandate as evidenced by a Band Council Resolution (BCR) or other form of approval appropriate to the Band(s) or Inuit group(s) granting the mandate
- evidence of successful financial and administrative experience in program management.

Successful experience in management of programs and finances need not necessarily be in health but may be in areas such as education, social services, and economic development.

Proposals may be from a Band, or from a group mandated by a number of Bands and supported by Band Council Resolutions or other formal mandate, or from an Inuit community. Proposals must establish a schedule leading up to Transfer and have a clear link between developmental activities and Transfer. The planning activities which are conducted during the Pre-Transfer Planning Phase and the Bridging Phase must lead to the development of a Community Health Plan and the decision whether or not to enter into a Transfer Agreement.

Figure 1: Phases of Health Services Transfer With Components of the Community Health Plan to be Completed

Phase 1 ←

Pre-Transfer Planning (1 year)

- Community Health Priorities and Needs (as identified in the Community Health Needs Assessment)
- Proposed Health Management Structure
- Management and Delivery of Mandatory Programs
- Management and Delivery of Community Health Programs

Phase 2 ←

Bridging (9 months)

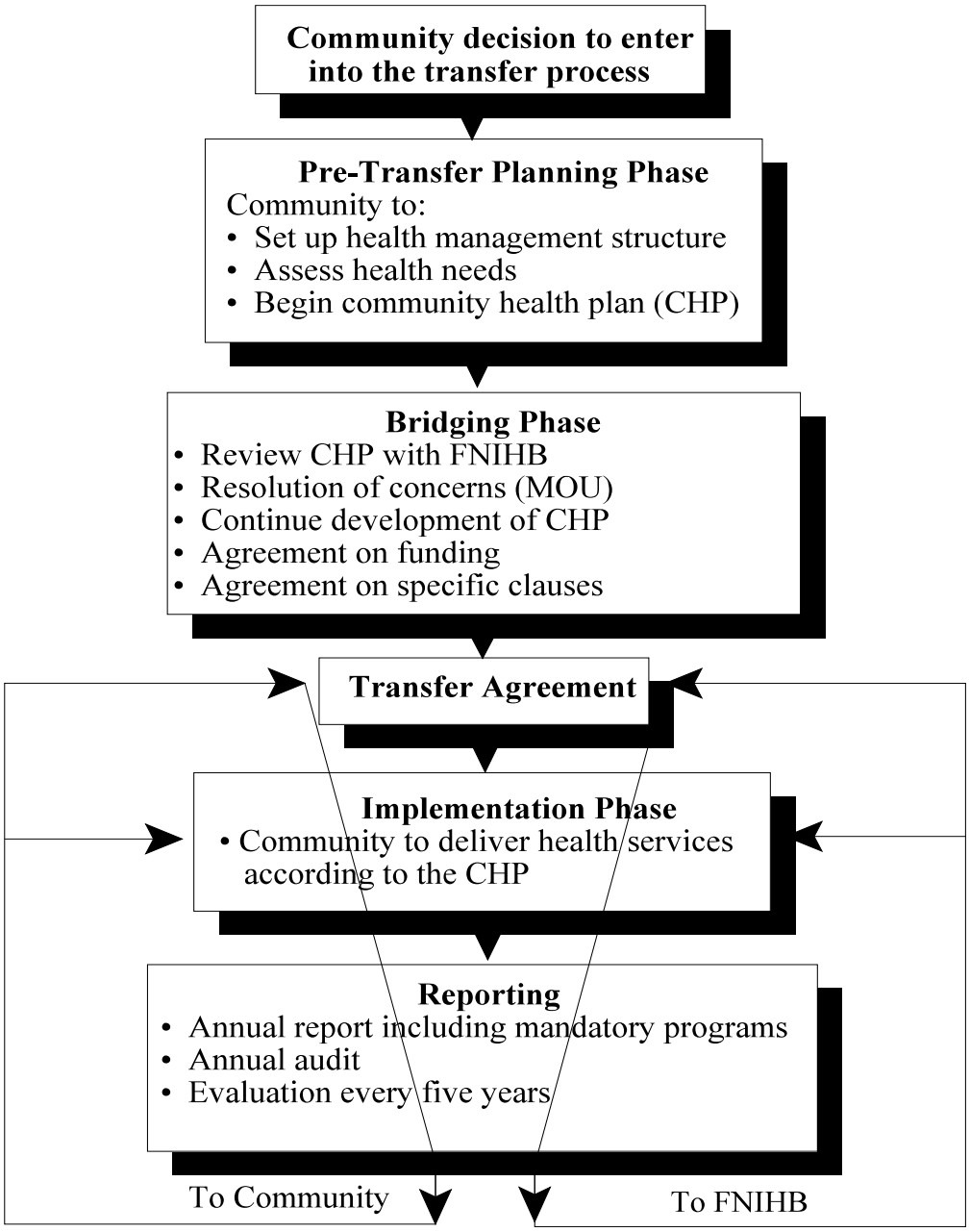
- Medical Officer of Health Services
- Liability and Malpractice Insurance
- Drugs and Medical Supplies
- Moveable Assets Reserve (MAR)
- Confidentiality Procedures
- Accountability and Reporting Mechanisms
- Professional Supervision
- Comprehensive Budget

Phase 3 ←

Implementation

- Training Plan (may be completed in the Bridging Phase)
- Emergency Preparedness Plan (may be completed in the Bridging Phase)
- Evaluation Plan (to be completed in the first year of Transfer)

Figure 2: Framework for Transferring Health Programs to Community Control



Based on Exhibit 13.11, Report of the Auditor General of Canada to the House of Commons, October 1997, Chapter 13, Health Canada - First Nations Health, pages 13-17.

Funding and Technical Support for Planning Transfer

Funding and technical support are provided to communities during all of the planning phases for Transfer as shown in Table 1. Funding is provided for the following planning activities:

- conducting the initial Community Health Needs Assessment (CHNA)
- establishment of a health management structure
- training needed during the planning process
- preparation of the 15 components of the Community Health Plan (CHP).

Communities planning for Transfer have access to one-time funds for conducting the initial Community Health Needs Assessment. This funding is based on the community population approved by FNIHB. (See Appendix A for the formula used to calculate the funding for the CHNA.)

Funding to support the establishment of a health management structure is determined by a Health Management Formula based on the population of the community and how remote it is. During the Pre-Transfer Planning Phase, the 50% Health Management Formula is used to calculate the support. (See Appendix B for the 50% formula used to calculate this funding.) Funding is calculated at 50% because communities are not yet managing programs but are doing the planning needed for management in the future. Regardless of how long the community takes to complete the activities in the Pre-Transfer Planning Phase, the funding given for the health management structure is the 50% formula amount *for one year.*

Funding to support the health management structure during the Bridging Phase is calculated using the 100% Health Management Formula. (See Appendix C for the 100% formula used to calculate this funding.) The funding increases from the 50% formula to the 100% formula in this phase because the health management structure is now functional. Regardless of how long the community takes to complete the activities in the Bridging Phase, the funding given for the health management structure is the 100% formula amount *pro-rated for nine months.*

Communities receive one-time funding for training needed during the planning process. They also receive funding to prepare their CHP in separate installments in each of the three phases.

Throughout all of the planning activities, funding continues for delivery of programs and services. Figure 3 provides a list of programs and services which are eligible for community control through a transfer arrangement. For a summary of all financial aspects of Transfer, including funding after Transfer is achieved, see Appendix D.

Table 1: Planning Activities and Related Resources for the Transfer Approach

Transfer Approach[1]	
Key Planning Activities	**Planning Resources**
Pre-Transfer Planning Phase Time Frame: 1 year • Submit planning proposal with BCR (or other approval appropriate to Band(s) or Inuit group(s) granting the mandate) and letter of audit • Conduct Community Health Needs Assessment (CHNA) • Establish community health management structure and provide training • Develop first 4 components of Community Health Plan (CHP): identify community health priorities; describe health management structure; describe management and delivery of mandatory programs; describe management and delivery of community health programs. • Decide on technical support needed from FNIHB staff.	• $38,000 - $96,000 (CHNA)[2] (per project) • One-time funds for pre-transfer training: $10,000 (per community) • $9,000 (per project) for 4 CHP components • 50% of management formula funding[3]
Bridging Phase Time Frame: 9 months • FNIHB reviews CHP to date • Develop 8 components of CHP to describe provisions for: Medical Officer of Health services; liability and malpractice insurance; drugs and medical supplies; moveable assets reserve; confidentiality procedures; accountability and reporting; professional supervision; comprehensive budget. • FNIHB reviews CHP. • Memorandum of Understanding signed.	• $15,000 for 8 CHP components • 100% of management formula funding[4] pro-rated for 9 months
Implementation Phase • 3 to 5 year Transfer Agreement signed. • During first year of agreement, develop final 3 components of CHP to describe plans for: training after Transfer[5]; emergency preparedness[5]; and evaluation.	• $2,000 for training plan • $5,000 for emergency preparedness plan • $11,000 for evaluation plan

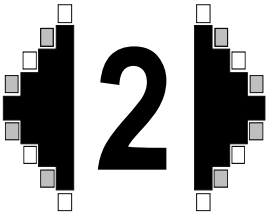
[1] Throughout all of the planning activities funding continues for delivery of programs and services.
[2] See Appendix A
[3] See Appendix B
[4] See Appendix C
[5] Training and emergency preparedness plans may be completed in the Bridging Phase.

Figure 3: Eligible Health Programs and Services Under the Transfer Approach

- **Brighter Futures**
- **Building Healthy Communities - Mental Health Crisis Management**
- **Building Healthy Communities - Solvent Abuse Program**
- **Canada Prenatal Nutrition Program** (excluding Development Funds)
- **Community Health Promotion and Injury/Illness Prevention**
  - Community Health Representatives
  - Community Nursing
  - Nursing Training
  - Support Services to Community Health
  - Health Education
- **Community Health Primary Care**
  - Community Nursing *
  - Support Services to Community Health
- **Dental Therapy** *
- **Environmental Health Program**
- **Health Careers** (excluding bursaries and scholarships)
- **Health Services**
  - Operations and Maintenance of Facilities and Residences
  - Communicable Disease Control
  - Health Board and Health Co-ordinators
- **National Native Alcohol and Drug Abuse Program**

* Limitations apply in some provinces because of the absence of applicable legislation.

Pre-Transfer Planning Phase

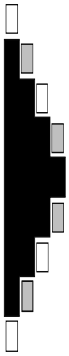


What is the Purpose of the Pre-Transfer Planning Phase? What Resources Are Available?

The purpose of Pre-Transfer Planning is to build health management capacity at the community level and to provide communities with time and resources to begin preparation for Transfer. Communities already are delivering community health programs through Contribution Agreements may have completed much of the work required in this phase.

Two things are assumed to have happened before a community enters this phase. First, its leaders have consulted with their community about what Transfer means. Second, the community agrees that its leaders should explore the possibility of taking over responsibility for delivering community health services. Communities also may have completed the Pre-Transfer Planning Proposal. Preparing the proposal allows communities to think through in advance many issues that they will need to resolve in preparing for Transfer.

A community sets its own schedule for completing planning activities and decides how it will carry out the necessary work. The Pre-Transfer Planning Phase can take up to 12 months to complete. FNIHB has established one-time funding and formulas for the resources a community will receive for completing each task in the Pre-Transfer Planning Phase as shown below:



• ***Community Health Needs Assessment***	• ***Funding by formula (see Appendix A)***
• ***Four components of the CHP***	• ***$9,000 to prepare all four components (per project)***
• ***Health Management Structure***	• ***50% management formula funding (see Appendix B)***
• ***Training***	• ***$10,000 (per community)***

Components of the Community Health Plan to be Completed

During the Pre-Transfer Planning Phase, communities conduct the Community Health Needs Assessment, set up their health management structure (called the health board or authority in this document) and train Health Board members, as well as any community members who will be participating in the preparation of the CHP.

Communities also prepare the first four components of their CHP. These components are:

- Community Health Priorities and Needs (as identified in the Community Health Needs Assessment)
- Health Management Structure
- Management and Delivery of Mandatory Programs
- Management and Delivery of Community Health Programs.

The following sections provide the requirements for the first four components of the CHP. The 15 components of the CHP are numbered CHP-1 to CHP-15 throughout this Handbook.

Although the Evaluation Plan component of the CHP is not prepared until the Implementation Phase, consideration of how the community will review and evaluate its own programs must begin during the preparation of the first four components of the CHP. Tasks related to evaluation are described in the relevant component sections that follow.

CHP-1 Community Health Priorities and Needs

Identifying community health priorities and needs through a Community Health Needs Assessment (CHNA) is an important research activity that is conducted at the beginning of this phase. Communities with experience in administering community-based health care programs and which have conducted a recent community assessment may use the results for their CHP.

Assessing community health needs involves surveying a minimum of 30 percent of the community to find out which health care problems are most prevalent and need most attention. The community can use this information to set its priorities in designing health care programs and services that will best meet its needs.

The Community Health Needs Assessment is the key basis for the CHP. It provides the foundation for all community health planning and as such must be completed carefully to ensure that it is representative of the community (appropriate sample size), addresses the real needs of community members (the right questions), and involves proper and accurate analysis and summary (report). For more information on carrying out the assessment, refer to *A Guide for First Nations in Developing a Community Health Needs Assessment*, available from FNIHB. Appendix A provides the formula used to calculate funding for communities completing the needs assessment.

CHP-2 Health Management Structure

The CHP must include a description of the structure that the community plans to use to manage the health programs and services. This component of the CHP includes:

- a brief description of the roles and responsibilities of each of the following as they relate to the transfer of community health services: Chief and Council, Health Portfolio Councillor, Community Health Board/Authority
- detailed job profiles including roles, responsibilities, qualifications, experience required, and the lines of supervision of all health services personnel to be involved in providing community health services after Transfer for:
  - all health care staff identified in the CHP under mandatory public health and safety programs and the community health programs
  - nurse practitioners (or nurses with extended duties) and dental therapists
  - support staff positions required to assist health care staff identified above
- an organization chart showing the reporting relationships of each of the health care staff positions to the proposed health management structure outlined above
- the personnel policies to be implemented including policies on:
  - salary levels, benefits and hours of work
  - professional registration and licensing
  - professional supervision
  - liability and malpractice insurance
  - confidentiality of medical records
- the benefits package to be offered to the health care staff.

For more information on establishing a health management structure, see Appendix E, Guide to Health Management Structures for First Nations.

Any questions related to human resources should be directed to the Regional Office of FNIHB.

CHP-3 Management and Delivery of Mandatory Programs

Three transferrable programs are "mandatory"—they must be available in all communities to ensure that provincial health and safety regulations are met. The mandatory health programs are:

A. Communicable Disease Control including Immunization

B. Environmental/Occupational Health and Safety

C. Treatment Services

Given the identification of the above programs as mandatory, the following services have been identified as mandatory, i.e., essential to meet mandatory program requirements:

- Environmental Health Services
- Medical Officer of Health Services
- Professional Nursing Supervision

For each mandatory program, the Community Health Plan must include information on its objectives, activities, indicators of effectiveness, and record-keeping systems. This information is the basis for communities to evaluate their mandatory programs later on to find out how effective they have been in maintaining or improving the health of the community.

Under a Transfer Agreement, a community is expected, *as a minimum,* to meet the requirements of mandatory programs. The following information is required for inclusion in the CHP for the mandatory programs:

A. Communicable Disease Control

The CHP must address both parts of Communicable Disease Control—communicable diseases and immunization:

1. Communicable Diseases

- the objectives of the Communicable Disease Control Program
- a list of the reportable diseases that must be reported monthly to provincial health officials after Transfer (obtain the most up-to-date list from your Transfer Officer)
- a description of the types and schedule of activities required to deliver the Communicable Disease Control Program
- the day-to-day records to be kept so that the community can:
  - report the monthly number of communicable disease cases to the province after Transfer
  - provide the information needed to complete the annual reporting requirements and to evaluate the effectiveness of this program
- the health care staff who will be responsible for maintaining these records and for preparing and submitting the required reports
- a list of the staff positions required to deliver a Communicable Disease Control Program
- a list of health care staff who will carry out the following tasks associated with the Communicable Disease Control Program: diagnosis, treatment, management of the outbreak, contact tracing and follow-up.

2. Immunization

- the objectives of the Community Immunization Program
- an outline of the immunization schedules and the activities planned for controlling diphtheria, pertussis (whooping cough), tetanus, poliomyelitis (DPTP); heamophilus influenza type b (Hib); hepatitis B; and measles, mumps and German measles (rubella) (MMR)

- the indicators that will be used to evaluate the effectiveness of the transferred Community Immunization Program in meeting its objectives
- the daily records to be kept so that the community can report the immunization levels to the province after Transfer, and provide the information needed to complete the annual reporting requirements and to evaluate the effectiveness of this program
- the health care staff who will be responsible for maintaining these records and preparing and submitting the required reports
- a list of the staff positions required to fulfil the requirements of the Community Immunization Program
- a plan for the use of the *BCG* vaccine against tuberculosis as recommended in the Canadian Immunization Guide
- a plan for using hepatitis A, influenza (flu), meningococcal, pneumococcal and varicella (chickenpox) vaccines if it were to become necessary to immunize community members
- how the community will deal with a resident who puts others at risk of contracting a communicable disease. (Specifically, the CHP must indicate whether the community will use provincial public health legislation or a health bylaw or Band Council Resolution to handle the situation).

B. Environmental/Occupational Health and Safety

Both the federal and provincial governments play a role in the environmental health program. The federal government is responsible for the Environmental Health Program on-reserve, and the provincial government is responsible for environmental health matters off-reserve in accordance with the Canadian Environmental Assessment Act (CEAA).

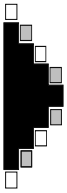
The environmental health program is based on the idea of sustainable development, i.e., development that meets the needs of the present generation without compromising the ability of future generations to meet their own needs. Sustainable development means:

- efficient and environmentally responsible use of natural resources
- balancing of economic, social and environmental goals
- preventing, minimizing or mitigating any adverse effects of development, including environmental risks to health such as the contamination of air, water, soil or food.

The CHP must include:

- the objectives for the Environmental Health Program
- the types of inspection activities that will be needed to deliver the Environmental Health Program, how often these activities will be carried out, and the planned inspection schedule for each of the following: water supplies; sewage disposal; solid waste (garbage) disposal; all food-service facilities; all public facilities (including recreational and institutional facilities); special events (such as pow wows); and housing
- the indicators that will be used to determine whether this program has been successful in meeting its objectives

- the records to be kept so that the community can both report to the provinces each year on safety inspections and violations, and provide the information needed to complete the annual reporting requirements and to evaluate the effectiveness of this program in the future
- the person who will be responsible for maintaining these records and for preparing and submitting required reports
- the provisions for investigating communicable diseases
- the person (Environmental Health Officer) who will be responsible for inspecting, testing and sampling the above (must be a Certified Public Health Inspector [Canada]; community health representative or other members of the community health team may collect environmental health samples and perform tests under the direction of the Environmental Health Officer)
- how the community will deal with any environmental health hazards. Specifically, the CHP must indicate whether the community will use provincial public health legislation, a health bylaw or Band Council Resolution (or a combination of these) to deal with the health hazard.



Communities can receive assistance from the Regional Environmental Health Manager in developing a suitable Environmental Health Inspection Program. The booklet entitled, "Your Environmental Health Program", describes the core activities involved in developing such a program.

C. Treatment Services

All communities must complete the following items in their CHP:

- the location where community members will generally receive the following services:
  - primary care treatment
  - specialist referrals
  - hospitalization
  - rehabilitation services
  - institutional services (e.g., substance abuse treatment)
  - home care
- the health care staff who will be responsible for arranging the following services:
  - referrals to specialists
  - medical transportation
  - accommodation near the referral site
  - follow-up
- the records to be kept so that the community can provide the information needed to complete the annual reporting requirements and to evaluate this program.

If treatment services currently provided directly in the community are to be included in the Transfer Agreement, the following conditions apply:

- Treatment centres/programs already have the health management capacity in place, in the form of a corporate entity and a Director.
- The transfer of treatment programs for Alcohol, Other Drugs and Youth Solvent Abuse, consists of the transfer of one program only. Therefore, an extensive planning period and the completion of a Community Health Plan would not be required. However, the operational or business plan, and supporting policies and procedures for the centre operations would need to be reviewed to ensure the programs are described and that objectives, job descriptions and personnel policies are in place.

A special policy exists for Treatment Programs for Alcohol, Other Drugs and Youth Solvent Abuse, primarily the National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Treatment Program (NYSATP). For more information, see Chapter 5, Other Transfer Issues. The policy on the Transfer of Treatment Programs for Alcohol, Other Drugs and Youth Solvent Abuse is available from FNIHB Regional Offices.

Table 2 summarizes the reporting requirements for mandatory programs once Transfer is completed.

Table 2: Mandatory Programs and Their Reporting Requirements

The community must report to the federal Minister of Health on the provision of mandatory programs according to the following schedule:

Programs	Information Required	Method/Frequency of Reporting
Communicable Disease Control	• Immunization levels (by age, sex, antigen)	• Annual according to the federal or provincial immunization schedule identified in the Community Health Plan
	• Report on communicable diseases as required by provincial regulation; including contact-tracing and follow-up	• Notification to province and department within 24 hours of diseases with epidemic potential • Annual Summary
Environmental Health	• Total number and percentage of facilities meeting provincial/federal health and environmental standards; food services; water supply; sewage and garbage; pollution; and hazardous substances	• Annual Summary • Notification within 24 hours of environmental hazards or conditions which may have any significant environmental impact; including steps taken to remedy the situation
Treatment Services*	• Total number of patients seen in diagnostic categories as specified in the Community Health Plan	• Annual Summary

* Only if treatment services are part of the Transfer Agreement.

CHP-4 Management and Delivery of Community Health Programs

Having completed the Community Health Needs Assessment, the community already will have identified priorities for its community health programs. These programs are in addition to the mandatory programs described in the previous section. The CHP should identify the following information related to community health programs:

- the name of each community health program
- the objectives for each program
- a description of the types and frequency of activities required to deliver these programs
- a list of indicators to be used to evaluate the extent to which each program has been successful in meeting its objectives
- the day-to-day records to be kept, such as morbidity and mortality rates, so that the community can evaluate the effectiveness of its community health programs
- the number and type of staff required to deliver each community health program.

Descriptions of community health programs should address how basic information will be collected that is needed to:

- describe what the program is trying to achieve
- describe implementation processes
- identify community impacts
- monitor progress against objectives
- demonstrate program effectiveness.

Figure 4 provides a checklist of considerations in each of these areas.

In addition, early in the process, communities need to identify the indicators of effectiveness and the sources of information on these indicators for each health program to allow them to conduct evaluations of community health programs at a later date. For further information on evaluation, see section CHP-10 and *A Guide for First Nations and Inuit Health Authorities on Evaluating Health Programs,* available from FNIHB.

Figure 4: Program Planning Checklist

A. Program Description

1. What is the program trying to achieve?

- ❑ Are objectives clearly defined?
- ❑ Where are they stated? (e.g., project proposal, pamphlet, other publication)
- ❑ Are they measurable? (i.e., specific targets identified)
- ❑ Do all program members agree on the objectives? (i.e., consensus, consultations have taken place)
- ❑ Are the agreements documented?

2. How is the program attempting to achieve it?

- ❑ Are descriptive documents available? (e.g., logic models, pamphlets, publications, etc.)
- ❑ Are formal planning documents available?
- ❑ Have the plans and program documents been agreed to by all parties?
- ❑ Have budgets and schedules been established, agreed to and approved?
- ❑ What progress reporting mechanisms have been established?
- ❑ Do we have access to the information?
- ❑ If not, who do we contact to discuss arrangements?

B. Process/Implementation

1. What has the program done?

- ❑ Are we collecting ongoing information for all participants?
- ❑ Information includes items such as:
  - events - # of participants, demographics
  - resources - products and utilization
  - training - #, composition, quality
  - consultations - #, nature, results
- ❑ Do we have progress reporting for all participants?
- ❑ Do we have access to evaluation and feedback forms, records, information systems data?
- ❑ How do we obtain access to needed information?
- ❑ Do we know of others collecting related information? Have we contacted them? Do we have agreements to share information?

C. Community Impacts

1. Who has been reached by the program?

- ❑ Do we have accurate and reliable information on our client groups?
- ❑ Do we have information on program participation or utilization rates?
- ❑ Do we know if others are collecting information on program participation?
- ❑ Are we developing event and resource evaluation forms?
- ❑ Are we keeping accurate consultation records, follow-up services, etc.?
- ❑ Are client surveys required?

2. What has been achieved as a result of the program?

- ❑ Is there interest and demand for our products and services?
- ❑ What evidence do we have of this?
- ❑ Are client groups and others adopting our policies, models, and strategies? What evidence do we have?
- ❑ Are clients using and/or providing feedback on our proposed concepts and themes?
- ❑ Have we enhanced the health-related abilities of our clients? What evidence do we have?
- ❑ What community action has resulted? Is it attributable to our program?
- ❑ What evidence do we have?

D. Monitoring Against Objectives

1. Are we getting closer to the objectives of the Program?

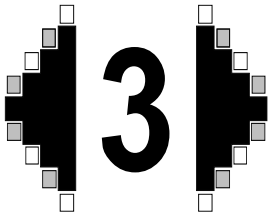
- ❑ Do we have data on the prevalence of the issue? (locally, provincially, nationally)
- ❑ Can we access resources (i.e., expertise) for secondary data analysis of relevant national or provincial surveys and relevant resource studies?
- ❑ Do we have local data in these areas?

E. Program Effectiveness

1. Are programs effective?

- ❑ Do we have access to formal evaluation research?
- ❑ Are we conducting formal process or evaluation studies?
- ❑ Are we conducting literature reviews in applicable areas?
- ❑ Can we obtain access to expertise in these areas?

Bridging Phase



What is the Purpose of the Bridging Phase? What Resources Are Available?

The Bridging Phase is a period when many of the decisions are made about how the community will manage its health services. Eight components of the CHP are developed in this phase. This phase takes up to nine months and when it ends, most of the CHP has been completed, a Memorandum of Understanding (MOU) is signed and the Transfer Agreement is being approved.

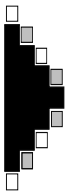
As seen earlier in Table 1, funding is available in the Bridging Phase as follows:

- to support the health management structure (100% of management formula funding, pro-rated for nine months)
- to prepare components five to twelve of the CHP ($15,000).

Components of the Community Health Plan to be Completed

Communities continue to plan how they will manage their health programs and services and prepare the next eight components of their CHP. These components are:

- Medical Officer of Health Services
- Liability and Malpractice Insurance
- Drugs and Medical Supplies
- Moveable Assets Reserve
- Confidentiality Procedures
- Accountability and Reporting Mechanisms
- Professional Supervision
- Comprehensive Budget.



In addition, during the Bridging Phase, the community and FNIHB work on finalizing the Transfer Agreement which is based largely on the first 12 components of the CHP. Information on finalizing the Transfer Agreement appears at the end of this chapter.

The following sections provide the detailed requirements of components five through twelve of the CHP.

CHP-5 Medical Officer of Health Services

In accordance with provincial health regulations, every transferred community must have a written agreement with a physician, agency, or health unit to act as the community's Medical Officer of Health (MOH). The responsibility of the MOH is to monitor public health and safety programs. The MOH must be a licensed physician who has training or experience in public health. Communities have the following options for obtaining the services of an MOH:

- through a neighbouring municipality
- contract for the service
- FNIHB continues to provide the service after Transfer.

The Community Health Plan should indicate:

- who will act as a Medical Officer of Health for the community after Transfer
- where the MOH will be located and when and how often the MOH will be accessible to community health care professionals providing primary health care
- the estimated cost of this service.

Additional information about the work of the MOH is available in the FNIHB publication, *The Medical Officer of Health.*

CHP-6 Liability and Malpractice Insurance

When a First Nations health board or authority plans and directs community health programs, it requires liability insurance. Under a Transfer Agreement, the First Nation or Inuit employer is legally responsible for any harm or damage resulting from its own activities and those of its employees including professionals, para-professionals, and support staff. Specifically, the employer must have liability insurance that covers them, contractors, and employees for actions in the performance of their duties and for accidents on the premises where the health program is provided.

Coverage for members of employee groups such as Community Health Representatives (CHRs), Environmental Health Officers, NNADAP counsellors and health support staff (clerks, receptionists, janitors) is usually provided through the health board or authority. For professional health care staff, i.e., nurses, physicians, dentists and dental therapists, personal liability and malpractice insurance coverage may be available through their professional associations. In any case, the health board or authority must ensure that all professional contract staff members are registered or licensed with provincial professional regulating authorities and that they have liability and malpractice insurance.

Communities should also have property insurance that covers loss or damage to, or theft of, any moveable assets transferred to the community under a Transfer Agreement.

To obtain insurance coverage, the First Nations health board or authority may wish to join a provincial hospital or health care association and secure liability insurance through this organization. This type of membership also broadens the health board or authority's network of health care organizations.

If this type of membership is not available, the health board or authority should review coverage options directly with insurance brokers and companies. It is advisable to obtain quotations from several companies before deciding upon the final insurance coverage contract.

Liability and malpractice insurance documents are important parts of the Transfer Agreement package that is signed by the federal government. For more information on insurance, see the FNIHB publication, *Guidelines on Insurance Coverage for First Nations and Inuit Organizations Administering Health Programs Under Transfer Agreements.*

The CHP must include:

- details of the cost and coverage of the malpractice, liability and property insurance to be purchased for the health program
- the name of the company that will provide the insurance.

CHP-7 Drugs and Medical Supplies

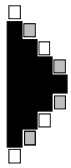
Funds for drugs and medical supplies used in health centres and facilities may be included in the Transfer Agreement. (This requirement varies by region.) The community may purchase drugs from the Drug Distribution Service of FNIHB or from another source.

In relation to drugs and medical supplies, the CHP must include:

- who will be responsible for authorizing the purchase of drugs
- details of community policies and procedures covering the ordering, purchasing, prescribing, dispensing, inventory control, storage and disposal of drugs as appropriate in accordance with regulations of the *Controlled Drugs and Substances Act.*

For additional information, see the FNIHB document entitled *Control of Drugs by First Nations Under a Health Service Transfer Agreement.*

CHP-8 Moveable Assets Reserve



"Moveable assets" are items that are not permanently attached to a building and can be moved, disposed of or replaced separately. These assets include items such as motorized vehicles, medical and office equipment and furniture in nursing residences.

All moveable assets contained in a health facility, including the resources required to replace these assets, may be included in a Transfer Agreement if the community chooses to operate and maintain the facility.

During the Bridging Phase, a detailed inventory including a description, serial numbers and value of all the moveable assets must be completed and included in the Transfer Agreement. In the case of a multi-Band Agreement, a separate inventory should be prepared for each facility.

FNIHB transfers ownership of existing vehicles and equipment to communities as part of the Transfer Agreement. Once FNIHB transfers moveable assets to a community, the community becomes responsible for maintaining and replacing them. It is recommended that a physical inventory be completed at least once every 3 years. The Transfer Agreement includes resources for insuring, operating and maintaining these assets, and for replacing them at the end of their useful life.

FNIHB transfers resources to the community for moveable assets in two forms:

- a one-time lump sum representing the accumulated depreciation of all moveable assets included in the Transfer
- an amount representing the annual depreciation of all moveable assets listed in the inventory.

Funds for replacing items valued at less than $1,000 are included as part of regular annual operating funds transferred to communities. Funds for replacing items which have been transferred to the community and have a replacement value of $1,000 or more, are kept in a separate reserve called the Moveable Assets Reserve.

The Moveable Assets Reserve (MAR)

Resources for replacing moveable assets that have been transferred to a community, and which have a replacement value of more than $1,000, are maintained separately in a reserve fund called the Moveable Assets Reserve (MAR).

- The lump-sum payment (for the accumulated depreciation) and the annual depreciation payments go into the MAR. Any interest or other income that the MAR earns and the proceeds from the sale of moveable assets must remain part of the MAR.
- FNIHB calculates the lump-sum payments according to a formula. This formula takes into account the age, replacement value and useful life of the individual asset.
- The FNIHB policy document, *The Transfer of Moveable Assets,* includes detailed procedures for using the formula to calculate lump-sum and annual depreciation amounts.

Lump-Sum Payment

The one-time, lump-sum payment applies to all moveable assets to be transferred to a community. This sum is equal to the accumulated depreciation of all moveable assets to be transferred.

Example:

Description of Asset	*Replacement Value*	*Useful Life*	*Annual Depreciation*	*Age of Asset*	*Lump Sum Calculation*
Computer	*$2,500.00*	*5 yr.*	*$500.00*	*3 yr.*	*$1500.00*

FNIHB transfers a three-year-old computer to a community. The replacement value is $2,500. The accumulated depreciation on the computer has been calculated at $1500. Therefore, FNIHB would transfer the computer and the accumulated depreciation of $1500 to the community, i.e., the lump sum of $1500 plus the annual depreciation of $500 for the next 2 years would provide sufficient funds to replace the computer at the end of the 5 years of its useful life.

The same principle applies to every moveable asset transferred and the total lump-sum payment would be equal to the total accumulated depreciation of all these items. The lump-sum payment must go into the community's MAR.

Annual Depreciation Payment

An annual payment is made to the community for the annual depreciation of moveable assets valued at $1,000 or more. This payment also must go into the community's MAR.

(Appendix F, Budgets and Cash Flow Forecasts, illustrates the MAR as part of the community's budget.)

CHP-9 Confidentiality Procedures

The Transfer Agreement includes clauses concerning respect for the confidentiality of information of a personal medical nature, as well as clauses that ensure community respect for confidential information relating to the affairs of the federal government, and government respect for confidential information relating to the affairs of the community.

The CHP must describe the system the community plans to use to ensure confidentiality of patients' medical information. Specifically, the CHP must show how the community will maintain the security of medical records, who the responsible person will be, and who will have access to medical records. Personnel policy guidelines can assist staff concerning confidentiality by including these procedures. The community should consult their legal counsel concerning the requirements of the applicable information law which may govern their medical information collection, use, retention and safekeeping procedures.

Although it is intended that Transfer Agreements will be renewed upon expiry, in the event of termination of an Agreement, responsibility for the administration and delivery of health programs and services would return to FNIHB. At such time, the Minister would have effective control over all records including medical records relating to the delivery of health programs and services.

CHP-10 Accountability and Reporting Mechanisms

This component of the CHP describes how the community will ensure that reports on health programs are prepared for community members and for FNIHB purposes. The policy document on Reporting and Auditing Guidelines is available from FNIHB Regional Offices.

The following reporting mechanisms are in place:

- an annual report to the First Nation or Inuit community
- an annual financial audit
- an annual report on the provision of mandatory programs
- an evaluation report every five years.

The CHP must include information on how the following reports will be prepared:

A. Annual Report to the Community

B. Annual Report to the Minister

C. Evaluation Report.

A. The Annual Report to the Community

Under Transfer, community members will hold their leaders accountable for the success of health programs in achieving what they were intended to achieve, and for ensuring that everyone in the community has fair and equal access to health services. The Transfer Agreement requires that the health authority or board reports each year to community members on the operation and results of health programs. Specifically, the annual report will contain the following information:

- a summary of health programs and services
- data on service operations and results
- explanation for any deviations from the Community Health Plan
- a copy of the annual financial audit report.

The report should be available to the entire community and to FNIHB.

The CHP should also describe the process for handling complaints and appeals from community members about health programs.

B. The Annual Report to the Minister

The community must provide a report to the Minister on an annual basis and within 120 days of the end of each fiscal year with the following information:

- A financial audit of the health programs and services which examines the adequacy of financial controls and certifies that sound accounting principles have been followed.
- A report on the provision of mandatory programs as specified in the CHP-3 section of this handbook.
- A copy of the annual report to community members referred to above.

C. The Evaluation Report

The Transfer Agreement requires that an evaluation be completed every five years and be conducted during the fourth year of the Transfer period. The purpose is to evaluate the effectiveness of community health programs and services (according to the current CHP) and to determine any changes in the health status of the members of the community.

Communities begin planning for evaluation of their health programs in the Pre-Transfer Planning Phase (see CHP-4) when they specify the following items:

- the programs and activities they plan to conduct
- the goals and objectives for each
- the indicators that they will use in their evaluations to measure how well programs meet their objectives
- the day-to-day records and other evaluation information (data) that staff collect when programs are running.

The CHP should link the objectives, plans and priorities of the community to the evaluation.

CHP-11 *Professional Supervision*

Access to professional supervision for all health professional employees is an essential requirement of Health Services Transfer. The Community Health Plan must include detailed information on how professional supervision will be provided for employees including nurses, environmental health officers and dental therapists. The plan should indicate:

- where, when, and how often this supervision will be provided for each health professional
- the estimated cost of each service
- who will provide this service
- the kind of professional supervision they will provide
- which health care staff they will be supervising.

Communities may access these services from the following sources:

- a local or provincial health unit
- a provincial nursing association
- First Nations and Inuit Health Branch health professional staff
- the community's own professional staff (employed or contracted)
- other sources that may be available.

Professional supervision is required as follows:

Health Professional	Requires the Professional Supervision of
Community Health Nurse	Senior Qualified Nurse
Nurse in an expanded role	Senior Qualified Nurse; consults with physician regarding patient care
Environmental Health Officer	Certified Public Health Inspector
Dental Therapist	Licensed Dentist

Supervision and the Special Interchange Arrangement

The Special Interchange Arrangement was implemented to enable communities to include as part of their community health team, health professionals who are not recognized under some Provincial Health Acts. These include Dental Therapists and Nurses working in an expanded role.

Under the Special Interchange Arrangement, participants are appointed to First Nations and Inuit Health Branch positions (term or indeterminate) through an Interchange Canada Letter of Agreement for Dental Therapists and for Nurses working in an expanded role. These health professionals function as members of the community health team under the day-to-day direction of the community health authority. Professional supervision may be provided by First Nations and Inuit Health Branch staff or other appropriate health professionals.

CHP-12 Comprehensive Budget

The Community Health Plan should include a detailed annual budget and cash flow forecast for managing and delivering each health service to the community. This budget is based on discussions with FNIHB concerning the costs of delivering the entire package of programs to be transferred. (See Appendix F for guidelines for a budget and cash flow forecast.)

Under Transfer, a community receives global funding to cover the cost of providing the transferred health programs and it is expected to manage its changing health priorities within the global budget provided. This may mean shifting resources from one program area to another.

The community receives a budget amount to cover the cost of delivering the entire package of programs each year. The transferred amount includes:

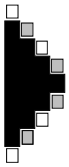
- program funds calculated according to the approved FNIHB program budget for the community at the community, zone, and regional levels (where applicable)
- funds for costs associated with general administration, accounting, liability insurance, personnel office space, employee training, equipment replacement and the annual audit; the amount for carrying out this audit is calculated as a percentage of the total program expenditures for a given year
- funds to cover the health management structure at the community level. See Appendix C for the health management funding formula.

Appendix D provides a summary of the financial aspects throughout the Transfer process from planning to implementation and on.

If the need arises, the base budget of the Agreement may be adjusted by FNIHB. These adjustments may reflect increases approved by FNIHB relating to the programs and services which are transferred. Adjustments may also be made for new program initiatives.

Here are a few additional points for consideration by the community in preparing its CHP:

- Communities can keep any funds that they have not spent and use it for health-related activities.
- Communities are responsible for any deficits.
- Communities must hire independent auditors to carry out annual financial audits.
- Communities can move funds from one program budget to another according to their own health priorities as long as they continue to meet mandatory program requirements. However, the integrity of the Moveable Assets Reserve must be maintained to ensure that the capital needs of the community are secured. The use of funds in the MAR is subject to audit and must be consistent with the purpose of the MAR.



Transfer provides flexibility in re-allocating resources across program areas. To meet the challenges of changing health priorities, communities can deal with their global health budget more strategically rather than managing it on the basis of individual program and budget lines.

Working on the Memorandum of Understanding and the Health Services Transfer Agreement

During the Bridging Phase, the community and FNIHB develop the Health Services Transfer Agreement. Before a community can begin discussions with FNIHB about the Transfer Agreement, it must have:

- a partially completed CHP (the first four components)
- formal permission or authorization from its members (in the form of a Band Council Resolution or other form of approval appropriate to the Band(s) or Inuit group(s) granting the approval) to work with FNIHB to finalize a Transfer Agreement based on the partial CHP
- designated the Chief and Council, or the Health Co-ordinator (or someone in a senior position on the Health Board or Health Committee whom they designate) to represent the community in discussions with FNIHB.

Finalizing the Transfer Agreement involves a full range of program and financial issues. The Regional Office of FNIHB and the community must agree on how to deal with these issues before a Transfer Agreement can be signed.

The two key events or milestones are:

- FNIHB and the community sign a Memorandum of Understanding (MOU)
- FNIHB and the community sign the Transfer Agreement.

For additional details about preparing the Transfer Agreement, see *FNIHB Contribution Agreement Discussion, Approval and Signature Procedures* (2003).

A. The Memorandum of Understanding (MOU)

The MOU is developed jointly by representatives from the FNIHB Regional Office and from the community. The MOU guides the process leading to a Transfer Agreement. It is a bridge or link between the CHP and the final Transfer Agreement. Typical issues in the MOU include any matters which were not part of the CHP or which require FNIHB management decisions because of other related agreements (federal or provincial) or policies. The MOU also sets a schedule for preparing, reviewing, approving and signing the Transfer Agreement. See Appendix G for a sample MOU.

B. The Transfer Agreement

1. Agreement Option

The community has the option of entering into a Health Services Transfer Agreement with Health Canada or entering into a multi-department agreement referred to as the Canada/First Nations Funding Agreement (CFNFA).

The CFNFA is a funding mechanism which may be used by First Nations who wish to have one agreement that includes several federal departments' programs, resulting in a

reduced number of agreements and less administrative burden for both First Nations and Federal Departments. First Nations that do not wish to have one agreement with multi-departments may continue with individual agreements with Health Canada.

The CFNFA is structured so that all federal departments can participate in the use of a CFNFA by including specific terms and conditions (e.g., Health Canada Schedule) appropriate to the specific federal department. There is no transfer of program responsibility between federal departments.

Standardized agreements like the CFNFA simplify the operating environment of First Nations. The agreement uses consistent authorities and management systems, streamlines administrative practices and improves accountability with respect to the collective impact of federal funding on First Nations.

The FNIHB Regional Transfer Officers can explain the merits of the options for Transfer and the community decides which option it prefers.

2. What the Transfer Agreement Covers

The Transfer Agreement is a legal document. It formalizes the relationship between the community and FNIHB in terms of delivering health programs and services and sets out the terms and conditions of the arrangement between the two parties in this area.

FNIHB uses the same form, a national Transfer Agreement template, for all First Nations or Inuit communities who wish to enter into a Health Services Transfer Agreement. In general terms, the Agreement covers the following matters:

- program resources to be transferred
- duration of the Agreement
- financial information
- requirement for audits and reports
- evaluation requirements
- confidentiality
- liability and indemnification
- Special Interchange and cost recovery
- termination
- intervention
- a dispute resolution process
- capital assets
- drugs and medical supplies
- clauses concerning Aboriginal treaty rights and land claims
- Special Provisions and applicable laws
- budgets and cash flow forecasts
- Mandatory Programs and their reporting requirements
- inventories of fixed and moveable assets

The national Transfer Agreement template (standard agreement) is available from FNIHB Regional Offices.

3. Finalizing the Transfer Agreement

After the MOU has been signed, discussions proceed at regular intervals. Decisions are reached according to the issues and schedule in the MOU. For additional details about preparing the Transfer Agreement, see *FNIHB Contribution Agreement Discussion, Approval and Signature Procedures* (2003).

4. Reviewing and Approving the Transfer Agreement

In general, the review and approval process involves the following basic steps:

- FNIHB and the community review and agree to a draft Agreement, which is based on the FNIHB national template. The draft Agreement may contain additional clauses that FNIHB and the community agree on based on unique issues relevant to the transfer that are not already covered in the template.
- The completed Agreement is routed to FNIHB regional and headquarters offices for review and approval.
- When the Chief and Council and FNIHB officials have reviewed, approved and signed the Agreement, it will govern the arrangements through which the community will run its health programs.
- A Transfer Agreement lasts three to five years. The Agreement will be renewed at the end of this period subject to mutual agreement by FNIHB and the community.

Official signing ceremonies and press releases require coordination between the community and FNIHB regional offices.

Implementation Phase

4

What is the Implementation Phase? What Resources Are Available?

The Implementation Phase refers to the first year of implementation of the Transfer Agreement. The community implements its plan for delivering health programs and services as described in its CHP and receives the annual amount based on the cash flow agreed to in their Transfer Agreement. In addition to their ongoing program budget, the community receives one-time funding to complete the final three components of the CHP as follows:

Training Plan	***$2,000***
Emergency Preparedness Plan	***$5,000***
Evaluation Plan	***$11,000***

As noted earlier, the Training Plan and Emergency Preparedness Plan may be completed in the Bridging Phase. See Appendix D for a summary of the financial aspects of Transfer including funding provided throughout the period of the Agreement.

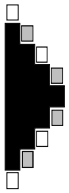
Components of the Community Health Plan to be Completed

CHP-13 *Training Plan*

Although communities hire trained professionals, these people need ongoing training and refresher courses throughout their careers to stay up to date and to improve their skills and expertise. Periodic training ensures that qualified staff will be available to administer and deliver health services. During the first year of implementation, communities are required to develop a plan for training staff involved in providing basic health care. The training plan becomes a component of the CHP.

Most professional staff require regular training to provide specialized care and to remain certified in their field. For example:

- Nurses working in isolated communities in an expanded role must have outpost or clinical skills training.
- Community Health Nurses should have appropriate training in health promotion, disease prevention, and public health.
- Nurses who immunize community members must meet provincial regulations concerning keeping up to date in their knowledge and skills.
- All Environmental Health Officers must have a Certificate in Public Health Inspection (Canada) issued by the Canadian Institute of Public Health Inspectors.



The Training Plan should list the different categories of workers identified in the CHP, outline the work responsibilities for each category, and indicate how and where training will be provided for each.

This component of the CHP:

- describes the immediate and long-term training requirements of the health care staff and the Health Board
- identifies training priorities
- indicates how and where this training will be secured and the cost of the training program each year. If these costs will be shared with another department or agency, the training plan should indicate who will be sharing the cost, and the amount the organization (or organizations) will be contributing.

Communities may want to develop a policy on professional development. The policy should tell employees what kinds of training will be supported, how much the employer will contribute toward the cost of this training, and how to apply for financial assistance.

CHP-14 *Emergency Preparedness Plan*

The CHP must include information on how a community proposes to respond to major disasters such as fire, floods and epidemics. This Community Emergency Preparedness Plan must define the role that health and medical staff would play in dealing with injuries and illness in an emergency situation.

Federal and provincial organizations share responsibility for matters relating to preparing for emergencies and responding to them. Indian and Northern Affairs Canada (INAC) is responsible for emergency response planning in First Nation communities. A community's responsibilities under Transfer include developing a plan to provide a coordinated and effective emergency response for the entire community.

All of the agencies listed below should be involved in one way or another to assist the community in developing emergency preparedness plans and coordinating community-based training to deal with various emergencies:

- FNIHB
- Provincial Emergency Measures Organizations (PEMOs)
- Indian and Northern Affairs Canada (INAC).

What the CHP Should Include About Community Emergency Preparedness

The CHP should include an emergency preparedness plan that provides the following information:

- name of coordinator, the person responsible for coordinating and directing emergency services in the community
- circumstances under which the Community Emergency Preparedness Plan should be activated, e.g., when major disasters such as fire, flood and epidemics cause or could cause health problems
- key contacts to be notified in case of emergency:
- local health care or other workers
- outside agencies (PEMOs, hospitals, INAC, Medical Officer of Health)
- community residents
- type of transportation and contact person:
  - to site of emergency
  - from site of emergency
  - to treatment centre
  - for evacuating the community
- contacts for medical emergencies:
  - contact at location for immediate care
  - contact for definitive care arrangements, i.e., comprehensive medical care after a disaster or emergency, including medical and health evacuation, dealing with outbreaks of infectious disease and providing psychological support
- communication, i.e., provisions to ensure communication and contact person for communications:
  - between transportation coordinator and the designated evacuation site
  - between emergency site and treatment centre
  - within response team
  - between hospital and emergency site
  - with community residents
- list of emergency agreements with other agencies
- training
  - whether the community will need emergency-response training
  - who will provide and pay for it.

CHP-15 Evaluation Plan

The Transfer Agreement requires that an evaluation be completed every five years and be conducted during the fourth year of the Transfer period. The purpose is to determine the effectiveness of community health programs and objectives (according to the current CHP) and any changes in the health status of the members of the community.

Communities begin planning for evaluation of their health programs in the Pre-Transfer Planning Phase (see CHP-4) when they specify the following items:

- the programs and activities they plan to conduct
- the goals and objectives for each
- the indicators that they will use in their evaluations to measure how well programs meet their objectives
- the day-to-day records and other evaluation information (data) that staff collect when programs are running.

The evaluation will result in production of a report which will be provided to the community and to the Minister prior to the end of every five-year period of transfer.

What the CHP Should Include About Evaluation

Transfer Agreements require communities to evaluate the effectiveness of their community health programs and services (according to the current CHP) and determine any changes in the health status of the members of the community. The evaluation component of the CHP describes how the community plans to use the data it collects to evaluate the effectiveness of its health programs. The evaluation plan should also indicate when the evaluation will be conducted and completed.

The booklet, *A Guide for First Nations and Inuit Health Authorities on Evaluating Health Programs,* available from the FNIHB Regional Offices, provides basic information about evaluation including program objectives, indicators, data and evaluation planning and reporting. It also describes how to set up community health programs to make it simple to keep records and collect information to evaluate program effectiveness in the future.

The evaluation plan includes the following components:

- the terms of reference for the evaluation, i.e., what programs and activities it will examine
- the questions that the evaluation will ask about the programs
- how the evaluation will be done, i.e., the approach or method to be used
- indicators and sources of data, i.e., what events or changes will be used to indicate degree of success and what records must be kept to demonstrate it
- a work plan and time frame for carrying out the evaluation.

FNIHB provides funding for carrying out program evaluations. Evaluation funding is usually about 5% of the costs of programs and activities with a minimum and maximum amount. See Appendix D for additional information on funding related to evaluation.

After the Transfer–The New Environment

Handbook 3 - After the Transfer—the New Environment, provides information on what happens after Transfer including roles and responsibilities, reporting requirements, financial audits, and Transfer renewal.

Other Transfer Issues

5

Multi-Community Transfer Agreements

A group of communities can work together on the planning, management and delivery of health programs and services to their members. Together the group conducts the Community Health Needs Assessment (CHNA) for all of its members, and establishes one health management structure and Community Health Plan (CHP). The CHP should specify the services to be provided in the communities, which of those services will be provided by the individual communities and which by the multi-community group, and how frequently the services will be provided.

Details of funding for planning activities are provided in Table 1. In the Pre-Transfer Planning Phase, one-time funding for multi-community groups is determined as follows:

- **Community Health Needs Assessment:** the funding is calculated with the formula in Appendix A using the total population of the participating communities.
- **Development of the Community Health Plan:** the funding specified in Table 1 is for development of a CHP for all of the participating communities.
- **Pre-Transfer Training:** the funding for training specified in Table 1 is provided to each community in the group.
- **Health Management Structure:** the funding is calculated using the 50% formula in Appendix B. The total amount provided to the multi-community group for its health management structure is calculated by applying the population of each community to the formula and then taking the sum of those amounts.

In the Bridging and Implementation Phases, the funding for the health management structure is calculated using the 100% formula in Appendix C. Again, the total amount provided to the multi-community group for its health management structure is calculated by applying the population of each community to the formula and then taking the sum of those amounts. During the Bridging Phase, the funding for the health management structure is pro-rated for 9 months.

Where a Transfer Agreement is signed with a multi-community group, the responsibility for the management of this Agreement lies with the group, whether or not the group provides all services directly. The responsibility for resolving differences within the group lies with all communities who are party to the Agreement. A process for handling differences should be developed by each multi-community group.

What About Transfer of 2nd and 3rd Level Services?

Second and third level services are those services provided at the regional or zone level, respectively. Generally, 2nd and 3rd level services are of a coordination, consultative and supervisory capacity as opposed to direct community-based services (1st level).

Typical positions in a Region providing 2nd and 3rd level services to communities include the following. Positions may vary somewhat from Region to Region.

- Regional Dental Officer
- Regional Nutritionist
- Community Health Coordinator
- Community Medicine Consultant
- Regional Nursing Officer
- Assistant Regional Nursing Officer
- Regional Nurse - Epidemiology
- Regional NNADAP Coordinator
- Brighter Futures Coordinator
- Regional Environmental Health Officer
- Zone Environmental Health Officer
- Regional Health Education Officer
- Zone Nursing Officer
- Zone NNADAP Consultant
- Zone Community Health Representative (CHR) Advisor
- Community Development Officer
- Maintenance Officer
- Maintenance Worker

Some communities may decide not to transfer 2nd and 3rd level services and in these cases, another First Nations or Inuit organization or FNIHB will provide these services on behalf of the community. A community or group of communities that has demonstrated the ability to deliver 2nd and 3rd level services may consider the transfer of mandatory and non-mandatory 2nd and 3rd level services as part of their Transfer Agreement.

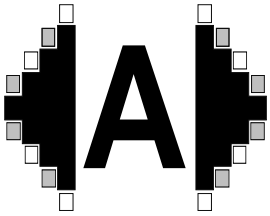
When communities choose to have another organization manage 2nd and 3rd level services on their behalf, the 2nd and 3rd level services Transfer Policy will apply. This policy is available from FNIHB Regional Offices.

What About Services Provided Under the Non-Insured Health Benefits (NIHB) Program?

The Transfer Framework and related Treasury Board authorities for the Non-Insured Health Benefits (NIHB) Program are currently under development. In 1997, a number of communities entered into NIHB pilot projects to be evaluated jointly by First Nations and FNIHB. The results of the pilot projects are to be used in the creation of an NIHB Transfer Policy. In 1998, Health Canada received Cabinet approval for the transfer of NIHB. FNIHB is currently seeking Treasury Board authority to transfer the full compliment of NIHB services. A separate handbook is being developed and will be issued once the appropriate authorities and program framework are finalized.

What About Transfer of Treatment Programs for Alcohol, Other Drugs and Youth Solvent Abuse?

The National Native Alcohol and Drug Abuse Program (NNADAP) Treatment Centres and National Youth Solvent Abuse Treatment Program (NYSATP) are non-medical residential treatment programs funded by FNIHB. The first transfer of a NNADAP treatment centre program occurred in 1993. The process for transfer of these treatment programs differs from transfer for other health programs and services. For treatment programs, the transfer initiative involves an administrative transfer between FNIHB and the corporate recipient for the treatment centre, as opposed to a community-based transfer with a Band or Tribal Council. The policy on Transfer of Treatment Programs for Alcohol, Other Drugs and Youth Solvent Abuse is available from FNIHB Regional Offices.

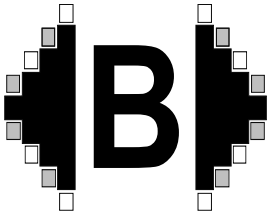


Formula for Determining Funding for the Community Health Needs Assessment (CHNA) in the Transfer Approach

Appendix A

Formula for Determining Funding for the Community Health Needs Assessment (CHNA) in the Transfer Approach

Population	Funds Available for Planning	Preparation	Implementation	Analysis	TOTAL
0-500	$4,000	$7,000	$10,000	$17,000	$38,000
501-1,000	$5,000	$9,500	$19,000	$18,000	$51,500
1,001-2,000	$5,000	$14,000	$31,000	$23,000	$73,000
Greater than 2,000	$5,000	$19,000	$49,000	$23,000	$96,000



50% Formula for Determining Annual Health Management Support Funds for Pre-Transfer Planning Phase

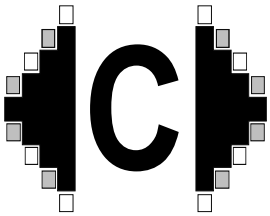
Appendix B

50% Formula for Determining Annual Health Management Support Funds for Pre-Transfer Planning Phase

Population*		(C) For the First	Amount for Population Shown in Column (C)	For Each Additional Member
From	To			
0	100	N/A	For populations of 100 or less, the 50% funding amount	$138.00
101	400	101	$13,800	$43.00
401	3,000	401	$26,700	$15.50
3,001	5,000	3,001	$67,000	$10.50
5,001	7,000	5,001	$88,000	$7.50
Greater than 7,000		7,001	$103,000	$5.00

50%

NOTE: A portion (80%) of the funding provided for management support is adjusted by a remoteness factor to compensate for the disadvantages created by isolation of a community.



100% Formula for Determining Annual Health Management Support Funds for Transfer

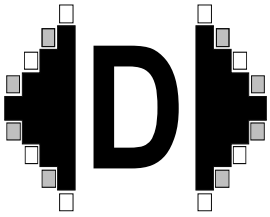
Appendix C

100% Formula for Determining Annual Health Management Support Funds for Transfer

Population*		(C) For the First	Amount for Population Shown in Column (C)	For Each Additional Member
From	To			
0	100	NA	For populations of 100 or less, the 100% funding	$276.00
101	400	101	$27,600	$86.00
401	3,000	401	$53,400	$31.00
3,001	5,000	3,001	$134,000	$21.00
5,001	7,000	5,001	$176,000	$15.00
Greater than 7,000		7,001	$206,000	$10.00

100%

NOTE: A portion (80%) of the funding provided for management support is adjusted by a remoteness factor to compensate for the disadvantages created by isolation of a community.

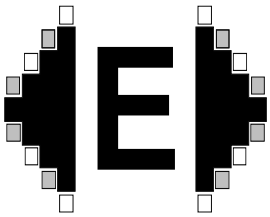


Financial Aspects of Transfer from Planning to Implementation

Financial Aspects of Transfer from Planning to Implementation

Phase	Item	Funding
Pre-Transfer Planning	Health management funding and training	50% health management formula (per community) $10,000 for training (per community)(one-time funding)
	Community health needs assessment	$38,000 to $96,000 (per project) (CHNA table formula, one-time funding)
	Community health plan (CHP) development (first 4 components)	$9,000 (per project) (one-time funding)
Bridging	Health management funding	100% health management formula pro-rated for 9 months (per community) (100% health management table formula)
	8 CHP components	$15,000 (one-time funding per project)
Implementation One-time funding	3 CHP components - Evaluation plan - Training plan - Emergency preparedness plan	(per project) $11,000 (one-time funding) $2,000 (one-time funding) $5,000 (one-time funding)
Implementation On-going throughout period of Transfer Agreement	Start-up costs	One-time payment based on the total transfer amount: - 5% on the first $300,000 plus - 1% on any remaining amount
	Health management funding	100% health management formula (per community)
	Evaluation report	$30,000 to $80,000 (5% of annual program costs) in lump sum OR pro-rated over the period of the Transfer Agreement
	Evaluation plan update	$3,500 each Transfer Agreement 5-year renewal period
	Program costs	Current program expenditures for FNIHB- delivered services and services delivered through contribution
	Personnel costs	Salaries and benefits for staff providing direct health services, support staff, and staff in Regions and Zones providing or supporting health services in communities
	Operating and maintenance costs	Health facilities (e.g., health centres, nursing stations)

Phase	Item	Funding
Implementation (cont.)	Administration	Including: - Basic overhead (determined by formula, usually 5% to 15%) - Office space for employees who work outside the health facility (approximately $4,327 per employee with a remoteness adjustment) - Audit costs (0.5% of the total funds transferred to community. A higher quote may be acceptable if the quote is forwarded to HQ and is reasonable, considering the amount of the Agreement and the nature of the services)
	Moveable assets reserve	A one-time lump sum payment provided upon the signing of the Transfer Agreement to cover accumulated depreciation to date, plus an annual depreciation payment determined by formula
	Remoteness and environmental adjustments	Based on remoteness and environmental factors
	Liability insurance	Actual costs of liability insurance coverage
	Employee training	$2,000 per FTE (equivalent of a full-time employee)
	Recruitment, including advertising and relocation	$2,000 per hiring of a nurse, adjusted by remoteness
	Leeway	10% leeway calculated using the total of the above allocations, with the exception of Brighter Futures, home nursing, mental health and solvent abuse (leeway already included). Allocations for these programs are added to the total after leeway has been calculated.



Guide to Health Management Structures for First Nations

Appendix E

Guide to Health Management Structures

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HEALTH MANAGEMENT STRUCTURES

Introduction

When First Nations establish health management structures, they first need to determine mandates and authorities for providing health care services for one or more communities. Chiefs and councils mandate First Nations health management structures through band council resolutions or other forms of approval appropriate to First Nations. These mandates cover planning, organizing and providing health care services to community members. Community health plans describe these services and become the operating guidelines for First Nations health management structures. These health management structures are the essential components of community health care initiatives.

Members or directors of First Nations health management structures need to have high levels of community commitment. These community members are responsible for ensuring that health management structures operate legally, that services are effective and that finances are wisely administered.

Canada's Health Care System

Understanding the Canadian health care system will assist First Nations to create efficient health management structures. Although the Community Health Plan sets out health management structure operating guidelines, understanding how to support the Plan within the context of the Canadian health care system is important.

The Constitutional Act of 1867 assigned various responsibilities to the federal and provincial governments, including health care, education and social services. Recently, two other important players have entered the health care sector—First Nations and other non-governmental organizations, and municipalities. The relationship among these governing partners is continually evolving as they redefine shared responsibilities. Establishing First Nations health management structures is another development in this relationship.

Integrated Health Services

Integration and harmony throughout the complete spectrum of health programs and services are important for First Nations communities. This integration reflects Aboriginal people's concepts of health and well-being (holism), which are similar to a wellness model based on broad determinants of health. Ideally, holism means that social and health services should be integrated.

At the very least, health and health-related services should be coordinated in a holistic manner which respects physical, mental, emotional and spiritual outcomes. When First Nations communities design health systems, they need to integrate health and health-related services that are holistic and compatible with their goal of self-determination.

Areas of Control and Responsibility

The Canadian health care system comprises several specialized, interrelated elements. Federal, provincial and municipal governments manage many of these elements. First Nations and non-governmental organizations are responsible for managing other elements. First Nations health management structures have an important role to play in adapting health service delivery to the specific needs of their communities.

Members of First Nations health management structures can examine the range of services managed by other jurisdictions when planning comprehensive community-based health care systems. The range of services needs to include appropriate referral access for the special needs of community members.

Listed below are examples of direct health services provided by various levels of government.

FEDERAL	PROVINCIAL	NON-GOVERNMENT
PUBLIC HEALTH AND PROMOTION	**ACUTE AND CHRONIC DISEASE**	
Public Health Public Health Promotion Public Health Protection Environmental Protection Non-insured Services	Diagnostic and Treatment Services Mental Health Rehabilitation Vital Statistics Hospitals/Boards Physicians/Nurses Insured Services	Nursing Homes Home Care Disability Services Addictions and Rehabilitation Services Red Cross

TYPES OF HEALTH MANAGEMENT STRUCTURES

Health Management Structure

A First Nations health management structure may be either a health committee or a health board/authority. A committee is not incorporated, but a health board/authority is incorporated under provincial or federal laws, or both. Either type of health management structure may employ a Health Coordinator/Director.

Health Coordinator/Director

The health coordinator/director manages the following day-to-day activities of the health management structure:

- directing health programs;
- managing financial budgeting, planning and accounting;
- hiring;
- managing and developing staff;
- promoting community awareness of health issues and programs;
- preparing all mandatory reports; and
- managing facilities and material.

Health Committee

A First Nations health committee comprises community members appointed by the chief and council who consult with the community and actively promote the delivery of appropriate health services. The health committee operates in a supportive role and is responsible for promoting community awareness of healthy lifestyles that reduce the need for medical care.

Health Board/Authority

A First Nations health board/authority is a separate nonprofit legal entity authorized by means of a band council resolution. It can be incorporated under either federal or provincial laws. Once chartered, it has the power to set by-laws governing its operations, to hire and manage staff, and to make financial decisions for providing services previously provided to First Nations communities by the First Nations and Inuit Health Branch of Health Canada. This guide focuses on establishing a health board/authority.

ESTABLISHING A FIRST NATIONS HEALTH BOARD/AUTHORITY

Authority

Establishing a First Nations health board/authority presupposes that, after consultation with the community, the chief and council have decided to entrust this body with the responsibility for health care programs. The First Nations health board/authority may have authority to obtain resources needed for controlling community health care services. Developing community health by-laws establishes this authority.

By-Laws

Community health by-laws set out a series of guidelines, including statements on the following items:

- determining community health objectives;
- nominating, appointing, and establishing the term of the board of directors;
- nominating, appointing, and establishing the term of the health coordinator/director;
- scheduling meetings, quorums and procedures;
- managing finance-accounting;
- assuring confidentiality;
- changing, deleting and adding health board by-laws;
- writing minutes and other records;
- planning, managing, and implementing programs; and
- evaluating programs.

Armed with an appropriate set of guidelines or by-laws, the First Nations health board/authority can then draft working rules for delivering community health care programs. These working rules define

- priorities
- programs
- policies
- procedures

Members

Health board/authority members and directors need to represent a good cross-section of the community benefiting from health programs.

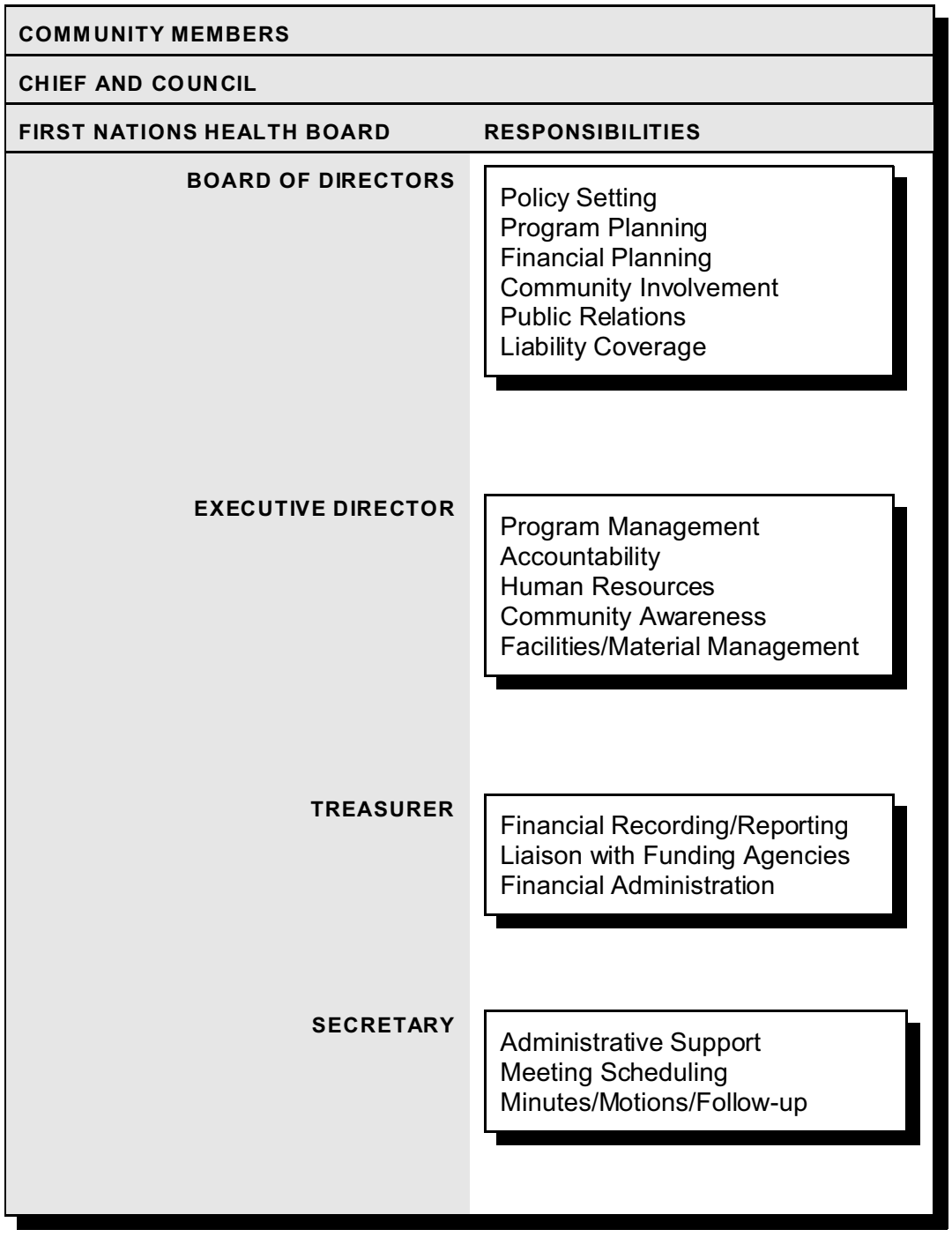
Mission Statement

At some point early in its mandate, the First Nations health board/authority will want to write its mission statement. A mission is a statement of intent about the overall job the health board wants to do. An example of a First Nations health board mission statement is the following:

> *The mission of the First Nations Health Board of Musquodobit is to assist First Nations people to achieve physical, mental, emotional and spiritual well-being through the provision of culturally appropriate health promotion, disease prevention activities and health services.*

MANAGING THE HEALTH PROGRAM

The following chart is a typical health board/authority management structure for delivering community health services in First Nations communities.



COMMUNITY HEALTH CARE SERVICE DELIVERY

FIRST NATIONS HEALTH BOARD			
EXECUTIVE DIRECTOR			
PROFESSIONAL/PARAPROFESSIONAL			
Treatment Services	**Public Health**	**Environmental Services**	**NNDAP**
Community Health Nurses Dental Therapists Contract Specialist Supervisors of Professionals Physicians Dentists Other Services Access to Provincial Hospitals and Medical Services	Community Health Nurses Health Educators Community Health Representatives Dental Therapists Mental Health Workers	Environmental Health Officers	Coordinators Counselors Youth Trainers
TECHNICAL SUPPORT STAFF			
Management		**Maintenance**	**Other**
Finance Officer Administrative Support Informatics		Caretakers Engineers Janitors	Cook

Staff

The professional and paraprofessional personnel who work for the health board/authority are responsible for delivering the health care services the community expects to receive under the Community Health Plan.

Duties and Responsibilities of a First Nations Health Board/Authority

After a community establishes a First Nations health board/authority with defined mandate and authority, the health board/authority defines its duties and responsibilities. Some of these duties and responsibilities are highlighted below.

Policy Setting

Following the objectives and priorities of the Community Health Plan, the First Nations health board/authority establishes policy directions reflecting the community's philosophy and goals. Also, it reviews its policies with the community at large once a year when it presents its annual program report on health care services.

Program Planning

The First Nations health board/authority ensures that health care programs address the community's needs and priorities. As circumstances or requirements change, the programs need to be flexible enough to modify easily.

Program Management

The First Nations health board/authority sets out personnel policies and establishes and applies procedures. It oversees the development of management and administrative practices. Also, it must ensure that its personnel follow procedures developed from policies. Finally, it must establish maintenance standards for its premises.

Accountability

Community Leadership to the Community

All community activities are sustained with the ongoing consent of the members of the community. The First Nations health board/authority is no exception. Although the chief and council create the board by a formal act, the board must follow the community's guidance in matters of health. This obligation is carried out through a process approved by chief and council that reinforces their authority to speak for all community members while being accountable to them.

Transfer agreements require that First Nations communities give their members annual reports within 120 days of the end of each fiscal year. The annual report, based on the Community Health Plan, contains the following information:

- a summary of health programs and services;
- data on service operations and results;
- an explanation of any deviation from the Community Health Plan; and
- a copy of the comprehensive audit report.

Community Leadership to the Minister

The chief and council are accountable to the Minister for meeting the terms and conditions of the transfer agreement. Transfer agreements require that First Nations communities give the Minister the following reports within 120 days of the end of each fiscal year:

- a comprehensive audit report;
- a report on providing mandatory programs;
- a copy of the annual report to community members, and
- a program evaluation every five years.

Human Resources

The First Nations health board/authority establishes standards of performance for personnel, management practices and service delivery. The health board/authority reviews individual staff performance based on these standards. Also, it is responsible for staff development. Staff participation in continuing education courses, workshops and training sessions helps them to update and improve their skills. Professional staff must keep current with advances in their disciplines by attending professional continuing education workshops, seminars and conferences.

Financial Planning

The First Nations health board/authority is responsible for approving the annual budget based on community health care priorities and for ensuring that expenditures are kept within budget. Its responsibilities include ensuring that funding arrangements with governmental and non-governmental agencies are in place and that funds are received on time.

Community Involvement in Community-based Health Care

Community involvement ensures that the community-based health care delivery system meets the needs of community members and provides for evaluation of community health programs. Community involvement provides a collective voice that shapes the health care delivery system by involving members in various processes leading to decision-making. Effective two-way communication ensures that community members are aware of health board/authority activities and encourages members to make suggestions to the health board/authority. These suggestions show that communication between the health board/authority and the community is working effectively. Health board members need to inform community members about success in addressing health problems and to inform them about continuing problems. Success stories assure everyone that progress is taking place and encourage community involvement in addressing health challenges.

Relations with Outside Agencies

To ensure accessibility to all available health care programs and sponsorships, the First Nations health board/authority needs to develop the best possible working relationships with appropriate federal, provincial, municipal and private agencies. In these contexts, the Community Health Plan becomes the most effective means of identifying how to meet community needs.

Liability and Malpractice Insurance

When a First Nations health board/authority plans and directs community health programs, it requires liability insurance. A First Nations health board/authority is legally responsible for its own actions and for the actions of those employed in the health program. It is responsible for all members of the community health care team, including the following members:

Paraprofessional

- Community Health Representatives
- NNADAP Workers
- Administration Support Staff
- Other Community Health Workers

Health care staff members need liability insurance to cover them while performing their duties and for accidents and mishaps on the premises where they provide health programs. Usually, this coverage is provided through the First Nation health organization.

Professional

- Nurses
- Physicians
- Dentists
- Dental Therapists
- Other Specialists

For professional health care staff, personal liability and malpractice insurance coverage may be available through their professional associations. In any case, the First Nations health board/authority must ensure that all professional contract staff members are registered or licensed with provincial professional regulating authorities and have malpractice insurance. Because the First Nations health board/authority may also be held liable for something a contract employee does that harms someone, the board/authority must carry liability insurance that covers contract employees and full-time, permanent employees.

Insurance Providers

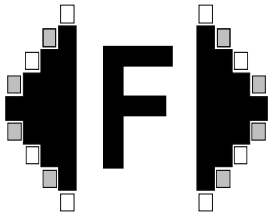
The First Nations health board/authority may wish to join provincial hospital or health care associations and secure liability insurance through these organizations. This type of membership broadens the health board/authority's network of health care organizations.

Should this type of membership not be available, the First Nations health board/authority needs to review coverage options directly with insurance brokers and companies. The management practice of obtaining multiple quotes will provide sufficient information on the appropriateness of insurance costs.

Note: See the *Guidelines on Insurance Coverage for First Nation and Inuit Organizations Administering Health Programs Under Transfer Agreements.*

CONCLUSION

The First Nations health board/authority is the implementor of the community's plan for current health care needs and for the timely development of improved health service as circumstances change.



Budgets and Cash Flow Forecasts

Budgets and Cash Flow Forecasts

Budgets:

The first section should include a breakdown, by yearly amounts, of the total contribution amount which is identified in the Transfer Agreement. Separate lines for the moveable assets reserve (MAR) and/or items funded on a temporary basis should also be included. For example:

- Budget for 12 months for the period from:

  April 1, 2003 to March 31, 2004 $1,000,000.00

  Moveable Assets Reserve $50,000.00

- Budget for 12 months for the period from:

  April 1, 2004 to March 31, 2005 $1,000,000.00

  Moveable Assets Reserve $50,000.00

etc…

Sample Cash Flow Forecast:

The second section should cover the cash flow forecasts as determined by the community for the duration of the Agreement.

Sample Cash Flow Forecast (for a three-year Agreement)

	2003/2004	2004/2005	2005/2006
April	$150,000.00	$100,000.00	$120,000.00
May	$800,000.00	$100,000.00	$120,000.00
June	$180,000.00	$100,000.00	$120,000.00
July	$150,000.00	$150,000.00	$180,000.00

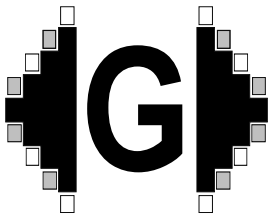
Cash flow means the actual funds required by the community to meet operational needs related to the programs and services. Each payment would reflect the cash requirements of the community based on their cash flow forecast.

The Treasury Board Cash Management Policy states that the maximum amount which may be advanced to a community shall be determined in accordance with the total amount of the first year's contribution as follows:

Total Annual Amount	Initial Payment	Subsequent Payments
$25,000 to $99,000	Up to 75%	Quarterly
$100,000 to $249,999	25%	Quarterly
$250,000 to $499,999	25%	Monthly beginning in 4th month
$500,000 and over	1/12, i.e., 8⅓%	Monthly

Payments are based on the cash flow statement completed by the community. Statements of expenditure are not required to release further payments to the community.

The community/organization has the option of a direct deposit made to their bank account. The appropriate form is available from the Regional FNIHB Office.



Sample Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING

BETWEEN

"X" FIRST NATION

AND

"X" REGION

First Nations and Inuit Health Branch, Health Canada

REGARDING

The process, time frame and issues to be discussed and completed in the Bridging Phase leading to a Health Services Transfer Agreement.

MEMORANDUM OF UNDERSTANDING

1.0 Purpose of the Memorandum of Understanding (MOU)

The purpose of this Memorandum of Understanding is to jointly outline the process, time frame and issues to be discussed and completed in the Bridging Phase leading to the transfer of control of health services from "X" Region to "X" First Nation.

2.0 Items to be discussed

The basis for discussion will be the draft Community Health Plan (CHP) which has been prepared by "X" First Nation and has been reviewed by the "X" Region, First Nations and Inuit Health Branch. The following are areas that have been identified for discussion in the Bridging Phase:

2.1 Review of the Community Health Plan components completed to date:

- Community health priorities
- Health Management Structure
- Management and delivery of mandatory programs
- Management and delivery of community health programs

2.2 Discuss the arrangements, policy or procedures for the following components of the CHP:

- Medical Officer of Health
- Liability and Malpractice Insurance
- Drugs and Medical Supplies
- Moveable Assets Reserve
- Confidentiality Procedures
- Accountability and Reporting Mechanisms
- Professional Supervision
- Comprehensive Budget
- Training Plan[1]
- Emergency Preparedness Plan[1]
- Evaluation Plan

[1] Training and Emergency Preparedness Plans maybe completed in the Bridging Phase.

2.3 Facilities, vehicles and equipment:

The transfer of the operation of the FNIHB nursing station, the accommodation for the nurses, and other assets such as garages will be included in the Transfer Agreement. A joint assessment will include a plan for replacement and repair. In addition, an inventory will be developed of the vehicles and equipment and will be attached to the Transfer Agreement (MAR).

2.4 Review the National Transfer Agreement Proforma

2.5 Phasing In of Transferrable Health Programs

As indicated in the Community Health Plan, upon signing of the agreement, the First Nation wishes to transfer resources for the following positions:

- Community Health Nursing
- Building Healthy Communities
- Brighter Futures
- Clerk
- NNADAP Prevention

After signing the Transfer Agreement, the First Nation would like to assume control of physician services and visiting specialists, including dental services and other services not yet transferred within a time frame to be determined by the First Nation.

Note: The programs and services transferred will vary in each project.

2.5 FNIHB's Post-Transfer Responsibilities

Specifically in the area of Non-Insured Health Benefits, professional nursing supervision, environmental health services and dental services.

2.6 Other relevant issues:

- Personnel policies
- Other (to be identified)

3.0 Approach to Special Issues

3.1 Services to adjacent communities

FNIHB and the First Nation are to ensure that there is a clear understanding in situations where services are provided to adjacent communities (e.g., Federal/Provincial agreements).

3.2 Special Interchange Arrangement

The First Nation may need to enter into a Special Interchange Arrangement to include as part of their community health team, health professionals who are not recognized under certain provincial health acts. These include Dental Therapists and nurses working in an expanded role.

3.3 Personnel

First Nations and Inuit Health Branch will be responsible for ensuring that all public servants whose jobs are involved in the program transfer are given at least (6) months surplus notice. These employees are guaranteed all entitlements under the Treasury Board's Workforce Adjustment Policy.

Effective on the signing date of this Memorandum of Understanding, FNIHB employees whose jobs are involved in the program transfer will be entitled to "affected status." The Regional Director, or his delegate, and a personnel officer will meet with each employee to discuss the implication of this status.

4.0 Process for Discussions

In the resolution of the above issues and in the finalization of the draft Health Services Transfer Agreement, the Regional Transfer Officer will meet with the Chief and Council and/or Health Coordinator in accordance with the schedule outlined below. Other FNIHB and community health professionals may be invited to participate in specific discussions.

The following timetable will guide these discussions.

Month of	Issue	Location of Meeting
July		
August		
September		
October		
November		
December		
January		
February		
March		

The target date for the signing of the transfer agreement is April 1, 200 _.

This Memorandum of Understanding dated this _____ day of _____, 200 _.

FOR THE FIRST NATION

_____	_____
Witness	**Chief**
	.....
	Print

FOR HER MAJESTY

_____	_____
Witness	**Regional Director** First Nations and Inuit Health Branch Health Canada