



Sioux Lookout First Nations Health Authority Spotlight

Rising to the Challenge With the Community Health Worker Diabetes Program

The Future Skills Centre (FSC) is a forward-thinking centre for research and collaboration dedicated to driving innovation in skills development so that everyone in Canada can be prepared for the future of work. We partner with policymakers, researchers, practitioners, employers and labour, and post-secondary institutions to solve pressing labour market challenges and ensure that everyone can benefit from relevant lifelong learning opportunities. We are founded by a consortium whose members are Toronto Metropolitan University, Blueprint, and Signal49 Research, and are funded by the Government of Canada's Future Skills Program.

In partnership
with:



Funded by the
Government of Canada's
Future Skills Program



Contents

4

Highlights

5

Going above and beyond

6

Providing support under challenging conditions

7

Integrating community health workers into rotating healthcare teams

10

Building a community health worker community of practice

11

Appendix A: Methodology

Highlights

- The Sioux Lookout First Nations Health Authority's approach with its Community Health Worker Diabetes Program reflects an understanding that supporting community health workers requires attention to the full context in which they work, including their position within the wider health system.
- Drawing on community-led principles, international best practices, and long-standing partnerships, the Community Health Worker Diabetes Program has evolved over more than a decade to respond to both workforce pressures and the ongoing diabetes crisis in Indigenous communities.
- The program operates under funding constraints, where community health workers serve multiple health needs amid persistent workforce shortages.
- The Sioux Lookout First Nations Health Authority has developed insights into how funding and compensation structures vary across the different roles community health workers perform, leaving some placements understaffed.
- High workloads that cover a range of different health needs can reduce community health workers' abilities to focus on diabetes care, even where they've been hired as part of the Aboriginal Diabetes Initiative. Stretching health workers' roles can lead to burnout and decrease retention.
- The Sioux Lookout First Nations Health Authority acts as an important intermediary to integrate community health workers into rotating healthcare teams, strengthening their role recognition, shared responsibility, and coordination with physicians, nurses, and navigators who arrange travel for doctors and nurses to work together in communities and guide patients through the healthcare system.
- Investments in relationship building and a community of practice build workforce resilience, using in-person and virtual spaces to reduce occupational isolation and facilitate peer learning for community health workers.

Going above and beyond

Through the Sioux Lookout First Nations Health Authority's (SLFNHA) Community Health Worker Diabetes Program, Indigenous community health workers (CHWs) across remote communities in Northwestern Ontario are benefitting from training and interventions that address occupational challenges.

Building on this foundation, the program extends beyond training to address the broader occupational realities CHWs face in their day-to-day work. These challenges—including role overload, under-compensation, limited formal recognition within healthcare teams, and professional isolation—are woven into CHWs' roles and are often systemic in nature, making it difficult to resolve these challenges through skills development alone.

The SLFNHA's approach reflects an understanding that strengthening community health workers requires attention to the full context in which they work, including how they are positioned within the wider health system. Drawing on community-led principles, international best practices, and long-standing partnerships, the program has evolved over more than a decade to respond to workforce pressures and the ongoing diabetes crisis in Indigenous communities. We document the program's approaches to addressing training-related barriers in a companion [impact paper](#).

Organizational profile

Sioux Lookout First Nations Health Authority Community Health Worker Diabetes Program

The Sioux Lookout First Nations Health Authority was established in 1990 to address ongoing community health concerns with a lack of health-service delivery and the requirement for better healthcare and health advocacy for members. The Health Authority is based in Sioux Lookout, Ontario, and serves 33 First Nations communities in Northwestern Ontario.

Service area

Indigenous community health

Location

Sioux Lookout, Ontario, with offices in Thunder Bay

Staff

Community Health Worker Diabetes Program: three full-time staff and one vacant position (February 2026)

Sioux Lookout First Nations Health Authority: ~600

Website

<https://www.slnha.com/>

<https://chwconnect.ca/>

Providing support under challenging conditions

Community health workers in the communities the SLFNHA serves routinely operate under conditions of substantial role stretch, a reality that has important implications for workforce retention. While the CHW's role can serve as an entry point into broader health careers—such as nursing or health leadership—it is also characterized by persistent shortages of health professionals in remote communities. In this context, CHWs are relied upon to apply wide and evolving skill sets, often without a regulated scope of practice. The SLFNHA's program design reflects an understanding of this reality and the need to support CHWs who are operating at the limits of their capacities.

As Dr. Sumeet Sodhi, a physician partner with the SLFNHA's Community Health Worker Diabetes Program, observes, CHWs are frequently called upon to fill multiple roles to maintain service continuity. In some communities, this includes responsibilities such as those of X-ray techs, phlebotomists, pharmaceutical assistants, and translators. While this flexibility highlights the value and adaptability of CHWs, if left unaddressed, it also creates workload pressures that can contribute to burnout.

These pressures are further compounded within the context of Indigenous Services Canada's Aboriginal Diabetes Initiative (ADI), which plays a central role in diabetes prevention and management among a population facing disproportionately high rates of type 2 diabetes. As Madison Pierce, manager of the SLFNHA Community Health Worker Diabetes Program, explains, CHWs wear many hats and take on roles and responsibilities beyond what they were hired for, which limits their ability to focus on diabetes care.

Compensation structures add another layer of complexity. In some cases, healthcare positions in communities can vary widely in their compensation structures, which may create competition for positions and limit members' availability for certain CHW roles. While the SLFNHA doesn't control funding parameters, the program's longevity underscores the need for funding allocations that better align compensation with responsibilities and needs.

The program responds by working within these structural constraints—recognizing role overload and supporting CHWs as they navigate competing expectations.



Integrating community health workers into rotating healthcare teams

Community health workers are critical to remote communities as they provide culturally safe and consistent healthcare. Despite their importance, CHWs aren't integrated within larger healthcare teams. Janet Gordon, Vice-President of Community Health at the SLFNHA, explains that community health workers' roles and recognition have diminished over time with the establishment of nursing stations and visits by allied health professionals such as doctors and nurses external to the communities they work in. The federal government initiated and took control of this process starting in the 1930s, with expansion in the post-war era. Doctors and nurses have since taken over more of the responsibilities that community health workers and traditional healers once held.¹ Today, CHWs' lack of recognition and integration into larger healthcare teams is compounded by the transience of nurses, physicians, and other allied health professionals who rotate through communities for short periods of time and don't always incorporate CHWs into their practice.

As Madison Pierce notes, lack of integration is also due to the transient nature of CHWs, where turnover limits opportunities to build shared understanding and sustained working relationships between these community health workers and incoming healthcare providers.

Limited formal recognition of CHWs' roles within healthcare teams can also reflect broader structural and cultural dynamics. As Dr. Sumeet Sodhi explains, biases related to credentialing, professionalization, and cultural difference can shape how nurses and physicians perceive and engage with CHWs.



¹ Alistair White, "Nursing Under the Midnight Sun: Public Health Nurses in the Yukon, 1945-1967" (University of British Columbia, 2025), <https://open.library.ubc.ca/soa/ciRcle/collections/graduateresearch/42591/items/1.0449153>; Waapihk Research, *Federal Indian Hospitals in Canada: A Brief History*, December 15, 2022, <https://waapihk.com/2022/12/15/blog-history-indian-hospitals/>.

While community health workers are widely relied upon to support patients in diverse and practical ways, these perceptions can constrain collaboration and limit the full use of their knowledge and skills.

The Sioux Lookout First Nations Health Authority has made deliberately integrating CHWs into broader healthcare teams a core program strategy. Rather than treating CHWs as supplementary or informal care providers, the program focuses on strengthening connections between community health workers and allied health professionals to enhance role recognition, shared responsibility, and more-coordinated care. This approach is informed in part by models such as the Alaska Community Health Aide Program (CHAP), which demonstrates how structured integration and supervision can improve worker wellbeing and system performance.

By actively building and maintaining these connections, the SLFNHA works to reduce professional isolation, to strengthen collaboration across rotating teams, and to ensure that CHWs are positioned as essential contributors to community-based care. The experience highlights an important lesson for health systems operating in remote and resource-constrained settings: Effective service delivery depends not only on who is present but also on how local and external providers are intentionally integrated into the circle of care.

Illuminating community health workers' roles within healthcare teams

A first step in strengthening integration is ensuring community health workers are visible and understood within local healthcare teams. The SLFNHA takes on the role of active intermediary by assessing how well allied health professionals understand community health workers' roles and by addressing gaps in awareness that can limit collaboration. As Madison Pierce explains, familiarity with CHWs varies considerably across communities. In some cases, nurses and physicians work closely with CHWs and rely on them regularly; in others, incoming providers may be unaware that a diabetes worker is present at all.

To respond to this variation, the program begins by engaging directly with health staff to understand existing relationships and points of disconnect. These conversations help clarify how CHWs are currently being utilized, where opportunities for collaboration exist, and where stronger connections need to be built. This approach allows the SLFNHA to tailor its integration efforts to local contexts rather than applying a one-size-fits-all model.

Targeted communication is a key tool in this process. The SLFNHA's Community Health Worker Diabetes Program uses physician newsletters and holds in-community meetings with nurses to highlight who the CHWs are and their roles, skills, and capacities, including recent training community health workers received. By making this information visible and accessible, allied health professionals are better able to understand how CHWs can support patient care and contribute meaningfully to the broader care team.

From awareness to working relationships

While improving awareness of CHWs' roles is an important first step, the program has learned that effective integration depends on relationships that have been built over time. Trust and rapport between CHWs and allied health professionals enable more-consistent communication, clearer role alignment, and shared responsibility for patient care. The Sioux Lookout First Nations Health Authority identified this relational gap as a key constraint on care coordination and has worked to create conditions that facilitate stronger working relationships across care teams.

As Janet Gordon explains, rapport between CHWs and physicians can directly affect service delivery. She notes that when trust is established, CHWs are better positioned to take on additional responsibilities—such as taking blood and undertaking A1C testing—when gaps in care emerge. These relationships allow care teams to respond more flexibly to patient needs, particularly in settings where access to clinical services is inconsistent.

The value of relationship-building is also evident in the collaboration between CHWs and the community health navigators who schedule travel for incoming doctors and nurses and help patients traverse the healthcare system. Pierce describes these relationships as critical to preventing patients from falling through the cracks, particularly in communities where providers rotate frequently. Navigators increasingly rely on CHWs for appointment reminders, follow-up, and coordination at the community level—tasks that depend on trust, familiarity, and ongoing communication rather than on formal protocols alone.

Importantly, the responsibility for integration should not rest solely with community health workers. As Dr. Sumeet Sodhi emphasizes, expecting CHWs to initiate and sustain these relationships places additional strain on a workforce already operating under pressure. Instead, integration is most effective when the broader circle of care actively engages CHWs as essential members of the team. This shared responsibility helps normalize collaboration, reduce role strain, and strengthen continuity of care across rotating health systems.

Building a community health worker community of practice

The Community Health Worker Diabetes Program has identified peer connection among CHWs as a critical strategy for sustaining the workforce in remote and resource-constrained settings. In many communities, CHWs work alone, carrying major responsibility with limited opportunities for informal engagements or professional exchange. Rather than treating this isolation as an individual challenge, there is an intentional focus on building a shared community of practice that connects community health workers across geographies and community boundaries.

In their own words

Watching CHWs respond to one another, share experiences, and offer advice has become a source of pride, says Madison Pierce, reflecting the emergence of a strong and self-sustaining community.

And just seeing that knowledge sharing [on regular Zoom meetings] has been so amazing... getting people to respond and share knowledge with each other is just so powerful... it's almost every meeting now, whereas before it wasn't, and it's just been so incredibly beautiful to watch.

Madison Pierce, Manager of the SLFNHA Community Health Worker Diabetes Program

One way the CHW Diabetes Program enables this peer community to connect is by creating regular opportunities for CHWs to come together in person. Annual forums and retreats provide space for relationship-building, shared learning, and reflection—functions that are difficult to sustain when workers are dispersed across remote communities. These gatherings take place at Onaman Ziibi, the SLFNHA's learning lodge located on the traditional territory of the Obishikokaang (Lac Seul First Nation) along the Vermillion River. The setting reinforces the program's community-led approach and provides a dedicated space for CHWs to connect outside the day-to-day pressures associated with service delivery.

The Community Health Worker Diabetes Program also provides ongoing connections through virtual platforms that create space for regular knowledge sharing, collective problem-solving, and encouragement. These virtual exchanges have evolved over time from tentative participation to active peer-driven engagement.

Together, these in-person and virtual spaces function as more than professional development opportunities. They reinforce a shared identity, reduce the strain of working in isolation, and facilitate the peer-to-peer learning that complements formal training and system integration efforts. The SLFNHA's experience highlights an important lesson for health systems operating in remote contexts: Sustaining community-based workforces requires not only skills and integration but also intentional investment in the social and relational infrastructure that allows workers to engage with one another.

Appendix A

Methodology

This Spotlight included interviews and a review of publicly available secondary documentation.

Literature review

As part of the larger project, 60 literature sources were reviewed, including peer-reviewed articles, policy reports, technical reports, and websites. The literature was organized by the themes relevant to the research questions. Sources were prioritized based on date of publication (with priority given to literature written within the last five years), being Indigenous-led or authored, and the credibility of the source material (e.g., author expertise, journal ranking).

Interviews

We conducted in-depth, semi-structured interviews with three (n=3) Sioux Lookout First Nations Health Authority staff and a partner from the Department of Family and Community Medicine, University of Toronto. These interviews were conducted virtually on MS Teams between October 23 and November 25, 2025. Each interview lasted approximately one hour. Interviews were transcribed and sent back to the interviewees for member checking. Interview transcripts were then imported into the NVivo qualitative software program, where initial codes were developed based on the questions in the Impact paper ED-146: ED30073: Impact paper: Training to Retain. Codes were then further refined and developed based on what emerged from the interview texts. Dominant themes were identified based on the frequency of mention both across and within interviews.

Acknowledgements

This research was prepared with financial support provided through the Government of Canada's [Future Skills Program](#). Signal49 Research is proud to serve as a research partner in the Future Skills Centre consortium.

Many Signal49 Research colleagues helped to bring this to life. This Spotlight was initiated by Adam Fiser, PhD, Principal Research Associate, who provided direction and oversight. Bethany Haalboom, PhD, Lead Research Associate, executed the Spotlight.

This output was designed by Mallory Eliosoff, Senior Graphic Designer.

We sincerely thank the following Sioux Lookout First Nations Health Authority Community Health Worker Diabetes Program leaders, staff, and partners for sharing their knowledge, perspectives, and experiences of the Health Authority's Community Health Worker Diabetes Program. Research Advisory Board member Madison Pierce also reviewed the Spotlight.

- **Janet Gordon**, Vice President of Community Health
- **Madison Pierce**, Manager of the Community Health Workers Diabetes Program
- **Sumeet Sodhi**, Academic Lead, Indigenous Health Partners Program, Department of Family and Community Medicine, University of Toronto

Sioux Lookout First Nations Health Authority Spotlight: Rising to the Challenge With the Community Health Worker Diabetes Program

Signal49 Research

To cite this research: Research, Signal49. *Sioux Lookout First Nations Health Authority Spotlight: Rising to the Challenge With the Community Health Worker Diabetes Program*. Ottawa: Signal49 Research, 2026.

Forecasts and research often involve numerous assumptions and data sources, and are subject to inherent risks and uncertainties. This information is not intended as specific investment, accounting, legal, or tax advice. The responsibility for the findings and conclusions of this research rests entirely with Signal49 Research.

An accessible version of this document for the visually impaired is available upon request.

Accessibility Officer, Signal49 Research

Tel: 613-526-3280 or 1-866-711-2262 | Email: accessibility@signal49.ca

Published in Canada | All rights reserved | Agreement No. 40063028

AERIC Inc. is an independent Canadian registered charity operating as Signal49 Research.



Where knowledge
inspires action