IPHCO DEVELOPMENT TOOLKIT

GUIDING DOCUMENT FOR EXECUTIVE LEADERS

JULY 2024

INDIGENOUS PRIMARY HEALTH CARE COUNCIL

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ABOUT THE INDIGENOUS PRIMARY HEALTH CARE COUNCIL

The Indigenous Primary Health Care Council (IPHCC) is an Indigenous-governed and culture-based organization established to support advancement and evolution of Indigenous primary health care planning and service provision and planning throughout Ontario. This is accomplished through partnerships, education, and advocacy.

The IPHCC prides itself in being status-blind, committed to promoting health equity for First Nations, Inuit, and Métis (FNIM) individuals and their families across the province.

IPHCC is a member-based organization with membership consisting of 23 Indigenous Primary Health Care Organizations (IPHCOs) located in 46 locations across the province. Former names for IPHCOs include Aboriginal Health Access Centres (AHACs), Indigenous Community Health Centres (ICHCs), Indigenous Interprofessional Primary Care Teams (IIPCTs), and Indigenous Family Health Teams (IFHTs).

IPHCC is a provincial leader in the areas of Indigenous Cultural Safety, Indigenous data governance, health systems transformation, and First Nation, Inuit, and Métis (FNIM) engagement and relationship development.

KEY ABBREVIATIONS

AHAC	Aboriginal Health Access Centres
AHWS	Aboriginal Healing and Wellness Strategy
AOHC	Association of Ontario Health Centres
AOP	Annual Operating Plan
BoD	Board of Directors
CHC	Community Health Centre
EOI	Expression of Interest
FNIM	First Nations, Inuit, Métis
HQO	Health Quality Ontario
ICHC	Indigenous Community Health Centre
IFHT	Indigenous Family Health Team
INPLC	Indigenous Nurse Practitioner-Led Clinic
IPCT	Indigenous Primary Care Team
IPHCC	Indigenous Primary Health Care Council
IPHCO	Indigenous Primary Health Care Organization
MOH	Ministry of Health
MWHW	Model of Wholistic Health & Wellbeing
OH	Ontario Health
OHT	Ontario Health Team
PCN	Primary Care Network
QIP	Quality Improvement Plan

KEY TERMS AND DEFINITIONS

Executive Leaders	Collective term used to refer to CEO, Executive Director, etc.

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INTRODUCTION, PURPOSE, AND STRUCTURE

In 2023, Ontario Health (OH) and the Ministry of Health (MOH) invited interested parties to submit Expressions of Interest (EOIs) to create more interprofessional primary care teams (IPCTs) that would increase accessibility to people who live in Ontario. As part of this process, a commitment was made to *"expand existing teams and/or create new teams in regions of the province identified as having the greatest need."*[1]

Recognizing the potential for this process to result in establishment of primary care teams designed specifically to work with FNIM communities, the Indigenous Primary Health Care Council (IPHCC) created this toolkit as a resource for the Executive Leaders of newly established Indigenous Primary Health Care Organizations (IPHCOs) who commonly have the title of Executive Director (ED) or Chief Executive Officer (CEO). This resource contains information relevant to the funding and structure of IPHCOs, key operational considerations and links to tools and resources to support their continued evolution.

Given the practical nature of the recommendations it contains, this toolkit can also be utilized to the support the following:

- The orientation of new Executive Leaders and other executive team members within existing IPHCOs;
- Providing support for existing IPHCO Executive Leaders; and
- Sharing information on the role of the Executive Leaders.

For example, the toolkit can provide IPHCO board members with an understanding of the wide-ranging and complex responsibilities of the Executive Leaders, thereby creating awareness of the types of supports that should be provided by the governing body to enable the Executive Leaders to successfully advance the goals of the organization.

The toolkit is divided into the following six sections:

1. **IPHCO background:** Information about the history of IPHCOs, their key characteristics, and the Model of Wholistic Health and Wellbeing (MWHW), a framework shared by Indigenous health centres that supports a population needs-based approach to health care planning and delivery for Indigenous people.
2. **IPHCO funding:** An overview of common funding sources, and the funding agreement between IPHCOs and MOH.
3. **IPHCO structure:** A summary of the respective roles of the Board of Directors (BoD) and Executive Leader, and guidelines for identifying, designing, and delivering programs and services in alignment with the MWHW.
4. **IPHCOs and Ontario Health Teams (OHTs):** Considerations for working with regional partners to advance integrated care.
5. **Data considerations:** An overview of information flows, reports, and resources available to IPHCOs.
6. **IPHCC membership:** The role of the IPHCC, its current members, and advantages of membership.

Each section includes a list of recommended tasks for new Executive Leaders intended to further their understanding of the organization and ensure its strategic and operational effectiveness.

1 Ontario Health, "Expression of interest checklist", Accessed on Jun 17, 2024 from: https://www.ontariohealth.ca/sites/ontariohealth/files/2023-05/PrimaryCareTeamExpansion-EOI-Checklist.pdf

SECTION 1: IPHCO BACKGROUND

Characteristics of IPHCOs

IPHCOs are Indigenous-led primary health care organizations that use Indigenous values and teachings as the foundation for all services provided. IPHCOs take an Indigenous-led and community-centred wholistic approach to improve the mental, emotional, physical, and spiritual health and wellbeing of Indigenous peoples. Within these organizations, it is recognized that Traditional knowledge, Traditional healing practices, and self-determination underpin Indigenous primary health care and are central to restoring balance at the individual, family, community, and nation levels.

IPHCOs operate under the Model of Wholistic Health and Wellbeing (MWHW), which is described below, and are experts in the provision of culturally based primary health care. IPHCOs who are members of IPHCC are "Indigenous governed" meaning that the BoDs are composed of at least 75% Indigenous voting directors who are not employed by those same organizations.

The Model of Wholistic Health and Wellbeing

IPHCOs programming is rooted in the MWHW, which was developed in 2011 by the AHAC Circle to represent the unique model of care provided by IPHCOs. The model focuses on the restoration and rebalancing of the physical, mental, emotional and spiritual wellbeing of FNIM families, communities, and nations. It supports a population-needs based approach to health care planning and delivery for Indigenous people and provides an important foundation for program and service delivery planning.

The Model of Wholistic Health and Wellbeing incorporates physical, mental, emotional, and spiritual elements of wellbeing and the belief that all these elements must operate in harmony.

The model outlines that health care planning must be based on population needs and excellence in Indigenous health, informed by Indigenous evaluation approaches and leading practices.

The model is based on a foundational belief that culture represents treatment and healing, and solidly implants a strong self-identity so that self-determination is fostered, and positive health outcomes are advanced.

It promotes and celebrates the diversity of Indigenous peoples so that all voices are elevated, and the power lies with FNIM communities to oversee their destinies.

Common service delivery areas

According to the MOH funding agreement, programs and services offered by IPHCOs must be based on the MWHW, and delivered using the following approaches:

- Land-based activities promote physical, mental, emotional, and spiritual wellbeing by connecting individuals, their families, and the community to the healing properties of the land. These activities are inclusive of water-based teachings, ceremonies and natural navigation techniques to be more in harmony with the inner self. These elements are integrated across all of the other activities undertaken by Recipients (client-based activities, community-based activities, and networking activities).

- Client-based activities use a *culture-as-healing and culture-as-treatment* approach to promote the physical, mental, emotional, and spiritual wellbeing of individuals and their families by providing preventative, curative, rehabilitative, and palliative care. This care is inclusive of traditional healing practices, the use of traditional medicines, integration of western primary care models and traditional approaches to healing, as well as mental health and community-based support.

- Group-based activities use a *culture-as-healing and culture-as-treatment* approach to promote the physical, mental, emotional, and spiritual wellbeing of the community by providing group programming that reflects local traditions and teachings, as well as addresses locally determined needs and priorities. These activities are inclusive of elements like talking circles, community feasts, traditional teachings etc.

- Networking activities use a approach to promote the physical, mental, emotional, and spiritual wellbeing of the community. IPHCOs collaborate with local Indigenous and non-Indigenous social service and health care providers to ensure seamless systems of support for clients and smooth care transitions. IPHCOs also help ensure that their Indigenous clients have access to safer care by promoting systemic organizational change with the goal of tackling anti-Indigenous racism in the local health care system to help limit impacts and remove systemic barriers.

Client-Based Activities – IPHCO Spotlight

IPHCC MEMBER SPOTLIGHT: WABANO'S HEALTHY LIVING PROGRAM (BESTI-OMI)

Wabano's Besti-Omi (Healthy Living Program) is health promotion that grounds itself in promoting a truly healthy community with abundance, generosity and wellness by being together. Offering program services to all age groups, Besti-Omi enables change by:

- Providing clients with a culturally safe environment to meet spiritual, cultural, physical and emotional needs.
- Providing high quality physical activity programming, nutrition and healthy eating supports, and reducing rates of commercial tobacco use.
- Empowering clients to make positive lifestyle choices and changes.
- Implanting culture as the foundation of all activities.

Included in the array of programs is the following activities:

- Community kitchen held every Friday where FNIM across the community can come together to gain essential cooking skills and explore nutritious recipes.
- Learn budget friendly ways to cook healthy meals for everyone to enjoy.

As access to quality and affordable nutritious food becomes increasingly difficult, Wabano's community kitchen provides a safe space for community members to come together and engage in healthy eating supports.

NORTH BAY INDIGENOUS HUB'S CHILD CARE AND EARLY ON CENTRE

To support FNIM families in the Nipissing District, North Bay Indigenous Hub (NHIB) established the Child Care and Early ON Centre, offering childhood development and learning services.

The centre reflects Indigenous approaches to childcare and families by incorporating language, traditional teachings, land-based activities, storytelling, Elder visits, and more. The intent is to support children emotionally, mentally, spiritually, and physically. The program follows the Ministry of Education's Pedagogical Approach of "how does learning happen" while offering children a culturally enriched experience that follows the Seven Grandfather Teachings. These teachings promote positive self-identity and connection to Indigenous ways of being.

Networking Activities – IPHCO Spotlight

MAAMWESYING AND ALGOMA PUBLIC HEALTH

In the height of the COVID-19 pandemic, Maamwesying responded to a community request for a local Indigenous specific coordinated plan to mobilize a response to an outbreak in the North Shore Tribal Council member communities. Maamwesying put together a COVID-19 task team comprised of both Indigenous and non-Indigenous organizations including Algoma Public Health, Canadian Red Cross, Public Health Sudbury & Districts and more. Together, they developed an action plan that focused on 7 pillars:

1. PPE/Swabs (Access and Training)
2. Testing, Surveillance, Contact Tracing, Vaccination
3. Redeployment (Ensuing that staff were available in each community in the event of an outbreak)
4. IPAC (Provide guidance and ensure infection control measures are in place)
5. Public Education and Communication Strategy (Consistent messaging, ongoing updates)
6. COVID-19 Community Wellness Support
7. Food Security

Partnering with Algoma Public Health was a success to both the staff at Maamwesying and local First Nation Communities as this was one step in establishing trust and rebuilding a relationship with public health that was previously broken. The supportive presence of the CEO/Medical Officer of Health at the Maamwesying COVID-19 Task Team meetings clarified roles, responsibilities, advocacy and communication.

IPHCOs themselves are responsible for the following:

- Determining the specific programs and services that they provide to meet the need of their intended communities.
- Programs and services in place must have clear objectives, targets, and performance indicators which are summarized in the Annual Operating Plans (AOPs) submitted to the MOH.

As outlined above, program and service planning, design, and delivery are based on data that reflects the needs of Indigenous people where possible.

Ministry-specific programs and services highlighted in the MOH funding agreements include:

Note that the Health Promotion and Prevention portion includes the following:

- Healthy Eating and Active Living (HEAL)
- Diabetes Prevention
- Indigenous Diabetes Regional Planning and Program Delivery, as well as
- Smoke-Free Ontario programs.

Similarly, the Journey Together portion includes the following:

- Nanda-Gikendan program
- Pain, Addiction, Mental Health within an Anishnawbek Recover (PAMHAR) System program.

It should also be noted that not all MOH agreement holders receive these program-specific funds. Individual IPHCOs are encouraged to review the eligibility criteria for funding opportunities with their designated MOH contact.

The History of IPHCOs

Early development

Today's IPHCOs have roots in the Aboriginal Healing and Wellness Strategy (AHWS), established in 1994 after many years of development. An amalgamation of two initiatives focused on improving Aboriginal health and reducing family violence, AHWS was based on the most extensive consultations with Aboriginal people in the history of Ontario. Implementation was overseen by a partnership between five provincial ministries and several representative Aboriginal organizations. Aboriginal Health Access Centres (AHACs) were one of several programs comprising the overall strategy. The original ten AHACs were initially modeled after CHCs but distinguished by the traditional healing practices identified as an integral part of their work. The pillars of the strategy continue to inform the Indigenous health policy in the province of Ontario to this day.

The emergence of Aboriginal Health Access Centres

By 1998, ten AHACs had opened their doors and began to join the Association of Ontario Health Centres (AOHC). In 2004, under the umbrella of the AOHC, the AHACs formed an AHAC Circle composed of executive leaders. This leadership group became very active, significantly influencing the AOHC policies and philosophy of "Indigenous Health in Indigenous Hands".

Introduction of Indigenous Family Health Teams and Nurse Practitioner-led Clinics

In 2006, the Ministry announced the creation of 200 Family Health Teams, including five Indigenous-led FHTs.

In 2009-10, the Government announced 25 Nurse Practitioner-Led Clinics (NPLCs), including 1 Indigenous NPLC under the governance of Anishnawbe Mushkiki located in Thunder Bay.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: LEARN THE HISTORY OF YOUR IPHCO

Knowledge of the evolution of your IPHCO provides important context for understanding its current governance, structure, and operations, and how it has adapted to meet the developing needs of its clients, their families and the communities they serve.

The following tasks are recommended to better understand the history of your IPHCO:

- Review documents and speak with individuals who can answer the following questions:
  - When was the IPHCO first established?
  - Which parties were responsible for developing the initial application to establish it?
  - What need/s was it designed to address?
  - How has it evolved over time?

Creation of Indigenous Interprofessional Primary Care Teams (IIPCT)

In 2017–18 and 2018–19, under the Liberal Government, IIPCTs were expanded to include 10 new Indigenous organizations and satellite expansions to 5 existing AHACs.

In February 2024, the MOH announced a further enhancement of $110M for Interprofessional Teams, which resulted in expansion of 11 existing IPHCOs and establishment of one new IPHCO.

Further to the $90M expansion announcement, in the 2024-25 Provincial budget, the Government announced an additional expansion for interprofessional primary health care for a total of $546 M over three years (or about $182 M annually). At time of publishing this toolkit, details on how this funding is to be allocated remained unknown.

The evolution of IPHCO oversight and funding

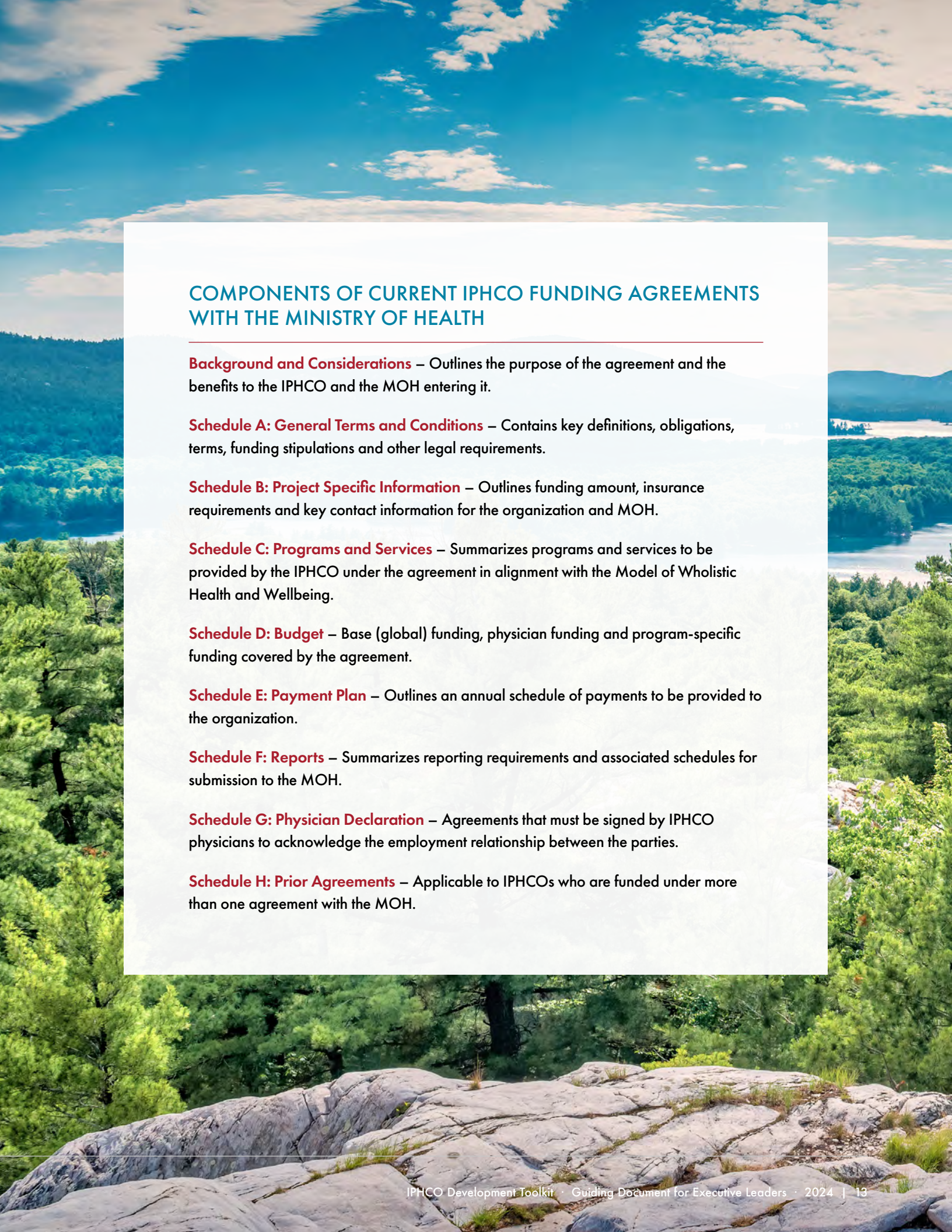
In 2011, the AHACs were transitioned from AHWS to a direct relationship with the Ministry of Health and Long-term Care. At that time, the AHAC Circle formalized the MWHW that was representative of the unique model of service that AHACs provided. Since then, their point of contact within the MOH has changed three times, and now lies within the Primary Care Branch of the MOH.

In January 2020, the MOH engaged with the IPHCC to develop a new funding agreement specific to Indigenous primary health care providers. The new agreement came into effect in April 2022, at which time the AHAC and IIPCT contracts were sunsetted and all Indigenous primary care organizations who signed the new agreement were referred to as IPHCOs.

This agreement embeds the MWHW and the service delivery areas, as well as consolidates management of several funding streams within the MOH. The new agreement replaced the AHAC and IIPCT contracts. Organizations who had FHT and CHC agreements had a choice to move to the new agreement or remain with the non-Indigenous specific agreements. As of the date that this toolkit was finalized, all but two IFHTs and two CHCs have transferred to the new agreement.

Establishment of the Indigenous Primary Health Care Council

In 2019, the Indigenous Primary Health Care Council became federally incorporated. The AHACs, ACHCs and new IIPCTs became members of both the IPHCC and the Alliance for Healthier Communities (formerly AOHC) – for different but inter-related supports. A formal ally relationship was signed by the Alliance and IPHCC in September 2023. Per the memorandum of understanding, the IPHCC designates one director and endorses a second director on the Alliance board.



COMPONENTS OF CURRENT IPHCO FUNDING AGREEMENTS WITH THE MINISTRY OF HEALTH

Background and Considerations – Outlines the purpose of the agreement and the benefits to the IPHCO and the MOH entering it.

Schedule A: General Terms and Conditions – Contains key definitions, obligations, terms, funding stipulations and other legal requirements.

Schedule B: Project Specific Information – Outlines funding amount, insurance requirements and key contact information for the organization and MOH.

Schedule C: Programs and Services – Summarizes programs and services to be provided by the IPHCO under the agreement in alignment with the Model of Wholistic Health and Wellbeing.

Schedule D: Budget – Base (global) funding, physician funding and program-specific funding covered by the agreement.

Schedule E: Payment Plan – Outlines an annual schedule of payments to be provided to the organization.

Schedule F: Reports – Summarizes reporting requirements and associated schedules for submission to the MOH.

Schedule G: Physician Declaration – Agreements that must be signed by IPHCO physicians to acknowledge the employment relationship between the parties.

Schedule H: Prior Agreements – Applicable to IPHCOs who are funded under more than one agreement with the MOH.

SECTION 2: IPHCO FUNDING

MOH-IPHCO Funding Agreement

Historically, there have been four types of agreements with Indigenous primary care organizations (i.e. AHACs, FHTs, CHCs and IIPHCTs). Some organizations were funded under more than one agreement, depending on when they were established.

As of April 1, 2022, the majority of IPHCOs moved to a new, consolidated funding agreement rooted in the MWHW. These new agreements provide global budgets to IPHCOs, with a designated budget line for physician services[2] through a salaried model with patients registering directly with the organization.

Reporting requirements

As part of their responsibilities under the current MOH funding agreement, IPHCOs are required to submit ***Annual Operating Plans (AOPs)*** comprised of the following sections:

- IPHCO profile containing information about:
  - Contact information
  - Service delivery sites
  - Governance structure and associated information
  - Population metrics, including population served
  - Service/referral networks
  - Highlights/pressures
  - Operational/financial pressures
  - Highlights
  - Capital plans
- Operating plan outlining:
  - How programs/services will be delivered
  - The overarching goals and objectives of each
  - Program-specific indicators defined by the MOH
- Staffing structure summarizing the human resources required to carry out the operating plan.

It is important to note, that AOPs can be used to identify on-going challenges that you might be experiencing within your IPHCO. It is an opportunity to specify human resource needs, opportunities for expansion into new locations, case load demand by linking your IPHCO data to need etc. In addition, capital needs can be highlighted so that it signals to the Ministry that a capital request may be forthcoming.

2 Refer to OMA 'Starting a Practice' resource to help address physician practice management topics.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: UNDERSTAND FUNDING AGREEMENTS AND REPORTING REQUIREMENTS

Understand the purpose of the various funding streams that your IPHCO receives, and the associated responsibilities of the organization under the agreement(s) with the funder(s) is foundational for budgeting and ensuring fiscal compliance. The following tasks are recommended for Executive Leaders to understand the purpose responsibilities associated with the funding it receives:

- Confirm the current source(s) of funding for the IPHCO.
- Obtain a copy of the associated funding agreement for each funding source
- Carefully review each agreement to understand the following:
  - Purpose of the funding
  - Deliverables associated with the funding
  - Amount of the funding
  - Reporting requirements
- Email info@iphcc.ca for support with reviewing funding agreements and determining associated reporting requirements and accountabilities.

Additional information about the reporting requirements associated with the MOH-IPHCO funding agreements are listed below:

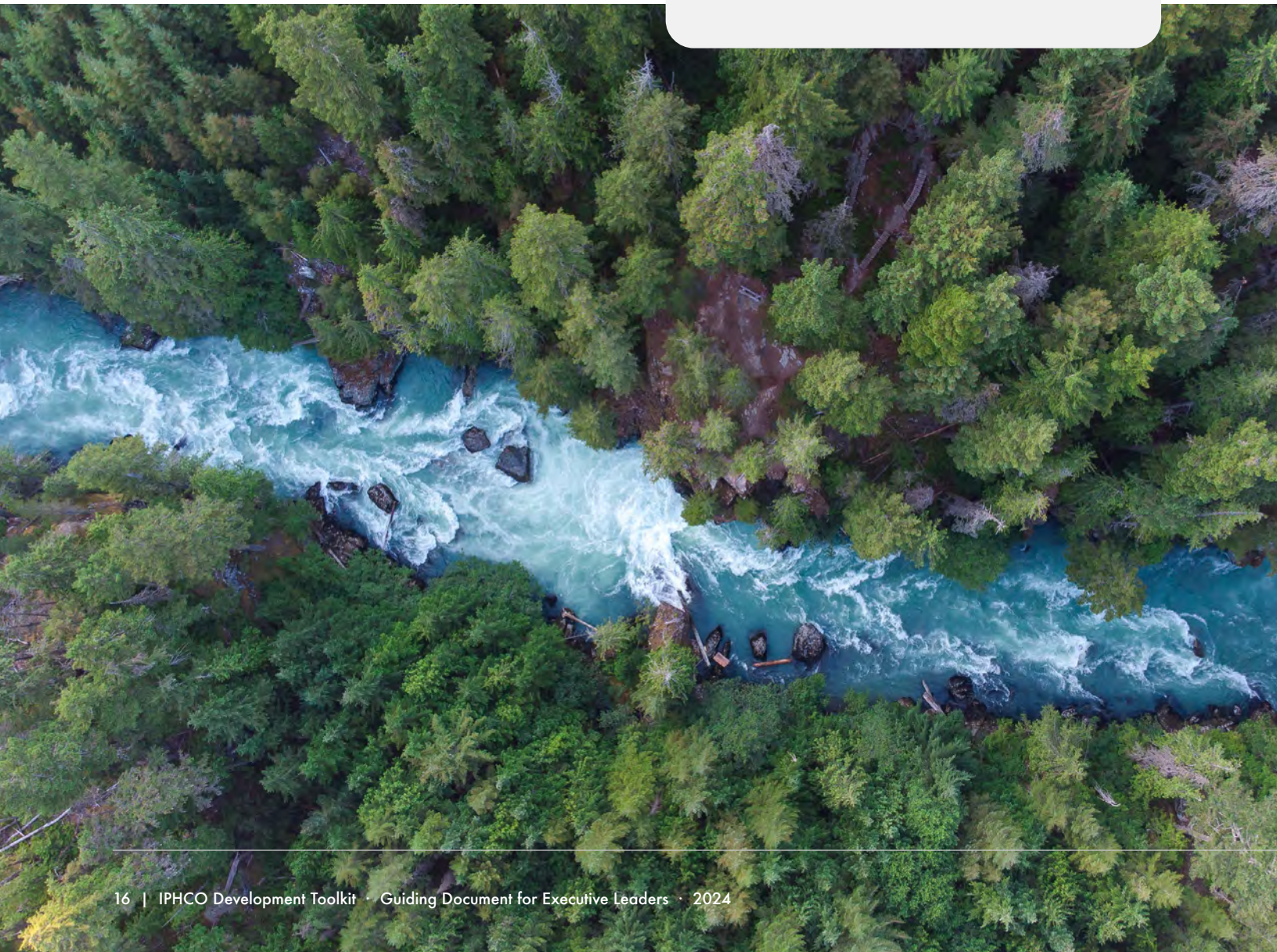
- Annual Operating Plan (AOP) due **April 30** or as otherwise determined.
- Quarterly activity/financial reporting – Excel template includes:
  - financial report
  - program indicators
  - hiring report
- Annual Reconciliation Report (ARR) due **June 30**
- Audited financial statements due **June 30**
- Up to 47 specific indicators to be reported on (developed and endorsed by the IPHCO sector in collaboration with MOH in 2022/23)
- Quality Improvement Plans (QIPs) are a separate process mandated by OH but listed as a requirement of this funding agreement due **March 31**

In addition, the agreement outlines that each IPHCO is required to submit a Quality Improvement Plan (QIP) to OH each year. Health Quality Ontario (HQO) provides guidance to primary care organizations on how to create QIPs and consults with organizations across the health sector to identify priority issues and associated lists of recommended indicators for inclusion in the plans. Organizations are also free to consider adding custom indicators to address their own improvement opportunities and collaborative work with other health service providers. For more information about QIPs please see the Quality Improvement section of this toolkit.

Other Funding Sources

It should be noted that some IPHCOs receive financial support from non-MOH funders. For example, ICHCs hold Multi-Sector Service Accountability Agreements (MSAAs) directly with OH, and other IPHCOs receive funding from regional and/or national (federal) organizations. Appendix A outlines a list of common funding sources, and the reporting requirements for each. In some cases, the MOH may inquire as to what all funding sources the IPHCO has accessed to get a sense of each IPHCOs bigger picture. It is not to limit its own funding obligations to the IPHCO.

> "In some cases, an IPHCO may by funded through multiple streams. In these cases, it is highly recommended that the Executive Leaders create an inventory of reporting requirements that includes the specific information that must be reported, the process and/or platform(s) through which it is provided, and the schedule when that information must be submitted to the funder(s)."
>
> *Anita Cameron, retired Executive Director – Waasegiizhig Nanaandawe'iyewigamig (WNHAC)*



SECTION 3: IPHCO STRUCTURE

The Role of the Board of Directors

IPHCC members are Indigenous-governed, meaning that their BoD is composed of at least 75% Indigenous voting directors. The board will operate according to an approved set of bylaws. The bylaws will outline membership categories, eligibility for board positions, minimum and maximum requirements for board composition and numbers, annual general meeting requirements, board decision making structure, voting structure of members, resolutions, and officers of the corporation. All of these aspects best position the IPHCOs to provide primary health care services that meets the needs of the Indigenous communities they serve, ensuring that from the highest level, Indigenous health is in Indigenous hands.

Successful IPHCOs are characterized by BoD who establish and nurture positive relationships with the Executive Leaders. Maintaining open lines of communication, trust, and support between BoD and Executive Leaders are essential for ensuring that the organization meets its defined objectives in a healthy way.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: GET TO KNOW YOUR BOARD OF DIRECTORS

A positive relationship between the BoD and Executive Leader is key to ensuring the overall effectiveness of an IPHCO. It is recommended that new Executive Leader within existing IPHCOs complete the following tasks to understand the dynamics of their BoD:

- Review current board policies and procedures. Refer to Appendix C for a list of relevant governance, operational and clinical policies.
- Review current board onboarding/orientation materials.
- Review minutes of meetings for at least the past 12 months to understand current board and IPHCO priorities, successes and pressure points.
- Meet with the BoD Chair and other Directors to discuss:
    - Whether the BoD is strategic or operational (or both) in focus
    - Expectations and processes for clear and timely communication
    - Short-, medium- and long-term board priorities for the organization

New Executive Leaders within recently established IPHCOs may be required to work with their BoD to develop the required policies, procedures and orientation materials to ensure sound governance of the organization.

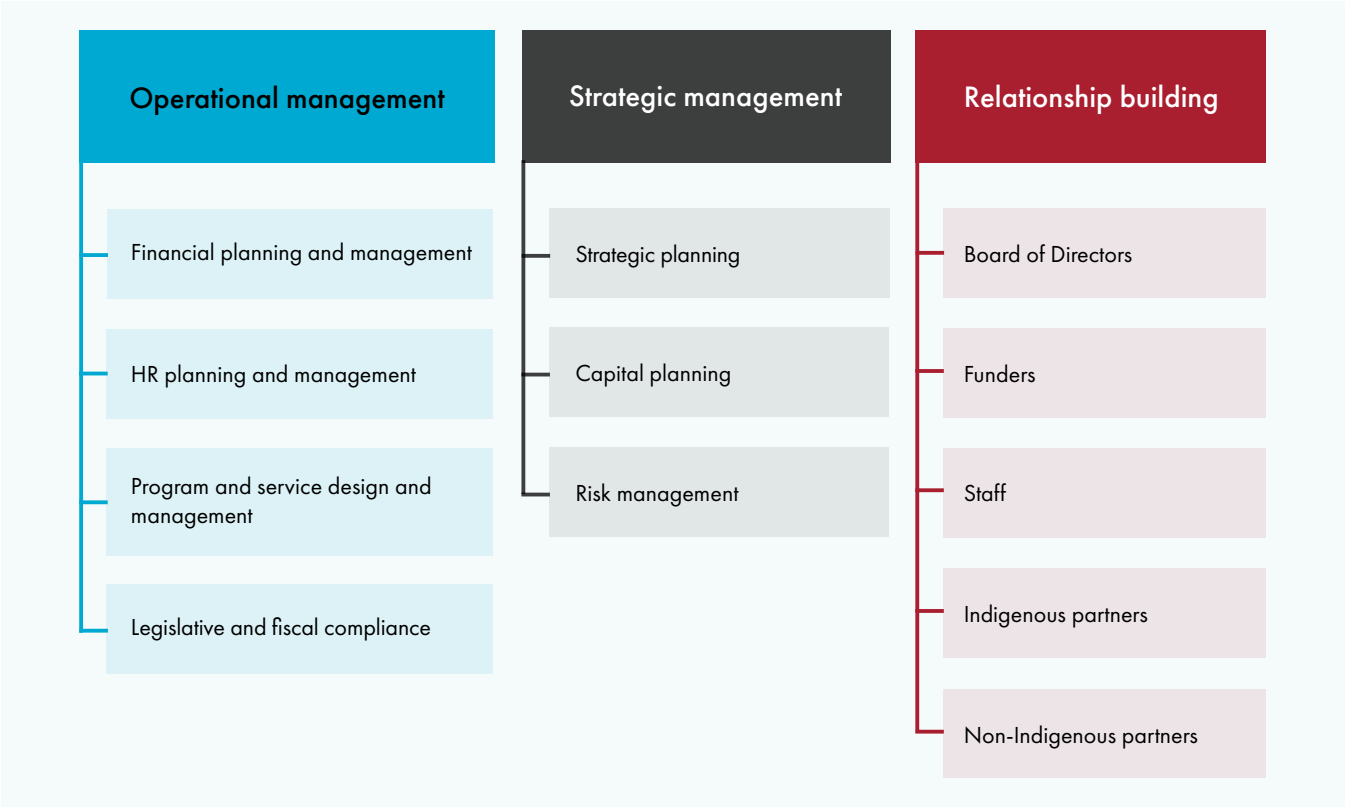
For support with board engagement, email info@iphcc.ca.

> "Regardless of board type or structure, it is important that board members have a clear understanding of their roles and responsibilities, and how they should work with each other and the organization's leadership team in an effective and collaborative way. Clear communication, transparency and establishing a shared vision are key elements for successful board dynamics."
>
> *Adrianna Tetley – former CEO, Alliance for Healthier Communities*

The Role of the Executive Leader

For the purpose of this toolkit, the term 'Executive Leaders' describes an organization's most senior administrative lead. Executive Leaders' roles within IPHCOs commonly have the title of Executive Director (ED) or Chief Executive Officer (CEO). A Lead Executive Role Assessment Framework was developed for interprofessional primary care organizations in 2018, and outlines that in order to be considered an Executive Leaders, a given position should have "significant decision-making ability, be accountable for the operations of the organization, report directly to the BoD, be responsible for managing staff, and be a signatory of the organization's QIP." A copy of the framework can be obtained by emailing info@iphcc.ca.

The following diagram summarizes the key responsibilities of IPHCO Executive Leaders, and a breakdown of the tasks required for each.



Key responsibilities of IPHCO Executive Leaders, and a summary of the tasks required for each. Executive Leaders are responsible not only for effective operational and strategic management of IPHCOs, but also for the important tasks of creating and nurturing the positive relationships needed to reach their goals.

"The jobs of leaders aren't easy ones. On trying days, we remember the story of a child walking on beach after a storm that had washed up a million starfish all along the shore. Someone saw him throwing as many as he could back into the water. They told the child that he wasn't impacting the situation, and that he might as well stop. But the child reminded him that his actions made a world of difference to each the creatures he returned."

Susan Alton (Health Director) and Chantel Gaudreau (Clinical Team Lead), Mino M'shki-ki

Operational Management

Financial planning and management

IPHCOs are funded to provide specific programs and services to clients which are outlined in their respective funding agreements. Budgets related to the MOH-IPHCO funding agreement consist of base funding that allows for required flexibility of expenditures between programs, a specified amount for physician services, and funding for designated programs funded by the MOH, which are included as distinct budget lines within the agreements. Annual spending must fall within the limits of each approved budget line.

Quarterly financial reports, annual reconciliation reports, and audited financial statements are required to verify that spending is appropriate and in alignment with approved budgets.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: FINANCIAL PLANNING AND MANAGEMENT

Ensuring that IPHCO spending aligns with their approved budgets is an important responsibility of the Executive Leader. To support this function, the following tasks are recommended as a starting point for new Executive Leaders within existing IPHCOs:

- Review the current budget and understand the expenditures associated with each budget line.
- Review, understand and abide by the IPHCO's financial policies and procedures, the standards or limits that must not be exceeded by the Executive Leader and develop additional policies where needed to ensure appropriate oversight and monitoring of financial management. Refer to Appendix C for a list of relevant policies.
- Work collaboratively with your Directors and Managers to ensure they are aware of their program budgets and are spending according to approved budgets.
- Meet regularly with your Finance Director to ask for updates and to flag any concerns.
- Work collaboratively with the BoD to seek out additional sources of funding, develop proposals, and raise required funds as appropriate for addressing current pressure points and future priorities.
- Provide required updates on program spending to the BoD and OH/MOH and other funders as required.

New Executive Leaders within recently established IPHCOs may be required to develop the required financial policies and procedures to ensure appropriate financial management.

For financial management and planning supports, email info@iphcc.ca.

Human Resources Planning and Management

Managing the human resources of the organization is one of the most important and complex responsibilities of the IPHCO Executive Leader. Staff must be hired, trained, and managed carefully to ensure that their skills, abilities, and aspirations are aligned with the objectives of the organization. It should be noted that in addition to specific workplace requirements, regulated health professionals are also required to uphold professional standards established by their respective Colleges, which function as governing bodies for each respective profession or designation.

Existing pay differentials between primary care and other parts of the healthcare system such as acute care have historically created barriers to the recruitment and retention of qualified staff within the sector. Ensuring competitive pay for primary care practitioners has been the focus of province-wide advocacy efforts for several years and has resulted in the allocation of specific funding by the MOH intended to enable primary care organizations to begin to effectively recruit and retain qualified employees. The current salary grid for MOH funded IPHCO positions was developed in 2018 and is provided in Appendix B. A market review of positions that are universal across community health organizations was published in November 2023, and highlights that current salary bands in the sector remain well under market rates.

Relative to other primary care organizations, human resource management within IPHCOs is made more complex due to the Indigenous focus of organizations, which requires the skills and contributions of staff who have not only required clinical training, but also a vested interest in the health of FNIM clients, families, and communities. Knowledge of current and historical trauma that impacts health outcomes for Indigenous persons is an imperative to ensuring culturally safe care.

In addition to the technical aspect of human resource management, Executive Leaders are also responsible for upholding a positive work environment and effective relationships. Refer to Relationship Building section of this toolkit for further information.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: HUMAN RESOURCE PLANNING AND MANAGEMENT

Ensuring that organizational staff are managed in alignment with the priorities of the IPHCO is one of the Executive Leaders most important roles. To support appropriate human resource management, the following tasks are recommended as a starting point for new Executive Leads within existing IPHCOs:

- Review the established staffing requirements for current programs and services.
- Review, understand, and abide by the IPHCO's human resource policies and procedures, the standards that must be met by the Executive Director and develop additional policies where needed to ensure appropriate oversight and monitoring of the management of staff. Refer to Appendix C for a list of relevant policies.

New Executive Leaders within recently established IPHCOs may be required to develop the required policies and procedures to ensure appropriate human resource management.

For tools to support effective human resource management, email info@iphcc.ca.

Program and Service Design and Management

IPHCOs provide office visits for services such as appointments with physicians and/or nurse practitioners, as well as specific services and programs in alignment with the MWHW, that are designed to meet the needs of their local communities. Sound program planning ideally involves asking the following questions:

- What are the needs of the client population and/or community?
- What will the priorities of the program be?
- What is the intended target population?
- Which staff members will be involved and in what capacity?
- How will cultural safety needs be addressed for Indigenous clients?
- What are the goals of the program? What outcomes are we expecting to achieve?
- How will we measure the performance* of the program? What indicators should be used? What should our targets be?

**Note: Consider using the Two-Eyed Seeing approach, which intentionally and respectfully brings together Indigenous and Western ways of knowing, for selecting appropriate performance indicators.*

To uphold Indigenous sovereignty, it is strongly recommended that IPHCO program and service design incorporate the voices of Indigenous people and communities where possible. Ongoing participation in the form of Indigenous advisory groups is ideal but focus groups and surveys offer time and cost-effective ways of assessing population needs as well. Always remember to consider literacy needs when implementing these strategies. Some community members may require assistance or translation services to participate.

An overview of common service delivery areas associated with the MWHW is discussed in a later section of this toolkit.

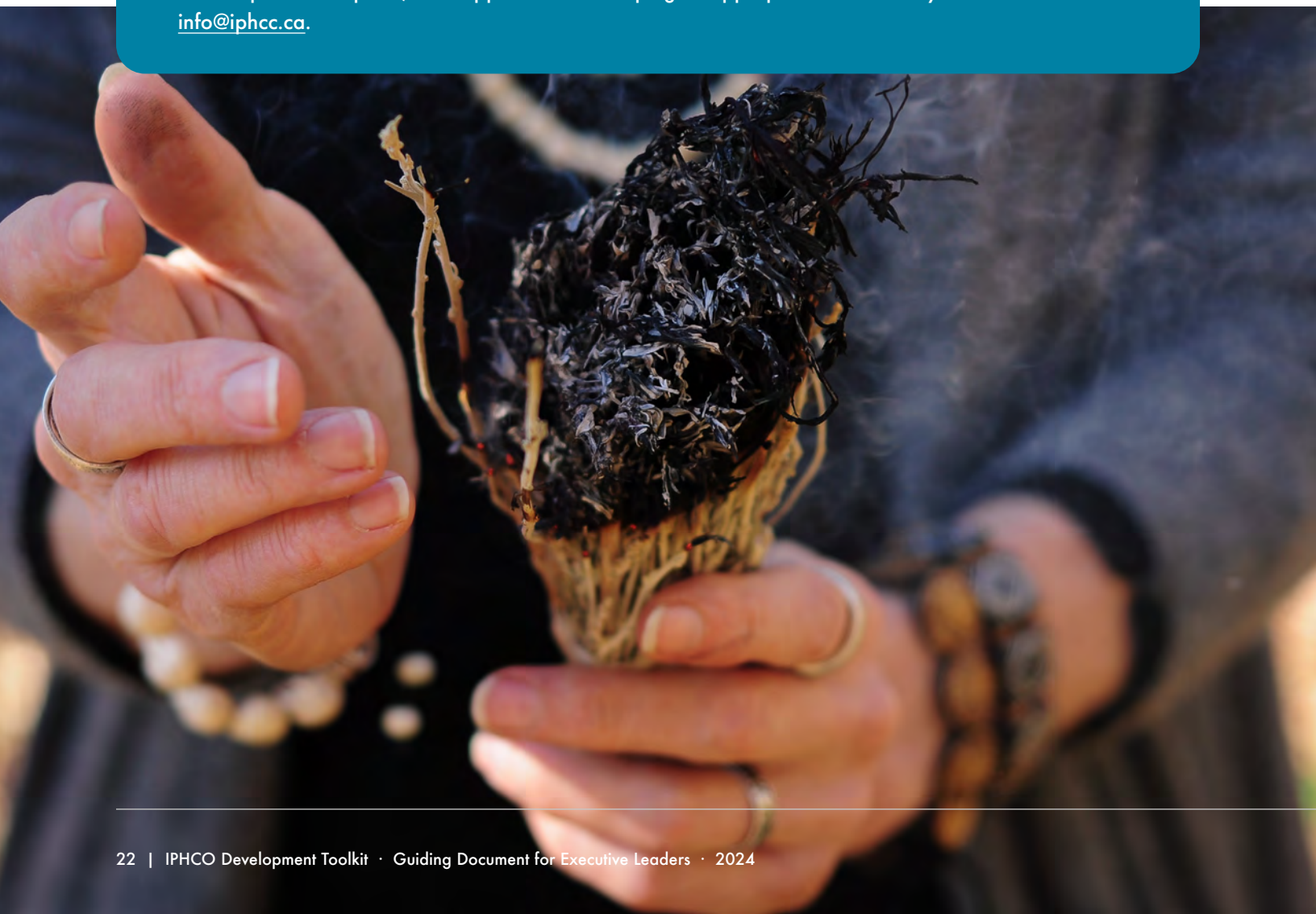
RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: PROGRAM AND SERVICE DESIGN AND MANAGEMENT

Careful planning and management of IPHCO programs and services is important to ensure that they are addressing the needs of the FNIM clients and communities they serve. The following activities are recommended for new Executive Leaders within existing IPHCOs:

- Review the most recent annual IPHCO program report to learn about the programs and services offered to clients.
- Understand the IPHCO's process for program planning, board requirements for reviewing and monitoring the process, and whether/how it incorporates the voices of Indigenous persons.
- Look to peers for examples of specific services and programs offered in alignment with the MWHW.

New Executive Leaders within recently established IPHCOs may be required to develop an organizational service plan.

For sample service plans, and support with developing an appropriate version for your IPHCO email info@iphcc.ca.



Legislative Compliance

Executive Leaders are responsible for ensuring that IPHCOs comply with necessary legislation that applies to health service organizations in Ontario including, but not limited to:

- The Personal Health Information and Protection Act, 2004
- The Occupational Health and Safety Act, 1990
- The Accessibility for Ontarians with Disabilities Act, 2005
- The Connecting Care Act, 2019
- The Human Rights Code, 1990
- Ontario Not-for-Profit Corporations Act, 2010

The BoD should be kept up to date on compliance with applicable laws, regulations, and government directives.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: LEGISLATIVE COMPLIANCE

Ensuring that IPHCOs abide by the laws that exist in Ontario that apply to healthcare organizations protects the organization from legal issues. The following activities are recommended for new Executive Leaders within existing IPHCOs:

- Review existing records pertaining to the organization's compliance with required legislation.
- Work with qualified professionals to address any identified gaps in compliance.

New Executive Leaders within recently established IPHCOs may be required to develop an organizational compliance checklist, a process for the BoD to review and monitor compliance, and associated schedule for completing the annual legislative compliance report.

For tools to support statutory compliance email info@iphcc.ca.

Strategic Management

Strategic planning

Executive Leaders work collaboratively with their IPHCO boards and other parties to develop strategic plans that outline 3–5-year goals for the organization. Strategic planning is most often facilitated by external consultants with specific expertise in the process and involves targeted engagement with selected parties that can include but are not limited to the BoD, Indigenous community members, IPHCO team members, and partner organizations.

The purpose of a strategic plan is to set the direction, or large-scale objectives of the organization by establishing priorities and associated tasks or action items. Strategic plans are achieved through the organization's operational plan as summarized by the annual program report that is submitted to the MOH.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: STRATEGIC PLANNING

Strategic plans set the direction for the organization and are achieved through annual operational or service plans. The following activities are recommended for new Executive Leaders within existing IPHCOs:

- Review the organization's current strategic plan.
- Understand the relationship between the strategic plan and operational plan summarized in the annual program report.

New Executive Leaders within recently established IPHCOs may be required to work with their BoD to develop a strategic plan.

For support with strategic planning email info@iphcc.ca.

Quality Improvement

Quality improvement has been a provincial focus since the introduction of the Excellent Care for All Act, 2010, which requires health care organizations to make demonstrated commitments to improving the quality of their care. One of those commitments was developing and posting annual Quality Improvement Plans (QIPs) that include improvement priorities, objectives, performance measures, and associated targets.

IPHCOs are required to submit QIPs to Ontario Health each year. Health Quality Ontario (HQO), a division of Ontario Health, provides QIP supports such as guidance documents, interactive webinars, a QIP submission platform, searchable databases and other tools and resources on its QIP Navigator.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: QUALITY IMPROVEMENT

Quality Improvement Plans represent a demonstrated commitment by IPHCOs to continuously monitor and improve their services. The following activities are recommended for new Executive Leaders within existing IPHCOs:

- Review the organization's current QIP.
- Understand the process through which the QIP is developed annually.
- Review the current QIP priorities for primary care and access supporting tools on HQO's QIP Navigator.
- Understand requirements for reporting on QIP progress to OH and the IPHCO BoD.

New Executive Leaders within recently established IPHCOs may be required to work with their BoD to develop a QIP.

For QIP tools and supports email info@iphcc.ca.

Risk Management

Risk management involves identifying, assessing, and controlling risks to an organization. It is highly recommended that Executive Leaders create a risk management plan that outlines how risks are being managed and mitigated. This is especially important if the IPHCO intends to seek accreditation status.

Risks can be identified through reviewing documents, brainstorming sessions, feedback from staff, board members and/or partner organizations, and/or data analysis. Common categories of risk faced by IPHCOs and associated examples are provided in the table below.

Risk type*	Example*
Financial risk	OH/MOH funding does not cover the cost of providing services to clients due to factors such as inflation or market increases in rent.
Compliance risk	IPHCO is not able to maintain compliance with relevant legislation due to capacity issues.
Operational risk	Staff vacancies prevent programs and services from being provided as planned. Inability to recruit and retain needed workers may see a temporary halt to that program or service. Ineffective succession planning may impact operations.
Reputational risk	Indigenous communities come to see IPHCO programs and services as colonialized in nature and/or unsafe.
Cybersecurity risk	Personal Health Information is accessed inappropriately by external parties.
Technology risk	Software failure results in loss of information.

**Note: This table is provided for illustrative purposes only and does not include all potential risk types or risk examples.*

Once identified, risks can be prioritized according to how likely they are to occur, paired with indicators that will be monitored to assess their occurrence and a plan created for reducing this likelihood.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: RISK MANAGEMENT

Risk management is essential for ensuring that potential issues facing IPHCOs are identified and managed before their occur. The following activities are recommended for new Executive Leaders within existing IPHCOs:

- Review the organization's current risk management plan.
- Understand the process that was taken by the BoD to create the plan.
- Confirm requirements for reporting operational risks to the IPHCO board.
- Ensure that interdisciplinary providers hold appropriate insurance coverage.
- Review the current IPHCO insurance policies and ensure that they meet the requirements specified in the respective funding agreement(s) it holds.

For sample risk management frameworks from other IPHCOs, email info@iphcc.ca.

Relationship Building

The ability to establish, nurture and sustain positive relationships is arguably the hallmark of a successful IPHCO Executive Leaders. Although not captured formally in many job descriptions, an Executive Leaders's ability to create a positive atmosphere in which learning, and innovation can thrive is key to organizational effectiveness. This section outlines important relationships that impact the success of IPHCOs.

Board of Directors

The relationship between the Executive Leader and the BoD sets the tone for the IPHCO. A positive relationship between these two parties allows the IPHCO to achieve its potential by providing effective leadership, motivation, and a strong example for others in the organization to follow. Strong governance is key to successful management and operations.

Funders

The relationship between the IPHCO and its funder(s) is important for ensuring that the IPHCO is meeting its contractual requirements and keeping lines of communication open for advocacy, including regarding expansion and/or additional funding opportunities.

Staff

Staff are recognized as an exceptionally important resource of IPHCOs, providing care to often medically complex Indigenous people using a trauma-informed approach. IPHCO staff often have a vested interest in the wellness of FNIM clients and communities and remain committed to their roles despite the availability of often higher-paying positions in other sectors of the healthcare system. As such, treating team members with respect, and providing safety and supports for growth, training, and improvement is essential for recruiting and retaining qualified staff.

Ensuring that IPHCO staff receive competitive pay is an important consideration, and significant province-

> When your people feel safe and free to be passionate, they can work magic. If I had advice for a new IPHCO leader, it would be to listen to what people are saying, then filter it through your own experiences. Offer suggestions, be a sounding board, brainstorming, consoling, encouraging all the way. Motivate them to step out of their comfort zone and reassure them that you'll be there to support them if things don't work out as planned.
>
> *Constance (Connie) McKnight – Executive Director, Misiway Milopemahtesewin*

wide advocacy efforts have resulted in a standardized salary grid for primary care practitioners in Ontario. The current version of the grid, which was last updated in 2017, is included in Appendix A.

It should be noted that an updated review is underway within the community sector. In addition, the IPHCC is currently developing a compensation review of traditional practitioners to ensure equitable pay between mainstream and traditional practitioners is rightfully recognized and implemented. The completion of this work will establish the first ever salary grid for Traditional and Cultural Practitioners.

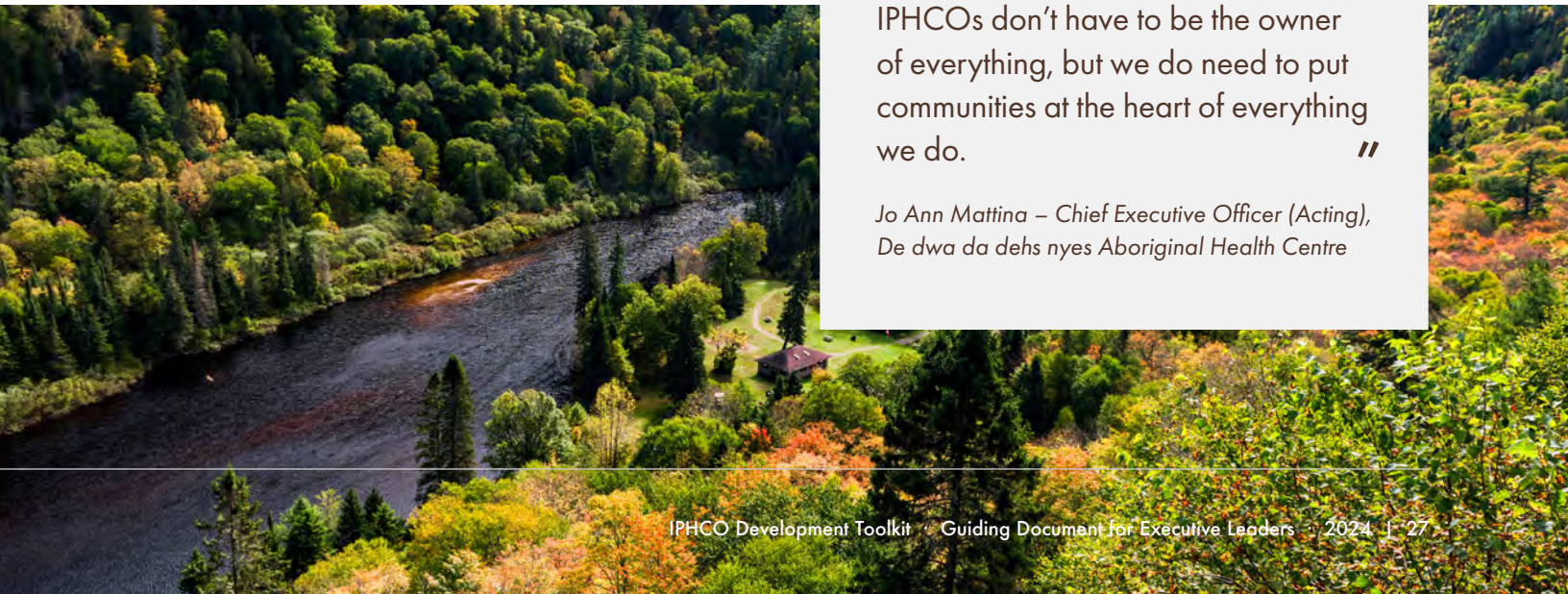
Indigenous partners (communities, organizations, individuals)

It is important that IPHCOs develop, establish, and nurture positive relationships with Indigenous partners which include Indigenous communities, organizations, and people. In the true spirit of partnership, IPHCOs must listen to their partners and provide them with meaningful opportunities to provide feedback. Such actions build trust and help create a feeling of safety for Indigenous people, many of whom distrust healthcare services because of their experiences with colonial policies and ongoing anti-Indigenous racism within health care.

Connections with other Indigenous organizations within the community creates a strong network of providers who can support IPHCO clients with access to social determinants of health such as housing, income support, traditional healing services, education and training.

For more information about how to effectively connect with Indigenous partners, please see the IPHCC's Patient, Family and Community Engagement Toolkit.

> Build relationships, not only with community partners, but with specific Indigenous communities. Talk to their leadership, and health councils. Be a part of their health planning. IPHCOs don't have to be the owner of everything, but we do need to put communities at the heart of everything we do.
>
> *Jo Ann Mattina – Chief Executive Officer (Acting), De dwa da dehs nyes Aboriginal Health Centre*



Refer to the figure below for examples of Indigenous organizations at the community-specific, regional, provincial, and federal levels whose influence shape the operating environments of IPHCOs.

Community-specific organizations	• Chief and Council of on-reserve First Nation communities • On-reserve health centres and nursing stations – in particular establishing a connection with the Health Director • Urban networks like local Friendship Centres, Metis Councils, and Inuit organizations.
Organizations with regional mandates	• Tribal councils (e.g. Sioux Lookout First Nation Health Authority [SLFNHA], Independent First Nations Alliance [IFNA]) • Political Territorial Organizations (e.g. Grand Council Treaty #3, Nishnawbe Aski Nation)
Organizations with province-wide mandates	• Chiefs of Ontario • Ontario Federation of Indigenous Friendship Centres • Ontario Native Women Associations • Métis Nation of Ontario • Indigenous Affairs Ontario (IAO)
Organizations with national/federal mandates	• Indigenous Services Canada (ISC) • Inuit Tapiriit Kanatami • National Association of Friendship Centres • Metis National Council • Assembly of First Nations

> "Our IPHCO has a dedicated community development team that does outreach within Indigenous communities, holding open houses, lunch and learns, screening clinics and other opportunities that we can think of to build relationships and get feedback from communities. This is our informal way of doing 'needs assessments'. It allows us to really listen and to design our programs and services so that they meet the unique needs of the people we serve."
>
> *Tera Osborne – Executive Director, Tsi Kanonhkhwatsheriyo Indigenous Interprofessional Primary Care Team*

Non-Indigenous partners

Mainstream organizations also serve IPHCO clients, and IPHCOs have a role to play in ensuring that mainstream services meet the needs of Indigenous persons. For decades, IPHCOs have partnered with organizations who can support them both strategically and operationally.

Many organizations within today's healthcare environment face stagnant operating budgets, increased administrative burdens, and higher levels of patient complexity than ever before. It is increasingly being recognized that partnerships between Indigenous and other organizations (both Indigenous and non-Indigenous) are key for optimizing patient care, with examples of collaborative service models and shared budgets now relatively common. The current Ontario Health Team model provides a platform for collaboration with partners across the continuum of care. Refer to the Ontario Health Teams section of this toolkit for more information.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: ESTABLISHING AND NURTURING EFFECTIVE PARTNERSHIPS

Successful IPHCO leaders inspire those around them, creating positive and effective relationships that help them advance the goals of their organizations. The following tasks are recommended for new Executive Leaders to assess the relationships that currently exist, and plan for meaningful engagements to further them:

- Reach out to members of the BoD, staff and your funder(s) to make introductions and determine mutual expectations for the respective working relationships.
- Reach out to info@ophcc.ca to determine which community-specific, regional, provincial and federal organizations are relevant to your organization, and to understand the partnerships that exist between them.
- Contact the organizations identified above to understand:
  - Relationship history
  - Current priorities and pressure points that may impact service delivery
  - Opportunities for engagement

Jurisdictional Considerations

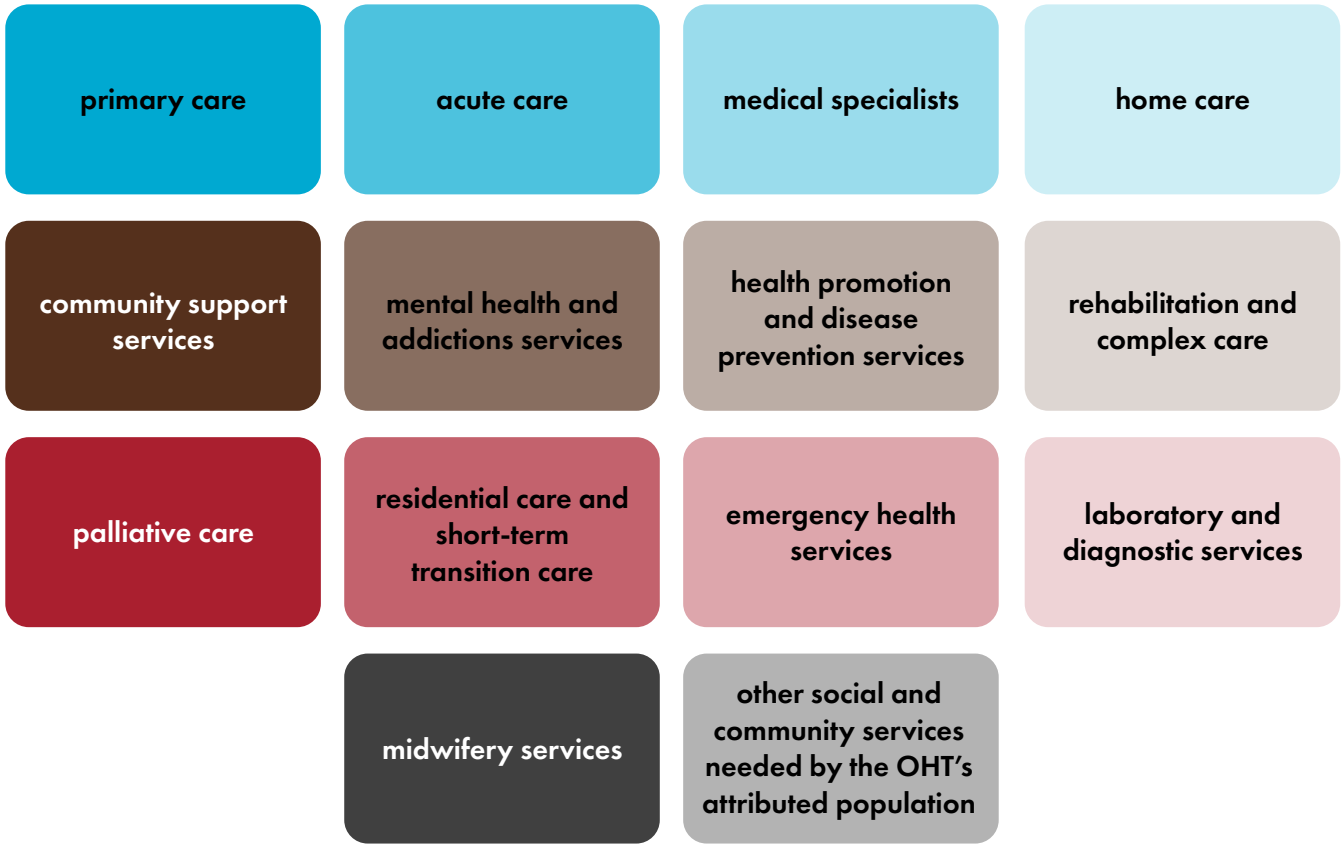
As outlined above, IPHCOs must navigate relationships with a complex network of groups and organizations where relationships can be affected by potential (or perceived) competition for resources. In arenas where mandates can be unclear, certain organizations such as Tribal Councils and Provincial/Territorial Organizations (PTOs) have extensive involvement with policy tables at the federal and provincial levels, and thus have significant impact on IPHCO operating environments. Therefore, it is important that IPHCOs maintain positive and effective relationship with these partners to ensure that the IPHCO voice is incorporated in decision-making.

Geographical considerations are also important to consider. For example, many funding formulas are population-based which results in organizations in the northern region of the province being relatively under-funded compared to organizations in the more population-dense southern regions. Northern IPHCOs also serve larger geographic areas relative to the south, requiring more travel to reach isolated residents and increasing the overall cost of providing services.

SECTION 4: ONTARIO HEALTH TEAMS

Ontario's Connecting Care Act, 2019[3] established new entities known as Ontario Health Teams (OHTs) as the provincial model for delivering health care services. The province is now fully covered by 58 approved OHTs at various stages of maturity.

Under the model, healthcare providers within a given OHT work as a single coordinated team to provide more coordinated and integrated care to a defined 'attributed' population. The following types of providers are eligible to participate in OHTs:



Primary Care Representation in OHTs

Based on recognition of the fundamental importance of primary care to effective and integrated health care systems, Primary Care Networks (PCNs) were introduced in 2024 as a way of establishing a common vision, objectives, and common functions for primary care within each OHT.

Although participation is voluntary, IPHCOs are strongly encouraged to become aligned with or participate in OHTs where the capacity exists to do so. Participation in PCNs are intended to function as vehicles for the implementation of local and provincial priorities, organize the local primary care sector within each OHT, and provide a voice for primary care to participate in OHT decision-making by fulfilling the following five functions[4]:

3 https://www.ontario.ca/laws/statute/19c05
4 https://www.ontario.ca/files/2024-01/MOH-primary-care-networks-guidance-en-2024-01-23.pdf

1. Connecting primary care within the OHT.
2. Serving as a forum for the local primary care sector's voice in OHT decision-making.
3. Supporting OHT clinical change management and population health management approaches.
4. Facilitating access to clinical and digital supports and improvements for primary care.
5. Supporting local primary care health human resource (HHR) planning within the OHT.

RECOMMENDED TASKS FOR NEW EXECUTIVE LEADERS: PARTICIPATING IN YOUR LOCAL OHT

OHTs provide effective forums for connecting with local providers and organizations, participating in regional decision-making, and accessing specialized resources and supports. The following tasks are recommended for new IPHCO Executive Leaders to understand their local OHT landscape:

- For Executive Leaders of new IPHCOs: Find your local OHT/s (Note: Some organizations may be affiliated with more than one OHT based on their existing partnerships and clinical pathways. Reach out to prospective OHTs to confirm their members so that you can understand where your IPHCO is best situated).
- Email info@iphcc.ca to better understand the OHT landscape in your region.
- For new Executive Leaders at existing IPHCOs: Connect with your board chair or administrative staff within the organization to learn which OHT your IPHCO is associated with.
- Meet with an OHT primary care representative to understand:
  - Appropriate forums for participation
  - Current priorities
  - Available supports

Respecting Indigenous Rights and Provincial Commitments in OHTs

Proposed regulations are currently silent with respect to the role for FNIM organizations in the new structure of OHTs. They are also silent on how the changes to OHTs will lead to more equitable health outcomes for Indigenous patients in Ontario. IPHCC is currently advocating for an equitable population health management approach for OHTs that prioritizes Indigenous approaches which are directed and managed by Indigenous people.

SECTION 5: DATA CONSIDERATIONS

Data Sharing and Privacy Protection

We must ensure that Data Sharing Agreements (DSAs) are established to protect Indigenous data and privacy, it is crucial for senior leadership and Executive Directors (EDs) to have policies and frameworks in place to support these agreements. These agreements safeguard the sovereignty, cultural integrity, and rights of Indigenous communities, ensuring data is handled respectfully and ethically.

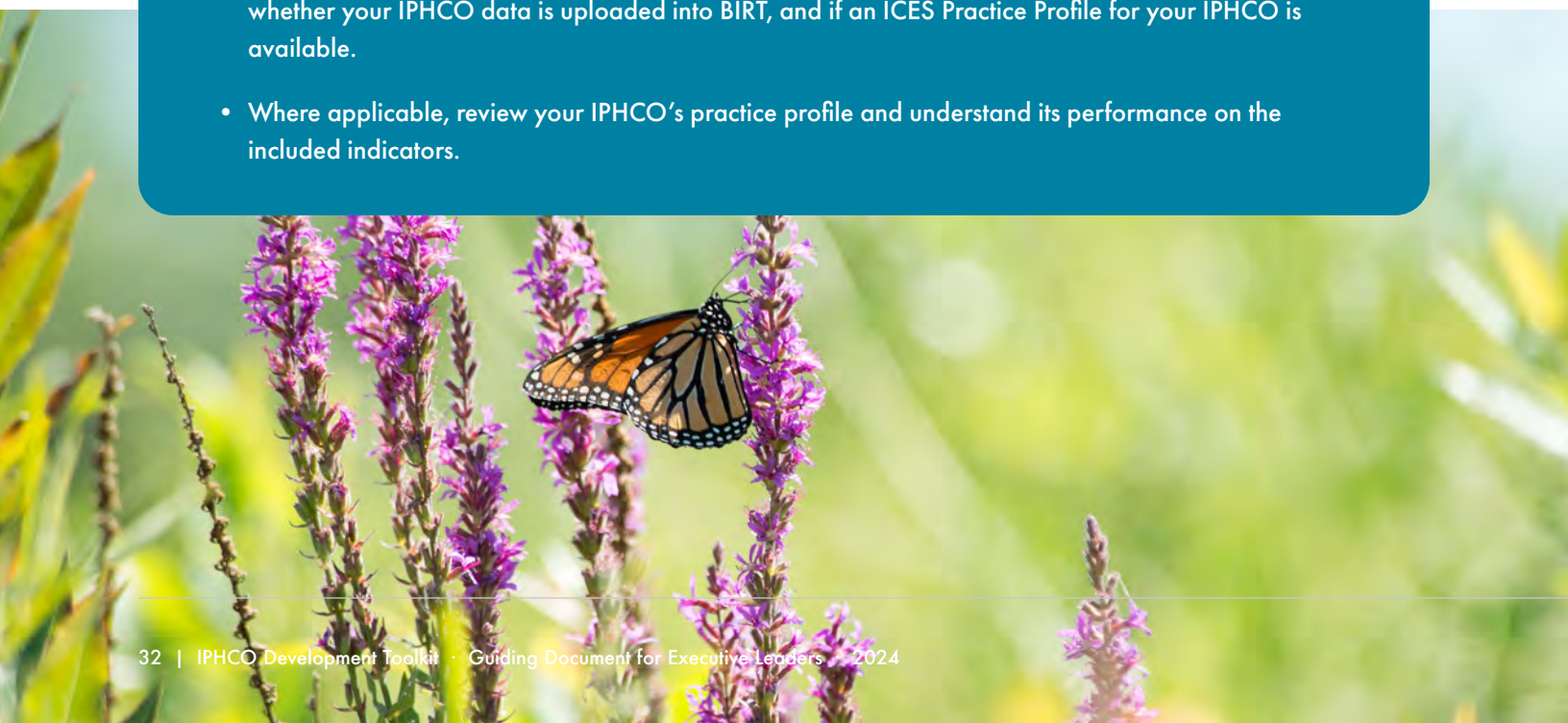
Indigenous data represents more than statistics—it embodies the heritage and knowledge of Indigenous peoples. DSAs outline consent processes, data ownership, and usage rights, ensuring IPHCO's and the communities they serve maintains control over their data.

DSAs also promote transparency and accountability, building trust and strengthening relationships with Indigenous partners. For EDs, championing these agreements aligns organizational practices with global standards on data governance and Indigenous rights.

RECOMMENDED TASKS FOR EXECUTIVE LEADERS: UNDERSTAND YOUR DATA

When analyzed and interpreted correctly, IPHCO EMR data can provide important insights into client characteristics and service delivery. The following activities are recommended to new IPCHO Executive Leaders for establishing an understanding of IPHCO data:

- Confirm the EMR software that your IPHCO uses to document client encounters.
- Email the IPHCC's Provincial Quality Decision Support Specialist, Al Syed asyed@iphcc.ca to confirm whether your IPHCO data is uploaded into BIRT, and if an ICES Practice Profile for your IPHCO is available.
- Where applicable, review your IPHCO's practice profile and understand its performance on the included indicators.



The Role of the Data Management Coordinators

Data Management Coordinators (DMCs) play a crucial role in Indigenous Primary Health Care Organizations (IPHCOs), ensuring that data related to primary care is meticulously managed. This role is particularly important within Indigenous contexts, where cultural sensitivity, community trust, and data sovereignty are paramount. The DMCs are tasked with supporting their local IPHCO in achieving quality improvement and operational funding objectives through the processes of data standardization, extraction, and analysis.

Below are a few roles and responsibilities of the Data Management Coordinator:

Key Roles	Responsibility	Details
Data Cleaning and Standardization	Ensure all data collected from various sources are cleaned and standardized to meet specific criteria for quality and consistency.	This involves removing inaccuracies, inconsistencies, and duplicate entries to create a reliable dataset. Standardization ensures that data formats and definitions are uniform, facilitating accurate analysis and reporting.
Cultural Sensitivity and Community Engagement	Incorporate cultural considerations into data management practices and engage with the community to build trust and ensure data is used ethically.	Respecting Indigenous cultural values is essential. This involves consulting with community leaders to align data practices with cultural norms and ensure the community retains control over their data.
Data Extraction and Analysis	Extract relevant data for analysis to support decision-making processes and meet reporting requirements.	The DMCs retrieve data from electronic medical records (EMRs) and other databases, analyze it to identify trends and areas for improvement, and generate reports that inform policy and practice within the IPHCO.
Quality Improvement Initiatives	Support quality improvement initiatives by providing accurate data and analysis that guide improvements in primary care services.	By analyzing data, DMCs identify areas where services can be enhanced, track progress over time, and help implement evidence-based changes. They collaborate with healthcare providers to ensure data-driven improvements are effectively integrated into care delivery

ICES Practice Profiles

The Practice Profile report is produced annually by the IPHCC and the Institute for Clinical Evaluative Sciences (ICES) for select IPHCOs. It combines IPHCO EMR data with provincial billing and administrative data to provide information on the clients served by IPHCOs.

The report and its associated appendices include aggregate data on the following categories of indicators for IPHCO clients:

- Complexity (SAMI), which reflects illness burden and expected need for primary care services.
- Other health care utilization, including use of acute care services.
- Sociodemographic characteristics
- Cancer screening
- Opioids dispensed

SECTION 6: IPHCC MEMBERSHIP

Role of the IPHCC

The IPHCC was established to support the advancement and evolution of Indigenous primary health care service provision and planning in Ontario, through partnerships, education, and advocacy. The IPHCC is the only provincially funded entity with members dedicated solely to providing culturally safe and appropriate primary health care and traditional healing to FNIM people, no matter where they reside in the province.

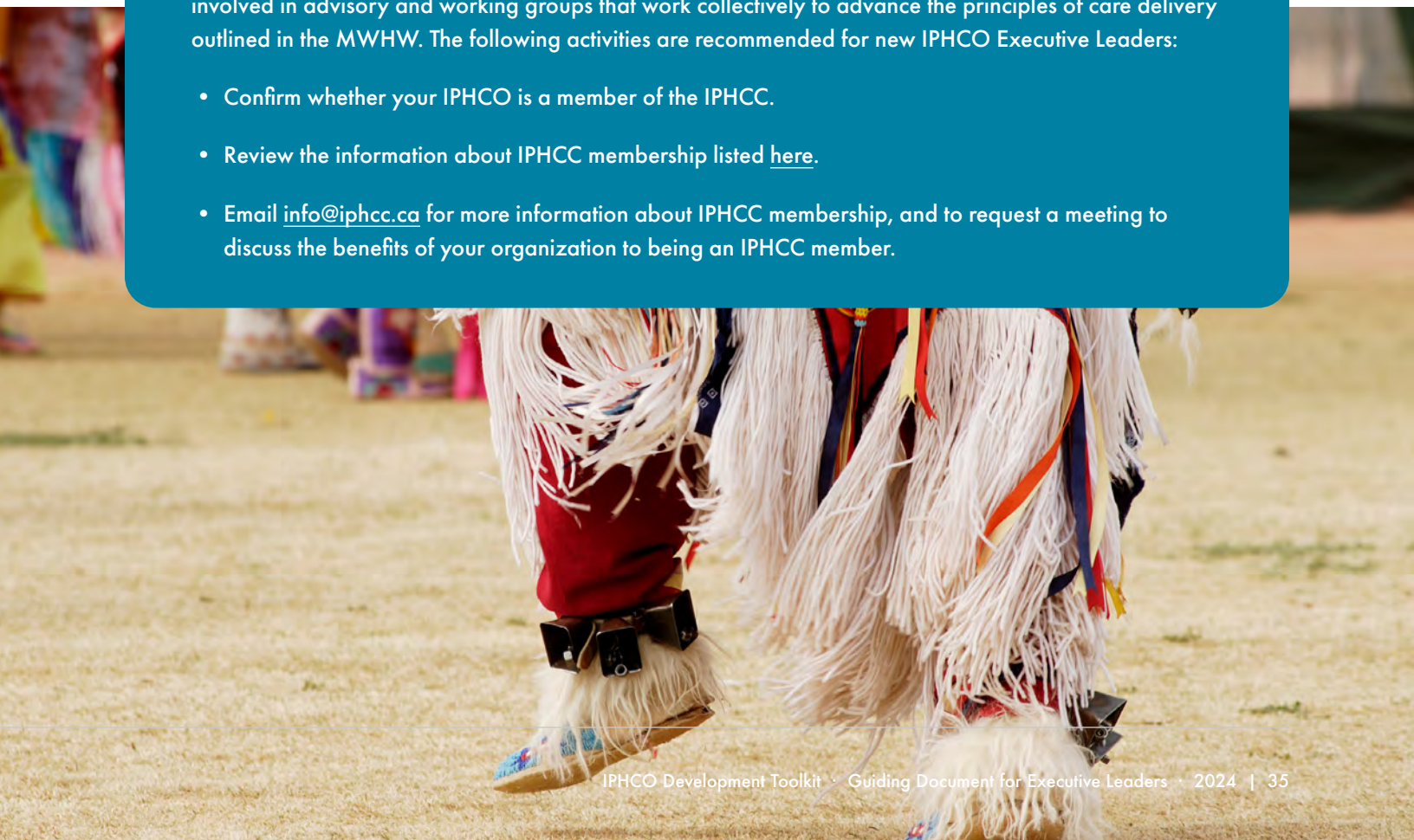
IPHCC/Alliance Dual Membership

Based on the recognition that the IPHCC and the Alliance for Healthier Communities offer distinct but complementary supports to their members, a joint application process has been developed through which new IPHCOs obtain membership and are able to access resources developed by both organizations should they wish to pursue membership with both organizations. For more information about the joint membership fee process, please contact the IPHCC at info@iphcc.ca.

RECOMMENDED TASKS FOR EXECUTIVE LEADERS: IPHCC MEMBERSHIP

IPHCC membership provides many tailored supports and tools for IPHCOs, as well as opportunities to be involved in advisory and working groups that work collectively to advance the principles of care delivery outlined in the MWHW. The following activities are recommended for new IPHCO Executive Leaders:

- Confirm whether your IPHCO is a member of the IPHCC.
- Review the information about IPHCC membership listed here.
- Email info@iphcc.ca for more information about IPHCC membership, and to request a meeting to discuss the benefits of your organization to being an IPHCC member.



Membership Advantages

IPHCC members have access to a wide range of supports and opportunities tailored to IPHCOs. The following diagram summarizes a list of advantages of IPHCC membership for organizations.

- Member of the IPHCC full council
- Right to vote in the IPHCC's annual general meeting
- Ability to run for and hold a position on the IPHCC board
- Networking and knowledge-sharing opportunities
- Ability to post an unlimited number of job postings on the IPHCC job opportunities web page
- Access to an online members portal containing a repository of resources including fact sheets, tools, legal reviews, webinars, sample policies and procedures, templates and sector-specific reports
- Full and formal inclusion in all advocacy efforts through the IPHCC including letters to government, sectoral proposals and letters of support
- Opportunities to participate in Indigenous-driven sector-relevant research projects
- Access to opportunities to engage in capacity building and resource sharing across Ontario's primary health care sector
- Opportunities to participate in advisory circles and working groups to develop Indigenous-specific models of care
- Opportunity to be a designated regional hub for anti-Indigenous racism training and the promotion of organizational change efforts
- Eligibility to participate in IPHCC-coordinated funding opportunities for federal, provincial and other funding grant agencies
- Professional development opportunities surrounding topics that include but are not limited to trauma-informed care provision, self-care and other sector-specific webinars
- Access to resources, tools and training developed by the IPHCC
- Opportunity to participate in the IPHCC sector data program that provides organizations with:
  - Harmonized Indigenous indicators to evaluate care delivery
  - Data reports focused on health outcomes
  - Data sharing agreement based on FNIM data sovereignty principles

Engagement Opportunities

The IPHCC provides many opportunities for engagement and has several committees and other advisory groups comprised of representatives from our member sites and their communities. Current working groups are summarized in the following table:

Group	Mandate
IPHCC Planning and Evaluation Committee	Supports the IPHCC Board and membership to deliver on their responsibilities relative to planning, evaluation, and related activities. The Committee focuses specifically on policy and process matters related to collecting, managing, and sharing data that facilitates the IPHCC's strategic priorities.
Knowledge Keepers Circle	Provides advice and guidance to shape the broad strategic direction of the work of IPHCC and ensure it is grounded within a cultural framework. This includes future development of the strategy as well as structural relationship(s).
Storytellers Circle	Informs and supports IPHCC projects and initiatives through storytelling. These stories ground the work of IPHCC in the experiences of Indigenous individuals, families, and communities as they navigate the health care system in Ontario.
Integrated Clinical Council	Provides clinical advice and guidance to the IPHCC and its members on an as needed basis to support optimal care delivery for Indigenous peoples accessing services through member sites.
Traditional Healing and Wellness Advisory Council	Leads the development of an infrastructure that will enhance, sustain, and promote growth in the Traditional Healing sector.
Mental Health Advisory Council	Explores strategic opportunities to build MHW service capacity, provides input into project specific initiatives, and shares information from across the network.
Clinical Leads Community of Practice	Network of support for clinical leadership to share wise practices and lessons learned.

Group	Mandate
Data Management Coordinator working group	Shares relevant IPHCC, Alliance and BIRT updates and discusses common issues, questions, and challenges related to PSS, workflows, reporting, training, and other role/sector-specific responsibilities.
Research and Ethics Committee (in development)	Ensures that research conducted by or on behalf of the IPHCC is ethical, respectful, and responsive to the needs and priorites of Indigenous communities.

The IPHCC also curates a list of resources relevant to IPHCOs which is available to the public here. IPHCOs have an important function in Ontario, ensuring that Indigenous people have access to evidence-informed and culturally safe primary care. The IPHCC supports IPHCOs in their mandate and provides customized tools and resources that can assist Executive Leaders with the operational and strategic management of their organizations. For more information about the advantages of membership please email info@iphcc.ca.

APPENDIX A: IPHCO FUNDING SOURCES

The majority of IPHCOs receive funding from the MOH-Primary Care Branch. However, some IPHCO are financially supported by other provincial, regional, and federal (national) funders. The table below outlines a list of common funding sources, the description of each stream and the respective reporting requirements for each.

Program (agreement)	Funder (term)	Description/Purpose of funding	Reporting requirements and schedule
Home & Community Care	Indigenous Services Canada (First Nation/ Inuit Health Branch) (2020-25)	• **provide community-based home care service on reserve** (and to community members living in town) for requesting communities	• annual activity report **(HC-P016 – FNIHCC Annual Report)**; due **Jul 29** • audited financial statements due **Jul 29** • Service Delivery Plan (must be reviewed/updated whenever there are any changes to the program, new staff, budget, reallocation of funds, etc.)
Community Health Nursing		• provide **public health services** such as immunization and communicable disease control on reserve	• annual activity report **(HC-P086-4 – Community Based Reporting Template (CBRT))** due **Jul 29** • audited financial statements due **Jul 29** • current reporting schedule specifies Mental Wellness program – this is not a funded activity, and reporting is NOT required
Children's Oral Health Initiative		• provide **oral health assessments, education and fluoride varnish, and interim stabilization therapy to children aged 0-6 on reserve**	• audited financial statements due **July 29** • semi-annual submission of **HE-P012** Children's Oral Health Initiative (COHI) & Oral Health Professional Form due **Sep 15** and **Apr 15** • HE-P012 is a declaration that detailed program data (OHDSR/Oral Health Daily Service Record and OSR/Oral Screening Record) has been uploaded by providers throughout the period

Program (agreement)	Funder (term)	Description/Purpose of funding	Reporting requirements and schedule
Transition facilitator	Indigenous Services Canada (First Nation/ Inuit Health Branch)	• supports **improved integration of services between hospital and community** including both on-reserve and off-reserve care providers (managed under FNIHCC within ISC)	• annual activity report (**HC-P016 – FNIHCC Annual Report**); due **Jul 29** • audited financial statements due **Jul 29** • new program since CFA signed in 2020
FASD/Child Nutrition	Ministry of Children, Community, and Social Services (2020-23) (2021-24)	• FASD/Child Nutrition no longer specifically identified but is meant to be the focus of this allocation within, *"community led, prevention-focused supports to improve overall health and well-being (through) culturally grounded, wholistic and prevention-focused programs and services for Indigenous children, youth and families*	• semi-annual financial reports due **Nov 30** and **Jun 15** • audited statements due **Jul 31** • annual data/narrative due **Jun 30**
HIV/AIDS Education	AIDS Bureau	• supports **primary and secondary prevention related to HIV/ AIDS in 14 area First Nations** by promoting sexual/reproductive health and harm reduction in relation to substance use	• Program plan submission due **Mar 10** • OCHART H1 due **Oct 31**; OCHART H2 due **Apr 30** • Annual Reconciliation Report (ARR) and audited statement due **Jun 30** • Financial projection report due **Oct 15**
Mental Health Case Management	Ontario Health (formerly the Local Health Integration Networks or LHINs) Multi-Sector Service Accountability Agreement or MSAA	• provides **primary mental health care** as defined by provincial mental health strategy	• Community Annual Planning Submission (CAPS) submission – *notice provided when required/ agreement is renewed* • 3 quarterly OHRS/MIS trial balance submissions including financial and indicator reporting through SRI (**due after end of Q2 and Q3, and two months after year-end**) • annual Declaration of compliance **due after year-end** • Annual Reconciliation Report (ARR) and audited statements due **Jun 30**

Program (agreement)	Funder (term)	Description/Purpose of funding	Reporting requirements and schedule
Healing Lodge	Collaboratively between the Ministry of Children, Community, and Social Services and the Indigenous Health and Wellness Strategy	• offer client-based services in residential and non-residential settings using traditional healing approaches to address the underlying impacts of sexual assault, physical, mental and emotional abuse, and family instability.	• interim financial report (to end of Q3) due **Jan 31** • year-end financial report due **Jun 15** • audited statements due **Jul 31** • quarterly service indicators due **Jul 31, Oct 31, Jan 31, Apr 30**
MH/A Treatment		• provide culturally safe residential mental health and addictions treatment services for First Nations, Métis, and Inuit peoples using a combination of Indigenous healing and clinical approaches in order to improve the overall health and wellness of individuals, families and communities	
Hostel		• provide short-term accommodation (including meals) and client-based services for Indigenous people accessing health care away from their homes in Timmins and Kenora	
Housing support services	Ontario Aboriginal Housing Support Services (OAHSS)	• provide support services within supporting housing complex aimed at supporting homeless people to improve health and quality of life in a housing first strategy	• quarterly financial and activity reports **(due 2 weeks after end of quarter)** • performance/health metrics • audited statements due **120 days after year-end** • annual investment plan (budget/ workplan for future year) due **Feb 3**

APPENDIX B: CURRENT SALARY GRID FOR MINISTRY FUNDED IPHCO POSITIONS

In 2018, the Ministry of Health released a planning document outlining salary maximums for ministry-funded primary care practitioner positions. This appendix includes the current salary grid for IPHCOs.

It should be noted that an updated review of this tool is underway within the community sector. In addition, the IPHCC is currently developing a compensation review of traditional and cultural practitioners to ensure equitable pay between mainstream and traditional practitioners.

Position	2017/18 Funded Rate	2018/19 Funded Rate	2019/20 Funded Rate	2020/21 Funded Rate
INTERDISCIPLINARY PROVIDERS				
Case Worker/Manager	$ 61,944	$ 64,075	$ 73,323	$ 74,148
Chiropodist	$ 69,335	$ 71,720	$ 73,323	$ 74,148
Chiropractor	$ 78,777	$ 81,990	$ 82,810	$ 83,742
Clinical Assistant	$ 38,217	$ 39,532	$ 40,827	$ 42,519
Community Health Planner	$ 68,181	$ 70,526	$ 72,836	$ 81,233
Community Health Worker	$ 55,857	$ 57,778	$ 58,949	$ 59,612
Counsellor/outreach worker	$ 55,857	$ 57,778	$ 58,949	$ 59,612
Early Childhood Development Worker	$ 55,857	$ 57,778	$ 58,949	$ 59,612
Health Promoter / Educator	$ 69,335	$ 71,720	$ 73,323	$ 74,148
Kinesiologist	$ 69,335	$ 71,720	$ 73,323	$ 74,148
Nurse Practitioner	$ 103,822	$ 108,494	$ 115,329	$ 122,178
Occupational Therapist	$ 69,335	$ 71,720	$ 73,323	$ 74,148
Pharmacist	$ 92,260	$ 95,257	$ 96,210	$ 97,292
Physician Assistant	$ 77,721	$ 78,498	$ 79,283	$ 80,175
Physiotherapist	$ 77,721	$ 78,498	$ 79,283	$ 80,175
Psychologist	$ 140,809	$ 142,217	$ 143,639	$ 145,075
Psychologist (CHC/AHAC)	$ 103,822	$ 108,494	$ 115,329	$ 122,178
Registered Dietitian	$ 69,335	$ 71,720	$ 73,323	$ 74,148
Registered Nurse	$ 69,335	$ 71,720	$ 73,323	$ 74,148
Respiratory Therapist	$ 69,335	$ 71,720	$ 73,323	$ 74,148
RPN	$ 49,115	$ 50,805	$ 52,469	$ 53,159
Social Worker	$ 71,756	$ 72,462	$ 73,323	$ 74,148

Position	2017/18 Funded Rate	2018/19 Funded Rate	2019/20 Funded Rate	2020/21 Funded Rate
Speech Pathologist	$ 69,335	$ 71,720	$ 73,323	$ 74,148
Supervisor / Lead	$ 68,181	$ 70,526	$ 72,836	$ 81,233
Traditional Healer	$ 68,712	$ 71,076	$ 73,404	$ 82,000
MANAGEMENT AND ADMIN				
Admin/Support for Blended Salary Model Physician	$ 38,217	$ 39,532	$ 40,827	$ 42,519
Administrative Assistant	$ 45,926	$ 47,506	$ 49,062	$ 52,568
Administrative Lead	$ 83,035	$ 86,606	$ 90,330	$ 93,853
Bookkeeper	$ 46,244	$ 47,835	$ 49,402	$ 52,568
Data Management Coordinator	$ 67,775	$ 70,689	$ 72,958	$ 74,148
Director	$ 81,814	$ 85,332	$ 89,001	$ 92,472
Executive Assistant	$ 52,426	$ 54,229	$ 56,005	$ 58,656
Executive Director – level 1	$ 83,035	$ 86,606	$ 90,330	$ 93,853
Executive Director – level 2	$ 94,536	$ 98,601	$ 102,841	$ 106,852
Executive Director – level 3	$ 110,218	$ 114,957	$ 119,900	$ 124,576
Finance Manager	$ 70,613	$ 74,042	$ 77,226	$ 80,238
HR Manager	$ 70,989	$ 74,042	$ 77,226	$ 80,238
IT Specialist	$ 60,960	$ 63,057	$ 65,448	$ 66,184
Maintenance Worker	$ 35,804	$ 36,162	$ 36,524	$ 36,889
Manager	$ 70,989	$ 74,042	$ 77,226	$ 80,238
Medical Record Clerk	$ 38,035	$ 39,343	$ 40,631	$ 42,519
Medical Secretary	$ 38,217	$ 39,532	$ 40,827	$ 42,519
Office Administrator	$ 52,426	$ 54,229	$ 56,005	$ 58,656
Program Coordinator	$ 70,989	$ 72,557	$ 73,323	$ 74,148
Quality Improvement Decision Support Specialist	$ 77,721	$ 78,498	$ 79,283	$ 80,076
Receptionist	$ 38,035	$ 39,343	$ 40,631	$ 42,519
Regional Decision Support	$ 67,775	$ 70,689	$ 72,958	$ 74,148
Secretary	$ 38,217	$ 39,532	$ 40,827	$ 42,519
Volunteer Coordinator	$ 52,426	$ 54,229	$ 56,005	$ 58,656

APPENDIX C: RECOMMENDED LIST OF ORGANIZATIONAL POLICIES & PROCEDURES

Category	Function	Policy Name
Board Governance	Structure	• Board of Directors List • Nominations to the Board • Board Committees • Various Board Committee's Terms of References

	Responsibilities	• Role of the Board of Directors
		• Role of Officers
		• Director Responsibilities
		• Board Code of Conduct
		• Conflict of Interest
		• Complaint Policy
		• Board Committee Principles and Structure
		• Board / Staff Relationship
		  • BSR #1 Global Board-Staff Relationship
		  • BSR #2a Unity of Control
		  • BSR #2b Accountability of the Chief Executive Officer
		  • BSR #2c Delegation to the Chief Executive Officer
		  • BSR #2d Monitoring Chief Executive Officer Performance
		  • BSR #2e CEO Executive Succession
		• Annual Board Planning
		• Quality Improvement of the Board
		• Role of the Executive Director / Position Description
		• Executive Limitations

	Bylaws	
	Strategic Plan & Directions (Ends)	
	Governance Policies	• Personnel Policy • Occupational Health and Safety Policy • Workplace Violence and Harassment Policy • Risk Management / Quality Assurance Policy • Personal Health Information Protection Policy • Confidentiality Policy • Conflict of Interest Policy • Accessibility for Patients with Disabilities

Category	Function	Policy Name
Risk Management	Financial and Administrative Control Policies	• Annual Audit Policy • Budget Approvals and Reporting Policy • Capital Assets Policy • Investment Policy • Cheque Signing Policy • Corporate Credit Card Use • Purchasing Supplies and Resources • Records Retention • Use of Corporate Assets • Emergency Preparedness Plan • Staff Expenses • Contracting for Consulting Services
	Clinical Policies	• Infection Control • Infection Control – Hand Hygiene • Infection Control – Staff Immunizations • Infection Control – Tuberculosis Screening • Staff Protection in the Event of Bodily Fluid Spill • Staff Needle Stick or Other Hazardous Fluids Exposure • Preventing & Managing Medication Errors • Storage of Medication • Credentialing • Reporting of Reportable Diseases • Child Abuse Reporting • Recognizing and Dealing with Abuse • Reporting of a Colleague • Medical Directives

Category	Function	Policy Name
Organizational / Operational Practices	Organizational Chart	
	Staff List	
	Staff Teams and Committees	• Joint Health and Safety Committee
	Clinical Health Services Programs	• New Patient Intake • Patients with no Fixed Address and no Health Card • Consent to Medical Treatment • Ensuring Patient Follow –Up • Triaging Patients • Inter-professional Delegation • HIV Testing • Clinical Record Audit Protocol • Home Visits • Chest Pain Protocol • Anaphylaxis Protocol • Advance Care Directives
	Patient and Community Relationships	• Patient Privacy under PHIPA • Anti-Discrimination Policies • Patient Complaint and Feedback Policy • External Communications • Retention and Destruction of Health Records

Category	Function	Policy Name
Human Resources	Personnel Policy	
	Employment Policy	• Recruiting, Hiring and Orientation Policy • Reference and Background Checks • Job Descriptions • Personnel Files • Termination of Employment • Exit Interview • Reference Letters
	Working Conditions	• Hours of Work • Overtime / Lieu Time • Workplace Attire

	Staff Benefits	• Salaries / Bonuses
		• Government Benefits
		• Paid Holidays
		• Vacations
		• Sick Leave
		• Leaves
		  • Pregnancy
		  • Parental
		  • Family Medical Leave
		  • Emergency Leaves
		  • Additional Leaves
		  • General Provisions while on Leaves

	Staff Relations	• Performance Appraisals • Professional Development • Performance Management • Internal Communications • Code of Conduct • Confidentiality • Issue Resolution • Professional Credentials • Employment of Family Members • Job Accommodation
	Health and Safety	• Responsibilities of Management and Employees • Reporting of a Safety Incident or Accident • Alcohol and Drug Policy • Non-Smoking and Scent Free Environment • Annual Flu Immunization • Emergency Evacuation Procedures • Safe Material Handling Practices

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