Evaluation Report, 2019-2024

Keewatinohk Inniniw Minoayawin

Jordan's Principle Pediatrician and Clinical Health Psychologist Services Project

v. 3.0

Executive Summary

The Keewatinohk Inniniw Minoayawin (KIM) Jordan's Principle Pediatrician and Clinical Health Psychologist Services Project aims to address critical healthcare gaps in Northern Manitoba First Nations communities by providing accessible pediatric and clinical health psychology services. Since its inception in 2018, the Project has expanded from 9 to 15 communities, offering transformative impacts for children, families, and healthcare providers.

Key Findings

- Service Expansion and Accessibility: The Project significantly increased service delivery, growing the number of children served annually from 111 in 2019 to 1091 in 2024. Communities such as Opaskwayak and Pimicikamak consistently benefited from high levels of engagement, while emerging communities like Chemawawin began receiving services in 2023. However, gaps remain in underrepresented regions like Sayisi Dene, highlighting opportunity for further outreach.
- Impact on Children and Families: Families overwhelmingly reported positive outcomes, with 100% of focus group participants expressing satisfaction. The Project saved families 1,880 trips—an estimated 67,680 hours. Potential savings for the system and families combined are estimated at $4.6–$7.5 million. Local service delivery reduced stress for families and improved access to timely diagnoses and support, particularly for developmental and mental health needs. Awareness of pediatric and clinical health psychology services also improved, with families gaining critical knowledge about conditions such as ADHD and autism.
- Impact on Providers and Practice: Providers adapted their practices to balance increased demand with quality care, transitioning from comprehensive assessments to developmental screenings to reach more children. The Project fostered cultural humility through community engagement, with providers integrating local traditions and addressing implicit biases. Collaborative efforts with community-based collaterals and increased professional development opportunities enhanced the delivery of culturally responsive care.
- Value Relative to Investment: The Project demonstrated substantial cost-effectiveness, with a cost per client served of approximately $3,011— lower than the typical urban-centered care model requiring families to travel. By providing access to specialists not otherwise available in 97% of clinics, the Project addressed critical service gaps while building local capacity through professional development and community engagement, which occurred on 62% of provider trips.
- Challenges and Opportunities: Persistent challenges include staffing shortages, logistical barriers, and limited follow-up services. Recommendations include expanding permanent positions, enhancing infrastructure such as dedicated telehealth facilities, and fostering collaboration among stakeholders. Increased training opportunities and culturally responsive capacity-building initiatives will also be essential for addressing systemic gaps and improving long-term outcomes.

The KIM Jordan's Principle Project has successfully narrowed healthcare gaps, improved quality of life for children and families, and demonstrated value relative to investment. Continued efforts to address underrepresented communities, enhance collaboration, and expand capacity will ensure the Project's sustainability and its role as a model for equitable healthcare delivery in Indigenous communities.

Scorecard

Narrowing the Service Gap

Has the Project improved access to pediatric medicine and clinical health psychology services for children in northern Manitoba First Nations communities? ✓

Impact on Children and Families

Have the services provided improved quality of life for children and their families? ✓

Has the Project reduced travel burden and associated time and financial costs for families? ✓

Has awareness of pediatric and clinical health psychology services improved? ✓

Impact on Providers and Practice

Have providers experienced changes in practice, including patterns of assessment, diagnosis, and consultation? ✓

Has the Project enhanced provider cultural humility and collaboration between providers and communities? ✓

Value for Investment

Are there financial and time savings available to families and the health system due to the Project? ✓

Is the cost per client served through the Project less than that for the typical model of care delivery? ✓

Contents

Introduction

Background

Canadian Human Rights Tribunal (CHRT) orders require Indigenous Services Canada (ISC) to administer the Jordan's Principle initiative to address the unmet needs of First Nation children with the objective of substantive equality. Recognizing the service gaps for children residing in northern Manitoba First Nations, Manitoba Keewatinowi Okimakanak (MKO) established partnerships with University of Manitoba Ongomiizwin Health Services (OHS) and Winnipeg Regional Health Authority (WRHA)—and later Shared Health—resulting in a proposal submission to ISC for a Jordan's Principle project designed to address unmet pediatric medical and clinical psychology needs. ISC provided funding to MKO for the Jordan's Principle Pediatrician and Clinical Health Psychologist Services Project (the Project) to be implemented from October 2018 to September 2019.

The original 9 communities to be served include:

- God's Lake Narrows First Nation
- Mosakahiken First Nation
- Nisichawayasihk Cree Nation
- Opaskwayak Cree Nation
- O-pipon-na-piwin Cree Nation
- Sapotaweyak Cree Nation
- Shamattawa First Nation
- Tataskweyak Cree Nation
- Wuskwi Sipihk Cree Nation

ISC has renewed the funding for the Project every year since the original proposal. In 2019, the Project was transferred to MKO's health transformation entity, Keewatinohk Inniniw Minoayawin Inc. (KIM). Funding for professional services now flows from ISC to KIM and is then disbursed to OHS and WRHA/Shared Health for remuneration of the care providers. KIM retains funding for a 1.0 FTE Project Director, 1.0 FTE Clinical Liaison and 0.2 Primary Care Advisor (the KIM Team).

The KIM Team meets regularly with representatives from OHS and Shared Health to coordinate pediatric medical and clinical psychology needs for participating Northern Manitoba First Nations. Since 2018, the Project has expanded and is responsible for coordinating varying levels of services and supports to the following 15 communities:

- Barren Lands First Nation
- Bunibonibee First Nation
- Chemawawin Cree Nation
- God's Lake Narrows First Nation
- Mosakahiken First Nation
- Nisichawayasihk Cree Nation
- Opaskwayak Cree Nation
- O-Pipon-Na-Piwin Cree Nation
- Pimicikamak Cree Nation
- Sapotaweyak Cree Nation
- Sayisi Dene Denesuline Nation
- Shamattawa First Nation
- Tataskweyak Cree Nation
- Wuskwi Sipihk Cree Nation
- York Factory First Nation

Purpose of Evaluation

Evaluation Goals

Assess Effectiveness

- Determine whether the Project successfully delivers pediatric medicine and clinical health psychology services to children in the target communities.
- Measure the reach, frequency, and quality of service delivery across participating northern Manitoba First Nations.

Assess Impact

- Evaluate the impact of these services on children and families.
- Assess how the Project has improved access to specialized care, reduced barriers such as travel burden, and enhanced overall quality of life for families.

Demonstrate Value for Investment

- Showcase the value created for families, communities, and the broader health system as a result of the Project.

Identify Growth Opportunities

- Identify areas for Project expansion and improvement based on stakeholder feedback and observed service gaps.
- Highlight opportunities to strengthen partnerships and enhance service delivery within communities.

Key Evaluation Questions

How has the Project narrowed the service gap?

- How has the Project improved access to pediatric medicine and clinical health psychology services for children in northern Manitoba First Nations communities?

What has been the impact on children and families?

- How have the services provided improved quality of life for children and their families?
- How has the Project reduced travel burden and associated time and financial costs for families?
- How has awareness of pediatric and clinical health psychology services changed as a result of the Project?

What has been the impact on providers and practice?

- How have providers experienced changes in practice, including patterns of assessment, diagnosis, and consultation?
- To what extent has the Project influenced cultural humility and enhanced collaboration between providers and communities?

How has the Project generated value relative to investment?

- What financial and time savings have been achieved for families and the health system as a result of the Project?
- How does the cost per client served compare to the typical model of care delivery?

Scope of Evaluation

The scope of this evaluation focuses on assessing the KIM Jordan's Principle Pediatrician and Clinical Health Psychologist Services Project within the context of its delivery to northern Manitoba First Nations communities. The evaluation examines the Project's effectiveness, impact, and value relative to investment, within the parameters outlined below.

Timeframe

- Project inception in 2018 to December 2024.

Geographic Reach

- Northern Manitoba First Nations served through the Project, which has grown from 9 at inception to 15 in 2024.

Data Sources

- Project administrative files and service delivery records.
- Surveys and focus groups with families, community-based Jordan's Principle staff, and service providers.
- Anecdotal stories highlighting the Project's impact on individual children and families

Limitations

The evaluation acknowledges limitations in data availability; however, the evaluation provides a fulsome analysis of Project value. Specifically, the following limitations were noted during the evaluation process:

- Incomplete Data: Some provider clinic reports lacked comprehensive information, limiting the depth of analysis for certain indicators.
- Low Survey Response Rates: Only 1 health director participated in the Health Directors' Survey, which cannot fully represent perspectives across all 15 communities.
- Inconsistent Record-Keeping: Administrative records were sporadic, which may have resulted in gaps in data regarding service delivery and finances.
- Lack of Baseline Data: Pre-existing baseline data were unavailable, making it difficult to make pre- and post-implementation comparisons.

Despite these limitations, the evaluation integrates data from multiple sources to provide a wide-ranging analysis of the Project's effectiveness, impact, and value.

Methodology

Data Sources & Collection Methods

The following data sources were used to inform the evaluation.

Surveys

- Providers' Survey: Distributed online to providers sitting on the Technical Working Group and those conducting community visits.
- Health Directors' Survey: Distributed online to health directors in each of the 15 communities served; 1 response was received.
- Families' Survey: Distributed on paper to family representatives in 5 communities, specifically chosen by local Jordan's Principle staff who also participated in the Families' Focus Group.

Focus Groups

- Families' Focus Group: Conducted virtually with family representatives from 5 communities. The sessions were recorded, transcribed, and supported with manual notes.
- Case Managers' Focus Group: Conducted in-person with Jordan's Principle Case Managers representing all 15 communities. These sessions were also recorded, transcribed, and supplemented with manual notes.
- Recordings were transcribed, and manual notes were reviewed to identify key themes and experiences.

Administrative Records

- Provider clinic reports
- KIM Team meeting minutes
- Technical Working Group meeting minutes
- Advisory Group meeting minutes
- Financial reports
- Annual reports

Data Analysis

Data analysis was carried out using a combination of quantitative and qualitative methods:

- Quantitative Analysis: Numerical data from provider clinic reports and financial records were analyzed to measure Project reach, frequency of services, cost savings, and access to care.
- Qualitative Analysis: Transcripts from focus groups and manual notes were thematically analyzed to identify trends and areas for improvement. Information from administrative reports and meeting minutes was synthesized to provide contextual insights.

Analysis

How has the Project narrowed the service gap?

From 2019 to 2024, the Project demonstrated remarkable growth in the number of children served, reflecting the Project's ability to expand and adapt to the needs of Northern Manitoba First Nations. The total number of children served increased from 111 in 2019 to 1091 in 2024 (Figure 1), representing a significant scaling of operations and reach. High-demand communities such as Opaskwayak and Pimicikamak exhibited strong engagement, with Opaskwayak reaching a peak of 174 children served in 2022 and Pimicikamak serving 150 children in 2023 (Table 1). These trends highlight the Project's success in addressing the needs of larger communities while responding to demand.

Figure 1. Number of children served, by year

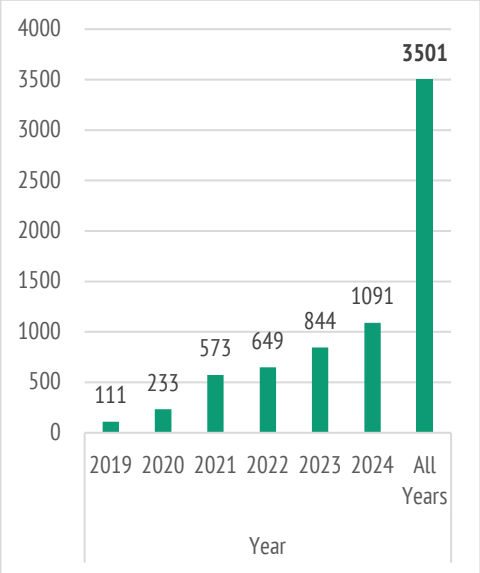


Table 1. Number of children served, by community

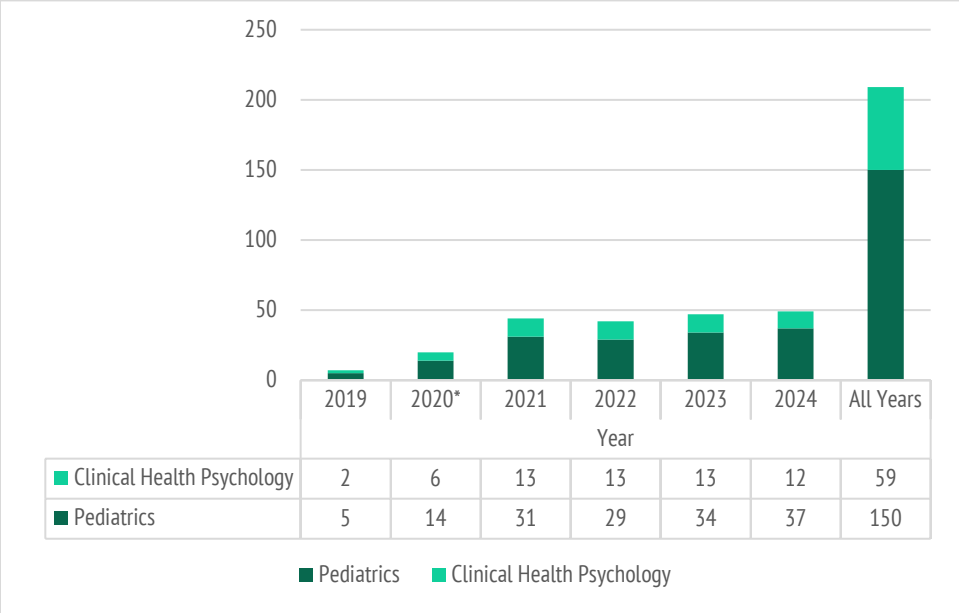
	Year					
Community	2019	2020	2021	2022	2023	2024
Barren Lands	0	15	71	56	68	53
Bunibonibee	0	0	11	33	14	9
Chemawawin	0	0	0	0	12	19
God's Lake Narrows	0	0	45	53	111	108
Mosakahiken	0	13	27	67	42	89
Nisichawayasihk	15	16	29	82	58	116
Opaskwayak	69	53	141	174	97	179
O-Pipon-Na-Piwin	0	16	2	24	57	97
Pimicikamak	0	0	30	78	150	103
Sapotaweyak	2	26	80	9	82	53
Sayisi Dene	0	0	0	0	0	42
Shamattawa	0	61	90	34	81	144
Tataskweyak	21	29	12	14	14	13
Wuskwi Sipihk	4	4	8	7	8	11
York Factory	0	0	27	18	50	55
Total	**111**	**233**	**573**	**649**	**844**	**1091**

Emerging communities, including Chemawawin, began receiving services in 2023 and showed steady growth, serving 12 children in 2023 and 19 by early 2024. However, some communities, such as Sayisi Dene remained underrepresented. Sayisi Dene did not receive their first visit until June 2024, indicating possible barriers to early implementation. In Wuskwi Sipihk, fewer than 10 children were served annually until 2023, however a comparison of children served to the population aged 19 or younger—60 in 2021—reveals that implementation in the community is relatively successful[1]. From 2020 onwards, only Clinical Health Psychology has been provided in Wuskwi Sipihk at the community's request.

[1] Statistics Canada. Wuskwi Sipihk First Nation 2 Census Profile, 2021 Census of Population. <https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Wuskwi%20Sipihk%20First%20Nation%202&DGUIDlist=2021A00054620060&GENDERlist=1,2,3&STATISTIClist=1&HEADERlist=0> Accessed Dec 20, 2024.

More specifically, Pediatrics (Peds) clinics increased from 5 in 2019 to 37 in 2024, while Clinical Health Psychology (CHP) clinics grew from 2 in 2019 to at least 12 clinics annually from 2021 to 2024 (Figures 2, 3, 4).

Figure 2. Number of Pediatrics and Clinical Health Psychology clinics, by year



* On March 16, 2020, a no travel advisory was issued due to the COVID-19 pandemic. Travel resumed in July 2020.

The data on Peds clinics highlight significant variation in service delivery across communities. High-demand areas such as Opaskwayak consistently received the greatest number of clinics, peaking at 13 in 2021, while God's Lake Narrows, Pimicikamak, and Shamattawa also experienced steady increases, reaching 4 clinics each in 2023 (Table 2). Additionally, variability in service levels was observed in communities like Sapotaweyak, which hosted 3 clinics in 2021 but only 1 in late 2024, pointing to potential logistical challenges or changing priorities.

CHP clinics followed a similar but more modest pattern, with fewer clinics held annually across communities. Core regions such as Sapotaweyak and Wuskwi Sipihk consistently hosted at least one CHP clinic per year (Table 3). Emerging service areas like Chemawawin showed promising growth, recording their first CHP clinic in 2023 and increasing to 2 clinics in 2024.

A comparison of Peds and CHP clinic data reveals discrepancies in service availability in areas like God's Lake Narrows, which hosted more Peds clinics compared to CHP clinics, suggesting room for better alignment in service delivery.

Figure 3. Number of Pediatrics clinics, by year

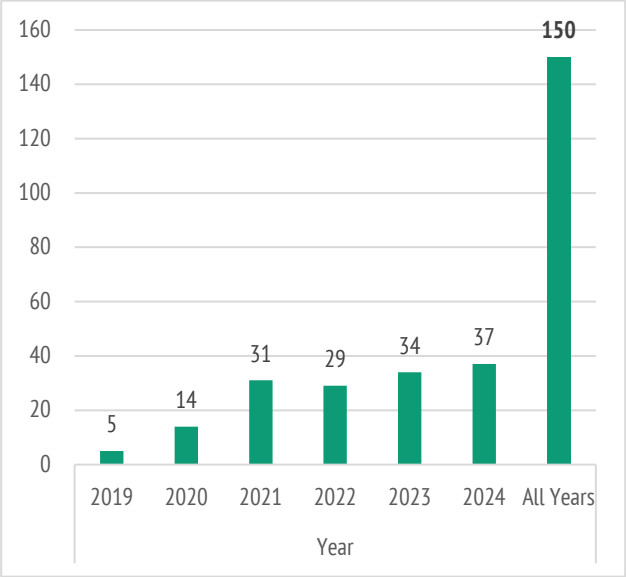


Figure 4. Number of Clinical Health Psychology clinics, by year

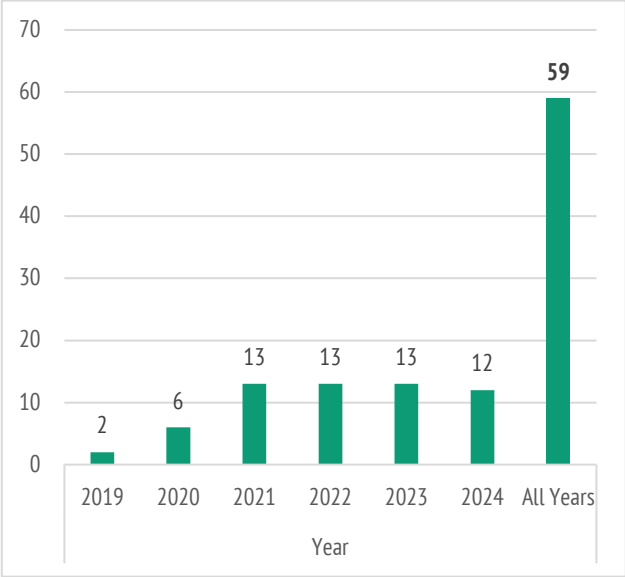


Table 2. Number of Pediatrics clinics, by community

	Year					
Community	2019	2020	2021	2022	2023	2024
Barren Lands	0	1	3	2	3	3
Bunibonibee	0	0	1	2	3	1
Chemawawin	0	0	0	0	0	0
God's Lake Narrows	0	0	2	3	4	3
Mosakahiken	0	1	1	2	2	3
Nisichawayasihk	1	1	1	3	2	5
Opaskwayak	2	5	13	5	3	5
O-Pipon-Na-Piwin	0	1	1	1	2	3
Pimicikamak	0	0	1	3	4	3
Sapotaweyak	0	2	3	2	2	1
Sayisi Dene	0	0	0	0	0	3
Shamattawa	0	2	2	2	4	4
Tataskweyak	2	1	1	1	2	1
Wuskwi Sipihk	0	0	0	0	0	0
York Factory	0	0	2	3	3	2
Total Peds clinics	**5**	**14**	**31**	**29**	**34**	**37**

Table 3. Number of Clinical Health Psychology clinics, by community

	Year					
Community	2019	2020	2021	2022	2023	2024
Barren Lands	0	0	1	2	1	1
Bunibonibee	0	0	0	0	1	1
Chemawawin	0	0	0	0	1	2
God's Lake Narrows	0	0	1	1	0	0
Mosakahiken	0	0	1	1	1	0
Nisichawayasihk	0	0	1	1	1	1
Opaskwayak	0	1	1	1	1	1
O-Pipon-Na-Piwin	0	1	1	1	1	0
Pimicikamak	0	0	1	1	1	1
Sapotaweyak	1	1	1	1	1	1
Sayisi Dene	0	0	0	0	0	1
Shamattawa	0	1	1	0	1	0
Tataskweyak	0	1	1	1	1	1
Wuskwi Sipihk	1	1	2	1	1	1
York Factory	0	0	1	2	1	1
Total CHP clinics	**2**	**6**	**13**	**13**	**13**	**12**

The data on average trip duration across communities from 2019 to 2024 indicate relatively consistent patterns, with most communities averaging trip durations of 3 to 5 days (Table 4). High-demand communities such as Opaskwayak show consistently longer trip durations, with averages ranging from 4 to 5 days annually, reflecting the sustained need for comprehensive service delivery. Emerging communities like Chemawawin recorded their first trip durations of 5 days in 2023 and 2024, highlighting the Project's expansion into previously underserved areas. Some variability is observed, such as the decline in trip duration for God's Lake Narrows from 5 days in 2023 to 3 days in 2024.

Table 4. Average trip duration in days, by year

	Year					
Community	2019	2020	2021	2022	2023	2024
Barren Lands	-	-	4	4	4	4
Bunibonibee	-	-	2	5	5	4
Chemawawin	-	-	-	-	5	5
God's Lake Narrows	-	-	4	4	5	3
Mosakahiken	-	3	3	3	3	3
Nisichawayasihk	5	3	4	4	5	5
Opaskwayak	5	4	4	4	5	5
O-Pipon-Na-Piwin	-	3	4	3	3	3
Pimicikamak	-	-	4	4	3	3
Sapotaweyak	1	2	2	3	3	3
Sayisi Dene	-	-	-	-	-	5
Shamattawa	-	3	5	5	3	4
Tataskweyak	2	4	4	5	5	5
Wuskwi Sipihk	3	2	3	2	4	2
York Factory	-	-	4	3	4	4

The finding that 97% of clinics provided access to specialists that would not have been otherwise available underscores the critical role of the Project in addressing service gaps in Northern Manitoba First Nations. Figure 5 illustrates the steady increase in referrals made through Project clinics, reflecting their growing impact over time and demonstrating the Project's success in identifying and addressing unmet healthcare needs. Table 5 provides further insight into the breadth of services accessed through referrals, with Speech-Language Pathology (SLP, 366 referrals), Occupational Therapy (OT, 243 referrals), and Physiotherapy (142 referrals) comprising the largest categories. This distribution aligns with the observed demand for developmental services across communities. The range of referral types, including Cardiology (9), Genetics (15), and Gastroenterology (6), highlights the Project's ability to provide access to comprehensive care spanning diverse specialties.

These data affirm that the Project clinics are a vital conduit for connecting underserved communities to essential specialist services. The findings also suggest a well-rounded approach to addressing both high-demand and niche needs.

Figure 5. Number of referrals made through Project clinics, by year

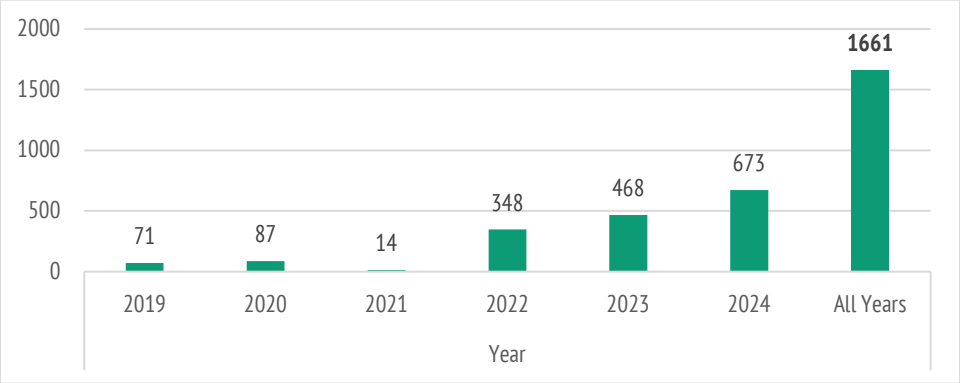


Table 5. Type and number of referrals made through Project clinics

Referral Type	Count	Referral Type	Count
Allergy	42	MATC/RNTS	22
Assistive Technology	1	Mental Health Worker	22
Asthma Education RN	2	Nephrology	10
Audiology	128	Neurology	8
Cardiology	9	Nutrition	3
Children's Therapy TGH	1	Ophthalmology	8
Clinical Health Psychology	11	Optometry	3
Clinical Psychology	89	Orthopedics	18
Community Mental Health Worker	3	Occupational Therapy	243
Dental	9	Other	17
Dermatology	5	Pediatrics	25
Development	120	Plastics	1
Dietician	53	Psychiatry	5
Disability Services	11	Psychology	111
EEG	1	Physiotherapy	142
Encopresis	1	Quest Health Mental Wellness	1
Endocrinology	6	Radiology	2
ENT	25	Respirology	3
Family Enhancement	2	Rheumatology	3
FASD clinic	16	Speech-Language Pathology	366
Gastroenterology	6	Speech Therapy	6
GDAAY	1	SSCY	4
General Surgery	8	St.Amant	71
Genetics	15	Urology	1
Infectious Disease	2		
Total: 1661			

In summary, the Project has significantly narrowed service gaps for children in Northern Manitoba First Nations communities by increasing access to critical healthcare services and connecting underserved populations with specialists. From 2019 to 2024, the number of children served grew from 111 to 1091 annually, reflecting a robust scaling of operations and outreach to high-demand regions such as Opaskwayak, Pimicikamak, and God's Lake Narrows. Additionally, average trip durations of 3–5 days per visit have ensured comprehensive care delivery in the communities served.

Furthermore, 97% of clinics provided access to specialists that would not have been otherwise available, and nearly 1,700 referrals were made through Project clinics, spanning critical specialties such as Speech-Language Pathology (366 referrals), Occupational Therapy (243 referrals), and Physiotherapy (142 referrals). These data highlight the Project's role as a key avenue for increasing equitable healthcare delivery.

While communities like Sayisi Dene remain underserved, the addition of emerging regions such as Chemawawin demonstrates the Project's ability to address previously unmet needs. Despite variability in service levels in certain areas, the Project's growth has laid a foundation for sustainable healthcare access in Northern Manitoba's First Nations communities.

Moving forward, the Project should focus on addressing barriers to implementation in underrepresented communities, maintaining high service levels in core regions, aligning Peds and CHP services more closely, and leveraging the successes of emerging communities to expand the Project's reach. These efforts will be critical to maximizing the Project's impact and achieving equitable healthcare access.

KIM Jordan's Principle Gathering, December 2019

What has been the impact on children and families?

The Project has had a transformative effect on the lives of children and families in Northern Manitoba First Nations. Satisfaction with the services received was overwhelmingly positive, with 100% of family focus group participants expressing satisfaction. Families reported reduced stress levels, a sense of support, and the life-changing effects of the services provided for their children. Many parents highlighted the convenience of receiving services locally, which spared them the need to travel, and those with multiple children emphasized the significant relief this brought to their lives.

> "Based on clinical health psychology and pediatrician recommendations [Jordan's Principle staff] are able to enhance children's safety and recreation opportunities, children have the ability to enjoy the outdoors, preventing parent burnout … "

The quality of life for children and families has also greatly improved, with 100% of focus group participants reporting a positive impact. Parents expressed a sense of relief and validation, particularly those with children diagnosed with autism, who felt supported in understanding their child's needs. Families appreciated the awareness raised about conditions like ADHD and alternatives to managing these conditions without relying solely on medication. The services were seen as an essential source of support, reducing stress and addressing immediate needs.

The convenience of local service delivery has alleviated financial and logistical challenges for many families. The Project has significantly reduced the travel burden for families, with 100% of participants acknowledging this benefit. By delivering services locally, the Project saved 1,880 patient trips, an estimated 67,680 hours, and up to $4.6M–$7.5M in associated costs. The project has been particularly beneficial for families with multiple children—and for those whose children do not have Registered Indian Status (who are therefore ineligible for travel coverage through ISC Non-insured Health Benefits).

> " … [Families' travel burden] has completely changed. Before this Project, they all would have had to travel outside the community to access … psychology care. Because of this Project, they don't need to arrange escorts etc. and problem-solve issues like child care to attend specialist appointments. In addition, many of these high-needs children have an extremely difficult time travelling and being away from their homes which causes significant stress and strain to them and to their families. … If we can have CHP provide diagnoses of developmental disorders (such as Autism) then families don't have to travel (and wait for over 18 months) to be seen … in Winnipeg."

Additionally, the Project has increased awareness about pediatric and clinical health psychology services at the community level, with 67% of focus group participants reporting a greater understanding of the roles of these providers. Families have learned about the distinct roles of pediatricians and clinical health psychologists and gained valuable insights into conditions like ADHD and autism. Since the Project's implementation, there has been a noticeable improvement in families' knowledge about these conditions and the importance of psychological and developmental support.

What has been the impact on providers and practice?

The Project has profoundly influenced providers and their practices, fostering adaptability, cultural humility, and innovative approaches to healthcare delivery in Northern Manitoba First Nations communities. Initially, providers focused on comprehensive assessments, dedicating significant time to evaluating each child's needs. This approach allowed for thorough evaluations but limited the number of children who could be served. As referral numbers grew, providers adapted their methods to prioritize developmental screenings, enabling them to serve a larger population while still delivering meaningful, actionable insights for families. These screenings often resulted in provisional diagnoses, with follow-up visits used to refine findings and address evolving needs. Family-centered care emerged as a key principle, with providers tailoring recommendations to individual families, focusing on referrals to therapy and support services, and empowering caregivers to advocate for their children. The pandemic compounded the demand for services by delaying early diagnoses and creating a backlog of older children requiring care, which further emphasized the need for adaptive practices.

Cultural humility has become an integral aspect of provider practices, driven by their commitment to understanding and integrating the unique cultural and historical contexts of the communities they serve. Providers actively engaged with local traditions, learning languages like Cree, reading literature about community histories, and adapting their approaches to better align with cultural values. These efforts enhanced trust and rapport with families and community-based collaterals, fostering a deeper connection and mutual respect. Families frequently described providers as empathetic, respectful, and attentive to their specific circumstances. Providers also reflected on their implicit biases, working to decolonize their practices and adopt a reconciliation-focused approach to care, ensuring their services were both inclusive and culturally appropriate.

> "I love the work. I love the community and I hope I am doing some good and really meeting the social accountability mandate that we talk about."

The Project has significantly enhanced collaboration between providers and communities by fostering meaningful partnerships, promoting shared learning, and improving service delivery processes. Data show that professional development and clinical teaching for nursing station and health center staff occurred on 32% of provider trips (Figure 6). Additionally, clinical partners engaged with community partners on 30% of trips (Figure 7), reflecting deliberate efforts to establish trust, integrate local knowledge, and align services with community-specific needs. However, challenges remain, including the need for improved coordination between healthcare systems, clearer communication pathways, and better integration of follow-up services. Inadequate infrastructure, such as clinical spaces and secure technology, also limits the depth of collaboration in some communities.

Figure 6. Percentage of trips with professional development and/or clinical teaching delivered to nursing station/health centre staff

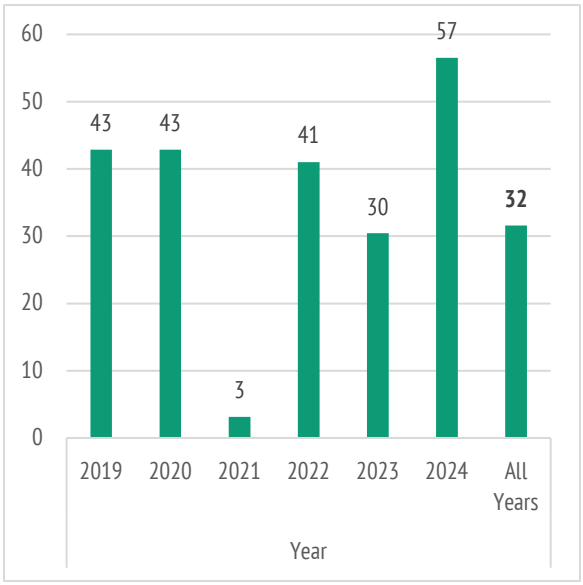
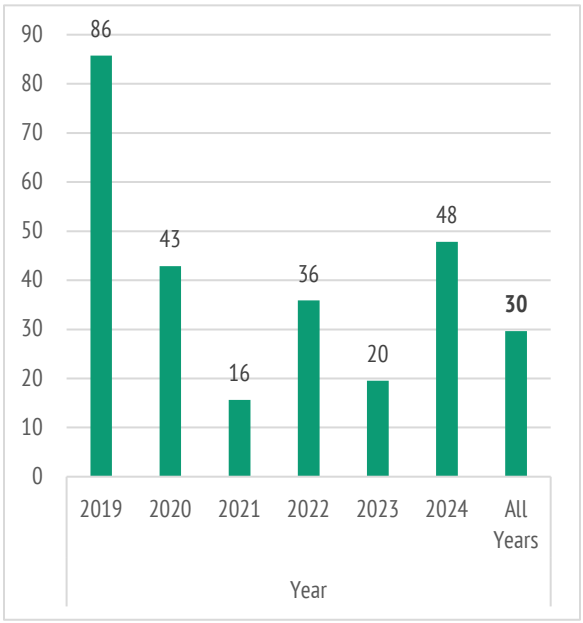


Figure 7. Percentage of trips where clinical partners engaged with community partners



While 83% of providers reported being 'highly satisfied' or 'satisfied' with the Project so far, they continue to face systemic challenges that hinder the Project's full potential. Paper charting creates inefficiencies and delays, limiting continuity of care. Furthermore, the lack of centralized systems for managing patient records contributes to missed opportunities for streamlined and integrated care delivery. Recruitment remains a persistent barrier, with temporary contracts and the absence of permanent positions reducing the Project's ability to attract and retain specialized providers, such as Clinical Health Psychologists. These staffing shortages limit the frequency of visits and constrain the breadth of services available to communities.

Logistical issues further complicate service delivery. Inadequate clinical spaces often require providers to relocate during visits. Providers also face difficulties with accommodations, transportation, and access to essential resources, such as secure technology and clinical equipment. These logistical barriers not only impede efficiency but also contribute to delays in diagnostics and referrals, leaving some families without timely support. The absence of robust follow-up services compounds these challenges, with children receiving diagnoses but lacking the ongoing therapy and monitoring needed to fully address their needs.

The broader social context also presents significant barriers. Historical traumas and stigma surrounding mental health services often discourage families from seeking care or accepting interventions. Grandparents and caregivers may express mistrust of medications, further complicating the provision of mental health and developmental services. Providers recognize the importance of addressing these barriers through culturally sensitive communication, education, and trust-building efforts to ensure that families feel supported and understood.

To sustain and expand the Project's impact, systemic improvements are essential. Investing in infrastructure, such as dedicated clinical spaces, secure technology, and streamlined data management systems, will enhance the efficiency and effectiveness of service delivery. Expanding staffing through permanent positions and offering competitive contracts will attract specialized providers and enable the Project to meet increasing demand. Collaborative efforts with schools, health

services, and community organizations are critical to ensuring the consistent implementation of care plans and bridging gaps in follow-up services. By addressing these systemic challenges, the Project can build on its successes, continuing to promote cultural humility and flexible service models while ensuring equitable, sustainable access to healthcare for Northern Manitoba First Nations communities. This approach will not only improve outcomes for children and families but also strengthen the trust and collaboration between providers and the communities they serve.

How has the Project generated value relative to investment?

The Project has delivered substantial value relative to its investment by improving healthcare access, reducing costs for families and the healthcare system, and facilitating efficient service delivery. One of the most notable impacts is the significant savings for families—1,880 trips saved, equating to 67,680 hours. Potential savings for the system and families combined are estimated at $4.6–$7.5 million. These savings, achieved by bringing pediatric and clinical health psychology services directly to communities, have alleviated the financial and logistical burdens typically associated with accessing specialist care.

In addition to these direct savings, the Project's approach has demonstrated a cost-effective model of care delivery. The cost per patient served under the Project was approximately $3,011, compared to the estimated cost of up to $4,000 to the system under the conventional model requiring travel to urban centers. This efficiency underscores the Project's ability to optimize resources while expanding its reach to underserved communities.

The value of the Project extends beyond financial metrics. With 97% of clinics providing access to specialists not otherwise available, the Project's localized delivery model has transformed the accessibility and continuity of care in Northern Manitoba First Nations. By bringing specialists directly to underserved regions, the Project has facilitated early intervention, streamlined referral pathways, and tailored care to the unique needs of families. The focus on in-community care has strengthened provider-family relationships, enabling more personalized recommendations, improved support to caregivers, and improved quality of life for families.

Additionally, the Project's localized delivery model has enhanced the overall quality of care. Average trip durations of 3–5 days allow for detailed assessments and follow-ups, ensuring meaningful provider-family interactions. This approach has not only reduced reliance on urban healthcare facilities but also minimized the stress associated with lengthy travel, especially for children with complex needs.

The Project's success in creating value is also reflected in its contributions to community capacity building. Providers frequently engaged in professional development, clinical teaching, and liaising with community services during their trips, with 62% of trips including these activities, fostering local healthcare expertise. This capacity-building aspect enhances the sustainability of healthcare delivery in participating communities, multiplying the long-term benefits of the Project.

In summary, the Project has generated exceptional value relative to its investment by improving healthcare accessibility, reducing costs, and building community capacity. These achievements highlight a sustainable and scalable model for addressing healthcare inequities in Northern Manitoba First Nations, positioning the Project as a cornerstone for future investments in equitable and efficient care delivery.

Opportunities

Enhance Staffing and Service Capacity

The feedback gathered from providers, community members, and families reveal a range of actionable recommendations to improve the Project and expand its impact. A recurring theme is the need to enhance staffing and capacity, including extending contracts beyond one year and establishing permanent positions to improve recruitment and retention. Families and community-based collaterals emphasized the need to increase the frequency of visits to high-demand communities. These changes would address high client volumes and ensure more consistent service delivery while fostering stronger relationships between providers and communities.

Improve Infrastructure and Logistics

Infrastructure and logistical improvements were also emphasized. Providers highlighted the need for reliable Wi-Fi, on-site computers, and updated equipment to streamline service delivery, alongside better accommodations during community visits. Addressing challenges such as airline luggage restrictions and improving transportation for families were also suggested to reduce logistical barriers. Proposals for dedicated Jordan's Principle facilities with accommodations and the development of a shared database accessible across communities were identified as key steps to enhance coordination and efficiency.

Prioritize Culturally Responsive Care and Capacity Building

Culturally responsive care and capacity building emerged as priorities, with recommendations for culturally based assessment tools, case stories, and Elder involvement to support families and staff. Training opportunities for roles such as Child Development Workers, Rehabilitation Assistants, and specialized service providers were also suggested to build local expertise. Providers emphasized the importance of engaging community leaders, healthcare providers, and families to align efforts with local needs, while community members requested educational resources in plain language and expanded peer support networks.

Strengthening Collaboration and Communication

Collaboration and communication improvements were frequently noted. Suggestions included regular case reviews, better coordination among FNIHB, NRHA, Shared Health, OHS, and KIM to avoid silos, and increased transparency about appointment outcomes to inform Jordan's Principle teams. Families also recommended faster processing of assessments and reports to reduce wait times and improve care continuity.

Advancing Innovative and Proactive Approaches

Expanding the model used by the Project to other specialists and services was also proposed. This suggestion reflects a collective desire for systemic improvements that ensure the Project continues to meet the evolving needs of Northern Manitoba First Nations.

Appendix A: Clinic Report Data Summary

Table A1. Clinic report characteristics

Year	Number of Clinics		Date Span		% report fields completed
	In-Person	Virtual			
2019	7	0	Feb	Jul	74.7
2020	14	6	Jul	Dec	56.6
2021	32	12	Jan	Dec	37.3
2022	39	3	Jan	Dec	52.7
2023	46	1	Jan	Dec	52.0
2024	46	1	Jan	Dec	75.7

Table A2. Clinic report qualitative field data

What went well?	**Any issues?**	**Opportunities?**	**Stories?**
2019			
- Having clinic present in the community strengthens knowledge about Developmental Disabilities. Saw the appropriate kind of clients for a developmental clinic. Great show rate for right kind of clients. Good room. - Jordan's Principle Case Manager was well organized. - Patients were seen with complete attendance once bus was repaired and running. - The nature of the team and their knowledge of the community was a great asset. Case conferences at the end of the week were very comprehensive. I would love to have a speech language pathologist / OT or PT there as well in the future to discuss cases together. - The children seen were able to be appropriately diagnosed or assisted / reassured as appropriate. - Teaching sessions went well to share knowledge with the community health support staff and providers. They also taught me important barriers to success of	- Without much pre-clinic information there are bound to be some surprises and mix-ups. 2 kids with same name. - Some confusion about the referrals CHP accepts. - Some confusion about the referrals CHP accepts. - No patients seen in the first morning with no bus unless X picked them up. - First trip, so understanding needs, will plan formal in-service teaching on next visit. JP team preference was case conference with individual teaching points for each of my new referral patients (covered eczema, hypertension for example) - The computer system - couldn't use a USB. Not enough quiet toys for kids in the room. No shows (as expected - and unlikely to change). Sometimes hard to know when the next patient had arrived. Confusing forms and hard to find them on the EMR (but happy to have an EMR!) - Large no show rate is my biggest concern. It was suggested we only start in afternoons but half of kids	- Some time to talk with JP team at end would help to see what worked. - Would not book again on a Monday, possibly allow time for repairs / breakdowns [of bus]. Not see after 5. - Better organization on the EMR. I was unable to upload or create templates. I had no way to pull in patient name/DOB/address for referrals. This added un-needed extra time. - I would be willing to start later and work longer but would only feel worthwhile if better show rate. - Better organization and administration. I had tasked letters to be formatted and sent to other physicians in March 2019. The admin staff did not know how to do this in the EMR and didn't ask for help but left them incomplete and not sent.	- There was a child that had a lot of activity and charting for a number of years (since 2013) that hadn't gotten anywhere. Family felt people were unwilling to help. I explained that likely all willing just unsure what they are dealing with and who can help. I felt fairly strongly I knew the correct diagnoses and resources and hopefully move forward from here. - My presence in the community has value in addition to my provision of specialist care, as it is an important step in showing our commitment to dismantle colonial systems that have oppressed and led to health disparities in Indigenous communities. Bringing care closer to home is a vital step as well as listening to the concerns of the community members as a white person whose ancestors were involved in a system of government that stole the children and culture of the Indigenous communities.

What went well?	Any issues?	Opportunities?	Stories?
proposed treatments in cultural context.	did come in morning. More an issue of scheduling only those that motivated? Provide childcare? - Yes! I arrived and no patients were booked all week! The NRHA did not figure out my privileges in time for my travel. Every day was a scramble for the JP team to call patients for me to see resulting in less patients seen than planned.		
2020			
- audiovisual support and quality was okay. - we saw lots of kids and had a chance to meet the Jordan Principle coordinator and plan for future - Patients appreciate the convenience of phone calls. - Patients appreciate the convenience of getting medical care over the phone. - Patients appreciate the convenience of getting medical care over the phone. Attendance rate was good at this half day clinic. - The show rate was fairly good as children were added whenever there was an open spot. The Jordan's Principle staff are helpful and eager to accommodate. - it is great when the JP coordinator is present. - There were a large number of children waiting to be assessed since trips stopped over the summer so it was easier than usual to fill gaps in the schedule when children did not show up to appointments. More parents were working from home and able to accompany children to appointments. - Good collaboration with nurses, reasonable show rate - Satisfactory. Good show rate until last day. JPI was willing to adjust	- Not all well-prepped; no charts sent for review beforehand; no indication given beforehand for visit. - My luggage was overweight by a few pounds which meant that I could not bring books to give the kids. We have a lot of papers to bring (referral forms etc. It would be great if they were on a computer that we could fill in so less papers to bring 60 lbs adds up fast. - [virtual] Inability to physically examine a patient with obesity or headaches for example. - Difficulty getting people on the phone, or phone # out of service, people running out of minutes on their phone. Phone call appointments are very difficult for a first encounter to build relationship and trust with a parent. - Not this time. - One of the challenges of adding patients as spaces come up is there is actually very little information known about the child prior. Without a clinical question around why you are seeing, there is the chance to get an incomplete history or physical compared to what you want, when you go in knowing the question you are trying to answer. There were a couple of parent/family groups	- travelling with a resident was great and having the coordinator there made all the difference. the JPI coordinator does not have a home base and the chief and council are not planning on giving them any space in the near future. I am not sure why. They stayed at the teacherages and have a temp office at the nursing station. other communities have their own buildings etc. This makes it difficult to set up programs etc. if no space. Perhaps we could meet with the chief and advocate for space similar to other communities. - I would love to have the children measured at the clinic the week before we talk as growth is very important in our decision making about medications and referrals. - Perhaps adding an element of video to all first consultations if possible so that they are more personal. This is limited by access to video technology in the home for some families. - Measurements available for the children ahead of time. - I think if there is a specific question the family/JPI staff or Nursing Station staff wants addressed Pediatrics can be best utilized. If there is no question, there is not a lot of value added by our visit. Being able to see what is	- Child missed in FU with severe issues; re-attention to subspecialists that need to be involved. - I had a family on this day that had previously driven to Thompson with no appointment looking for pediatric care for their children as they were frustrated with lack of access to a pediatrician locally during the pandemic. - This day I was able to clarify a previous diagnosis as not likely being accurate and refer on to an appropriate specialist in search of the correct diagnosis. This was very helpful to be able to do this virtually for the family and saved a trip for them to Winnipeg for initial care with me. - Families appreciate the time that is spent with them in clinic addressing their specific concerns about their children. Quite often physicians are rushed during their appointments, and these clinics are the ones where ample time is booked for a thorough assessment of the child and meaningful changes can be made to support the family. Often my biggest value to the family is for advocating for other supports that their child needs (e.g. needs glasses replaced, need respite for parents, need to have access to a fitness facility, need creams for eczema that aren't

What went well?	Any issues?	Opportunities?	Stories?
schedule / volume. Nursing Station / staff willing to give up a room for us to meet in. - Home visits. it is great when the JP coordinator is present.	that didn't know why they were being seen and one parent that ultimately didn't want to be seen which made for an awkward interaction. - weather, could not land so had to return to Thompson, rent a truck and then drive in the next day as too late to drive that night - It was very hard to keep children occupied in the room now that we are not providing books and toys due to pandemic restrictions of shared items. This made it hard for families to cope with a long first assessment appointment with me. - Nurses think we are only there for behavioral issues, but as I explained, we can also see and follow other pediatric care. - No accommodations in community. Had to drive in and out from Thompson each day. - More driving required, but suggests that we could maybe go more often with shorter duration. Clinic would likely be improved if knew in advance why wanted to be seen. - the medical van had a flat tire so limited patients getting in to see us	in Accuro in Split Lake would help in certain instances. Timely returning of our transcribed reports to the Nursing station and JPI staff is likely more helpful than long delays. If I have the transcriptions promptly, makes referral to our colleagues in Psychology more informed. - access to allied health even knowing who they are and contact information - Access to Accuro from Winnipeg, better coordination between specialists who bring children to Winnipeg for appointments. Consistent access to therapists in the community. Better communication between JP team and school of how to support our patients in their learning environments. - More continuity of care, better FU of patients, and reporting back to me while I am not there, and a better width of patients for consultation. - If could have had wifi access at Nursing Station would have been able to see child's EMR / ACCIRP record from Thompson, could have made req's directly rather than back to office - access to allied health even knowing who they are and contact information	covered) rather than a medical treatment or specialist referral. - Building skills for the nurses and other JP workers through education was much appreciated, and I think us coming to them is very much appreciated as well. - A parent with a concern was able to have it addressed on her lunchtime. A new diagnosis was made in a child that had not been anticipated, caregiver had not approached anyone for concern. - one family had no coats so couldn't go to school or come to the nursing station as it was cold out not. We gave flu shots and dealt with the head lice and other health concerns. Mom pregnant and 7 kids.... got them coats to help. Advocate for a new home.
2021			
- Good attendance - Good reception on calls, mostly up to date phone numbers. - The case manager was incredibly helpful in accessing all families to provide them information about the service and obtain informed consent as well as scheduling, staying late one evening so that I could assess a few extra children etc. I was able to test kids in 2	- One of the patients was not expecting my call and did not know who I was but had time to talk to me anyhow. 2 of my patients still required a trip to Winnipeg after seeing them virtually, 1 was coming anyways to see a specialist so no extra trip, 1 will need a trip as no Primary Care locally is able to see her.	- Weights, heights and blood pressures available. It is very hard to know how well the children are growing. I have managed to get these after the appointments so far with talking with my team but not able to have many prior to the appointments unfortunately. - There are ongoing difficulties with my patients accessing Primary Care in the community or basic	- Many of the families are now hoping and looking forward to me being able to be back in the community in person. It has been great to hear that they want to see me. There has been extra value as there have been clinic closures recently at Beatrice Wilson due to the pandemic and consistently no access to a Family MD. Unfortunately for many of my

What went well?	Any issues?	Opportunities?	Stories?
different schools and school personnel were extremely accommodating and welcomed our services. Met with personnel from 2 of the 3 schools the children attend, discussed additional cases they would like seen as well as our general services, also provided some informal psychoeducation around developmental disabilities. - Clinic generally went well. Given that it was our first visit to the community there was some confusion about the nature of our services and how often we are able to travel to the community. Because it was our first visit I think many families were unsure about what to expect and that may have been the reason a few did not attend the clinic. JP Staff did a great job of communicating with families and making the space we were using for clinic welcoming for the kids and provided the younger kids with activities to do while I spoke to parents. Met with JP staff, discussed their programming, discussed new building they are moving into and renovating, discussed how they might be able to use the new space to provide programming. Discussed cases that I had seen while there/provided initial recommendations. - The JP staff were great and did a great job of communicating with parents about CHP coming to the community. This was a short trip as it was added on to the Mosakahiken trip. There had only been 5 referrals so we had planned on having 1 1/2 days of clinic. 2 kids did not attend their appointments the first day and we were able to get 2 other kids (who had appointments the following	- No show rates were higher than previously experienced for the virtual clinics. First consultation appointments are much more challenging compared with in-person assessments as often the family was not expecting or prepared for my call and luckily it was a good time to talk. There have been frequent no-shows for lengthy first consults which are not ideal as they are longer appointments and often there are families waiting to be seen who do not get a chance. - Difficulty getting parents to bring their children to their appointments or send them to school for their appointments. According to the case manager, there is some general mistrust of health care professionals in the community which may have played a role in their hesitancy to have their children seen. A bit difficult to find ideal space to see patients. - Difficulty getting parents to bring their children to their appointments. Clinic space was a bit of an issue- we saw children in the new Jordan's Principle building which did not have a working washroom and was not yet renovated. - No shows were biggest issue. - No shows were biggest issue. - According to the JP coordinator and to staff at both schools, there are a large number of children in the community that need psychological assessments for possible intellectual disabilities and possible Autism. Unfortunately these children did not come to the attention of the JP Case Manager until immediately before my visit there, therefore there was not time for school staff	measurements and blood pressures that I need. I understand that my Nurse is now managing the nursing needs of the whole Health Centre rather than just our JP program so challenges are expected (Centre is mostly closed, regular nurses have been pulled to do COVID testing/ followup/ immunization jobs instead). - I think everything went very well aside from some no-shows. There is a Jordan's Principle building under construction in the community so I anticipate for future visits there will be more appropriate space available for testing/meeting with patients and families. - I think everything went very well aside from some no-shows. When the new JP space is up and running I think future visits will be great. - Timely referrals sent to me well ahead of scheduled community visits. - It would be helpful to have a list of referrals (and referral information) ahead of arrival in community.	patients I am hearing that I am the only access to any Physician care that they have right now at all. - The community clinics now have increasing value as it is not only providing specialist care but attempting to fill some of the unfortunate gaps in Primary Care. Ongoing virtual support is needed in the community and hopefully in person support again soon! - There was one young lady I saw while I was there who has significant learning challenges that have not previously been assessed. The school staff were quite concerned as she is finishing grade 12- their school psychologist could not prioritize this young lady because there are so many children with extremely high needs in the community. School staff was incredibly grateful to have me complete her assessment and provide recommendations for post-secondary education for her (as well as adaptations) which would not have been possible without the assessment. Because of the assessment, she will likely be able to access needed supports to be able to attend a post-secondary institution and pursue higher learning. - According to school staff, the band made a decision to sever service ties with MFNERC for the community. Because of that, the schools have no access to specialist services that would typically be provided by MFNERC. I spent quite a bit of time discussing the necessity of accessing school psychology services for the high school with school staff and the difference between what kinds of cases should be referred to school psych.

What went well?	Any issues?	Opportunities?	Stories?
day) to come in, therefore we only needed 1 clinic day. The community may need another trip soon. - When the 2 scheduled kids did not attend, JP staff was able to find another child who needed to be seen. - JP staff in the community were very supportive and did a great job of communicating with families about appointments etc. and trying to ensure that families did attend. - Did a workshop at the Wellness Centre so met most of the staff working there; also discussed CHP services with JP staff. The clinic was very well organized, JP staff did a great job of ensuring that everyone attended their appointments. The space I was given to see families was perfect and met our needs very well. 1 of the no-shows was due to the family not having child care for the other children. The other one did not attend because the child was sick.	to get consent from all the families to see me. - None - Clinic was a bit disorganized, I did not receive referrals in advance. Clients did not attend their scheduled appointments. The 2 clients I did see were referred by pediatrics when they saw them and they sent them directly over to see me.		and what kinds of cases should be referred to CHP. Hopefully this will help the school arrange for contract school psychology services to meet some of their needs in a timely manner. - One of the families I saw is at imminent risk of breaking down due to the extremely difficult behaviours of one of the children. Because I was in the community (and not providing services virtually or from a distance) I was able to connect the family with essential community services (by getting in touch with staff from Hope North for crisis services and finding out the referral process for local Community Mental Health) and also made referrals to St. Amant Centre and RNTS for supports. - Access to medical charts- consistently an issue in this and other communities which has still not been adequately addressed.
2022			
- Reviewed cases and services with school. Good to have JP worker on site. - JP staff were extremely organized and ensured every family arrived on time for their appointments. One family had to cancel their consultation due to the child being ill. - We were able to see a few of the kids in the school which was convenient because JP has no clinic space available - Clinics in this community are always very well organized. They had the days mixed up but they immediately readjusted and rescheduled people when we	- it was busy,, on my own so had to do all heights, and weights etc. no JP personnel to assist - 2 of the no shows were children who were out of the community, 2 were cancelled because they are children in care and JP was unable to get consent from CFS for assessment/ consultation, the other 3 cancelled because the children were ill with symptoms consistent with Covid. - The 4 no-shows were all due to the kids having Covid-like symptoms. - Perimeter airlines changed the flight to earlier without notifying passengers. I have experienced flight delays but never early	- need someone to assist with follow-up, Ht, Wt, etc. - dictate and be able to leave the notes behind - Nursing assistance with vaccine catchup and drawing of vaccines. Which I mentioned to the NIC (Joe Degrafe) and he has already discussed this permission from FNIHB for access to the vaccines and storage areas. Doris had a family emergency - looking forward to next time - Working on admin. JP coordinator must get a fax machine and phone supplied for off-site office. - Communication of dates with the nurse assisting with clinic dates in	- Saw a young boy with ASD raised by grandma now who is an elder. He needed an assessment and letters written and consults. She couldn't leave the community. - people are appreciative of one coming to their home communities. I enjoy doing home visits - One of the families that we consulted with has numerous children with extremely high needs- all children in care. The family is extremely stressed and have received few resources; we are able to advocate for the resources that this family desperately needs to that the family does not break down.

What went well?	Any issues?	Opportunities?	Stories?
arrived in community (a day before they thought we were arriving). - generally went well; There was an ill child there and planes were not going due to fog so I provided daily care to a medically fragile child who was at nursing station for many hours: ultimately he didn't need transfer as we were able to get hiim better before the fog cleared! - Space was fantastic, Health Centre staff and JP staff were extremely helpful and supportive. The families that we saw were engaged and interested in seeking out services. With JP staff: Went over referral list and schedule, discussed appropriate/inappropriate referrals. Discussed assessment/consultation findings and referrals for follow-up. - Space was good, staff were helpful - Space was fantastic, Health Centre staff and JP staff were extremely helpful and supportive. The families that we saw were engaged and interested in seeking out services. With JP staff: Went over referral list and schedule, discussed appropriate/inappropriate referrals. Discussed assessment/consultation findings and referrals for follow-up. - Clinic was initially somewhat disorganized with no referrals received prior to arrival- spent the first half day generating a list of children to be seen. Made for a very slow start but once clinic started, JP staff were excellent at getting families to appointments. - Families were receptive. Doris organized schedule and charts. Access to eChart was made available when needed.	departures/ flight change without a notice. - - minor flight delay (1 hour) - No issues aside from a delayed flight into community that led to us shuffling the schedule to get the kids in that were scheduled to be seen that afternoon - Just no-shows which are typically an issue in this community. - No issues aside from no-shows- many of the no-shows are children in care of CFS agencies- according to JP staff, CFS staff did not communicate with families about appointments. - It would be helpful to have a list of referrals (and referral information) ahead of arrival in community. - Space for clinical work and admin work was the same, ideally these would be separate. Patients were not booked before arriving, addressed with Doris for next visit. - Patients were not scheduled ahead of visit. I can ameliorate this by communicating with the JP staff and NIC and confirming dates. Hydro scheduled a power outage one day of the trip. Queen Elizabeth's state funeral closed the nursing station on the first day when administrative tasks are often done (reviewing scheduling etc). - Just that the plane was delayed by 2 hours (nothing new). - Flat tire, limited places to get it fixed so silled with air and left. - This community has been identified as having a large number of children in need of diagnostic assessment however referrals are not being completed and not being sent to me.	advance of arrival will improve efficiency. - Need someone to assist with follow-up, Ht, Wt, call for rides. - Timely receipt of referrals from Jordan's Principle staff. - It would be supper helpful if a nurse could be assigned from the nursing station to help out with clinic. Getting heights, Weights, vitals and POC hgb, and then being able to provide immunizations, dispense meds, would allow me to see more children. - Timely receipt of referrals from Jordan's Principle staff. Ensuring referrals to CHP are appropriate referrals - Better internet to access Accuro	- Families are thankful that they do not have to leave the community and other family members in order to attend appointments. - One child needs neurosurgery but caregiver reluctant to go: they had already missed appointments in Thompson due to reluctance: I was able to organize and they have been seen by neurosurgery now. - Many of the kids I saw would have an extremely difficult time traveling to Winnipeg or Thompson to access services due to extreme anxiety and hyperactivity and developmental delays. - Many of the kids I saw would have an extremely difficult time traveling to Winnipeg or Thompson to access services due to extreme anxiety and hyperactivity and developmental delays. - Disrupts families less if I come to them. They start to see a familiar face coordinating care. - With return visits I am getting to know the staff and families. They are also getting to know me and building trust as an advocate for the health of the children in NCN - I was able to meet with a family with a child with a chronic illness and see him in both Winnipeg and in his own community: I think this helps families feel taken care of, and feel like they can trust the hospital better if they see the same face in both places. By having a pediatrician come to the community it helps nurses feel like they have someone they can reach out to at Children's if they need to. It also helps for being on MB First Nations pediatrics call because the MDs who do that call generally also do OHS or JP trips and it helps

What went well?	Any issues?	Opportunities?	Stories?
- JP staff was very organized, space to see the families was great, staff transported families who needed transportation, staff ensured parents attended with all kids. - The referral binder within the office of the NIC was filled with names of children. With JP staff: Discussion surrounded referrals to JP program. System/procedure of OT, PT, and SLP referrals from nursing getting to JP co-ordinator to be mimicked with revision of consult letter drafted by NIC. Copy will be made by front admin staff to be given to Hazel to schedule. - The clinic ran well; both the JP personnel and nursing station staff were very welcoming and helpful. I toured the school w JP staff and met with the Principal, and discussed overall care for the children and together we discussed JP services. I informally me some of the teachers. The JP staff took me on a tour of the community. - Great to have case workers there the whole time. - Discussed CHP services and discussed some specific children identified by the school who are in need of assessment/diagnosis with school. I had not received any referrals from the Jordan's Principle program. I had 11 referrals that I had received from staff at the nursing station and from pediatrics. I had ample time available to see more children than I did see, however staff had no additional referrals ready for me to see. - I thought the staff at the nursing station were suportive, JP program was suportive - Nursing station staff were incredibly helpful in running our	- No Shows and organizing to have time spent in the most efficient way is a big barrier - I had not received any referrals from Jordan's Principle ahead of the visit. I had 1 referral from pediatrics and had sent a list of children who did not attend their last scheduled visits from 2021 and asked to have them scheduled. I was given numerous new referrals during the community visit by the Jordan's Principle case manager. Many of the children I had asked to see did not attend and it was unclear whether the families were given appointments prior to my arrival in the community. It seemed as though they were not contacted for appointments until we were in the community. Jordan's Principle staff were not on site and did not facilitate families attending clinic and did not reliably contact us during our visit. We were often left wondering whether or not a family was coming in and when they might be coming in. Nursing station staff mentioned a number of children in the community are in need of developmental assessment, however none of those children were referred to CHP or identified by Jordan's Principle. A large number of the children I was asked to see presented with mental health concerns, not developmental or health-related concerns. - Need someone for JP program to be on-site - Difficult clinic, no contact with JP coordinator, I had to call in the patients, take Ht & Wt. Really need JP staff assistance.		w relationship building with the nurses. - A valuable visit for the resident to visit the community. - I have a family with multiple children with Intellectual Disability who need genetic work up. If the children were never brought in together and identified as siblings this likely would never have been identified as a potential genetic issue.

What went well?	Any issues?	Opportunities?	Stories?
clinics while in the community and providing us with supports (such as getting charts ready, tracking when families arrived for appointments etc.). - went fine but NIC wants us to use JP staff not theirs			
2023			
- JP staff was very organized, space to see the families was great, staff transported families who needed transportation, staff ensured parents attended with all kids. - had a CHR to help us, she called in everyone and was helpful - First day was busier than expected, likely due to cancellation of clinic the day prior. - I always had someone to work with, doing the Ht/Wt and call all the patients in which was wonderful. - when patients showed up, nice to see them - the staff at the nursing station are helpful to get things set up - Case reviews of all patients seen. Update on available travelling specialists/plans to increase therapists attendance rates/back-up list. Most patients who attended came on time. We had plans for dietician support during clinic (but she was sick so it didn't happen). Had a chance to meet GPs in clinic. - The clerk for the nursing station was helpful - had a very short meeting to talk about the importance of having someone from JP at the nursing station as it increases the amount of kids that can be seen. it was busy, on my own so had to do all heights, and weights etc. Had access to accuro which was great as we immediately did the note and left them there. JP personnel	- none - need Jordan's Principle assistance while in community - unable to coordinate visit with JP lead for community which was unfortunate. - no issues, loved it. I had sent a text to the JP coordinator and an email prior to coming (few days before) but he still had no idea what time I was to get there. - nobody from Jordan principle came to the clinic. I was on the phone with them 3 times a day while there asking for patients. No Jordan Prinicple staff came to discuss or see me . All communication was done by phone. I would phone to initiate patients to come. They gave me a verbal list even though I had asked them to fax one for all 3 days. I offered to do home visits with the staff and offered to use my vehicle. I spoke with Mabel Cook to plan for the next visit. She mentioned Sept. One patient came at the end of the day and then there was no way for them to get home as it was after 430 pm and no answer on the JP phone so I drove them home. - It would be nice to meet up with co-ordinator. - No-show rates were relatively high - it was busy,, on my own so had to do all heights, and weights etc. no JP personnel to assist , I called in patients. - We wrote alot of advocacy letters which upset the co-ordinator, so I	- Better electronic access to charting - always having a local staff member to work with you ALL the time to call patients, take Ht/Wt etc., label forms and keep the general flow going. - improve clinic flow, it was busy,, on my own so had to do all heights, and weights etc. no JP personel to assist. dictate and be able to leave the notes behind - Dietician support in clinic. Enhanced plans for getting exercise covered for the patients. I need patients emails, can this be added to the referral form? - dictate and be able to leave the notes behind and have a Jordan Personal available to assist with contacting patients, rides, list of kids, and overall flow of the clinic - have a Jordan Personal available to assist with contacting patients, rides, list of kids, and overall flow of the clinic - "To provide a consultant referral. - Investigations/consultant letters in chart" - CORTEXT for the RNs. A dietician routinely available during the week I am at clinic to support my suggestions to family about changes to foods and drinks so as not to lose momentum. - no - dictate and be able to leave the notes behind and have a Jordan Personal available to assist with contacting patients, rides, list of kids, and overall flow of the clinic	- A number of the families seen have never seen a specialist of any kind before my visit. Making that initial contact with them as a specialist and trying to ensure that the experience of working with me was a positive one hopefully not only connects these families with needed resources but also reassures them that we are there to help and will make it easier for them to agree to see a range of specialists in the future. - people were really appreciative and the staff were lovely to work with - people are appreciative of one coming to their home communities. I enjoy doing home visits and I feel that the parents to as well. it give us an opportunity to see the struggles. - A mother came with one of her children this week. She had been very lost trying to find medical care for her children. For years she has been advocating when things were wrong but it was taking years to connect with a doctor that offered continuity for a diagnosis. We diagnosed asthma and changed her medications/plan to be comprehensive and preventative. - taking a resident and getting them to do home visits as they have an opportunity to see firsthand the challenges of our First Nations children and parents have. She really enjoyed Moose Lake

What went well?	Any issues?	Opportunities?	Stories?
to assist as not someone there all the time. - most patients showed up. The booking clerk does an excellent job of booking patients. - "Accuro - good organization" - Reviewed all patients seen that week and their immediate and f/u plans. RNs were aware of patients needing consents and blood work done and to follow-up with them. The clinic went well. Attendance was very good. An initial 5 day week was condenses to 4 days due to lack of a Monday flight so the clinical days were very busy. - Generally well organized - it was busy,, on my own so had to do all heights, and weights etc. - JP personel to assist as not someone there all the time. - the after hours transportation was fantastic to bring patients in or do home visits	asked for her or JP personnel to be at the appts so we know the background with the family and their request. Made note of this for next time. - "Those who are referring the patient to me are not consistently providing a reason for the referral. Most do not provide a consultant referral. - Delay in receiving travel itinerary." - travel back home, multiple delays. Poor communication from perimeter airline - The car rental company was not aware that I arrived on a charter flight so there was difficulty with my Monday morning transportation to the clinic. - no		- I have noticed a shift in the value that families place on their want to be seen in the pediatrician clinic as they trust my assessment and input to be helpful for health maintenance and diagnosis for their child. At times previously it seemed that a pediatrician visit was a means to access what they might have wanted and they often didn't know if my visit with the child had value. - I have been able to follow several children in the community over serial visits and have been able to help the parents with difficult behaviour management problems that their children have. These are problems that need ongoing follow up and are not sorted out in a single consultation that would happen for children who are coming to appointments in the city.
2024			
- Had a multidisciplinary meeting on Teams with mental health clinician, 2 PTs and 1 SLP to discuss 7 cases. Clinic went well. We had good attendance rates and the virtual/in-person format to our end of week clinic was very helpful and collaborative. We were able to slot in some children by request which was very appreciated but the families. The addition of Garret Froese from Red Ladder doing Psychology assessments in a timely manner has greatly enhanced my ability to help children in OCN. - Families were grateful and welcoming. - "Hillary was outstanding. In order to assist and take us to home visits, even brought in extra kids who she knew needed help.	- Flight was 2 hours late (Calrm Air) on the way there. Some visits required more time than allotted to completely address multiple issues. - No ticket ahead of trip, no dictaphone; scheduling done the night before or day of in most instances - this did not allow for chart pulling and review ahead of time. This disrupts efficiency. But kids were seen and assessed. My visit folder Doris made was AWOL at the start because the space I use keep changing depending on providers in community. - We still need to figure out a way to have the Peds list have more information so the booking clerk and I can triage the patients better. - It was busy, had to do all heights and weights etc. no JP personnel to	- More consistent primary care collaboration at the health centre. Access to social workers to help family navigate difficult circumstances. System in place for caregivers to fill out online rating scale re: mental health symptoms prior to appointments. - Mostly administrative First day to have chart reviews with clinic nurse on same day as travel. Run clinic for 2-3 half days and then travel back home. Logistics sorted out with more lead time in planning on a Jordan's principle side of things - have a Jordan Personal available to assist with contacting patients, rides, list of kids, and overall flow of the clinic - This was a more challenging visit than some with regard to the	- At the end of our team meeting one of the team members who is connected to the community mentioned that she sees a real difference in people's lives now as a result of visits with me that involve counselling and interventions. She sees that people are making changes that are resulting in better health for their children and families. - Some patients would never access care otherwise - a boy waiting since 2019 for speech delay. Presented in clinic as on the Autism spectrum. - taking a resident and gettign them to do home visits as they have an opportunity to see first hand the challenges of our First Nations children and parents have. She really enjoyed Moose Lake

What went well?	Any issues?	Opportunities?	Stories?
- She took us to homes so kids could be seen . Had access to accuro which was great as we immediately did the note and left them there." - There were many referrals from the nursing station so we saw many of those children. The medical assistant and NIC at the nursing station are very welcoming and helpful. - overall, it was a good community visit because most of the patients showed up. Not a lot of patients to see. - the staff at the nursing station are helpful and the phone calls were good as all had phone numbers - Met with Hazel Sinclair (Jordan's Principle clinical case coordinator), James Weenusk (health leader) and Nellie Erickson (nurse for clinics): - We discussed barriers to clinic organization and followup; engagement of community.	assist except for in the evening we had a drive to do home visits. JP coordinator only had 3 kids in her list. The rest came from the nursing station NIC. - flight was not able to land and resulted in an additional roundtrip and standby flight the following morning. Weather and haze were the factors contributing. The scheduling of patients and communication about patient arrival by transport van is lacking effectiveness. This disrupts efficiency. Finding a space to have clinic was initially a challenge.	Jordan's Principle personnel. There was an opening of an addictions centre in the community and also women's gathering happening at the same time as the trip and this took up much of the time of the Jordan's Principle personnel. I had checked in advance to confirm that it was a good time for me to come: I am not sure if the other events were booked after I confirmed my dates, or if the Jordan's Principle staff had just not noticed the conflict. I didn't see anyone from Jordan's Principle office for the whole time I was there apart from transport to and from the airport. I know the nursing station staff were a bit frustrated that they had to support me more than usual (eg contacting families to come in etc). - lost wifi so had to do all dictations once back as could not access Accuro while in community to dictate. - Mostly administrative. First day to have chart reviews with clinic nurse on same day as travel. Run clinic for 2-3 half days and then travel back home. Logistics sorted out with more lead time in planning on a Jordan's principle side of things (same as last time).	- The resident that I brought with me wants to do General Pediatrics for a career and wants to do trips to communities, so this was a great opportunity to show her a community and how the visits work in God's Lake (recognizing that every community is a little bit different in terms of how things work). - people are appreciative of one coming to their home communities. I enjoy doing home visits. - - - The families are building trust and we are getting to know one another.

Appendix B: Families Focus Group Data Summary

1. How has your awareness about the role of pediatrician and clinical health psychologist changed as a result of this project?

    - Some participants had no prior awareness of the roles and learned about the services provided. They learned the differences between the pediatrician and clinical health psychologist roles.
    - There was greater understanding about conditions like ADHD and autism, as well as the role of the clinical health psychologist, though a few still were unsure about the latter's role.

2. How has your family's travel burden changed as a result of this project?

    - The project significantly reduced travel burdens by bringing services to the community, alleviating the need for families to travel to other locations.
    - The convenience of services being delivered locally was particularly beneficial, especially for families with multiple children and those whose children do not have Status.

3. How has your family's quality of life changed as a result of this project?

    - Families expressed a significant positive impact on their quality of life, with parents feeling relieved due to the access to services and the support provided.
    - Parents with children diagnosed with autism reported feeling validated and supported, especially in terms of understanding their child's needs.
    - Participants felt informed and appreciated the awareness brought to conditions like ADHD and how to manage without necessarily using medication.
    - The services were seen as a source of relief, reducing stress and improving immediate support for children's needs.

4. How have providers become more culturally aware/sensitive/humble as a result of this project?

    - Providers were described as respectful, non-judgmental and sensitive to the families' circumstances.
    - Positive interactions were highlighted, particularly during home visits where providers recognized and addressed family needs, such as helping secure basic necessities.
    - Parents felt that the providers were not only professional but also empathetic and understanding of the community's cultural values.

5. Are you satisfied with the services you have received?

- Overall, families expressed high satisfaction with the services provided, noting that their stress levels had decreased and they felt supported.
- Many participants appreciated the convenience of receiving services locally, which saved them from having to travel and felt the services had been life-changing for their children.
- Parents with multiple children emphasized the relief that came from having the services available.

6. What could be changed to better meet your needs?

- All participants suggested increasing the frequency of visits.
- There was a desire for more educational resources for parents, including simplified language and more accessible information about the services.
- Some expressed concerns about the time it takes to receive assessments and reports, with a request for faster processing.
- Parents also suggested the creation of peer support groups or opportunities for parents to connect, either in-person or online, to share experiences and advice.
- It was suggested that the model used for KIM Jordan's Principle services could be expanded to other types of specialists and services.

Appendix C: Case Managers Focus Group Data Summary

1. What has been the impact on children and families?

    a. How has awareness about the role of pediatrician & clinical health psychologist changed as a result of this project?

        - Pediatrician
            - Parents want this now and are going to the nursing station for this service
            - In some communities the nursing station has taken over the pediatrician's work, which enables direct referral to clinical health psychology
        - CHP
            - Parents experience relief once a diagnosis is obtained and it opens up other doors for support

    b. How has families' travel burden changed as a result of this project?

        - Families experience relief about not having to travel as much
        - Some parents are afraid to travel because of language differences, safety concerns, racism, feeling intimidated
        - People's time is valuable, sometimes people are traveling for 10 hours for a two-minute appointment
        - Travel is exhausting

    c. How have families' quality of life changed as a result of this project?

        - Having a diagnosis helps with increasing parents' skill base and establishing routines which increases quality of life
        - Generally quality of life is being improved for those accessing the services
        - We think it's working
        - Families are better able to take charge of their child's well being and are reaching out more for services

2. What has been the impact on neuropsychological assessment, developmental diagnoses and health psychology consultation?

    a. How have providers experienced cultural humility changes as a result of this project?

        - Providers want to learn and engage
        - Providers have become more involved in community events and want to be involved
        - Some are trying to learn the language

    b. How have providers experienced changes in practice as a result of this project?

        - Providers have had eye opening experiences learning to adapt to Rez Style
            - The whole family might come to an appointment
            - Shifting to afternoon and evening appointments
            - Don't come during Canada child benefit

c. How have patterns of neuropsychological assessment, developmental diagnoses and health psychology consultation changed?

- *none*

3. How has the service gap been narrowed?

a. What stories can you share about the service gap being narrowed?

- Its good that now families get support when having to travel for medical or other appointments
- Of all health programs Jordan's Principle has had the biggest impact on holistic health
- Advocacy through Jordan's Principle has fueled system changes
- Off-reserve quality of life has been declining over time but now Jordan's Principle has helped to address this
- Based on clinical health psychology and pediatrician recommendations we are able to enhance children safety and recreation opportunities, children have the ability to enjoy the outdoors, preventing parent burnout and decreasing likelihood of children going into care
- Wait times are coming down, yet they are still long
- Empty cups can't fill the cups of others
- Families with multiple children with higher needs don't have to travel as much
- Providers recognize that families attached to Jordan's principle need the services
- Parents knowing a child's needs routine likes dislikes helps caregivers to train other caregivers
- Having a diagnosis in the first place is an initial step in this process

4. What challenges and barriers have been encountered?

a. Challenges

- Clinical Health Psychology
    - Need more visits with clinical health psychology, more capacity
    - Providers sometimes cancel due to lack of accommodations
    - Weights are too long
    - It's a perfect storm: multiple factors have to align for successful assessment
    - Budget supports two times per year, but staffing only permits one time per year
    - Year to year funding is not conducive to increasing staffing
    - NCN did some engagement with providers and families, which can be shared with Randi
- Lack of services from 35 years ago means parents now are struggling
- Poor access to charts
- PHIA requirements
- Mistrust of Jordan's Principle program/staff with health data
- Flow of client data sometimes slow (CHP reports)
- Medication review and follow up not happening often enough which can result in emergent situations
- Some families want the trip out of community
- Paper charting
- Criteria for stabilization spots

- Follow-up services aren't in place to support those who are assessed diagnosed in most communities
- There needs to be a collaborative, concerted effort for transformation, including schools Jordan's Principle staff and other health services
- There aren't enough EA's in the schools
- School staff need training to be able to support children with behavioral challenges as opposed to just sending children home
- Frontier won't let Jordan's Principle staff in schools and haven't trained their EA's
- Some Ped's waitlists are 2-4 months
- MATC is being used for crisis/higher needs
- Stigma still exists around accessing mental health services
- Sometimes grandparents have fears about medications
- Virtual care and tell the health are less effective and not as well received
- Perimeter is not able to accommodate higher needs children
- Perimeter flights are often canceled, delayed or full
- Not controlling our own funds not being aware of account balances
- Accommodations
- Not enough service providers
- Frequency and duration of visits could be more
- Lack of clinical space and equipment
- Working around other clinician's schedules
- No secure fax or computer for visiting providers
- Paper charts
- Local community transport for clients
- Telehealth assessments are not as good as in person, but better than nothing
- Liability

b. Opportunities

- Collaborative case conferencing in community
- Nuka model
- Need psychiatry
- Need therapists
- Want to see more culturally based assessment questions/tools/interview methods with accessible/plain language
- Capacity building for staff and parents: hands-on, culturally appropriate, using case stories and Elder knowledge
- Culturally responsive and hands on capacity building for staff and families/caregivers
- Dedicated Jordan's principal telehealth
- Jordan's principal buildings and facilities through chrt 41 with accommodations
- Jordan's principal wide database for all communities
- More training opportunities to graduate CDW's, RA's, IT, PT, OT, SLP, Audiology, Medical Technologist (Xray, Phlebotomy)
- Service provider listing
- Urban navigation
- Transportation services
- Training on general vehicle maintenance

- Central referral at KIM and expansion of specialist services

5. What are the perceptions of the end-users, community-based collaterals and service partners regarding the program?

   a. Are you satisfied with the Project so far?

      - Overall things are going well but there's always room for improvement
      - The pediatrician who comes to Barren Lands, Dr. Florescue, is very good

   b. How can the Project be improved? What changes do you recommend?

      - Case managers and community collaterals want to know how to better support the visiting providers
      - Leadership needs to know what the case managers are dealing with

Appendix D: Providers' Survey Data Summary

1. How has awareness about the role of pediatrician and clinical health psychologist changed as a result of this project?

- As a healthcare system perspective, I think our services are still so hit an miss that people aren't aware of which communities receive what services and at what level.
- Clients are attending appointments & this area needs improvement, as some are not being seen in follow-up, many variables.
- I am not sure I can speak to awareness about the role of the pediatrician - I think with the pediatrician's visiting, we have been able to answer question and offer ways of helping that community members might not have been aware of e.g., disability tax forms for children with complex needs. Being part of this project helped me better understand the contributions of clinical health psychology in remote sites and how we can work together as a team with them as well as the other visiting health care professionals. With more understanding of each other's contributions, there will be more opportunities for improvement and collaboration. I also hope that there is better coordination of consults or special tests when patients do have to go into Thompson or Winnipeg.
- I am not sure. As I have only been on a few community visits, I cannot speak to this question.
- I recently heard of families coming to the Nursing Station asking for their child to be seen by the Pediatrician on my next visit. So, the word is out in the community
- I think that with each community visit each of us make and with our increased interaction with community members during those visits our roles have become clearer to the communities. This is also quite clear when we go to new communities and realize that, in general, community members do not really yet understand what our roles are. I make a great deal of effort to explain my role clearly to each of the families I see and I hope that has helped them to understand the unique role we have.
- In community I believe people have awareness that pediatric services are available that weren't previously. I'm not sure they know this is directly through KIM or JP.

2. How has families' travel burden changed as a result of this project?

- Family care in Jordan Principle.
- I hope that the burden is reduced ... With providers going into community, this means less time off work for caregivers, less time away from school for the children and less carbon footprint from a sustainability perspective. This would especially be important when the weather makes travel difficult such as heavy rain or snow especially since there are zones with no internet access on the main highway. I expect that there would be some financial savings for not having to make the trip into Thompson or Winnipeg for some of their care. I wonder if telehealth could alleviate the burden further once relationships have been established between the care provider and the families. This could allow us to see more new patients if follow-up does not require a physical exam.
- I think more virtual health appointments could better serve clients in the community. & community accumulative traumas affect all the families. Wrap around services are needed for all.

- I would imagine that the travel burden has changed significantly. Many of the assessments provided by psychologists could not have been completed without the family traveling to Winnipeg without this program.
- It has completely changed. Before this project, they all would have had to travel outside the community to access pediatric or clinical health psychology care. Because of this project, they don't need to arrange escorts etc. and problem-solve issues like child care to attend specialist appointments. In addition, many of these high needs children have an extremely difficult time travelling and being away from their homes which causes significant stress and strain to them and to their families. In addition, if we can have CHP provide diagnoses of developmental disorders (such as Autism) then families don't have to travel (and wait for over 18 months) to be seen at SSCY in Winnipeg.
- Many families … miss scheduled appointments in Winnipeg and Thompson owing to issues with travel from this very remote community. Seeing the children in the community avoids this issue. Some families however report that they prefer to leave community to see Peds as they enjoy the trips away
- Many patients have avoided travel to Winnipeg or Thompson.
- Sometimes 2 escorts are needed
- Travel is arranged. Accommodation is not perfect especially for those with physical mobility challenges.

3. How has families' quality of life changed as a result of this project?

- Ability to access care for patients closer to home or access care for patients for whom they wouldn't have accessed care previously due to barriers.
- As I have only been on a few community visits and not a second visit to the same community, I cannot speak to this question.
- Basic needs, food clothing shelter residence furnishings are available by the program.
- Children's special needs are identified & efforts to make service need available are organized & yes not always easily delivered
- I don't actually know how their quality of life has changed and I feel that they need to answer this question. What I hope has changed is their access to much-needed supports as a result of our consultations and referrals to supports. I hope that their understanding of their children's difficulties and challenges has increased as a result of our project. I hope they have been empowered a little bit to understand that they have the right to decide on the type of health-related care they and their children can receive and that they are allowed to say "no thank-you" when offered services etc. that they do not feel comfortable engaging with. I hope that they feel supported by us and the services to which we refer them. Most of all, I hope these families feel understood after meeting with us the first time.
- I hope less time travel and better access to care means more time for self and family, more time to focus on managing health concerns of their children. Hopefully when care is what the families would hope for then there would be less worry and stress. They would have their questions answered. There are other more community-based matters like vaccines, safety, healthy active living that care providers will encourage and facilitate and hopefully that leads to healthier individuals, families and communities and therefore everyone's quality of life
- Information about needs is made available to families
- Too early for me to fully assess this; but hopefully I great sense of health empowerment

4. Have you experienced cultural humility changes as a result of this project?

- I feel that I learn all the time from the patients, families and caregivers as well as the nursing staff and Jordan's Principle staff - with every interaction. I try and reflect on how I could do better and if I have met the needs of the patients and their caregivers. I am still trying to figure out if I am meeting the needs and expectations of the community. I am trying to learn how to pronounce some Cree words … which has been very humbling.
- I learn something related to the importance of culture with each visit including strengths of Indigenous communities and teachings, challenges created by our shared history and colonization, and my personal role in reconciliation.
- I truly make every effort to learn as much as I can about each community's unique identity and history. I try very hard to work with community supports (such as Jordan's Principle staff) by learning about their perspectives regarding their community, their community's needs and strengths. I try to use that knowledge to inform recommendations that I make for families. I am always learning from the families I work with and I have to constantly consciously remind myself to ask about their lives so that I can learn more about their perspectives as parents and as individuals as well as members of their larger community. Changes I have made are probably clearest in the types of questions I ask, which have become more open-ended and designed to allow families to tell me about how their family/community are unique which helps me to see where I might be able to help them. I constantly still have to battle my own underlying assumptions when working with families and it is a conscious process I go through when working with families (I ask myself "what assumptions am I making? What can I ask to clarify?")
- Not sure. I did read "Night Spirits" about the history of the Sayisi Dene community and I found it very profound
- yes

5. Have you experienced changes in practice as a result of this project?

- I think when this project started referral numbers were quite low in each community and we approached our work in this project as being the same type of work we would do in our outpatient clinics, which meant comprehensive developmental assessments for each child referred (which can take up to an entire day to complete). As referral numbers increased (making it necessary to choose between "comprehensively assess a few kids or do a good developmental screen with a lot of kids") the type of assessment I complete with families has changed. This is combined with the fact that most families who arrive at appointments with us don't actually know how long the process will take and they are expecting a short appointment like when seeing a nurse or doctor at the nursing station, so they often balk at needing to complete a lengthy consultation. I have begun to focus much more on specific recommendations for each family- which support services do they need/do I need to refer to? What therapies does the child need? What is the most important few things for school and family to know about this child and about their differences? Typically, my initial consultation with a family will occasionally lead to a firm diagnosis with recommendations and often leads instead to a provisional diagnosis- at which point I make referrals to essential services and plan on following up during the next community visit so that I can hopefully clarify the diagnosis (once the child has had some services/therapy).
- not sure
- Trying out Telehealth from my home in Wpg for the first time (although I have previously used TeleHealth while working in Thompson)

- Trying to anticipate who will need disability tax forms completed and reviewing charts and discussing with families as many are not aware. The dispensing of medications is not a usual part of my practice nor is delegating vaccinations to vaccine clinics. Still trying to figure out how to ensure timelier follow-up and better triage of consults - a work in progress.
- Yes. I am learning to do my best to be flexible in my approach based on the specific situations the communities I visit. I also continue to engage in learning and training opportunities to improve my competence in working in community.

6. How have patterns of neuropsychological assessment, developmental diagnoses and health psychology consultation changed?

- Due to our inability to provide enough service to communities in a regular way, a step-wise approach to assessment is often required. This means collecting initial data to provide some support to the family and then collect more data on subsequent visits.
- Many children are seeing a general pediatrician earlier in the assessment process. I'm not certain that formal diagnosis by psychology or child development has substantially changed.
- More diagnoses being made
- The pandemic was highly disruptive in this space. Kids who should have been diagnosed before entering school are being diagnosed much later. Some of them are not entering school or unable to enter school for a variety so the typical access for health services like OT, PT, Audiology, Vision Screen etc isn't happening. So the patterns is one of increase to me because we are seeing the typical younger child as well as the older child who did not receive the services needed the pandemic from 2020-2023.
- Well I think what I said above applies here. We have never offered neuropsychological assessments in this project as those types of assessments are extremely specialized. If we felt a child needed a neuropsychological assessment, we would likely refer to our CHP pediatric neuropsychologist for that. I don't think our patterns have changed but certainly the nature of how we approach the diagnostic process and the types of recommendations we make have changed (see response above for more detail). These assessments are viewed more as consultations than comprehensive assessments and recommendations are largely tailored to referrals to appropriate services (e.g. SLP, OT, St. Amant Centre, Mental Health etc.) and helping families to better understand their child's unique needs (although quite often they are already experts in that and my role is to empower them to continue being their child's advocate and to support them in doing that). Also (completely unrelated) when we are doing these types of assessments through our outpatient services we typically have a great deal of background information available to us (medical reports, previous assessment reports, information from schools, developmental history etc.). With this project, I typically only have a referral form with a box or two checked off and none of that collateral information which makes any assessment I am able to do much less comprehensive than it would be if I was seeing this family through an outpatient clinic.

7. How has the service gap been narrowed? What stories can you share about the service gap being narrowed?

- Better coordination of care as I can email or secure message colleagues to ask questions about best test, timing of consultation and coordination. Would be ideal if different types of care providers could be seeing the patients concurrently and support the patient and caregiver better as well as learn from each other. Some consults are

expedited and also advocacy around things like fencing, appropriate beds, travel route (plane rather than bus ride for kid with ADHD in addition to other health problems).

- I believe many of the children and families we see would not have received the services they currently have as travel to get the specialized assessment would have been challenging. And then without the assessment, additional, follow-up and treatment services could not have been coordinated.
- More assessments are getting done and more diagnoses getting made--particularly in young children with autism who, if residing in an remote community, almost never made it to the WPG SSCY Developmental clinic before their age cut off of 5 years.
- Some gaps have been narrowed but still a long way to go.
- The gap is narrowed by clients being seen. Preschool children can be reassessed in the school service in terms of school readiness. Stories that I know are about cases being referred & a plan is started & in place for ongoing care & treatment. When families are informed & given information/knowledge about the clients needs, client growth & development often improves.
- This is a really difficult question to answer as we are such a small part of much larger systems providing (or not providing) services to these communities and families. In terms of narrowing the service gap to getting timely developmental diagnoses, I suppose that has been narrowed somewhat, yet somehow referrals keep increasing exponentially in some of our communities. I think most of the "stories" I have about the gap being narrowed just involve the fact that these families no longer have to travel outside their communities to access our services. I think that is no small thing for these families and something that not a lot of people understand. When I review medical charts it is so often noted that these families have had their files closed in larger centres because they have not attended appointments. What is never noted is that they may be missing those appointments because they didn't have anyone to provide care to their other children when they took one to an appointment. Or that their flight was cancelled and no one told the centre their appointment was at that they couldn't attend. Or their child (or perhaps multiple children) has such extremely high needs that the idea of travelling outside of their community without multiple escorts seems impossible to these parents. Or they are forced to take an overnight bus to Winnipeg for an appointment so their child (and the parents) arrive at their appointment exhausted and any attempt at assessment is possibly invalid. It also appears that the referral process (to all the services being offered under Jordan's Principle) has become easier to navigate as we have all become more and more familiar with each service, so I do think that getting these kids the therapies they need has become easier. I have also been able to make some really unique and specific recommendations for some children based on my understanding of what is available in each community. For example, for one child I made a recommendation that they be able to attend a cooking program through Jordan's Principle and that Jordan's Principle staff would facilitate them having facetime calls with their grandmother. For another, I recommended a purely land-based high school curriculum (including learning about trapping and hunting from the child's grandfather and uncle) rather than have the child attend high school outside the community where they would have no supports at all.

8. What challenges and barriers have you encountered with the Project and/or with providing service?

- It is challenging to recruit and hire additional psychologists to do this work without being able to offer permanent positions. It is challenging to provide service to families when there are not enough supports in the community to help families get to appointment times. Sometimes there is not adequate, private space to complete assessments. Getting referrals, for planning purposes, in a timely way is a challenge to organizing trips to communities.

- JP workers are not considered health care workers, don't have access to charts, reason for referral or ability to follow up on medical plans. Documentation is different between NRHA, Shared Health (if children visit children's hospital) and the Federal Nursing stations. Often incomplete documentation in multiple places. Support for physician services has been variable (e.g help with clerical tasks, faxing ect, medical tasks bloodwork, immunizations, med dispensing, drivers to get children to appointments). Renumeration and billing process is often unclear with account statements.
- Recommendations are not being followed through as not enough support for families at home and in the school. This is particularly true of OT, PT and SLP recommendations. The Jordan's Principal team needs more education and resources to be able to go do visits at home and school to see that kids are following through on the recommended care plan. There are ""Jordan's Principal Child Development Workers"" in the community but they do not seem to have clearly defined roles and as a result kids are not getting the ongoing therapy they need
- Space is not designed for the programs need. Currently we are very mobile, moving from room to room or where room is available. This can be distracting for our clients, and is disruptive to listening to caregivers concern & communication. Children with challenges like attention deficit, autism, need calm & minimal stimulation in the environment. I think client cases need access to wrap around services with more focus on family care & home visiting. In my short time working with Jordan's Principle many parents have accepted referrals to MHT & I know MHT also refers them to specialty providers. Historical traumas for Indigenous people continue to affect children & community. Workers need to be well.
- The biggest challenges have been families not knowing/understanding the nature and purpose of their appointments with us before our clinics. This has become better in communities to which we have travelled many times as the community has become more and more familiar with us. One of the biggest challenges I am seeing lately over the last few months is the narrowing of other services (such as St. Amant Centre, off-reserve Jordan's Principle, MATC etc.) which have somewhat changed their eligibility for services (or moved services back onto the community in the case of off-reserve Jordan's Principle) so that they are no longer providing service to families that we are providing services to- this makes coordinating services and ensuring that every family is receiving the supports they need extremely difficult. Also completely unrelated but the volume of no-show appointments is also very frustrating as it means we see less kids/families during our visits.
- The lack of internet on the road was worrisome at times when I was going back and forth between the community and Thompson everyday. It is much better now that onsite accommodations are available. I didn't know about the process to get wifi initially so orientation and set up would be great ahead of time. There have now been 3 different staff from Jordan's Principle and it does mean getting to know different ways of working together etc - minor issue and no different than when doctor or other health provider changes. Have been dictaphone failures and trying to find things in a paper chart that leads to inefficiencies. All staff including transcriptionist should have a PHIA compliant email. Once the hotel and car were not booked in time. I find the paperwork cumbersome and wish there was some other way to collect the statistics about number of patients that was more automated.

9. Community-based collaterals want to know how to better support you—what do you need from them?

- better coordination between FNIB, NRHA, OHS and KIM (often doing similar things but in silos). Clerical and other assistance on trips. Funding for innovative programs and projects.

- Having supports for families to attend appointments would be helpful. This could include rides and childcare for other children in the home. It is very important that we be able to talk with family members who care for the children so that we have all the information we need to do a good assessment.
- Open communication - there needs to be case reviews, not to evaluate the family but to assess the plan of care for the child, is the plan working, are changes needed, does the family need more info. I think you need a case worker to ensure the clients needs are being addressed in the day to day of the client. I think the case management similar approach as done in Home care.
- Providing us with as much collateral information as possible before our community visits would be extremely helpful. Receiving referrals well ahead of our community visits would be helpful. Ensuring that families understand the nature and process of our consultations would be really helpful.
- Still developing my needs. A clean apartment to stay would be nice (on my first visit the apartment I stayed in was not clean at all...except the bed sheets were clean)
- Would like to be able to meet with community leaders and providers such as vaccine clinic, TB nurse, public health, treaty number clinic to find out how I can support better. Wifi is critical as well as a computer on site.

10. How can the Project be improved? What changes do you recommend?

- Extending our contract beyond one year. There are too many referrals and too many communities for one Clinical Health Psychologist to manage and without having a contract that extends beyond one year we are unable to recruit for another psychologist. This means that a number of communities will not be receiving CHP services until we have a second psychologist. In addition, as referrals increase in a number of communities, we need to do more than one trip per year to these communities, again this cannot be done until we are able to hire another psychologist. Also travel issues continue to cause problems- for example, Perimeter has just changed their luggage allowance and the limit placed on luggage weight means that we are not able to take all of our much-needed assessment material. It would be great if this project could somehow reach out to Perimeter and try to problem-solve these types of issues with them.
- Having permanent positions to help with recruitment would be very helpful. If we could increase the number of psychologists involved, we could expand how often they visit and the services they could provide and support relationship building between providers and the community.
- I love the work. I love the community and I hope I am doing some good and really meeting the social accountability mandate that we talk about. I want to make sure that I am an antiracist and that I am working to decolonize care and my practice. Feedback would be really helpful. I like having the different opportunities to learn about aspects of the truth about today and the past in terms of the oppression and down stream impacts. I would love a space where multiple practitioners could work together. I would like to see some more subspecialists come to certain areas based on need. Then we can work on better coordinating visits and travel so that we can build connection between providers and save the planet by reducing our carbon footprint. See above about electronic medical record, wifi, need for computer, more connection to community (recognizing that it takes time to build the trust) as well.
- More contact with clients family. Recruit a case manager … [to work] with Drs clinic. The case manager needs to be approachable, reliable, trustworthy, good communication skills. The JP program manager is too busy with administration. There is minimal time to review cases seen by pediatrician during the on-site clinic visit. No reporting off actually creates communication barriers because not all workers can access FNIH medical file. Every effort is worth it, because there was a day there was no program. The case load numbers are high.

- Unfortunately ... Jordan's Priniciple have been come associated with buying things for kids rather than working with kids. While some purchases are essential-- communication boards, sensory tools for kids with autism etc-- some are perhaps outside the intended scope (video game systems, clothing etc). I would love to see more kids getting home and school based therapy done.

11. How satisfied are you with the Project so far?

- Highly satisfied
- Neutral
- Satisfied
- Satisfied
- Satisfied
- Satisfied