



**National Aboriginal Health  
Organization (NAHO)**



*First Nations, Inuit and Métis  
Health Human Resources  
Inventory Advisory Committee  
Year-End Summary*

**Submitted to: The National Aboriginal Health  
Organization**

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# Table of Contents

<b>1. Introduction .....</b>	<b>1</b>
<b>2. Background .....</b>	<b>1</b>
<b>3. First Nations, Inuit and Métis Advisory Committee – Terms of Reference.....</b>	<b>2</b>
<b>4. Important Considerations .....</b>	<b>2</b>
<b>5. Health Human Resources Minimum Data Set for First Nations, Inuit and Métis.....</b>	<b>3</b>
Priority Information Areas .....	3
Definitions .....	5
Demographics.....	6
Education and Training.....	6
Geographic Distribution .....	7
Mobility.....	7
Healthy Workplace Characteristics .....	7
Workload.....	8
Health Professions.....	8
<b>6. Health Human Resource Data Sources.....</b>	<b>8</b>
Consensus about Data Sources .....	9
<b>7. The Approach – The “Count Me In” Campaign .....</b>	<b>9</b>
Consensus for the Approach .....	10
<b>8. Privacy and Data Collection.....</b>	<b>11</b>
<b>9. Communications Strategy.....</b>	<b>12</b>
Consensus on Communications Strategy.....	12
<b>10. Moving Forward .....</b>	<b>13</b>
<b>11. APPENDICES .....</b>	<b>14</b>
<i>Appendix A – Advisory Committee Membership.....</i>	<i>14</i>
<i>Appendix B – Advisory Committee Agendas.....</i>	<i>17</i>
<i>Appendix C – First Nations, Inuit and Métis Health Human Resources Inventory Advisory         Committee Terms of Reference.....</i>	<i>21</i>
<i>Appendix D – First Nations, Inuit and Métis Health Human Resources Inventory Priority         Information Data Elements and Indicators.....</i>	<i>24</i>
<i>Appendix E – Communication Strategy.....</i>	<i>37</i>
<i>Appendix F – First Nations, Inuit and Métis Health Human Resources Inventory Fact Sheet ..</i>	<i>41</i>

## **1. Introduction**

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This paper provides a summary of discussions of the First Nations, Inuit and Métis Health Human Resources Advisory Committee convened by the National Aboriginal Health Organization (NAHO) on October 24-25, 2006 and February 21 -23, 2007. The Advisory Committee had as its purpose to:

- Review and recommend the health human resources minimum data set.
- Discuss the approach to data collection.
- Review the roles and responsibilities.
- Review the results of the national environment scan concerning data sources.
- Discuss progress on the development of privacy policies and procedures.

A list of Advisory Committee members and the agendas for both meetings can be found in Appendix A and B.

## **2. Background**

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In 2004, an Aboriginal Health Human Resources Initiative that would commit \$100 million over five years was announced at a special meeting with the Prime Minister, First Ministers and Aboriginal leaders. This Initiative was to lay the foundation for long-term systemic change in the supply and demand for First Nations, Inuit and Métis health human resources. Health Canada, working with Aboriginal, federal, provincial, territorial organizations/agencies and health professional associations, as well as educational institutions, has three main objectives. They are to:

1. Increase the number of Aboriginal people working in health careers.
2. Improve the retention of health care workers in Aboriginal communities.
3. Adapt current health care educational curricula to improve cultural competence in Aboriginal health care.

NAHO, in partnership with the Canadian Institute for Health Information (CIHI) and the First Nations and Inuit Health Branch (FNIHB), initiated the development of a comprehensive framework on Aboriginal health human resources. This framework includes identifying:

- Core components that lead to First Nations, Inuit and Métis participation in health careers.
- Data elements and sources for a health human resource minimum data set.

The core components are intended to assist the identification of data elements and a planning method for projecting, deploying and monitoring First Nations, Inuit and Métis involvement in health careers. The minimum data set is the foundation for development of the database. NAHO is the data steward for this effort and adheres to the principles of Ownership, Control, Access and Possession (OCAP) in its work. NAHO will also work within similar principles that may be developed by Inuit and Métis.

### **3. First Nations, Inuit and Métis Advisory Committee – Terms of Reference**

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The purpose of the Advisory Committee is to guide NAHO in the development and implementation of the First Nations, Inuit and Métis health human resources minimum data set, the data collection methods and the protection of data within the agreed upon principles such as current privacy legislation and Ownership, Control, Access and Possession (OCAP)<sup>1</sup>. The detailed Terms of Reference can be found in Appendix C.

### **4. Important Considerations**

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*“When you allow someone else to define who you are, you are not you anymore and the burden of proof should be on the other side. There should be enough flexibility in the criteria to invoke your own definitions. We are trying to enhance the professionalism of our healthcare workers without them compromising who they are. [We need to] integrate the traditional way of conducting these affairs.” (Elder)*

The members of the Advisory Committee identified some overarching points that are **essential** to this effort. They are:

- We must be clear about the purpose of this effort (e.g., for whom is the data being collected, for what purpose, etc.). In essence, we need a road map of where we are going and why. We want to make sure that our work is ethical and that it has value for First Nations, Inuit and Métis.
- We need to develop a preamble to this work that tells the history of education for First Nations, Inuit and Métis. As an Elder said, it is important to know where we are coming from.
- It is not our place to limit the identification of indicators or data elements. Rather, it is important that we identify what we need, and develop a process and approach to get there. Further, we cannot prioritize the health professionals. They are all important. No one individual is less important than another.
- We need to be explicit about how these data are collected, who takes care of it (steward), who authorizes use of it in what form, and how it is interpreted.

- We need to take into consideration that many of the indicators and data elements are not relevant when speaking about traditional practices. This means indicators and data elements should be developed to reflect practical/functional experience.
- We need to present the qualitative data/information (decolonized research methods) with the quantitative data/information from the minimum data set.
- We also need to assure the voices of First Nations, Inuit and Métis are distinct, acknowledging that the capacity is not the same for each.
- We need to make sure we minimize the burden for data collection.
- Sustainability is a concern we all share. If this is to be sustainable, we need partnerships and sharing of resources. We need to make sure our work is useful to communities, hamlets and settlements.

This is ambitious work and it is important. As we proceed, we may find areas that are not important or other areas that are. We should also look at what priority information needs were excluded from other data sets (i.e., New Zealand).

## **5. Health Human Resources Minimum Data Set for First Nations, Inuit and Métis**

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The Advisory Committee received an overview of the work-to-date on the development of the minimum data set. This included that the construction of health human resource minimum data sets follow similar criterion, including:

- Identifying data already collected and relevant to HHR planning.
- Specifying priority information areas for measurement, what data to capture (data elements), and where the data resides (sources).

This meant giving priority to existing and potential supply inputs, including but not limited to: date of birth of health professional; certified area of specialization; employment; place of work, and employment position.

Acknowledging that this work is a starting point, the committee members worked in small groups over four days (two meetings) to review and provide input on the draft minimum data set.

The consensus arising from the discussions follow. The specific worksheets for each information area can be found in Appendix D.

### ***Priority Information Areas***

A review of the literature found that Canada, Australia and New Zealand used a similar approach for categorizing what to measure (Table 1). The United States plans to use similar categories with the addition of health care expenditures (HRSA, Bureau of Health Professions, n.d).

**Table 1 – Priority Information Areas by Country**

PRIORITY INFORMATION AREA	CDN	AUS	NZ
Demographics of Health Professionals	✓	✓	✓
Employment/ Practice Characteristics	✓	✓	✓
Education / Training	✓	✓	✓
Geographic Distribution	✓	✓	✓
Migration	✓	✓	✓
Non Migration	✓	✓	✓
Productivity	✓	✓	x

Canada is the only country that has developed indicators. Priority has been given to quantitative indicators such as: number of health personnel by personnel type; percentage of graduates who enter the workforce within one year of graduation; personnel to population ratio; percentage of health professionals entering the workforce as a result of immigration; ratio of health personnel working full time to part time; and hours worked by profession.<sup>2</sup>

The Advisory Committee reviewed the priority areas in the pan-Canadian minimum data set with the addition of those included in the Maori minimum data set. One group indicated the first three priority areas are good and the remaining categories (e.g., migration, non-migration, etc.) should be consolidated to reflect a new category entitled 'healthy workplaces'. The group referenced the Pan-Canadian Healthy Workplace Initiative and indicated this is important for retention. They noted that the definition for migration is not relevant to First Nations, Inuit and Métis. Rather, it is important to know where First Nations, Inuit and Métis are educated, where they are working and where they are from. This category should also include productivity, equipment, supports, job satisfaction, etc. For job satisfaction, develop questions that identify enablers for staying in the job (e.g., do you see yourself making a positive difference, do you consider this your home).

***Consensus About Priority Areas***

At its meeting in February 2007, the Advisory Committee agreed to the priority information areas delineated in Table 2.

**Table 2 – Priority Information Areas**

<b>FIRST NATIONS, INUIT &amp; Métis PRIORITY INFORMATION AREAS</b>	<b>CANADIAN PRIORITY INFORMATION AREAS</b>
Demographics of Health Professionals	Demographics of Health Professionals
Education / Training	Education / Training
Geographic Distribution	Geographic Distribution
Mobility	Migration
	Non Migration
Workload	Productivity
Healthy Workplaces	Employment/ Practice Characteristics

***Definitions***

The definitions should reflect the broader determinants of health and the full scope of the workforce. For example, the definition for demographics is limited to registered or licensed health professionals. This definition should be revised to be inclusive of those within the workforce who are not registered or licensed. Further, education and training does not account for the traditional paths (e.g., traditional healers, etc.).

Terms should be properly defined (e.g., urban, rural, isolated, etc.). For example, Statistics Canada includes large isolated communities within its definition of urban. Also, community should be defined to include hamlets and settlements.

The definition for language needs review to account for each language spoken.

***Consensus on Definitions***

Review the definitions contained within the CIHI health human resources minimum data set, and amend those (e.g., geography, community, language, nation, etc.) for relevance to First Nations, Inuit and Métis.

## **Demographics**

The committee members agreed that the information area is relevant. They agreed that the ratios (i.e., per 10,000) specified within the draft minimum data set are not relevant, and believed that 500 or 1,000 might be a potential relevant number, however they suggested that statistical work be done to identify what the appropriate ratio is. It was further noted that there may need to be a different ratio for Inuit, given the total size of their population.

Language – need to draft a data element(s) to obtain the individual's ability, capacity and opportunity to deliver services in an Aboriginal language and what languages are being used in the service delivery setting. Consider asking whether there was opportunity for education in language of choice.

## **Education and Training**

The members agreed that this information area is relevant and noted that work needed to be done to include:

- Seats for Aboriginal candidates; ratio of seats filled; and seats in other professions.
- Whether the student has financial and social supports; add source and type of funding (e.g., childcare, tuition, mentors, role models, computer access, community nearby, etc.). Mentors and role models should include retired workers. Should also include career awareness at primary/high school.
- Incentives (supports at school) and barriers to entry starting at primary; also need to account for the bridging programs (year to upgrade), whether this year is funded and whether it impacts total funding for completion of post secondary education. Examples of questions could include, did you have to up-grade post grade 12 and/or did you have trouble when you got to university?
- Age of entering training; whether full-time, part-time; breaks from school.
- Whether student has opportunities for placement/practicum in their environment (rural or remote).
- Questions concerning new graduates who work in community (e.g., what supports are available in community, mentors, practicum, etc.).
- Cultural competency and safety. For example, consider obtaining information about non-Aboriginals providing services within community. Were they provided with mentorship/support experience prior to their work in community? Have they been exposed to traditional knowledge and healing practices? Also need to ask students whether the school is safe.
- Whether the individual may have higher education but practices at a lower level (e.g., RN works as an LPN); this may be by choice or due to job availability.

Further, more work needs to be done to include indicators and data elements about primary, secondary and entry to post-secondary education. Consideration should also be given to linking this data with self governance of education.

### ***Geographic Distribution***

The members agreed that this information area should include identifying the community of employment; whether the individual lives on or off reserve<sup>3</sup>; and possible levels of isolation (e.g., fly-in, remote, OR remote, northern, Arctic, etc.)<sup>4</sup>. Consideration should be given to defining geographic area in terms of a First Nations Tribal Council, Inuit Hamlet or Métis Settlement.

Further, they emphasized that we must ensure when using postal codes that there is not residual disclosure. For example, use only the first three digits of the postal code.

### ***Mobility***

The members agreed the name of this information area should be changed from 'migration' to 'mobility'. This change is important as the term 'migration' speaks to migration of birds, etc.

The members also agreed that it is not important to know about immigration of health personnel to Canada. Rather, it is more important to know about the emigration and the migration of health personnel across communities, settlements and hamlets.

We need to determine a method to account for those health professionals who are not registered or licensed, and a way to obtain vacancy rates in communities/regions.

### ***Non-Mobility Attrition***

The members agreed that the information should include why health professionals are no longer practicing within their professions (e.g., coping skills, stress, safety, maternity leave, parental leave, wages, professional support, etc.). Further, it is important to know how many times the individual has moved in and out of the profession, and the attrition to administrative positions.

### ***Healthy Workplace Characteristics***

The members agreed to change the name of this information area from 'employment characteristics' to 'healthy workplaces'. They agreed that the data set should include:

- Indicators about the work place environment (e.g., do you have the equipment to do your job; do you have access to the technology to do your job; do you feel safe at work; do you receive support/guidance needed from your supervisor/manager; do you have a support network at work; do you have access to the information you need to do your job; etc.).
- Data elements concerning supports (e.g., safe and adequate housing, sign-on and/or retention bonuses, etc.).
- Clear definitions for locums, casual, permanent part-time or full-time, contract and self-employed. Consideration should also be given to asking whether the individual is satisfied with their status. We also should be inclusive of traditional and functional expertise.

- Identify where the individual is working – service locations; this could be more than one. For example, do you practice in multiple locations? How many days do you practice in communities?
- A way to obtain information about professionals working below their credentials (i.e., Registered Nurse working as a Licensed Practical Nurse).
- Consideration for whether the practitioner incorporates traditional knowledge within their practice.
- Questions about retention (e.g., why did you stay; why did you go; why are you working full-time).
- Consideration of questions to address the capacity of the community to employ graduates.

### **Workload**

The members agreed that the term ‘productivity’ needed to be changed to ‘workload’, as productivity is not a reflection of how healing occurs. Because of this, the definition and data elements for outputs require further refinement. They agreed the data set needed to include:

- An indicator and data elements for work other than job (e.g., board, voluntary, research, AHHRI, etc.).
- A data element concerning wage parity based on sex.
- Data elements that divide by clinical work vs. other duties
- An indicator that reflects quality of work and not just quantity (for example, productivity is determined not only by the number of patients that you see during a day, but also takes into account the amount of time you may need to spend with each patient to gain trust and thereby provide a better quality of healthcare).

### **Health Professions**

The members agreed they could not prioritize the health professionals for which data should be collected initially. They are all important. No one health profession is less important to have data on than another. The results of the environmental scan on existing data sources will inform where we start.

## **6. Health Human Resource Data Sources**

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NAHO reported working on a national scan of data sources which they expect to be completed by the end of March 2007. FNIHB is also conducting regional scans which should be available about the same time. The members noted the dilemma of the timing and use of different methodologies for collecting the data.

## **Consensus about Data Sources**

The Advisory Committee recommended that the data sources be identified in the worksheets prepared for the next draft of the minimum data set. As this work is done, an analysis should be completed about data gaps.

## **7. The Approach – The “Count Me In” Campaign**

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*“Get information we need, working the right way, with the right people.  
No one-size-fits-all solutions.”*

The representative from the Aboriginal Nurses Association of Canada suggested and the members agreed that a good starting point would be using a campaign approach called “Count Me In”. The members believed this could be linked to Aboriginal Health Day, and honour the contributions of health professionals.

As one of our Elders said:

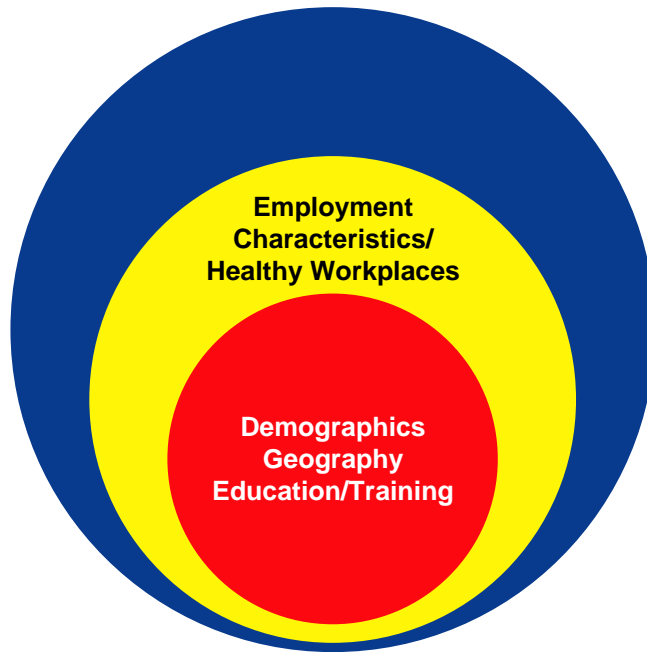
*“What is the objective of the survey? Extract numbers or can we change to more positive? Acknowledge the wonderful work they have done [health workers]. It is easier to criticize than it is to praise. Utilize the moccasin telegrams that are still effective. Even on the guise of numbers, we should transform that this is an acknowledgement of health professionals, licensed or not. Most regions have some form of communication (newsletter etc). This could be expanded to the past and present of healthcare workers. We are not just trying to get numbers; we need to acknowledge the work being done”.*

Members discussed some of the logistics including defining the audience(s) and associated benefits, sample size, data collection and timing. They agreed the goal was to establish a baseline of who is working in health careers, understanding that there will be those who choose not to participate. The members expressed the necessity for clarity of audience(s) and associated benefits. They suggested looking at the National Aboriginal Role Model Program, the Vancouver calendar for the Aboriginal Employee Network, LifeLines and the Cree calendar for further developing the approach. Further, consider questions like:

- Why did I choose health care?
- Who is my role model/mentor?
- I am proud to be a health care worker because ...

The members agreed that the survey design take into consideration that this is the starting point for this effort and that the survey itself should require about 20 minutes to complete. Figure one depicts how the members viewed the evolution of this effort. This is a draft and will be refined based on the campaign and information from the environment scans for data sources. They also concurred that every effort should be made to develop partnerships with others who are collecting related data. This enables parallel processes and a holistic approach to analysis and interpretation.

**Figure 1 – Evolution of Survey Design**



They also noted that if the survey were disseminated directly to individuals, it would eliminate a number of barriers concerning privacy. Dissemination could occur through a variety of means (e.g., professional associations, political, organizations, Centres at NAHO, etc.). It could also be disseminated directly by the Centres at NAHO. Once the data collection approach is approved, NAHO needs to ensure all partners have the necessary information about the campaign and its approach and methodology.

Two points central to the campaign design concern specifying the benefits of being counted, including what will change as a result of this work. Further, the campaign should show the faces of health care workers and acknowledge their contributions.

The members suggested securing technical assistance CIHI, Statistics Canada or another source to assist with the design and methods.

### ***Consensus for the Approach***

Develop a draft of the campaign “Count Me In”. Link this campaign with the Aboriginal Health Day for 2008, and include in the draft the: benefits of participation by audience; campaign approach; survey; and the proposed approach and methods for collecting and analyzing the data. Secure technical assistance (statistician) to assist with the approach and methodology. Prepare an approach that includes working through organizations with a national overlay. This draft campaign is expected to be reviewed at the next meeting of the Advisory Committee.

## **8. Privacy and Data Collection**

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*“We’re never going to have good data as long as we are not allowing communities to gather the information that is needed.”*

A set of principles were developed by the HHR National Roundtable to guide the development and implementation of the health human resource data collection, analysis and dissemination. Those **Foundational Principles** follow:

NAHO is the Aboriginal partner responsible for the development and implementation of the HHR planning model and minimum data set. As the agreed-upon data steward for this effort, NAHO honours the following principles:

1. Our work recognizes and works within the Canadian Constitution, treaties and land claims agreements.
2. Our work is participatory and seeks the voices of First Nations, Inuit and Métis.
3. Our work contributes to self-determination by enhancing social change, the use of language and cultural maintenance and revitalization.
4. We work in partnership while ensuring cultural competency and safety, the development of skills and employment, and the use of language.
5. Our work respects the principles of Ownership, Control, Access and Possession (OCAP).
6. We maintain transparency and accountability to First Nations, Inuit and Métis and those who fund this work.

NAHO indicated the importance of reflecting principles like collective privacy that may be forthcoming from Inuit and Métis. Given the importance of this topic, a small group of volunteers from the Advisory Committee agreed to work with NAHO to begin delineating relevant policies and procedures. The first meeting of this group occurred in December 2006 with the second scheduled for early March 2007. A first draft of those policies and procedures are expected by the end of March.

Further, NAHO has contracted with a lawyer to conduct a privacy impact assessment who has done similar work concerning the First Nations Regional Longitudinal Health Survey.

## **9. Communications Strategy**

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NAHO shared with the Advisory Committee the final communications strategy, including the one page fact sheet (Appendix E & F). The recommended changes to the strategy follow.

- Remove reference to hosting an online survey, as the method has yet to be reviewed.
- Amend reference to providing information in “Aboriginal languages”. Rather indicate that NAHO will provide information in all three languages.
- Assure all material references the name change from the ‘Aboriginal’ to the ‘First Nations, Inuit and Métis’ Health Human Resources Minimum Data Set Inventory.
- Amend list of organizations to reflect government, government institutions and agencies while making sure the titles are correct, include provincial and territorial health authorities under government).
- Amend NAHO is the data steward to NAHO is expected to be the data steward.

### ***Consensus on Communications Strategy***

The Advisory Committee recommended NAHO adopt the communication strategy as amended.

## **10. Moving Forward**

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The following work plan outlines the steps toward approving a First Nations, Inuit and Métis Health Human Resource Minimum Data Set by May 2007.

- 1. HHR Minimum Data Set and Campaign** – Secure technical assistance and prepare final documents by May 2007 that include:
  - Those definitions unique to this minimum data set.
  - Complete minimum data set with indicators, data elements and current available data sources.
  - An approach and methodology for conducting the “Count Me In” campaign. This needs to include the: benefits of participation by audience; campaign approach; and the proposed approach and methods for collecting and analyzing the data.
  - A draft survey to support the campaign.
  
- 2. Privacy Policies and Procedures** – Prepare and present the draft policy and procedure concerning data collection, analysis, interpretation, and dissemination, and the results of the privacy impact assessment at the next Advisory Committee meeting.
  
- 3. Communications** – Initiate implementation of the communications strategy, including dissemination of a fact sheet.
  
- 4. Story** – Prepare a brief history of First Nations, Inuit and Métis education. Such a document/documentary could establish context for the minimum data set.
  
- 5. Figure** – In preparation for the May 2007 Advisory Committee meeting, refine the figure that conveys First Nations, Inuit and Métis participation in health careers such that a comparison is not draw with non-Aboriginal participation.

## 11. APPENDICES

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### **Appendix A – Advisory Committee Membership**

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**First Nations, Inuit and Métis Health Human Resources Inventory  
Advisory Committee Year-End Summary**

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**First Nations, Inuit and Métis Health Human Resources Inventory  
Advisory Committee Year-End Summary**

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**Appendix B – Advisory Committee Agendas**

**National Aboriginal Health Organization  
Aboriginal Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
Advisory Committee  
Agenda  
14<sup>th</sup> Floor Boardroom, 220 Laurier Avenue  
October 24 and 25, 2006 Ottawa, ON**

**Tuesday, October 24, 2006**

8:30	Coffee/Introductions
8:45-9:00	Elder Opening and Welcome Remarks  Mark Buell, Manager Policy/Communications Simon Brascoupe, AHHRI, FNIHB, Health Canada
9:00-9:20	Role of the Advisory Committee Agenda/Objectives
9:20-10:15	Overview - Draft Data Set
10:15-10:30	Nutrition break
10:30-11:30	Defining the Parameters for Data Collection - Small Group Discussion
11:30-12:00	Small Group Reports
<b>12:00-1:00pm</b>	<b>LUNCH</b>
1:00-1:30	Refining the Data Collection Parameters
1:30-2:30	Defining What Data to Collect - Small Group Discussion
2:30-2:45	Health break
2:45-3:30	Defining What Data to Collect - Small Group Discussion
3:30-4:00	Small Group Reports
4:00-4:30	Summary of Day One

***First Nations, Inuit and Métis Health Human Resources Inventory  
Advisory Committee Year-End Summary***

**Wednesday, October 25, 2006**

8:30	Coffee
8:45-9:15	Overview - Data Sources
9:15-10:30	Identifying the Data Sources - Small Group Discussions
10:30-10:45	Overview - Privacy
10:45-12:00	Identifying the Privacy and Confidentiality, OCAP Requirements - Small Group Discussions
<b>12:00-1:00pm</b>	<b>LUNCH</b>
1:00-2:00	AHHRI Updates Privacy Working Group Communications Strategy
2:00-2:30	Advisory Working Group Terms of Reference
2:30-2:45	Summary
2:45-3:00	Closing Prayer

*February 14, 2007*

**National Aboriginal Health Organization  
Aboriginal Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
Advisory Committee  
Agenda  
14<sup>th</sup> Floor Boardroom, 220 Laurier Avenue  
February 21 – 23, 2007 Ottawa, ON**

**Wednesday, February 21, 2007**

- |             |  |
|-------------|--|
| 3:00-3:30   | Elder Opening and Welcome Remarks                |
| 3:20 – 3:40 | Agenda and Objectives for the Advisory Committee |
| 3:40 – 4:15 | Review of Definitions for the Minimum Data Set   |
| 4:15 – 4:30 | Elder Closing                                    |

**Thursday, February 22, 2007**

- |                     |   |
|---------------------|---|
| 8:30                | Coffee/Introductions  |
| 8:45-9:00           | Elder Opening   |
| 9:00-10:00          | Review and Recommendations: Definitions for Minimum Data Set    |
| 10:00-10:30         | Overview - Final Draft Minimum Data Set                         |
| 10:30-10:45         | Nutrition break   |
| 10:45 – 12:00       | Review Final Draft of Minimum Data Set - Small Group Discussion |
| <b>12:00-1:00pm</b> | <b>LUNCH</b>  |
| 1:00-2:30           | Review Final Draft of Minimum Data Set - Small Group Discussion |
| 2:30-2:45           | Health break  |
| 2:45-3:30           | Small Group Reports   |
| 3:30-4:15           | Consensus Recommendation on Minimum Data Set                    |
| 4:15-4:30           | Elder Closing   |

**Friday, February 23, 2007**

8:30	Coffee
8:45-9:00	Elder Welcoming
9:15-9:45	Overview - Approach to Data Collection Roles and Responsibilities
9:45-10:30	Discussion - Approach to Data Collection Roles and Responsibilities
10:30-10:45	Nutrition Break
10:45-12:00	Discussion and Recommendations - Approach to Data Collection and Roles and Responsibilities
<b>12:00-1:00pm</b>	<b>LUNCH</b>
1:00-2:00	AHHRI Updates National Environment Scan Privacy Working Group
2:00-2:30	Communications Strategy
2:30-3:00	Elder Closing

## **Appendix C – First Nations, Inuit and Métis Health Human Resources Inventory Advisory Committee Terms of Reference**

*Revised November 29, 2006*

**Name:** First Nation, Inuit and Métis Health Human Resource Advisory Committee

### **Background:**

In 2004, as a result of the special meeting of the First Ministers and Aboriginal leaders, the Federal Government made a commitment \$100M over five years for an Aboriginal Health Human Resource Initiative (AHHRI). This Initiative is to lay the foundation for long-term systemic change in the supply and demand for First Nations, Inuit and Métis health human resources. The AHHRI Initiative has the following three main objectives:

1. Increase the number of Aboriginal people working in health careers.
2. Improve the retention of health care workers in Aboriginal communities.
3. Adapt current health care educational curricula to improve cultural competence in Aboriginal health care.

NAHO, in partnership with the Canadian Institute for Health Information (CIHI) and the First Nations and Inuit Health Branch (FNIHB), initiated the development of a comprehensive framework on Aboriginal health human resources. This framework includes identifying:

- Core components that lead to First Nations, Inuit and Métis participation in health careers.
- Data elements and sources for a health human resource minimum data set.

The core components are intended to assist the identification of data elements and a planning method for projecting, deploying and monitoring First Nations, Inuit and Métis participation in health careers. The resulting information is intended to assist health professional and health education institutions and organizations with evidence for policy and practice initiatives toward increasing participation.

The minimum data set is the foundation for development of the database. NAHO is the data steward for this effort and adheres to the principles of Ownership, Control, Access and Possession (OCAP) as well as related principles that may be developed by Inuit and Métis.

### **Mandate:**

- To guide NAHO in the development and implementation of the First Nations, Inuit and Métis health human resources minimum data set, the data collection methods and the protection of data within the agreed upon principles such as Ownership, Control, Access and Possession (OCAP).<sup>5</sup>

**Objectives:**

- To ensure a unique collaborative effort is supported by partnerships with other First Nations, Inuit and Métis health professionals and organizations as well as non-Aboriginal health professional; federal/ provincial / territorial government; academic institutions and research agencies.
- To guide the development of a health human resource minimum data set that reflects information/data requirements important to First Nations, Inuit and Métis about participation in health careers.
- To guide the development of the best methods and frequency to collect data once the minimum data set is approved.
- To guide the development of policies and methods to ensure this work respects ethical standards, privacy and confidentiality requirements, the principles and applications of OCAP, and other applicable principles that may be developed by Inuit and/or Métis.

**Members:** One or more representative from each of the following organizations or areas of knowledge, inclusive of First Nations, Inuit and Métis:

- The National Aboriginal Health Organization (NAHO), as lead organization, has an internal Advisory Committee and will request a minimum one representative to a maximum of four.
- University/College education boards.
- Health professional organizations, both Aboriginal and non-Aboriginal.
- Canadian Institute for Health Information (CIHI).
- National Aboriginal Organizations(Assembly of First Nations, Métis National Council, Native Women’s Association of Canada, Congress of Aboriginal People, Inuit Tapiriit Kanatami and Pauktutit Inuit Women of Canada).
- Research / Policy.
- Traditional Knowledge.
- Elder/ Community Representatives.
- Federal Government, First Nations, Inuit Health Branch, Health Canada and Human Resources and Skills Development Canada.

**Role of Advisory Committee:**

- To assist in the identification of indicators and data elements for the minimum data set.
- To assist in the selection of priority health professions for the inventory.
- To assist in the development and implementation of the communication plan, including networking/liaison activities with our audiences.
- To liaison with project coordinator as required.
- To assist in the establishment of working committees when necessary.
- To assist in the annual evaluation of project's effectiveness.
- To assist in securing representation of First Nations, Inuit and Métis. This includes health professionals, students and community health providers.
- To assist in the development of a critical path as a foundation document for work in upcoming years.

**Accountability:**

- All members of the Advisory Committee are accountable to the organization they represent and to NAHO's guiding principles on the ethical treatment of others, as well as issues of OCAP.
- To remember we are accountable to First Nations, Inuit and Métis for this work.

**Meetings:**

- It is expected that each member of the committee is available for two annual face-to-face meetings, in addition to conference calls as required for the planning of each phase of the minimum data set and data collection.

**Resources:**

- Travel and accommodation for meetings and other administrative costs of the FNIMHHRI advisory will be covered by specific inventory funds secured by NAHO.

**Term:**

- The term of the Advisory Committee is for the term of the project, which is estimated to be three years (2006-2009).
- Advisory members are expected to commit to a minimum one year's tenure on the Project Advisory Committee and facilitate the nomination and transfer of his/her role to the incumbents.
- Each year the terms of reference will be revisited and reaffirmed by the Advisory Committee.

**Notwithstanding clause:**

- All aspects of the TOR are subject to the data sharing agreements that NAHO negotiates with the data providers.

**Appendix D – First Nations, Inuit and Métis Health Human Resources  
Inventory Priority Information Data Elements and Indicators**

**Development of the HHR Minimum Data Set  
March 17, 2007**

***Priority Information Needs***

<b>Priority Need</b>	<b>Summary Definition</b>
Demographics	The number and demographic characteristics of health personnel who are registered or licensed or who otherwise are part of the available health workforce.
Education/training	The number and characteristics of applicants to, and graduates of, health education/training programs. The number of institutions, the characteristics of each institution, the programs within each institution, and the faculty employed within each institution.
Geographical distribution	The number and characteristics of health personnel employed by geographical distribution.
Mobility  Similar to the Migration in the Pan-Canadian Minimum Data Set	The number and characteristics of health personnel who emigrate from Canada to other countries and those who migrate between geographical locations within Canada (for example, between provinces and/or territories, between communities).
Non Mobility Attrition  Similar to Non Migration in the Pan-Canadian Minimum Data Set	Losses due to retirement, change of profession, etc. The number and characteristics of health personnel leaving the health workforce through various sources of attrition, other than inter-provincial/territorial or international migration.
Healthy Workplaces  Similar to the Employment/practice characteristics in the Pan-Canadian Minimum Data Set	The number and nature of health personnel engaged in employed activity (for example, whether personnel are working full-time or part-time). This also includes number and nature of supports for recruitment and retention in the workplace.
Workload  Similar to the Productivity in the Pan-Canadian Minimum Data Set	The output of any health human resource (for example, per unit of input, earned compensation).

Adapted from Canadian Institute for Health Information. (February 2005). *Guidance document for the development of data sets to support health human resources management in Canada.*

**First Nations, Inuit and Métis Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
March 17, 2007**

***Demographics Indicators and Data Elements***

PRIORITY INFORMATION AREA	INDICATORS	DATA ELEMENTS
<p><b>Demographics of Health Personnel</b> The number and demographic characteristics of health personnel who are registered or licensed, or who are otherwise part of the available health workforce.</p>	<ul style="list-style-type: none"> <li>• Number of health personnel by type of health worker per 500 or 1,000 population.</li> <li>• Distribution of health personnel by type of health worker and sex (percentage of health personnel that are male or female).</li> <li>• Distribution of health personnel by type of health worker and by five-year age groups.</li> </ul>	<ul style="list-style-type: none"> <li>• National unique identifier or jurisdictional unique identifier.</li> <li>• Personnel type.</li> <li>• <i>Ethnicity for First Nations, Métis and Inuit.</i></li> <li>• <i>Nation (define).</i></li> <li>• <i>Legal Status(define).</i></li> <li>• <i>Language(s) spoken at home and at work.</i></li> <li>• Sex.</li> <li>• Year of birth.</li> </ul>

**Consensus**

- The definitions should reflect the broader determinants of health and the full scope of the workforce. For example, the definition for demographics is limited to registered or licensed health professionals. This definition is revised to be inclusive of those within the workforce who are not registered or licensed. Further, education and training does not account for the traditional paths (e.g., traditional healers, unregulated paraprofessionals, etc.).
- Change the denominator for 10,000 population to something more relevant (e.g., 500, 1000); determine appropriate number for Inuit.
- Define Nation, status/non-status.
- Language – need to draft a data element(s) to obtain the individuals ability/capacity to deliver services in the language and what language is being used in the service delivery setting.
- Need to draft a data element(s) that addresses whether the student/employee is a parent or guardian (e.g. number of children, etc.).

**First Nations, Inuit and Métis Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
March 17, 2007**

***Geography Indicators and Data Elements***

PRIORITY INFORMATION AREA	INDICATORS	DATA ELEMENTS
<p><b>Geographical Distribution</b> The number and characteristics of health personnel by geographical distribution. Use Statistics Canada definitions.</p>	<p>Personnel to population ratio:</p> <ul style="list-style-type: none"> <li>• Number of health personnel per 500 or 1,000 population.</li> <li>• Number of health personnel employed in urban areas per 500 or 1,000 population.</li> <li>• Number of health personnel employed in rural areas per 500 or 1,000 population.</li> </ul>	<p>Health Personnel</p> <ul style="list-style-type: none"> <li>• <b>Blind</b> - National unique identifier or jurisdictional unique identifier.</li> <li>• Personnel type.</li> <li>• <i>Community of employment.</i></li> <li>• <i>On or off reserve.</i></li> <li>• <i>Level of isolation.</i></li> <li>• <i>Home community.</i></li> <li>• Current – province / territory or country of residence.</li> <li>• Primary employment – province / territory or country.</li> <li>• Primary employment – postal code.</li> <li>• Secondary employment - province / territory or country.</li> <li>• Secondary employment – postal code.</li> <li>• Current province/ territory of registration.</li> </ul>

**Consensus**

- Geographic Distribution – should include identifying the community of employment; whether the individual lives on or off reserve<sup>6</sup>; and possible levels of isolation (e.g., fly-in, remote, OR remote, Northern, Arctic, etc.)<sup>7</sup>. Consideration should be given to defining geographic area in terms of a First Nations Tribal Council, Inuit Hamlet or Métis Settlement.
- Postal Code – Ensure in using postal code there is not residual disclosure. For example, use only the first three digits of the postal code.

**First Nations, Inuit and Métis Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
March 17, 2007**

***Mobility Indicators and Data Elements***

PRIORITY INFORMATION AREA	INDICATORS	DATA ELEMENTS
<p><b>Migration</b> The number and characteristics of health personnel who emigrate from Canada to other countries, as well as those who migrate between geographical locations within Canada (for example, between provinces and territories, between Tribal Councils, Hamlets and Settlements).</p>	<ul style="list-style-type: none"> <li>• Percentage of health personnel workforce who move between provinces/territories, Tribal Councils, Hamlets and Settlements in Canada annually.</li> <li>• Percentage of health care workforce who leave the workforce annually as a result of emigration from Canada.</li> <li>• Annual net interprovincial migration rate, by personnel type and province/territory.</li> <li>• Annual net FNIM community migration rate, by personnel type and Tribal Council, Hamlet and Settlement.</li> <li>• Annual net international migration rate, by personnel type and province/territory.</li> </ul>	<p>Health care personnel:</p> <ul style="list-style-type: none"> <li>• <b>Blind</b> - National unique identifier or jurisdictional unique identifier.</li> <li>• Personnel type.</li> <li>• Previous province/territory or country of residence.</li> <li>• Previous province/territory or country of employment.</li> <li>• Previous postal code of employment</li> <li>• Current—province/territory or country of residence.</li> <li>• Primary employment— province/territory or country.</li> <li>• Primary employment— postal code.</li> <li>• Secondary employment— province/territory or country.</li> <li>• Secondary employment— postal code.</li> <li>• Province/territory of initial registration in Canada.</li> <li>• Current province/territory of registration.</li> <li>• Previous registered activity status.</li> <li>• Current registered activity status.</li> </ul>

**Consensus**

- The members also agreed that it is not important to know about immigration of health personnel to Canada. Rather, it is more important to know about the emigration and the migration of health personnel across Tribal Councils, Hamlets and Settlements.
- We need to determine a method to account for those health professionals who are not registered.
- We also need to find a way to obtain vacancy rates in communities/regions.

**First Nations, Inuit and Métis Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
March 18, 2007**

*Non Mobility Attrition Indicators and Data Elements*

PRIORITY INFORMATION AREA	INDICATORS	DATA ELEMENTS
<p><b>Non Migration-Related Attrition -</b> The number and characteristics of health personnel leaving the health workforce for various reasons other than migration (retirement, change of profession, etc.).</p>	<ul style="list-style-type: none"> <li>• Percentage of losses to the health personnel workforce due to non migration-related attrition (by geographical location and personnel type).</li> <li>• Percentage of losses to the health personnel workforce due to specific reasons for non migration-related attrition.</li> <li>• Average duration of departure (for select types of attrition, such as parental leave or education).</li> <li>• Annual net attrition rate (non migration-related, by personnel type, type of attrition, and province/territory).</li> </ul>	<p>Health care personnel:</p> <ul style="list-style-type: none"> <li>• <b>Blind</b> - National unique identifier or jurisdictional unique identifier.</li> <li>• Personnel type.</li> <li>• Current registered activity status.</li> <li>• Previous registered activity status.</li> <li>• Previous employment— duration (in months).</li> <li>• Previous employment— reason for leaving.</li> </ul>

**Consensus**

- Include information about why health professionals are no longer practicing within their professions (e.g., coping skills, stress, safety, maternity leave, parental leave, wages, professional support, etc.); how many times the individual has moved in and out of the profession; and the attrition to administrative positions.

**First Nations, Inuit and Métis Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
March 17, 2007**

***Education and Training Indicators and Data Elements***

PRIORITY INFORMATION AREA	INDICATORS	DATA ELEMENTS
<p><b>Education/Training</b> The number and characteristics of applicants to, and graduates of, health education/training programs that may potentially enter the workforce. In addition: the number of institutions, the characteristics of each institution, the programs within each institution and the faculty employed within institutions.)</p>	<ul style="list-style-type: none"> <li>• Ratio of qualified applicants to entrants within a given year.</li> <li>• <i>Percentage of First Nations, Métis and Inuit attending a qualifying year for entrance into a post secondary program.</i></li> <li>• Ratio of entrants to graduates within a given year.</li> <li>• Ratio of new graduates to number of health personnel in the current workforce.</li> <li>• Percentage of all new graduates who enter the workforce within one year of graduation.</li> <li>• Percentage of all new graduates who continue with further education (i.e. after entry/initial practice education) within one year of graduation from health personnel–related education programs, by education/program type and credential sought.</li> <li>• Average time to complete program.</li> <li>• Distribution of health personnel by place of education/training related clinical placement and province/territory or country of education/training-related clinical placement.</li> <li>• Distribution of health personnel, by personnel type and highest level of health Personnel specific education.</li> <li>• Distribution of health personnel by province/territory or country of graduation.</li> </ul>	<p>Health personnel: Personnel entry to and exit from education/training (prior to entering the workforce).</p> <ul style="list-style-type: none"> <li>• National student/trainee unique <b>blind identifier</b>.</li> <li>• Year of birth.</li> <li>• Sex.</li> <li>• <i>Parent or guardian.</i></li> <li>• <i>Full-time, part-time student.</i></li> <li>• Postal code of residence at application to program.</li> <li>• Province/territory or country of residence at application to program.</li> <li>• Highest level of education at application to program.</li> <li>• Pre-qualifying year.</li> <li>• Post secondary institution unique identifier.</li> <li>• Education/training program type.</li> <li>• Expected date of completion.</li> <li>• Date of entry (month, year).</li> <li>• Date of graduation (month, year).</li> <li>• Credential conferred on Graduation.</li> <li>• <i>Reason for interruption.</i></li> <li>• Place of education/training related clinical placement (i.e. hospital, community, private).</li> <li>• Province/territory or country of education/training-related clinical placement.</li> </ul> <p>Personnel entry to and exit from education/training (after entry to the workforce).</p> <ul style="list-style-type: none"> <li>• Entry/initial practice education—personnel-type specific.</li> <li>• Highest level of education—personnel-type specific.</li> <li>• Postsecondary institution unique identifier.</li> <li>• Certified area of specialized</li> </ul>

PRIORITY INFORMATION AREA	INDICATORS	DATA ELEMENTS
		<p>training—personnel-type specific.</p> <ul style="list-style-type: none"> <li>• Source of certification.</li> <li>• Province/territory of initial personnel-type specific registration in Canada.</li> <li>• Year of initial personnel-type specific registration in Canada.</li> <li>• Other education/training— non-health personnel specific.</li> </ul> <p>First Nations, Métis and Inuit participating in continuing education.</p> <p>Institution: Health personnel education/ training institution.</p> <ul style="list-style-type: none"> <li>• Postsecondary institution unique identifier.</li> <li>• Education/training program type.</li> <li>• Postal code of education/ training program site.</li> <li>• Level of credential offered.</li> <li>• Available seats.</li> <li>• Applicants.</li> <li>• Entrants.</li> <li>• Graduates.</li> </ul> <p>Faculty: Personnel education/training faculty</p> <ul style="list-style-type: none"> <li>• National postsecondary institution faculty personnel unique identifier.</li> <li>• Year of birth.</li> <li>• Sex.</li> <li>• Postsecondary institution unique identifier.</li> <li>• Education/training program type.</li> <li>• Highest educational designation.</li> <li>• Faculty or primary area of concentration.</li> </ul>

**Consensus**

- Include seats for Aboriginal candidates; ratio of seats filled; and seats in other professions.
- Include whether the student has financial and social supports; add source and type (e.g., childcare, tuition, mentors, role models, computer access, community nearby, etc.) of funding. Mentors and role should include retired workers. Should also include career awareness at primary/high school.

- Identify incentives (supports at school) and barriers to entry starting at primary; also need to account for the bridging programs (year to upgrade), whether this year is funded and whether it impacts total funding for completion of post secondary education. Examples of questions could include, did you have to up-grade post grade 12 and/or did you have trouble when you got to university?
- Need to include age of entering training; whether full-time, part-time; breaks from school.
- Include whether student has opportunities for placement/practicum in their environment (rural or remote).
- Consider questions concerning new graduates who work in community (e.g., what supports are available in community, mentors, practicum, etc.).
- Cultural competency and safety – we should consider obtaining information about non-Aboriginals providing services within community. For example, were they provided with mentorship/support experience prior to their work in community? Have they been exposed to traditional knowledge and healing practices? Also need to ask students whether the school is safe?
- Need to capture that individual may have higher education but practices at a lower level (e.g., RN works as an LPN); this may be by choice or due to job availability.
- More work needs to be done to include indicators and data elements about primary, secondary and entry to post-secondary education.
- Consideration should be given to linking this data with self governance of education.

**First Nations, Inuit and Métis Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
March 18, 2007**

*Healthy Workplaces Indicators and Data Elements*

PRIORITY INFORMATION AREA	INDICATORS	DATA ELEMENTS
<p><b>Healthy Workplaces</b> The number of and nature of health personnel engaged in employed activity. The qualitative factors that influence employment.</p>	<ul style="list-style-type: none"> <li>• Percentage of the <b>registered / licensed workforce</b> currently employed in their specific profession (by profession, by sector, by age, by sex).</li> <li>• Percentage of the <b>registered / licensed workforce</b> not currently employed in their specific profession (by profession, by sector, by age, by sex).</li> <li>• <b>Ratio of health personnel working full-time to part-time to casual health personnel working part-time.</b></li> <li>• Proportion of employed health personnel by:               <ul style="list-style-type: none"> <li>• Place of work (for example, hospital or community).</li> <li>• Area of responsibility (for example, direct care or administration).</li> <li>• Position (for example, manager, direct care personnel or researcher).</li> </ul> </li> <li>• Percentage of health personnel with multiple employers <b>and locations.</b></li> <li>• Percentage of health personnel with certified.</li> </ul>	<p>Health personnel</p> <ul style="list-style-type: none"> <li>• <b>Blind - National unique identifier or jurisdictional unique identifier.</b></li> <li>• Personnel type.</li> <li>• <b>Parent or guardian.</b></li> <li>• Certified area of specialized training—personnel-type specific</li> <li>• Source of certification.</li> <li>• Current registration status</li> <li>• Current province/territory of registration.</li> <li>• Previous registered activity status.</li> <li>• Current registered activity status.</li> <li>• Other provinces/territories or countries of registration.</li> <li>• Primary employment— employment/practice status.</li> <li>• Primary employment— preferred employment/practice status.</li> <li>• Primary employment—place of work.</li> <li>• Primary employment—area of responsibility.</li> <li>• Primary employment— position.</li> <li>• Primary employment— duration of service.</li> <li>• Secondary employment— same elements as for primary employment.</li> <li>• All employment—more than two distinct employers?</li> </ul>

**Consensus** – All of the indicators are relevant

- Indicators about the work place environment (e.g., do you have the equipment to do your job, do you have access to the technology to do your job, do you feel safe at work, do you receive support/guidance needed from your supervisor/manager, do you have a support network at work, do you have access to the information you need to do your job, etc.).

- Data elements concerning supports (e.g., safe and adequate housing, sign-on and/or retention bonuses, etc.).
- Clear definitions for locums, casual, permanent part-time or full-time, contract and self-employed. Consideration should also be given to asking whether the individual is satisfied with their status. We also should be inclusive of traditional and functional expertise.
- Identify where the individual is working – service locations; this could be more than one. For example, do you practice in multiple locations? How many days do you practice in communities?
- A way to obtain information about professionals working below their credentials (i.e., Registered Nurse working as a Licensed Practical Nurse).
- Consideration for whether the practitioner incorporates traditional knowledge within their practice.
- Questions about retention (e.g., why did you stay, why did you go, why are you working full-time).
- Consideration of questions to address the capacity of the community to employ graduates.

**First Nations, Inuit and Métis Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
March 18, 2007**

*Workload Indicators and Data Elements*

PRIORITY INFORMATION AREA	INDICATORS	DATA ELEMENTS
<p><b>Workload</b> The output of any health human resource (for example, clients/patients seen by health personnel) per unit of input (for example, earned compensation).</p>	<ul style="list-style-type: none"> <li>• The proportion of health personnel working beyond some measure of maximum capacity.</li> <li>• Worked hours/activity statistics.</li> <li>• Earned compensation/activity statistics.</li> <li>• <i>Ratio of First Nations, Métis and Inuit earned income to non-Aboriginals performing the same job (wage parity).</i></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Blind</b> - National unique identifier or jurisdictional unique identifier.</li> <li>• Personnel type.</li> </ul> <p>Output elements:</p> <ul style="list-style-type: none"> <li>• Activity statistics (patient days, visits, exams, procedures, attendance days, workload units, etc.).</li> </ul> <p>Input elements:</p> <ul style="list-style-type: none"> <li>• Earned compensation.</li> <li>• Worked hours.</li> </ul>

**Consensus**

- Need to add an indicator and data elements for work other than job (e.g., board, voluntary, research, AHHRI, etc.).
- Add data element concerning wage parity based on sex.
- Output elements should divide by clinical work vs. other duties.

**First Nations, Inuit and Métis Health Human Resource Inventory Project  
Development of the HHR Minimum Data Set  
March 18, 2007**

*Health Professions*

PRIORITY INFORMATION AREA	IMPORTANCE
• Aboriginal Health Ombudsman.	O 1    O 2    O 3
• Elders, and Traditional Healers.	O 1    O 2    O 3
• Aboriginal Midwives.	O 1    O 2    O 3
• Community Health Representatives (CHRs). <sup>8</sup>	O 1    O 2    O 3
• Interpreters, Patient Navigators, Medical Transport, Employed Health Relatives.	O 1    O 2    O 3
• Physicians. <sup>9</sup>	O 1    O 2    O 3
• Dental professionals. <sup>10</sup>	O 1    O 2    O 3
• Nurses. <sup>11</sup>	O 1    O 2    O 3
• Social Workers.	O 1    O 2    O 3
• Mental Health Workers (i.e., Counsellors) and Psychologists.	O 1    O 2    O 3
• Addiction/Substance Abuse Workers.	O 1    O 2    O 3
• Pharmacists and Pharmacy Technicians.	O 1    O 2    O 3

PRIORITY INFORMATION AREA	IMPORTANCE
• Other Allied Health Workers including Occupational, Speech and Physiotherapists, Nutritionists and Dieticians, and Audiologists.	O 1      O 2      O 3
• Telehealth Coordinators.	O 1      O 2      O 3
• Early Childhood Educators.	O 1      O 2      O 3
• Educators/Assistants and Family Visitors (health promotion for young children).	O 1      O 2      O 3
• Technicians (X-Ray, Lab, etc.).	O 1      O 2      O 3
• Health Administrators (Managers, Clerks).	O 1      O 2      O 3
• Health Professional Educators /Trainers.	O 1      O 2      O 3
• Optometrists.	O 1      O 2      O 3
• Health Researchers.	O 1      O 2      O 3
• Complementary health professionals (e.g., Homeopaths, Naturopaths, and Chiropractors, etc.).	O 1      O 2      O 3
• Volunteers.	O 1      O 2      O 3

**Consensus**

- We cannot prioritize the health professionals. They are all important. No one individual is less important than another.

## **Appendix E – Communication Strategy**

This Communications and Dissemination Strategy has been developed in order to provide recommendations and propose activities relating to the Aboriginal Health Human Resources Inventory (AHHRI). The Strategy provides goals, key messages, and short and long term activities relating to the communications and dissemination components of the AHHRI. It will also provide a basis for dissemination activities relating to the long term data gathering exercise that aims to collect Aboriginal Health Human Resources data throughout Canada.

### **Inventory Methods:**

There will be two phases involved in the design of the comprehensive framework on AHHRI, which will guide the development of Data Sets to support AHHR management and planning. The first phase included a roundtable with First Nations, Inuit and Métis health professionals, and representatives from various stakeholder organizations which occurred February 14 – 15, 2006. The expertise of a variety of individuals and organizations provided input to build on existing knowledge in the development of the Inventory. The roundtable assisted in developing a framework that accommodates specific factors related to the needs of gathering data related to Aboriginal health human resources.

The overall outcome will contribute to long-term, effective, health human resource planning in the areas of recruitment, retention and improved professional support.

### **Goals of the Strategy:**

1. To inform and obtain the support of project partners and stakeholders about the **Inventory of First Nations, Inuit and Métis Health Human Resources**.
2. To gather essential data related to Aboriginal health human resources.

### **Key Messages:**

- Effective health care delivery requires access to a skilled and responsive health care team. Enabling such access is an ongoing concern for many First Nations, Inuit and Métis communities across Canada.
  - The number of Aboriginal health professionals is in chronic shortage.
- There is a need for the collection of baseline data to identify and document these shortages and support the need to increase the numbers of First Nations, Inuit, and Métis people working in health careers.
- NAHO will develop a First Nations, Inuit, and Métis minimum data set, conducted by a phased approach over a two to three year period. NAHO will honour OCAP/ and privacy standards in order to assist all communities in their Health Human Resources planning, recruitment and retention efforts.

### **Audiences for Goals 1 and 2:**

National Aboriginal organizations, community health organizations, and regulatory bodies are the audiences for this communications/dissemination strategy in order to increase awareness about the project and wider AHHR issues and subsequently gather accurate data. The project will seek to inform the following groups in order to build a network of individuals and organizations that are aware of the AHHRI in order to maximize the effectiveness of the data gathering phase.

**Aboriginal Peoples and Communities, including but not limited to:**

- Assembly of First Nations (AFN).
- Inuit Tapiriit Kanatami (ITK).
- Métis National Council (MNC).
- Native Women's Association of Canada (NWAC).
- Congress of Aboriginal Peoples (CAP).
- Friendship Centres.
- Health Directors in First Nations and Inuit communities.
- Regional/provincial/territorial organizations.
- Organizations such as health authorities and health care workers associations.

**Health, educational and Professional Associations:**

- Royal College of Physicians and Surgeons Canada (RCPSC).
- Colleges of Nursing (Provinces/Territories).
- Canadian Medical Association (CMA).
- College of Family Physicians of Canada (CFPC).
- Association of Faculties of Medicine of Canada.
- Indigenous Physicians Association of Canada (IPAC).
- Aboriginal Nurses Association of Canada (A.N.A.C.).
- National Indian and Inuit Community Health Representatives Organization (NIICHRO).
- Mental Health Workers.
- National Native Addiction Partnership Foundation.
- Health professional associations and specialist associations (i.e., Canadian Nurses Association, Society of Rural Physicians of Canada, etc.).<sup>12</sup>
- Midwifery associations.

**Government:**

- Health Canada, First Nations Inuit Health Branch (FNIHB), Health Policy Branch.
- Indian and Northern Affairs Canada.
- Human Resource Skills Development Canada.
- Community Health Centres / Social and Health services.

**Other:**

- Universities, Colleges, Technical institutes, libraries.
- Canadian Council on Health Services Accreditation, etc.

## **Communications/Dissemination Methodology:**

### **Goal 1:**

Inform project partners and stakeholders about the Aboriginal Health Human Resource Inventory and obtain support for the short and long-term outcomes of the Inventory.

Time: Current to March 31, 2007

Proposed activities include:

- Establish contact with network of agencies, organizations, associations, and individuals that provide HHR or health education who will then share the project with their constituents.
- Information kits will be developed for individuals, communities and media relating to the Inventory. Contents include: regional FAQs, project paper, presentation, project summary sheet, public service announcements for radio and a brochure.
- A website, hosted on the NAHO website, will be developed to share information related to the project and host the proposed online survey (see Goal 2 proposed activities which follow).
- Develop advertisements and editorials for both mainstream health media and Aboriginal media sources relating to the Inventory and upcoming data gathering exercise.
- Use of Web-based media to inform individuals about the upcoming survey. (i.e., web banner advertising, list serves, e-fax, etc.).

### **Goal 2:**

To gather essential data related to Aboriginal health human resources, which conforms to NAHO's privacy policy.

Time: After March 31, 2007

Proposed activities include:

- Host regional meetings to determine local data resources, stakeholders and consult with regional scan initiatives to ensure synthesis between projects.
- Develop a survey for First Nations, Métis, and Inuit people to gather baseline data on health human resources.
- Disseminate the survey to an established network of Aboriginal organizations.
- Distribute the survey through the network of agencies, organizations, associations, and individuals that provide HHR or provide health education, refer to target audience section for more details.
- Disseminate project information via list serves, post information on a wide array of stakeholder websites, and budget permitting, develop website advertising relating to the project.

### **Considerations:**

1. The proposed communications activities should conform to the overall goals of the Aboriginal Health Human Resource Inventory and will incorporate the recommendations of roundtable participants.

2. The messages should be culturally appropriate and translated into Aboriginal languages (i.e., Inuktitut) to obtain the widest support and awareness about the Inventory.
3. The roundtable dialogue serves as a springboard from which baseline data can be collected leading to a First Nations, Inuit and Métis health worker inventory. This inventory will include the number, sex, age and geographical location of First Nations, Inuit and Métis health workers.
4. Comprehensive Inclusion: Through the development of a comprehensive list of participants in roundtable discussions and a wide target audience, the intent is to reach audiences on a national scale, inclusive of First Nations, Métis, Inuit, in remote/rural and/or urban areas, including women, men and male and female youth.
5. Privacy Policy: It is expected all data gathered will be housed at NAHO within our Information Centre on Aboriginal Health (ICAH). NAHO's privacy policy, including OCAP will provide a high standard of informant privacy and security. Appropriate public access will be considered in the stewardship development phase. For further information regarding NAHO's current privacy policy see:  
[www.naho.ca/english/nahoprivacypolicy.php](http://www.naho.ca/english/nahoprivacypolicy.php).

**Outcomes:**

- A. Increased awareness of the wider issues of health human resources including the Aboriginal Health Human Resources Inventory.
- B. Comprehensive survey for data collection and mechanisms to disseminate survey.
- C. Informed Aboriginal Health Human Resource Planning based on the data collected.



## Endnotes

- <sup>1</sup> As the principles of OCAP were developed by First Nations, it is understood that Inuit and Métis are likely to develop their own principles which will also be reflected in this work.
- <sup>2</sup> Canadian Institute for Health Information. (2005). Guidance Document for the Development of Data Sets to Support Health Human Resources Management in Canada.
- <sup>3</sup> The intention is to determine whether the First Nations, Inuit or Métis health professional is living in and working in community, living in community and working elsewhere or living outside of community yet working in community.
- <sup>4</sup> The data element concerning 'levels of isolation' requires further delineation.
- <sup>5</sup> As the principles of OCAP were developed by First nations, it is understood that Inuit and Métis are likely to develop their own principles which will also be reflected in this work.
- <sup>6</sup> The intention is to determine whether the First Nations, Inuit or Métis health professional is living in and working in community, living in community and working elsewhere or living outside of community yet working in community.
- <sup>7</sup> The data element concerning 'levels of isolation' requires further delineation.
- <sup>8</sup> Community Health Representatives (CHRs) and community health workers (wide definition and can include outreach workers, community-based para-professionals, home care workers, NAADPP and wellness workers, etc.).
- <sup>9</sup> General Practitioner, Specialists, Emergency Medicine.
- <sup>10</sup> Dentists, dental therapists and dental hygienists.
- <sup>11</sup> Nurse Practitioners, Registered Nurse, Public Health Nurse, Licensed Practical Nurse.
- <sup>12</sup> In order to reach physicians, nurses, psychiatric nurses and nurse practitioners.