Our Healing Journey

Pikangikum First Nation's

Comprehensive Community Health Plan

December 15th 2014- DRAFT IN PROGRESS

Acknowledgements

Chi Miigwetch, a great thank you to all the 864 community members who have participated in our Community Health Needs Assessment and Comprehensive Community Health Planning Process over the past 2 and a half years. The time you took to get involved and your willingness to share your stories, experiences, ideas, needs and perspective have made this process a success and a true reflection of our community's vision for health. Thank you also to the many individuals and staff in our health system who contributed time and experience through conversations, interviews, meetings and workshops during this process.

Thank you to the leadership of Pikangikum, our Chief and Councils, our community Elders, the Pikangikum Health Authority under the leadership of Billy Joe Strang, and the members of the SHEE Committee for initiating, supporting and guiding this process. This plan was officially adopted by a Band Council Resolution on December 5th, 2014.

Thank you to the Pikangikum Community Health Planning Team under the guidance of Brian Keeper and Samson Keeper, our translators, our volunteers and the members of the Pikangikum Working Group. Thank you to our funders (Health Canada, Aboriginal Affairs and Northern Development, and the Province of Ontario) for funding this important community planning process.

Thank you to Amos Pascal, Lawrence Peters, Laura Loewen, Sylvain Langlois, Mike Lovett, Yana Sobiski, Nursing Station staff and Dr. Anthon Meyer for your assistance and support of this planning process. Thank you to the Beringia Community Planning team of Jeff Cook, Sarah Gillett, Marena Brinkhurst, Gaye Hanson, Melanie Harding, Sherri Corrie and Leslie Pang for your support, guidance and dedication to this process.

To the Creator who sustains all life – *Kitchee Meegwetch.*

All direction in this Comprehensive Community Health Plan is premised upon respect for Aboriginal and treaty rights.

Executive Summary

Our Pikangikum Health Authority (PHA) is leading a process of coming together to strengthen our community's health by identifying and assessing our health needs and planning for a stronger future. Pikangikum First Nation (PFN) has undertaken a two and a half year process of coming together to strengthen our community's health by first conducting a Community Health Needs Assessment (CHNA) and then completing a Comprehensive Community Health Plan (CCHP) to address our health needs. The objectives of our CCHP are to give voice to our community's vision for a healthy community; determine our health priorities (directions and paths); identify principles and a set of strategic actions; build commitment and capacity to carry out our plan; and evaluate how our plan is doing.

Using an approach to community health planning that empowers our community, honours our Anishinaabe culture, builds community skills and capacity, and includes participation and collaboration, we engaged 864 individuals including Youth, Elders, PHA leadership and staff, women and men, Chief and Council, agency and organization representatives, health professionals, teachers and education staff, and community support services staff.

Are planning process, and our CCHP report, are organized into five phases of planning which are each guided by a question:

1 **Preparing** *Are we ready?*

2 **Discovery** *Where are we now?*

3 **Vision** *Where are we going?*

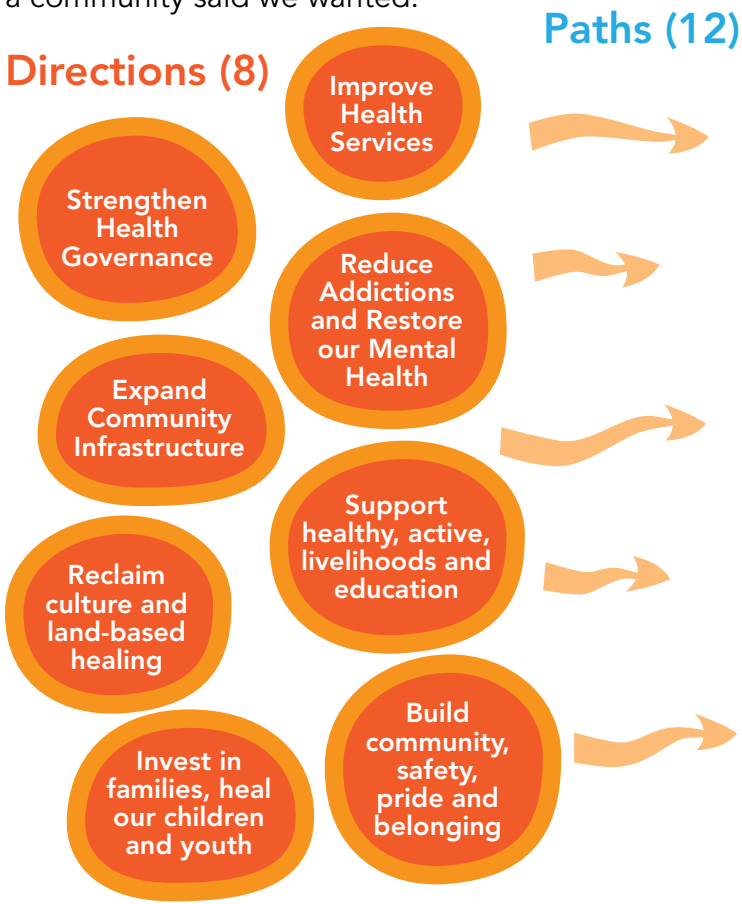
4 **Action** *How do we get there?*

5 **Results** *Are we getting results?*

A community-designed public engagement strategy successfully provided a diversity of fun engagement methods (online, door-to-door, radio, surveys, workshops, open houses, live clicker surveys, storytelling, discussions, art, video) to make wise decisions about the future. In addition to analyzing community input, we conducted a situational assessment including a community profile, health system review, Continuum of Care analysis and SWOT to help us identify opportunities for a stronger community.

As a community, we have crafted a community vision statement together based on us talking about what is working and not working well, and understanding why, within our community health system. We identified 18 high-level Principles to guide our process, decisions and our actions.

The following Directions (8) and Paths (12) are meant to capture the health issues and needs identified in our CHNA, and focus attention on identifying our top priorities for action. Combined, these elements make up our vision framework, which in turn allows us to set targets to measure change and results we as a community said we wanted.



1. **Increase local authority, capacity** and responsibility for health delivery and governance
2. **More health services** from prevention into treatment and recovery
3. Improve ways of **working together** between all health and social service providers
4. Expand healing and alcohol/solvent/drug **treatment options**
5. Create **stronger laws** and policies to control health related actions
6. Promote **cultural healing** and land-based skills and activities
7. Bring **Elders' teachings** to Youth to learn and heal
8. Support, involve and **celebrate our Youth** in making strong futures
9. Improve access to **education**, life and job skills and **livelihoods**
10. Build a community where individual **healthy choices** are easy
11. Create **safe places** for community members where they do not experience violence or abuse
12. Build **trust and love** toward one another

In total 69 core actions were identified, organized into five clusters of action (Healing, Health System, Families, Youth and Culture) and 21 sub-themes. Action were further analyzed by considering the popularity of individual actions ideas based on community engagement and ranking and the strategic advantage of individual actions based on how well they meet our plan's 8 Directions and 12 Paths. This allowed us to distinguish actions by priority level (quickstart, critical, essential, very important or supporting). It also allowed us to identify 25 priority actions, 5 for each cluster of actions:

HEALING

1. Youth suicide prevention program
2. Suicide risk assessment training
3. Grief counselling services
4. Stormer Lake operational plan
5. Intoxicant supply study

HEALTH SYSTEM

1. Case management & continuum of care system
2. Interagency protocol
3. Staff support network
4. Clinical & mental health staff training
5. Hire clinical supervisor

FAMILIES

1. Healthy parenting program
2. Housing & water infrastructure
3. Community kitchen
4. Whitefeather training center
5. Daycare expansion

YOUTH

1. Anti-bullying campaign
2. New school, gym & fitness center
3. Women and Youth safe house
4. Youth recreational & cultural coordinator
5. Youth leadership & mentorship program

CULTURE

1. Elder's health teaching circle
2. Community justice review
3. Traditional food & hunting progrm
4. Cultural orientation workshop
5. Cultural education & arts program

Our implementation strategy and plan are founded on a set of implementation principles (9) that value building off strengths; increasing capacity; promoting inter-dependence; being proactive; incremental change; reclaiming culture; promoting multiple pathways; expanding the continuum of care; and learning and adapting.

We identify implementation risks, challenges and best practices and mechanisms that we will use to ensure successful implementation. A work plan, phasing strategy, a work plan and budget will help us move our vision framework into action as well as a set of 11 implementation tools in our CCHP appendix.

Summary of budget inserted here.

Our plan also involves a strategy for monitoring and evaluating our plan so that we can learn and adapt as we implement our plan. Our strategy involves a combination of compliance monitoring, impact monitoring, standards-based evaluation and responsive evaluation to help us choose indicators, set targets, monitor progress and notice unexpected results of our actions. A step-by-step monitoring and evaluation plan is supported by 11 tools and a process for plan revisions.

"Teach skills so families can learn to understand each of their children"
(Key informant interviews)

"Build new buildings like pool halls, coffee shops for all ages to hang out"
(Community session #1)

"Have more community gatherings"
(Staff Report #1)

Table of Contents







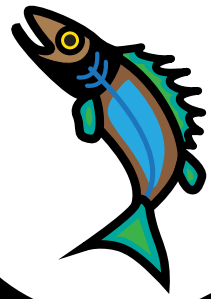







Preparing

1



In the Preparing phase of our planning process we seek to answer the question “Are we ready?”. In this chapter, we explain how we prepared for and organized our health planning process including our approach, methodology and tools to carry out our porcess. It includes organizing capacity, people, resources, information and time necessary to complete our planning process. We focus on forming our local planning team, talking with advisors, building relationships and working together. This chapter also introduces our community.

Chapter 1

Preparing

INTRODUCTION

Preparing to plan involves understanding our current context, understanding what is a Comprehensive Community Plan (CCHP), deciding on our approach and methodology and mapping out our planning process. In this chapter we introduce the community and planning context, decribe CCHP, our approach, methodology, planning process by phase and community engagement and communication strategy.

Welcome to Pikangikum

We are an Anishinaabe, Ojibway-speaking community of approximately 2,600 members. Our traditional territory includes the rivers, lakes, and forests of what is today called the Sioux Lookout district of northwestern Ontario. The community of Pikangikum is located on the eastern shores of Pikangikum Lake. Our relationship with the land is deeply rooted in our culture. We are surrounded by boreal forest and many of our community members continue Anishinaabe traditions of hunting, trapping and gathering. Through our historic Whitefeather Forest Initiative, we are working to build a strong future for our community through sustainable forestry and timber management.

Our community is one of the largest First Nations in the Sioux Lookout District, and it continues to grow rapidly because of our young population, birth rate and the high percentage of members who stay in our community. Our growing population is putting pressure on our services, programs and infrastructure. There is an urgent need to increase employment and education opportunities, as well as housing, water, utilities, and road infrastructure to strengthen the health and wellness of our member (see Chapter 2 for full community profile).

We are governed by a Chief, Deputy Chief, and nine Council members selected by the community through elections. As well, our Elders and increasingly our Youth provide guidance to our Leadership. Our Pikangikum Education Authority (PEA) governs our school and the Pikangikum Health Authority (PHA) governs many of Pikangikum's local health services (in collaboration with our Nursing Station, which is currently run by the First Nations and Inuit Branch of Health Canada). (Our health system is described in Chapter 2.)

Our community health planning process, spearheaded by our Leadership and the PHA, is a community-based initiative to bring our community together to heal and strengthen our individual, family, and community health, now and in the future.

Health Planning Context

Our community health today is influenced by our collective, family, and individual histories. Our ancestors' way of life prior to contact was different from ours today in many ways, but these changes did not happen all at once. Many things have influenced and impacted our community life and health in Pikangikum over the last century, including: changing from our traditional lifestyle to a settled, cash-based lifestyle; colonization and the Indian Act; the residential school system; religious influences; changes in transportation and communications technology; introduction of Western-style health services; and more recently, a process of healing and reclaiming our culture and self-determination (see Chapter 2 for more complete community health history).

Pikangikum's health planning journey builds on a history of building our local governance over health and community development, including recent initiatives to develop local community-based planning capacity. In 1996, our Elders gave our leaders a mandate to develop the Whitefeather Forest Initiative, a community economic renewal and resource stewardship initiative. This was an important step in PFN taking a lead on planning for our future. Our 2006 Land Use Plan *(Keeping the Land)* articulates our customary ways, our cultural values, our Elders' teachings and a plan to carry forward our ancestral stewardship responsibilities of our lands.

The establishment of the PHA in 2008 started a process of increased self-determination. We have been making significant strides in planning for our future and gaining more responsibility over our health system, but challenges and pressing health issues continue to dominate.

Between 2006 and 2012 a series of tragedies in Pikangikum drew international attention to the high level of mental health challenges, particularly Youth suicide, that our community is struggling with. It was reported that 60 teenagers have committed suicide in the past decade[1] and that Pikangikum was "the suicide capital of the world."[2]

1 Toronto Sun. (Sept. 16, 2011). www.torontosun.com/2011/09/16/remote-reserve-plagued-by-epidemic-of-youth-suicides
2 Maclean's. (Mar. 30, 2012) www2.macleans.ca/2012/03/30/canada-home-to-the-suicide-capital-of-the-world

The situation triggered an inquest by the Chief Coroner of Ontario (2011), which reported on our community's challenges with addictions, inadequate housing, gaps in healthcare and education, and obstacles to economic development.[1] The scale and urgency of these health issues continue to grow today (see Chapter 2 for more complete summary of issues and challenges).

While these investigations focused on the negatives in our community, they did draw attention to the needs and challenges that are undermining our individual, family, and community health. PFN's leaders and community staff have worked tirelessly to address community challenges, including programming for maternal health and early childhood development, services for acute and chronic health care needs, and supports for suicide prevention and addictions counselling. Community nurses, teachers, local mental health workers, PFN and PHA staff and many others have been contributing to the effort through a number of initiatives (such as: school food programs, food hampers for new mothers, diabetes programming) to improve the health of our members.

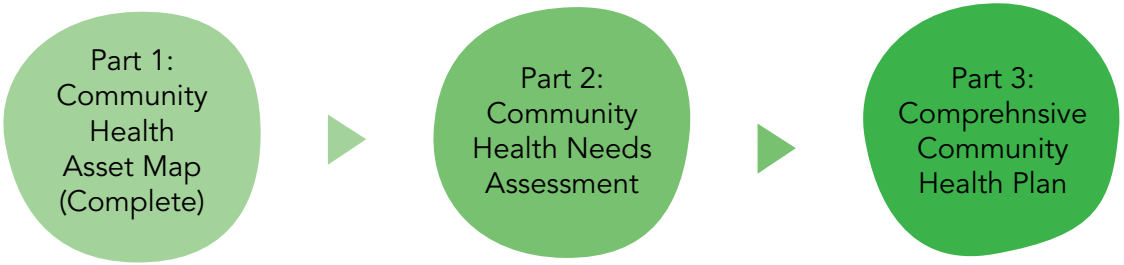
However, local capacity and resource challenges, lack of interagency coordination, combined with limited unpredictable funding have created interruptions of delivery and development of important social, health, education, and Elder programming especially given the scale, degree and urgency of the mental health and addiction challenges in Pikangikum (challenges are discussed further in Chapter 2). Given these ongoing challenges, our comprehensive community health planning process is timely and needed.

---

1 Office of the Chief Coroner for Ontario. (2011). Death Review of the Youth Suicides at the Pikangikum First Nation, 2006-2008 http://provincialadvocate.on.ca/documents/en/Coroners_Pik_Report.pdf

Project Launch and Leadership

In 2011 and 2012, the Leadership of PFN granted the PHA under the leadership of Billy Joe Strang, the mandate to initiate a community health planning process in response to a series of mental health crises in the community and the recommendations made by the 2011 report on Pikangikum by the Ontario Chief Coroner's Office. The SHEE (Social, Health, Education, and Elders) Committee, including representation from community leadership, agencies and funding partners, was established to help oversee and guide a Community Development Strategy comprised of three parts:



An initial community health assets map was completed for the PHA in 2011. To move forward with a health needs assessment and health plan, an innovative tri-partite funding arrangement was negotiated with Health Canada, Aboriginal Affairs Canada, and the Ontario Ministry of Aboriginal Affairs. With this support, in 2012 a comprehensive Community Health Needs Assessment (CHNA) process was started. A local Pikangikum Working Group was established to help manage the needs assessment and subsequent health plan process, PHA hired Beringia Community Planning Inc. to help facilitate both the needs assessment and health plan. A local planning team was established, led by Project Managers Samson Keeper (Phase 1) and Brian Keeper (Phase 2) and a team of planners including oversight by the Executive Director of the PHA, Billy Joe Strang (see Figure 1).

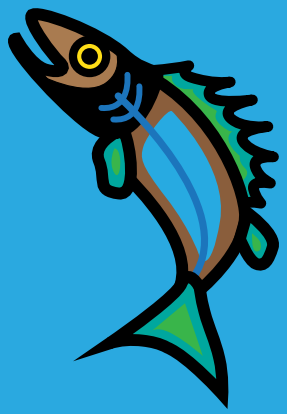


FIGURE 1: Players in our Planning Process

Our CHNA report was completed in December 2013. This report summarizes a 20 month process of listening, preparing, relationship-building, researching, discussing, learning, and analysing community results to understand and document our community's health issues, needs and strengths to begin defining our priorities to target actions (further described on page 28).

Our CHNA lays the foundation for our health planning process by providing us with the context and assessment of where we are now in terms of individual, family, and community health, and in what areas we need to take action to change our community and improve our health for the future.

Our overarching community health planning project includes nine different phases, to complete our CHNA and CCHP (Figure 2). The first three phases of the project focused on the CHNA, and the remainder on the CCHP.

The information collected in our CHNA process directly led into our CCHP vision framework, starting with a process to identify our Health Vision, Principles, Directions, and Paths and through them, the identification of our strategic actions/interventions, and overall implementation strategy (Figure 3).

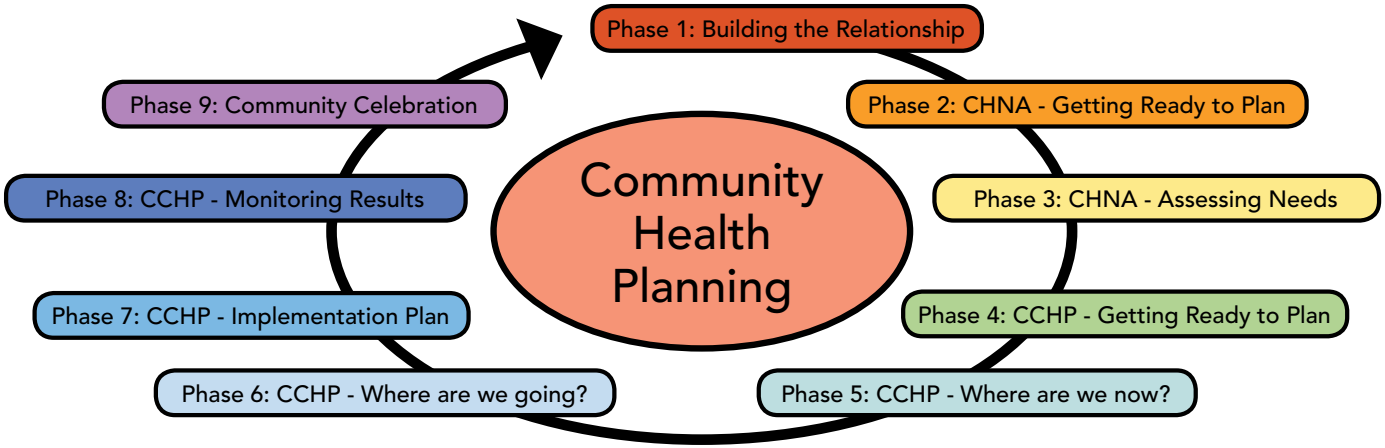
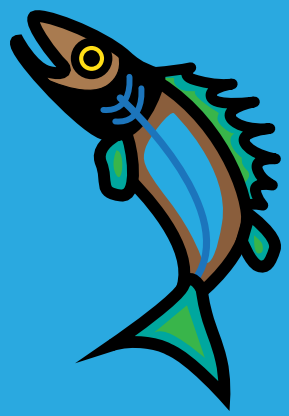


FIGURE 2: CHNA and CCHP Planning Phases



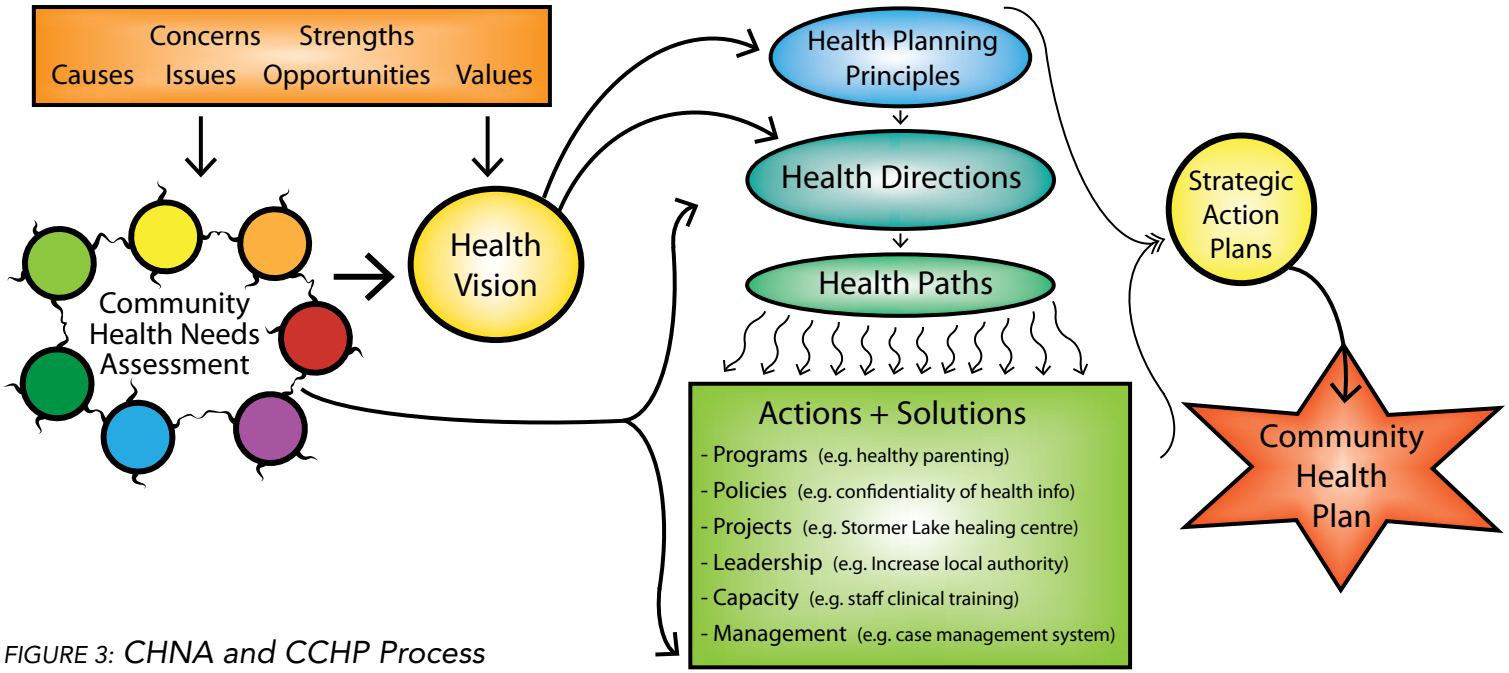


FIGURE 3: CHNA and CCHP Process

What is a Comprehensive Community Health Plan (CCHP)?

A CCHP is a carefully researched and designed strategic action plan for improving the health of individuals, families, and the community. Health planning itself is a process that supports improved health "by creating an actionable link between needs and resources."[1]

Health plans can be used to improve health management and governance, guide programs and services, ensure priority health needs are met, and leverage opportunities for partnerships and health funding.[2]

To begin a CCHP, we needed to look at our current situation, in part based on our needs assessment, in order to know where we want to go. This means assessing our health concerns, strengths, causes, issues, opportuities and values. Then, we identified a vision statement and set of Directions for how we want to

1 Province of Ontario. 2006. The Health Planner's Toolkit, p.1
2 Health Canada. 2007. A guide to developing and implementing a health plan, a guide for First Nations and Inuit., p.6

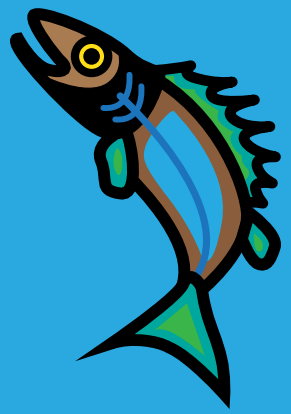
focus our health and community. These directions, supported by pathways, helped us identify, evaluate and prioritize action ideas/interventions (programs, projects, policies) This is how we intend to bring about the changes we need to restore our community health.

A CCHP considers the integration and inter-relationships among all parts of a community: culture, social, spiritual, economic, governance, infrastructure, health, education, and environment. It also focuses on building relationships, engaging community, and building a living plan that is ongoing, useful, and adapted to new situations. In short, a CCHP:

- ✓ Brings everyone together
- ✓ Guides decision-making
- ✓ Determines priorities
- ✓ Helps use resources wisely
- ✓ Increases benefits
- ✓ Provides momentum and direction for positive change

Our Health Plan

Pikangikum's health planning journey builds on a history of strengthening our local governance over health and community development, including recent initiatives to develop local community-based planning capacity. Our plan is comprehensive because it looks at health from a broad and holistic perspective that includes both the outcomes of health (such as rates of illness) and underlying factors that influence health (such as housing, education, or household income). Our plan is also inclusive and based on wide community engagement – our planning process was designed to include voices and knowledge from all across the community, as well as from health staff and professionals. It was designed to strengthen relationships across a diversity of agencies, create ownership of the process, nurture local capacity and build feelings of confidence, inclusion and belonging. As well, our plan includes a five phase cycle of preparation, assessment, visioning, action, implementation, and monitoring and adaptation to keep our plan a living tool for change.



Planning Objectives

This planning process was an unprecedented opportunity to bring together our members, staff, and leadership and other partner organizations to discuss, understand, and plan for our community health in a holistic and participatory way. The objectives of our CCHP process were to:

- Identify and give voice to our community's vision for a healthy community
- Identify principles and guidelines to lead us
- Determine our health priorities (Directions and Paths) based on needs, values and preferences
- Celebrate our culture and integrate our traditional knowledge
- Evaluate and prioritize strategic actions to meet our health vision and priorities
- Build local planning capacity to carry out our plan and evaluate how we are doing (results)

How to Use this Plan

Our CCHP is useful in a number of ways:

For our **community health staff** and **leadership**:

- ✓ It provides clear direction to strengthen our community health
- ✓ It presents strategic packages of actions and how to implement them in a format that can be adapted as circumstances and opportunities change
- ✓ It informs and supports our efforts to have more self-determination over our health system through increased health transfer
- ✓ It informs project and program planning in the community and assists staff in developing and expanding work plans and reporting
- ✓ It builds commitment and responsibility to our overall health vision.

For **community members** generally:

- ✓ It represents a shared conversation about how we want to strengthen our individual, family, and community health
- ✓ It is a tool for engaging with leadership to push for continual improvement
- ✓ It is an expression of cultural revitalization and respect.

For **funders and partner organizations**:

- ✓ This plan is a powerful presentation of Pikangikum's shared vision for health
- ✓ It is a tool to have our community voices inform and support development of new and existing health programs, services, and infrastructure.

Organization of Report

Our community health planning process and plan are organized into five main parts, summarized in the table below and explained in the next section.

Report Section	Guiding Questions	Contains	Page
Ch. 1 Preparing	• Are we ready to plan? • What do we need to do to get ready? • What is the process to make this plan together? • How do we build relationships for our planning process? • How will we engage our members? • How can we make a great plan for our community?	• Introduction • Health Planning Context • What is CCHP? • Organization of Report • Approach & Methodology • Planning Process	1
Ch. 2 Discovery	• How has our past influenced us today? • Where are we now? • What is our current situation?	• Community Health History • Community Profile • Our Health System • Community Health Needs • Situational Assessment	45
Ch. 3 Vision	• Where do we want to go? • What do we want to change? • What vision, values and actions will guide us?	• Community Health Vision • Health Planning Principles • Health Directions and Paths • Action Areas • Priority Actions	95
Ch. 4 Action	• How will we get there? • What do we need to organize ourselves? • What is the timing, phasing and sequencing of actions? • Who does what? • What is the cost and how do we fund our health vision?	• Organizational Readiness • Implementation Principles • Strategies and Mechanisms • Roles and Responsibilities • Phasing and Timing • Budget and Funding Strategy	120
Ch. 5 Results	• Are we getting results? • How are things changing? • How will we update and adjust our health plan? When?	• Introduction to Monitoring and Evaluation • Types of Monitoring • Types of Evaluation • Step by Step Strategy • Plan Revision Process	159

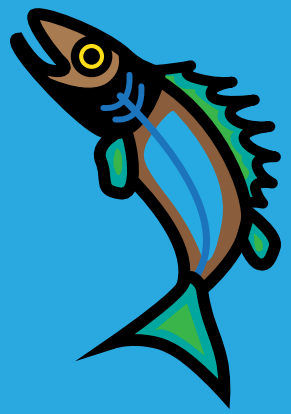


Figure 4 summarizes how our process led us from understanding our current situation all the way to results: first by identifying and verifying a vision statement and set of principles; then by drafting and verifying directions and paths to help us identify strategic actions/interventions (and corresponding action plans); and finally by identifying desired outcomes (indicators), impacts and measuring results.

FIGURE 4:
Our Health Planning Process

APPROACH & METHODOLOGY

Approach

Our approach to community health planning is one that empowers our community, honours culture, builds skills and capacity, and includes participation, engagement and collaboration. This is a grass-roots process that has made a strategic action plan for our community, emphasizing both our strengths and opportunities. It has uncovered our priorities and lays out a framework for using our resources and strengths to make wise decisions in achieving our vision for community health.

Our plan and approach is based on traditional and local knowledge, and values. Our efforts are informed by four principles that are central to Anishinaabe teachings about our lives as individuals, families, and a community: Ohniisheesheen (Health); Chiimeenoowe-chiiteeyong (Relationships); Oohuhchikayween (Planning); and Anishiinaabe-Bimaadiziwin (Way of Life) (Figure 5). These Anishinaabe principles are central to how we think about health and healing in our community. This broad and holistic approach to health is shown in the definitions and understandings of 'health' as shared by our community members (quoted around the central circle in Figure 5):

"We are all of one mind- we can help heal together"
Elders session, May 2012

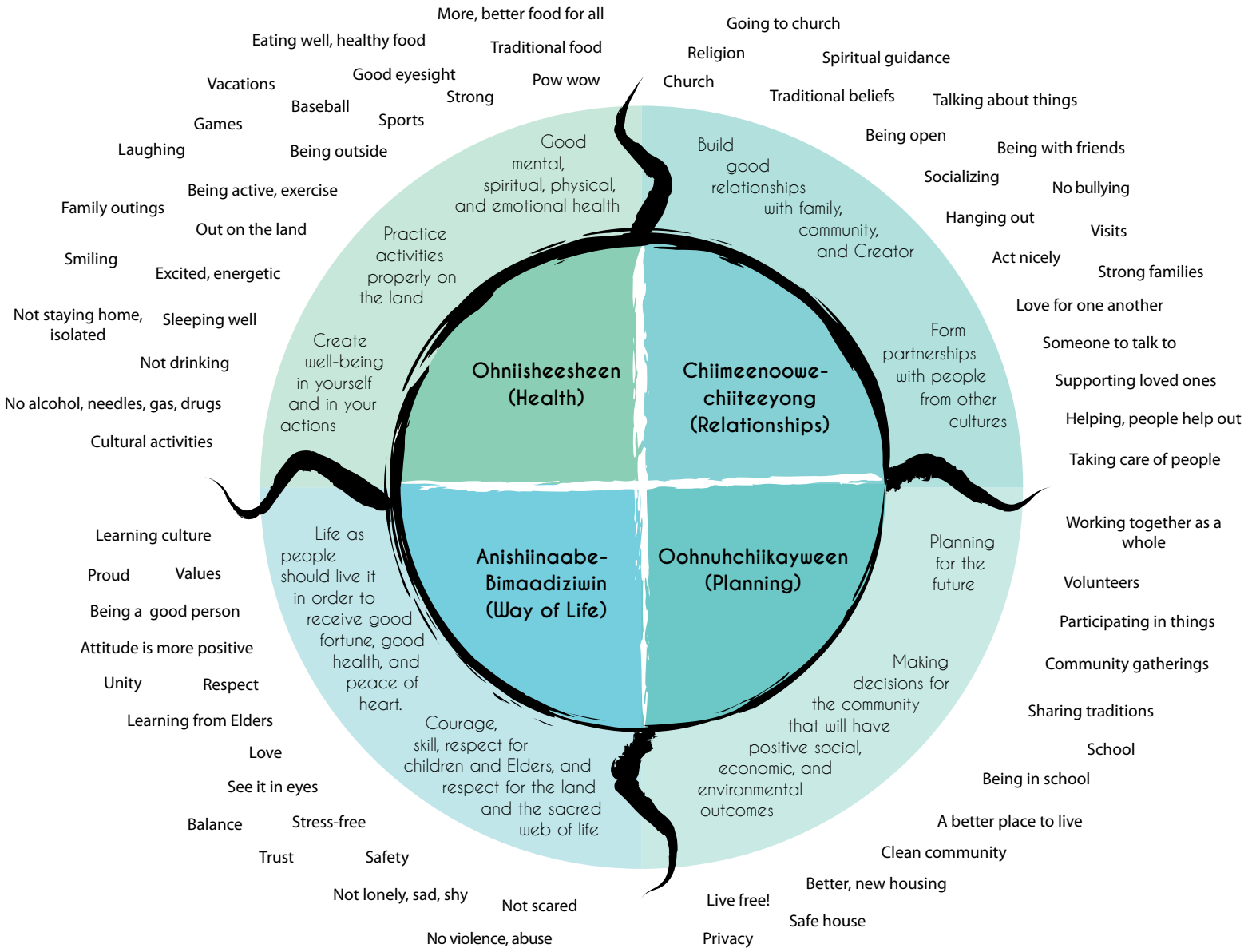


FIGURE 5 – Anishinaabe Principles and Community Definitions of Health, Source: Life and Journey Principles (informed by The Whitefeather Forest Land Use Strategy, Shearer (2008), and Zhaawano Ghiizik (n.d.))

In Pikangikum today, we are using these principles. Through community Planning we are working to restore and strengthen our Health, Relationships, and Way of Life that have been, and continue to be, damaged by generations of trauma through oppression, abuse, addiction, and violence.

In addition to these four Anishinaabe principles, we agreed upon the following five pillars and additional 13 process principles, identified in Figure 6, to guide our planning process:

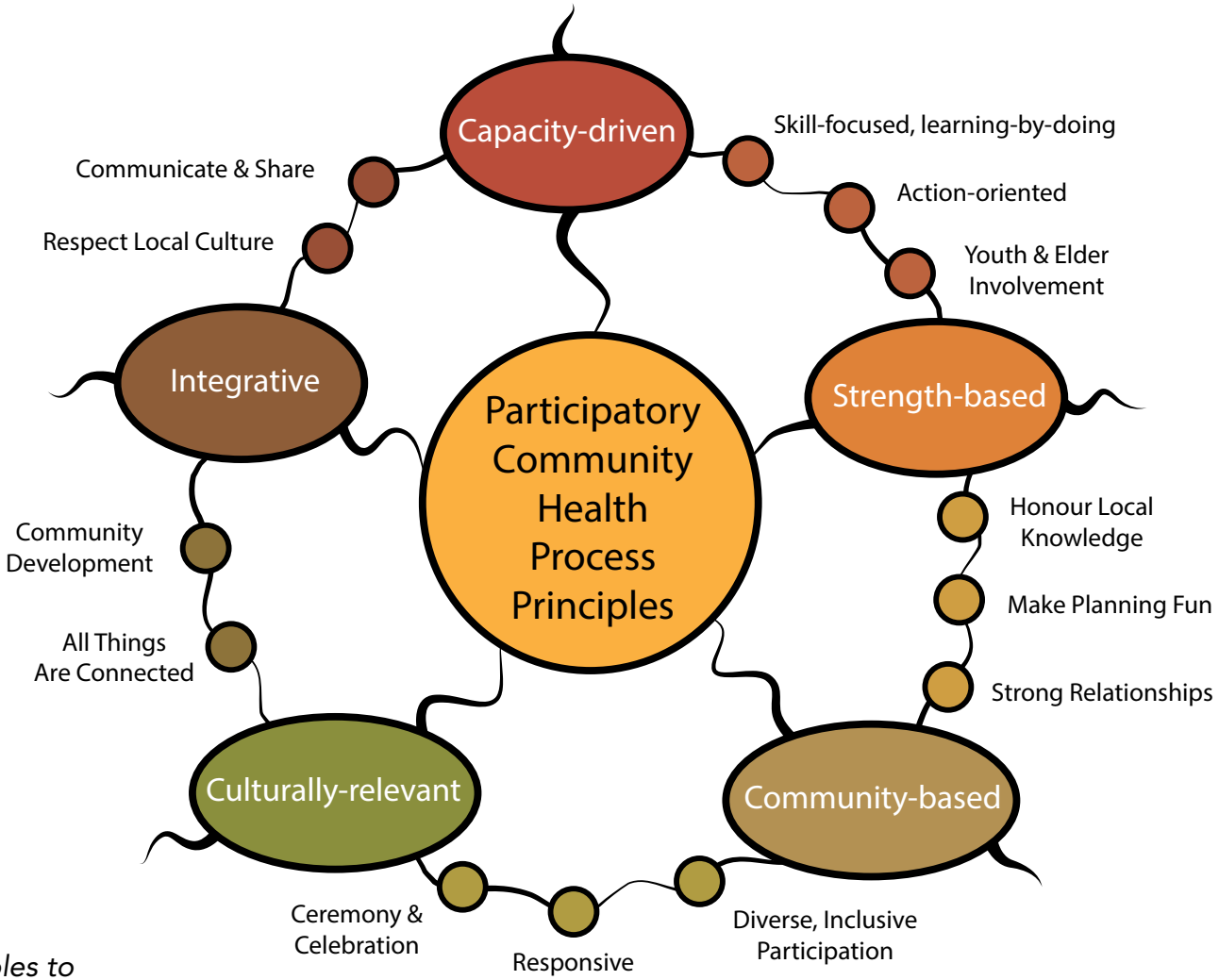
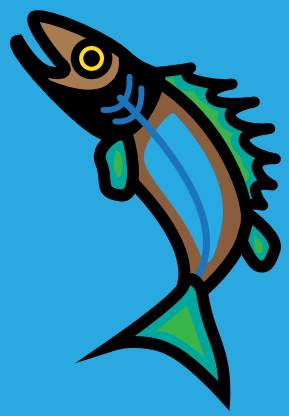


FIGURE 6: Principles to Guide our Planning Process



Our original ten principles in our CHNA process were:

- **Empower Youth and Elder involvement:** opportunities to meaningfully involve, respect, celebrate and empower our Elders and Youth were emphasized throughout this process.
- **Honour local knowledge:** we worked closely with the Community Planning Team, Pikangikum Working Group, SHEE committee, PHA, and Elders so that the results of our work truly honour and reflect local knowledge and way of understanding.
- **Make planning fun:** community engagement events were interactive, fun and always involved food and prizes.
- **Build strong relationships:** we emphasized taking the time to listen and learn about one another, and to build trust and learn from one another.
- **Diverse and inclusive participation:** it was crucial that we included all perspectives and voices in our community, and to nurture a process that supported a plan made by our community, for our community.
- **Planning as ceremony and celebration:** opportunities for ceremony, recognition and celebration were built into our process and events.
- **All things are connected:** our entire approach to this process and our understanding of community health emphasized the interconnectedness of all parts of our community and the need to use a wide and holistic lens when looking at health and healing.
- **Community development:** as part of our holistic approach to health, it was important that we considered community development in our plan, such as jobs and livelihoods, education, and community infrastructure, because these are all foundations of good health.
- **Respect local culture and customs:** our work was driven and shaped by a respect for local culture, protocols and customs.
- **Communicate and share:** a communications strategy ensured that results were shared with the community in a visual and user-friendly way using newsletters, summary posters, presentations, reports, community radio and facebook.

For our CCHP process we added three more principles to guide us:

- **Skill-focused, learning by doing:** opportunities for learning new skills, reflection and mentorship were built into our process. A Planner's Binder was developed for the community with planning tools and resources.
- **Action-orientated:** our plan included all of the implementation tools necessary to help ideas become tangible actions
- **Responsive:** a monitoring and evaluation strategy was built into our plan to ensure maximum learning, to celebrate our successes and to allow us to adapt our plan.

5 Phases of Planning

We organized our planning process into five overarching phases of a cycle, which connect and occurred at times throughout the process. We use these five phases to organize this report, illustrated in Figure 7. This illustration draws inspiration from traditional Anishinaabe art and Anishinaabe artists working in the 'Woodland' art tradition. The seven animals around the outside represent our traditional 7 clans (Loon, Crane, Fish, Bear, Martin, Bird, Deer). At the centre of the illustration is two people in a canoe, reminding us that we are part of the system of the landscape; that we are travelling together on this planning journey, and that it takes our effort and initiative to paddle through all the parts of this planning process and implementation. The energy lines connecting the creatures and the process illustration show that every part of this process is connected to the landscape that supports our people, and that all parts of the landscape are connected to each other as well. Within the circle is our planning process, illustrated in 5 phases.

We are surrounded by and live our life around water. Our 5 phases are connected by flowing rivers which emphasize the dynamic and fluid connections between all parts of a planning process. Each phase of the process is accompanied by a descriptive keyword and guided by a question:

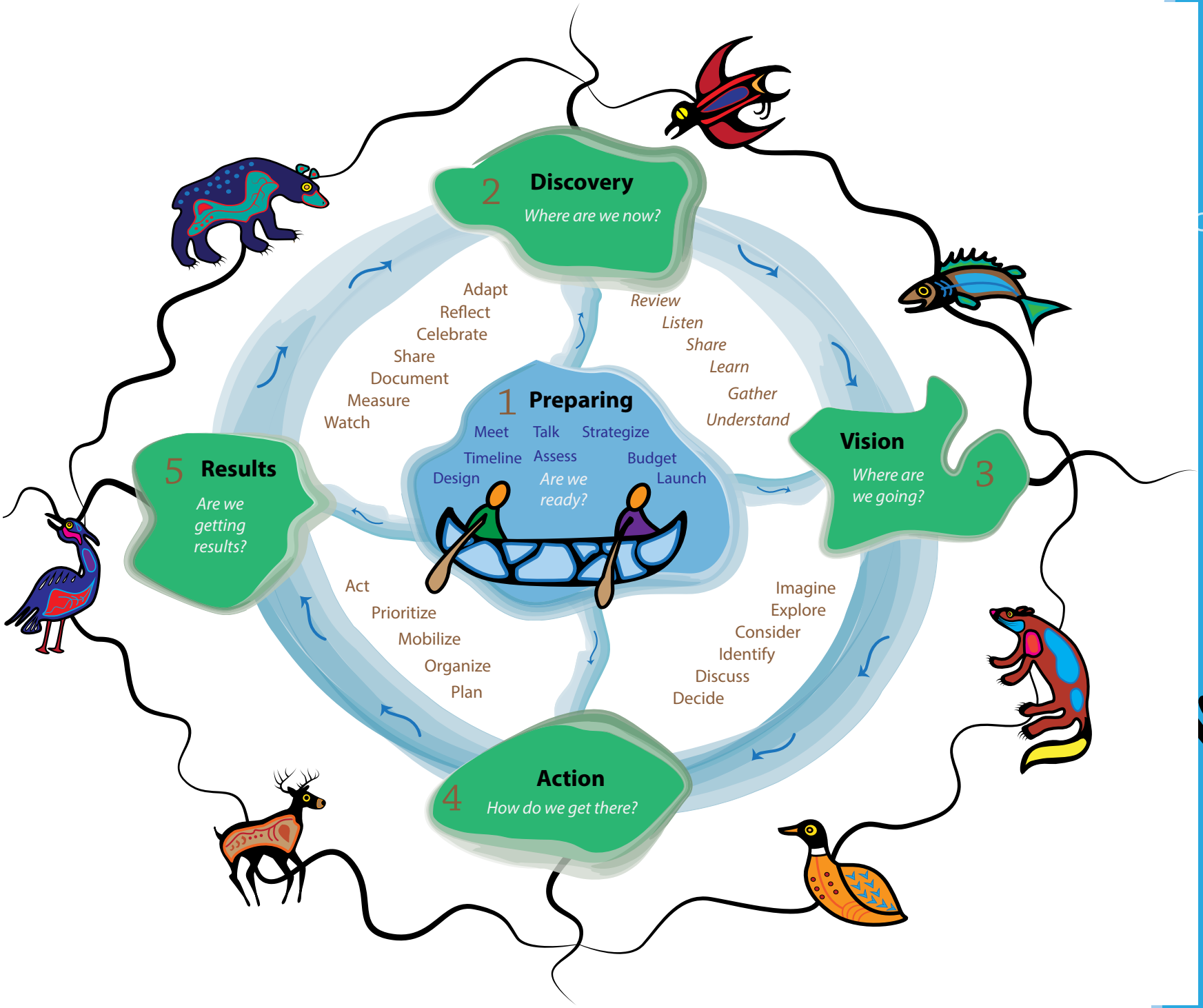


FIGURE 7: 5 Planning Process Phases

Phase 1:

Preparing

Are we ready?

Core elements:

- **Meet** to build relationships with local planning team, working group, and SHEE committee
- **Talk** with Chief and Council and Elders for their approval and welcome
- **Strategize** and design planning process
- **Assess** capacity and information needs
- Make **timeline**, work plans, and **budget**
- **Launch** project and welcome feast
- **Design** engagement & communications strategy

This phase of the planning process includes assessing capacity for planning, organizing people, time and resources, and collecting existing information necessary for planning and decision-making. There is a focus on building relationships and working together to create a planning process.

In our CHNA, we began with assembling the Planning Team (Samson Keeper, Gloria Keeper, Rex King, Greg Pascal, Tracy Black, Alex Quill, Lloyd Quill, Brian Keeper) and then spent time building relationships between Leadership and staff, Elders, the SHEE committee, the PEA board, the PHA board, the Working Group, the Planning Team and Beringia. We held a series of introductory community sessions and project launch meetings. Using a holistic definition of health created by the community (see Figure 8), we determined the scope of information needed. Relevant documents and data sources within the community were identified and reviewed. We collaboratively developed our planning process, engagement strategy, and work plans. We maintained these successful practices throughout all parts of our planning process.

In the CCHP process, we revisited this part of the planning cycle by taking stock of what we accomplished and how, in the CHNA, and created a work plan and process to complete the CCHP. We reflected on what had worked well in the CHNA and made a strategy for continuing to engage with community and staff members in the CCHP process.

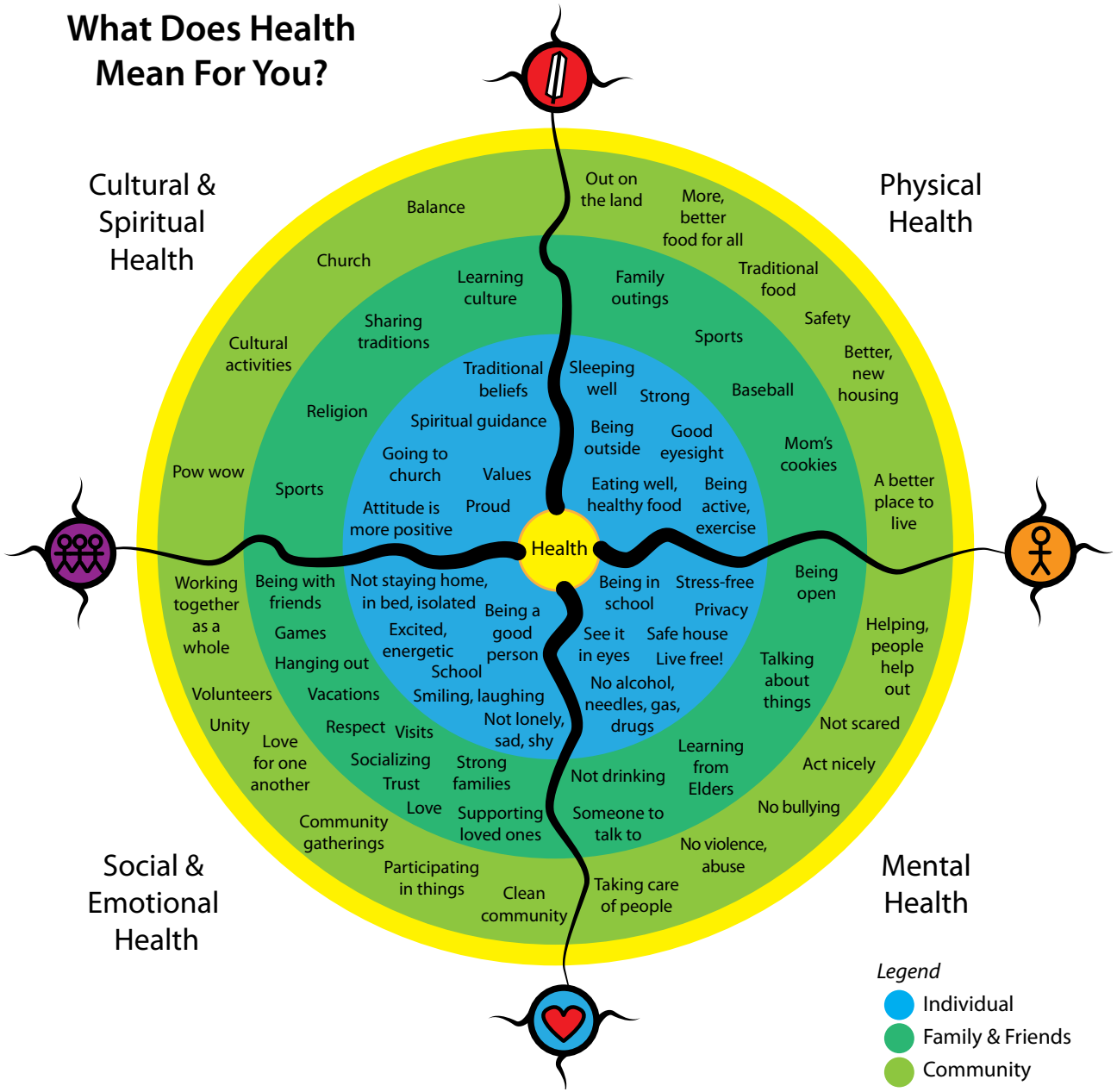


FIGURE 8: *Community Definition of Health*

Phase 2:

Discovery

Where are we now?

Core elements:

- **Review** existing data, reports and summaries
- **Listen** to each other
- **Share** through community participation
- **Learn** through data collection and analysis
- **Gather** existing information, background, and past planning efforts
- **Understand** the current situation

This phase of the planning process is about gathering and sharing information with individuals, groups, and the community to learn about where we are now, where we have come from, and where we want to go. This is essential in making wise decisions about the future.

We started the CHNA with background research, including a Community Health History report, Community Health Status report, Community Health Trends Analysis, and a Community Health Systems report (see CHNA Appendices 5-8). Then we embarked on a process of broad, holistic, and inclusive community engagement. Over 20 months, 574 members and staff came together to share and discuss our community strengths, concerns, health issues and some of their causes, community values, and opportunities. We hosted large scale community events and conducted interviews and focus groups (Youth, Elders, Teachers, Women, Staff). We analyzed this information and presented summaries back to the community for feedback and ranking. This information, along with health data collection, a Community Health Issues Analysis, and a Program Review, allowed us to identify and prioritize our community health needs in our CHNA report.

In our CCHP process, we engaged another 290 members, reviewed all the information from the CHNA and conducted additional assessments. The results of these assessments are summarized in this report and found in Appendix 11 and 13 as the Continuum of Care analysis and Situational Assessment. Combined, these allowed us to define our Directions and Paths as part of our Vision for community health.

Phase 3:
Vision

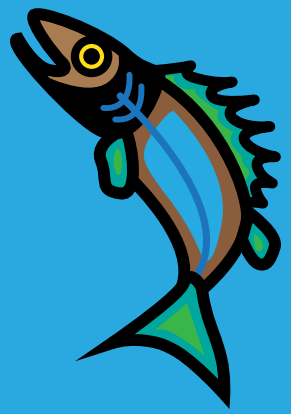
Where are we going?

Core elements:

- **Imagine** a future Vision
- **Explore** values and guiding Principles
- **Consider** Health Directions and Paths (Ends and Means objectives)
- **Identify** potential actions and opportunities
- **Discuss** action ideas and priorities
- **Decide** on strategic packages of actions

In this phase of the planning process, we consider the potential and desired changes that the community wants to see. To lead a Vision for health and the future of our community, we define our vision statement and develop a set of principles to guide us in our planning and actions. Choosing Directions and Paths point the way towards the changes we want to see. To make our Vision real, we collect and develop actions and interventions, and package these into an action plan and strategy to bring about our desired change and results.

We collected over 200 ideas for actions and solutions during both the CHNA and CCHP processes. As the process unfolded, community members and staff identified and ranked actions/interventions through a series of workshops, tools and finally with a live clicker survey in which 366 participants voted for their favourite action/intervention ideas. This allowed us to group and narrow the list of actions down through time (see Figure 11). A total of 69 priority actions were identified through the process and grouped into 5 broad action clusters (Healing, Health System, Families, Youth, Culture) that represented the dominant themes that emerged from the action ideas. Within these 5 clusters, actions were further grouped with related actions to form 21 action themes (example: Local healing system, parenting support, violence prevention). A prioritization framework considered the relative popularity, impact and feasibility of each action idea in order to identify 25 top priority critical and essential actions to help focus efforts and resources.



Phase 4:

Action

How do we get there?

Core elements:

- **Plan** implementation of chosen actions
- **Organize** roles and responsibilities
- **Mobilize** resources and funding
- **Prioritize** action phasing and sequencing
- **Act** on implementation plans

This phase of the planning process looks at carrying out actions to bring about specific changes and outcomes, with clear steps. Implementation is defined and overall implementation principles and values were communicated, as well as core components for successful implementation. Challenges to implementation are considered and strategies to address these challenges are suggested. An overall implementation strategy in six phases starting with a 'getting ready to implement' phase, that lays the foundation for successful implementation of the remaining five phases of actions. Actions are sequenced and phased logically so that actions built on a series of incremental steps. Roles, responsibilities and budget are proposed to ensure sucessful implementation.

"Change will come from the people themselves. Commitment to change – respected Elders, youth, elected leaders engagement"
(Key informant interview)

Phase 5:
Results

Are we getting results?

Core elements:

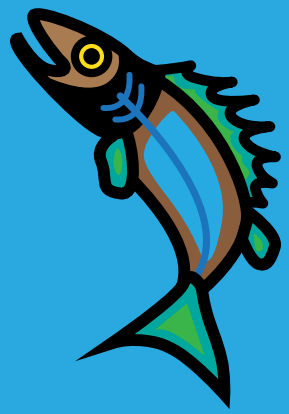
- **Watch** targets and indicators
- **Measure** changes
- **Document** improvements and struggles
- **Share** results and progress
- **Celebrate** successes
- **Reflect** on progress and learning
- **Adapt** plan as needed

Any plan should lead to results. In this phase of the process, we need tools to help us measure our progress towards our Directions and to adapt our plan as needed to stay on course. To keep our plan alive we need to monitor our progress effectively and transparently, communicate results, and revisit the planning cycle if adaptation is needed.

In the CHNA and CCHP processes, community members and staff discussed what things would show them that there is positive change in Pikangikum and that we are moving towards stronger community health. These things were framed as indicators that can be measured and compared to targets to inform the evaluation of our plan and actions. In addition, a series of tools are suggested to help us continuously track the expected and unexpected outcomes of our health plan. We also made a strategy for communicating results and a process for reviewing and updating our CCHP.

What would tell you that your community is getting healthier and stronger?

"More graduates, less violence, more community events, graffiti (no more!)"
(November 2013 survey)



Community Engagement & Communication

We started our community engagement efforts by asking our membership how they wanted to get involved to build a community-based process through a survey at our first open house in July 2012. Based on this survey and guidance from our Elders, Chief and Council, our Project Manager (Samson Keeper) and local planners, we designed an inclusive, participatory, capacity-focused, ongoing community engagement strategy. We engaged with Youth, Elders, PHA staff, women and men, Chief and Council, agency and organization representatives, health professionals, teachers and education staff, and community support services staff. Participants shared their experiences and knowledge and discussed their ideas for building a stronger, healthier Pikangikum. Over 864 individuals participated over the 28 months of our CHNA and CCHP processes.

Our vision for community participation and communication was as follows:

> *Our planning process creates a diversity of ongoing opportunities for a wide range of community members to gather, participate, engage, learn, make decisions, have fun and feast together. Participants have multiple opportunities to increase skills and learn by doing. Our planning process supports increased confidence for individuals, better understanding of community issues and need, more recognition of the role of traditional and local knowledge in our health system, and healing for individuals, families, and our community.*

Examples of how we achieved our participation vision are illustrated in Figure 9 and described on the following page.

FIGURE 9: Community Engagement Tools and Techniques

Multiple scales of participation:

- Large-group Community Open Houses and Sessions (6)
- Small-group sessions (32)
  - » Elders meetings (4)
  - » Neighbourhood sessions (2)
  - » Youth sessions (8)
  - » Staff sessions (14)
  - » High-school class sessions (3)
  - » Women's Circle (1)
- Advisory meetings (Chief and Council, SHEE, Project advisors) (50)
- Team meetings (Planning Team & Working Group) (27)
- Interviews (77)
- Survey respondents
  - » Door-to-door (46)
  - » Online (17)
  - » Live clicker survey
    - › Community (288)
    - › Highschool (57)
    - › Staff (21)
- Facebook group (234 members)

Diversity of engagement tools and methods:

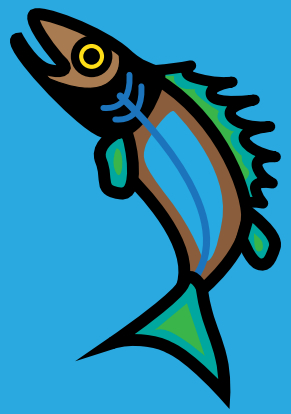
- Open discussion and brainstorms
- Writing stories and poems
- Drawing
- Creating comic strips
- Sharing ideas on video
- Writing ideas on a postcard
- Adding to community history timeline
- Adding to a wheel of community strengths
- Completing four parts of health circle (mental, emotional spiritual, physical)
- Brainstorming ideas for actions and solutions
- Picking favourite action ideas from a list
- Ranking draft directions, paths and approaches
- Voting on actions as part of a live clicker survey

Recognize and celebrate community involvement:

1. Door prizes
2. Logo design contest
3. Free t-shirts with our logo
4. Honouring names of participants in reports and newsletters
5. Fun activities and games at community sessions
6. Sharing food together
7. Community Bingo

Increase skill base of members:

- Using tools and communication to help teach how planning works
- Sharing community newsletters and reports with community members
- Discussions on the radio
- Ranking draft directions and paths
- Editing draft vision statements
- Writing a letter to Chief and Council
- Sharing ideas of how to spend a community health grant
- Brainstorming health indicators
- Using tools to teach about action prioritization



Continuous ongoing opportunities to get and stay involved:

Between March 2012 and January 2015, ongoing engagement activities were being held ranging from team meetings, advisory meetings, small and large commmunity sessions, interviews and surveys. The distribution and timeline of these activities is illustrated in Figure 10.

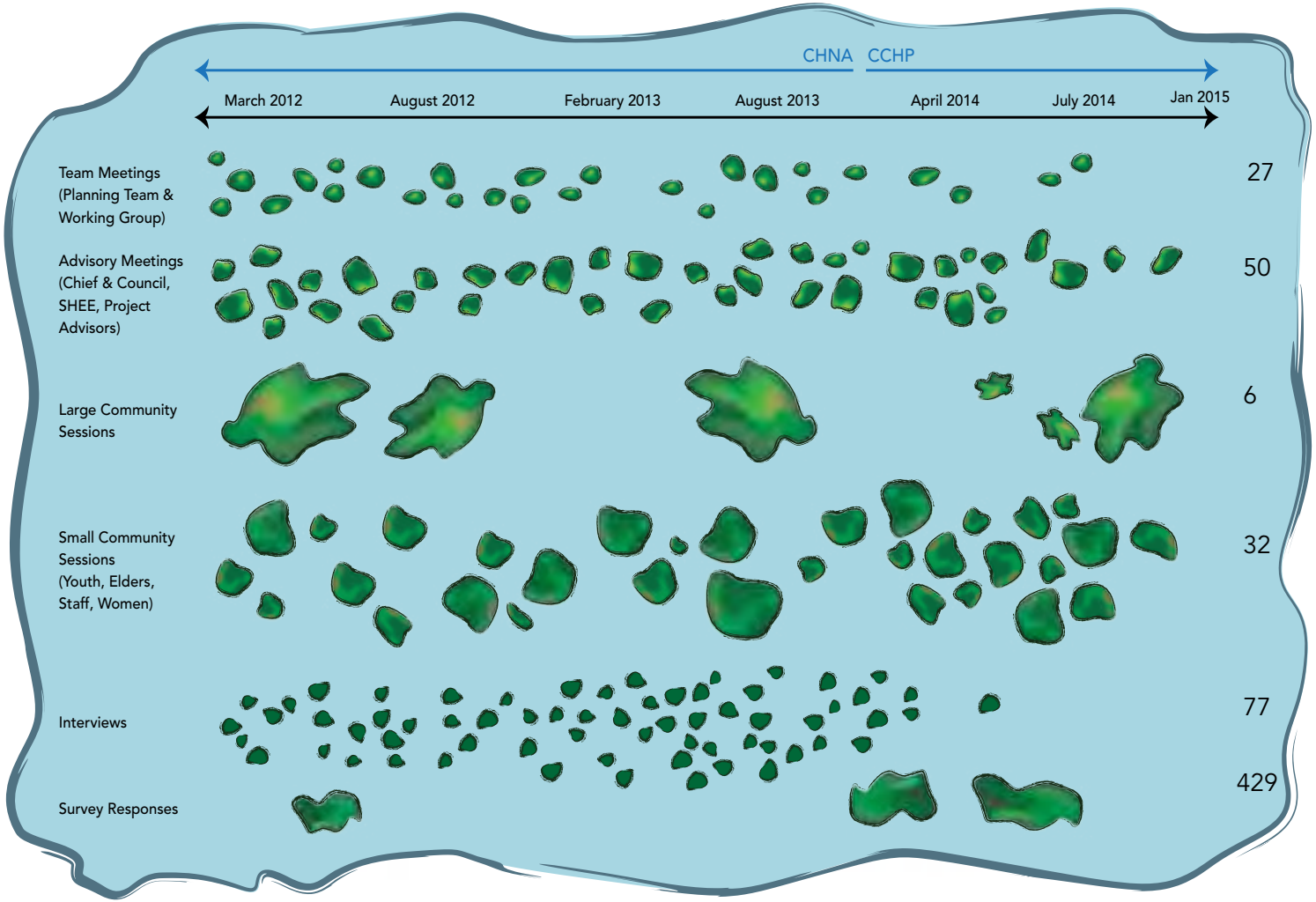


FIGURE 10: Engagement Timeline

Communications

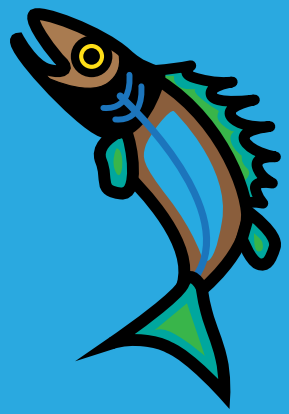
Throughout our CHNA and CCHP processes, the importance of communicating information and findings back to the community was clear. Our strategy was to make findings visual, fun and easy to access. We updated members on the progress of our process through regular newsletters, reports, radio announcements, summaries at events, mail outs, a Facebook group, word of mouth, walkie-talkie announcements, and translations into written and spoken Anishinaabe.

Analysis Methodology

CHNA Methodology Summary

Our CCHP builds on the strong foundation set by our CHNA process and its methodology. Our CHNA was based on a combination of quantitative data and qualitative data collected through research, review of existing reports and internal records, community workshops, focus groups, meetings, and interviews. We asked community members and staff to validate and expand upon findings to ensure accuracy on an ongoing basis. As our information on community health needs grew, we identified themes and labeled information under different large-group categories. We allowed themes to emerge organically from the data and as the list of labels and categories increased we grouped related labels together. Community members ranked their top health needs from a list of 137 needs. Our final list of health needs was shaped by the results of this community ranking exercise along with knowledge gathered from interviews, focus groups and research.

Our final analysis assigned a level of priority to the main health needs to highlight which needs to start with in terms of strategic interventions, implementation and feasibility. A prioritization exercise was conducted which considered the popularity, urgency and strategic advantage of addressing each need. Although all of the needs described in the CHNA are considered high priority, to help distinguish where needs fell after the prioritization exercise, each need is identified as either a critical, high priority or supporting need. See the CHNA report for a full description of the CHNA methodology.



CCHP Methodology: Situational Assessment

As we moved into our CCHP process, one of the first tasks was to review and reframe all of the information we learned in the CHNA process. The CHNA process provided an opportunity to develop a strong understanding of where we are now. We began the CCHP process with a review of all of the reports and notes from the CHNA process and the development of a community profile. Our CCHP community profile synthesized the information learned from our CHNA Health Status Report, Issues Analysis, History Profile and Health Systems Profile (see CHNA Appendix 5-7 & 19).

To orient this information towards action planning and prioritization we condensed and repackaged the CHNA information using two added tools:

1. The first was a Continuum of Care analysis, where we considered the strengths and weaknesses of Pikangikum's current health system at every stage of the Continuum of Care. This analysis was conducted with help from existing information from the program review, but also from new information gathered during an interagency meeting and regular conversations and interviews.

2. The second was a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis, which helped us identify important factors to consider as we defined our Vision statement, Directions and Paths (based on our needs), and decided what actions would bring about the change we need.

"Our tragedy with our youth is crippling us" (Elders report)

"I think our culture is the most important thing and not losing our language"
(Community Session #1 Report)

CCHP Methodology: Vision Statement and Principles

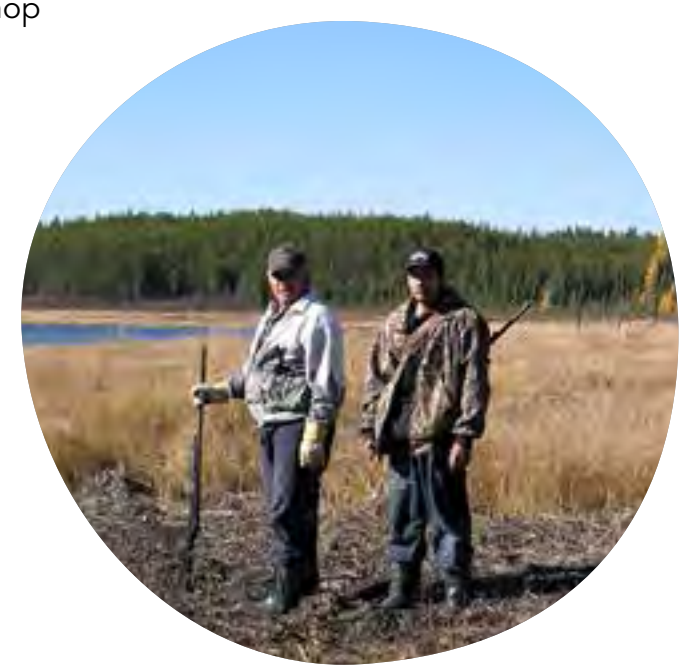
COLLECTING VISION AND PRINCIPLE IDEAS

A central part of our CCHP was to identify a community health Vision statement, as well as guiding Principles, Directions, and Paths in order to create the action framework of our CCHP. The purpose of a Vision statement and set of health Principles is to direct and inform a set of actions to achieve the change we want to see in our community.

Throughout our CHNA process, we asked community members to share ideas for vision and principles. Example questions we asked were:

- My vision for a strong and healthy community is: (Community Open House June 2013)
- What does your family need to be healthy? (Community Open House October 2012)
- How can Anishinaabe knowledge, activities and values support health? (Community Open House October 2012)
- What caused past health problems? (Community Open House October 2012)
- What does being healthy mean to you? (Youth workshop October 2012)
- The thing that is helping me improve my community's health is: (Community Open House June 2013)
- How can Anishinaabe knowledge, activities and values support health? (Community Open House and Staff Workshop October 2012)

In addition, in small group sessions with Staff, Elders, and Youth, and in interviews, we had many discussions about the future health of Pikangikum, what changes people want to see, and what principles need to be part of improving our health system.



DRAFTING AND VERIFYING VISION AND PRINCIPLES

Based on the answers to these questions and other ideas and knowledge shared by members throughout the process, we drafted a series of possible vision statements and health principles. During neighbourhood workshops in October participants gave feedback on which statements they liked and which ones they would change. The most popular vision was circulated as part of the November door-to-door survey and respondents were asked to circle words they liked, cross out words that did not belong and add their own ideas. Based on this exercise the final vision statement was edited, further discussed and finalized.

Participants in October 2013 and May 2014 workshops also reviewed our draft set of health principles. These were based on listening to members and summarizing responses from tools and exercises used throughout the CHNA process.

CCHP Methodology: Health Directions and Paths

STEP 1: GATHERING IDEAS FOR HEALTH DIRECTIONS AND PATHS

We asked community members to share concerns, strengths, and ideas about what they want to see change in Pikangikum in order to identify Directions and Paths (Ends and Means Objectives) that would support our Health Vision. We asked members:

- What three things would you like to change in your community today? (Community Welcome July 2012)
- How do we cross over to a healthier happier family and community? (Community Open House October 2012)
- What is Pikangikum's most important health concern? (Staff Workshop October 2012)
- What do you need to be healthy and strong? (Youth workshop October 2012)
- What is needed to build a healthy and strong Pikangikum? (Staff workshop October 2012)
- Why are community members not using your program? (Staff survey November 2013)

STEP 2: DRAFTING DIRECTIONS AND PATHS

Based on extensive community input and analysis of our CHNA information, we developed a set of Directions and Paths. In creating our Directions and Paths we considered:

- The issues identified in our issues analysis
- The needs identified by our CHNA, especially the priority needs
- The possible reasons for the needs identified in our CHNA
- Trends in issues, needs, reasons and causation

Together, our Directions and Paths reflect our current understanding of our strengths and what needs to change in our community. Our Directions and Paths are meant to address all of the issues and needs identified in our CHNA process. They are meant to be independent from each other as much as possible and not be repetitive to allow us to use them to evaluate action ideas.

We drafted several sets of Directions and Paths to help decide what actions support the changes we want to see. By comparing and combining the different sets, 8 Directions and 38 Paths were drafted for community review.

"We are responsible for creating a safe environment for our community"
(Key informant interview)

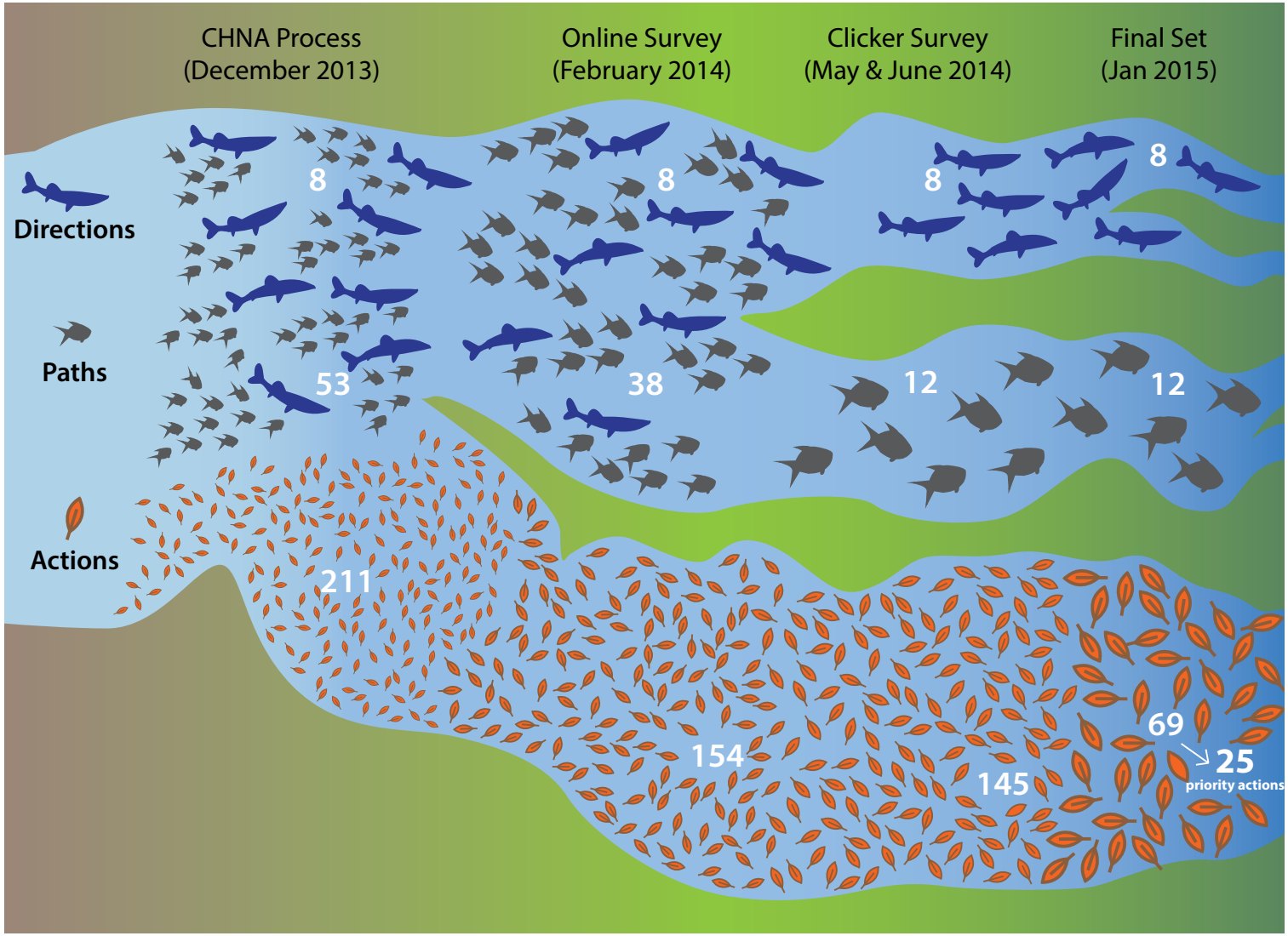


FIGURE 11: Evolution of Directions, Paths and Actions

STEP 3: VERIFYING DRAFT DIRECTIONS AND PATHS

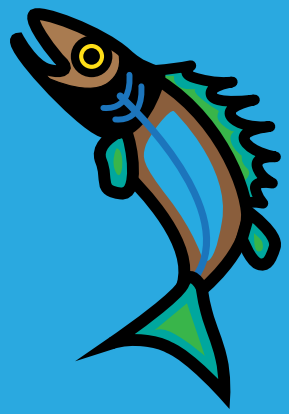
A set of draft Directions and Paths was presented to participants who ranked them to show which ones they think are most important. The following questions helped us verify and rank our draft Directions and Paths:

- Do you agree with each of the following health directions? Rank them in order of importance (Neighbourhood Sessions October 2013)
- Circle the top 3 Paths for each Direction (Neighbourhood Sessions October 2013)
- Circle from a list the 10 paths you think will lead us to our Health Vision (Door to door survey, November 2013)
- Things I want to see change to make Pikangikum healthier (Youth session January 2014)
- Number our 8 health directions in order of importance from 1 to 8 (Community Sessions May and June 2014)
- Circle the 5 paths you think are most important (Community Session June 2014)

We also verified our Directions indirectly by analysing priorities identified by Youth in our January 2014 sessions and by observing which Directions the most popular Paths were related to.

The final wording of our Health Directions was based on feedback received during the verification process. We also verified our set of Paths by comparing the growing list of action ideas (described in detail in next section) with our draft Paths. This exercise helped identify Paths that were similar and where there was significant overlap. Comparing which Paths had the most community generated actions related to them, provided us with one indication as to which Paths were most popular.

This exercise above, along with reviewing results of community feedback described above, allowed us to narrow the list of Paths down to 12. Rather than have 4-6 Paths per Health Direction, our analysis allowed us to identify the 12 Paths that best represent the action needed across all 8 directions. Figure 11 demonstrates how the number of draft Directions, Paths and Actions evolved over time. The table in Appendix 1 demonstrates how our 12 Paths relate to our 8 Health Directions. These 12 paths were ranked by participants at our June 2014 event.



CCHP Methodology: Collecting and Ranking Actions

STEP 1: COLLECTING ACTION IDEAS

During our CHNA process, we kept track of any ideas for solutions or actions shared by community members and staff. We also reviewed our Needs, Sub-Needs, Directions and Paths and identified any other potential actions not already suggested by community members. This list grew once we started our CCHP process and designed activities aimed specifically at gathering specific solution and action ideas. We asked community members questions such as:

- How do we cross over to the healthier happier family and community? (Community Open House October 2012)
- What is needed to build a healthy and strong Pikangikum? (Staff session October 2012)
- What will have the biggest impact in the short-term? In the long-term? (Key informant interviews, May 2013)
- I would spend a community health grant on...(Youth session, January 2014)

To ensure we received a broad list of actions, we prompted community members for action ideas in a diversity of ways. We asked community members to brainstorm actions based on:

- The needs identified in the CHNA (Staff session, December 2013)
- Our health directions (Staff session, December 2013; Interagency session, March 2014)
- By stage of the continuum of care (Staff session, March 2014)

STEP 2: PRELIMINARY RANKING OF ACTION IDEAS

As the list of action ideas grew, we started asking community members to pick their preferred ideas from lists of actions and solutions collected by asking them:

- Below is a list of solutions we have heard from community members. Circle your 10 favourite solutions (Door-to-door survey, November 2013)
- Pick your favourite solution ideas from this list (Staff session, December 2013)
- What are your top 3 health actions and why? (Youth session, January 2014; Staff session, March 2014)
- Choose your top 5 solution ideas from this list (Online survey, February 2014)

As we had community members rank action ideas, we also asked them to identify any missing action ideas, to keep the list of action ideas growing as we talked to new people (see Appendix 4-6 for community engagement summary reports). Meanwhile, a series of meetings with PHA leadership and staff helped identify additional strategic priority actions.

STEP 3: GROUPING OF ACTION IDEAS

We started to group similar solutions by type (policy, program, infrastructure etc.), by Need/Sub-need, and by Direction and Path (see Appendix 2). We tried to identify actions that were an anchor for other actions. For example, the idea of having a Family Center related to all of the action ideas related to parenting programs and supports for families. We looked for connections between actions, for example how a training center would have connections to other project ideas such as Stormer Lake or the Whitefeather Forest Initiative. We started to evaluate action ideas relative to each other based on how well they met our needs, sub-needs, Directions and Paths noting ideas that addressed multiple needs, Directions and/or Paths (see tool in Appendix 3).

We also started to consider sequencing of actions, what actions we are already doing that we need to continue, what needs to happen in order for other actions to be feasible, paying attention to projects that could be considered a "Quick start". These projects are identified as being relatively easy to implement, and ones that could easily be implemented by building on existing resources.

We started to think about all of the different factors that could influence the way actions could be prioritized. These included:

- How highly community members ranked action ideas
- How many Needs and Sub-needs different actions addressed
- How many of our Health Directions and Paths different actions address
- How easily could different projects be implemented
- How effective different ideas were at meeting top needs identified in CHNA

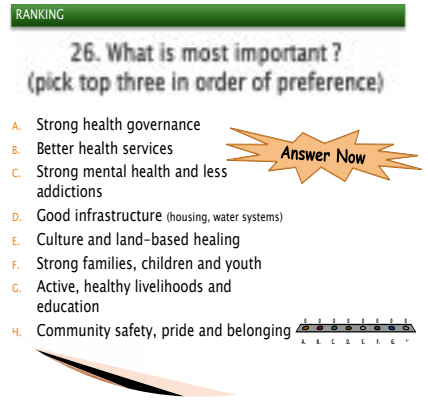
STEP 4: VERIFYING EMERGING PRIORITY ACTIONS

Based on this preliminary analysis of our actions, we started identifying some emerging priority actions.

To verify our emerging list of priority actions, we engaged 366 community members in an interactive live community survey, to help us narrow down the most effective actions for improving our community health (see Appendix 7 for full results).

To do so, we asked community members to:

- Pick their favourite action ideas from a shortened list of action ideas by Health Direction: to help us identify the most popular action ideas
- Rank the importance of our 8 Health Directions: this helped us identify that all Health Directions were evenly important
- Pick their favourite of our 12 Health Paths: to better help us understand priority paths to health.
- Rank their favourite approach (more people, cultural revival, family-centered, do it ourselves): which helped us understand that multiple approaches were popular



A series of questions for this survey were drafted and then reviewed with the Community Planning Coordinator, PHA director, and other PHA frontline staff. This review helped ensure appropriate wording of questions and catch any actions that were missing from the survey.

STEP 5: CLUSTERING AND EVALUATING ACTION PRIORITIES

Our live community survey allowed us to determine for which priority actions we would conduct further analysis. We started to review actions to see if there are natural groups of actions that form together, such as a series of administrative actions, to enhance the overall impact on the objectives. We also identified action ideas that are inter-dependent, in that one cannot proceed without the other. An example would be linking the action of developing an electronic database with the action of collecting more health data through an annual community health survey.

From our list of clustered actions, we fleshed out our action ideas in such as way that they could meet as many of our Directions and Paths as possible. For example, for the action of a Family Center, if we include in this idea family-based addictions prevention programming and family based cultural programming, we could expand this action's affect to "reducing addictions" and "reclaiming culture".

After clustering and enhancing our actions, we conducted a final prioritization analysis to identify the most impactful actions. Each action was given a total score composed of three scores (see Appendix 8 for full prioritization methodology and Appendix 9 for full results):

- Popularity: considers the combined popularity scores from the CHNA process, early community ranking and popularity during clicker survey
- Impact: considers how many of our CHNA needs, Health Directions and Health Paths each action addresses
- Feasibility: considers the relative cost, time requirement and human resource requirements for each of the actions.

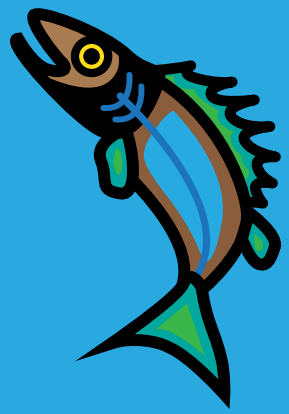
This exercise allowed us to assign each action with a prioritization categorization: quick start, critical, essential, very important or supporting (see page 110). This allowed us to identify the top scoring critical and essential actions for each of our health clusters. The results of the prioritization exercise were further refined by extensive review with PHA staff, Chief and Council, PEA Board, PHA Board and key informants.

CCHP Methodology: Implementation Planning

We started by identifying some principles to guide implementation (see page 125). One of these principles is to implement in phases, allowing us to build momentum with small-scale projects and invest in projects that deliver steady, incremental change. The first phase, called "Getting Ready for Action" involves a series of steps to help build excitement about the plan, mobilize resources and confirm implementation strategy, approach and players.

Considering the relative ease of implementation of each individual action (and what needs to happen before other actions), actions were organized by subsequent phase, starting phase 2 "Building Momentum" followed by Phase 3 "Strengthening Existing Health System", followed by Phase 4 "Honouring our Culture", followed by Phase 5 "Expanding our Capacity"; finishing with Phase 6 "Increasing Scale and Impact".

To ensure our plan moves from a list of actions to change on the ground, actions are budgeted (see page 150) and then populated a work plan which identifies timelines and roles and responsibilities for each of our actions (see Appendix 20).



CCHP Methodology: Monitoring & Evaluation Strategy

Throughout the process, we asked community members to share ideas as to how we might monitor and evaluate our plan. We did so by asking questions such as:

- What would tell you that your community is getting healthier and stronger? (Door-to-door survey, November 2013)
- What would tell us that we have arrived? (Interagency session, March 2014)

For our CHNA we developed a long list of potential indicators to do a baseline assessment of our community health today (see Appendix 10 for list of indicators). We based this initial list of 90 indicators on a review of other community health plans, the aboriginal health management literature, and the indicators used by other health agencies and researchers. We organized these indicators into Health Outcomes (health status measures, such as rates of illness) and Health Determinants (things that influence and underpin health, such as safe water). We included indicators at the individual and community level, as well as indicators for environmental conditions and social and cultural health. While many of these indicators were not appropriate or feasible for our CHNA due to limitations on what data was available and what we were able to collect (we were able to use 17 indicators), this review of potential indicators was the beginning of our process to develop a list of potential community health monitoring indicators (see Appendix 10). Ultimately, it is necessary to match the set of indicators we use to the specific context and requirements of our community, including an assessment of what indicators are appropriate and feasible to collect information on, to ensure that our monitoring is as effective as we can make it.

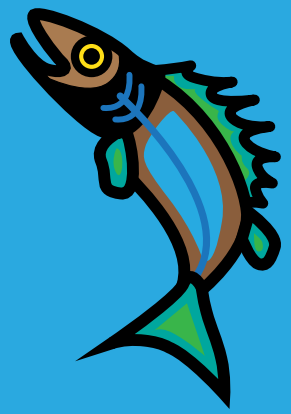
Finally, we reviewed different models of evaluation and proposed an initial evaluation strategy that matches Pikangikum's need for indicators as well as more fluid, culturally relevant and responsive evaluation tools.

Summary of Communications and Reporting Tools

Table 1 lists all of the communications and reporting tools as well as where they can be found.

Communications and Reporting Tool	Location
Community Health History Report	CHNA Appendix 7
Community Heatlh System Profile	CHNA Appendix 6
Community Health Status Report	CHNA Appendix 5
Community Health Trends Analysis	CHNA Appendix 8
Community Participation Survey Report (July 2012)	CHNA Appendix 9
Staff Report #1 (October 2012)	CHNA Appendix 12
Staff Report #2 (June 2013)	CHNA Appendix 16
Staff Report #3 (September 2013)	CHNA Appendix 18
Youth Report #1 (October 2012)	CHNA Appendix 13
Elders Report (June 2013)	CHNA Appendix 14
Community Open House Report #1 (July 2012)	CHNA Appendix 10
Community Open House Report #2 (October 2012)	CHNA Appendix 11
Community Open House Report #3 (June 2013)	CHNA Appendix 15
Key Informant Interview Report	CHNA Appendix 17
Issues Analysis	CHNA Appendix 19
Program Review	CHNA Appendix 20
Newsletters 1-6	CHNA Appendix 21
Community Survey Report (November 2013)	CCHP Appendix 4
Highschool Sessions Report (January 2014)	CCHP Appendix 5
Youth Sessions Report (January 2014)	CCHP Appendix 6
Clicker Survey Report (June 2014)	CCHP Appendix 7
Summary of CCHP Engagement Results (June 2014)	CCHP Appendix 15
Impact Analysis Report	CCHP Appendix 3
Continuum of Care Analysis	CCHP Appendix 11
Guide to Action Clusters	CCHP Appendix 16
Priority Action work plans	CCHP Appendix 10
Implementation Funding Resource List	CCHP Appendix 26
Newsletters 7-11	CCHP Appendix 27

TABLE 1:
List of CCHP Supporting Communication Tools and Reports



Working It Out Together

Issue 1 · June 10, 2012

Pikangikum First Nation's Vision for a Strong Commu

This Issue

Dear Community Members!

The Pikangikum First Nation is star

Issue 3 · January 17, 2013

Pikangikum First Nation's Vision for a Strong Community

In This Issue

- Updates
- Highlights from October Sessions
- New Reports
- Logo Contest Winner
- Next Steps

Get Involved!

Share your ideas about community involvement! Please contact Samson Keeper, Project Manager: 807-773-1179 (tel) or samsonkeeper@knet.ca

Community Planning Team

Samson Keeper
Lloyd Quill
Alex Quill
Gloria Keeper
Rex King
Greg Pascal

ringia Team

ff Cook
ye Hanson
Mussell
na Brinkhurst
nthon Meyer

ikum Group

Dear Community Members!

Aanii! Boozhoo! Welcome to the third newsletter for our community health planning project. The second newsletter was in July, so we have some catching up to do!

All through the late summer and fall we have been reviewing all the information you shared with us in July at the community BBQ and continuing to develop our planning process and relationships with the planning team members. The team from Beringia Community Planning visited in early October to reconnect and then again in mid-October to run a series of events to have more conversations about our community health needs.

This newsletter summarizes what was discussed in the October events and sessions. It also gives a summary of two new reports that we've got coming - *Our Community Health System Profile* and *Our Community Health History*. Now that we have collected a lot of information about our community and current health issues, we are about to enter a new phase of our planning process to identify needs and gaps in our community health system. Once we have done this, we can begin to design plans, projects, and programs to fill those gaps.

So Miigwetch, Thank you to the approximately 360 people who came out to our community open house, youth sessions, staff sessions, and small group sessions in mid-October, as well as everyone who has participated and supported the process so far. Your participation and support are very important to our community planning because we need all of our community to get together to discuss health and share many voices on health needs.

Thanks again for coming out. We hope you enjoy reading this newsletter and continue to be involved. Watch for community posters and listen to the radio for more information about our community health planning process

The Community Planning Team

Issue 4 · April 4, 2

Pikangikum First Na Vision for a Strong Co

n This Issue

Community Health News
Call for Storytellers
Summary of Stage 1 Translation
Facebook page
Next Steps

t Involved!

re your ideas about nunity involvement! contact Samson , Project Manager: 3-1179 (tel) or eeper@knet.ca

ity Team

Aanii, dear Community Members!

Thank you to the over 400 members who have participated in our p welcome to the 4th newsletter of our Community Health Needs Plan We are excited to say that we are close to finishing this stage of our p are starting to write up a report. This newsletter gives a quick summ will present results at a community event scheduled for May. Once t Needs report is done, we will begin another stage of planning to crea vision for Community Health.

We also want to share some highlights from things that are already h our community to support health. And we want more stories! (See F

We look forward to sharing the results with you and starting wo next stage!

The Community Planning Team

Community Health News

- Specialized mental health **Trauma Team** is working in th
- Youth are learning about suicide prevention and now Counsellor in the school
- 16 kids have started in a preschool program
- Planning for the new school building
- Increased counselling wit sniffing

Issue 2 · July 16, 2012

Pikangikum First Nation's Vision for a Strong Community

In This Issue

- Phase 1 Planning
- Community Launch Barbecue
- Participation Survey
- Logo Contest
- Next Steps

Get Involved!

Share your ideas about community involvement! Please contact Samson Keeper, Project Manager: 807-773-1179 (tel) or samsonkeeper@knet.ca

mmunity nning Team

ria Keeper
King
scal
ill
per

Dear Community Members!

Thank you to the nearly 360 members who came out to our barbecue on Monday July 9, 2012!

The event marked the public start of our community planning process. We wanted to from members about how they want to be involved in our process.

Members signed in at the welcome table (Station 1) and picked up a 'passport.' They w asked to visit three stations. Planning activities included sharing important events and dates on a community dateline, filling in a participation survey, and sharing strengths what members love about our community.

An art table station was also set up for children to draw a picture of their community. Thanks to all the children who shared a picture.

Once members finished the planning activities, they ate dinner. We finished with remarks, had a draw for door prizes, and ended with a community photo.

The results of the 135 completed surveys and other information from the used to create a community participation strategy, community profile community health needs assessment.

Thanks again for coming out. We hope to see you again August 27th. Look for the next community poster information.

The Community Planning

Working It Out Together

Issue 6

Pikangi Vision

Issue 10 · Nov

Pikangikum First Vision for a Strong

Boozhoo, dear Community Members!

Welcome to our tenth newsletter for Pikangikum's Community process. Over 864 community members have participated in o process since July 2012. Thank you for this amazing participa

We wrapped up our community engagement sessions this ear series of workshops aimed at ranking actions, directions, par to health planning.

Since then we have been busy analyzing and writing up th rrently finalizing our plan's priority actions and impl loping a monitoring and evaluation system to h letter provides an update on our plann at organizes our plan

---

Issue 5 · June 24, 2013

Pikangikum First Nation's Vision for a Strong Community

Issue

nity Health News ary of Elders and essions ary of June 6th unity Session elling for Health teps

volved!

ir ideas: Find us on t at Pikangikum y Health contact Samson t Manager: tel) or net.ca

Boozhoo, dear Community Members!

Welcome to our fifth newsletter for Pikangikum's Community Health Planning process - over 500 community members have participated in the process so far

We are excited to share the results from our latest meetings with Elders, Pikangikum Health Authority staff, and the Community session held on June 5th and 6th. Thank you to the 243 community members who came out to these three events and participated in a series of activities to share their perspectiv experiences, and stories about individual and community health in Pikangik This newsletter shares some of the highlights and results from these events.

We also highlight some community health updates and outline the next ste for the Community Health Planning process. Thank you for reading and participating, we look forward to more sharing and health planning this s

The Community Planning Team

Community Health News

- Summer is here! That means a lot of us are spending more tim enjoying the lake, playing sports, and being active. Be safe a
- There have been lots of great activities for Youth in our
  - School Trip to Toronto
  - the Bands!

Issue 7 · Januar

Pikangikum First N Vision for a Strong Co

Boozhoo, dear Community Members!

Welcome to our seventh newsletter for Pikangikum's Community Heal Needs Assessment and Planning process - over 570 community membe participated in the process so far! This is historic participation, thank y your involvement.

In this issue, we provide an update on our process and give an overvie completed draft Community Health Needs Assessment report.

We are now working on compiling our Comprehensive Community H Plan. This newsletter summarizes our health planning community s surveys delivered in October, November, and December. We preser of our health vision statement, principles, directions, and paths dentify and prioritize actions and solutions for a stronger, he

included in this newsletter are community health ne ps. Thank you for reading and participating next community sessions and on

---

Issue 8 · March 28, 20

Pikangikum First Nation's Vision for a Strong Community

lews

on

Boozhoo, dear Community Members!

Welcome to our eighth newsletter for Pikangikum's Community Health Planning process. Over 640 community members have participated in the process so far! Thank you!

We dedicate this newsletter to highlighting the thoughts, ideas and dreams of our Youth. We also share results from a staff workshop and an inter-agency meeting. We finish with some initial results from our Comprehensive Community Health Plan (CCHP) process.

We are now gearing up for our next community session where community members will participate and decide on health actions, strategies and directions through interactive technology (clicker survey). This session will allow us to begin shaping our health plan. We look forward to seeing you!

The Community Planning Team

Issue 9 · July

Pikangikum Firs Vision for a Stro

Discovery

2

The Discovery phase of our planning process involves understanding the question"Where are we now?". This phase is about gathering and sharing information and knowledge with individuals, groups, and the community to learn about where we are now and where we've come from. Before we begin the plan for our journey to health, we need to know where we are starting from and how our current health system works. This is often called a 'situational assessment.' This chapter describes our community, provides context to the current state of health in Pikangikum and analyzes pressing health issues and needs to set the stage for what we want to change. It finishes with a high-level summary of the strengths, weaknesses, opportunities and threats to assist us in making wise decisions about our future. Our situational assessment provides us with a baseline from which we can measure our progress as we implement our community health plan.

Chapter 2

Discovery

Discovery involves understanding our current situation. This chapter presents our community health history, a community profile, an overview of our health system, and a situational assessment including a health system review, and SWOT.

COMMUNITY HEALTH HISTORY

To gain a rich understanding of "Where we are now?", we must start by exploring "Where have we been?" and consider the chain of events and history that have brought us to where we are today. Placing health in the context of our history, culture and past and current relationships with Canadian institutions helps us understand the forces that have shaped our community's health. The following text provides some core highlights, see CHNA Appendix 7 for a full Health History Report. Our community health today is influenced by our collective, family, and individual histories. Our ancestors' way of life prior to contact was different from ours today in many ways, but these changes did not happen all at once. Many things have influenced and affected individual and community life and health in PFN over the last century.

Our people have lived off this land and practiced traditions of hunting, fishing and gathering food since time immemorial. We lived in small in small family or kinship groups, deep in the landscape that supported us with hunting, trapping, fishing and gathering wild foods.[1] Most summers, when the land could support large groups of people, we gathered together in celebrations of community and culture.[2]

"Long long ago we used to live by hunting and fishing growing potatoes. Used to live in tents, wagwams. We never used to use chainsaws, just axes for wood"
(Story from Storytelling for Health Exercise)

1 PFN (2006) Keeping the Land: A Land Use Strategy for the Whitefeather Forest and Adjacent Areas
2 Auger, Donald J. (2001) The Northern Ojibwe and Their Family Law. D.Jur Dissertation. Osgoode Hall Law School, North York, Ontario, Canada.

Initial contact with Europeans was minimal and we relied on our own health traditions well into the mid-1900s. The settlement at Pikangikum began after Peter Pikangikum opened Hudson's Bay Company outposts in Poplar Hill in 1895 and then in Pikangikum in 1925.[1] People began to settle in the village around the store, though most continued to live off the land and trade with furs and wild foods. Our people had many traditions and practices to support health and healing. Natural remedies from the land were used in conjunction with spiritual healing from various ceremonies such as sweat lodges and shaking tents.[2]

Starting in the 1920s, mission teachers began to visit PFN, and in 1925 the mission at PFN became a United Church of Canada.[1] In 1939 the federal Sioux Lookout Indian Agency assumed responsibility for supervising federal relations with PFN which included annual visits by the Superintendent and the building of new residences on the Reserve to encourage people to settle in the community.[1] Around this time, government officials began to tell our people to send their children to residential schools.[1] Until the 1940s, PFN only had access to a Western physician during federal agent annual visits, otherwise our people relied on themselves, their families and community healers.[1] Starting in the 1940s our community gradually shifted from a local, subsistence-based economy, to a wider and more cash-based economy. Gradually, the Federal Government became more directly involved with individual and community life through such things as delivery of Western-style health service, child welfare programs and social assistance payments. In 1951, a three-bed nursing station was built in PFN, and this also managed the delivery of medications, radio communication with the hospital, and air transportation for patients.[1]

"Our great grand fathers and mothers they used to make our clothes and moccasins by moose hide. We never used to have candies"
(Story from Storytelling for Health Exercise)

1 Dunning, R.W. (1959) Social and Economic Change among the Northern Ojibwa. University of Toronto Press.
2 Auger (2001)

Starting around the 1970s, our people's demands for increased authority and self-determination, locally and regionally, led to a new period of change.

- In 1973, the Nishnawbe Aski Nation was established and began its work representing Anishinaabe people in relationships with provincial and federal governments.[1]
- In 1984, the Ontario Child and Family Services Act was amended to allow for First Nations child welfare authorities, thus the creation of Tikinagan Child and Family Services.[2]
- In 1988, PFN began to deliver its own education programs and established the Pikangikum Education Authority. The Sioux Lookout First Nations Health Authority was established to address region-side issues the health system.
- In 2000, the Whitefeather Forest Initiative steering group was formed and our Land Use Strategy for the Whitefeather Forest is completed in 2006
- In 2007, our school burns down and our students attend school is temporary portables to this day
- Between 2006-2008 a series of cluster suicides prompted a Chief Coroner's Review of the Youth Suicides which produced the 2010 Chief Coroner's Report
- In 2008, the Pikangikum Health Authority was empowered to deliver and manage health care services as an independent body linked to the overall governance authority exercised by Chief and Council.

Building on this momentum, today our community continues it work to increase control over our health system and improving our local health capacity, infrastructure and resources.

Figure 12 provides a summary timeline of some of the key dates that shaped Pikangikum's health history.

"We used to leave at fall time and stay there till the ice melted"

Story from Storytelling for Health Exercise

1 Nishnawbe Aski Nation- About us: http://www.nan.on.ca/article/about-us-3.asp
2 Tikinagan- Our History: http://www.tikinagan.org/gettoknowus/ourhistory

PIKANGIKUM HEALTH HISTORY HIGHLIGHTS

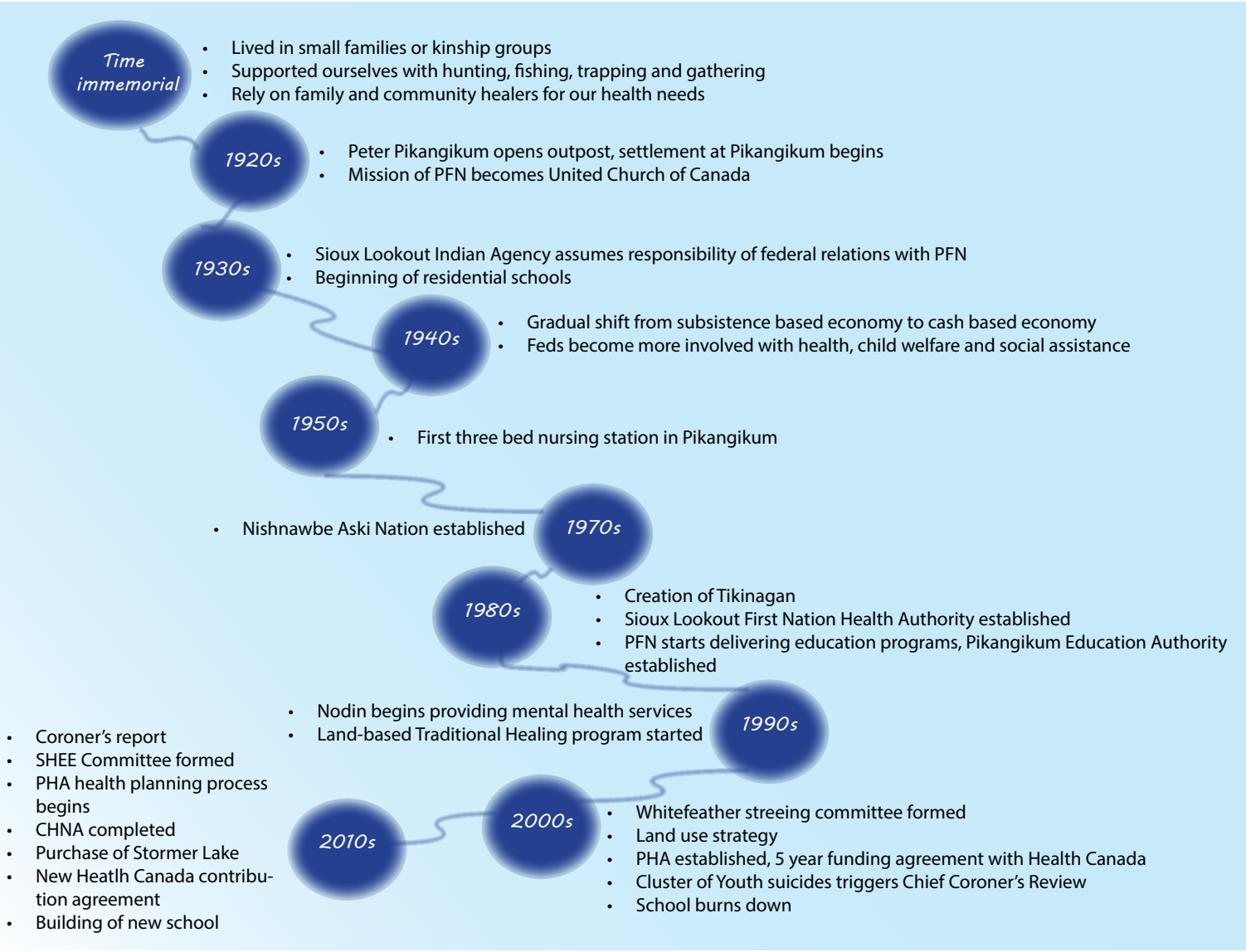


FIGURE 12: Pikangikum Health History Highlights

COMMUNITY PROFILE

Our community profile summarizes key demographic and social-economic facts about PFN. Its purpose is to create a shared understanding as the starting point for our Community Health Planning process. A community profile is a tool that can be used for informing members, decision-making, proposal writing, referencing, program development and performance monitoring.

Methodology

Because existing health data in Pikangikum is limited, the information in our community profile is a combination of community health data, external research and community member contributions. It reflects our understanding of key demographic and socio-economic facts based on this research.

We have been gathering information about our community in a number of different ways:

- By collecting community data, knowledge and information to help us understand our community's health status such as suicide, disease and crime rates (see Health status report, CHNA Appendix 5)
- By conducting web and report research on the community such as reviewing the Chief Coroner's report and our Community Asset Mapping (see Community Health System Profile and Trends Analysis Report, CHNA Appendix 6 and 8)
- By asking community members, Leadership and staff to identify their priority health issues and needs (see CHNA and Issues Analysis Report, CHNA Appendix 19)

The following section combines all of the information gathered and presents a series of 24 statements that describe the main things we have learned about Pikangikum so far to help us understand Pikangikum's current situation and implications. After each statement, text describes what we have learned and explores why this finding is important to consider as we continue health-planning.

Our Land and Culture

1. **Our relationship with the land is deeply rooted in our culture:** Today our community is located on the eastern shores of Pikangikum Lake. Our location and traditional territory is illustrated in Figure 13 and our Reserve can be seen from a satellite picture in Figure 14. The Anishinaabe traditional territory spans the landscape between the Great Lakes and Hudson Bay, including deciduous forest, mixed forest, boreal forest, boreal barrens, tundra and coastal landscapes.[1] The Pikangikum reserve is currently 1,808 hectares in area.[2] We are surrounded by Boreal forest and many of our community members continue Anishinaabeg traditions of hunting, trapping and gathering. Our connection to the land highlights the opportunity to invest in improving opportunities for livelihoods on our traditional territory.

FIGURE 13: Location of Pikangikum

1 Royal Ontario Museum (2013) Ontario's Species at Risk- Regions. www.rom.on.ca/ontatrio/risk.php
2 AANDC (2013) Community Profiles-Pikangikum.

FIGURE 14:
Satellite image, Pikangikum. Source: Bing

2. **Our language and culture is alive:** Our community is fortunate to have the strength of our Ojibway language and culture, with an almost 100% retention rate of Ojibway fluency (see Figure 15). Every year we take a break from school or work to participate in cultural activities held during Culture Break every September. Our people belong to the larger Anishinaabe family, which includes the Odawa, Ojibway and Algonquin peoples. Although our culture is one of our strengths, community members identify opportunities for it to be strengthened, especially given the role that culture can play in health and healing.[1]

1 Chandler, M and Lalonde, C (2008) Cultural Continuity as a moderator of suicide risk among Canada's First Nations, University of British Columbia Press.

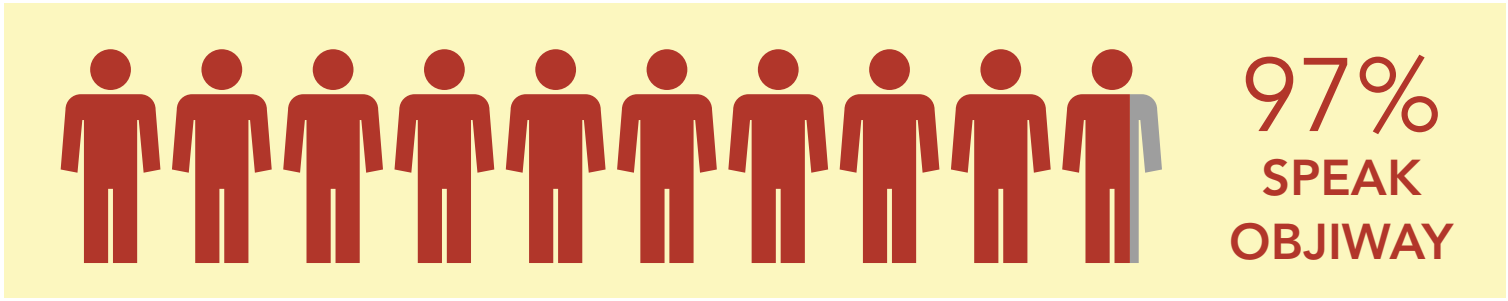


FIGURE 15: Language retention

Our People

3. **We are growing:** Our community has grown to be one of the largest First Nations in the Sioux Lookout District, and is continuing to grow. Between 1998 and 2008 our population has grown by 26% (from 1,690 to 2,133). On average we are growing by 2.4% each year.[1]

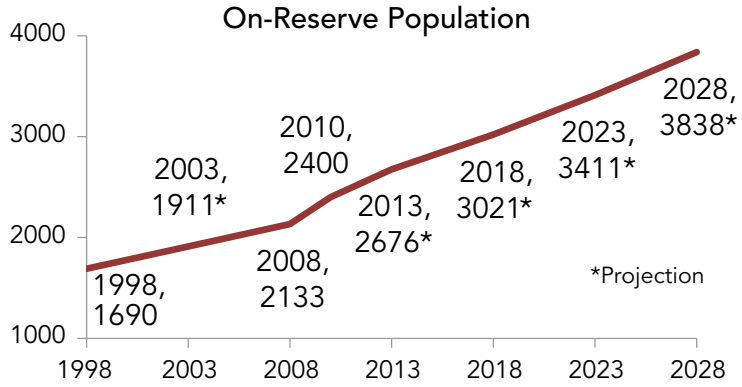


FIGURE 16: Projected population growth

This means that there are about 70-90 babies born each year in PFN[2]. Our recent physical development plan has projected a steady increase in the on-Reserve population over the next 20 years. As Figure 16 shows, by 2028, 16 years from now, our population is projected to be 1.5 times larger than our current population (3,838 people). As our population grows, we will need more housing, services and facilities for all age groups. Given our existing mental heatlh crisis, existing pressure on our health system and mental health supports will be compounded as our population grows.

1 Capital Planning Study, 2011, 2-1
2 OCCO, 2011, 106

FIGURE 17:
Off vs On Reserve Population

4. **Most of us do not leave the Reserve:** Approximately 95% of our members are living on reserve[1] (Figure 17). Our percentage of members living off-Reserve is significantly lower than other First Nation communities across Canada where the average off-Reserve membership is estimated at between 30%-50%.[2] This suggests that community members are not leaving the Reserve to pursue other opportunities, thus building a strong case for increasing education resources, health resources and economic opportunities locally.

5. **We have a young population:** An estimated 75% of our population is under thirty-five years of age (Figure 18) and 35% is less than 15 years of age[3]. This has significant implications to the types of services and programs our population needs. It builds a strong case for increasing supports to families and youth. It provides an opportunity to focus on youth and families through education and parenting as an intervention point for building healthy lifestyles, building an economy and preventing illness, addiction or injury.

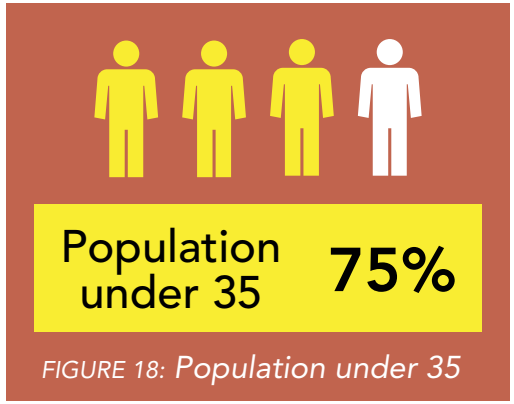


FIGURE 18: Population under 35

1 AANDC, 2012 http://pse5-esd5.ainc-inac.gc.ca/fnp/Main/Search/FNRegPopulation.aspx?BAND_NUMBER=208&lang=eng
2 MCS, 2010, 8
3 Capital Planning Study, 2011, 2-1

TABLE 2: Population Quick Facts

Current population	2,600
Annual growth rate	2.4%
Babies born each year	70-90
Projected population 2028	3,838
% of population on Reserve	95%
% of population under 35	75%
% of population under 15	35%

Our Health and Safety

6. **Too many of us die from preventable causes:** We have an unusually high percentage of deaths from suicides, organ failure and infant deaths. We have high rates of preventable chronic conditions, especially diabetes and high blood pressure.[1] Many deaths in our community are associated with our living conditions, which builds a strong case for investing in community infrastructure and poverty alleviation.

7. **Alcohol and other substance abuse and addictions harm our community:** Healing from addictions was the top health issue identified by community members during our needs assessment process, which highlights the opportunity to focus on mental health and addictions in our health plan. Solvent abuse in our community is on the rise.[2] 97% of all of our Tikinagan child welfare cases are alcohol related.[3] 90% of all probations in our community are related to alcohol abuse.[4]

"Kids turn to sniffing when there's lots of drinking in their home. Seeing a lot of kids sniffing makes me very sad" (Womens circle)

1 Pikangikum Chronic Care Register (unknown data range)
2 Pikangikum First Nation, Land Based Traditional Healing Program Proposal, 1997
3 Pikangikum Tikinagan Client Register (2010-2013)
4 Pikangikum Probation Visits Register (2010-2012)

8. **Too many of us take our own life:** Our suicide rate is over 40 times higher than Ontario's which builds a strong case for focusing on mental health and suicide prevention in our health plan. In 2000, we had the world's highest suicide rate. Many of our suicides have been young people and have happened close together.[1]

9. **Many of us suffer from grief:** Between 2009 and 2012 there was an increase in mental health visits. Grief and addictions are the most common reasons people seek mental health help. There is a high demand for grief counselling which relate to the number of deaths and suicides in our community.[2]

10. **Violent crime is high:** Between 2001 and 2012 incidents of violent crime increased[3]. Calls for police service in our community are significantly more than in other nearby First Nations.[3] Given the connection between addictions and crime (90% of all probations in our community are related to alcohol abuse)[4] this also suggest a need to focus on mental health and addictions in our plan.

11. **Many of us struggle to access healthy food:** Community members have identified access to healthy, affordable and traditional food as one of Pikangikum's top health needs. A combination of lack of availability of healthy food, the high cost of food, lack of nutritional knowledge and lack of access to traditional food have contributed to the prevalence of dietary related chronic conditions such as diabetes, high blood pressure.

12. **Opportunities for social and recreational activities are limited:** Community members consistently identified the need for more recreational activities, sports and social support (see CHNA). Given the role of recreation and social support networks in prevention of illness, injury and addictions, it provides an important opportunity for investment.

"Need to get out on the land, promote wellness and spirituality"
(Key informant interviews)

1 Office of the Chief Coroners Ontario (2011) Death Review of the Youth Suicides at the Pikangikum FN
2 Pikangikum Mental Health Record January 2009-March 2012
3 Police Violent Crime Statistics Pikangikum FN 2001-2013, updated August 24, 2013
4 Pikangikum Probation Visits Register

13. **We want to support one another:** Many community members speak of the importance of our social networks of family and friends in the role this plays in supporting health. The breakdown of community supports, loss of pride and loss of community involvement are identified by community members as an issue that impairs our ability to tackle physical and mental health issues.

TABLE 3: Health and Safety Quick Facts

% of us over 20 suffering from diabetes	33%
Average mental health care visits per month 2009	7.5
Average mental health care visits per month 2011	25.5
Estimated solvent abusers 1997	142
Estimated solvent abusers 2008	352
Attempted suicides between 2001-2012	708
Suicides between 2001-2012	70
Annual violent crime investigations	500
% of Tikinagan cases related to alcohol	97%
% of probations related to alcohol	90%

Our Education and Livelihoods

14. **Many of us are poor:** The majority of families in our community are receiving social assistance – over 540 households[1]. Most of the families in our community are considered low-income and receive less than $10,000 per year. Given the link between income and health,[2] alleviating poverty is a key opportunity.

15. **There are limited on Reserve jobs:** Although about 1000 of our community members are between 20 and 59 years old, only 130 of us hold permanent jobs[3]. An additional 60 seasonal jobs exist during the summer months. It is estimated that our community receives about $5.5 million in income from these jobs and about $8 million in government benefits[4]. Increasing opportunities for local employment could significantly help alleviate poverty.

1 Office of the Chief Coroners Ontario, Death Review of the Youth Suicides at the Pikangikum FN 2006-08, 2011
2 Canadian Medical Association (2013) Health Care in Canada: What Makes Us Sick?
3 Health Canada Community Based Reporting, Pikangikum 2009-2010
4 Pikangikum Health Authority, Community Health Assets Map 2010

16. **Our traditional economy continues:** Customary land uses include traditional pursuits protected by treaty and Aboriginal rights, (including but not limited to trapping, hunting, fishing) and other historical livelihood activities. Some of these customary land uses, such as trapping and fishing, provide an opportunity for a livelihood and incomes for our community members.[1]

17. **We are working on a local economic development project:** The Whitefeather Forestry Project is a potential large-scale project based on forestry in the Whitefeather Forest, a section of the Boreal forest that covers much of our Nation's traditional territory, that is expected to generate a significant number of jobs (between 150 and 300).[2] Our Elders are the inspiration of the Initiative and gave the original mandate to develop the Whitefeather Forest Initiative in 1996.[3]

18. **Many of our children do not complete their education:** School enrollment in our community has dropped since our Eechokay Birchstick School burned down in 2007. As Figure 19 shows, in 2011 only 619 of our kids were enrolled in school – down from 750 in 2007[4]. It is estimated that 300-500 school-aged children in our community are not currently going to school.[4] There is an opportunity to explore how our education system, resources and infrastructure could better meet the needs of our children and youth.

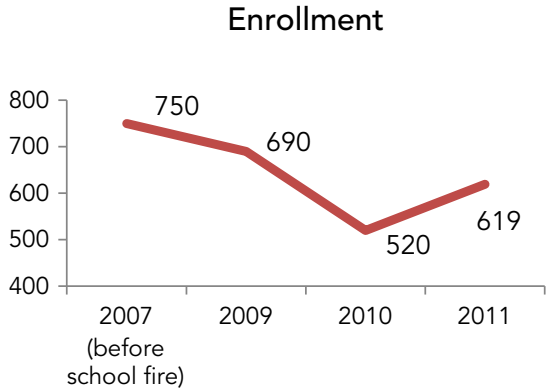


FIGURE 19: Enrollment

19. **Our children are behind other Ontario students:** Our school offers schooling from junior kindergarten through to grade 12. The Ontario curriculum is being taught and credits are transferable. However, the age/grade gap in Pikangikum is about 3 years[4]. This could have significant consequences on our children's ability to access future opportunities such as postsecondary education.There is an opportunity to examine how our curriculum could be adapted to better meet the needs of our students.

"We need students to finish school and go to college so they can get their diplomas" (Community Session #1)

1 Keeping the Land, 2008, 37
2 NSPC, 2009, 13
3 Whitefeather forest initiative, www.whitefeatherforest.com
4 Pikangikum Health Authority, Community Health Assets Map 2010

TABLE 4: Education and Livelihoods Quick Facts

Permanent jobs in the community	130
Seasonal jobs	60
Jobs held by outsiders	50
Income from community jobs	$5.5 million
Income from government benefits	$ 8 million
School enrollment 2007	750
School enrollment 2011	619
School-aged children not in school	300-500

Our Infrastructure

20. **We do not have enough houses:** There are 487 housing units in Pikangikum, which means that on average, about five community members share a home[1]. The IFNA says we need to build or repair 200 homes right now to address overcrowding[2]. To meet future demand in the year 2038, it is predicted that 400 new homes need to be built. There is an opportunity to examine how increased land supply and funding for housing can help us meet future demand.

21. **We lack access to running water and sewage systems:** 447 of Pikangikum's 487 homes are not connected to the water and sewage system[2]. Most in our community get water from eight water distribution points or delivered in trucks, but many of these are prone to freezing and service disruptions. Our water treatment plant that supplies this drinking water is frequently under a boil-water advisory and this can cause disruptions like school closures.

"Catch up with short fall. Every family needs a home" (Key informant interviews)

1 Office of the Chief Coroners Ontario, Death Review of the Youth Suicides at the Pikangikum FN 2006-08, 2011
2 Pikangikum First Nation, Capital Planning Study 2011

22. **Our power supply is unreliable:** Power service comes from a diesel power generating station and local distribution system which PFN owns and operates. This provides electricity to 469 out of 487 of the homes in our community. Our local power generation station is out-dated and operating beyond capacity[1]. Many community buildings like our school, have generators for heat but fuel shortages are an issues and can cause closures.

23. **We are a remote community with substandard roads:** Pikangikum is accessible by air, by a combination of boat and road in the summer and by winter road in the winter. Our 2011 Capital Planning Study concludes that our roads are in substandard condition. Challenges associated with transportation contribute to the high cost of food, the high cost of travelling out of the community and limited training and employment opportunities.

24. **We have been resourceful in addressing communications infrastructure challenges:** PFN established Pikangikum IT Services to provide homes and institutions with television, phone, and internet access. Our IT services employs three community members and over three hundred homes have internet connections.[2] In addition to IT services, we work with the regional Kuhkenah Network (K-Net) to provide information and communication technologies. We also established our own radio station to supports community communication, although there is currently no funding to support hiring a station manager.

TABLE 5: Infrastructure Quick Facts

Total number of current housing units	487
Average number of occupants per house	5
Number of new houses needed to meet current demand	200
Number of houses needed to meet future demand	400
Number of houses connected to water and sewage	40
Number of houses connected to local power distribution system	469

1 Clibbon, Jennifer. December 20 2012. "Plight of Pikangikum native reserve spurs Toronto relief effort." CBC News.
2 Medicine Creek – community assets 2010 p.22

OUR HEALTH SYSTEM

Our "health system" is made up of many relationships, resources, individuals, organizations and activities who share the purpose of promoting, restoring and maintaining health in our community. The different parts of the health system connect through functions and roles including policymaking, health service provision, financing and managing resources. Part of understanding "where we are now?" and identifying opportunities for improvements involves understanding how our health system currently works and then talking about how it can improve. This section provides an overview of how our health system is governed, the different agencies that fund and deliver our local health programs, and identifies key challenges, strengths and opportunities.

Provision and administration of health services and programs within Pikangikum are shared between the Pikangikum Health Authority (PHA), Sioux Lookout First Nations Health Authority (SLFNHA), and Health Canada's First Nations and Inuit Health Branch. In addition Pikangikum First Nation (PFN) has a health portfolio which oversees the PHA and NAN programs, and manages other community programs and services that are not directly health-related but that support health and well-being, such as housing, economic development, education, justice, infrastructure and employment services.

Pikangikum Health Authority

The Pikangikum Health Authority (PHA) is responsible for overseeing the health and wellbeing of it on-Reserve members and has administered and delivered programs and services since it was formed in 2008. The PHA works in connection with the Nursing Station, FNIHB, and SLFNHA but is a separate entity. The PHA is funded by Health Canada based on an official contribution agreement (signed in 2013). In 2012/2013, the PHA received $1,997,876 to run 14 health services and programs (listed on following page, see Figure 21 for how these programs are organized).[1] Over the next three years (2013-2016), PHA will receive $5,639,289, distributed between each year.[2]

1 PHA programs are funded primarily by the FNIHB but in some cases also receive funds or resources from the SLFNHA or Nishnawbe Aski Nation tribal council.

2 Health Canada FNIHB, 2013-2016, Health Funding Consolidated Contribution Agreement. We are in discussions with Health Canada around Health Transfer which would give the PHA more decision making power around how health funding is used.

Although the PHA has some flexibility on how to distribute funds, PHA's programs follow a Program Plan agreed to by Health Canada. Health Canada funded primary health care programs are organized by category as displayed in Figure 20.

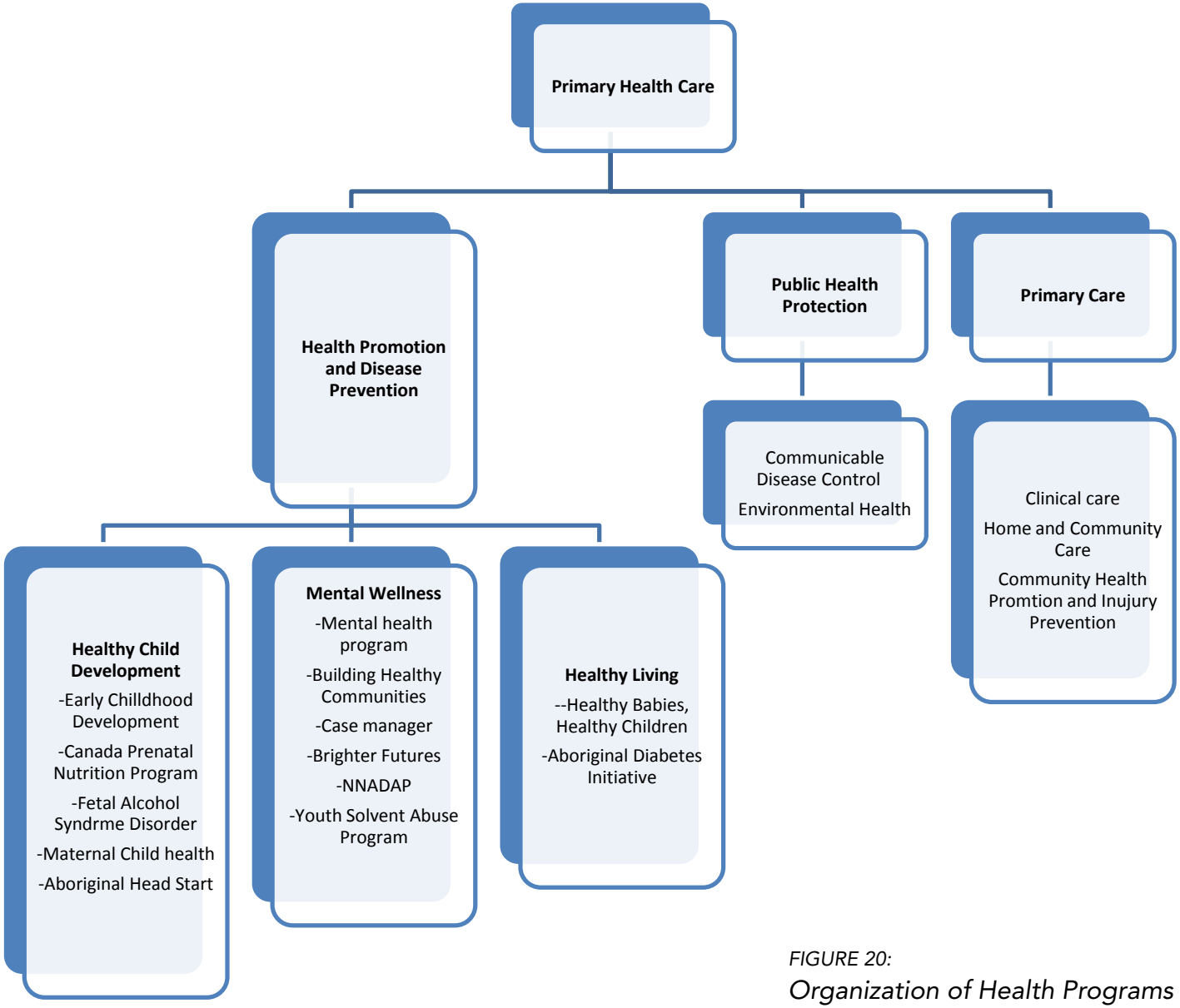


FIGURE 20:
Organization of Health Programs

Community health programs currently managed and delivered by the PHA are:[1]

1. **Aboriginal Head Start On-Reserve (AHSOR)** – The Pikangikum Daycare has approximately 30 childcare spaces and is located in the Community Center. Four daycare staff have received Early Childhood development training.
2. **Fetal Alcohol Spectrum Disorder (FASD)** – Works to reduce the number of babies born with FASD and support children diagnosed with FASD and their families. An FASD and Child Nutrition worker has concentrated efforts on prevention in the school and working with prenatal clients in the community.
3. **Canada Prenatal Nutrition Program** – A Prenatal Nutrition Worker works in the community providing education and support to community members to improve maternal and infant nutritional health.
4. **Maternal Child Health** – Supports pregnant women and families with infants and young children. In Pikangikum the MCH program staffs a coordinator, two (2) Home Support Workers, and a MCH Nurse who visits 3 - 4 days a month.
5. **Aboriginal Fetal Alcohol Spectrum Disorder and Child Nutrition** – A program for families with children and youth affected by FASD, focusing on providing information and support activities to families as well as education and activities about nutrition and FASD to the wider community education. One project coordinated has been supported by NAN and the Ontario Ministry of Children and Youth Services.
6. **Aboriginal Healthy Babies/Healthy Children** – Supports families with healthy development for children up to 6 years of age. One community-based staff member works to support program implementation and is supported by NAN and the Ontario Ministry of Children and Youth Services.
7. **Mental Health Program (Brighter Futures/Building Health Communities)** – PHA employs five Mental Health Workers who work in collaboration with Nodin Child and Family Intervention Services.

---

1 Following taken from Medicine Creek assets map 2010 p 13

8. **National Native Alcohol & Drug Abuse Program** – Promotes Healthy Lifestyle practices through prevention, intervention, and aftercare and follow-up services. Staffed by 1 full time worker and part-time (0.5 EFT) worker who focus on alcohol abuse and work with the Mental Health workers.

9. **Youth Solvent Abuse Program** – Goal is to establish prevention, intervention, after-care and in-patient programs for Youth who are addicted solvents or at risk. The Meekeeseewaug Auhyuhwaug Aughgummeeng (Beginning Your Healing Journey) wilderness land based camp is located across the lake from Pikangikum. The camp is supported by a coordinator and eight (8) youth workers, elders and community members.

10. **Crisis Intervention Workers** – Supported by the NAN Crisis Intervention Coordinator, these staff provide suicide prevention and intervention services, referrals, support and case management to clients. The Workers assist clients in developing post-intervention action plans and hold crisis intervention debriefing sessions to reduce the risk of recurrence of violence and/or suicide attempts.

11. **Aboriginal Diabetes Initiative (ADI)** – Staffed by a coordinator, an ADI worker and a nurse, working out of the nursing station.

12. **Community Health Promotion and Injury/Illness Prevention** – Two Community Health Representatives work within the community and collaborate with other programs.

13. **Communicable Disease Control (Air-borne, blood-borne, and vaccine preventable diseases)** – Primarily the responsibility of nurses at the nursing station.

14. **Home & Community Care Program (HCCP)** – Staff for the Home and Community Care Program is comprised of a coordinator, a registered nurse in the community fourteen days a month and six personal support workers.

In total, the PHA directly employs 57 community members to help deliver these programs, mostly based out of the Community Center. In addition to hosting PHA staff and administration, the community center houses the Tikinagan Child & Family Services staff and NODIN counsellors and is the space most often used for community gatherings, large meetings, court days, and indoor gym class (until the new school is built).

The PHA is comprised of a Chair, three (3) community members, and the Pikangikum First Nation Health Portfolio Councillor. PHA receives funding from FNIH, Health Canada through a contribution agreement to support the delivery of community programs. The PHA oversees the management of community health programs. The PHA administrative team is comprised of the PHA Chairman of the Board, Health Director, Assistant Health Director, Finance Clerk, and a Human Resource Clerk.

See the PHA's organizational chart (Figure 21).

PHA Organizational Chart 2013

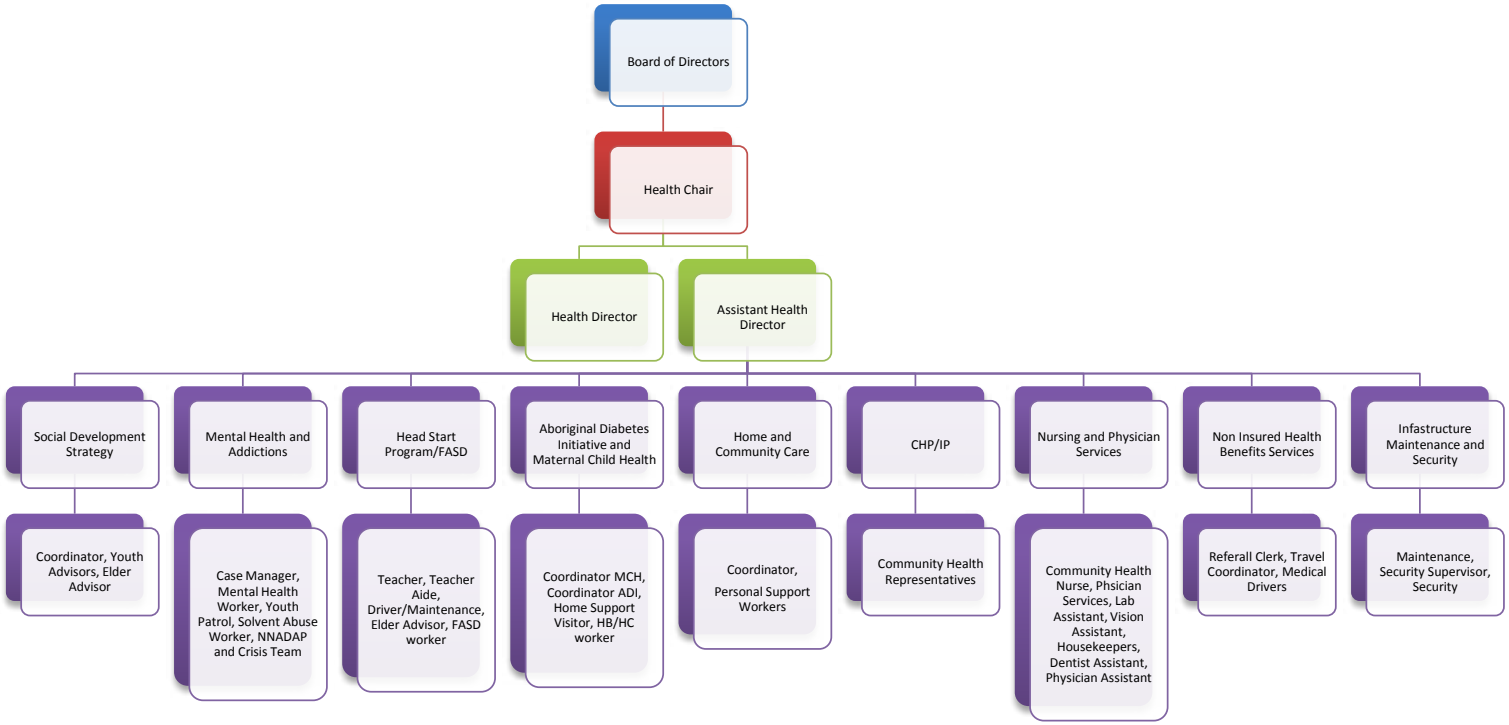


FIGURE 21: PHA Organizational chart

FNIHB & Pikangikum Nursing Station

The Pikangikum Nursing Station is the centre of primary health care service delivery in Pikangikum. FNIHB works with Pikangikum through its Sioux Lookout Zone Office to ensure the availability of and/or access to primary health services.[1] Pikangikum's nursing and physician services are funded by the Ontario Ministry of Health and Long Term Care. Funding for public health programs and services is provided by Health Canada. Management of the nursing station and primary care services is done by the Nurse-In-Charge with direction and support from the FNIHB Sioux Lookout Zone office. The Nursing Station has 9 equivalent full-time nurses. Average staffing is 4 full-time and 4 part-time staff.[1] Physicians are in the community 25 days per month, as well as visiting specialists and technicians, such as dentists and optometrists. Pikangikum also has three trained community members as x-ray technicians. The nursing station also oversees Capital Facilities Operations and Maintenance and Medical Transportation. The nursing station facility is approximately 25 years old and in need of expansion.

Sioux Lookout First Nations Health Authority

In addition to the nursing station services, the SLFNHA provides services in Pikangikum, with a focus on health promotion and disease prevention, supporting communities to deliver quality primary health care services and support First Nations health staff, and provide specialized and regional services not otherwise provided by communities.[1] The SLFNHA is a regional aboriginal organization that provides program consulting and specialized expert services to assist aboriginal communities in local health service delivery. For Pikangikum, SLFNHA has supported:

- Physician Services;
- Tuberculosis Control and Surveillance Program;
- Canada Prenatal Nutrition Program (CPNP) (1 staff member);
- Developmental Services Program;
- Telemedicine Program (under development);

1 Medicine Creek – Assets Map 2010, p.12

- First Nations and Inuit Health information System;
- Nodin Child & Family Interventions Services (including Crisis Counselors);
- Trauma Teams;
- Client Services Program;
- Visiting Psychiatrist/Mental Health Specialists.

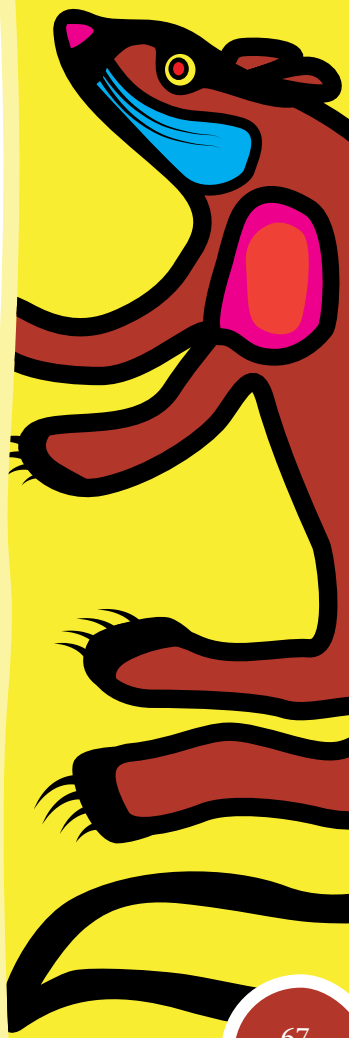
Some of these services operate out of the nursing station and others are based in offices in the Community Center across the road from the nursing station. Nodin provides a suite of services, including: counseling, education and training in community development, crisis intervention services, cultural restoration and traditional healing, and specialised resources. Nodin has trained three Mental Health Aboriginal Community Service Workers in Pikangikum and other mental health staff provide services on a visiting basis.[1]

Nishnawbe Aski Nation (NAN)

Nishnawbe Aski Nation (NAN) is a political territorial organization representing 49 First Nation communities within northern Ontario.[2] NAN works with funding agreements with the governments of Canada and Ontario to deliver a number of Health Promotion programs including Fetal Alcohol Syndrome Disorder (FASD) and Healthy Babies, Healthy Children (HBHC). They also support Pikangikum's Crisis Teams.

PFN Governance and Community Services

Pikangikum is governed by a **Chief, Deputy Chief, and nine Council members** selected by the community through **custom elections**. Each councillor manages a suite of portfolios grouped into: Service Delivery, Health, Education, Justice, Economic Development, Social Assistance, Social Services, Human Resources and Community Events/Businesses. The Health portfolio includes oversite of NAN, Mental Health and Home/Community Care programs and the Pikangikum Health Authority and Wasaya. The Band Council Office administers the Social Assistance Program which provides basic shelter and northern allowance to recipients. The Band also manages infrastructure construction, management, and repair, including housing, roads, and water treatment. Pikangikum's public works includes a fire truck and Fire Marshall (see Figure 22).



1 Medicine Creek assets map – 2010, p.17
2 Nishnawbe Aski Nation Member Nations, www.nanbroadband.ca/article/about-nishnaebe-aski-nation-nan-6.asp

FIGURE 22: PFN Organizational Chart

Other agencies that deliver community services (hiring approximately 129 people) include:

- **Pikangikum Education Authority:** Formed in 1988, governs Pikangikum's school. Comprised of a Chairman, Director of Education, Assistant Director of Education, and four School Board Trustees who are community members. The education authority is responsible for overseeing school operations including hiring of teachers and administrative positions. The school administrative team includes the Principal, a Senior Vice-Principal, an Elementary Vice-Principal and a Vice-Principal of Native Language and Culture. The Administrative team is supported by the School Secretary. The Kindergarten and Elementary Division includes 19 teachers and 19 teacher's assistants and the High School Program includes 8 teachers. The school also has a Social Counselor, 9 specialty positions (Religious Studies, Special Education Coordinator, Elders Program, Cultural Quilting and Crafts, Outdoor Cultural education and Computer Technician), and 12 Tutor Escorts who work with children with special needs.
- **Tikinagan Child & Family Services:** Based in Sioux Lookout, Tikinagan runs the Band Family Service Worker Program to provide child and family services (family support, child protection and emergency services). 6 full-time and 9 part-time community-based workers deliver these services out of the Pikangikum Community Centre. Tikinagan's Sioux Lookout office manages the hiring of community workers and providing program direction and support.
- **Policing & Community Safety:** Police Services Police services in Pikangikum are provided by Ontario Provincial Police (OPP). Funding for police services are provided by the federal and provincial governments. Pikangikum has eight equivalent full-time police officers (2 are resident community members and the remainder rotate in from the Red Lake Detachment). The detachment has 1.5 equivalent full-time administrative assistants and approximately 22 civilian members serve as jail guards. As well, the Pikangikum First Nation has hired a team of Peace Keepers from the community who patrol the community in eight hour shifts (they carry radios so that they may request police assistance when required).
- **Community Churches:** There are four churches active in Pikangikum: a Roman Catholic Church, United Church, Evangelical, and Mennonite Mission. As well, the Living Hope Native Ministries, a charitable ministry, operates the Night-Light mission which hosts bible-studies, women's' gatherings, Sunday school, and a Youth Drop-In. The financial resources required for activities are provided by the Mission and fundraising, with occasionally contributions from the Band.

- **Ontario Works:** Funded by Ontario's Ministry of Community and Social Services (MCSS), Ontario Works provides work and like skills training to community members through community placements, workshops and client support. They also provide social assistance and run social activities. 15 staff manage and run these programs.

Table 6 organizes the health services and programs available to our members by 10 categories and summaries where they are available, and who delivers them.

TABLE 6: Health Services by Category

Clinical Services	• Nurses and Physicians at Nursing Station • Visiting clinical specialists • Meno-Ya-Win Health Centre (Sioux Lookout) • Regional health centres & hospitals	**Community & Public Health**	• Information: PHA, Nursing Station, Community Centre, School, Meno-Ya-Win, SLFNHA, NAN, NWHU, online (e.g. Communicable Disease Control & Immunizations; Sexual health; Nutrition; Disease and Injury prevention) • Aboriginal Diabetes Initiative • Maternal Child Health, Prenatal Nutrition; Healthy Babies, Healthy Children
Specialist Services	• Oral health: visiting dentists, dental hygienists • Vision care assistant • Diagnostic services and advanced care: Regional health centers & hospitals	**Child Welfare Services**	• Tikinagan Child & Family Services workers • Nodin Child and Family Intervention Services • Brighter Futures program • Early Childhood Development & daycare • Customary community-based child care, support

Emergency Care & Crisis Support	• Nursing Station, Police, Medevac • Regional health centers & hospitals • PHA Crisis Team • Crisis counselling (Mental Health workers, • Tikinagan, Nodin, Trauma Teams) • Meno-Ya-Win Assault Care Treatment • NAN Victim Quick Response program	**Social & Community Supports**	• Family and friends • School programming; Youth drop-ins • Tikinagan Mamow Oshki Pimagihowin (Life Skills program) • Project Journey (OPP) • Ontario Disability Support Program; Ontario Works; Social Assistance • Housing and infrastructure improvement initiatives (CHMC housing, new playground, water treatment training and maintenance)
Mental Health & Addictions	• Nursing Station, Police • PHA: Mental Health workers, Solvent Abuse Worker, Trauma Teams • Regional treatment centers & hospitals • National Native Alcohol & Drug Abuse Program • Counseling (Tikinagan, Nodin)	**Health Research, Planning, & Advocacy**	• Local: PHA, Chief & Council, SHEE Committee • Regional: NAN; SLFNHA; NW-LHIN • Government: MCSS; MOAA; FNIH
Non-medical Patient Support Services	• NIHB funds for health travel, accommodations • SLFNHA/Men-Ya-Win Client Services • Home or in-community care: PFN/PHA • Traditional health services (Meno-Ya-Win)	**Spiritual & Cultural Supports**	• Churches and spiritual communities • Ceremonies (grieving, tent circles) • Cultural practices (drumming, artwork, music, dance) • Traditional knowledge and activities (hunting,trapping, fishing, crafting, story-telling)

Our Local Health Funding

Table 7 represents the health related programs by program cluster and funder available in Pikangikum. As you can see, a network of funders is behind the full set of our health programs. At times, this complicates efforts to improve coordination of health services.

TABLE 7: Local Health Funding

Program Cluster	Program	Funder
Health Management	1. Health Planning and Management	Health Canada
Community Programs: Mental Health and Addictions	2. Mental Health Program (MHP)	Health Canada (NNADAP)
	3. Building Healthy Communities- Solvent Abuse Program (BHC-SAP)	Health Canada
	4. Building Healthy Communities- Mental Health Crisis Management (BHC-MH)	Health Canada
Community Programs: Mental Health and Addictions	5. Case Manager	Health Canada
	6. Brighter Futures (BF)	Health Canada
	7. Crisis Team	NAN
	8. Trauma Team	SLFNHA
	9. NODIN Child and Family Intervention Services	SLFNHA
Community Programs: Healthy Pregnancy and Early Infancy	10. Canada Prenatal Nutrition Program (CPNP)	Health Canada
	11. Fetal Alcohol Syndrome Disorder (FASD)	NAN
	12. Maternal Child Health (MCH)	Health Canada
Community Programs: Early Childhood Development	13. Early Childhood Development (ECD)	NCB Health Canada (AHSOR)

Program Cluster	Program	Funder
Community Programs: Chronic Disease Prevention and Management	14. Healthy Babies, Healthy Children (HBHC)	NAN
	15. Aboriginal Diabetes Initiative (ADI)	Health Canada
Primary Care	16. Home and Community Care (HCC)	Health Canada
	17. Community Health Promotion and Injury Prevention (CHP/IP)	Health Canada
	18. Community Primary Care (CPC)	Province
	Nursing and Physician Services	Health Canada
Non Insured Health Benefits Services	19. Dental Benefit Coordinator (NIHB-DA)	Health Canada
	20. Medical transportation (NIHB-MT)	Health Canada
	21. Vision Care Coordination	Health Canada
Infrastructure Maintenance and Security	22. Health Facilities Operation and Maintenance	Health Canada
	23. Security Services in Health Facility	Health Canada
Other	24. Ontario Works	Province

Other Players in our Health System

As well as directly provide programs, a larger group of agencies and groups participate in health system governance, planning , coordination and research. These roles are summarized in Figure 23 and detailed in Appendix 6 of the CHNA. Some agencies and groups work largely independently, others work through partnerships and shared responsibility agreements, and many overlap in their areas of focus. While there are efforts to coordinate and collaborate, many providers continue to deliver services "in silos".[1]

FIGURE 23:
Roles in our Health System

1 Office of the Chief Coroner for Ontario (2011) Death Review of the Youth Suicides at the Pikangikum First Nation 2006-2008. p. 47

SITUATIONAL ASSESSMENT

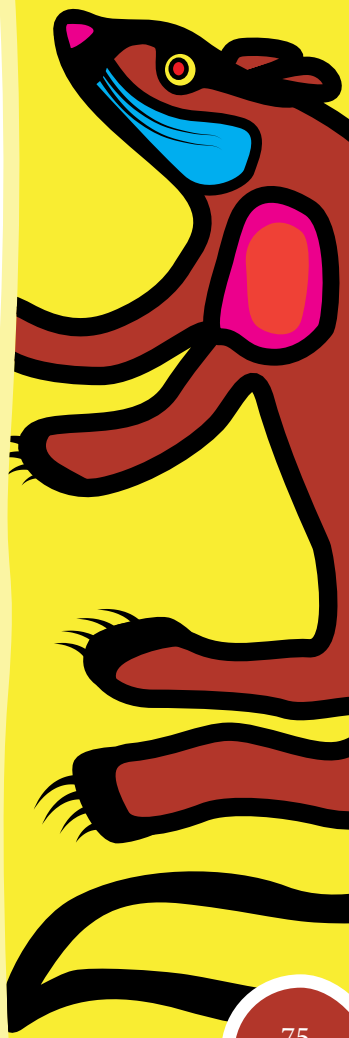
Health System Review

Now that we have a general understanding of who the players are and how are health system works, we want to assess what is working well, what is challenging and what could work better. To do this, we conducted a program review (Appendix 20 of CHNA) and used a continuum of care model to consider all of the different parts of a well functioning health system, and assess how well each stage of the continuum of care is being met by current programming.

Continuum of Care Analysis

Everyone in our community is served by the health system, but depending on our health needs, the level of care we require along this continuum of care is different. When we are healthy, the health care system serves us through health promotion and prevention activities. When we are at risk of being ill or injured, assessment and diagnosis services can help us. When we are injured, ill or suffering from a mental health issue, we have needs for acute (short-term) or chronic (long-term) treatment. When we are recovering from an illness, injury or mental health issue we need rehabilitation and aftercare services and support. In preparation for the end of our life, we need palliative care. To help us navigate the health system and move from one stage of the continuum to another, or one health provider to another, we have a need for care facilitation including opportunities for self-management and self-reliance in managing illness. Figure 24 provides a summary of these different stages of care in relation to each stage's treatment needs.

Health is a dynamic state. On any given day, an individual's health needs may be different from the day before. If we think of our individual health as a journey in a river, we most likely are hoping to travel towards a state of health and low treatment needs. However, at certain points of our life, our treatment needs increase when our physical or mental health worsens or we are injured. We hope to receive the health care services we need to help us head back towards good health. Because we often deal with more than one health issue, an individual can be at many places on the care continuum at once, as one health condition could be improving, while another is worsening. At any given moment, we may need different things from the health system depending on where we are in this journey for any particular health need.



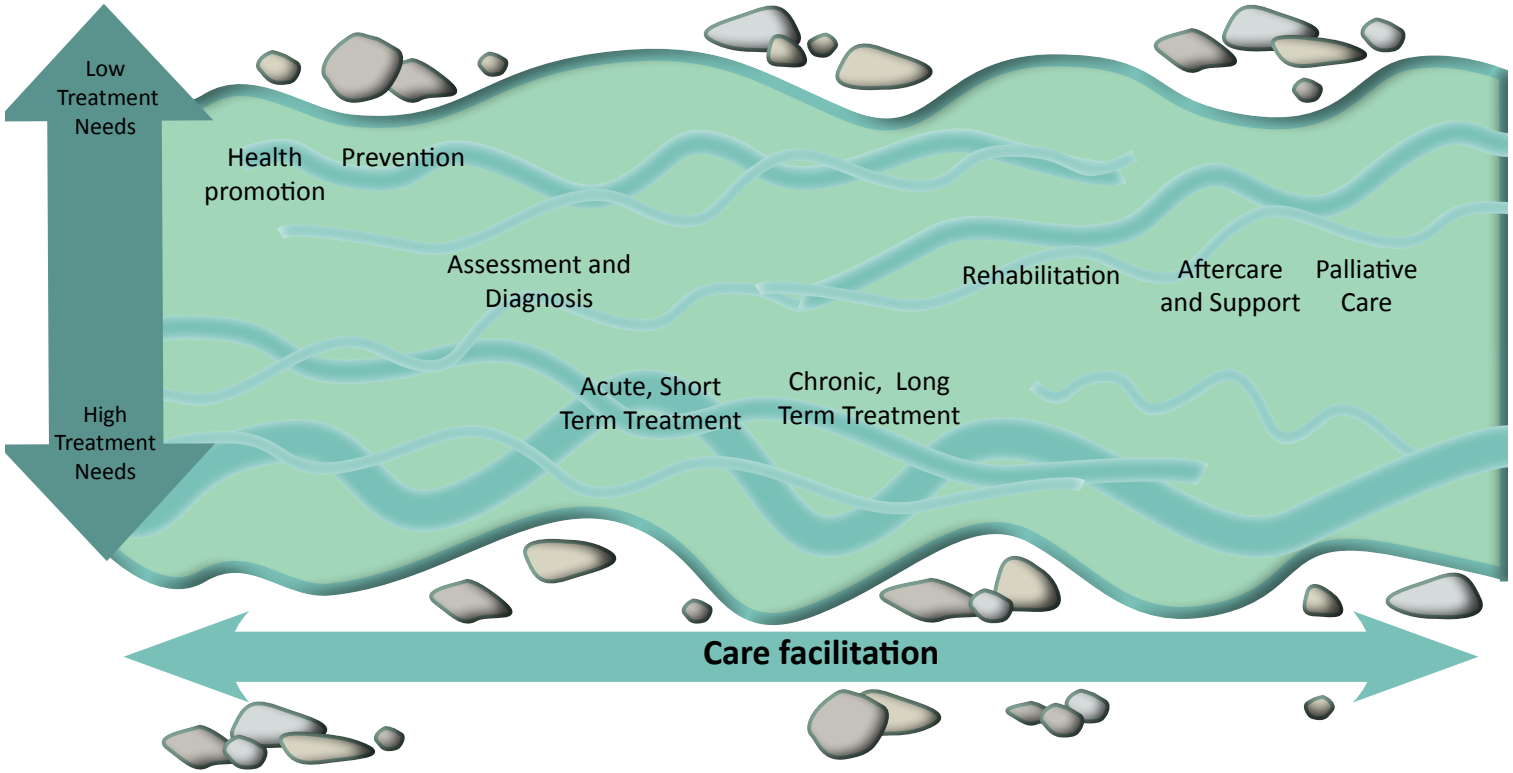


FIGURE 24: Continuum of Care Model

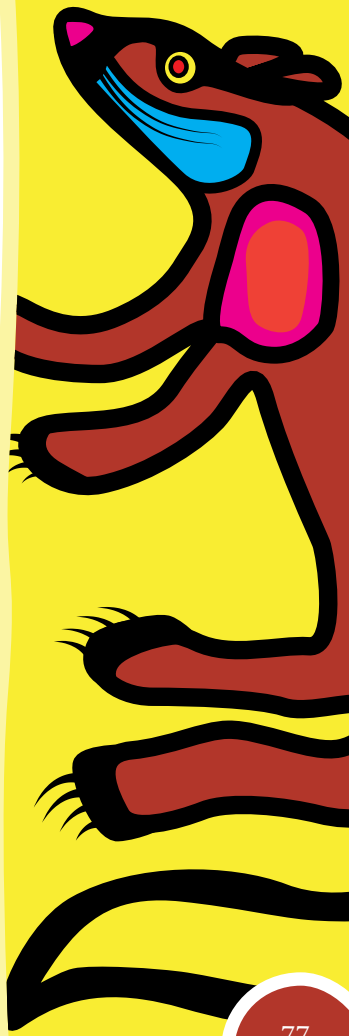
Considering the continuum of care in relation to our local health system helps us identifying any strengths or weaknesses in our current health system. Does our health system allow us to move easily from one stage of the continuum to another? Are some of us better served than others depending on where we are on this continuum? And if so, what do we need to improve service across the full continuum of care?

Table 8 provides a summary by stage of:

- the number of existing programs we have that address each stage
- examples of existing programming, and
- strengths, challenges and opportunities related to each stage.

TABLE 8: Summary of Continuum of Care Analysis

	# of programs	Example	Strengths	Challenges	Opportunities
Health Promotion	11	Public health clinics	• Social networks • Activities out on the land • High language retention • Health promotion campaigns	• Human resources • Awareness of programs • Low mental health awareness • Interagency coordination • Program design • Infrastructure • Few resources	• Training • Advertising • Interagency meetings • Mental health awareness • Training center • Housing policy • Translation
Prevention	13	Recreational activities	• Land based camp for Youth • Cultural activities • Maternal health programs • Diabetes programs	• Awareness of programs • Interagency coordination • Human resources • Funding for youth camp • Access to food • Access to recreation	• Advertising • Interagency meetings • Training and staff orientation • More funding • Cultural orientations • Recreational facilities • Evaluation
Assessment and Diagnosis	10	Pre natal screening	• Nurses and doctors • Existing skills and training of staff • Doctors and HCC collaborate	• Interagency coordination • Awareness of programs • Case management • Staff capacity • Privacy and trust • Connecting with target groups	• Training • Mental health awareness • Interagency meetings • Mental health building • Confidentiality policies
Acute, Short Term Treatment	9	Crisis team	• Nurses and doctors • Transportation support • Crisis resources and supports • Food hampers	• Resources • Awareness of programs • Few volunteers • No safe places • No crisis plan • Counselling for staff	• Crisis protocol • Volunteer recruitment • Interagency meetings • Training • Safe house • Debriefing for staff • Mental health building



	# of programs	Example	Strengths	Challenges	Opportunities
Chronic, Long Term Treatment	4	Treatment center	• Home visits • Local counsellors • Transportation support	• Few local resources • Mistrust of outside • Communication with outside service providers • Mental health stigmatization • High staff turnover	• Local healing center • New approaches to treatment • Mental health awareness • Cultural orientation for staff
Rehabilitation	0	Physio	• Friends and family • Home and Community Care	• No rehabilitation specialists	• Visiting specialists • Local rehabilitation assistant • Collaboration between treatment and rehabilitation
Aftercare and Support	3	Home & Community Care	• Support of those who have been successful in their healing • Home visits • Community workshops	• Continuity of care when returning from treatment • Coordination and communication • Limited local aftercare resources	• Aftercare drop in center • Interagency collaboration
Palliative Care	1	Emotional and spiritual counselling	• In community traditional and/or spiritual knowledge • HCC	• Funding • Access to specialists • Capacity • Lack of a plan	• Training for HCC and others • Funding • Hiring specialist • Local cultural and spiritual approaches
Care facilitation	1	Case manager	• Solvent abuse case manager position • HCC	• Information management • Lack of interagency awareness of programs • Limited care facilitation resources	• Health data gathering and sharing • Develop case management policies

Results of Program Review

For each of the stages identified in Figure 25, we assessed how many programs address this stage and considered the strengths, challenges, and opportunities related to current programming at each stage of the continuum of care. The full results of this analysis can be found in Appendix 11. Some of the overall reoccurring themes across phase are summarized here:

Health Programming Strengths

Our existing land-based programs: We value existing programs that provide us with opportunities to engage in activities out on the land such as our land-based camp for Youth. We are witnessing tangible results from existing programs.

Our people: Our social networks, strong culture and language support our community health programs.

Current staff and experiences: Our nurses, doctors and staff have many skills and experiences. Our staff have some existing experience in areas such as: suicide risk assessment, case management, overcoming addiction, emotional and spiritual counselling. Our staff have skills such as teamwork, communication and relationship building.

Health Programming Challenges

Capacity of staff: Our programs suffer from a lack of reliable, experienced and trained staff.

Ineffective program resources: Our staff are often delivering programs based on program models developed outside of the community which are not relevant in Pikangikum. There is often a lack of clarity on purpose of programs, roles and responsibilities of staff.

Collaboration: There is a lack of coordination between different programs and confusion of what different programs do. There is a lack of awareness as to what different programs are offered in the community and little opportunity for programs to work together.

Participation: In general, there is low participation in programs because people are unaware or do not trust programs. Stigmatization of mental health prevents some for accessing services. The intended recipients of a program are not always being reached. The needs of solvent abusers (sniffers) in particular are not being effectively met by current programming.

Infrastructure: There are a lack of appropriate facilities to deliver programming such as a safe place for those in crisis and a private place to access mental health services.

Limited local resources: There are limited local resources and funding to support existing programs. There is limited access to health specialists, long-term treatment options, rehabilitation, aftercare and palliative care. There is also a lack of access to health promotion resources for community members such as healthy food and recreation opportunities.

Information management: Information management, reporting and evaluation of programs are inconsistent. As a result, it is difficult to assess to effectiveness of different health programs.

High turnover: Our nursing station staff have high turnover and it is difficult to retain them.

Limited volunteers: There is a lack of volunteers to support programs.

"There isn't a system in place to bring programs together and work together in dealing with clients"
(Staff report #2)

Health Programming Opportunities

Treatment center: A local healing and resource center for family-based healing, treatment and aftercare.

Training: On the job training opportunities for staff, including cultural and language training for new staff.

Coordination and collaboration: More interagency communication, collaboration and coordination such as the development of protocols for interagency coordination and communication in crisis situations and a coordinated approach to health and healing (case management).

Data management: More data collection and information sharing to allow for better monitoring and evaluation of existing programs.

Supports for staff: Counselling and support for staff, including sensitivity guidance for staff outside the community.

More staff: More committed and reliable staff including more volunteers.

More resources: More tools and equipment such as office and program space, vehicles, materials and computers and more consistent funding for salaries and programs.

More outreach: More communication with potential program participants to increase awareness and involvement with available programs.

More awareness: More community awareness and less stigmatization of mental health issues with a mental health awareness campaign.

Mental health services building: To deliver programming and provide clients privacy.

Improved infrastructure: To support health promotion such as better housing, recreational facilities and upgraded water/sewage.

Community Health Needs

All of the health issues, challenges and opportunities identified so far in this chapter were ultimately organized and described in our CHNA report. Our CHNA process resulted in a comprehensive and holistic summary of the health needs of our members, families and community (see CCHP methodology section for a description of how the health needs were identified). The assessment identified 23 main health needs all organized into seven categories (illustrated and summarized in Figure 25). It also identified 117 more specific sub-needs presented in Appendix 12.

,

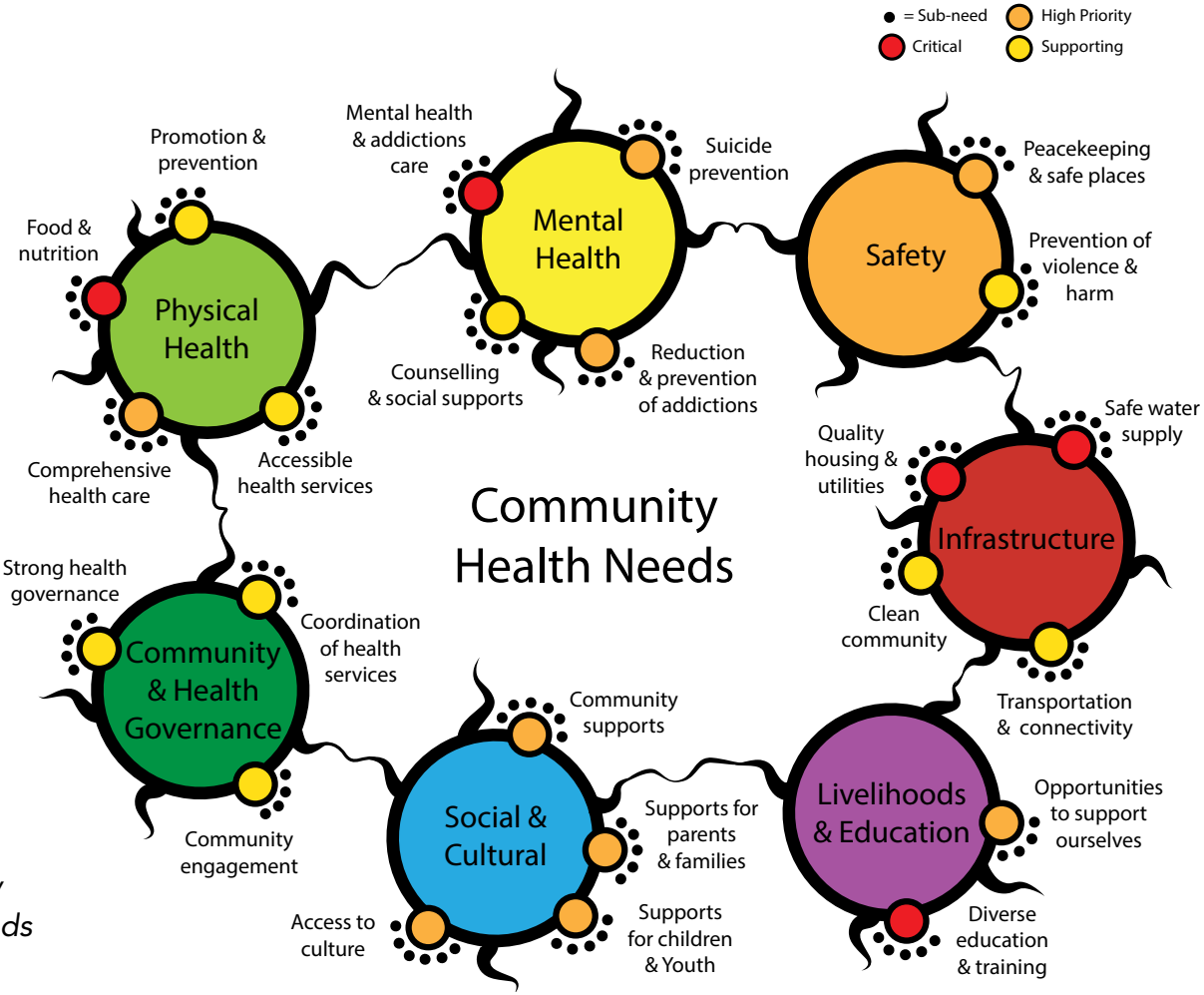
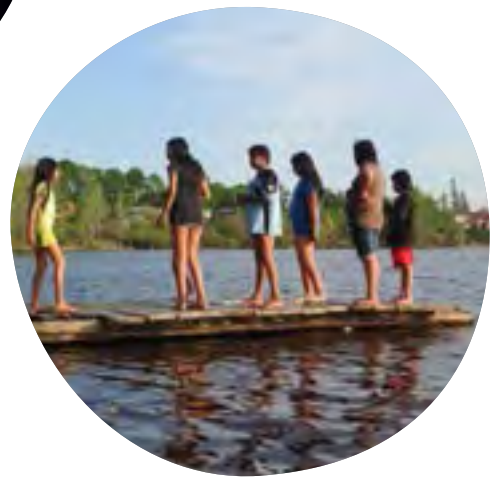


FIGURE 25:
Community Health Needs

Given the interconnected nature of our health needs, all community health needs are important and depend strongly on other needs. However, it is also helpful to define which needs should be addressed first. To do this, our CHNA process assigned priority levels to the main needs identified, based on nine criteria that measured popularity, urgency, and strategic advantage of addressing each need. The priority levels assigned were Critical,' 'High Priority,' and 'Supporting.' As well there are several needs identified as cross-cutting (*) and so should be considered when addressing any of the other needs. Table 9 lists all of our needs by prioritization level.

"Need more healthy exercises for adults and kids"
(Key informant)

"Build me a treatment place for people"
(Community session 1)



"We need our people who know our teachings
(Elders, 2013)

Critical	These are in the top five highest scoring needs based on overall ranking. These are the most critical needs to address and those that make sense to start with.	Mental health and addictions care
		Diverse education and training
		Quality Housing and Utilities
		Safe Water Supply
		Food and Nutrition
High Priority	These are in the top ten highest scoring needs based on overall ranking and are crucial to achieving our overall health vision. They may have ranked lower on any or all of our three evaluation criteria of popularity, severity and strategic advantage.	Supports for Children and Youth
		Access to culture*
		Supports for Parents and Families
		Reduction and Prevention of Addictions
		Suicide Prevention
		Opportunities to support ourselves
		Community Supports
		Comprehensive health care
		Peacekeeping and safe places
Supporting	These are not in the top ten highest scoring needs based on our initial overall ranking but these are still crucial to supporting efforts to address other health needs. They set the foundation for other needs being addressed.	Counselling and Social Supports
		Accessible health services
		Prevention of violence and harm
		Health Promotion & Prevention of illness and injury
		Coordination of health services *
		Strong Health Governance*
		Transportation and Connectivity
		Clean Community
		Community engagement*

Table 9: Needs by Prioritization Level

SWOT Analysis

As part of our situational assessment we completed a SWOT analysis. 'SWOT' stands for an analysis of Strengths, Weaknesses, Opportunities, and Threats. Our SWOT is the final piece of our "where we are now?" assessment for our community health planning. It is a tool to help organize our information about what things we need to and want to change and why, and to inform how we plan to makes these changes. We use our SWOT to organize and filter what we learned from our CHNA process (issues, needs, strengths, goals etc.) to highlight the most pressing and relevant information in terms of our CCHP and action planning. We use these highlights to shape our CCHP directions and paths, discussed in Chapter 3: Vision.

Our SWOT summarizes:

- Knowledge and experience we bring on our community health process (Strengths)
- Weak points or challenges (Weaknesses)
- Supplies, knowledge and tools we may capture along the way (Opportunities)
- Obstacles we may anticipate along the way (Threats)

Our SWOT does not include every single strength, weakness, opportunity or threat identified in our CHNA process. Instead, it highlights information that is particularly important to consider as we choose the directions and paths that will guide our health plan. Figure 26 summarizes the content of this analysis, a more detailed list can be found in Appendix 13 of this report.

"Initiatives get overwhelmed, projects end up collapsing – volunteerism is low"
(Key Informant Interview)

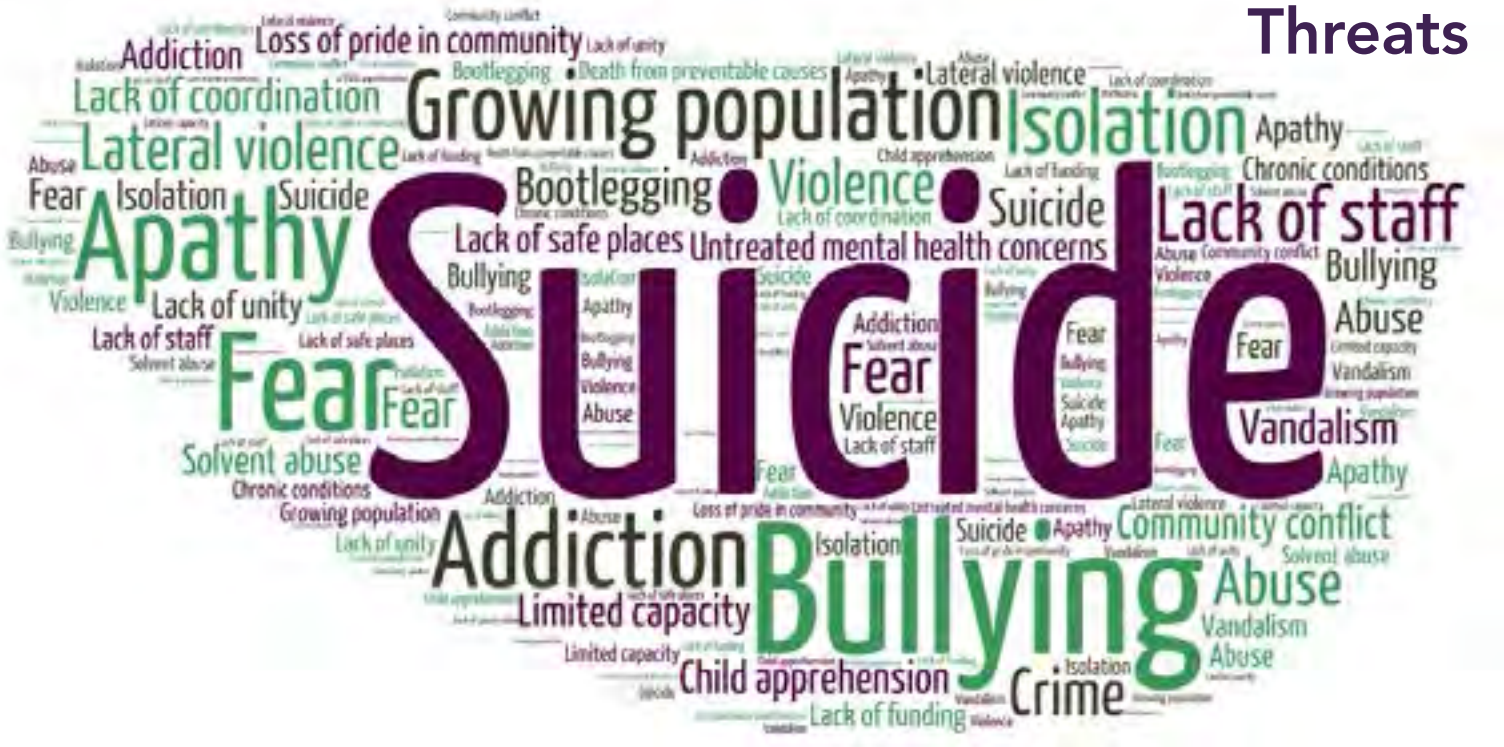
Strengths

FIGURE 26:
SWOT analysis

Weaknesses

Opportunities

Threats



Strengths

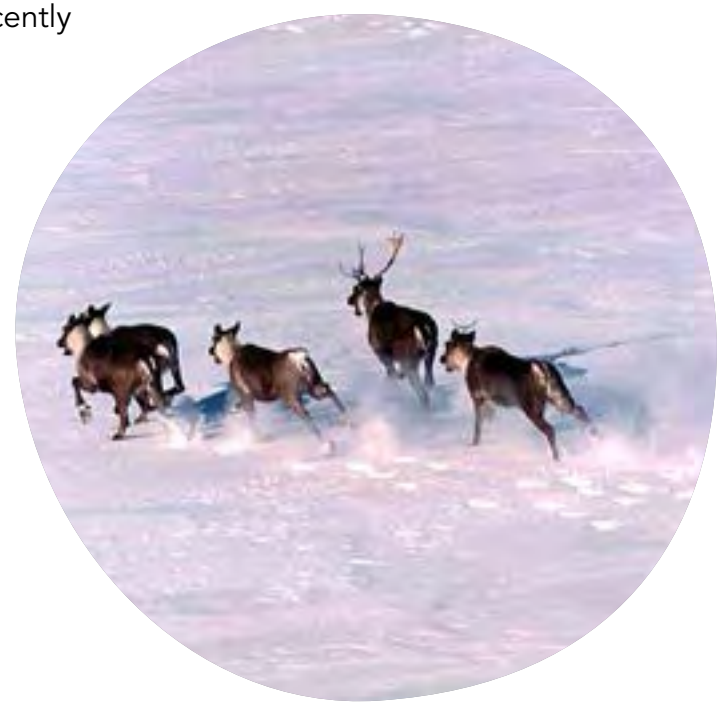
On our journey to community health and healing we can rely on the strength and resilience of our people, and especially our Elders and Youth. We can rely on our close-knit and connected network of families, friends and neighbours. We are strongest when working together and helping each other. We will harness the love that we have for our children and Youth and the faith we have in their strengths and potential. We have the strength of our school, which we have been running since 1988 and will soon have a new building. We will continue to gain strength from our lands, waters and beautiful places that provide our traditional medicine and food, and provide us with a relationship with the land that is rooted in strong cultural values.

As our health planning journey continues, our culture, history, language and living cultural knowledge will continue to give us strength and enrich our lives. We will build on the successes of existing programs, especially those that are on the land. We will use our experience from our Whitefeather Forest Initiative and the living knowledge and traditions that support our livelihoods. As we work to improve our health system, we have the skills and experience of our existing staff, our nurses and doctors, the leadership of our Chief and Council and the SHEE committee, and our experience in health and social programming. Our health governance system is growing stronger and stronger: we are actively regaining control over parts of our health system and recently received a top grade on our PHA audit (see figure 28).

"We still have our native language"

"Helping one another makes our community strong"

(Community session #1)



Weaknesses

As we embark on making and implementing our community health plan, we must be aware of our conditions and challenges so we can start changing things ourselves. Our existing health system suffers from gaps in staff capacity and a lack of health care resources, particularly in managerial or supervisory positions and in mental health services. Our current health service delivery suffers from a lack of programs and approaches that are locally and culturally relevant for members. There is often a lack of clarity on the purpose of our programs, or the roles and responsibilities of staff. Community members are not always accessing existing health resources that they need due to challenges with transportation, fear of stigmatization, lack of culturally appropriate services or lack of awareness of existing programs. Lack of health data and information management is hurting our ability to effectively monitor our community's health. It also reduces our ability to communicate and coordinate between health programs and agencies. Currently, lack of inter-agency coordination slows us down by preventing effective coordination of health care services across the full continuum of care. Staff who are unfamiliar with programs and services available from other agencies and organization struggle to refer patients to the right services and there is a risk of duplicating efforts and confusing patients about where to get help.

Today, many families in Pikangikum are struggling to build strong foundations for health (such as housing, sanitation, education, employment). Our health journey is challenged by inadequate housing and water infrastructure and insufficient community and health infrastructure. In particular, our long-term health is challenged by limited access to healthy food and limited recreational and social activities. Current and future livelihoods and families are weakened by low education rates and gaps in parenting skills. Families and individuals feel isolated and divided by a lack of trust and communication. We are struggling with protecting people from violence, bullying, and abuse. As well, our community has high levels of addictions and mental health challenges – every family is affected by these, and by trauma and grief. The shame, stigmatization, and lack of understanding about mental health and addictions issues in our community today are serious barriers to healing the mental health and well-being of all in our community.

Opportunities

Through our planning process we have learned much about our community health. This learning has inspired many new ideas and options for supporting our community health and healing, such as starting our own local treatment program now that we have secured Stormer Lake. By showing clearly how health is connected to all other parts of our lives and community, we can increase interest in and commitment to improving the foundations of our health. By taking a broad and holistic approach to health and healing, we are creating opportunities to work on a wide range of community goals. We have identified many opportunities to strengthen our cultural knowledge and activities, promote land-based activities, involve Elders and Youth together, and teach traditional values such as our family system. Further investment in the Whitefeather forest could expand our options for training and livelihoods. We have also identified many opportunities to promote and support healthy lifestyles, celebrate and invest in our children and Youth, and build community spirit and pride. If we can increase trust and love towards one another this could help us work more effectively together.

Our health-planning journey also presents many opportunities to increase our capacity for local health authority and responsibility. It is an opportunity to build stronger agency partnerships through coordination protocols and improved health data management. We may choose to improve our community's health governance by strengthening our health laws and policies, or increasing community engagement. Increased local health authority may increase our flexibility in the funding, design and delivery of health services. We may gain access to new resources such as health funding, increased staff and new health infrastructure. Health services may also be improved by building our health staff's capacity and providing staff with more support such as counselling and debriefing.

"Talk to those who have addictions"
(Community session #2)

"More information on issues that are coming up with youth"
(Staff report #1)

"Stop teen violence against other teens"
(Community welcome report)

"More knowledge about culture"
(Community Session #3 Report)

"Going to trap line to get healed"
(Staff Report #1)

"Listen to one another and help each other be a supportive community"
(Community Session #2 Report)

"More workers and a better building to fit everyone in"
(Staff report #1)

"Helping each other be healthy"
(Community Session #1)

Threats

In addition to our current challenges and weaknesses discussed above, there are potential future obstacles that we must be prepared to meet along our journey. Our community health is currently compromised by high levels of solvent abuse and addiction, suicide, trauma and grief. Left untreated, these mental health concerns will continue to undermine our community's ability to heal and potentially worsen other challenges, like poverty, fear, and isolation. Crime and vandalism, violence and abuse, child apprehension and community conflict all threaten to decrease pride in our community and hurt our ability and willingness to come together as a community. Lack of unity and healing relationships could seriously hamper our efforts to travel forward.

Our population is very young and is growing rapidly which means that current challenges are compounding at an alarming rate as our population grows, if underlying causes and problems are not addressed. Many cases of chronic and acute illness in our community are a result of living conditions and limited access to things necessary for healthy lifestyles. Our growing population will worsen these challenges, strain our existing health and social resources, and stress our infrastructure, such as housing and water.

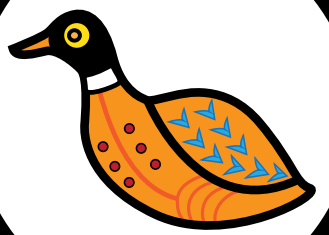
Other important threats for us to keep in mind are ones that impair our ability to act and make the changes that we want to see. These threats include staff burn-out, mindsets of disempowerment or apathy, lack of grieving time and feeling overwhelmed by the needs of projects. Our progress may be restricted by limitations in our management capacity, leadership gaps, and difficulties in recruiting, training and retaining qualified staff. Our weaknesses around co-ordination and communication between staff, programs, agencies, and other actors could also seriously threaten our ability to organize efforts to implement new projects and programs. As well, the volatility of health and community funding has serious implications for our ability to deliver quality health care and supports. As we consider health transfer or devolution, we must be aware of the threats of shortfalls in funding commitments and other risks associated with health transfer.

"Lack of communication between frontline workers. Need to work together"
(Key informant interviews)

"Not enough staff knowledge"
(Staff report #2)

Vision

3



The Vision phase of our planning process involves asking the question “Where are we going?”. On our journey to community health, we need to know our destination and what can guide us there. To create our Vision for health and the future of our community, we consider the desired changes that our community wants to see based on our current situation as defined in our Discovery phase. Based on a Vision statement we develop Principles to guide us in our planning decisions and actions, and choose the Directions and Paths that will point the way towards the changes we desire. This allows us to use our values and principles to guide actions/interventions (our projects, programs, policies). We then organize actions/interventions by priority, phasing and scaling to ensure greater success.

COMMUNITY HEALTH VISION

In our CCHP process we have created a community health Vision Framework together. This consists of a Vision statement, principles, a set of Directions and Paths, and a set of priority actions/ interventions. This chapter presents these as well as demonstrates the relationship between our Diretions, Needs, Issues and Strengths. It also presents our full set of actions/interventions and priority actions/interventions.

Our vision statement guides decision making and is meant to paint a picture of how we want our community to be in the future as a strong and healthy community:

We are a healthy, safe, strong, clean, loving, peaceful, happy and supportive community where active, caring members and families are thriving at home, staying in school, supporting themselves, doing fun activities, learning together, eating well, and participating in community life and governance. We are connected, working together and living in harmony with our land and culture to restore our health, mental well-being, sobriety, trust, respect, happiness, responsibility and community pride for current and future generations.

COMMUNITY HEALTH PLANNING PRINCIPLES

As Anishinaabe, we are guided by traditional principles of Ohniisheesheen (Health); Chiimeenoowe-chiiteeyong (Relationships); Oohuhchikayween (Planning); and Anishiinaabe-Bimaadiziwin (Way of Life).
In our Community Health Planning we also need specific Principles that flow from our vision statement that can further guide our process, decisions, and actions/interventions. Together we identified 18 Principles to lead us. Figure 27 shows our vision statement, 18 principles, surrounded by our Anishinaabe traditional principles. Our full principles are listed in Figure 28.

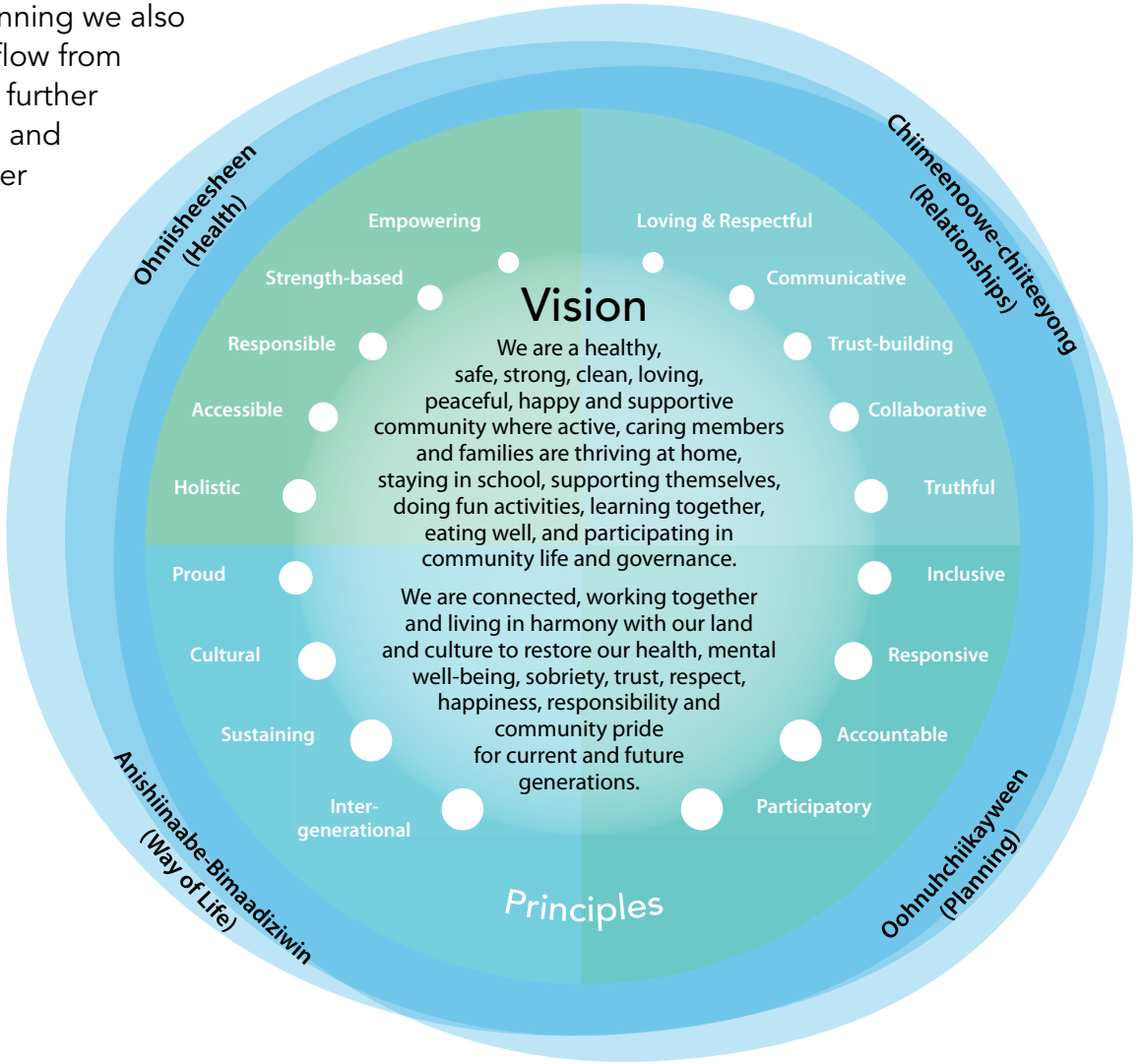


FIGURE 27:
Vision Statement and Principles

18 Community Healt

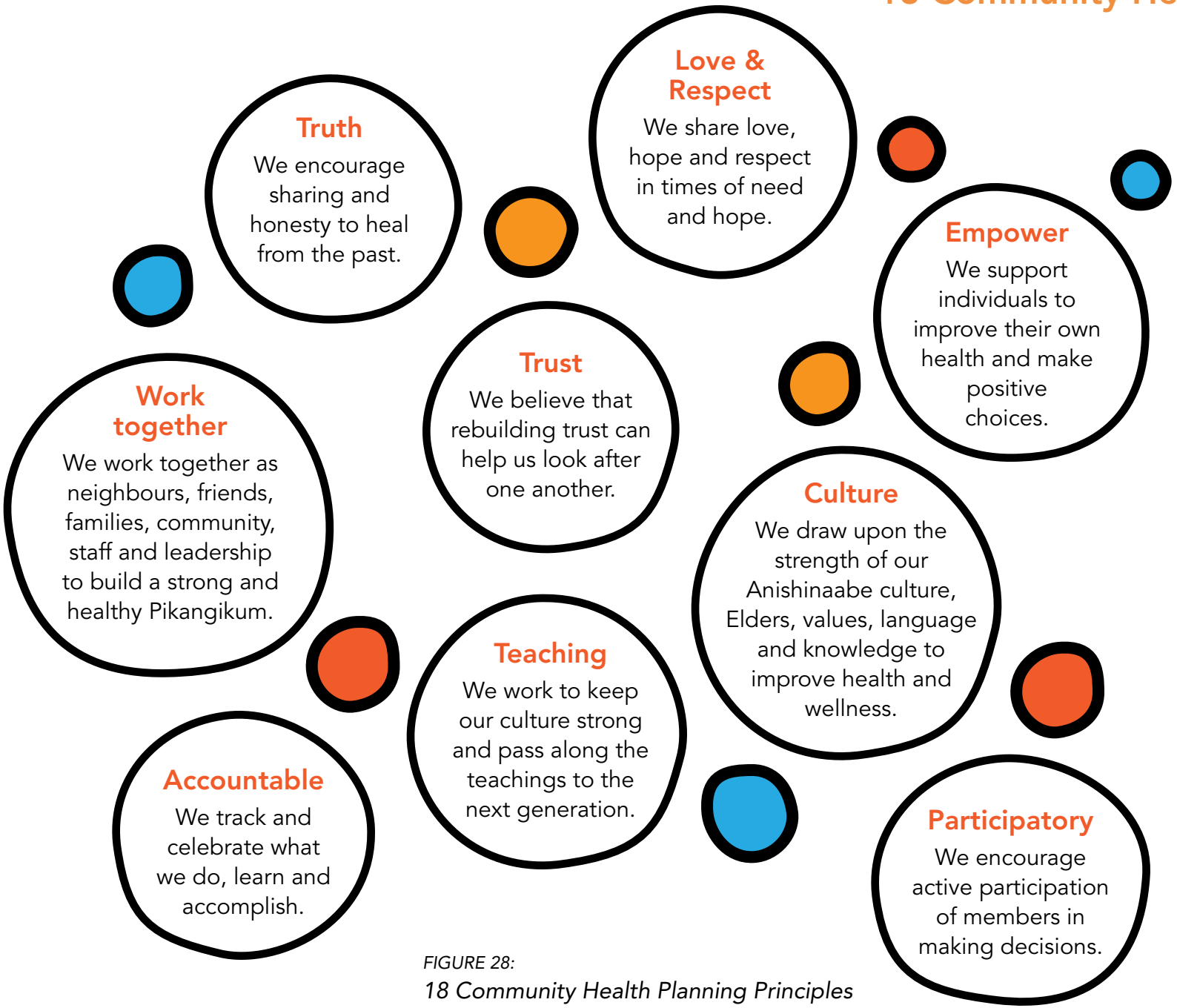


FIGURE 28:
18 Community Health Planning Principles

h Planning Principles

Holistic
We think of health, healing and wellness using a whole approach that considers mental, physical, social, cultural, emotional, spiritual and economic health.

Inclusive
We include everyone in building health and strengthening our community health system.

Responsive
We listen to our members' issues and needs and take action together as needed.

Strengths
We recognize and use our strengths and resources to improve our health.

Communicate
We monitor and communicate results of our health decisions and adapt our plan and work as needed.

Inter-generational
We approach health, healing and wellness with a view that we need to connect with our ancestors, Elders, adults, Youth, children and future generations.

Accessible
We help members understand and access their specific pathways to health.

Responsibility
We support individuals to take responsibility for their health and make positive choices.

Pride
We honour the gifts and pride of our members.

OUR DIRECTIONS AND PATHS

In addition to our Principles, our health plan needs more specific Directions (ends objectives- value priorities to guide actions) and Paths (means objectives- strategy). As a complete set, our Directions and Paths cover all of the 117 sub-needs identified in our CHNA. See Appendix 14 for a comparison of how our sub-needs relate to our Directions. Our Directions and Paths help us translate our health issues and needs into action by providing us with specific goals to which to tailor our strategies and actions. Our Vision statement, Principles, Directions and Paths combined make up our vision framework (illustrated in Figure 29) which in turn allows us to set targets to measure change and results we as a community said we wanted.

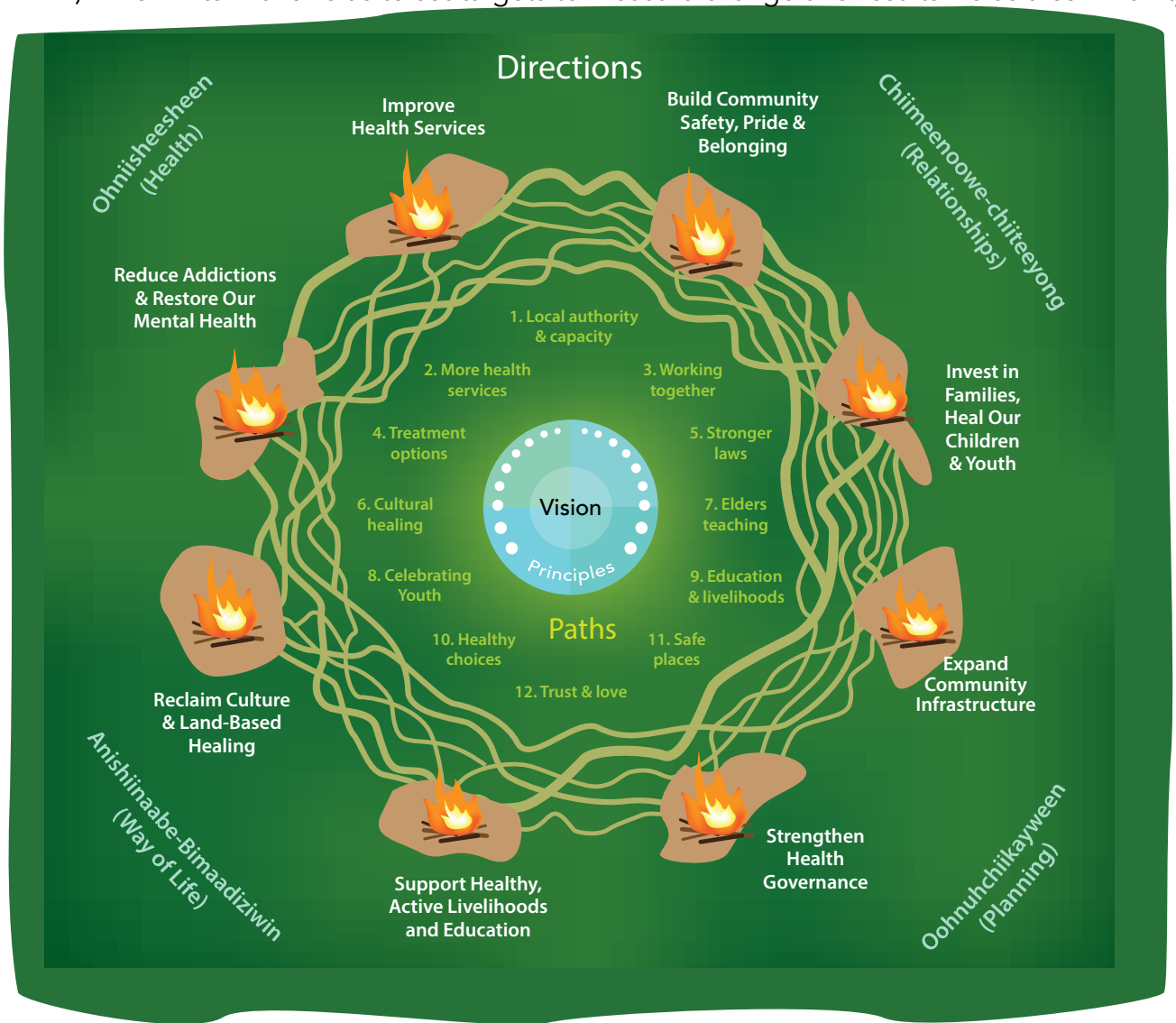


FIGURE 29:
Vision Framework

Directions (8)

- Strengthen Health Governance
- Improve Health Services
- Reduce Addictions and Restore our Mental Health
- Expand Community Infrastructure
- Reclaim culture and land-based healing
- Invest in families, heal our children and youth
- Support healthy, active, livelihoods and education
- Build community, safety, pride and belonging

Paths (12)

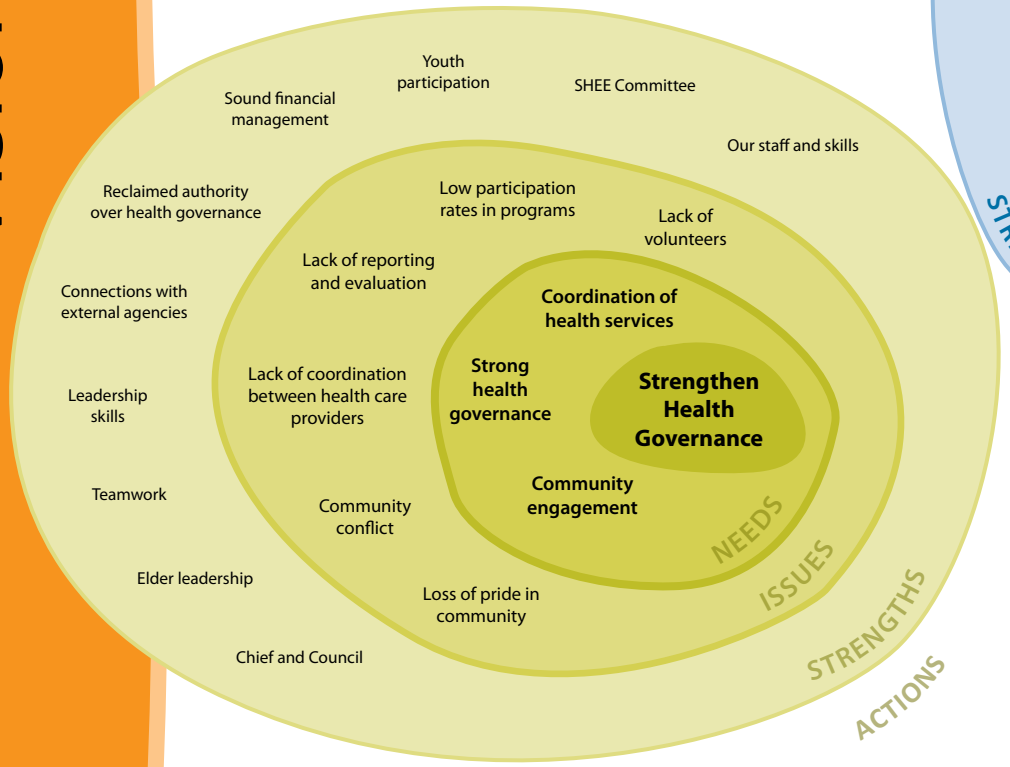
1. **Increase local authority, capacity** and responsibility for health delivery and governance
2. **More health services** from prevention into treatment and recovery
3. Improve ways of **working together** between all health and social service providers
4. Expand healing and alcohol/ solvent/drug **treatment options**
5. Create **stronger laws** and policies to control health related actions
6. Promote **cultural healing** and land-based skills and activities
7. Bring **Elders' teachings** to Youth to learn and heal
8. Support, involve and **celebrate our Youth** in making strong futures
9. Improve access to **education**, life and job skills and **livelihoods**
10. Build a community where individual **healthy choices** are easy
11. Create **safe places** for community members where they do not experience violence or abuse
12. Build **trust and love** toward one another

Actions/ Interventions

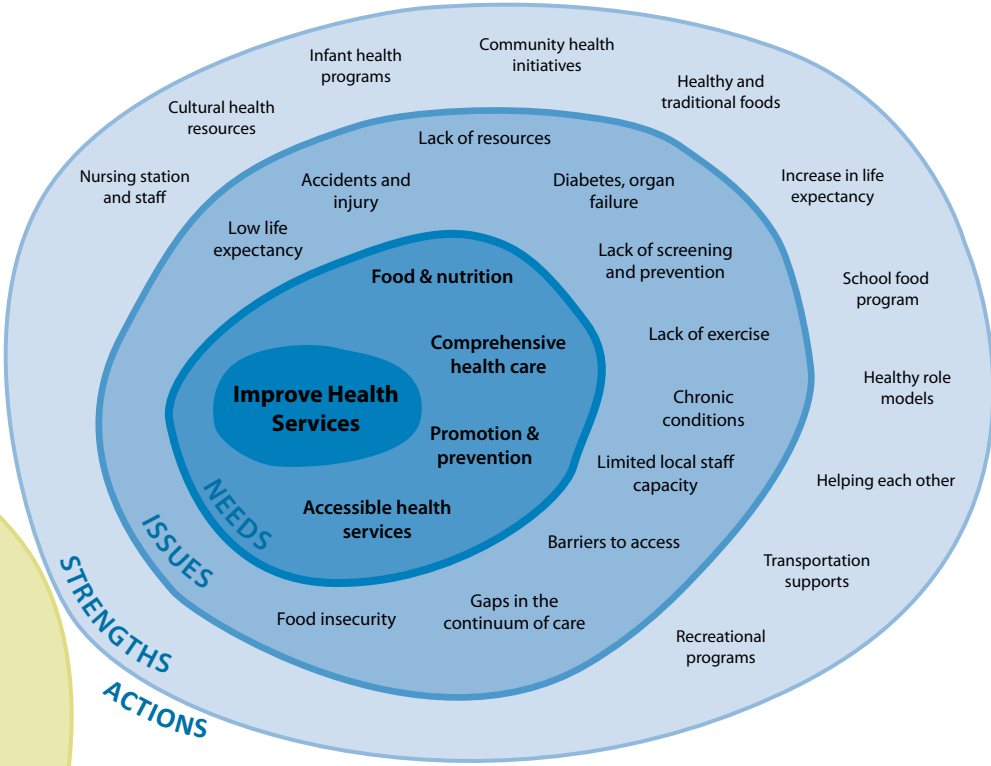
Relationship of Health Directions to our Needs, Issues and Strengths

Our 8 Directions and 12 Paths are meant to capture health strengths, issues and needs identified in our CHNA and focus attention on identifying our priorities for action/intervnetion (such hire a mental health worker). The following figures show how our Directions are the direct result of our understanding of our strengths, issues and needs (see Figure 30).

"Combine western medicine and medicine from the land"
(Key informant interview)

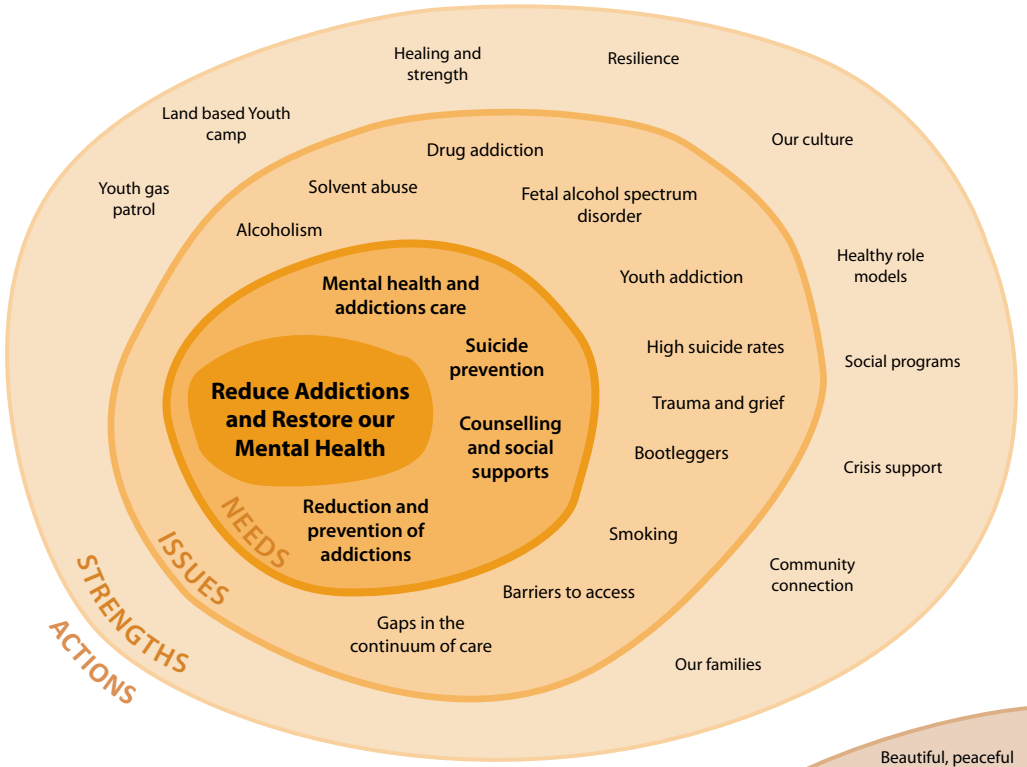


Direction 1:



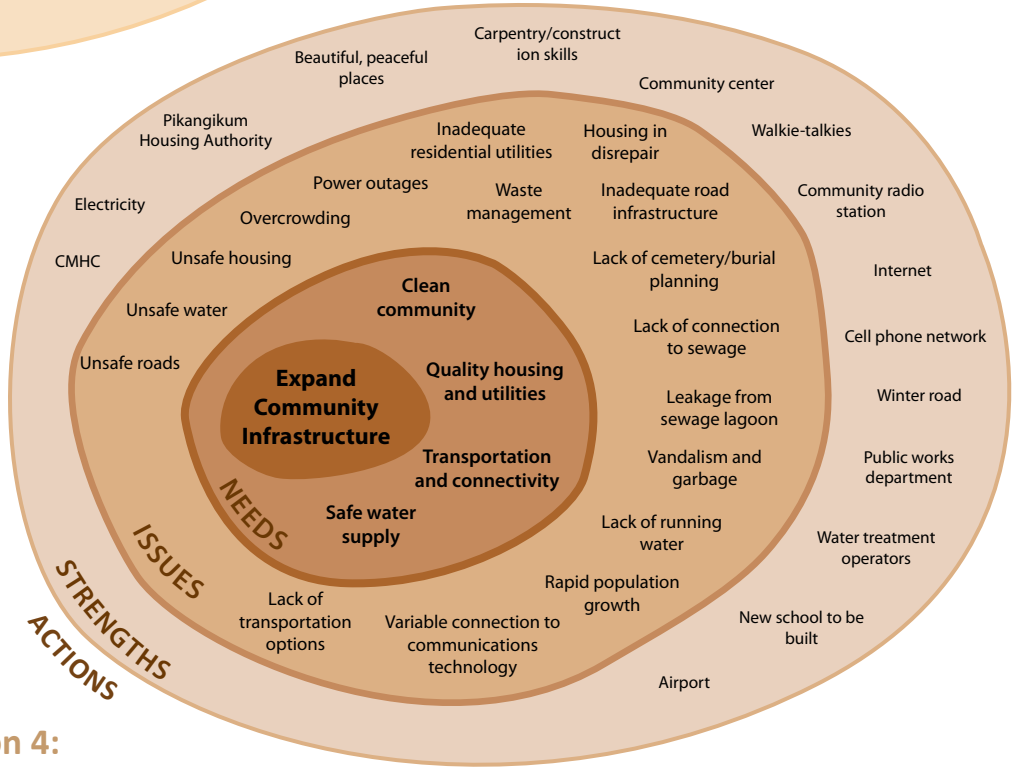
Direction 2:

FIGURE 30:
Relationship of Health Directions to our Needs, Issues and Strengths

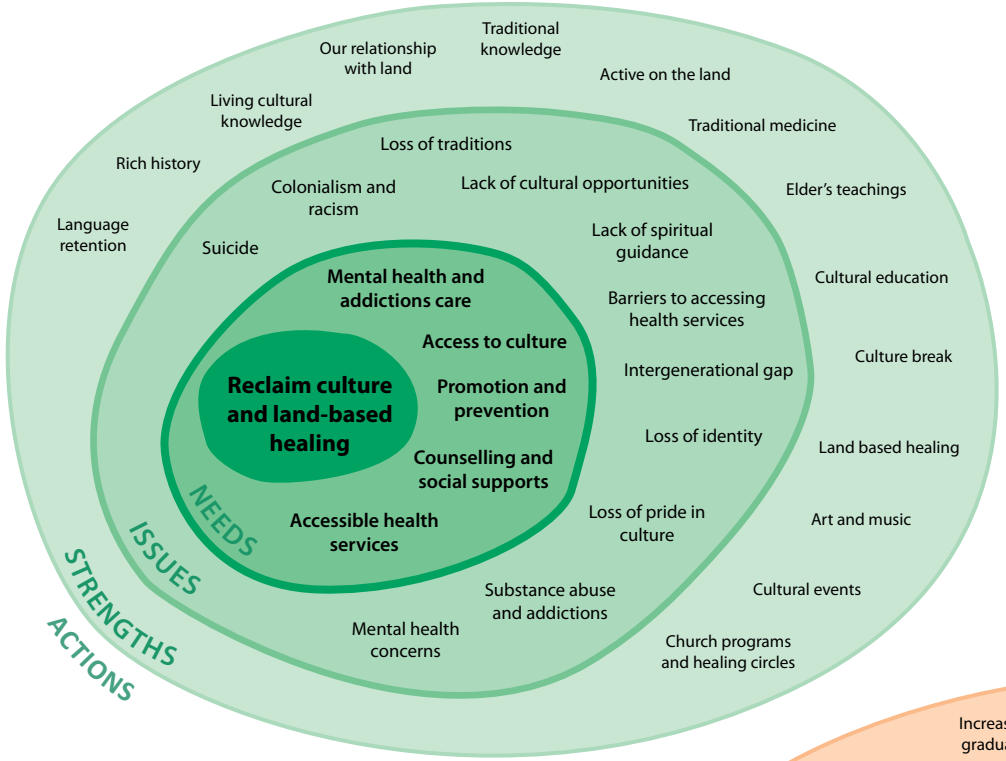


"Somewhere to send families for time away for family counselling on multiple issues. Restful and peaceful"
(Key informant interviews)

Direction 3:

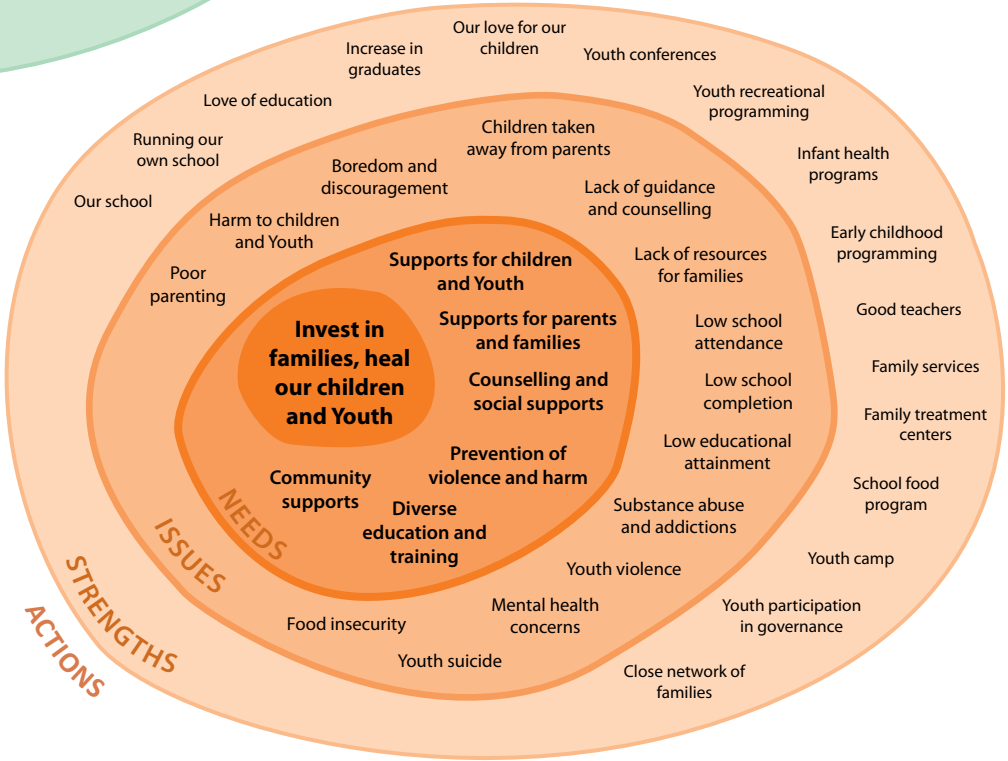


Direction 4:



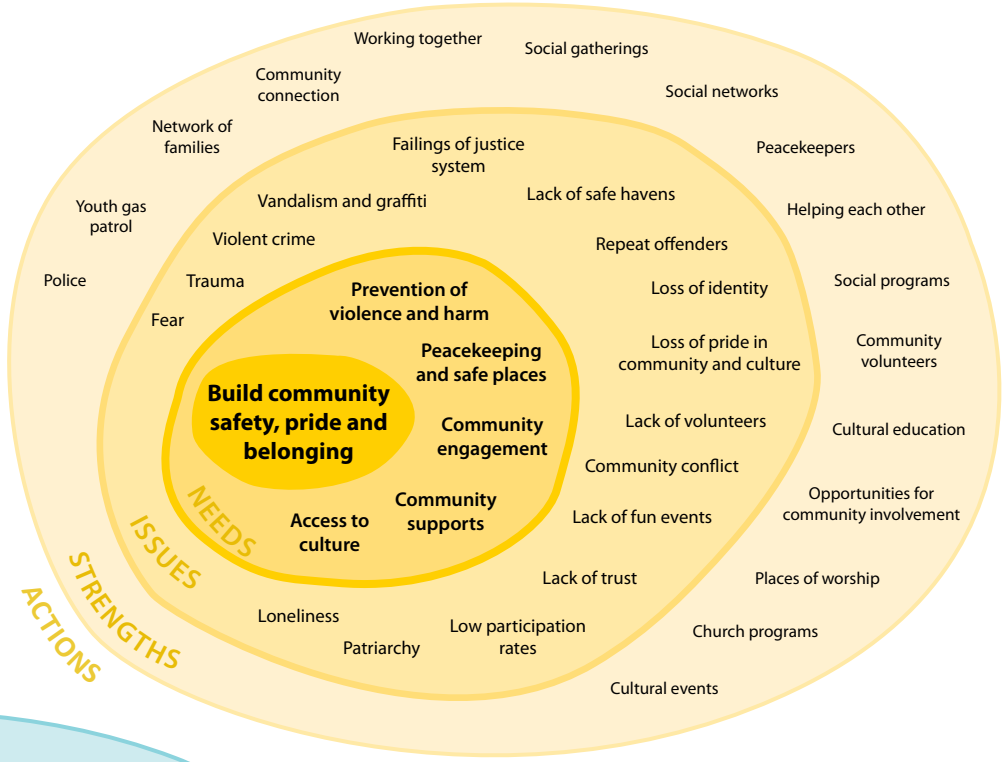
Direction 5:

"Rebuild family structure, role of parent and child" (Key informant interview)

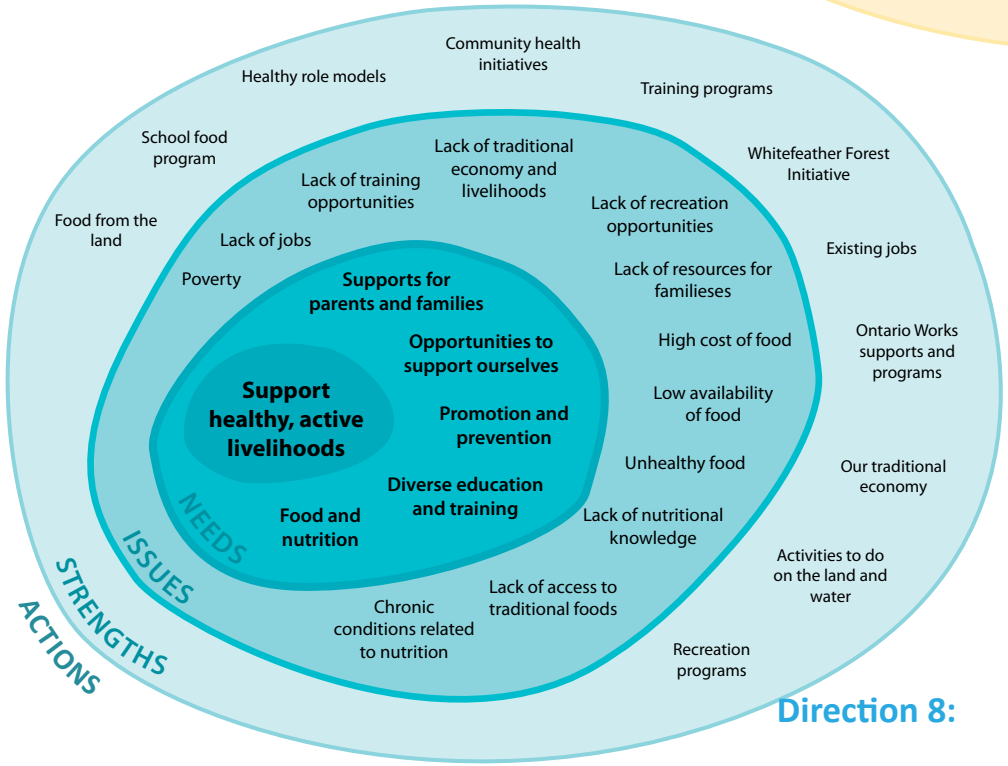


Direction 6:

"Youth need confidence to use the system to protect themselves, have to get security in community"
(Key informant interview)



Direction 7:



Direction 8:

ACTION AREAS

The following 5 action clusters (Healing, Health System, Families, Youth and Culture) were identified by our health planning process as top priorities to best meet our 8 Directions and 12 Paths. These clusters were identified by considering the popularity of individual actions ideas based on community engagement and ranking (see analysis report in Appendix 15) and the strategic advantage of individual actions based on how well they meet our plan's Health Directions and Paths (see Appendix 3 for full analysis). In addition, they were identified by reviewing options with the Planning Support Team. Actions were then organized by 21 sub-themes within clusters of actions as illustrated in Figure 31. Table 10 on the following page lists all 69 individual actions by cluster and sub-theme.

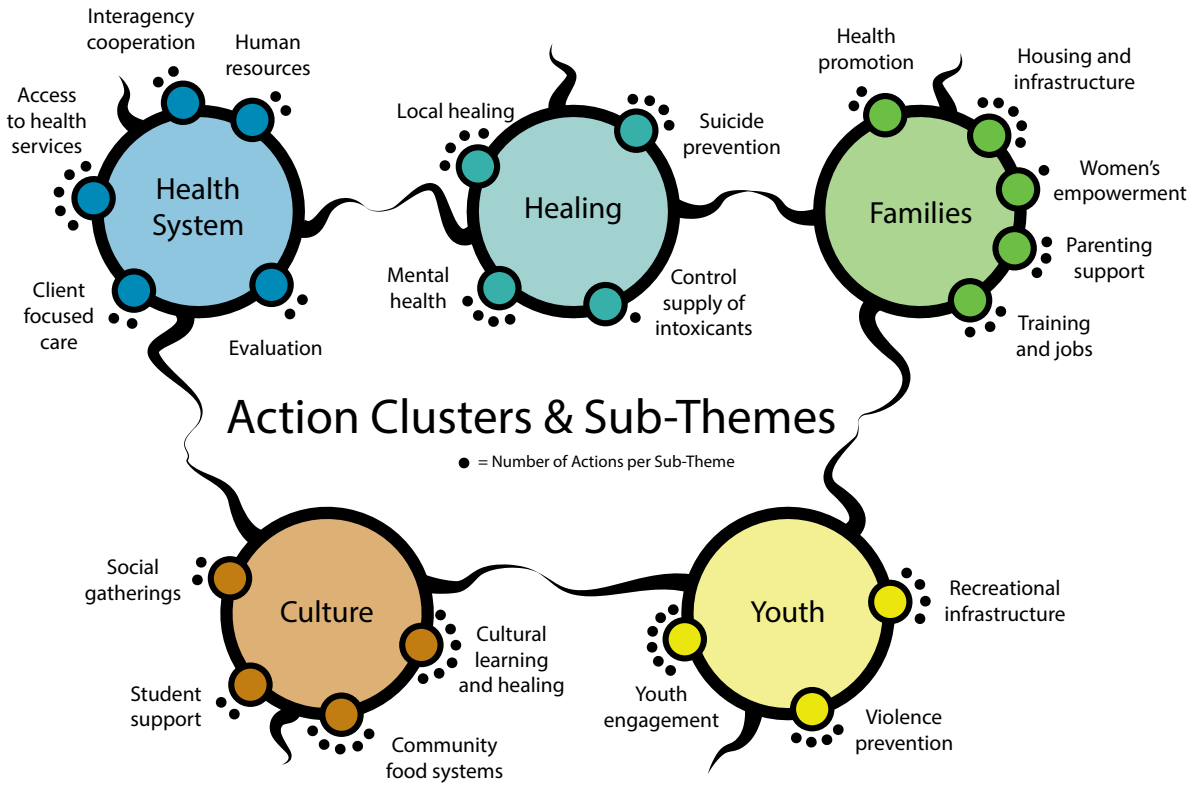


FIGURE 31:
Action Clusters and Themes

TABLE 10: Actions listed by Cluster and Sub-Theme

HEALING

Local healing
- Stormer Lake operational plan
- Stormer Lake treatment program development
- Hire and train Stormer Lake staff
- Aftercare program

Control supply of intoxicants
- Study on controlling supply of intoxicants

Suicide prevention
- Grief counselling services
- Mental health awareness campaign
- Suicide risk assessment training
- Youth suicide prevention program

Mental health
- Hire 3 mental health workers
- Mental health strategy
- Mental health resource center
- Mental health and clinical training

HEALTH SYSTEM

Client focused care
- Case management and continuum of care training
- Case management & continuum of care system

Interagency cooperation
- Hire interagency liaison
- Interagency protocol

Human resources
- Hire clinical supervisor
- Staff support network

Evaluation
- Monitoring and evaluation system
- Planning and health information department

Access to health services
- Home visits
- Community program guide
- Expand hours of outreach
- Health phone line
- New nursing station

FAMILIES

Health promotion
- Health living campaign
- Health promotion programming

Parenting support
- Expand daycare
- Healthy parenting program
- Parenting resource center

Training and jobs
- Whitefeather Forestry Initiative
- Whitefeather training center
- Community skills inventory

Housing and infrastructure
- Housing and water infrastructure expansion
- Reserve boundary expansion
- Road improvements
- Street lighting
- Power station upgrade

Women's empowerment
- Women's circle

YOUTH

Youth engagement
- Youth council
- Youth leadership and mentorship program
- Youth center
- Anti-bullying campaign
- Sex education
- Achievement awards

Recreational infrastructure
- New school, recreation center and gym
- Sports fields upgrades
- Youth recreational & cultural coordinator
- Walking trails system

Violence prevention
- Lateral & domestic violence prevention program
- Safe house for Women
- Safe house for Youth
- Men's anger management workshops

CULTURE

Cultural learning and healing
- Elder's teaching circle for health
- Cultural orientation workshop
- Traditional healing ceremonies
- Cultural center
- Film project
- Community justice review

Social gatherings
- Agencies host community feasts
- Social and cultural events program

Community food system
- Food bank
- Community garden
- Community kitchen
- Annual community hunt & feast
- Traditional food & hunting program

Student support
- School curriculum review
- Cultural education & arts program

Action Themes and Action Descriptions

Each action theme is described in detail in Appendix 16. For each action theme, we describe it, how it can be implemented, and why it has been identified as a priority theme. It then describes desired outcomes, explores implementation challenges and strategies and lists related individual actions.

See Appendix 17 for a description of each individual action.

"Providing healthy meats through hunting and fishing"
(Key informant interview)

"[We need a] communication/ collaboration protocol on working together"
(Key Informant Interview)

"More activities for the youth, especially the youth that are having family issues"
(Staff report 1)

ACTION PRIORITIES BY CATEGORY

Our plan has identified many actions to address our Health Directions and Paths (as listed in Table 10). We recognise that capacity, funding and resources will limit how much we can accomplish at once. Therefore, all of these 66 actions were further analysed to prioritize actions in degrees of importance. We did this by considering the popularity (including popularity scores from CHNA and CCHP processes), impact and interconnectivity (how well the action meets our health needs, Directions and Paths) and feasibility (cost, time and human resources required) of each action (see Appendix 8 and 9 for prioritization methodology and results). Table 11 shows us in which prioritization category each of our 69 ideas ranked (see Appendix 18 for all actions by prioritization category and type):

Quick Start: A relatively easy action that can be implemented right away as a way to build momentum for future actions

Critical: The most important and urgent of our actions, we should actively try to mobilize resources to implement

Essential: The most important of our actions, but less urgent, we should try to mobilize resources to implement

Very Important: Also important actions, to be implemented as resources become available

Supporting: Actions that are necessary to support actions in other categories

In addition, Table 2 identifies 9 actions we are already doing, but that our planning process has identified as important to continue.

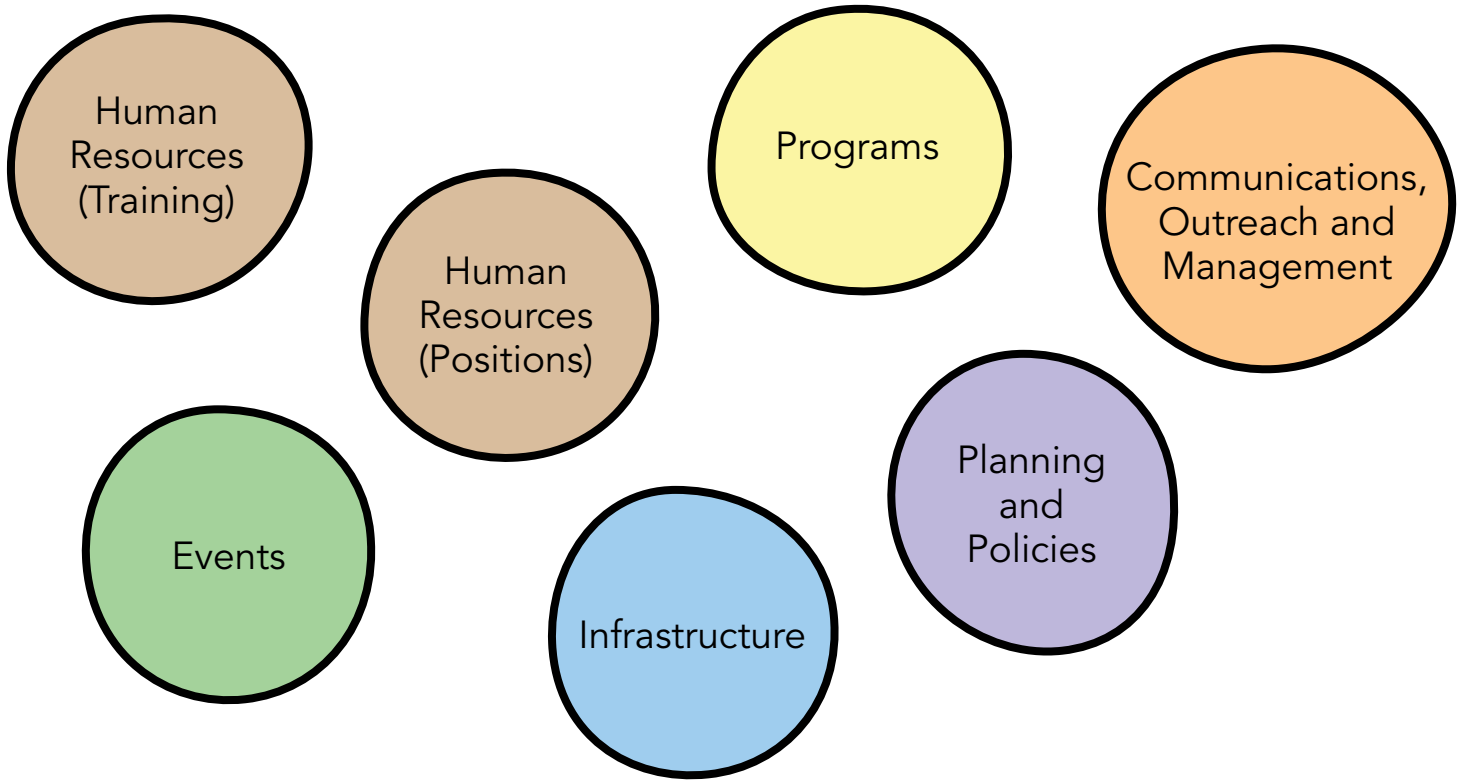
TABLE 11: Actions by Priority Category

Priority Category	Actions (In no particular order)		
Continue (9 actions)	• Health newsletter • Health fair • Youth school counseling	• Chronic disease program • Diabetes prevention • Youth Patrol	• Food hamper • Community restaurant • Project journey
Quick Start (13 actions)	• Women's circle • Men's anger management workshop • Agencies host community feast • Youth achievement awards	• Community hunt and feast • Youth council • Walking trail system • Expand home visits (health vehicle)	• 3 mental health workers • Traditional healing ceremony • Health phone line • Health program guide • Expand hours of outreach
Critical (15 actions)	• Interagency protocol • Case management and continuum of care system • Case management training • Staff support network • Grief counselling services • Suicide risk assessment training	• Healthy parenting program • Community kitchen • Housing and water infrastructure • Anti-bullying campaign • Suicide prevention program and pilot	• New school, gym and fitness center • Youth and Women's safe house • Elder's health teaching circle • Community justice review

Priority Category	Actions (In no particular order)		
Essential (12 actions)	• Clinical supervisor • Clinical & mental health training • Intoxicant supply study • Social & cultural events program • Cultural orientation workshop	• Lateral & domestic violence workshops • Stormer Lake operational plan • Sex education program • Youth recreational & cultural coordinator	• Daycare expansion • Whitefeather training center • Traditional food & hunting program
Very Important (11 actions)	• Planning & health information department • Monitoring and evaluation system • Mental health strategy	• Whitefeather Forestry Initiative • Food bank • Street lighting • Stormer Lake family healing program	• School curriculum review • Youth mentorship program • Cultural education & arts program • Hire and train Stormer lake staff
Supporting (18 actions)	• Interagency liaison • New nursing station • Mental health awareness campaign • Mental health resource center • Aftercare program • Youth leadership program	• Community skills inventory • Healthy living campaign • Expand health promotion programming • Cultural center • Sports field upgrade • Youth center	• Parenting resource center • Community garden • Expand Reserve boundary • Road improvements • Power upgrade • Film project

ACTIONS BY TYPE

Our plan identifies a large range of actions that can be organized into 7 types of actions/interventions: 1) Human Resources- training; 2) Human Resources- positions; 3) Events; 4) Programs; 5) Communications; Outreach and Management; 6) Planning and Policies; and 7) Infrastructure. Figure 32 shows ONLY the quick start, critical and essential priority actions (see Table 1 for full list of actions) by type. This diagram demonstrates the range of types of actions/interventions, and also sorts of actions at individual, family and community levels.



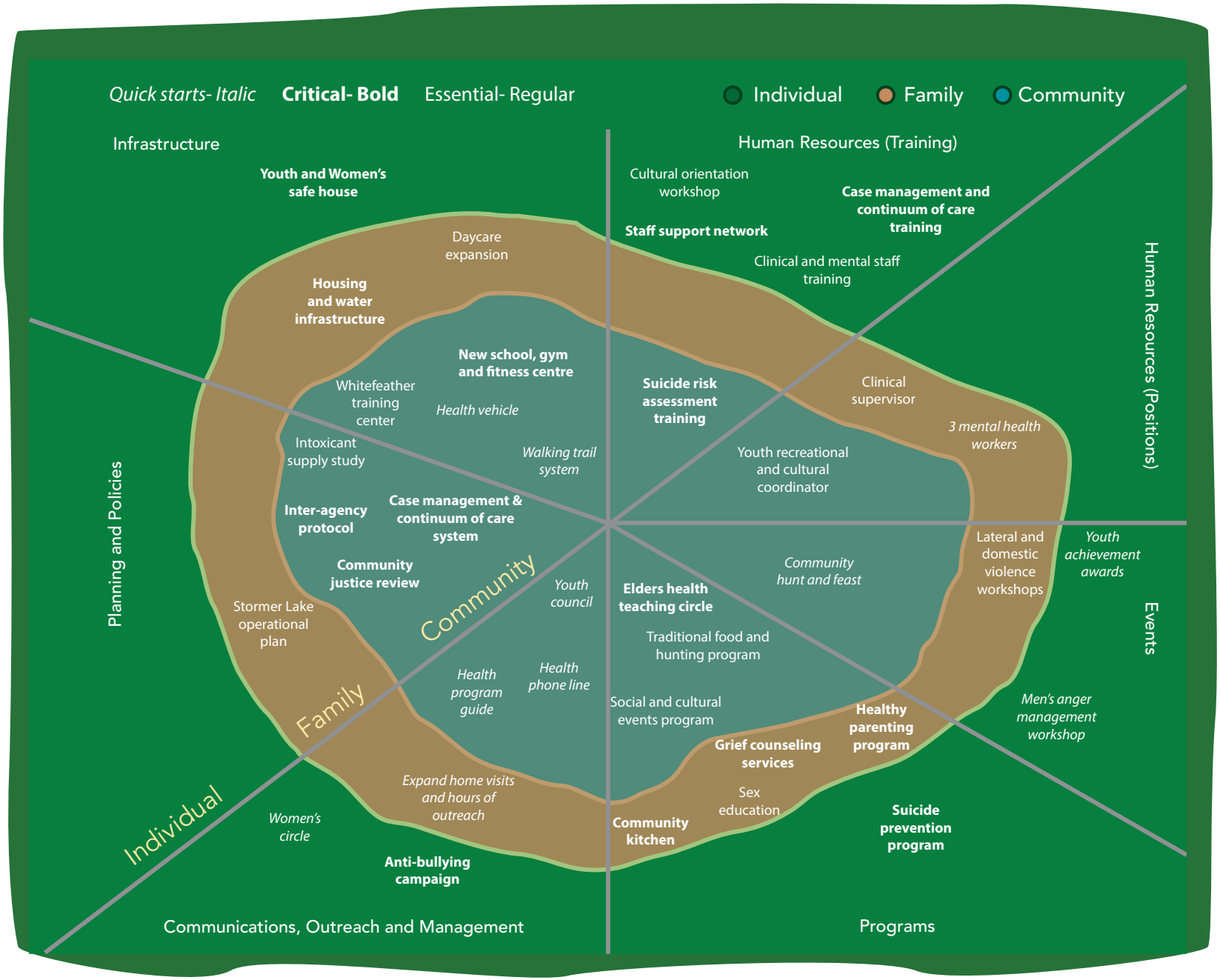


FIGURE 32: Quick Start, Critical and Essential Actions by Type

TOP 25 ACTIONS

We identified the top 5 critical and essential priority actions for each cluster: the actions that are the most important for us to focus our resources on as a starting point. The following table lists the 25 top priority actions by cluster, with short project descriptions and suggested quick starts. These priorities could change and be modified through our implemention process (see page 178 for process -to- modify our CCHP).

Healing

TOP PRIORITIES		QUICK START
1. Suicide prevention program:	A Youth specific suicide prevention program will be developed that integrates overall efforts to revive culture and build community pride and belonging.	• **Hire 3 mental health workers:** 3 new mental health worker positions will be created by reassigning existing budgets and searching other funding • **Health vehicle:** a new vehicle will be purchased to faciliate increased home visits
2. Suicide risk assessment training:	Existing staff will receive training on how to recognize suicide danger signs.	
3. Grief counselling services:	Expand existing opportunities to provide grief counselling for those experiencing personal trauma.	
4. Stormer Lake operational plan:	To prepare for the launch of Stormer Lake programming, an operational plan will identify the resources and actions required to do so.	
5. Intoxicant supply study:	Conduct a feasibility study to explore the viability of options such as: 1) Switching to Opal fuel; 2) Banishing bootleggers; and 3) Lifting the alcohol ban and controlling liquor sales.	

Health System

TOP PRIORITIES		QUICK START
1. Case management & continuum of care system:	Expanding operational support and tools necessary to support our case management system such as an interagency communication system, staff training and an information management system.	• **Expand home visits and hours of outreach:** increasing the number of home visits conducted by existing PHA staff and expanding hours of service • **Health program guide and phone line:** A guide to all available programs, and a phone line you can call if you have health questions
2. Interagency protocol:	An interagency protocol is a tool to help increase coordination, collaboration and communication between different health agencies to serve the needs of PFN.	
3. Staff support network:	Staff with similar roles and background meet to review cases, their response to cases and provide mutual support through debriefing, counselling and recognition.	
4. Clinical & mental health staff training:	Existing staff will receive mental health training including clinical training, suicide prevention and outreach standards.	
5. Hire clinical supervisor:	Hire a well-educated and experienced clinician (ideally in the addictions and mental health field) to assist PHA staff expand the capacity of its health system.	

"Lack of communication between frontline workers. Need to work together" (Key informant)

Families

TOP PRIORITIES		QUICK START
1. Healthy parenting program:	A program to provide guidance and tools to parents covering topics such as pre-natal care, conflict resolution and nutrition.	• **Women's circle:** an opportunity for Women to discuss community health issues and strategize action to help increase their involvement in health promotion.
2. Housing and water infrastructure:	Providing more community members with access to safe, clean and adequate housing.	• **Men's anger management workshop:** aimed at helping members manage anger and stress.
3. Community kitchen:	A place where members can gather to cook together.	• **Walking trail system**: Providing members with safe places to participate in outdoor activity.
4. Whitefeather training center:	Preparing the workforce for the future jobs with the Whitefeather Forestry Initiative and a facility for various health training initiatives.	
5. Daycare expansion:	Expanding daycare to provide more opportunities for early childhood education and to better support parents.	

"Young couples need parenting skills, both traditional and mainstream"
(Key informant interviews)

Youth

TOP PRIORITIES		QUICK START
1. Anti-bullying campaign:	Deliver campaign that explores how to recognize and prevent school and workplace bullying as a first step towards a series of lateral and domestic violence workshops.	• **Youth council:** a group of Youth who meet to advise Chief and Council on issues that affect Youth, giving Youth meaningful and important leadership roles and voice in shaping the future of their community.
2. New school, gym & fitness center:	As part of the new school, a gym & fitness center to increase access to recreational facilities.	• **Youth achievement awards:** an opportunity to celebrate and recognize our Youth for a wide diversity of achievements ranging from cultural, social, artistic and educational achievements.
3. Women and Youth safe house:	A place to shelter women and Youth who are seeking to escape abuse and violence or who are experiencing a mental health crisis.	
4. Youth recreational and cultural coordiantor:	Responsible for planning and supervising activities specifically for Youth as well as recreational and cultural events for the community.	
5. Youth leadership & mentorship program:	A program aimed at developing leadership skills and providing mentorship opportunities for Youth.	

"The bullying [can be] merciless – [it follows kids] out into the street, on the internet, kids are hiding under porches..."
(Key informant interview)

Culture

TOP PRIORITIES		QUICK START
1. Elder's health teaching circle:	Coordinating a group of Elders to facilitate a series of health teaching circles where community members can gather with Elders to discuss community health and well-being.	• **Community hunt and feast:** A community hunt involves gathering a group of community members for a collective hunt, and sharing the catch from this hunt at a community feast.
2. Community justice review:	A review of our current justice system to explore alternatives such as restorative justice.	• **Traditional healing ceremony:** This action may start an a single cultural healing event, but can grow to be an integrated set of service options.
3. Traditional food & hunting program:	Support for people to get out on the land to learn how to hunt with training, equipment and transportation support.	
4. Cultural orientation workshop:	Program designed by Elders to help teach culture and orient newcomers who work in our community.	
5. Cultural education & arts program:	Program to give community members an opportunity to engage in artistic and cultural activities.	

"The way my Elders taught me was if you listened to an Elder, the more days you would have in your life, added onto the number of days that the Creator gave you"
(Elders report)












Action

4

Now that we have identified our 25 priority actions to meet our Vision and Directions, the next phase of planning involves asking the question "How do we get there?". This phase of the planning process is about mobilizing resources (people, information, tools, budgets) to move the plan forward, to begin getting the desired (improved) results and outcomes we state in our vision. To help implement our overall plan we lay out an implementation strategy that includes an overall philosophy and set of principles to continue our community-based process of change. Getting from plans to action involves organizing who and what needs to be involved, assigning roles and responsibilities, and mobilizing funding and resources. It also requires a structure to map out a timeline, phasing, sequencing and scaling of actions/interventions. Our implementation chapter is divided into two parts to reflect the two major parts of implementation: 1) Organizational readiness (readiness to carry out the plan); and 2) the structure of specific actions/interventions (programs, policies, events).

ORGANIZATIONAL READINESS

Implementation involves building readiness to move our CCHP forward. This involves examining our organizations, human resources, budgets and policies, and identifying what needs to be strengthened to allow for the effective implementation of our health plan. In this section we start by defining implementation; then we present our overall implementation approach and principles; then we explore implementation challenges, risks and strategies and finish with an overall work plan to begin preparing and getting ready to implement.

What is Implementation?

Implementation is all about putting our ideas to action. It is the process of putting a plan into effect, or executing the plan. It is a specified set of activities designed to put into practice the plan, program or activity[1].

It is time of transition from planning to action and the most critical point of our planning cycle. It is now that we need to mobilize and organize action, people, time, money, relationships and tools/resources to move the entire plan forward along the planning cycle.

We may feel a sense of accomplishment now that our plan has been completed, but this might mislead us into thinking that we have finished the process. If we stop our efforts now, our plan will likely sit on a shelf and not be used. Follow through is now needed to extend our community process so that we can realize the desired change we expressed in our 10 year vision for community health.

Staff are most typically involved in implementation, although a whole host of players are necessary for effective implementation (see roles and responsibilities on page 136). For example, a local planning

1 Fixsen, D. Naoom, S. Blase, K. Friedman, R and Wallace F. (2005) Implementation Research: A Synthesis of the Literature. University of South Florida

committee of Pikangikum members will be set up to champion implementation. In addition, renewing the mandate and role of the SHEE committee is essential in keeping our plan alive. The commitment of funders is critical to set this CCHp into motion.

Effective implementation has the potential to increase feelings of local control and ownership as people see their vision come to life as long as we continue to build our community process and local ownership. This process has to be sustained.

In a nutshell, implementation can be defined as "coordinated change" in which systems, organizations, programs and practices are coordinated to help us realize our Vision.

Implementation Activities and Outcomes

Implementation involves two sets of activities:

1) Implementation level activity: actions we undertake to strengthen and prepare our organizational system (building organisational readiness, for example, hiring a CCHP implementation coordinator and forming an implementation working group and defining roles and responsibilities); and

2) Intervention-level activity: the actions (specific programs like youth mentorship, policies like an interagency protocol, or events like a community feast) we undertake to meet our plan's overall Vision and Directions (e.g. to reduce addictions).

Thus, there are two different sets of outcomes to implementation[1]:

1) Implementation outcomes: our effectiveness at carrying out the implementation of our overall health plan as intended (Are we using the plan and doing what we set out to do?); and

2) Intervention outcomes: the effectiveness of the actions we are undertake to meet our plan's overall vision and directions (e.g. How is the treatment program at Stormer Lake reducing rates of addiction in the community?)

---

1 Fixen, D. Naoom, S. Blase, K. Friedman, R and Wallace, F. (2005) Implementation Research: A Synthesis of the Literature. University of South Florida.

Degrees of Implementation

Implementation can have varying levels of effectiveness depending on the degree of implementation. The three degrees of implementation include 1) paper implementation, 2) process implementation and 3) performance implementation. These are defined as follows:

1) **Paper implementation:** stating new actions (e.g. policies or procedures) without putting innovations into practice.

   Example: we develop a thorough community-based health plan and then do not put any resources into implementing it.

2) **Process implementation:** putting new operating procedures in place to conduct training workshops, provide supervision, change information reporting forms to support implementation of actions/ interventions. Activities related to innovation are occurring and events are being monitored, but there is a danger that people are going through the motions without necessarily ensuring implementation success[1].

   Example: we conduct cultural orientation workshops for new staff (example: nurses, doctors, teachers) without building any understanding as to the role cultural orientation can play in improving relationships and services for community members or our overall healthsystem.

   Example: we create an interagency protocol with different agencies without tracking accoutability, buy-in and follow-through

3) **Performance implementation:** putting procedures and processes in place in such a way that implementation of actions produce and show actual benefits to community members and our health system. High levels of community participation and support from local champions allows for understanding and commitment to implementation to develop (see Figure 33 for levels of organizational commitment from "I'm aware" of the plan to "It's mine!"). Our monitoring and evaluation system (described in Chapter 5) plays an important role in ensuring we are not only doing what we said we would do, but also documenting and celebrating the effectivess of our actions on the health status of our members.

1 Studies have shown that information alone appears to have little impact on people's performance, and instead a high level of involvement by program developers on a continuing basis is a feature of many successful implementation programs. (Fixen, D. et al)

Example: Not only do we carry out actions of our plan, but we teach the plan, make the case for intended changes and help community members and staff build understanding, buy-in and commitment to the plan on an ongoing basis. An interagency protocol, for example, does not just mean that agencies meet every month, but that agencies commit to action, are effective and take responsibility.

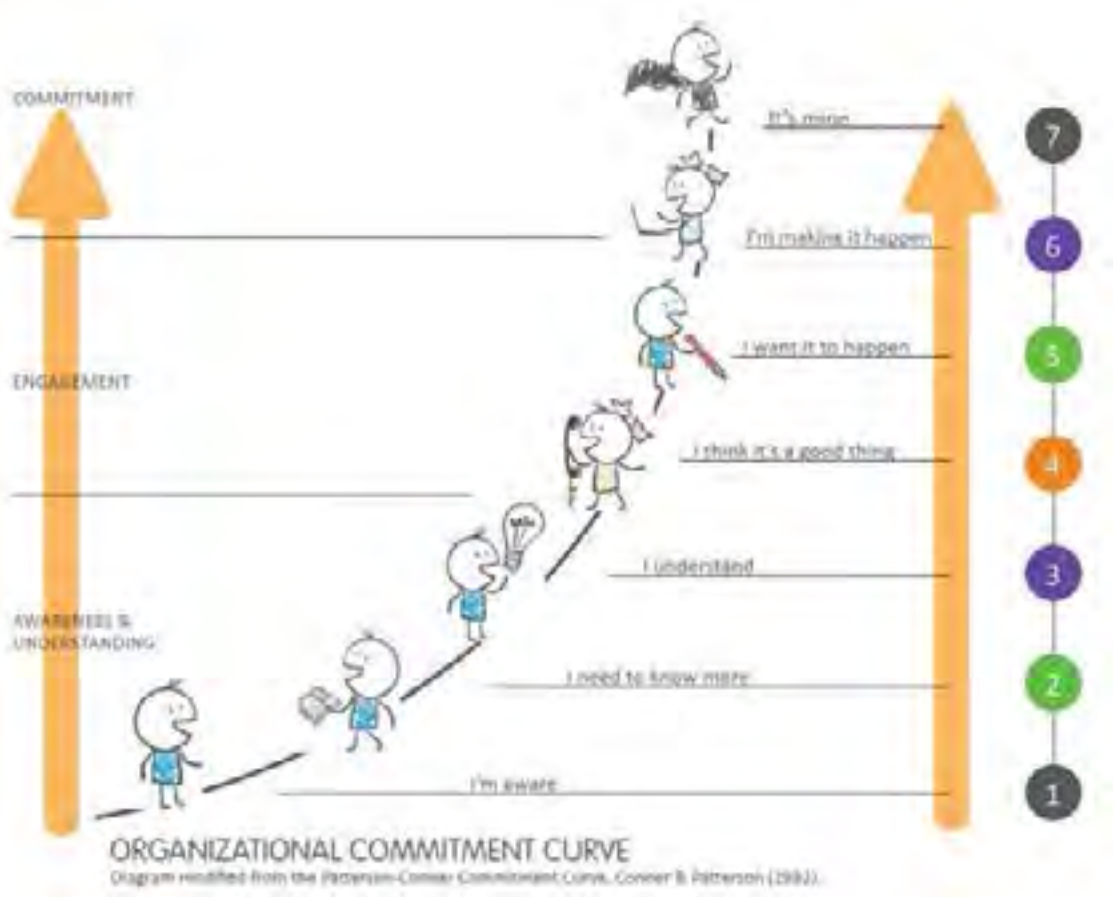


FIGURE 33: Continuum of Organizational Commitment Source: Ontario Centre of Excellence for Children and Youth Mental Health

Approach and Principles to Getting to Action

Our implementation strategy is founded on 9 strategic principles to guide our readiness and approach to action.

1. Strengthen what we already do: We want to start by acknowledging what human resources, programs and funding we currently have and what is working well. Our planning process emphasized this principle by identifying general community strengths as well as focusing specifically on existing strengths of our health system as part of our Program Review (see CHNA Appendix 20). Our health review highlighted the strength of our existing programs such as the Land-Based Healing Camp, the Youth Patrol, and Project Journey. It also highlighted a diverse set of skills and experiences of our nurses, doctors and health staff.

2. Increase local skills, responsibility, abilities and confidence: While there is a role for external support in strengthening our local health system, the longer-term priority is to build the capacity of existing staff and nurture our ability to take more control and ownership ourselves. It is essential that we scale up the number and capacity of local support to increase our health governance and invest in on our Youth as the staff of our future health system.

3. Promote inter-dependence and connection: Our actions should help build trust and relationships between staff and agencies and facilitate collaboration. Our health system involves multiple players and agencies. Interagency cooperation is crucial to the success of our plan.

4. Be pro-active: Although our long-term strategy is focused on actions that can be sustained, we also recognize that there are small things we can do right now with existing resources that will contribute to our overall effort. We highlight opportunities for "quick start" projects, which can be implemented with existing resources to build momentum and commitment to the plan. We also identify a list of priority actions that we are ready to respond to should the financial and human resources become available. Being proactive also means we are teaching this plan and Vision to our funding partners.

5. Incremental change: For complex community challenges such as addictions, trauma, violence and poverty, there is no "quick fix". Yet these challenges affect almost every aspect of community life and addressing them is necessary for community healing. Our implementation strategy commits to investing in long term, steady and incremental change over time.

6. Reclaim and honour our culture: We believe that central to the implementation of our health vision is an acknowledgement and revival of our cultural ways of governing and managing our health and healing. This principle is based on the belief that the loss of our cultural knowledge and identity is one of the root causes of our health challenges.

7. Promote multiple pathways: While our Health Plan identifies priority directions and actions, it does not prescribe a single route from here to our vision. We hope members understand this opportunity. Our implementation strategy acknowledges that there are multiple routes to success, and that depending on the resources that become available or priorities that gain prominence, we have choices as to where to focus. Our implementation strategy offers choices as to whether to focus on a particular part of our health system (Infrastructure vs Programs vs Human Resources), or to focus on a particular pillar of actions (Support Families vs Teach and Celebrate Culture).

8. Expand the continuum of care: Recognizing that our health programs and services should provide care along a continuum of health needs (from health promotion to prevention to assessment to treatment to aftercare), our actions attempt to expand services so that members are better served in our community along the full continuum of care, although this will take time and patience.

9. Learn and adapt: Recognizing that we are dealing with complex systems, our implementation strategy has both standards-based and responsive evaluation techniques built it. Specifically, our strategy adopts a developmental approach based on observing what is emerging through our actions, learning from observation and reflection, talking together and adapting our implementation strategy and actions to reflect results and what we are learning along the way. This approach recognizes that there is no one straight forward solution to any of the challenges we are tackling, and that there will be many unpredictable results of our various initiatives in an interconnected system. Rather than a traditional linear evaluation model that focuses first on planning, then action and then evaluation, our monitoring and evaluation strategy builds in tools to plan, learn and adapt as we go (see Figure 34).

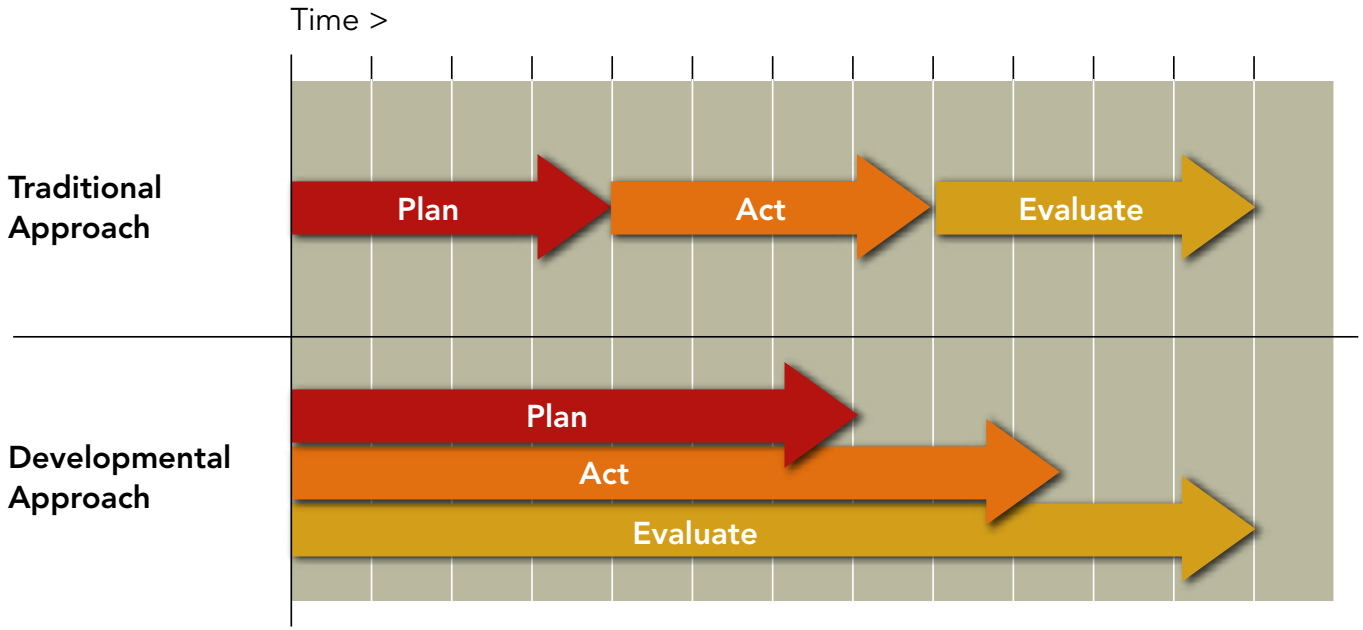


FIGURE 34: Traditional vs Developmental Evaluation. Source: McConnell Foundation

Core Components for Successful Implementation

The overall goal of building organizational readiness is to develop organizational structures that ensure self-sustaining implementation. That is to say, implementation should not be dependent on external agencies and players alone, it has to be a collaborative relationship. To ensure implementation success, we need a strategy that includes a set of supporting practices, values, strategies and mechanisms to help ensure that the entire health system is behind us and working together.

Ten implementation supporting practices are listed in Table 12 and supporting mechanisms identified by the Planning Support Team.

Implementation Supporting Practices	Mechanisms Identified by PFN
1. Build on current strengths and needs of the community prior to implementation	✓ Completed a Comprehensive Community Health Plan before transitioning to Health Planning ✓ Prioritizing actions that build on existing strengths ✓ Hire technical support to guide implementation
2. Institutionalize the plan, ensure buy-in and support from leadership and management	✓ Chief and Council endorsement through BCR ✓ PHA Board endorsement ✓ PEA Board endorsement
3. Assign an individual or team of individuals responsible for implementing the plan	✓ Hire CCHP planning coordinator ✓ Form a local Implementation Committee
4. Invest in strengthening the institutional structures needed to lead implementation of CCHP	✓ Create and sign off-interagency protocol ✓ Host monthly interagency meetings ✓ Launch revised SHEE Committee
5. Develop skills necessary for implementation through training (information collection, action planning, monitoring and evaluation) and ensure ongoing coaching	✓ Host regular staff training sessions to teach and understand the plan ✓ Create communications strategy and tools to communicate and teach the plan
6. Cleary define roles and responsibilities	✓ Expand staff job descriptions to include responsibility for carrying out the plan ✓ Create tools and work plans to assist staff
7. Create an implementation budget	✓ Secure more funding/authority to spend
8. Create a culture of learning, reflection and adapting as we go	✓ Create monitoring and evaluation tools ✓ Host monthly interagency meetings

TABLE 12: Implementation Supporting Practices and Implementation Mechanisms

Implementation Supporting Practices	Mechanisms Identified by PFN
9. Phase and sequence actions to break plan up into realistic pieces	✓ Create tools and work plans to assist staff to carry out actions
10. Build staff and community awareness and commitment to the plan by promoting plan and increasing visibility	✓ Host Staff training sessions to teach the plan ✓ Appoint an Implementation Committee (Community, Interagency) ✓ Create communications Tools: Quick guide and posters ✓ Have a permanent planning booth at Health Fair ✓ Create an audio clip for community radio ✓ Create a 5 minute video on CCHP ✓ Increase visibility by putting up posters on the wall around the community and office

Community Strengths

As we embark on this implementation phase, we are equipped with many existing strengths:

- Our CHNA and CCHP were built on thorough, holistic, community-driven processes
- There is broad commitment to the plan from Chief and Council (Band council resolution) and the PHA, whose leadership and staff have been involved in all parts of the process leading this implementation based on results from the community
- We are building on our existing case management experience
- We are working better together and have built strong relationships including technical support from Beringia Community Planning inc.
- We have acquired the property for Stormer Lake, an important first step in launching our community-based treatment program
- We have a strong financial and managerial track record
- We have experienced many program successes such as our Land Based Solvent Camp, Project Journey, our food hamper program and Youth Gas Patrol
- We are equipped with a wide diversity of implementation tools for our staff to help

Potential Challenges, Strategies and Mechanisms

Part of getting ready involves preparing ourselves for potential implementation challenges. The following list of 11 implementation challenges (Table 13) has been developed based on discussions with the Planning Team and experience from other planning projects. For each implementation challenge, a strategy is suggested to move our plan forward.

Challenge	Strategy	Mechanisms
1. No one knows about our Health Plan and what it can do to help our community	Community endorsement and approval of our Plan	Through a Band Council Resolution (BCR) and a community presentation, feast and celebration we can ensure that the plan is publically endorsed. We also want to acknowledge and thank our membership.
2. There is a lack of understanding of what the plan is	Teach the plan	User-friendly planning and communications tools will be used teach the plan and to keep our community members up-to-date on the plan's progress. Communicating our results and successes will help demonstrate the value of planning and keep community members informed and engaged.
3. Our Health Plan sits on a shelf and never gets used	Build excitement for the plan and celebrate results	To ensure buy-in and enthusiasm for our CCHP, we need a communications strategy. First, we need to have our health plan formally adopted and celebrated at a public event. The feast and celebration will help to honour the contributions of community participants, build pride and ensure commitment.
	Establish a process to change our plan	To increase the resilience of our CCHP it is important to know that our CCHP can be change and prepare ourselves for potential changes as priorities change or we learn through monitoring and evaluation. Establishing a procedure for this ahead of time will allow changes to be made in a smooth way (see page 178 of Ch 5).

TABLE 13: Implementation Challenges, Strategies and Mechanisms

Challenge	Strategy	Mechanisms
4. Community expectations are unrealistic	Keep individuals informed and communicate results	It is important to explain the implementation process to individuals so that they do not have any false expectations of when some of the actions will take place. Setting priorities helps to focus resources and manage expectations, as well as communicate with members on an onging basis.
5. No one is taking responsibility for the plan	Establish implementation working group for local control	Representatives from different agencies will be invited to participate in an implementation working group. These community members should be those most committed to the plan's implementation. In addition, renewing the mandate and role of the SHEE committee is essential in keeping our plan alive.
6. There is a lack of capacity and willingness to implement our health plan	Ensure adequate human resources and increase responsibility	The more time and resources we invest in getting ready for implementation, the more capacity and commitment we can generate. Part of this phase involves defining what implementation skills are needed, and assessing existing capacity. Next, investing in an implementation coordinator and specific training for implementation team members to help build the skills they need to be successful. Staff job descriptions should be revised to include that they are responsible to follow and work with the CCHP.
7. Leadership disruptions and staff turnover impact our health plan	Keep members involved and connected to the process	Consistent communications tools and sustained community engagement will help build a strong and wide knowledge base relating to the plan which will help minimize disruptions.

Challenge	Strategy	Mechanisms
8. There is too much to do!	Create an action plan and establish priorities	Once the community implementation group is created, Terms of reference and a work plan listing who is responsible for what can help to manage the workload and ensure action and follow through (see Phase 1 workplan, Appendix 20).
	Share responsibilities and commitment	An interagency protocol will ensure that staff from different agencies are working together to share the load and responsibility for the plan's success.
	Schedule regular meetings	Implementation team members should check in often to assess progress and to redistribute tasks according to individual's workload.
9. There is limited or a lack of funding	Create a funding strategy and hire a proposal writer	We will need to invest time to ensure up-to-date-research on potential funding opportunities. A strategy is required to secure additional funding from governments, industry and various agencies as well as hiring a proposal writer to secure funding.
10. We are not working together	Work to coordinate agency players	A series of regular interagency meetings with key implementation players will help coordinate our efforts to implement the plan as well as our interagency protocol and liaison.
11. We are taking too much on too soon	Start small, demonstrate results, scale up gradually	Starting with smaller projects first is a way to build confidence and capacity as well as minimize risk. Scale up projects over time. Funding agencies need to support sequential funding based on results and success.

Challenge	Strategy	Mechanisms
12. We do not know if what we are doing will work	Commit resources to monitor and evaluate our overall plan and actions	Our monitoring and evaluation strategy will ensure that we keep track of our progress as outcomes emerge, and that we take time to take stock of what is working well and what could be improved. This will help us adapt our strategy as needed, and communicate emerging results as they are observed. It also helps to validate the value of planning in our community.

Mechanisms to Keep our Plan Alive

In summary, the mechanisms that will help keep our plan alive include:

- ✓ Chief and Council endorsement through a BCR
- ✓ Community feast and celebration
- ✓ PHA Board endorsement
- ✓ PEA Board endorsememt
- ✓ Hire a CCHP coordinator
- ✓ Form a local implementation committee and establish Terms of Reference
- ✓ Create and sign off-interagency protocol
- ✓ Host monthly interagency meetings
- ✓ Renew mandate and role of the SHEE committee
- ✓ Host regualar staff training sessions
- ✓ Expand staff job descriptions to include responsibility to carry out the plan
- ✓ Create tools and work plans to assist staff
- ✓ Create communications tools (quick guide, posters, video)
- ✓ Have a permanent planning booth at Health Fair
- ✓ Establish procedure for changes to the plan
- ✓ Creating a funding strategy and hire a proposal writer
- ✓ Start with small projects and scale up gradually
- ✓ Implement our monitoring and implementation strategy

Implementation Work Plan

The first phase of our six phased implementation strategy (see page 138) focuses exclusively on getting ready for implementation. Table 14 summarizes the 12 actions involved in the building readiness for implementation phase of our plan. In Appendix 20, a detailed work plan lists all of the 12 actions, 48 activities, deliverables, outcomes, roles and responsibilities associated with Phase 1.

TABLE 14: Summary of Phase 1 Actions

1. Obtain a mandate and budget for implementation	• Resolution from PHA adopting plan as a managerial tool • Prepare presentation package, and present plan to Board, governments and key agencies • Identify and secure sources of funding for implementation
2. Form an implementation working group	• Identify people who are committed to the health plan • Take stock of implementation skills
3. Create Terms of Reference for working group	• Agree on group's mandate, tasks, timeline, roles and responsibilities, organizational structure, meeting schedule and decision making process
4. Define and assess implementation skills and gaps	• Identify implementation skills needed (project management, fundraising, teamwork, leadership, communications) • Organize implementation skills training workshops
5. Assign staff and develop training plan	• Complete orientation and training • Look to fill implementation skill gaps
6. Develop strategy and approach to implementation	• Agree on overall implementation strategy and approach • Review plan's implementation principles, values and strategies

7. Review and confirm action priorities	• Review plan's action priorities • Confirm importance, sequencing and timing of actions
8. Complete additional project planning	• Additional project planning and study for large actions • Ensure due diligence and feasibility
9. Determine and secure project funding	• Undertake project costing and budgeting • Create a fundraising strategy and submit funding proposals
10. Identify project champions	• Assign responsibility for specific implementation projects to specific team members
11. Develop communication strategy	• Create plan as to how to build excitement for the plan and teach the plan • Develop media strategy • Keep community members updated on implementation progress
12. Implement projects and monitor and evaluate project impacts	• Keeping track of data and observations • Evaluating our project's impacts and successes

Roles and Responsibilities to Move our Plan Forward

Implementing our CCHP requires the participation and coordination of the many players involved in our health system. All agencies will participate in implementation by:

- Linking their agency mandates to our CCHP
- Advocating and promoting our CCHP
- Helping to secure funding for the implementation of our CCHP
- Gathering data for monitoring and evaluation of our CCHP

All players will play an active role in tasks necessary for building implementation readiness as well as rolling out specific actions identified in our CCHP. Table 15 lists the agencies that will need to be involved and specific actions they will be responsible for:

Table 15: Roles and Responsibilities

Agency	Responsibilities	
	Example Implementation Activities	Relevant Actions
Pikangikum Health Authority	✓ PHA Board endorsement ✓ Hire/appoint 2 planning champions ✓ Form implementation committee ✓ Create and sign off-interagency protocol ✓ Expand staff job descriptions to include responsibility for carrying out our CCHP ✓ Host monthly interagency meetings ✓ Launch revised SHEE Committee ✓ Secure more funding/authority to spend	• Expand hours of outreach • Establish health phone line • Cultural orientation for new staff • Healthy parenting program
Implementation Committee	✓ Develop communication tools to help teach the plan (film, events, posters, etc) ✓ Monitor and evaluate the plan	• Hire interagency coordinator • Healthy living campaign

Agency	Responsibilities	
	Example Implementation Activities	Relevant Actions
Pikangikum Education Authority	✓ PEA endorsement ✓ Host training sessions to teach the plan to staff ✓ Participate in interagency committee ✓ Gather data for monitoring and evaluation of the plan ✓ Oversee actions pertaining to education and livelihoods	• School curriculum review • Anti-bullying campaign • New school, gym and recreation center • Sex education
Pikangikum First Nation	✓ Chief and Council endorsement ✓ Plan funding negotiations ✓ Expand staff job descriptions to include responsibility for carrying out the plan ✓ Gather data for monitoring and evaluation of the plan ✓ Participate in interagency committee ✓ Develop communication tools to help teach the community the plan (film, posters, etc)	• Road improvements • Expand reserve boundary • Increase street lighting • Expand housing and water infrastructure
Ontario Works	✓ Gather data for monitoring and evaluation of the plan ✓ Secure funding for Whitefeather training ✓ Participate in interagency committee	• Whitefeather training center • Community skills inventory • Traditional food and hunting program
Ontario Provincial Police	✓ Expand staff job descriptions to include responsibility for carrying out the plan ✓ Participate in interagency committee	• Lateral and domestic violence prevention program
Health Canada	✓ Secure more funding/authority to spend	
LHIN		
Nodin		
Other?		

ACTION PHASING AND TIMING

Now that we have invested in building readiness for implementation, this next part of the chapter focuses on organizing our actions into 6 phases to increase the success of our implementation. The phasing of our actions is based on readiness, ease, scale, relationships to other actions, cost, time and timing. This chapter acknowledges the players involved, and provides some initial costing projections to set funding needs into motion.

Action Phases

Our implementation strategy is organized into six phases of implementation actions (see Figure 35), (Phase 1: Getting Ready for Action; Phase 2: Building Momentum; Phase 3: Strengthening Existing Health System; Phase 4: Honouring our Culture; Phase 5: Expanding our Capacity; Phase 6: Increasing Scale and Impact) which reflect our implementation philosophy and principles. These phases recognize that human resources, funding, time and learning will influence how much we can do at once, and that big changes take small steps that build off each other overtime.

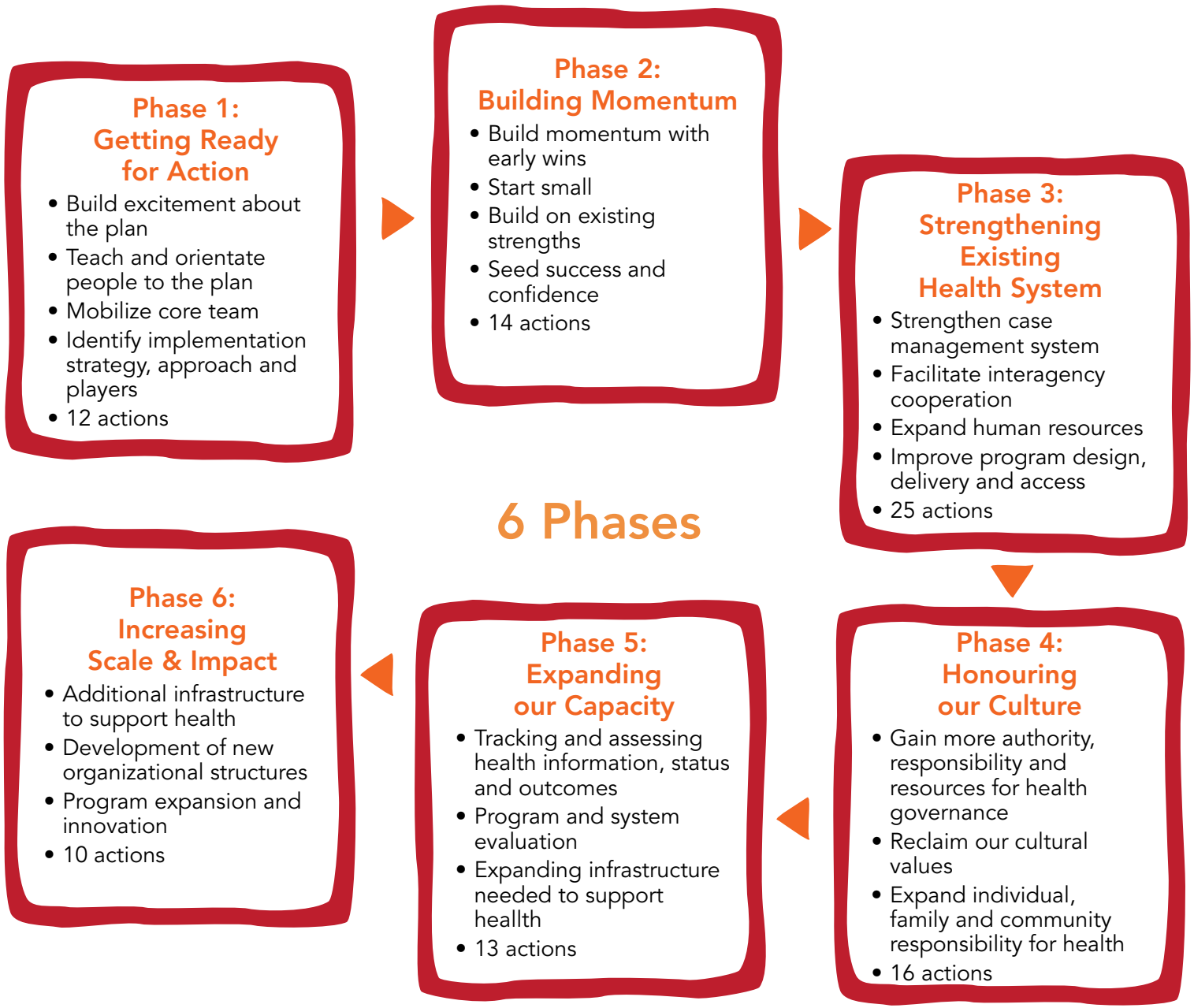


FIGURE 35: 6 Phases of Implementation

Phase 1: Getting Ready for Action

Welcome to the most exciting part of the planning process! This is where the hard work begins making ideas for action come to life. Before diving into our implementation strategy, in this phase we spend some time building readiness for implementation. This phase is explored in detail in the first part of this chapter. This phase is characterized by:

- Building exctiement about the plan
- Teaching and orientating people to the plan
- Mobilizing resources for implementation (human resources, funding)
- Finalizing implementation strategy and apporach
- SEtting up monitoring and evaluation system

Phase 2: Building Momentum

Now that we have spent time building our capacity for implementation, this phase is about getting to action. We start with a number of small actions to help build momentum with early wins. The goal is to build on our existing strengths, and plant the seeds for success to build confidence for future implementation. This phase is characterized by:

- Building confidence with quick start projects demonstrating efforts to membership
- Validating the CCHP

Phase 3: Strengthening Existing Health System

This phase focuses on building on PFN's existing strengths and accomplishments and identifying the most strategic areas of improvement in meeting Pikangikum's health needs. This stage focuses on what we can do right now with existing resources to prepare ourselves for bigger changes in the future with a focus on health programs, health staff and management systems. This phase is

characterized by:

- Strengthening PHA's case management system
- Facilitating interagency coordination and collaboration
- Expanding human resources and local capacity
- Improving program design, delivery and access

Phase 4: Honouring our Culture

In this phase, the focus is gaining more authority and resources for improved management of our health system. We also focus on reclaiming cultural values, knowledge and traditions into our health system and building more community responsibility for health by adopting a culture of mentorship, expanding the role of the family in health and recruiting a volunteer base.

We are developing programs that could eventually be housed in expanded infrastructure in stage 5 (such as a parenting program in a family resource center), but are getting programs started with existing infrastructure. This phase is characterized by:

- Gaining more authority, responsibility and resources for health governance
- Reclaiming our cultural values, knowledge and traditions
- Expanding individual, family and community responsibility for health

Phase 5: Expanding our Capacity

In this phase, we set out to achieve some of the bigger actions we have identified. This includes some of the expanded infrastructure needed to expand system effectiveness, choice and health outcomes such as a parenting resource center, a Youth center, a walking trail system and road improvements. In this stage we start tracking and assessing the impact of our health programs and services. This phase is characterized by:

- Tracking and assessing health information, status and outcomes
- Completing program and system evaluation
- Expanding infrastructure needed to support health

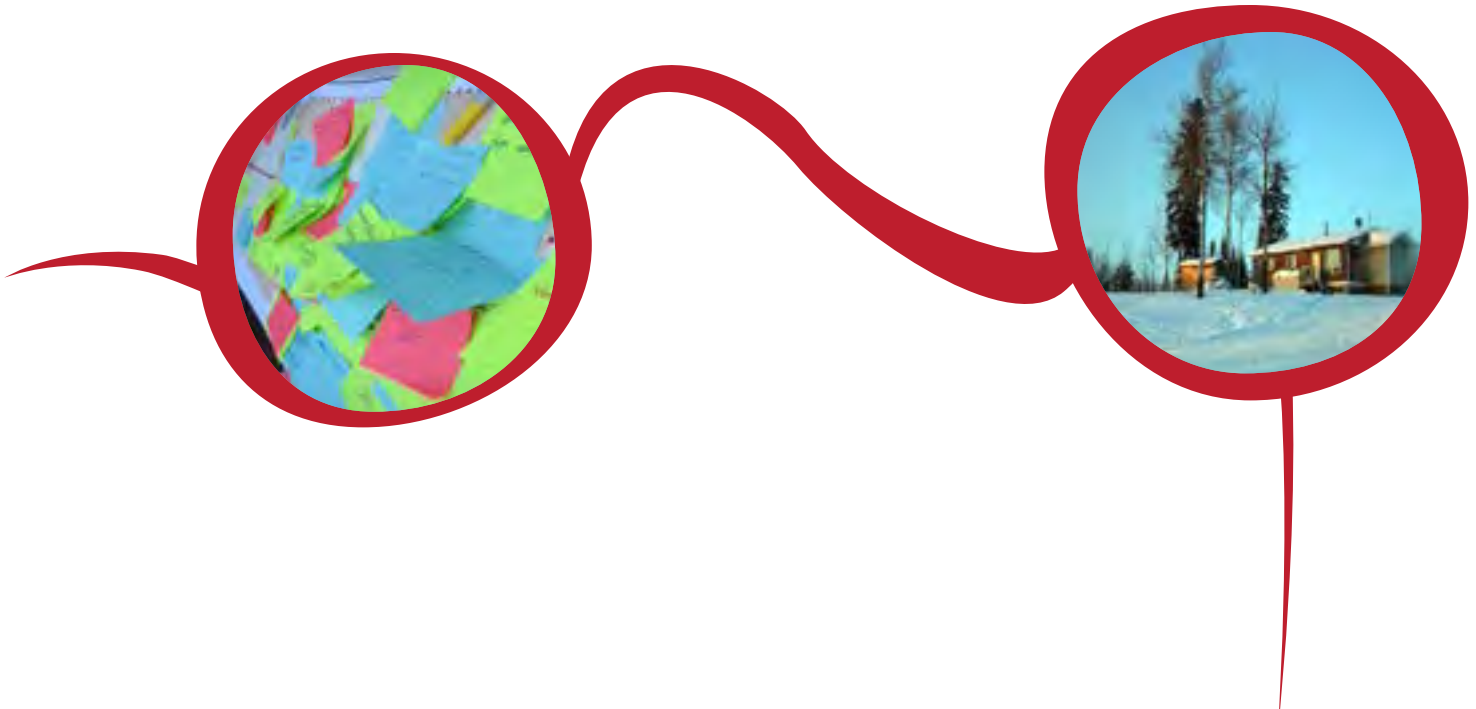
Phase 6: Increasing Scale and Impact

Finally, in this phase, we find many of our big ideas that require significant funding and/or human resources. While it may not be realistic to achieve all of these actions in the next 10 years, they are included here as possibilities for where our plan could lead us in the future. In this stage we develop new organizational structures such as a planning and health information department. This phase is characterized by:

- Buildling additional infrastructure to support health
- Developing new organizational structures
- Expanding and innovating programs

Summary of Actions by Phase

All of the actions identified in our CCHP are part of one of six phases of action as listed in Figure 36. Phase 1 is comprised of our building implementation readiness actions. The following five phases contain our actions spread over a 10-year period. This figure also shows how our top 25 priority actions are distributed across our 6 phases and are listed in white.



Phase 1

Getting Ready for Action

1. Obtain a mandate and budget
2. Form working group
3. Create terms of reference
4. Define and assess skills and gaps
5. Assign and develop training plan
6. Develop strategy and approach
7. Review and confirm action priorities
8. Complete additional project planning
9. Determine and secure project funding
10. Identify project champions
11. Create communications strategy
12. Implement projects and monitor and evaluate project impacts and success

Phase 2

Building Momentum

1. Expand home visits
2. Expand hours of outreach
3. Health vehicle
4. 3 mental health workers
5. Youth council
6. Youth achievement awards
7. Annual hunt and feast
8. Anger management workshops
9. Women's circle
10. Community kitchen
11. Health program guide & health line
12. Agencies host community feasts

Phase 3

Strengthening Existing Health System

1. Mental health strategy
2. Clinical & mental health training
3. Suicide risk assessment training
4. Clincial supervisor
5. Grief counselling
6. Interagency liaison and protocol
7. Stormer Lake operational plan
8. Food bank & community garden
9. Expand health promotion programming
10. Street lighting
11. Suicide prevention program
12. Anti-bullying campaign
13. Lateral and domestic violence workshop
14. Mental health awareness campaign
15. Elder's teaching circle
16. New shool, gym & fitness center
17. Sex education
18. Youth recreational & cultural coordinator
19. Social and cultural events program
20. Daycare expansion
21. Expand housing & water infrastructure
22. Power upgrades
23. Case manangement & continuum of care system and training
24. Staff support network

Phase 4

Honouring our Culture

1. Healthy parenting program
2. Stormer Lake program development
3. Hire & train Stormer Lake staff
4. Cultural orientation workshop
5. Traditional food & hunting program
6. Youth leadership & mentorship program
7. Community skills inventory
8. Healthy living campaign
9. School curriculum review
10. Intoxicant supply study
11. Youth safe house
12. Women's safe house
13. Whitefeather training center
14. Cultural education & arts program
15. Traditional healing ceremony

Phase 5

Expanding our Capacity

1. Aftercare program
2. Launch Whitefeather Forestry Initiative
3. Monitoring & evaluation system
4. Community justice review
5. Sports field upgrades
6. Youth center
7. Walking trail system
8. Expand Reserve boundary
9. Road improvements
10. Parenting resource center

Phase 6

Increasing Scale & Impact

1. Mental health resource center
2. New nursing station
3. Film project
4. Planning & health information department
5. Stormer lake expansion
6. Cultural center

FIGURE 36: Actions by Phase

Figure 37 illustrates how our actions by type are sequenced across phases. This allows us to see how infrastructure, planning and policies, communications, programming, events, training and positions are spread out over 20 years.

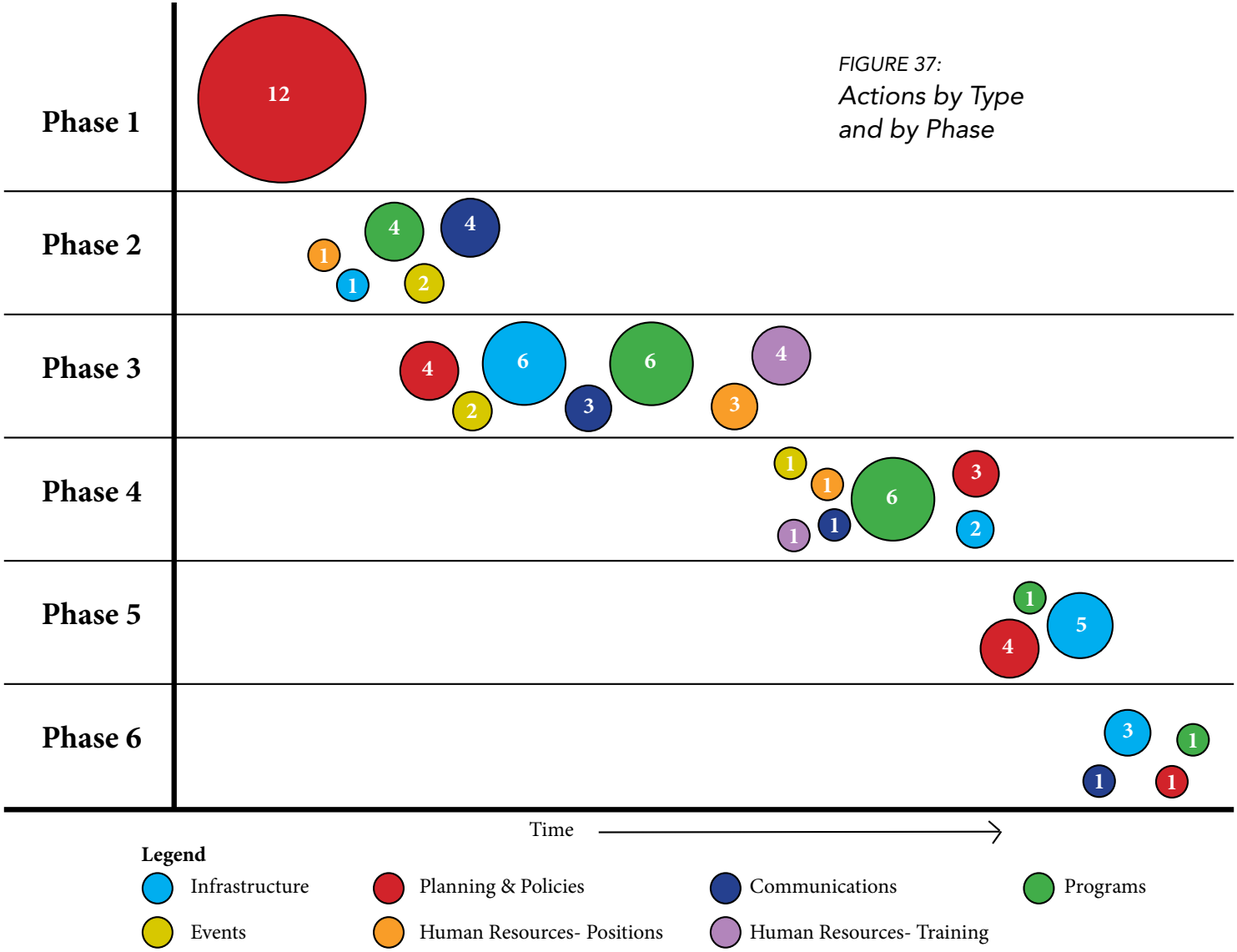


FIGURE 37:
Actions by Type and by Phase

Timeline of Actions

Table 16 presents an action plan for our 69 actions by the 5 action clusters of Health System, Families, Youth, Healing and Culture. In these tables we see how actions by cluster and by type will roll out over the next 10 years. This tool helps us see how projects will be sequences and allows us to budget out implementation year by year.

TABLE 16: Sequencing of Actions

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
HEALTH SYSTEM	**Human Resources**										
	Interagency liaison		•								
	Clinical supervisor		•								
	Staff support network			•							
	Case management training			•							
	Infrastructure										
	New nursing station										•
	Programs										
	Increased home visits	•									
	Expand hours of outreach	•									
	Communications										
	Community program guide	•									
	Health phone line	•									
	Planning										
	Interagency protocol		•								
	Case management system			•							
	Monitoring & evaluation system							•			
	Planning & health information department									•	

Action

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
FAMILIES	**Infrastructure**										
	Housing & water expansion		•	•							
	Street lighting			•							
	Expanded daycare		•								
	Power station upgrade			•							
	Whitefeather training center						•				
	Parenting resource center							•			
	Road improvements								•		
	Programs										
	Women's circle	•									
	Health promotion programming			•							
	Healthy parenting program				•						
	Communications										
	Healthy living campaign					•					
	Planning										
	Community skills inventory						•				
	Launch Whitefeather Forestry Initiative							•			
	Reserve boundary expansion									•	

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
YOUTH	**Human Resources**										
	Youth council	•									
	Youth recreational & cultural coordinator		•								
	Infrastructure										
	New school, gym & fitness center			•							
	Youth and Women safe house			•							
	Sports fields upgrades								•		
	Walking trails system							•			
	Youth center									•	
	Programs										
	Sex education			•							
	Lateral & domestic violence prevention		•								
	Youth leadership/mentorship program				•						
	Events										
	Men's anger management workshops	•									
	Youth achievement awards	•									
	Communications										
	Anti-bullying campaign		•								
	Planning										
	Community justice review									•	

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
HEALING	**Human Resources**										
	Hire 3 mental health workers	•									
	Mental health & clinical training		•								
	Suicide risk assessment training		•								
	Hire & train Stormer Lake Staff				•						
	Infrastructure										
	Mental health resource center										•
	Programs										
	Youth suicide prevention program		•								
	Grief counselling services		•								
	Stormer Lake treatment program				•						
	Aftercare program							•			
	Communications										
	Mental health awareness campaign			•							
	Planning										
	Stormer Lake operational plan			•							
	Mental health strategy		•								
	Study on controlling supply of intoxicants					•					

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
CULTURE	**Infrastructure**										
	Community garden		•								
	Cultural center										•
	Programs										
	Community kitchen	•									
	Elder's teaching circle for health		•								
	Social & cultural events program			•							
	Food bank		•								
	Traditional food & hunting program				•						
	Cultural education & arts program					•					
	Events										
	Annual community feast & hunt	•									
	Agencies host community feasts	•									
	Cultural orientation workshop					•					
	Traditional healing ceremonies						•				
	Communications										
	Film project										•
	Planning										
	School curriculum review					•					

CCHP Budget

Insert introductory text here.

The following 5 Tables (Tables 17-21) provide us an overall summary of how our Health Plan is budgeted.

Table 17: Budget by Phase

Phase 1	
Phase 2	
Phase 3	
Phase 4	
Phase 5	
Phase 6	
Total	

TABLE 18: Budget by Priority Level

Quickstarts	
Critical	
Essential	
Very Important	
Supporting	
Total	

TABLE 19: Budget by Cluster

	Quickstarts	Top 25 Actions	Remaining Actions	Total by Cluster
Healing				
Health System				
Families				
Youth				
Culture				
Totals				

TABLE 20: Budget by Health Direction and Type

	Infrastructure	Planning & Policies	Communications, Outreach & Management	Programs	Events	Human Resources (Positions)	Human Resources (Training)	Total by Health Direction
Strengthen Health Governance								
Improve Health Services								
Reduce Addictions and Restore our Mental Health								
Expand Community Infrastructure								
Reclaim Culture & Land-Based Healing								
Invest in Families, Heal our Children & Youth								
Support, Healthy, Active, Livelihoods & Education								
Build Community Safety, Pride & Belonging								
Total by Type								

TABLE 21: Budget by Phase and by Type

	Infrastructure	Planning & Policies	Communications, Outreach & Management	Programs	Events	Human Resources (Positions)	Human Resources (Training)	Total by Phase
Phase 1								
Phase 2								
Phase 3								
Phase 4								
Phase 5								
Phase 6								
Total by Type								

Table 22 presents the full detailed budget by year for carrying our Health Plan, by action, cluster and type of action.

TABLE 22: Budget timeline

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
HEALTH SYSTEM	**Human Resources**										
	Interagency liaison										
	Clinical supervisor										
	Staff support network										
	Case management training										
	Infrastructure										
	New nursing station										
	Programs										
	Increased home visits										
	Expand hours of outreach										
	Communications										
	Community program guide										
	Health phone line										
	Planning										
	Interagency protocol										
	Case management system										
	Monitoring & evaluation system										
	Planning & health information department										
	Totals by Year										
										Health System Total:	

Action

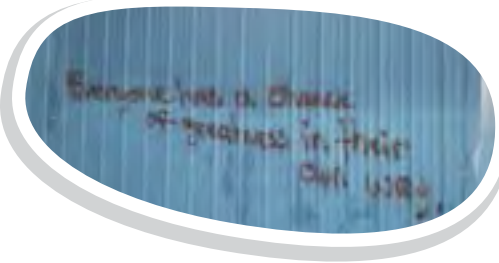
		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
FAMILIES	**Infrastructure**										
	Housing & water expansion										
	Street lighting										
	Expanded daycare										
	Power station upgrade										
	Whitefeather training center										
	Parenting resource center										
	Road improvements										
	Programs										
	Women's circle										
	Health promotion programming										
	Healthy parenting program										
	Communications										
	Healthy living campaign										
	Planning										
	Community skills inventory										
	Launch Whitefeather Forestry Initiative										
	Reserve boundary expansion										
	Totals by Year										
										Families Total:	

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
YOUTH	**Human Resources**										
	Youth council										
	Youth recreational & cultural coordinator										
	Infrastructure										
	New school, gym & fitness center										
	Youth and Women safe house										
	Sports fields upgrades										
	Walking trails system										
	Youth center										
	Programs										
	Sex education										
	Lateral & domestic violence prevention										
	Youth leadership/mentorship program										
	Events										
	Men's anger management workshops										
	Youth achievement awards										
	Communications										
	Anti-bullying campaign										
	Planning										
	Community justice review										
	Totals by Year										
										Youth Total:	

Action

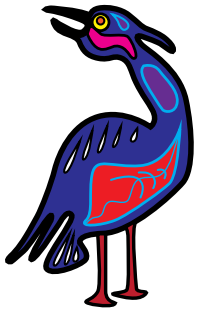
		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
HEALING	**Human Resources**										
	Hire 3 mental health workers										
	Mental health & clinical training										
	Suicide risk assessment training										
	Hire & train Stormer Lake Staff										
	Infrastructure										
	Mental health resource center										
	Programs										
	Youth suicide prevention program										
	Grief counselling services										
	Stormer Lake treatment program										
	Aftercare program										
	Communications										
	Mental health awareness campaign										
	Planning										
	Stormer Lake operational plan										
	Mental health strategy										
	Study on controlling supply of intoxicants										
	Totals by Year										
										Healing Total:	

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
CULTURE	**Infrastructure**										
	Community garden										
	Cultural center										
	Programs										
	Community kitchen										
	Elder's teaching circle for health										
	Social & cultural events program										
	Food bank										
	Traditional food & hunting program										
	Cultural education & arts program										
	Events										
	Annual community feast & hunt										
	Agencies host community feasts										
	Cultural orientation workshop										
	Traditional healing ceremonies										
	Communications										
	Film project										
	Planning										
	School curriculum review										
	Totals by Year										
										Culture Total:	



Results

5



The Results phase of the planning process involves asking the question "Are we getting results?" to ensure that our vision, priorities and actions align and result in the change we desire. Monitoring and evaluation allows us to adapt our plan as needed so we stay on course. This work connects back to the Discovery phase of our process because to keep a plan alive and relevant, we need to effectively track and measure our results and impacts based on how things have changed from where we started. Understanding our current situation, setting indicators and defining targets is the first step in assuring information is collected, documented, shared and evaluated. We require commitment and a fair and transparent process to undertake this responsibility. Results and impacts need to be celebrated, and we need a process for making changes to our plan as needed. This chapter sets out a process and a set of tools and steps for us to use in the monitoring and evaluation of our community plan.

MONITORING AND EVALUATION

Monitoring and evaluation is a process which allows us to check results, notice impacts, celebrate results and adapt our plan as needed. This chapter defines monitoring and evaluation, explores monitoring and evaluation success factors, demands and strategies, and presents a number of different types of monitoring and evaluation tools and methods. It ends with a step-by-step proces for monitoring and evaluation and a process for plan revisions.

What is Monitoring and Evaluation?

How do we observe, learn and adapt based on noticing the world around us? Since time immemorial, our people have been learning from lived experience and passing along information and teachings orally[1]. As natural as learning from observation may be, sometimes our senses do not tell us the full picture or oral knowledge is lost, which is why there is a need for a process to track and record to provide us with an accurate understanding of what is unfolding. Monitoring and evaluation support our natural abilities to make sense of the world.[2]

When most people think about monitoring and evaluation, they think about report writing and accountability. What is sometimes lost is the potential for monitoring and evaluation to be an empowering tool to assess the vision forward and guide future decision-making[3]. Because this is our plan, we have an opportunity to control what the monitoring and evaluation system looks like, and how we do it and why.

We get to ensure we get the information we want to know, and control how information is collected, including how it is stored and shared. Monitoring and evaluation allows us to track the impacts of our hard work, identify things that are working, ask ourselves why, and then change or adapt our plan.

---

1 Best Start Resource Centre. (2012). Supporting the Sacred Journey: From Preconception to Parenting for First Nations Families in Ontario. Toronto, Ontario, Canada.

2 Mark, M. Henry, and Julnes, G (2000) Evaluation: An integrated framework for understanding, guiding and improving pubic and non-profit policies and programs. Jossey-Bass, San Francisco.

3 Westley, F. Zimmerman, B and Patton M. (2006) Getting to Maybe: How the World is Changed. Random House Canada.

Monitoring and Evaluation Success Factors

Ensuring the success of our monitoring and evaluation depends on the following factors:

- ✓ Leadership to oversee the monitoring and evaluation system
- ✓ Commitment from staff, managers and leadership to keep monitoring and evaluation system alive
- ✓ Skills, capacity and effective tools, including training and mentoring
- ✓ Clear roles and responsibilities
- ✓ Effective tools for communicating results
- ✓ A clear understanding of the value and demands of monitoring and evaluation including strategies to manage demand (see Table 23).

Understanding the Value and Demands of Monitoring and Evaluation

TABLE 23: Monitoring and Evaluation Values, Demands and Strategies

Value

- Advance self-governance, demonstrate that PFN is increasing its control
- Members reach higher levels of health status
- Wise decisions make more effective uses of funding, skills, resources
- Shows we are capable, willing and effective
- Reduce dependence on outside evaluation
- Get to tell our own story and rewrite history
- We track progress on our overall objectives
- Better understanding of what is happening and why
- Strong rationalization for spending
- We can celebrate our successes

Demands

- We are not realizing anticipated benefits of our actions
- We learn that things are not improving
- We learn that we are not getting the quality/quantity/ level of the results we need
- Monitoring and evaluation not seen as important, system not implemented
- We find that monitoring and evaluation takes a lot of effort and commitment
- Lack of cooperation and sharing of information

Strategy

- Change our course of action when not getting the results we need
- Build capacity (hire staff), leadership and effective tools to facilitate monitoring and evaluation
- Define clear roles and responsibilities for our monitoring and evaluation system
- Check in regularly by following a schedule
- Share results consistently to maintain momentum

TYPES OF MONITORING

What is Monitoring?

Strictly speaking, monitoring means to "observe" or to "check performance". Monitoring is a continuous process of collecting information based on a set of indicators or performance measures, to gauge the progress of our plan. Monitoring gives us the opportunity to capture the momentum gained by successes of our actions and to catch things that are having undesirable impacts[1]. There are two common forms of monitoring:

1. Compliance Monitoring

This type of monitoring asks the question "did we do what we said we would do; yes or no?" It is as simple as defining a process to track and communicate results in relation to our vision framework (vision, directions, paths and set of actions) by checking the completion of actions (yes or no) we committed to each year (see example tool #1). This helps managers keep track of results. This tool can also help us total how many actions or activities we have completed overall and identify what percentage of actions has been completed. It gives us a place to note why an action has not been completed, or why an action was successful. Communicating our progress with community members and funders, helps maintain support for the plan and build momentum (see compliance monitoring tool in Appendix 22)

EXAMPLE TOOL #1: Compliance Monitoring Tool

Action	Responsibility	Completed? Yes or No	Why or Why Not?	Date	Notes
Suicide risk assessment training	PHA	Yes	Trainer in Thunder Bay identified and able to complete training	April 2015	Training attended by 20 staff

1 Trousdale, W (2005) The Local Economic Development Series: Promoting Local Economic Development through Strategic Planning. Nairobi: United Nations Human Settlements Program.

We can also track if and how the plan is being used, and by who (PHA, PFN leadership and departments, staff and community agencies) (see example tool #2). This allows us not only to see how agencies are complying to the actions they've committed to our CCHP, but see what other ways the plan has been used.

EXAMPLE TOOL #2: Plan Usage Tool

Agency	Plan actions completed this year	Other ways the plan has been used
Pikangikum Education Authority	• Anti-bullying campaign • Sex education • Interagency protocol • Curriculum review	• Collaboration with PHA on development of suicide prevention program • Continuing school counselling

2. Impact Monitoring

This type of monitoring asks the question "what is the impact of what we are doing?" One way of assessing the impact of our actions involves identifying indicators that will be used to measure success of our Vision statement, Directions (8) and Paths (12) (see standards-based evolution description on page 167). Targets are then set to inspire action and change.

An indicator is a measure of something, expressing a value to indicate change. For each indicator chosen, baseline data will need to be collected and targets will need to be set to see what effect the action is having in our community.

Baseline data helps us understand our current situation and provides us with information with which to compare future results. We want to record and document how our health status is changing.

Targets are an expression of the desired change we would like to see in the future.

For example, in example tool #3, our baseline data tells us that we currently have 487 houses, and our capital plan identifies a shortfall of 200 houses to meet current demand and the need for 385 new houses to meet future population growth. By 2020 we would like have 20 new houses, and by 2025 an additional 38. Our tool allows us to compare the number of houses actually built to the targets we set. Revisiting this tool over time allows us to compare progress year-to-year. The example of a indicator framework

below (example tool #3) shows how a standards based impact monitoring tool can be set up by collecting baseline data, setting targets and comparing results with the targets set (see full impact monitoring tool in Appendix 23).

EXAMPLE TOOL #3: *Indicator Framework*

Direction	Indicator	Baseline Data	Target 2020	Actual 2020	Target 2025	Actual 2025
Expand community infrastructure	# of new houses built	2012 Capital Plan identifies total of 487 houses	507		545	

TYPES OF EVALUATION

What is Evaluation?

Evaluation uses the information from monitoring (compliance and impact) to determine if and why here are opportunities for changes and improvements to our CCHP. Evaluation is used to determine if actions are meeting our Vision statement, 8 Directions and 12 Paths efficiently, effectively and/or at all.[1]

Evaluating our results will allow us to communicate the value of the decisions we made and allow us to adjust our plan or actions if we are not getting the results we desire. It also helps us understand what actions are working well, so that we can celebrate success and communicate these successes to community members and funders. Finally, it monilizes our community, increases our control, ownership, pride and self esttem as we strengthen the health of our Nation.

Assessing the results and impacts of our planning allows us to determine what changes need to be made to the plan and keep it a living document. Evaluation involves discussing, analyzing and interpreting changes taking place in our community.

There are many types of kinds of evaluation. Given both the breadth and complexity of the objectives we are attempting to monitor and the limited human resources we have on the ground, our Monitoring and Evaluation plan is a hybrid between Standards Based Evaluation (tracking progress of indicators) and Responsive Evaluation (constant observation of impacts and outcomes).

1 Trousdale, W (2005) The Local Economic Development Series: Promoting Local Economic Development through Strategic Planning. Nairobi: United Nations Human Settlements Program.

1. Standards-Based

Standards-Based evaluation looks at the analysis of descriptive variables[1].

This type of evaluation attempts to create a roadmap with which to plan and evaluate the process that links directions and indicators in a linear fashion. Our Directions need to have measurable indicators so we can study our plan's performance over time (see indicators brainstorm example bellow and full list in Appendix 10). We can also set indicators for specific actions, to measure success of specific actions (e.g. How will we measure success of Stormer Lake program?)

This type of evaluation relies heavily on choosing effective indicators, and then collecting information and data so we compare performance overtime. As we can see in example tool #4, a single Direction or action can be monitored by a number of different indicators, we just need to decide on which indicators make the most sense for our situation given availability of data, feasibility of monitoring the indicator, and the direct relationship of the indicator to the Direction or action we want to measure.

This approach works well when the problem is well understood, has clear boundaries and there is a limited set of possible solutions. For example, tracking how many houses are built is a straight forward way of measuring progress on the action "expand housing and water infrastructure".

A potential limit of this approach is that if we only focus on indicators, we may miss other unexpected impacts of our plan. For example, it is important not only to count how many houses are being built in the community, but also take time to observe and record how people's well-being is being effected[2].

1 Stake, R (2004) Standards-Based and Responsive Evaluation. Sage Publications, Thousand Oaks.

2 Westley, Zimmerman and Patton (2006) Getting to Maybe: How the World is Changed. Random House Canada.

EXAMPLE TOOL #4: Indicator Brainstorm by Direction or Action

Direction	Possible Indicators
Reduce addictions and restore our mental health	• Suicide rate • Mental health related police calls • Reported addictions • Self-rated mental health status • # of members accessing treatment • Wait times to get into treatment • # of support groups • # of mental health staff
Action	Possible Indicators
Expand housing and water infrastructure	• Number of houses built • Average number of people living per house • % of houses with water & sewage • Water-borne illness rate

Selecting Indicators

An indicator is a measure of something, expressing a value or quantity to indicate change. It is usually a number (quantitative), but it could also be a letter grade, or a subjective assessment by community members of how they feel about something (qualitative).[1] Given the holistic and interconnected nature of health, we need our indicators to reflect the breadth and diversity of our health plan's directions and paths, including our set of actions.

Selecting effective indicators requires recognition that:

- Most indicators are imperfect measures to expalin what chanages are taking palce
- We are always limited to indicators for which we have the resources and ability to collect information and data in our community, and from agencies

1 First Nation's Health Development Project (2006) Community Health Indicators Toolkit. University of Regina & University of Saskatchewan

- Indicators offer signs of progress, but do not always tell us why things are changing (causal relationship)
- If indicators are the only data being considered, they can limit and control what we learn, and how we decide things

Appendix 10 presents a list of possible indicators brainstormed by Health Direction and Appendix 25 lists indicators for which we already have baseline data.

2. Responsive Evaluation

Much as our ancestors learnt from the environment in which they lived[1], responsive evaluation builds upon experience and personal knowledge.

When innovating with a complex health system, there is a high degree of connectivity and interdependence between variables and it is difficult to understand the impact of change. In this situation, an evaluation system is needed that can respond to limited control and for us to stay in touch with what is unfolding so we can provide a strategic response.

It involves asking questions and tracking results to provide feedback that can improve planning and actions and results for our members[2]. This approach values the fact that the meaning of accomplishment and success are situational, reflecting the cultural context of the community conducting the evaluation[3].

This approach to evaluation is potentially more time intensive and human resources demanding than standards-based evaluation, as it requires different methods (e.g. storytelling), consistent observation, analysis and reporting rather than checking for performance on indicators at pre-determined times.

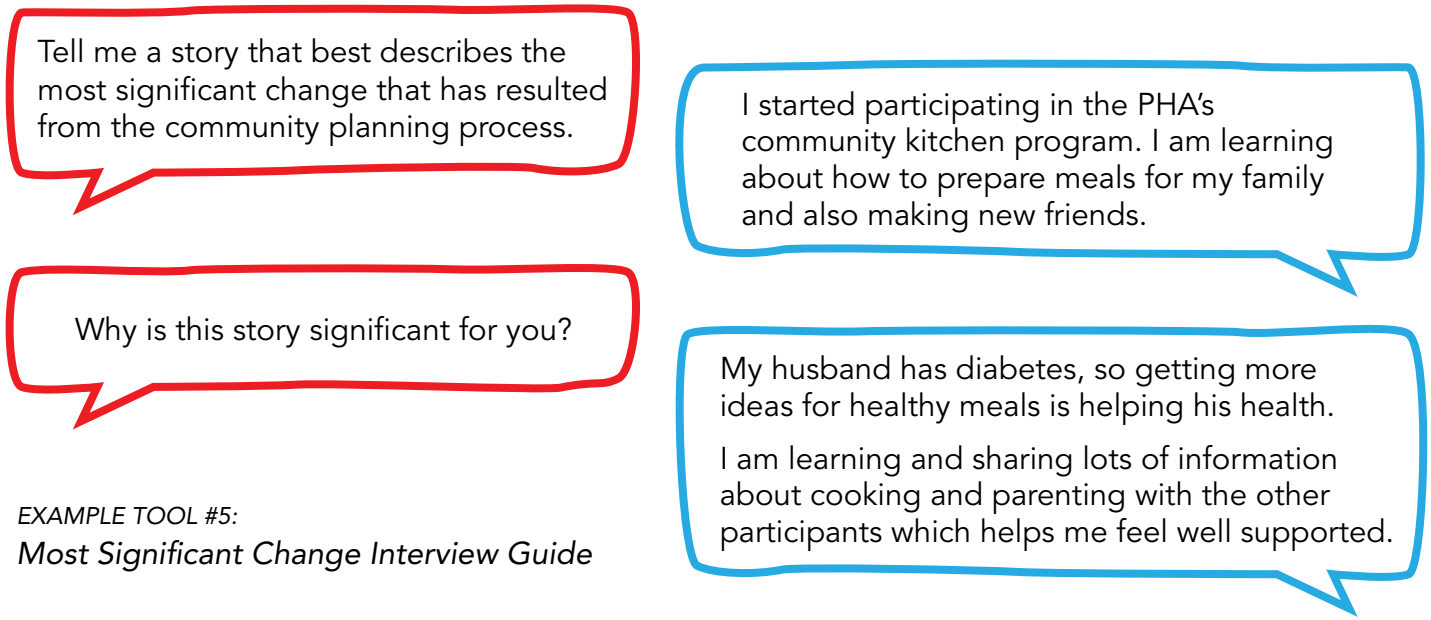
Two responsive evaluation methods are described on the following pages:

FIGURE 38:
Source: Davies and Dart (2005) The Most Significant Change Technique

1 Henderson, James (Sákéj) Youngblood (2000) Aykpachi: Empowering Aboriginal Thought. In Battiste, Marie. Reclaiming Indigenous Voice and Vision, UBC Press.
2 The J.W McConnell Family Foundation (2008) A Developmental Evaluation Primer. Gamble.
3 Westley, Zimmerman and Patton (2006) Getting to Maybe: How the World is Changed. Random House Canada

Most Significant Change: This is an evaluation technique that relies on the act of storytelling. The process involves collecting Significant Change stories from community members and then a systematic selection of the most significant of these stories by panels of agency representatives and an analysis of the themes noted in the stories collected[1] (see tool in Appendix 24). As you can see from the story provided in example tool #5, this technique allows us to collect more details than if we were simply tracking an indicator (as illustrated in the comic in Figure 38). While an indicator might tell us how many people are participating in the community kitchen program, Most Significant Change allows us to learn how participating in the community kitchen program is impacting individuals and their families. We may learn some unexpected impacts that we would not have noticed through tracking an indicator.

1 Davies, R and Dart, J (2005) The Most Significant Change (MSC) Technique: A Guide to Its Use. Version 1



EXAMPLE TOOL #5:
Most Significant Change Interview Guide

Outcome Mapping: This evaluation technique focuses on outcomes as behavioural change. It defines outcomes as changes in the behaviour, relationships, activities or actions of the people, groups and organizations with whom a program works directly.

This method focuses tracking outcomes in a journal and evaluating these based on what we should keep doing, change, add or drop[1]. As example tool #6 demonstrates, journaling outcomes allows us to consider not only what indicators are showing us, but contributing factors, unanticipated changes and lessons learned through our observations.

See Appendix 24 for more outcome mapping tools to help identify expected outcomes, track outcomes and respond to observations.

EXAMPLE TOOL #6: *Outcome Journal*

Description of change:	10% drop in the suicide rate
Contributing factors:	More kids in school because of new school and new programming More recreational and community events Land based suicide prevention program
Sources of evidence:	Suicide rate compared to base line data Stories from community members, teachers and nurses
Unanticipated change:	Increase in participation in cultural education programs More Youth volunteers
Lessons learned:	The importance of land based and cultural programming in reducing suicide The importance of increasing opportunities for Youth

1 Earl, S; Carden, F and Smutylo, T (2001) Outcome Mapping: Building Learning and Reflection into Development Programs. International Development Research Centre.

Table 24 summarizes the key differences between Standards Based and Responsive Evaluation. As the table below demonstrates, both types of evaluation have their advantages and limitations, but work well to complement each other:

	Standards Based Evaluation	Responsive Evaluation
Relies on:	• Data	• Observation
Works well for:	• Problem well understood • Clear boundaries to problem • Limited set of solutions	• Cultural model that prioritizes learning through observation • Difficult to understand impact of change • Lot of connections between Directions, Paths and Actions
Methods:	• Set indicators and targets • Collect baseline data • Compare data with targets	• Ask probing questions • Tracking stories and results in journal • Reflect on necessary changes
Tools:	• Indicator framework • Compliance and impact monitoring tool	• Most significant change • Outcome mapping
Limitations:	• Indicators are imperfect measure of what we are measuring • May miss important unexpected outcomes and impacts • May experience challenges in getting data (cost, time, consistency, policitics, privacy, confidentiality)	• Time intensive • Requires human resources for consistent observation, analysis and reporting

TABLE 24:
Comparision of Standards Based and Responsive Evaluation

MONITORING AND EVALUATION STEPS

The following section breaks down monitoring and evaluation step-by-step:

Step 1: Prepare the monitoring and evaluation framework (using Directions to pick indicators) to determine what will be monitored and what information is required and how it will be collected

- Before starting, it is important to agree on the objectives and value of monitoring and evaluation and develop a shared understanding of why it is important or necessary
- It is also important to anticipate any challenges to launching monitoring and evaluation system and develop strategies to overcome these challenges
- It is important to pick indicators for which information can easily be collected and that accurately reflect our Direction
  - » In example tool #7, the Direction of "Build Community Safety, Pride and Belonging" is assigned the indicator of "violent crime rates" which are readily available through the Pikangikum Police records
- There could be multiple indicators for each Direction to help capture a range of outcomes and impacts
- We could start with a small number of indicators and increase over time

EXAMPLE TOOL #7: Linking Direction, indicator and information

Direction	Indicator	Source of Information
Build community safety pride and belonging	Violent crime rates	Pikangikum Police records
Invest in families and heal our children and youth	# of children enrolled in school	Pikangikum Education Authority
Improve health services	Diabetes rate	Pikangikum Health Authority

Step 2: Determine who will be involved in monitoring and evaluation and how

- Involve as many implementation players as possible to share the responsibility and build commitment to carry out our monitoring and evaluation system
- Determine what methods and tools will be used and the source of information
- Identify who is responsible for data collection, evaluation and sharing results
  - » In example tool #8, for the indicator of "number of households on social assistance" the information source (social assistance records) is identified. While Ontario Works is responsible for collecting and storing this data, the PHA will be responsible for evaluating the data once a year. Results of this evaluation will be shared through the PHA health newsletter.
- Create job descriptions and provide training for those responsible for monitoring and evaluation

EXAMPLE TOOL #8: ***Roles and responsibilities tool***

Indicator	Information source	Who is responsible for collecting data?	Who is responsible for evaluating data and when?	Who will share results and how?
Number of households on social assistance	Social Assistance Records	Ontario Works	PHA, once a year	PHA, health newsletter

Step 3: Identify baseline data and set targets for each indicator

- Review what information is available and how it is currently being collected
- Start with the indicators for which baseline data exists
- Determine what other baseline data is needed
- Determine what methods and tools are needed to collect data
- Set targets for defined time periods (every year, five years or ten years)
  - » In example tool #9 we start with the school enrollment data from our school capital planning study (baseline data), and set school enrollment targets for 2018 and 2023

EXAMPLE TOOL #9: *Setting targets for each indicator*

Indicator	Baseline Data	Target 2016	Target 2017	Target 2018	Target 2019
School enrollment	619	700	750	800	850

Step 4: Determine when to monitor and evaluate

- Keeping in mind that monitoring and evaluation takes time and money:
- Set a time in which the implementation team meets to share observations and discuss progress (eg. monthly, yearly).
- Set specific times to check progress on compliance of tasks and check in on performance of indicators
  - » Example tool #10 shows which monitoring and evaluation activities will be conducted monthly, yearly, every 5 years or as needed

EXAMPLE TOOL #10: *Monitoring and Evaluation Schedule*

	Compliance monitoring	Impact monitoring	Meetings to discuss ongoing observation
Monthly			
Yearly			
Every 5 Years			
As needed			

Step 5: Determine the documentation and reporting protocol

- Example tool #11 has us consider the following questions which help us determine the documentation and reporting protocol for each indicator:
  - » How will the monitoring and evaluation process be documented and communicated? (e.g. newsletter, radio, posters)
  - » What happens to the data? Where will it be stored?
  - » Who gets access to it?
  - » How will it be communicated? (e.g. On an evaluation form, verbally?)
  - » How will the results be used and by whom? (privacy and ethics)

EXAMPLE TOOL #11: *Communications Plan*

Indicator:	Diabetes rate
How will data be documented?	Health Canada community based reporting
Where will data be stored?	Information management system
Who will have access to the data?	Health Canada, PHA
How will it be communicated?	PHA annual report

PROCESS FOR PLAN REVISIONS

Once we begin to implement our Health Plan, we should expect that the plan will need revisions. Having a process in place to adapt and modify our plan will make it more effective for us.

The need to review and revise our CCHP may be due to any of the following:

- The actions identified by the plan are not being carried out or are not being carried out effectively (as determined by our monitoring and evaluation system)
- The actions identified by the plan are not addressing the scale, urgency or rate of conditions we are working to improving
- New opportunities, issues or concerns arise, changing our priorities
- A community crisis or emergency causes us to change our priorities
- The implementation process takes longer than expected

Revisions can come about based on a set interval (such as monitoring and evaluation cycles) or the need to revise the plan may be in response to a current issue, crisis or funding requirement. The revision process provides an opportunity to bring the community together to reflect, discuss and suggest changes.

The steps to revise our Health Plan are illustrated in Figure 39.

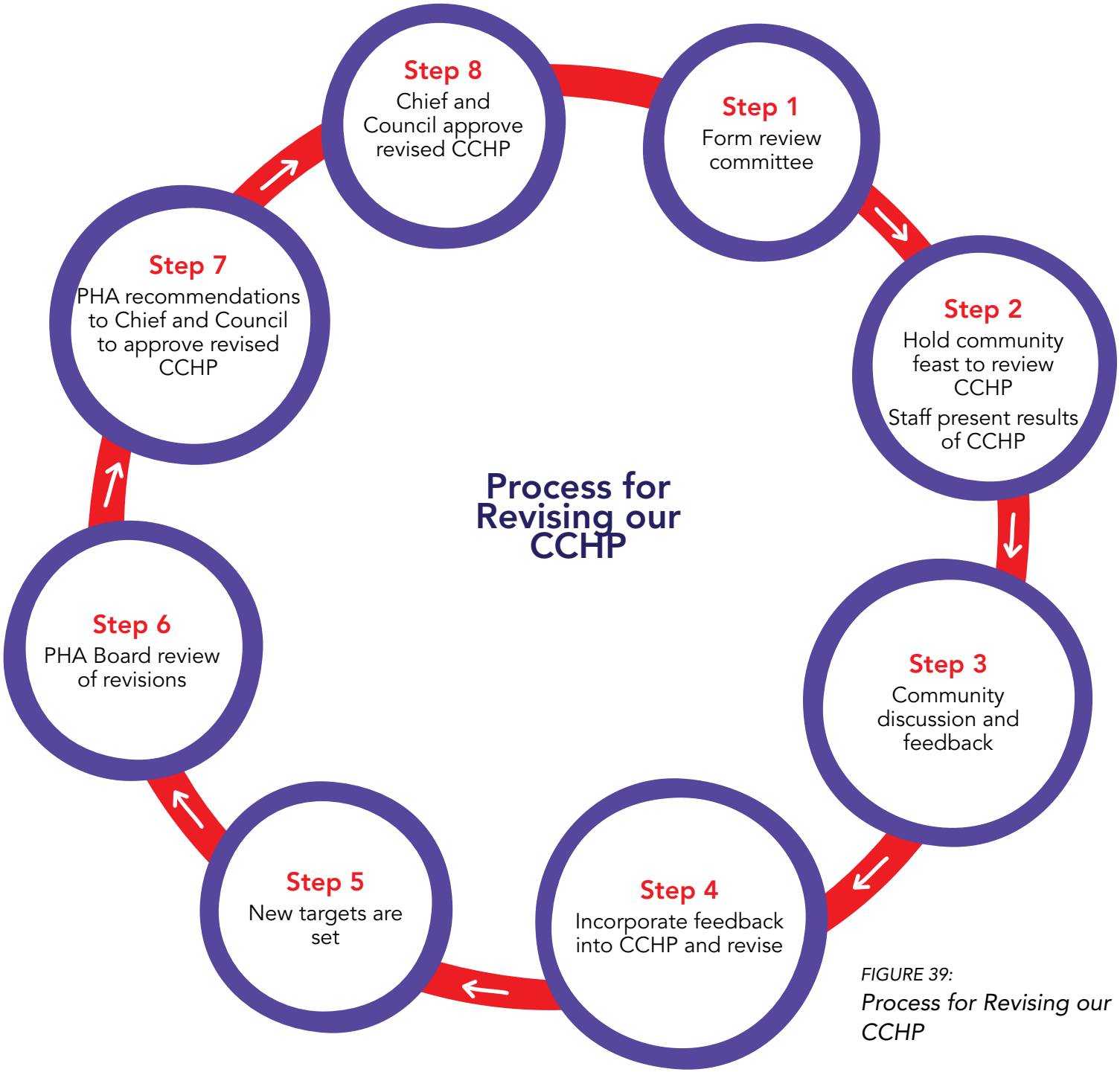


FIGURE 39:
Process for Revising our CCHP

CONCLUSION

Our two-year process of gathering as a community to explore our health needs and create a vision for the future has now come to a close. In total, 864 community members gathered to share their stories, experiences, ideas and perspectives in a process of gathering, visioning and healing.

Building on our award-winning CHNA, our CCHP is a great achievement for our Nation. As a governance tool, it provides leadership with clear direction to strengthen our community health based on our shared conversation on how we want to strengthen our individual, family and community health. It is an important step in reclaiming control over our heath system. It is a powerful tool to ensure that our community voices continue to inform and support development of new and existing health programs, services and infrastructure.

Not only is the final CCHP a great governance tool, but the process of coming together as a community has played an important role in community healing. Our community-based process has helped built confidence, encouraged feeling of belonging, strengthened relationships, built local planning capacity, reclaimed our culture and helped us tell a positive story about our community and where we are going.

Now begins the hard work of putting our vision and goals into action. Successful implementation involves not only funding, capacity building and mobilizing resources, it also involves changing our mindsets and approaches, continuing to build relationships and pride, committing to change, and restoring individual, family and community strength.

Equipped with our community's strengths, implementation tools and monitoring and evaluation tools, we will see the results of our hard work in the years ahead.

List of Appendices

Please see the accompanying Appendices Binder for the following appendices:

Number	Appendix Title
#1	Relationship between our 8 Health Directions and 12 Paths
#2	Actions by Direction and Type
#3	Impact Analysis
#4	Community Survey Report
#5	High School Report
#6	Youth Report
#7	Community Clicker Survey Report
#8	Prioritization Methodology
#9	Prioritization Results
#10	Indicators Brainstorm
#11	Continuum of Care Analysis
#12	List of CHNA Subneeds
#13	SWOT
#14	Comparison of sub-needs to Directions
#15	Internal Analysis Report- CCHP Engagement Activities
#16	Action Theme Descriptions
#17	Individual Action Descriptions
#18	Actions by Prioritization Level and Type
#19	Priority Action Work Plans
#20	Phase 1 Work Plan
#21	Implementation Roles
#22	Compliance Monitoring Tool
#23	Impact Monitoring Tool
#24	Responsive Evaluation Tools
#25	Indicators for which we have Baseline Data
#26	Implementation Funding Sources
#27	Newsletters 7-11