Final Evaluation Report of the 2012-2022

Kahnawà:ke Community Health Plan (CHP)

ONKWATA'KARITÁHTSHERA

Kahnawà:ke's One Health & Social Services Agency

Final Evaluation Report of the 2012-2022
Kahnawà:ke Community Health Plan (CHP)

Tsothohrkó:wa (January) 2023

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Onkwata'karitáhtshera

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Original cover illustration elements by Cheryl Delaronde

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Acknowledgements

The author expresses his gratitude to the entire Onkwata'karitáhtshera Committee and team for their support throughout the evaluation. Special thanks to Derek Montour, Executive Director of Kahnawá:ke Shakotiia'takehnas Community Services, and Lisa Westaway, Executive Director of Tsi Tehshakotitsèn:tha' Kateri Memorial Hospital Centre for their leadership and guidance. Many thanks to Valerie Diabo, Director of Community and Nursing Care of Tsi Tehshakotitsèn:tha' Kateri Memorial Hospital Centre for her ongoing support, input and review of the evaluation.

Sincere appreciation to the following Onkwata'karitáhtshera team members for their wonderful assistance and teamwork throughout the entire project, in relation to enabling all major functions and activities of the evaluation: Karonhiaroroks Picard (Manager), Kiersten Two-Axe Myiow (Health Programs Liaison) and Vivienne Walz (Community Health Plan Liaison).

The author sincerely thanks everyone who took the time to contribute to this evaluation – including those who participated in interviews, focus groups, facilitated site visits and tours, participated in the workshops and contributed content.

Most importantly, my gratitude to the community for welcoming me to Kahnawà:ke, and making me feel at home.

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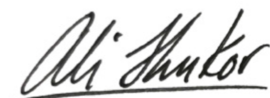

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1. Acronyms

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ADHD: Attention-deficit/hyperactivity disorder	**EMR:** Electronic Medical Record
ALS: Assisted Living Services	**e-SDRT:** electronic-Service Delivery Reporting Template
ARS: Addiction Response Services	**FASD:** Fetal Alcohol Spectrum Disorder
CBRT: Community-Based Reporting Tool	**FNHRDCQ:** First Nations Human Resources Development Commission of Quebec
CRCF: Centre for Research on Children and Families	**FWC:** Family and Wellness Center
CFS: Child and Family Services	**HCC:** Home and Community Care
CHP: Community Health Plan	**HCCS:** Home and Community Care Services
CHPI: Community Health Plan Initiative	**ILC:** Independent Living Center
CHSLD: Residential and long-term care center	**ISC:** Indigenous Services Canada
CHU: Community Health Unit	**KCI:** Kahnawà:ke Collective Impact (Skátne Teionkwaká:nere)
CIF: Community Initiatives Fund	**KEC:** Kahnawà:ke Education Center (KEC)
CISSS: Integrated Health and Social Services Centres (Quebec)	**KFB:** Kahnawà:ke Fire Brigade & Ambulance
CLSC: Local community service centers	**KMHC:** Kateri Memorial Hospital Centre / Tehsakotitsén:tha
COPD: Chronic Obstructive Pulmonary Disease	**KOR/KORLCC:** Kanien'kehá:ka Onkwawén:na Raotitióhkwa Language and Cultural Center
CPR: Cardiopulmonary resuscitation	**KSCS:** Kahnawà:ke Shakotiia'takéhnas Community Services
CQI: Continuous Quality Improvement	**KSDPP:** Kahnawà:ke School Diabetes Prevention Project
CQIC: Continuous Quality Improvement Committee	**KCSC:** Kahnawà:ke Combined Schools Committee
CWP: Community Wellness Plan	**KSS:** Kahnawà:ke Survival School
EHO: Environmental Health Officer	**KTE:** Knowledge Transfer and Exchange

KYC: Kahnawà:ke Youth Center	**QIRMI:** Quality Improvement, Risk Management and Innovation (KMHC)
LPN: Licensed Practical Nurse	**RN:** Registered Nurse
LTC: Long Term Care	**SBS/SBSCFC:** Step by Step Child and Family Center
MCK: Mohawk Council of Kahnawà:ke	**SDH:** Social Determinants of Health
MSSS: Ministère de la Santé et des Services Sociaux	**SMART:** Specific, measurable, achievable, relevant, and time-bound
NGO: Non-Governmental Organization	**STC:** Short Term Care (KMHC)
NIHB: Non-Insured Health Benefits	**STI:** Sexually Transmitted Infection
OCAP: Ownership, Control, Access, Possession	**TBEL:** Turtle Bay Elders Lodge
OCC: Office of the Council of Chiefs	**COHI:** Children's Oral Health Initiative
OMEC: Outil d'évaluation multiclientèle	**TNP:** Topical Negative Pressure
OPD: Outpatient Department	**TRP:** Thérapeutes en Réadaptation Physique
OT: Occupational Therapy	**TSC:** Teen Social Club
PAB: Préposé aux bénéficiaires	**WAT:** Wellness Action Team
PAP test: Papanicolaou test	**WBC:** Well Baby Clinic
PK: Kahnawà:ke Peacekeepers	**YAP:** Young Adults Program
PT: Physiotherapy	**YP:** Youth Protection
	2SLGBTQ+: Two-Spirit, lesbian, gay, bisexual, transgender, queer (or questioning). The plus sign represents other sexual identities, such as pansexual or asexual

2. Executive Summary

2. Executive Summary

A large array of programs, services and initiatives in Kahnawà:ke address the community's population health needs across the entire lifespan, from pre-conception to palliative care. The evaluation's findings indicate a significant developmental transition over the past ten years, moving from the provision of disparate services for specific diseases and conditions, towards the development and alignment of outcomes-oriented systems that integrate Indigenous and Kanien'kehá:ka concepts of health, wellness and wellbeing.

Furthermore, there is increasing focus on developing systems are person and family-oriented, with an emphasis on communication, coordination, cultural safety, family preservation, community engagement, evaluation and continuous quality improvement (CQI).

2.1 Background

The 2012-2022 Community Health Plan (CHP) is the third plan developed by Onkwata'karitáhtshera, (Kahnawà:ke's one health and social service agency), as part of a ten-year funding agreement negotiated with Health Canada. The CHP was developed in alignment with Onkwata'karitáhtshera's strategic goals and was designed to enable strategic alignment of the community's health and social services.

Through the iterative use of data (including literature reviews, community health needs assessments, qualitative and quantitative data and population health statistics), stakeholder consultations and community engagement, seven health priorities and four contributing services were identified.

As part of the Health Funding Consolidated Contribution Agreement, Onkwata'karitáhtshera committed to conduct a summative evaluation at the end of the funding period. The purpose of the evaluation is to assess and evaluate the impact of the CHP, particularly in relation to the health priorities and supporting areas. The summative evaluation questions were developed inductively and iteratively through document review, as well as engagement with Onkwata'karitáhtshera and program staff from Kahnawà:ke health, social and educational organizations. The main evaluation questions are:

- What programs, services and initiatives are in place to address the CHP health priorities?
- What is the performance of these programs, services and initiatives, within the context of meeting individual and population health needs related to the CHP priorities?
- What is the impact of the CHP on the health priorities?

The findings and recommendations of this summative evaluation will also support the development of the new ten-year plan, beginning in 2023.

2.2 Evaluation design and methodology

The evaluation design is based on a mixed methods approach, leveraging multiple data sources and qualitative and quantitative analyses. The project leveraged a systems-oriented evaluation framework that incorporated important domains related culture, cultural safety, Kanien'kéha language, Indigenous and Kanien'kehá:ka concepts of health, wellness and wellbeing.

The mixed methods evaluation approach leveraged multiple data sources, including:

- Site visits
- Staff engagement meetings and participatory observation
- Document review
- Quantitative data (mainly descriptive statistics)
- Interviews
- Focus groups
- Content validity workshop

2.3 Findings

The evaluation produced a comprehensive and updated inventory of programs, services and initiatives that address the seven health priorities outlined in the CHP. The detailed descriptive evaluation provided useful insights regarding their respective structures, functions, activities and desired outcomes.

Similar to the findings of the 2016 mid-term CHP evaluation by Niska, there remains insufficient quantitative data to statistically assess the impact of the CHP on the specific health priorities and supporting areas, or to measure and assess trends in performance and outcomes over time. However, there is clear and sufficient evidence that the large array of Kahnawà:ke programs, services and initiatives directly address all health priorities, and beyond – comprehensively addressing population health needs across the entire lifespan, from pre-conception to death.

The performance of these programs, services and initiatives was assessed using a comprehensive systems-oriented framework, with a focus on their respective structures, processes and outcomes. Generalized system level findings indicate a significant developmental transition over the past ten years, moving from the provision of disparate services for diseases and conditions, towards the development, integration and alignment of outcomes-oriented systems that integrate Indigenous and Kanien'kehá:ka worldviews and concepts of health, wellness and wellbeing.

Furthermore, there is increasing focus on developing systems that are person and family-oriented, with an emphasis on communication, coordination, cultural safety, community engagement, data-driven governance, evaluation and continuous quality improvement (CQI).

Importantly, these focused efforts link to the challenges identified in the 2016 mid-term CHP evaluation. Services for complex clients (e.g. the frail elderly, individuals with concurrent mental health and substance use disorders, individuals with special needs, and individuals with multi-morbidities and chronic illness and disease) remain somewhat fragmented and often operate in siloes. Inter-organizational and cross-sectoral communication, collaboration and coordination functions are particularly important for these services and need to be improved.

The lack of reliable quantitative data to assess the impact of the CHP on the health priorities is due to issues related to data and information systems (i.e. data entry, storage, quality, linkage and analytics capacities). Evaluation and CQI functions are also limited within most organizations; however, there is significant improvement in capacities and capabilities within KMHC that present opportunities for cross-learning. Related to evaluation, there is increasing recognition of the importance of focusing on client experiences, along with the importance of community engagement – particularly in relation to reaching vulnerable individuals and populations with limited access to services. There is also increasing acknowledgment of the importance of integrating culture and language within programing, as well as the use of cultural safety and cultural competency frameworks.

There is general agreement that the next iteration of the CHP should be designed and developed as an ***outcomes-oriented "Community Wellness Plan" (CWP)***. This Plan should integrate Indigenous and Kanien'kehá:ka wholistic concepts of health, wellness and wellbeing, and be oriented around social determinants of health and family wellness. It is important that the CWP integrate an outcomes-oriented performance framework, with indicators of health, wellness and wellbeing to enable alignment of cross-sectoral collaboration efforts and initiatives. This would enable shared accountability towards achievement of common outcomes, provide clarity in terms of the respective roles, functions and activities of stakeholders. Furthermore, it would enable ongoing measurement and assessment of performance and quality of services.

It is also important to recognize the significant impact of the Covid-19 pandemic on the entire community, as well as on staff. Despite significant efforts and resources dedicated by organizations to ensure the sustainability of essential service delivery and staff wellness, the symptoms of burnout and trauma are widespread. Staff wellbeing is therefore a high priority that is universally recognized by organizations across Kahnawà:ke, and is being increasingly addressed and incorporated into strategic planning and initiatives. The results of this evaluation provide evidence of the strong contributions of staff from across all organizations in the community, who demonstrated resilience and high levels of intrinsic motivation, driven by a sense of social purpose towards the health and wellbeing of Kahnawakehró:non.

Further details of the key system-level findings, relating to each of the evaluation framework's performance domains are synthesized in Section 1.5 of the Executive Summary.

2.4 Recommendations

The evaluation's findings and content validation exercises resulted in the following fourteen strategic recommendations being drafted:

(1) **Organizational needs domain:** That programs and services proactively assess organizational needs, to identify gaps in resources, knowledge, practices and/or skills.

(2) **Human resources domain:** That health, social and educational (technical and vocational) organizations collaboratively explore the development of a recruitment and internal talent development strategy, to ensure the long-term sustainability of Kahnawà:ke's health and social services systems.

(3) **Service delivery models domain:** That all service delivery models have mechanisms that ensure core standards are periodically reviewed and updated.

(4) **Teamwork domain:** That organizations support their programs and services to improve teamwork, by routinely assessing team experiences, and providing technical and administrative support for continuous improvement and change management.

(5) **Communication, collaboration and coordination domain:** That Kahnawà:ke explores steps towards alignment of health and social services at governance, organizational and administrative levels, to enable integration of service delivery and coordination of care for all Kahnawakehró:non.

(6) **Community engagement domain:** That organizations, programs and services work together to develop and align strategies for ongoing community engagement, including a focus on sensitively engaging individuals and families with access challenges, special needs and /or highly impacted by trauma.

(7) **Client, family and caregiver experience domain:** That organizations, programs and services develop and implement systems for the collection, analysis and use of client, family and /or caregiver experience data on an ongoing basis.

(8) **Evaluation, performance assessment and quality improvement domain:** That organizations, programs and services develop robust systems for evaluation, performance assessment and quality improvement, that integrate Indigenous and Kanien'kehá:ka frameworks.

(9) **Data and information systems domain:** That Kahnawà:ke organizations, particularly health and social services, develop and implement robust data and information systems strategies.

(10) **Staff wellbeing domain:** That organizations continue to prioritize staff health and wellbeing by periodically assessing staff wellbeing, motivation and burnout, and ensuring that staff have low-barrier access to wellness supports and services.

(11) **Culture and language domain:** That organizations continue to develop and implement strategies and action plans relating to the integration of Kanien'kehá:ka culture and language within all levels of governance, including macro system and policy levels, senior administration, programming and service delivery.

(12) **Culture and language domain:** That organizations continue to develop and implement strategies relating to trauma-informed service delivery and cultural safety.

(13) **Community Wellness Plan (planning and development):** That stakeholders from across Kahnawà:ke co-develop a Community Wellness Plan premised on mutually agreed upon principles, concepts and approaches, with a focus on health and well-being outcomes.

(14) **Community Wellness Plan (health, wellness and wellbeing priorities):** That Onkwata'karitáhtshera continues working with all relevant partners to gather and analyze data from available sources, to update the health, wellness and wellbeing priorities.

2.5 Synthesis of key findings by performance domain

A synthesis of the key generalized system-level findings relating to each of the evaluation framework's performance domains are summarized below. Further detailed analyses of the programs, services and cross-cutting initiatives are provided in Sections 5 – 7 of the report.

Organizational needs:

- Organizations, programs and services are continuously adapting and evolving to meet the biopsychosocial needs of the community (which are increasing in scope, complexity and intensity).
- Several programs and services have indicated that their resources need to be expanded, upgraded and/or updated, to proactively and effectively meet the increasing needs of the community.

Service delivery models:

- Organizations across Kahnawà:ke are continuously redesigning their programs and services, to ensure accessible, effective, efficient, equitable and culturally safe service delivery.
- There is increasing standardization of multidisciplinary team-based service delivery models, particularly in relation to professionalization, and the use of standardized assessments, guidelines, protocols and processes.
- However, depending on program or service, there is significant variability and sometimes ambiguity in relation to the use and implementation of standards, as well as the availability of updated logic models and/or service delivery model descriptions.

Access:

- Kahnawà:ke's health, social care and educational organizations recognize the importance of enabling low-barrier access to services, and are often actively working to address access-related challenges and barriers that limit participation by community members and families. The use of technology (e.g. virtual and tele-services) has been broadly implemented across many organizations. Programs such as home and community care are extremely high performing, with same or next-day services, and virtually no wait list.
- It is challenging to reach some vulnerable families, particularly those with special needs. Furthermore, there are significant challenges to engage teens (particularly those with anxiety, depression and/or who have unhealthy home environments) and enable their participation. The lack of transportation also limits access to services for lower income families.
- Some organizations (e.g. those serving frail elderly and or special needs clients) require additional and/or upgraded resources, particularly in relation to physical space, staffing and equipment.
- Timely access to primary care services is challenging; furthermore, a significant proportion of Kahnawakehró:non are not attached/registered to a family physician.

- There are gaps in service delivery, particularly in relation to services for teens, intermediate care (i.e. between home and community care and long-term care), mental health care and substance use supports.

Teamwork:

- Virtually all health, social care and educational programs and services across Kahnawà:ke leverage multidisciplinary team-based approaches, incorporating a comprehensive array of professions and disciplines.
- Team members often have difficulties reconciling the various perspectives of differing professions and disciplines (e.g. biomedical vs psychosocial), and do not always understand the various professional standards, legal designations or scope of practice of different team members.
- Ongoing proactive assessments of team experience and staff motivation are necessary, to ensure the optimal function and performance of teams.

Communication, collaboration and coordination:

- Extensive formal and informal mechanisms relating to the communication, collaboration and coordination do exist within and between the community's various programs and services. The Wellness Action Team (WAT) survey is a strong example of successful cross-sectoral collaboration, that should be supported.
- Communication, collaboration and coordination functions are particularly critical to ensure the continuity and quality of care for individuals with complex needs, who require services from multiple organizations (e.g. the frail elderly, individuals with concurrent mental health and substance use disorders, individuals with special needs, and individuals with multi-morbidities and chronic illness and disease). Services for clients with these conditions are significantly fragmented and often operate in siloes The development of robust and coordinated systems for these health and wellbeing domains is required.
- It is important to identify and address the structural barriers that limit communication, collaboration and coordination functions and activities (e.g. governance, organizational, professional, disciplinary, IT and personal factors) and lead to programs and services operating in isolation.

Community engagement:

- Although there is universal consensus regarding the relevance, value and importance of community engagement, there is no commonly agreed upon definition of the concept.
- Often, there is a lack of clear, comprehensive and systematic strategies for planning, implementing and evaluating community engagement functions.
- There are significant challenges in relation to meaningfully and sensitively engaging individuals and families with access challenges, vulnerabilities, special needs and/or highly impacted by trauma.
- It is also important that stakeholders work together to ensure alignment of community engagement strategies, initiatives and activities.

Client, family and caregiver experience:

- There is widespread agreement regarding the relevance, value and importance of measuring, assessing and using client, family and/or caregiver experience data. However, there exists significant variability in how (content, mechanisms, frequency) and to what extent experience data is collected and used (e.g. for quality improvement).
- It is important to note that there are significant ethical, conceptual and technical challenges associated with designing appropriate and culturally safe approaches and tools. Dedicated technical and administrative supports and resources are required to support functions associated with experience measurement and assessment and quality improvement.

Evaluation, performance assessment and quality improvement:

- Since the 2012 Community Health Plan (CHP), many resources, efforts and initiatives have been dedicated to evaluation, performance assessment and quality improvement functions. For example, a particularly strong example is KMHC's Quality Improvement, Risk Management and Innovation (QIRMI) team.
- However, there remains significant variability and weakness across most organizations, in terms of capacities, resources and competencies related to evaluation, performance assessment and quality improvement. Teams often exhibit significant difficulties developing and using robust logic models. Often, logic models lack a strategic orientation (focusing on workplan tasks rather than functions) and are not tied to measurable performance indicators.
- To promote and enable evaluation, performance assessment and QI, it would be beneficial for health, social services and educational organizations to arrange cross-learning and Knowledge Translation and Exchange (KTE) mechanisms.

Data and information systems:

- Various organizations, programs and services across Kahnawà:ke are collecting and storing masses of client data. Organizations recognize the importance of transforming this data into useful information for effective and efficient decision-making functions across all levels of governance.
- Strong examples of the successful use of multi-sourced data are the 'Onkwaná:ta Our Community, Ionkwata'karí:te Our Health' Portraits (Volumes I and II). The Health Portrait reports leveraged multi-sourced data to provide useful population health statistics.
- To move towards the vision of developing learning systems, it is critical to dedicate resources and investments towards advanced data analytics, business intelligence (BI) and health informatics functions.

Pandemic impact and response:

- Staff demonstrated admirable levels of resilience, courage, selflessness, and empathy during the pandemic, and worked collaboratively to ensure continuation of service delivery. Staff also demonstrated high levels of intrinsic motivation, particularly a sense of social purpose during the pandemic.

- Organizations provided a number of supports for staff, to protect and promote their health and wellbeing, and to ensure the continuation of service delivery and teamwork. However, the symptoms and indicators of burnout are widespread.
- Change management was particularly challenging, particularly due to high levels of uncertainty and the rapid rate of change. Programs and services often struggled to maintain essential services, due to several factors that caused staffing shortages. Many essential functions (e.g. performance appraisals, evaluation, team-building) had to be postponed, to focus on maintaining essential service delivery.
- The Wellness Action Team (WAT) is an example of a successful cross-sectoral collaboration effectively assessing and addressing the wholistic health and wellbeing needs of the community, particularly within the context of the pandemic. The WAT has surveyed over 400 community members to assess needs and health status, and has compiled an inventory of over 120 activities across the community, focusing on health and wellness within the context of the pandemic.
- Kahnawà:ke demonstrated highly successful community-wide mobilization in response to the pandemic, reflecting high levels of solidarity, and effective communication, coordination and collaboration.

Culture and language:

- There is increasing recognition of the well-established link between language and culture as mediators and manifestations of wellness, and significant healing forces for Onkwehón:we. Culture and language are therefore often directly integrated into organizational Strategic Plans and programming.
- Collaboration and alignment between the various culture and language programs in the community need to be further strengthened. The Wellness Action Team's (WAT) work on enabling collaborations integrating tradition and culture programs and activities is a good example.
- Culture and language-related programs and services were disrupted during the pandemic, demonstrating the need to invest resources to ensure their sustainability.
- Culture and language, along with cultural safety and competency frameworks need to be systematically integrated across all levels of governance, from leadership to programming and service delivery.

Perceptions regarding the CHP:

- Conceptually, the next iteration of the CHP needs to be oriented around outcomes relating to health, wellness and wellbeing, rather than being focused on specific diseases, illnesses or conditions. Furthermore, it should integrate Indigenous and Kanien'kehá:ka wholistic understandings of health, wellness and wellbeing.
- The CHP had limited integration of performance indicator frameworks, which limited the ability to conduct ongoing and systematic evaluation, performance assessment and quality improvement activities. Furthermore, Knowledge Translation and Exchange (KTE) activities were limited; therefore, staff from organizations across Kahnawà:ke often had little awareness of the content or purpose of the CHP.

- There was significant variability in the performance of the CHP Sub-Committees, as well as the experiences of their respective members. Most were found to functioning at early developmental stages, rather than being high performing.
- Existing data largely support and validate the relevance of the seven CHP health priorities. However, Kahnawà:ke stakeholders suggested that additional health, wellness and wellbeing domains should be considered, defined and assessed for inclusion, using comprehensive engagement strategies.
- To shift the strategic orientation of the CHP towards an outcomes-oriented "Community Wellness Plan" (CWP), a number of principles, concepts and orientations could be considered for guidance.
- The CWP should integrate a comprehensive outcomes-oriented performance framework. This common framework would enable all Kahnawà:ke stakeholders to align efforts and collaborate to achieve commonly desired health, wellness and wellbeing outcomes. The framework's process indicators would clearly reflect the functions and activities of the respective stakeholders, and the outcome indicators would enable ongoing measurement and assessment of the performance and quality of services.

3. Evaluation design and methodology

3. Evaluation design and methodology

The purpose of the evaluation is to assess and evaluate the impact of the Community Health Plan (CHP), particularly in relation to the health priorities and supporting areas. The summative evaluation questions were developed inductively and iteratively through document review, as well as engagement with Onkwata'karitáhtshera and program staff from Kahnawà:ke health, social and educational organizations. The main evaluation questions are:

- What programs, services and initiatives are in place to address the health priorities outlined in the Community Health Plan (CHP)?
- What is the performance of these programs, services and initiatives, within the context of meeting individual and population health needs related to the CHP priorities?
- What is the impact of the CHP on the health priorities?

The evaluation design is based on a mixed methods approach, leveraging multiple data sources and qualitative and quantitative analyses. The project leveraged a systems-oriented evaluation framework that adapted and built upon domains identified through the WHO PHC-IMPACT framework, Starfield's model for health services research, Donabedian's model for quality of care and the Institute for Healthcare Improvement (IHI) Quintuple Aim (1–6).

Through engagement with Onkwata'karitáhtshera and program staff, as well as document review, additional domains were integrated into the evaluation framework, based on their relevance, essentiality and importance, namely: culture, cultural safety (including cultural awareness, sensitivity and competency), Kanien'kéha language, Indigenous and Kanien'kehá:ka concepts of health, wellness and wellbeing, community engagement and pandemic impact (7–10).

This resulted in the development of the systems-oriented conceptual framework outlined below, which was used to frame the findings and recommendations of the evaluation. Further details regarding the content and definition of the framework's domains are provided in Appendix Section 1 (Evaluation matrix).

Systems-oriented conceptual framework

Structures / Capacity	Performance / Functions	Outcomes / Impact
Structural enablers and organizational resources: (e.g.	Access	Client, caregiver & family experiences (outcomes)
Funding, Facility infrastructure	Teamwork (functions and activities)	Team / staff experiences (outcomes)
Information technology,	Communication	Employee health, wellness and wellbeing
Equipment, Supplies)	Collaboration	Culture and language (outcomes)
Human resources	Coordination	Cultural safety (including cultural awareness, sensitivity and competency) outcomes
Education	Community engagement	Pandemic impact
Training	Client, caregiver & family experience (processes of measurement, analysis and use)	Impact on CHP health priorities (health outcomes, population level)
Governance	Evaluation	
Leadership	Performance assessment	
Program model (e.g. selection of services, design, organization, management, standards, protocols, guidelines)	Quality improvement	
	Information systems (use of, for data-driven governance and decision making)	
	Pandemic response	
	Change management	
	Cultural safety and cultural competency (functions)	
	Culture and language (functions and activities)	

3.1 Data sources

The mixed methods evaluation leveraged multiple data sources, including:

- **Site visits (July 10 – 13, 2022), staff engagement meetings and participatory observation**
    - Sites included: Tehsakotitsén:tha Kateri Memorial Hospital Centre (KMHC), Kahnawà:ke Shakotiia'takéhnas Community Services (KSCS, main building), Whitehouse, Turtle Bay Elders Lodge (TBEL), Kahnawà:ke Fire Brigade and Ambulance, Kahnawà:ke Youth Center (KYC), Assisted Living Services Independent Living Center (ILC), Family Wellness Center (FWC), Tsi ionterohwaienhstakwa ne Kahwatsiranó:ron (Step By Step Child and Family Center).

- **Document review, including:**
    - Community Health Plan (CHP) related documents
    - Organizational strategic planning documents
    - Evaluation reports (programs, services and initiatives)
    - Annual reports (organizational, program and service levels)
    - Health Portraits reports (Onkwata'karitáhtshera, Onkwaná:ta Our Community, Ionkwata'karí:te Our Health, Volumes I and II [forthcoming])
    - Internal organizational documents
    - Logic models (Sub-Committee, organizational, program and service levels)
    - Community Health Plan Initiative (CHPI) applications and reports
    - Organizational websites and social media pages; Google searches, including grey literature and news articles. Where possible, website searches were performed in a systematic manner, using specific keywords relating to evaluation framework domains. Site maps, publication links and internal website search engines were leveraged, when available.

- **Quantitative data:**
    - KSCS Research & Systems reports (Penelope case management system reports; KSCS program and service level Excel Grids; Home and Community Care Services statistics program)
    - MYLE EMR-derived reports and statistics
    - Statistics reported in Annual Reports and Strategic Planning documents
    - Community Based Reporting Tool (CBRT) statistics

- **Interviews and Focus Groups:**
    - 20 key informant interviews and 10 focus groups (8 of which were "mini" focus groups, with ~4 participants each) were conducted with staff from relevant stakeholders, including Tehsakotitsén:tha Kateri Memorial Hospital Centre (KMHC, several programs),

Kahnawà:ke Shakotiia'takehnas Community Services (KSCS, several programs), Whitehouse, Turtle Bay Elders Lodge (TBEL), Kahnawà:ke Fire Brigade and Ambulance, Kahnawà:ke Youth Center (KYC), Assisted Living Services Independent Living Center (ILC), Family Wellness Center (FWC), Tsi ionterohwaienhstakwa ne Kahwatsiranó:ron (Step By Step Child and Family Center), Connecting Horizons, PeaceKeepers and Jordan's Principle.

  - Participants were selected in relation to their respective experience, roles and functions, and identified through document review and consultations with the Onkwata'karitáhtshera team. Participants represented various disciplines and professions, and included frontline staff, managers, directors and executive leaders.
  - Interviews and focus groups lasting anywhere between 1 – 3 hours, and were conducted using virtual technologies (MS Teams, Google Meets). On a few occasions where video calls were not feasible, phone calls were used. Where possible and feasible, interviews and focus groups were recorded, for transcription and thematic analysis. 30,000+ lines of transcript were generated. Notes were also taken during interviews and focus groups. All interview recordings, transcripts and notes are securely stored and password protected, and will be promptly erased/destroyed upon completion of the project.

- **Content validity and prioritization workshop:**
  - The evaluation also leveraged input and data from a workshop that was held on October 18-19, 2022. During the workshop, the evaluation's key findings and draft strategic recommendations were shared with diverse Kahnawà:ke stakeholders, who participated in a content validation and prioritization exercise. The workshop included a variety of participants from organizations and groups such as Onkwata'karitáhtshera, MCK, KSCS, KMHC, KFB, KYC, SBS, Connecting Horizons and the PeaceKeepers. Most individuals participated in person, and some participated virtually.
  - Participants broke out into groups, to assess the content validity and priority status of the draft recommendations. Using a scoring and feedback template, the groups rated the recommendations for clarity, relevance, essentiality, importance and urgency (Appendix section 2: content validity scoring template). The participants then regrouped, and presented and discussed their scores and feedback. The completed scoring and feedback templates were returned to the evaluation specialist, for analysis (Appendix section 3: content validity and prioritization results).
  - Participants were also requested to complete an online survey (confidential and voluntary), to individually score the draft recommendations for their content validity and priority status (Appendix section 3: content validity and prioritization results). This exercise enabled triangulation of results from the workshop, and to ensure that individuals had a safe and confidential space to provide candid feedback (particularly for individuals that did not feel comfortable or safe voicing differing perspectives within a group setting). The survey thereby served as a mechanism to ensure that all voices are heard.
  - Feedback from the workshop was analyzed and used to revise the recommendations. A subsequent process of validation of the redrafted recommendations was also conducted with the Onkwata'karitáhtshera team.

3.2 Data analysis

The team from Onkwata'karitáhtshera and staff from relevant organizations, programs and services were requested (during the site visit, and by emails) to forward documentation that would support the evaluation. A list of examples of the types of documents and information that would be useful was sometimes provided, to support and direct staff in relation to the information request. The evaluation specialist worked closely with the Onkwata'karitáhtshera team to conduct the initial selection of relevant documents.

Inclusion and exclusion criteria related to whether documents contained meaningful content in relation to the evaluation questions and framework. Snowball searches were performed by leveraging citations and references in documents, articles and reports. Included literature was categorized, catalogued and stored in a secure password-protected online folder.

Data and themes from the documents, interviews and focus groups were organized, coded and synthesized both inductive and deductively according to the evaluation framework's domains, using thematic content analysis. Findings were synthesized and triangulated against available data sources. Data or findings that were unclear were shared and discussed with the relevant stakeholder(s), to validate the accuracy and completeness of findings and analyses. The workshop on October 18-19 provided an opportunity for stakeholders to validate and provide feedback regarding the accuracy and completeness of the evaluation's findings.

Data from the content validation exercises (group exercises and survey results) was analyzed using qualitative and quantitative methods, and used to revise the draft recommendations.

Evaluation high-level timeline

3.3 Limitations

- Limited quantitative data: there was very limited quantitative data available for quantitative and statistical analyses, to support the evaluation's findings. Data quality and reliability issues also limited the ability to conduct analyses (e.g. to assess performance using logic model indicators, or to conduct cross-sectional quantitative analyses or to measure and assess longitudinal trends).
- Interviewee and/or evaluation participation and biases: Although active efforts were made to ensure participation of diverse disciplines and professionals across all governance levels (i.e. frontline staff, management, directors and executives), it is important to recognize that the perspectives of staff and/or programs who did not participate may have been missed. Mainly due to time and resource constraints, it is also important to note that it was not possible to interview the totality of stakeholders who may have important roles and contributions in relation to the CHP (e.g. the Kahnawà:ke Education Center (KEC), Tewatohnhi'saktha, Kanien'kehá:ka Onkwawén:na Raotitióhkwa Language and Cultural Center (KORLCC), Kahnawà:ke Schools Diabetes Prevention Project (KSDPP)). However, publicly available resources (e.g. from their respective websites, reports, publications etc) were used to provide descriptive analyses of these organizations and programs where possible, to meaningfully reflect their respective roles and contributions. Time and resource constraints were limiting factors, relating to achieving study saturation (which the evaluator strived towards). Furthermore, there is always the possibility of selection and respondent biases, which the study attempted to mitigate by triangulating findings from multiple sources.
- Evaluator and interviewer bias: the evaluator attempted to mitigate the effects of such biases using data triangulation, re-listening to interview/focus group recordings, self-reflection and open discussions with various team members. Furthermore, the workshop enabled participants to validate evaluator perceptions and findings.
- Due to the lack of accurate longitudinal data and ongoing (e.g. annual) systematic evaluations, it was challenging to assess development, growth or performance trends over the past 10 years. Therefore, the evaluation is focused on the past few years, and particularly on the present state of performance.
- Client/patient input: The study did not directly interview or survey clients/users/patients; rather, it relied on client experience data collected by the respective organizations, programs and services, as well as input from community-based / patient advocacy organizations (particularly those dedicated to vulnerable groups and those with complex biopsychosocial needs). The fact that a significant proportion of interviewees and study participants are Kahnawakehró:non and community members provided insights into experiences and perspectives of those using the systems and services.

4. Introduction

4. Introduction

The 2012-2022 Community Health Plan (CHP) is the third plan developed by Onkwata'karitáhtshera, (Kahnawà:ke's one health and social service agency), as part of a ten-year funding agreement negotiated with Health Canada (11). The CHP was designed and developed to enable strategic alignment of the community's health and social services, and operationalization of Onkwata'karitáhtshera's overarching goals:

- To assume responsibility and control to determine health priorities and resource allocation for all health and social services in Kahnawà:ke.
- To promote and advocate for optimum health and social services for Kahnawakehró:non.
- To plan and manage global health and social services by assuming responsibility and control to determine health priorities.
- To build capacity within the community to deliver quality health services.
- To develop a structure responsible for establishing long-term goals (15-20 years) for improving health of Kahnawakehró:non, integrated with existing planning structures and partnerships.

Through the iterative use of data (including literature reviews, community health needs assessments, qualitative and quantitative data and population health statistics), stakeholder consultations and community engagement, the following **seven health priorities and four contributing services** were identified.

Health priorities	Contributing services
1. Addictions 2. Cancer 3. Cardiovascular 4. Developmental Disabilities 5. Diabetes 6. Mental health 7. Obesity	8. Multiple support priority 9. Primary health 10. Home and community care 11. Health management

Seven CHP Sub-Committees were established by Onkwata'karitáhtshera to address the health priorities, to enable cross-sectoral collaboration in relation to conducting the following key functions:

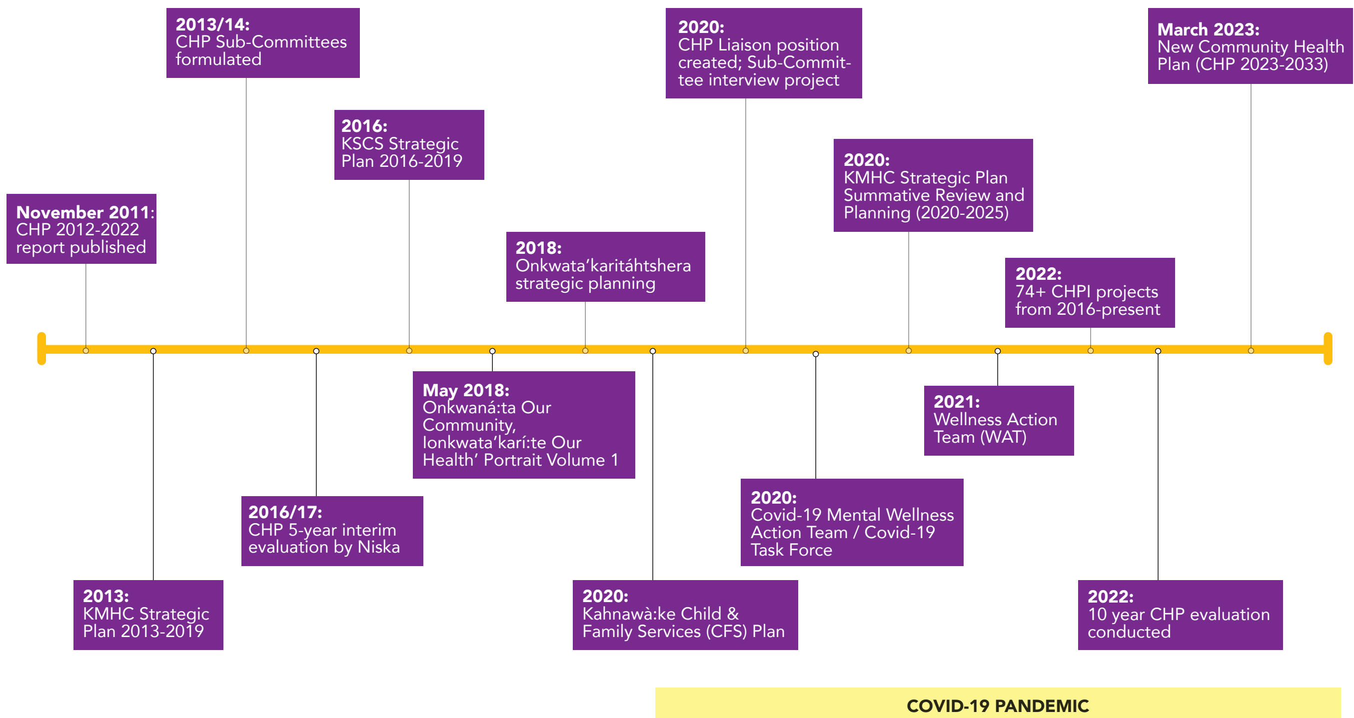
- Assessments of needs, gaps and linkages
- Development of service inventories for each priority area
- Strengthening logic models to be outcomes-oriented, and to have SMART objectives
- Developing frameworks and strategies for the respective priorities

As part of the Health Funding Consolidated Contribution Agreement, Onkwata'karitáhtshera committed to conduct mid-term and end-point summative evaluations of the CHP. The mid-term evaluation was conducted in 2016, resulting in the following key findings (12,13):

- Progress was made in completing the activities linked to the seven health priorities, and most organizational needs identified in the CHP had been at least partly addressed.
- Programs and services are benefitting those who use them, but more community outreach was needed to reach the most vulnerable. Furthermore, improvements could be made to enhance the benefits of services.
- General consensus that the health priorities reflect the major issues faced by Kahnawakehró:non. However, better statistical data is needed to determine the accuracy of the health priorities. Violence should be reconsidered as a health priority.
- Inter-organizational collaboration and coordination are important and need to be improved, to ensure effective implementation of the CHP. Increased promotion of the CHP to frontline staff and to the wider community is required. The CHP would benefit from increased integration of Kanien'kehá:ka culture, language, and a wholistic approach to wellness.
- There was insufficient quantitative data to measure the impact of the CHP on the health priorities. Insufficient coordination of data collection and storage among programs and organizations limits the ability to assess the overall impact of the CHP. The monitoring and evaluation tools (e.g. logic models) were not used to the extent that they could be, and there are no annual reports for the CHP as a whole. However, significant advances were made through efforts such as data mining and the centralization of data management and analysis at KSCS.
- The CHP was widely seen as a living, working document used to inform the planning and delivery of programs and services, and the creation of the health priority subcommittees had contributed to enhancing inter-organizational collaboration.
- The findings of the mid-term 2016 CHP evaluation resulted in the drafting of 12 recommendations, relating to the following themes: Data; Community Engagement; Language & Culture (Tsi Niionkwarihò:ten); Client and Family-Centred Care (Full Spectrum); Collaboration Challenges; Focus on High Risk and Most Vulnerable; Collaborative Planning; Community Wellness Plan (CWP); CHP as Tool & Resource; and Communications (Appendix section 4: 2016 CHP evaluation recommendations).

The high-level timeline below visualizes some of the key milestones and events related to the CHP over the past dozen years:

CHP high-level timeline



Recap

The purpose of the evaluation is to assess and evaluate the impact of the CHP, particularly in relation to the health priorities and supporting areas. The summative evaluation questions were developed inductively and iteratively through document review, as well as engagement with Onkwata'karitáhtshera and program staff from Kahnawà:ke health, social and educational organizations. The main evaluation questions are:

- What programs, services and initiatives are in place to address the CHP health priorities?
- What is the performance of these programs, services and initiatives, within the context of meeting individual and population health needs related to the CHP priorities?
- What is the impact of the CHP on the health priorities?

The findings and recommendations of this summative evaluation will also support the development of the new ten-year plan, beginning in 2023.

5. Organizational performance

5. Organizational performance

This section provides detailed descriptions and analyses of the performance of 22 organizations and programs, that comprehensively address Kahnawà:ke's population health needs across the entire lifespan, from pre-conception to palliative care. It addresses the following two key evaluation questions:

Question 1: What programs, services and initiatives are in place to address the health priorities outlined in the Community Health Plan (CHP)?

Question 2: What is the performance of these programs, services and initiatives, within the context of meeting individual and population health needs related to the CHP priorities?

The list of organizations and programs assessed include:

- Environmental Health
- Kahnawà:ke Youth Center (KYC)
- Tsi Ionterihwaienhstakwa Ne Kahwatsiranó:ron (Step By Step Child and Family Center)
- Kahnawà:ke Education Center (KEC)
- Whitehouse Prevention Programs
- Family & Wellness Center (FWC) – Parenting Services
- Family & Wellness Center (FWC) – Traditional Counseling
- Jordan's Principle
- KSCS Child And Youth Wellness
- KSCS Mental Wellness and Addictions
- Assisted Living Services
- Connecting Horizons
- Home & Community Care
- Turtle Bay Elders Lodge (TBEL)
- Tehsakotitsén:tha Short Term Care (KMHC)
- Tehsakotitsén:tha Long-Term Care (KMHC)
- Tehsakotitsén:tha Outpatient Clinic Services (KMHC)
- Tehsakotitsén:tha Community Health (KMHC)
- Tekanonhkwatsherané:ken (Two Medicines Working Side by Side / KMHC Traditional Medicine)
- Kahnawà:ke Fire Brigade & Ambulance
- Kahnawà:ke Peacekeepers
- Tsi Niionkwarihò:ten (Our Ways, KSCS)
- Tehsakotitsén:tha Quality Improvement, Risk Management and Innovation (KMHC)

5.1 Environmental Health

Highlights

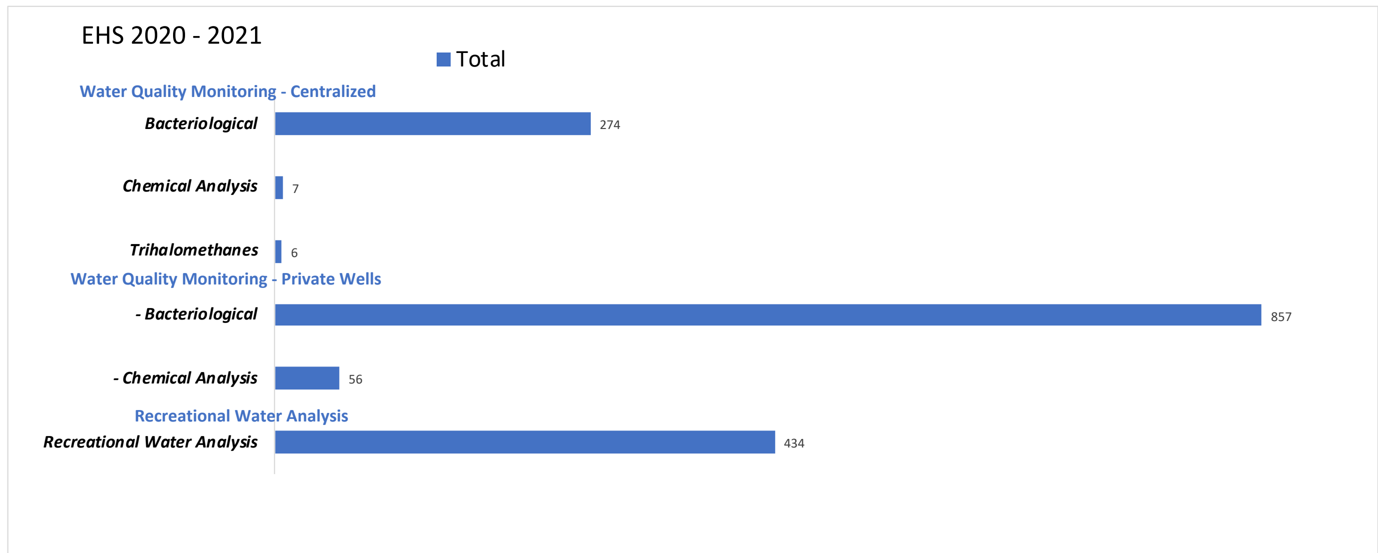
- CHP health priorities: cross-cutting
- Essential upstream services that protect and promote environmental health, and the wellbeing and safety of Kahnawakehró:non, particularly in light of the effects of climate change and pandemics.
- Further coordination with the other health and social services across the community (particularly in relation to emergency preparedness and response) will enable alignment of efforts, and contribute to the overall safety, health and wellbeing of the community.

Overview

The Environmental Health Services (EHS) program provides essential upstream services that protect and promote environmental health, and the wellbeing and safety of Kahnawakehró:non, particularly in light of the effects of climate change and pandemics. Primary functions relate to the identification, monitoring and mitigation of health hazards in the environment, with a focus on the following areas:

- Water quality monitoring and chemical analysis (central and well water, recreational waters)
- Waste disposal
- Food safety inspections
- Health hazard investigations
- Indoor air quality/mould investigations
- Communicable disease interventions
- Building safety (private & public)
- Health and social care organizational inspections (air quality, sanitation, water testing, food safety), including schools and daycares
- Occupational health & safety
- Emergency preparedness

Chart 1: EHS Water Quality Monitoring Services descriptive statistics (2020-2021)



As part of the COVID-19 pandemic response, in collaboration with the Kahnawà:ke Task Force, EHS conducted 2,294 special projects in 2020/2021, including inspections of community restaurants and businesses.

Team-based service delivery model

The mandatory components of environmental health and safety in Kahnawà:ke are carried out under Environmental Health Services (EHS) of KSCS. The EHS team consists of a manager, environmental health technicians, and the support of an Environmental Health Officer (EHO) with a Certificate in Public Health Inspection (Canada). The EHO is presently shared with Indigenous Services Canada, and is responsible for upholding the standards we follow in accordance with all inspecting, testing and sampling.

Staff training and continuous professional development are significant issues that need to be addressed, especially post-pandemic, to ensure staff catch up on required training and have access to updated training sessions (especially in light of the rapidly changing technological environment). Human resources will likely need to be increased in the near future, to meet demands in the community exacerbated by climate change and the pandemic.

The team has access to a state-of-the-art water treatment plant, and continuously updates its testing and analysis equipment, as well as its data and information systems. For centralized, well water and recreational water testing, EHS uses two Tecta B16 units, pocket colorimeters to detect free and total chlorine and turbidimeters to measure turbidity in water. The Tecta automated microbiological platform enables testing of samples at any time and can provide E. coli and Total Coliform results in 2-18 hours, depending on the level of contamination. The units automatically transmit data through a network connection allowing for immediate notification on electronic devices, such as cell phone or laptops, as soon as a contamination event is detected. For inspections (e.g. air quality, food safety), the EHS team utilize tools that include: TPI 1010a Indoor Air Quality Meters, FLIR MR277 Moisture Meters, Traceable 4475 Mini IR Thermometers and GasAlertMicro 5 Gas Detectors.

Client engagement

The EHS program's interactive services and inspections focus on client engagement, experience and satisfaction, and emphasize the value of individualized conversations, and the provision of customized advice. The team also welcomes advice and input from clients, in terms of the perceived quality and timeliness of services, as well as potential areas for improvement.

The EHS program leverages technology to improve communication and the overall client experience. For example, EHS reports are sent out to client emails and phone numbers, which enables efficient and effective communication, resulting in better customer service (while improving the efficiency of the overall program).

Communication, collaboration and coordination

EHS management participates in various groups (e.g. the KSCS health and safety committee), which enables issues in the community to be brought to the EHS team's attention. However, there exists opportunities to further improve communication and coordination with Kahnawà:ke's health and social services organizations, particularly in relation to sharing information and enabling alignment (which is especially important during emergencies, such as pandemics). The EHS program is somewhat (inadvertently) segregated within the overall system in Kahnawà:ke, by virtue of the distinct content of its portfolio.

Further coordination with the other health and social services across the community will enable alignment of efforts, and contribute to the overall safety, health and wellbeing of the community.

Evaluation, performance and quality

The EHS program collects masses of data continuously from multiple sites and across different services, requiring a strong data and information management system. Therefore, the EHS program makes use of databases (e.g. for water quality testing and chemical analyses), as well as a logic module, which guides data collection and reporting.

Many of the information systems are now digitized and online, enabling easy access to information when required, especially when off-site. Phone and tablets are now used for data collection, which also enables the collection and storage of photos and videos, and their incorporation into reports. The Tecta microbiological units automatically transmit data through a network connection, allowing for immediate notification on electronic devices (e.g. cell phone or laptops) as soon as contaminations are detected.

Program-specific CHP input

The EHS program is an essential upstream service that protects the safety, health and wellbeing of the community. As community needs increase in scope and intensity, particularly in relation to the impact of pandemics and climate change (i.e. air and water quality), proactive plans should be put in place to support the team with required resources.

Climate change is a major factor that should be addressed, due to its impact on the air and water quality, as well as its impact on the ecosystem and recreational activities (e.g. beach water quality, heat), causing secondary impacts on psychosocial wellbeing of the community. It is important to identify mechanisms to mitigate and adapt to the effects of climate change on the environment, facilities, and health and wellbeing of the community.

Cross-sectoral communication, collaboration and coordination also need to be improved within the context of emergency planning and response. In particular, the sharing of information, protocols and processes during pandemics and emergencies, to ensure alignment.

5.2 Kahnawà:ke Youth Center (KYC)

Highlights

- CHP health priorities: cross-cutting. KYC consciously addresses all CHP health priorities via targeted programming, and active participation in Community Health Plan Initiative (CHPI) initiatives.
- Major focus on chronic disease (including diabetes, cardiovascular disease, hypertension and obesity).
- Approach leverages / focuses on upstream prevention, healthy lifestyles, social inclusion, culture and family preservation. Social prescribing is increasingly being promoted and embraced.
- Focus on enabling low-barrier access for the entire community, including individuals with special needs, and families with financial challenges.
- Emphasis on cross-sectoral collaborations and community engagement functions.

Overview

The mission of the Kahnawà:ke Youth Center (KYC) - now 50 years old - is to offer recreational, sports, fitness, educational and cultural programs (14). Through dedication, collaboration and support, KYC's services strive to make a positive impact on the youth, families and the community within a safe, fun and secure environment. It is a vital service to the community, offering a wide range of programming that address CHP priorities, by promoting healthy living, active lifestyles and community involvement. The three-story facility includes a gymnasium, kitchen, climbing wall, games lounge, fitness studio, art room, Homework Hut/Culture Room, weight room and a cardio zone.

Youth are kept active and involved through the After School program, Summer and March Break camps, various yearly youth events and the new Outdoor Adventure for Teens Club. Adults in the community have access to a range of fitness programs, a full weight room and various sport leagues. The center offers traditional Haudenosaunee cultural teaching such as basket making, beading, social singing and dancing, smoke dancing, powwow dancing and moccasin making. Kahnawa'kerό:non are kept involved through large scale community events such as the Winter Carnival and Mohawk Miles, which has been running since 1985.

Figure 1: The Eastern Door article regarding the KYC (Source http://kahnawakeyouthcenter.ca/)

Kahnawake Youth Center 1972-1997

25 years of Excellence

Kahnawake Youth Center 1972-1997

By Alex M. McComber

Youth Center Trivia Quiz

THE EASTERN DOOR • Vol. 6 No. 17 • May 23, 1997

Team-based service delivery model

KYC has served several generations of Kahnawakehró:non over the past 50 years of its operations. The organization is governed by a transparent Board of Directors, with representation from the community, and its various health and social services. Its team is comprised of staff dedicated to various functions and activities, including operations, program management, dedicated program staff for youth and teens, fitness instructors and a community events coordinator.

KYC have a comprehensive range of programming, including specific programs for: youth (0-12 years), teens (13-17 years), adults and families, sports leagues (recreational and competitive), fitness programs, cultural programs (e.g. traditional teachings and activities led by Onkwehón:we instructors, focusing on crafts, moccasin making, basket making, Inuit games and social dancing and singing), arts, dance and social programs.

KYC turns 50 this year, and the leadership team is keen on updating programming to further adapt to and reflect new realities. The leadership team is therefore exploring options to implement new, creative, engaging and effective activities.

The KYC aims to provide low-barrier access to all of its programs and services. For example, it offers online registration for programs and activities on the KYC website, which was especially useful during the pandemic period. KYC is also encouraging and implementing a social prescribing model, by accepting referrals (formal or informal) for social/fitness/health/wellbeing activities from all health and social care organizations in Kahnawà:ke. For example, KYC is accepting prescriptions from physicians, for clients to access and use the gym or social recreation activities, regardless of ability to pay. KYC's programs and activities offer significant benefits to physical and mental wellness (e.g. physical exercise for individuals experiencing mild depression).

KYC is very engaged and active in CHPI activities, with multiple projects being successfully designed, implemented and evaluated, with integrated logic models.

Kahnawà:ke Youth Center (KYC) CHPI Initiatives:

Community events CHPI project (2020/21):

- Objective: The Community events will bring the community together, getting the community active, and in doing so providing an opportunity to get healthy, stay fit, and have a positive impact on the 7 health priorities listed within the Community Health Plan.
- Activities: 7 Large scale community events: Mohawk Miles, Zombie Run, Cultural Awareness activities, Christmas Hayride, Winter Carnival, SOW Sports Tournaments, March Madness Basketball Tournament
- Indicators and desired outcomes: More participation and stronger families would mean a healthy active population and stronger family circles. By continuing to offer the various community events, we could eventually address statistics relating to diabetes, exercise, obesity and activity.

Community fitness CHPI Project (2020/21):

- Goal: The goal of the program is to continue offering fitness classes to each member of the community no matter their means, allowing them to achieve a healthy lifestyle.
- Activities: Weight room facilitator (20hrs/week); Steady, strong and day break fitness classes (3 times/week); Yoga and Pilates classes (twice a week).
- Indicators: Evaluation forms to garner feedback regarding experiences; complete evaluation report with statistics.

Outdoor Adventure for Teens CHPI Project:

- Goal: To provide opportunities for our teen population to participate in new healthy physical activities taking place in the outdoors.
- Activities: Healthy active activities and trips planned with the input from teens, including hiking, rafting, canoe-camping, snow shoeing, skiing.
- Indicators: Evaluation forms will be given to participants to gain feedback on their experience; Participant photos and videos reflections; Annual stats will be kept on participation levels.

Community engagement

KYC organizes and hosts many community events (often in collaboration with other community organizations), which aim to be inclusive and family friendly, focusing on ensuring that fun activities are available for the entire family – children, youth/teens, parents and Elders – to enjoy.

KYC's website aims to provides transparent and comprehensive information, including:

- Online registration for programs
- Transparency regarding Board membership and team composition
- Clear contact information
- Descriptions of programs, services and community events calendars

Communication, collaboration and coordination

As highlighted in the previous section, the KYC team work closely with partners in the community (e.g. KSCS, KMHC, KFB, PeaceKeepers, Non-Governmental Organizations (NGOs), MCK) to co-host many community events. Many of these organizations are also represented on KYC's Board of Directors (including upper management levels). The team work particularly closely with social services (e.g. KSCS) and schools (e.g. via joint planning meetings), to improve linkages and partnerships.

Client, family and/or caregiver experiences

The KYC is focused on ensuring positive client experiences, and therefore emphasizes one-on-one conversations with clients, to garner information and feedback. Furthermore, surveys and evaluations are often conducted for community events and fitness activity programs.

Evaluation, performance and quality

The KYC dedicates significant time and resources to evaluate ongoing programs, services and initiatives. For example, CHPI initiatives and several community events and activity programs are systematically evaluated. Logic models are developed and used for evaluation of CHPI activities and outcomes.

KYC relies heavily on feedback provided via one-on-one conversations with clients and families, which usually indicate that clients/families are largely satisfied with the services and programming. High participation rates and full classes are leveraged as indicators of satisfaction with services, and high performance.

Some program areas have strong data (e.g. participation and retention statistics), but others do not. A systematic approach to data collection would be helpful, to streamline evaluation and QI activities. Furthermore, data is required regarding individuals or families that do not – or can not – participate in KYC programs and activities, particularly those with vulnerabilities, special needs and/or limited resources. It is important to understand the reasons why they are unable and/or unwilling to participate, and how to address these issues to improve access, participation and engagement.

The team is relatively understaffed and is therefore focused on maintaining regular operations. There is very limited time for data collection, data analysis or evaluation – or time for structured team activities relating to self-reflection and quality improvement.

Culture and language

KYC staff are always encouraged to update language skills, and to embed culture and language in a thoughtful manner in all aspects of KYC programming.

Specific programming is dedicated to cultural activities and classes, including art, crafts, singing and dancing for children and youth. Elders are always welcomed to participate and share their knowledge with the KYC team, and to participate in designing activities. KYC recognizes the diversity of the community, and strives to provide a safe, inclusive and enjoyable environment for all community members.

Organization-specific CHP input

The CHP is the main driver behind all of KYC's programming, and is considered a guiding document in relation to identifying the health and wellbeing priorities of the community. Therefore, KYC makes a conscious effort to explicitly design programs that directly target CHP priorities. Furthermore, the CHP is perceived as a common framework for collaboration and cooperation with all other organizations in the community, including KSCS, KMHC, KFB, the PeaceKeepers and the schools.

It is important to focus on teen health and wellbeing. Teens are largely isolated, and are not participating much in social, community or fitness events. It is important to re-engage teens (particularly those with vulnerabilities, facing high risks and/or challenging family/home contexts), to ensure their participation in salutogenic and productive activities, and to design effective family-oriented programs and services that protect and promote their health and wellbeing.

5.3 Tsi Ionterihwaienhstakwa Ne Kahwatsiranó:ron (Step By Step Child & Family Center)

Highlights

- CHP health priorities: Early childhood wellness, mental health and wellness.
- Strong multidisciplinary team-based approach that supports all families in their child's physical, cognitive and social-emotional development, based on Kanien'kehá:ka culture, traditions and perspectives.
- Provides a comprehensive array of upstream prevention and early intervention and educational services and supports to children and their families, which are culturally guided, evidence-based and associated with optimal child outcomes.
- Genuine collaboration with families by acknowledging and seeking out their expertise regarding their children, and by engaging them in the curriculum.
- Robust Quality Program using the organization's Quality Programming Guide, which defines how Kanien'kehá:ka culture, Tsi Niionkwarihò:ten and historical perspectives shape quality programming. The Cultural Curriculum framework is integrated into the Quality Program, embodying the organization's vision in relation to its cultural practices and pedagogical perspectives.
- It is important to recognize the importance of investment in early intervention, and to recognize and build awareness of how resource-intensive early intervention approaches are, if properly designed.

Overview

Tsi ionterihwaienhstahkwa ne Kahwatsiranó:ron
Step By Step Child and Family Center

Tsi ionterihwaienhstakwa ne Kahwatsiranó:ron (Step By Step Child and Family Center, or SBS) is an inclusive early intervention program for children between the ages of 18 months and 6 years and their families (15). SBS traces its roots to 1983, when a small group of mothers of children with special needs self-organized and mobilized, to establish an inclusive center for early intervention and preventative educational and training programs. Their tireless grass-roots advocacy and perseverance brought their vision to fruition, with comprehensive early intervention programs now being offered to Kahnawakehró:non children and families.

SBS aims to support all families in their child's physical, cognitive and social-emotional development, based on Kanien'kehá:ka culture, traditions and perspectives. SBS believes that every child has the right to be a contributing member of the community. At SBS, inclusion is a

value that is demonstrated through carefully preplanned inclusive learning experiences among parents, children, and the community that foster not only societal acceptance and stigma reduction, but also promote learning of important social and academic skills.

SBS provides a comprehensive array of upstream prevention and early intervention and educational services and supports to children and their families, which are culturally guided, evidence-based and associated with optimal child outcomes. SBS uses developmental screens, assessments, parent questionnaires as well as in class observations to assure knowledge of each child's development level, and to deliver individualized programs to develop each child to his/her full potential. Teacher-child ratios are used to ensure that each child's needs are met.

Risks, population health needs, prevention and early intervention (excerpt from SBS report)

Many children become vulnerable as a result of certain factors which threaten their development. Research shows that children from such environments are likely to be unprepared for school or social learning and consequently do poorly in school and other social contexts. Some of those factors include:

- Poor care giving environment such as a family with parent(s) who abuse alcohol and drugs.;
- Behavioral problems such as very low or very high infant activity at age one;
- An environment which is not stimulating and where the child has little interaction with the caregiver and then only to attend to basic needs;
- Little or no physical contact such as hugs, kisses, and words of caring and love;
- Fetal Alcohol Syndrome, Fetal Alcohol Effects;
- Congenital defects, physical handicaps, learning disabilities, children with pervasive developmental delays, "autistic" characteristics, Asperger syndrome, Cerebral Palsy, Muscular Dystrophy, Downs Syndrome, etc.;
- Parent(s) raised in multi-generational family trauma environments (i.e. sexual abuse, physical abuse, drug and alcohol abuse (co-dependency, ACOA), residential schooling) and who therefore experience difficulties with child rearing and relationships;
- Teenage parents, Blended families, Divorced Families, Inconsistent primary attachment figures, multiple foster placements, parent literacy, parental socioeconomic status, parental criminal offence, parents experiencing the results of historical oppression and racism e.g. loss of culture, language, spirituality, identity;
- The more risk factors that a child is exposed to the greater the risk of poor development, poor school performance, juvenile delinquency, etc.

Prevention and Early Intervention

In the first five years of life, a child learns more than in any other five year period. Learning social interaction, to trust, to communicate and think logically are some of the essential steps in development. These become the building blocks for the foundation of future growth.

Studies of the long term effects of individually and developmentally appropriate early childhood programs reveal that such programs lead to positive academic achievements, decreased special educational placements and retention later in school.

For the vulnerable child, the child with a handicap, the child with a developmental disorder, the early years of rapid growth and learning are therefore critical periods. The idea behind prevention and early intervention is often to expose "at risk" children to protective factors to increase their resilience.

Step By Step takes a multi-pronged approach by including non-educational supports such as providing health care, involving parents in the program and offering specific services to the families of children enrolled.

Step By Step helps parents support their child's physical, cognitive and social-emotional development. Clearly, the job of parenting cannot be reduced to eight lessons on specific skills. It depends as much on values and attitudes as it does on skills. Each parent has a unique history that has formed in them an approach to parenting with both positive and negative aspects. The challenge is to begin where each parent is, supporting their strengths while helping them to examine their weaknesses.

Governance & leadership

SBS is led by clearly articulated vision, mission and mandate statements. It's governance and organizational structures are clearly established, with a Board of Directors, an Executive team, and teams for Pedagogy, Finance, Specialists, Human Resources, Maintenance, Administration, Information Systems and Communications. The organizational charts are transparent and posted on SBS' website.

Members of the Board are parents, guardians, and/or persons with a biological link to a child attending SBS. As a governing Board, it is responsible for all of the Center's activities which reflect the intensity and importance of parental involvement and engagement. Through authorized policies and procedures, the day-to-day operations are delegated through the Executive Director.

Team-based service delivery model

Presently SBS provides programs and services to approximately 180 children and families with ~ 60 full time and up to 20 part time staff members. The extended team includes classroom

coordinators, resource teachers, education and classroom assistants, child and family support workers, psychologist, speech and language therapist, clinical consultant, nurse, IT, HR consultant, dental hygienist, occupational therapist, physiotherapist, inclusion specialist, food preparation worker and lunch monitors and substitutes.

SBS' multidisciplinary team-based service delivery model is underpinned by a philosophy that every child and family are unique, with an early intervention approach that identifies and builds upon the child and family's strengths and psychosocial assets. The health and wellbeing needs of the child are therefore assessed from a wholistic perspective, taking into account the family and community contexts.

The focus is always on identifying a child's needs, particularly in relation to what supports and resources (from SBS, the family, the community, and health and social care systems) are required to enable them to reach their full potential as human beings, and as active members of the community. This includes intangible needs, such as love, relationships, support, caring, mentoring and upbringing. SBS believes that it takes a community to raise a child; therefore, the input and collaboration of all partners are required, and foremost, the parents and relatives.

SBS' approach to service delivery is premised on peaceful, non-violent ways. The philosophies of reciprocity and respect for children as little people are fundamental, with the view that children are important members and contributors to our community, who are genuinely valued.

SBS therefore uses a comprehensive and systematic approach to individualized service delivery, that includes:

- Screening and assessment
- Individual Education Plans
- Family Support
- Speech and Language Support
- Occupational Therapy Support
- Physiotherapy Support
- Psychological Support
- Dental hygiene
- Health & Nutrition Support

SBS leverages a wholistic multidisciplinary team approach to address the complexity of a child and family's needs, assessing health and wellbeing from a multidimensional perspective. The entire team is engaged, to comprehensively assess symptoms and sentinel signs, including using information from referrals from other health and social services. Each team member brings different perspectives (e.g. psychologists, resource consultants, family support workers, speech language pathology), and explore options to support the family in crisis. The team leverages an assets and strengths-based approach, and works in close partnership with the family. The team recognizes that every child's case is unique, and that an individualized approach to assessment and service planning is essential.

The team leverages rigorous standards to ensure quality of service delivery, and aims to individualize plans, with a strong focus on family preservation. The team does not use the phrase "special needs"; rather, the team focuses on identifying the child's special gifts, and to

find ways to build on those gifts. The team does not solely focus on child and/or family deficits; rather, focusing on identifying assets and/or areas of strength to build upon. The strength-based approach is also applied to the staff and team, to identify assets and strengths to leverage, and to enable ongoing skills development and professionalization.

SBS dedicates significant time and resources to keep updated in relation to the domains of early learning, psychology and child development. Information is derived from reviews of the literature, and collaborative work with partners and participation in committees. As has been identified in the literature on early intervention and cultural difference, SBS recognizes the need to develop new practices specifically for Indigenous people. As a learning organization, SBS innovates and develops new screening and assessment tools; new education and intervention strategies; new tools for monitoring child development; and alternative ways of reaching out to parents and children.

In collaboration with Quebec universities and other partners in Canada and the U.S., SBS has begun to introduce and research a new process of screening and assessment that will prevent the mislabeling of cultural difference as individual or group pathology. SBS believes that all professionals who assess and intervene with Indigenous children and families must understand how to build on their strengths and cultural/family values and to clarify what goals, supports and development activities are most appropriate.

SBS is also always engaged in a process of curriculum review and revision. SBS seeks to create inspired and inspiring learning environments that help to build a child's knowledge and skills in ways that are culturally relevant and culturally rich. SBS is intentional in making curricular choices that are built on a foundation of cultural openness, cultural pride and a positive image of the child and his/her potential.

Communication, collaboration and coordination

The SBS team works hard to improve the dynamics of collaboration and communication with educational, health and social services in Kahnawà:ke, and actively works to build mechanisms of cooperation and partnership.

SBS has very strong relationships with KSCS programs and KMHC, and accepts referrals from both internal and external community social service and health centers. Organizations may refer children and families based on their assessment or informed impression of risk factors present, which without early intervention would have a negative impact on the development of the child.

Family engagement

SBS engages with families in a nonintrusive manner, using gatherings and events, such as breakfast or lunch invites. This is an opportunity to connect families with the child and family support workers. The team therefore leverages a proactive approach, taking every opportunity to meet with the parent to form connections. The team uses an open and friendly approach, with no preaching, shame, blame and/or judgement. SBS uses a non-hierarchical approach, where the team is on an equal level with parents.

SBS recognizes that many families are in crisis; therefore, a gentle approach is required. The focus is on supporting building relationships, trust and respect, which enable dialogue. The process

starts with providing basic supports, insights and guidance, and building a relationship of trust and communication.

SBS considers parental involvement in a child's education as essential for growth and development. Therefore, SBS works towards a genuine collaboration with families by acknowledging and seeking out their expertise about their own children and by engaging them in the curriculum, in ways that also highlight their gifts to the community. Successful outcomes for individual children, families and for SBS as a community service is dependent on authentic collaboration and partnership with families.

Quality programming

As a learning organization, SBS continuously updates and redesigns its service delivery model, to ensure that programming is on the cutting edge in terms of design, service delivery, assessment and evaluation (15,16).

The team puts a special emphasis on identifying and adapting to changing community and family needs. The team conducts self-reflection exercises relating to problems and gaps in service delivery, and collaboratively discuss causes and propose potential solutions for consideration.

Regular pedagogy meetings are conducted with all teachers, to assess their knowledge and understanding of key concepts. Surveys and questionnaires are used to assess levels of understanding, and whether teachers have effectively integrated key principles into their daily practices. This approach informs the strategic planning process, as it indicates whether goals are being achieved. Although based on the foundation of Quebec's educational platform, pedagogy training is adapted to ensure suitability and appropriateness in relation to community's context. SBS puts a special focus on developing competencies and capacities, and continuous professional development.

SBS' Quality Program is developed, implemented and assessed using the organization's Quality Programming Guide. The documents attempts to define how Kanien'kehá:ka culture, Tsi Niionkwarihò:ten and historical perspectives shape quality programming, while taking into consideration the following documents:

- SBSCFC Cultural Curriculum Framework
- "Accueiller La Petit Enfance" (Educational Programming Guide for Early Learning Centers)
- Scale of Observational Qualities in Children's Facilities 18 months and over
- Classroom Assessment Scoring System [CLASS
- Guide to Prevention and Treatment of Inappropriate Attitudes and Behaviors in the Workplace (Ministere de la Familie)
- Developmental checklists (e.g. social emotional, cognitive, language, physical development)

SBS Quality Programming Guide content

Quality of Structure section:

- Educator-child ratios
- Staff training and education (including Trauma Informed Attachment Based Training)
- Resources and supports
    - Screening and assessment tools (examples below)
        - Ages and Stages Questionnaire: Social Emotional Edition (ASQ-SE)
        - Ages and Stages Questionnaire (ASQ)
        - Assessment, Evaluation and Programming System (AEPS)
    - Individualized Educational Plan (IEP) / Family Support Plan (FSP)
        - An IEP is created when the need has been established by the resource professionals to identify the strengths, challenges and needs of a particular child and their family. Priority objectives and strategies are developed, to support the child in achieving their potential with regards to learning and overall development.
        - The IEP/FSP is a true collaboration between the resource team, specialists, classroom team and the family. The IEP/FSP is regularly reviewed and updated in order to monitor progress, and to make adjustments as needed.
    - Psychological support
    - Occupational therapy and physiotherapy supports
    - Health and nutrition support
        - SBS supports and educates parents through newsletters, nutrition workshops as well as the Kahnawà:ke Schools Diabetes Prevention Program promotional activities. Monthly breakfasts are held at SBS, where extended family members are also welcome to join for meals together.
- Physical surroundings
- Classroom activities

Quality of programming section:

- Tsi Niionkwarihò:ten (Our Ways)
- Classroom Assessment Scoring System (CLASS), particularly in relation to the following three dimensions:
    - Emotional support
    - Classroom organization
    - Instructional support
- Pedagogy meetings
- Transition process
    - The process entails the parents completing a transition booklet, which acts as a portrait to help the incoming school with recognition of child's needs and strengths, and to enable continuity of services. Transition meetings are also set up for children with IEP/FSPs in place
- Performance management and development process
    - Annual performance evaluation for all teaching and administrative staff
    - Teacher checklist, teacher package, education assistant checklist and education assistant package

Culture and language

SBS Cultural Curriculum framework is integrated into SBS' Quality Program, embodying the organization's vision in relation to its cultural practices and pedagogical perspectives. The framework is leveraged to shape and define best practices within the organization, and is used in collaboration with other key documents (e.g. Accueiller La Petit Enfance, Scale of Observational Qualities in Children's Facilities 18 months and over, and the Classroom Assessment Scoring System [CLASS]) to define the overall educational program.

As a foundation for children's learning at SBS, culture and language are therefore incorporated seamlessly into the curriculum. The experience and expertise of the individual staff with culture and language is the advantage to teaching our children. To further improve upon staff, children and families' learning, the position of Mohawk Language and Cultural Facilitator was created in 2006.

Some further examples of how SBS integrates Kanien'kehá:ka culture and language include:

- By developing a curriculum guide in collaboration with parents and staff
- By using the guide when researching and planning developmentally appropriate activities for the daily schedule
- By deliberately weaving culture and language within daily teachings
- By teaching the parents about the curriculum
- By celebrating the Cultural Calendar including the Thanksgiving Address, the Harvest, Mid-Winter, Maple and Strawberry Festivals with children and families and continuously conveying their importance through role modeling
- By creating in-house materials when none are available e.g. legends and stories in big book format, culturally relevant tools and assessments
- By using community elders to teach the staff, children and parents traditional knowledge and behaviors e.g. social dance steps, their meaning; role of the longhouse and respect when one enters the longhouse
- By putting in place guidelines for classroom staff to continue these teachings on a daily basis
- By encouraging parents to continue these teachings at home
- By inviting elders into the center as much as possible for storytelling, language and wisdom teachings for staff, parents, and children
- By creating deliberate partnerships between Mohawk staff and non-Mohawk staff so that they may both value and learn about the commonalities and differences in their cultures
- By assuming an active and collaborative role in teaching the culture and language, continuously fostering racial acceptance

- A 2005 partnership with Karihwanoron, an independent Mohawk Immersion school in Kahnawà:ke, founded in 1988 by a group of parents who were concerned about the loss of language. Karihwanoron's founding principles were that the best way for young children to learn was in a home environment and have Kanien'kéha speakers with them at all times so that they could hear and eventually understand and speak the language as their first language.

As a learning organization, SBS continues to study, discuss, and reflect, and continues to make shifts in their practices. As has been identified in the literature on early intervention and cultural difference, SBS recognizes the need to develop new practices specifically for our people; new screening and assessment tools; new education and intervention strategies; new tools for monitoring child development; and alternative ways of reaching out to parents and children.

Organization-specific CHP input

It would be beneficial to leverage new methods of inquiry (e.g. appreciative inquiry) that would help generate new and innovative ideas, and develop models that effectively meet and adapt to changing community and family needs.

It is important to recognize the importance of investment in early intervention, and to recognize and build awareness of how resource-intensive early intervention approaches are, if properly designed. The wholistic framework and multi-professional approach that SBS uses to comprehensively identify, assess and address child and family needs is person-oriented, and conceptually aligned with the tenets of primary health care, upstream prevention, family preservation and early intervention. Therefore, there needs to be wider recognition and awareness of the scope and intensity of services offered by SBS. Children attending SBS sometimes present with very high levels of biopsychosocial complexity, and some families experience crises, requiring intensive multi-disciplinary and multi-professional supports and resources, along with significant resources dedicated to planning, management and evaluation.

To further assess the effectiveness of the range of programming and services offered by SBS, a family-oriented and longitudinal approach to measuring health outcomes and wellbeing is required.

5.4 Kahnawà:ke Education Center (KEC)

Highlights

- The KEC oversees programs and services for Kahnawà:ke students attending elementary, secondary and post-secondary institutions, and administers and operates three community schools: Karonhianónhnha Tsi Ionterihwaienstáhkhwa School, Kateri School and Kahnawà:ke Survival School.
- The KEC works in close collaboration with MCK, KORLCC, KSCS and local community services.
- The KEC offers educational services and programming based on Tsi Niionkwarihò:ten at its three schools and post-secondary institutions. The KEC is dedicated to continuously developing curriculum and quality programming based on Rotinonhshón:ni world view, beliefs and traditions.

Overview

In 1980, the Kahnawà:ke Education Center (KEC) was established to administer locally controlled educational programs and services, previously administered by the Federal Department of Indian and Northern Affairs Canada and the Mohawk Council of Kahnawà:ke (17). The Kanien'kéha Owén:na Otióhkwa Curriculum Center is responsible for the development, design, and production of Kanien'kéha educational resources used within the Kahnawà:ke Education System. In 1988, the KEC assumed complete control over all education programs and services when the administration of Federal schools was transferred to the Kahnawà:ke Combined Schools Committee (KCSC). The KEC administers and operates three community schools:

- Karonhianónhnha Tsi Ionterihwaienstáhkhwa School
- Kateri School
- Kahnawà:ke Survival School

The KEC oversees all programs and services for Kahnawà:ke students attending elementary, secondary, and other post-secondary institutions within the Greater Montreal Area. The KEC also provides services to Kahnawà:ke students attending programs and services at post-secondary institutions within Canada and the United States, and beyond.

The Director of Education is responsible for building an education center that is responsive to the needs of the three schools under its supervision. In conjunction with the Director of Finance and Administration, the Director of Education ensures that the KEC provides wholistic, inclusive, and culturally appropriate education programs, services,

and resources to the stakeholders within the community. The primary purpose of the Director of Education is to develop and oversee a high standard in all Kahnawà:ke schools and by extension, supporting students to excel to their full academic and personal potential.

Communication, collaboration and coordination

The KEC works in conjunction with the following local community organizations:

- The Mohawk Council of Kahnawà:ke (MCK), which also administers the School Transportation Program.
- The Kanien'keha:ka Onkwawen:na Raotitiohkwa Language and Cultural Center (KORLCC)
- The Kahnawà:ke Shakotiia'takehnhas Community Services (KSCS)
- And other local community services

The KEC maintains open lines of communication with Indigenous and Northern Affairs Canada (INAC), in addition to various Provincial school boards that provide education services to Kahnawà:ke students.

A key strategic goal of KEC was to "strengthen school, parent, family and community partnerships". Key indicators of success relating to this goal included:

- Increased formal and informal parent involvement. Formal: includes consultations, report card meetings, in-school, etc. Focus on in-school and more input from off-reserve parents. Informal: includes focus on strengthening parental advocacy skills
- Deeper and more collaborative partnerships with outside educational institutions
- Develop deeper and more collaborative partnerships with internal partners to support student learning.
- Yearly communication plans are developed, implemented and evaluated

Some key objectives related to this strategic goal include:

- Each school are expected to have developed, implemented and evaluated a plan to increase parental involvement.
- Review of partnerships and implementation of priority relationships.
- Implement and evaluate communications plans with an emphasis on promotion and sharing of key school initiatives, administrative processes, and maintaining internal and external communications.

Culture and language

Under the governance of the Kahnawà:ke Combined Schools Committee and guided by parental input, the KEC offers educational services based on Tsi Niionkwarihò:ten to students at its three schools and post-secondary. The KEC is dedicated to continuously developing curriculum and programming based on Rotinonhshón:ni world view, beliefs and traditions.

The Kahnawà:ke Education Center's Tsi Niionkwarihò:ten Program is guided by the community's desire for a culturally rich education for all students of Kahnawà:ke. The KEC Tsi Niionkwarihò:ten

program ensures that students are being taught in a culturally engaging way by embracing who they are as Onkwehón:we people through the highest quality curriculum.To support the development of the KEC's Tsi Niionkwarihò:ten program, a definition of a culturally sound Kanien'kehá:ka curriculum was developed in 2015. This definition is now the foundation of KEC curriculum in all areas of studies:

> *"Kanien'kehá:ka based curriculum is instilling an understanding of Tsi Niionkwarihò:ten for our learners. This is done by using the foundational teachings of who we are which are rooted in our Kanien'kehá:ka world view. Our world view originates from the lessons in our creation story, the values of giving the words of the Ohén:ton Karihwatéhkwen each day, the structure and purpose of the Kaianerehkó:wa and maintaining our connection and gratitude for the natural world through our cycle of ceremonies. The curriculum will be guided and developed utilizing all of these principles." (17)*

The KEC Tsi Niionkwarihò:ten Program Framework underpins the design and implementation of all programming. Rooted in Rotinonhsión:ni epistemology, the framework below has 4 guiding principles at its core and is surrounded by 9 interconnected elements, representing the functions of the program. A one-world approach means students will be proud Onkwehón:we, with the ability to be successful in any life-path they choose, guided by the teachings and philosophies of their ancestors.

Figure 2: The Kahnawà:ke Education Center's Tsi Niionkwarihò:ten Program Framework (17)

Examples of culture and language-related school programming

Kateri School:

- Kanien'kéha language classes offered - All Grades, including Nursery
- Language and Cultural Teachings through Art for Grades 1-6
- Staff facilitated Traditional Singing Group
- Outdoor Classroom/School Garden
- Tsi Niionkwarihò:ten Program & Pilot Project Development
- Community Elders and Speakers coming in to speak with classes on various culturally relevant topics throughout the year.
- Cultural Teachings for staff following traditional/spiritual calendar
- Kanien'kehá:ka Cultural Teachings Program for Grade 5-6 girls

Kahnawà:ke Survival School:

- The name "Survival" signifies the vision of KSS in offering education that is all-inclusive and rooted in Haudenosaunee culture.
- Kanien'kéha Language Program - All Grades
- Exploratory Student Council and Traditional Crafts - Middle School
- Social Studies "Great Tree and Mohawk Territory" - Middle School
- Social Studies Seven Generations Program - Senior School
- Wampum Belts Creation - Grade 9
- Traditional Studies Program
- Rites of Passage -- Girls and Boys
- Tsitsonthaharà:tha Room
- Mohawk Valley Trip - Graduating Class
- Tsi Niionkwarihò:ten Program & Pilot Project Development

Karonhianónhnha Tsi Ionterihwaienstáhkhwa:

- Kanien'kéha Language Immersion School based on Tsi Niionkwarihò:ten principles. Students are fully immersed from Nursery through Grade 4, learning core and specialty subjects in Kanien'kéha.
- Kanien'kéha Immersion from Grades N-4 & continuation of language classes in Grades 5 & 6
- Curriculum materials generated via the Kanien'kehá:ka Owén:na Otióhkwa Curriculum Center
- Kanien'kéha Reading Assessment for Grades K-4
- Tsi Niionkwarihò:ten Program & Pilot Project Development
- Greenhouse - Environmental Science Program - Outdoor Learning in Nature & Outdoor Classrooms
- Traditional Monthly Showcase
- Ongoing opportunities for Kanien'kéha language support for staff
- Voice Over Project - Interactive Kanien'kéha text

KEC CHPI project: Encore!Sistema

KEC has been actively involved for several years in the CHPI initiative through the Encore!Sistema project. The goal of the project is to ensure all KEC students from Kateri, Karonhianónhnha and Kahnawà:ke Survival School excel in every aspect of school life and become productive community members by developing strategies and skills through music education. The objectives are to improve behavioural and social development skills, emotional stability, as well as improvement in academic achievement.

The Encore!Sistema program provides in-school and after-school instruction working towards social development through music excellence. The Encore!Sistema program creates a pathway for students from grade 2 through high school, thereby providing continuity. All students learn to play a musical instrument and participate in musical ensembles. The program is open to all KEC students during the school year and to all Kahnawakehró:non children during the summer.

The program includes traditional singing, following the cycle of ceremonies and volunteerism from local elders. Students develop social, leadership, and collaborative skills, responsibility, respectfulness, and empathy, all important culture and community values.

In 2021-2022 Encore!Sistema celebrated its 10th year at Kahnawà:ke. During these past 10 years, 367 Elementary School students and 15 High School students have registered to participate in the extra-curricular music program. In the last 10 years, KEC students were involved in more than 32 concerts, presentations, annual collaborations with professional orchestras featuring famous guest artists and participated in 3 summer camps. The work of the KEC students has been the subject on radio shows, YouTube videos and numerous articles in local and major newspapers and journals.

The pandemic, in the spring of 2020, brought to the forefront the need for creative ways to teach (remotely, virtually). This remote option has enabled Encore!Sistema to continue to engage the KEC students in unique and impactful ways.

5.5 Whitehouse Prevention Programs (KSCS)

Highlights

- CHP health priorities: Cross-cutting.
- Comprehensive community-based and family-oriented programming and services focused on upstream prevention, early intervention, family wellbeing, healthy lifestyles (mental, physical, social, emotional and spiritual), life skills, culture, traditional values and respect.
- Sophisticated programming that encompasses challenging domains such as behavioral and social issues, violence and healthy sexuality.
- Intimate setting, focusing on developing close relationships built on trust with the children and teens - enables articulation and identification of needst
- The teams are identifying significant social, behavioral and mental health issues, particularly anxiety and depression in children and teens. Violence and bullying are significant problems that warrant immediate attention and cross-sectoral action. Many of these issues were exacerbated by the pandemic and social isolation.
- Engaging teens is particularly challenging, especially vulnerable teens with high levels of anxiety and depression, and who have unhealthy home environments. Presently, there is a need for programs specifically designed for teens, for example youth mentorship and programs that engage them in productive and salutogenic activities.

Overview

The Whitehouse offers a comprehensive range of family-oriented prevention programming and services for children and youth (ages 6-17 years, including their families), relating to all seven Community Health Plan (CHP) priorities. Program design, implementation and evaluation are always guided by Tsi Niionkwarihò:ten (Our Ways).

The Whitehouse team focus on upstream prevention, early intervention, life skills development, healthy lifestyles (mental, physical, social and spiritual well-being), Kanien'kehá:ka culture and identity,
traditional values and the cultural aspect of respect. In addition, the Whitehouse team also offers programming related to challenging yet important issues in the community, such as violence (family, lateral violence) and healthy sexuality.

Programs and services are offered in an intimate community-based setting, focusing on developing close relationships built on trust with the children, teens and families. The Whitehouse team also dedicates significant resources and time for meaningful community engagement functions, and works with health, social care and educational partners to organize family-friendly events – to ensure community participation, engagement and awareness.

Programs offered to the community include the following, further described below:

- Onkwanèn:ra (after school program children 6-12 years)
- A:se Tahonatehiarontie (New Generation teen group)
- Family violence prevention
- Drama program

Onkwanèn:ra

The Onkwanèn:ra after-school and summer program is a community-based social and life skills program for Kahnawakehró:non children between the ages of 6-12 (Grades 1-6). The program focuses on group inclusion, self-awareness, understanding relationships, social skills, cultural awareness and the world around us. The program incorporates Kanien'kehá:ka values and the cultural aspects of respect, while group members receive the information about healthy lifestyles (mental, physical, social and spiritual well-being).

The stated objectives of the program are:

- To increase the children's knowledge of the health issues in Kahnawà:ke according to the Community Health Plan (2012).
- To facilitate the process of group cohesion throughout the summer in a physically active and fun environment.
- To develop the youth's ability to cope with social issues and make healthy decisions.
- To help parents acquire skills to provide open communication with their children.
- To promote cultural awareness by incorporating Mohawk values, traditions and language.

The program aims to have the following impact on health and wellbeing:

- Children will be empowered to make healthy choices through positive self-esteem.
- To promote interaction of children with fellow group members in a physically active environment.
- To promote healthy eating habits by packing healthy lunches.
- Parents will be more comfortable in speaking with their children and will be open to accepting support and feedback on parenting issues.

Table 1: Whitehouse prevention program (Onkwanèn:ra) event and participation statistics (April 2021 - March 2022 data). Note that data quality has not been validated.

Topic (health and wellbeing priority)	# of Events	Total # of participants
Addictions	12	111
Diabetes	6	57
Cancer	3	32
Mental health	24	212
Cardiovascular	8	82
Developmental disabilities	5	40
Obesity	10	100
Culture	22	215
Social life skills	65	612
Violence	18	148
Family	32	284
Other	32	324
Total	**237**	**2,217**

Health topics and Kanien'kehá:ka values are incorporated throughout each session in interactive ways. Facilitators have also incorporated more cultural teachings with the Cycle of Ceremonies Calendar, and the children have taken vast interest in learning about themselves as Kanien'kehá:ka.

The Onkwanèn:ra staff place a heavy emphasis on establishing meaningful conversations, and listening carefully to the children. This enables staff to identify needs at an individual level, as well as to become aware of trends and topics that are health and wellbeing priorities in the community (e.g. online bullying). The team also derives information from school reports and conversations with parents and families, who are asked to share concerns. Furthermore, the staff are all community members, who are active in community events and social media platforms.

The Whitehouse is small, personal and intimate, helping build connections, relationships and trust with the children and families. Onkwanèn:ra is small enough to make a positive individual impact, and to ensure proper and continuous follow-up. The program welcomes families from all backgrounds, to enable social integration and reduce stigma. The children build close connections with the staff: relationships of trust.

After-school and summer programs

In 2019/20, Onkwanèn:ra After School program had 30 children enrolled, with a roughly equal gender distribution. The after-school program runs from September to June, and is comprised of two age brackets: Juniors between ages 6-8 (Grades 1-3) attending on Tuesdays and Thursdays; and Seniors between ages 9-12 (Grades 4-6) attending Mondays and Wednesdays.

Onkwanèn:ra facilitators have promoted the program via the KSCS Facebook page, Karonhianonhnha and Kateri schools, as well as promotion at both schools during November Report Cards. Onkwanèn:ra reserves two spaces during the course of the year in both the Junior and Senior groups, in case a referral is made.

The program incorporates a variety of activities, aimed towards helping the children explore their thoughts and feelings in a safe and relaxed atmosphere. Activities include interactive lessons, team building, guest speakers, arts and crafts, role playing, games and field trips. The entire group also participate in a variety of community and social events, such as Earth Day clean up, learning planting songs and planting seeds, and an End of year party. The older group members learn about giving back to the community, by volunteering to fundraise with a lemonade stand that is usually held in May. The group members learn about teamwork, explore and decide on who to donate to, and present the cheque to the selected non-profit group or organization.

2019 Annual Lemon Aid Stand:

This activity gives the children the opportunity to learn about compassion, charity and selflessness. They also learned about non-profit organizations in the Montreal area and came up with a list to choose from. The children discovered there are homeless native children who reside with their mothers and the various reasons why the moms have to leave their home and/or relationships (eg. Violence and addictions). They selected "The Native Women's Shelter of Montreal (NWSM)". The representative that came to accept the donation shared her family background which is that she is a Sixties Scoop Survivor and explained briefly what it was. The children presented a cheque that totalled $398.80 as well as several bags of clothes and toiletries that were collected throughout the month of May.

Guest speaker topics for Onkwanèn:ra's 2019-2020 year included:

- KMHC - Sun Safety
- KEPO-in Summer Program & Afterschool Program
- Fishing – giving thanks/how to clean a fish
- The History of Lacrosse
- Search & Rescue, being safe in Tiowero:ton
- Addictions & mental health lessons
- KSCS Violence Prevention (Consent)
- Healthy sexuality, suicide prevention & depression
- Pilates-Spirit of Wellness Activity
- Peacekeepers - Halloween safety
- Hatowi Ceremony

The summer program is similar to the after-school program, in which health topics and Kanien'kehá:ka values are incorporated throughout each session in an interactive way. In total, the Onkwanèn:ra Summer Prevention Program enrolled a total of 79 children.

The summer program enabled promotion of the Prevention Campaign on "Healthy Relationships" which was suggested by KSCS Violence Prevention Worker as an important topic to complement the month of July (Violence Prevention Month). The summer students promoted this campaign at Onake in July as well as at the Young Adults Program (YAP) Fun Fair in August. Summer program registration are open for caseworkers, with two spots per session reserved for referrals from caseworkers.

Each summer session had orientation on the first day which included rules, emergency evacuation procedures, and ice breakers. Children do "Ohen:ton Karihwatekwen", and weekly activities consist of: biking to the Marina (swim/fish/play), Onake Canoe Club, Splash Pad, rock wall climbing at the KYC, Paint Day (cultural topics), pottery, scavenger hunt, tie dying. The Summer program also offers fun and exciting trips local as well as on a larger scale such as Super Aqua Club, Tsiionhiakwatha (Droulers), Skyzone, Railway Museum, Cote. St. Catherine Beach, Movies, Oka Beach, Tiowero:ton and Ile St. Bernard.

Communication, collaboration and coordination

The program closely collaborates with health, social care and educational organizations across the community. Examples include collaborations with other KSCS programs and KMHC (cardiovascular and diabetes prevention programs, as well as cancer/sun safety). A policy manual outlines processes relating to child disclosure and reporting, as well as how referrals to and from social services are to be processed. Guest speakers are often invited, to present and discuss a variety of topics.

The program could benefit from additional mechanisms of engagement, collaboration and coordination with stakeholders across the community (e.g. schools, other prevention programs including at the Family Wellness Centre). A stakeholder engagement meeting with relevant actors is required, to promote open communication, collaboration and alignment. Furthermore, referrals from social services often do not come with sufficient information, which limits the ability of the program to customize service delivery to individual children and families.

Evaluation, performance assessment and quality improvement

Assessments and evaluations of activities are explicitly linked to the specific CHP priorities that they are designed to address. The team leverages innovative methods and approaches of evaluation, which are age-appropriate, such as gamification of feedback (e.g. end of year jeopardy style learning reviews and the use of game boards).

Apart from descriptive statistics (e.g. demographics), participation statistics and experience/satisfaction assessments, evaluations of health impact and long-term outcomes are challenging. The focus is therefore on qualitative feedback from parents, families and children (e.g. sessional feedback), staff observations (e.g. continuity of family participation, and returning for new programs), participation statistics and process metrics. In the past, pre/post evaluations were conducted (e.g. happy/sad face satisfaction assessments); however, this was challenging in light of the range of reading skills and comprehension of children.

Á:se Tahonatehiaróntie (New Generation teen group)

The Á:se Tahonatehiaróntie Teen Group is a prevention program for Kahnawà:ke youth in high school, between the ages of 12-17. A:se Tahonatehiaróntie translates to "The New Generation", which was named by a former youth member of the program.

The purpose of the Á:se Tahonatehiaróntie Teen Group is to empower youth, enhance life skills, increase cultural knowledge, teach leadership skills and enable personal growth. The program aims to encourage healthy lifestyles and decision making, and to engage youth in volunteering and fundraising activities, with a focus on promoting Kanien'kehá:ka culture. The program strives to have a positive health impact on youth, including increased self-esteem and identity through building leadership skills, responsibility, empathy, community, teamwork, and exposure to Kanien'kehá:ka culture and global society.

Table 2: Whitehouse prevention program (teens) event and participation statistics (April 2019 - March 2020 data). Note that data quality has not been validated.

Topic (health and wellbeing priority)	# of Events	Total # of participants
Addictions	1	5
Global citizenship	22	196
Cardiovascular	19	154
Volunteering	19	129
Culture	31	271
Diabetes	16	150
Social life skills	54	462
Fundraising	4	27
Family	29	257
Leadership	38	339
Mental health	20	186
Obesity	9	100
Other	19	164
Team building	55	498
Violence	5	32
Total	336	2,938

The program operates two evenings a week, with some weekend trips or volunteer initiatives within the community. The program is facilitated by two prevention workers, who deliver life skills workshops covering a wide range of topics and activities. All projects and activities are outlined and documented in the KSCS Teen Group Annual Workplan. Some examples include:

- Teamwork activities, with a focus on improving listening, communication and joint problem-solving skills
- Volunteering: volunteering in community events like KSCS annual Fun Fair with the Young Adult Program, Mohawk Miles, the community Trunk or Treat event, Winter Carnival and volunteering as a "worker for a day" at the local daycare
- Leadership skills: monthly cooking activities that the group decides on. Members will follow recipes or lead the group if they are familiar with what is being made that night. This allows for members to use their communication skills as well as team build by assisting one another and sharing the responsibility of cooking and cleaning.
- Teaching healthy decision making and promoting healthy lifestyles through physical activity at the local gyms every other month, as well as promoting healthy cooking.
- Self-awareness as Kanien'kehá:ka people: the group participates in cultural history lessons, traditional crafts, and participate in Family Socials at the local Mohawk Trail Longhouse. This allows them to learn songs and use traditional instruments, and learn social dances.
- Participation in special projects, such as with McGill Masters students. The goal of the Digital Mapping Project was to familiarize the members with creating maps, researching history through interviewing and libraries, teamwork, photography skills, online publishing guidelines (consent, plagiarism, design elements), and more. The digital map was meant to provide insight to their own community, and history of culture, while developing social and digital skills.
- Giving back to the community: the members come up with different ideas as their "Giving back" initiative. Some of the activities included the large fundraising project, "Montreal Children's Hospital Toy Drive" (over $2000 to purchase new toys), "Trunk or Treat" (candy donations and a booth at the Halloween Event, and the "Kateri Food Basket" food drive.
- Special trips and engagement with the broader Iroquois Confederacy: The teen group had an opportunity to attend a Youth Gathering in Seneca Falls New York with other youth from across the Iroquois Confederacy. The trip was beautiful and enriched in so many ways from participating in energy games, gardening, listening to our elders speak about spiritual gifts, experience a social and condolence ceremony.

The team focuses on building a trusting relationship with the children and teens, continuously asking about their interests, what motivates them, problems being faced, trends, and what they would like to do in the program. The programming consists of a blend of fun and open activities to engage members, as well as structured teaching (e.g. leadership, critical thinking, teamwork).

The A:se Tahonatehiarontie also accept student employees working through the summer contracts or through stagiere/practicum programs at CEGEP and University levels. The goal is to give them meaningful learning experiences, connections with youth and youth issues, and work experience on an organizational level.

Communication, collaboration and coordination

The program closely collaborates with health, social care, educational and other community-based organizations across Kahnawà:ke, as exemplified by the quote below:

> *"A huge part of our job is networking. Yes, it's about building those bridges and helping each other, to nurture healthy growth. We're going to be using resources from CrossFit, from the Youth Center, from Collective Impact, from the Wellness Action Team, from Nurturing Healthy Growth, cultural workshops, etc. So it's really just a community collective thing that merges together". ~ A:se Tahonatehiarontie prevention worker*

In addition to closely collaborating with other KSCS programs and KYC, A:se Tahonatehiarontie collaborates with other community-based organizations such as Kahnawà:ke CrossFit, to ensure their clients can participate in their activities. Other collaborations include entities such as Kahnawà:ke Collective Impact, even though their target age range is older. The teen program also encourages the teens to participate in events involving or affecting external organizations (e.g. fundraising for teens at the Children's Hospital).

The Wellness Action Team (WAT) is also an excellent platform for communication and collaboration between different organizations, and to share information regarding their respective activities. It enables cooperation and collaboration between partners serving the same audience, and helps avoid duplication. The team reaches out to all community members and organizations, to set up events in the WAT or Spirit of Wellness calendars. This not only promotes collaboration and expands networking, but it provides further information and awareness for the community at large.

Family and community engagement

The program dedicates significant resources and time towards promotion to families and the entire community, especially to enable and encourage teen participation in programming, which is a very big challenge. Similar to KYC, the Whitehouse team perceives that teens have been (and remain) highly isolated and disengaged from community and social events.

Social media has been an excellent enabler for community engagement (e.g. the community calendar, Facebook, Instagram). The team is exploring how to optimize the use of social media to engage with teens and the community.

For vulnerable families who are unable to access the Whitehouse, the team works in partnership with other organizations (e.g. KSCS, for the distribution of swag bags to clients of their services, who are unable to participate in Whitehouse activities). However, there exists a need to develop robust cross-sectoral mechanisms to identify vulnerable and marginalized families, that presently do not, or can not, access services.

Evaluation, performance assessment and quality improvement

Similar to the Onkwanèn:ra program, all assessments and metrics are directly tied to specific CHP priorities, in the Whitehouse data collection spreadsheet. Evaluation is embedded into many aspects of the programming, with assessments conducted at the end of sessions with both

participants (e.g. teens) and the team. For example, feedback forms are sent to the children's homes, to enable parents to provide feedback. Furthermore, the facilitators receive feedback from the members and parents on a regular basis either through informal conversations, in workshops, and through email. Written evaluations are done periodically to collect data on the area that need improvement. Feedback is used to make changes and accommodate the needs of the group. The program is always evolving, and making modifications to the hours, the activities, and policies each year to best suit the community's needs.

The program also maintains and assesses participation and attendance records, yielding useful descriptive statistics. Team debriefings and self-reflection activities are also conducted routinely, including the use of a workplan to note and assess observations or feedback.

It is important to note that the community has an oral tradition, so much of the feedback is qualitative in nature, and often comes back from the community through informal conversations. Therefore, evaluation encompasses both quantitative and qualitative data. However, as a social and community program, evaluations are highly contextualized and qualitative in nature, using an immersive and participative approach.

It is also important to note that it is challenging to measure quantitative outcomes for primary prevention, as longitudinal metrics and data are required. Furthermore, there are many confounding variables that must be taken into account, which are further complicated by the relatively small sample sizes.

It is also very challenging to compile data relating to violence, which is a sensitive topic and multi-dimensional concept, that is extremely difficult to measure.

It would possibly be beneficial for representatives of the team to participate in the KSCS status meetings, to share information (e.g. statistics regarding domestic violence, suicidal ideation, lateral violence), and to engage with other programs to explore opportunities for alignment.

Family Violence Prevention

The family violence prevention program is comprehensive, focusing on strengthening family bonds, while also encompassing domains related to bullying, sexual violence, intimate partner violence, healthy relationships, consent, social media, gender diversity, and other important and relevant topics. The prevention worker facilitates, plans and prepares prevention campaigns, programming and trainings in the field of violence prevention, gathers information on sexual violence within the community and prepares proposals for Family Violence programming.

Programming focuses on workshops, education and providing tools to enable the community, families and individuals to address such issues. The prevention worker also collaborates with partners in the community in relation to developing a prevention and sexual assault working group, which aims to develop a robust system for both victims and perpetrators.

The goals of the program relate to reducing the incidence of violence in the community, to increase knowledge and awareness regarding sexual violence, and to foster healthier lifestyles and provide a platform for healing and support.

In terms of topics such as sexual assault, sexual violence and intimate partner violence, information is constantly changing; therefore, it is critical to update and find out what can be done in the community, and to get he ball rolling in relation to fast-tracking services for

community members. The goal is to get information out to the community as efficiently as possible (in a sensitive manner), and to ensure all the issues are being addressed comprehensively. Therefore, the prevention worker must work in partnership with various stakeholders, such as the Peacekeepers, hospitals, KSCS Addictions Response Services (ARS), secondary prevention and the Family Wellness Center.

Drama program

The Whitehouse drama program partners with educational organizations such as Kateri School, to offer drama programming for children between the ages of 6-12 years old, including an after school group.

The children learn through prevention messages such as anti-bullying, self-esteem, healthy eating, peer pressure, and teamwork. The drama program focuses on expanding the children's creative skills, by developing their own play.

Emerging issues and problems

The Whitehouse team are identifying significant social, behavioral and mental health issues, particularly anxiety. Children often show a lack of knowledge on how to properly interact with peers or society. The summer program therefore places a heavy emphasis on re-socializing the children and developing social skills.

The Onkwanen:ra team is observing significant levels of violence (verbal and physical), bullying, lack of respect, swearing at teachers and rudeness. The staff also sometimes observe a lack of ethics, decency and politeness amongst the children, which indicates a lack of alignment with the traditional community value of respect.

Historically, the community supported the upbringing of children. Nowadays, parents do not have those levels of support from the community. Parents may not have the time or skills to teach the children how to properly communicate. The team believe it is important to develop and teach kindness and respect to the children, and that a traditional perspective and approach is helpful, especially in the sense of community solidarity in relation to promoting prevention and wellbeing of children.

The programs and services need to keep up with rapidly changing times and problems, such as vaping and problems such as lateral violence on social media and cyber bullying. There is a need to assess and address issues related to suicidality, self-harm in youth, and eating disorders.

Family violence, and particularly sexual violence is a potentially serious problem that is not well understood and addressed. These issues are highly complex, as they stem from multi-generational trauma and the residential schools. Therefore, these are very difficult and sensitive problems, that the community is not comfortable talking about, often due to stigma and shame. One of the most profound prevention initiatives relates to the development of the Kahnawà:ke Sexual Assault Plan. The work entailed developing a multi-disciplinary sexual assault committee and terms of reference that acknowledges all those affected by sexual violence.

Service delivery challenges

It is important to explore ways to identify vulnerable families, especially those who may not be KSCS clients, but require support (e.g. those on social assistance or food bank support). Furthermore, despite referrals, some families lack transportation options, which severely limits access.

Children with complex needs require additional supports and resources, such as behavioral supports. Presently, the resources in place are not sufficient to address the substantial needs of the children and families. A behavior technician is needed, to enable staff to focus on proper involvement with all the children.

It is also important to increase levels of engagement and collaboration with parents, as well as Elders – not only in relation to their children, but also for input relating to programming design.

The program could benefit from enhanced communication, collaboration and coordination mechanisms with stakeholders across the community. Information sharing mechanisms also need to be improved (e.g. sharing information when referrals are made from social services).

It is also important to ensure continuity of services for the kids, in terms of ensuring smooth transitions to the teen and youth programming available in the community, and also to maintain longitudinal relationships with the children. The children develop a strong connection and relationship with the staff, and want to remain in contact, even after they age out of the program.

Teen participation is a very big challenge, particularly in relation to reaching vulnerable teens with high levels of anxiety and depression. Youth are often on the streets, due to a lack of suitable alternatives to keep them productively occupied. This is particularly problematic for vulnerable youth from unhealthy homes, who need a safe and salutogenic space, that offers them the support needed.

The pandemic also caused much of the programming to shut down, which was problematic since the services are very important to children, parents and families. Much of the team was reassigned to deliver mandated emergency services for KSCS. Furthermore, physical space is very limited, particularly in light of social distancing requirements.

Culture and language

Culture and language are well integrated into the programs and services, and are manifested through cultural activities, Indigenous foods, and the increasing use of language. Indigenous approaches such as talking circles are used, as well as inviting guest presenters and speakers with experience and knowledge to share. Program design is consciously guided by Tsi Niionkwarihò:ten principles and content.

The programs are underpinned by a shared philosophy, that protecting and promoting Kanien'kehá:ka identity and culture is at the center of primary prevention. All program logic models are reviewed to ensure that culture and language are considered. The concept of self-reliance is also central: the concept that it is the community's responsibility to protect and enable the culture and language to thrive. As one staff member shared, "Nobody is going to save us. Nobody's coming to save our language, nobody's committed to our culture. It's up to us, and we each got to do the work." ~ Whitehouse staff.

The programs continuously engage with the children and teens to co-design cultural activities (e.g. sewing ribbon skirts). The staff encourage children, teens, families and the entire team to bring in their own personal teachings, and to normalize the use of language within activities, according to their comfort levels.

It is important to note that culture and language are incorporated in a sensitive manner (i.e. it is not forced or imposed). Team members are encouraged to embed their knowledge within the program, and to embark upon their healing journey. For example, a team member who graduated from the Mohawk Immersion Program is encouraged to utilize and share their knowledge and language skills.

The team engages and works with the teens to create Kanien'kéha names for the programs and activities, that are meaningful to them. Indigenous singers and Elders are always invited to the Whitehouse (e.g. as guest speakers, or to lead cultural activities).

Program-specific CHP input

Parenting and family preservation are extremely important priorities, especially in relation to vulnerable families experiencing problems with substance use, mental health, social problems, poverty, food and housing instability and violence.

It is important to explore ways to identify and engage with vulnerable families, especially those who may not be KSCS clients, but require support (e.g. those on social assistance or food bank support). Presently, a significant proportion of Whitehouse clients are from healthy families.

Transportation options for vulnerable families needs to be assessed, and potentially addressed, to improve access to essential services.

A youth mentoring program is needed urgently, and is requested by youth themselves. Such programs would be particularly beneficial for vulnerable youth from unhealthy homes, who need a safe and salutogenic space, that offers them the support needed. The KYC is a great space, but it is drop-in, vs a program that actively identifies youth urgently requiring supports.

Violence, as a multi-faceted concept, including family violence, needs to be incorporated in the CHP and assigned a high priority status. Family violence, and particularly sexual violence is a serious problem that is poorly recognized and addressed. The issue stems from multi-generational trauma and the residential schools. These are therefore very difficult and sensitive problems, that the community is not comfortable talking about. Stigma and shame are associated with these problems.

5.6 Family & Wellness Center – Parenting Services (KSCS)

Highlights

- CHP health priorities: Mental health and wellness; substance abuse/addictions; early childhood wellness.
- The team strives to provide offer welcoming and family-friendly services, with equitable and low-barrier access.
- Strong focus on family preservation and wellbeing. The team plans, designs and implements a wide range of programming, and strives to adapt to meet the changing needs of families and the community.
- Programs are designed to meet the needs of parents who are young, single, socially isolated, or who have low income or limited formal education. Programs are also offered that focus on supporting parents of children and teens with behavioral and emotional problems.
- Increasing focus on developing evaluation competencies, to enable measurement and assessment of program performance and quality of services.

Overview

The Family and Wellness Center's (FWC) parenting team provides individual and group parenting programs and support services, with a focus on family preservation. The program aims to offer welcoming and family-friendly services, with low barriers to access. The parenting team plans, designs and implements a wide range of programming, and strives to adapt to meet the changing needs of families and the community. The team accepts referrals from other health and social services in the community (e.g. Youth Protection), for families that could benefit from parenting support services.

The Parenting team provide individual support and guidance for parents, including those with child(ren) who have neuro-behavioural differences and developmental delays. The service never ceased operations during the pandemic to ensure that the mental health of the family was supported. The team also started a series of roundtable Facebook Live weekly sessions on topics that included mental health, suicide, addictions and trauma, and What's for Lunch, a healthy cooking activity for the whole family, as well as the popular family bingo.

The team leverages the knowledge and experience of experts, and increasingly uses virtual technology to ensure convenience and ease of access for clients (e.g. virtual services for new mothers who are unable to attend in person at the FWC). Programs and services encompass prenatal wellbeing, parent activity groups, parenting teens, parent/child interactions, and individual parent supports.

Team-based service delivery model

The parenting team plans, designs and implements a wide range of programming, and strives to adapt to meet the changing needs of families and the community. Status meetings are used by the team to discuss community trends and family needs that arise, such as postpartum depression. In response, the team quickly designs and implements services targeting these issues.

The parenting team is exploring different types of assessment tools that could be adapted and leveraged, and participates in well-established programs, such as "Nobody's Perfect". This program is a facilitated, community-based parenting program for parents of children from birth to age five. The program is designed to meet the needs of parents who are young, single, socially or geographically isolated, or who have low income or limited formal education.

The team are presently training to incorporate the Triple P (Positive Parenting) program, that has been successfully adapted to other indigenous communities. The Triple P parenting and family support system is designed to prevent – as well as treat – behavioral and emotional problems in children and teenagers. The interventions have been shown to be effective, and the team are keen on implementing the program.

The FWC parenting team also designs and implements special projects, to support and meet the psychosocial needs of parents. An example is highlighted below.

Special project: Support Group for Parents of Teens – Winter 2022

Target population: caregivers/parents of teens (12-19) in the community.

Problem statement: A Facebook post led the Parenting Team to move forward with a virtual support group for parents of teens which started in May 2021 and ran for 6 weeks with 3 additional weeks added on at the participants' suggestions. Another session was added in the Fall of 2021 running 8 weeks from October 6 to November 24. A support group for parents of teens was something that has always been on the radar of the Parenting Team, so we thought to attempt it virtually to address common issues in parenting teens, specifically those unique to Covid. A survey was put out to parents and the top issues were acceptance (peer pressure, self-esteem, body image), anxiety/depression, cyber addiction/social media, motivation, disrespect/defiant behaviour, and sexual identity.

The special project had a completed logic model, activity report and descriptive statistics.

Increasing focus on developing evaluation competencies, to enable measurement and assessment of program performance and quality of services.

The program is in the process of formulating a clear vision and goals, which has been a challenge due to management turnover in past years. Further communication, direction and guidance from senior governance levels are required to ensure alignment of vision and goals.

As the complexity and severity of family needs increase, there is a need to increase the scope of services, and to design new intensive parenting services. To meet the needs of the community, and complex referrals from partners such as Youth Protection, new intensive parenting programs are needed,

that are run by skilled front-line professionals such as behavior technicians and psychoeducators. At-risk families with complex problems may benefit from such therapeutic parenting programs (e.g. parenting through anxiety and depression, parenting through recovery, parenting after trauma, etc.).

Communication, collaboration and coordination

The FWC parenting team attempts to closely collaborate with a range of partners, from across Kahnawà:ke's health and social services. Communication, collaboration and coordination are particularly important within the context of complex families accessing multiple services across the community. However, these functions are somewhat challenged due to the fact that FWC is a satellite building. Therefore, the management is keen on promoting the importance of case conferences, so all partners routinely collaborate on care planning.

The team charts case notes in Penelope case management system, and the manager reviews client files to ensure completeness of records. Sharing information between programs is limited due to privacy concerns, as well as the lack of interoperability between data systems, which has an impact on communication and coordination of care.

Evaluation, performance and quality

The FWC parenting programming is increasingly being designed, developed and evaluated based on logic models. The process of getting the team comfortable with developing logic models is gradually taking root, with the active support and encouragement of management. The logic models are meant to empower the team, in that they are able to assess their performance and evaluate what they have accomplished. The management is working with the team to continuously improve their ability to interpret and use evaluation results for quality improvement (QI) purposes.

5.7 Family & Wellness Center – Traditional Counseling

Highlights

- CHP health priorities: Cross-cutting (but mainly mental health and wellness)
- The team works in collaboration with health and social care partners across Kahnawà:ke, to incorporate traditional, cultural and spiritual approaches and perspectives within care plans.
- Traditional Support Counselors work longitudinally with individuals and groups to enable healing, and to encourage healthy lifestyles through promotion, prevention and wellness activities using traditional cultural and spiritual teachings.
- To address trauma and grief in the community, program offers grief workshops (Ase:sasatonhet: Starting a New Life Grief Support Group).
- The program offers special services such as a Teen Healing Camp for teens presenting with anxiety, depression, self harming behavior, suicidal ideation and suicide attempts.
- Due to cross-cutting trauma, there is a major need for the development of a multidisciplinary family healing center focusing on the entire family, including children, teens and adults.

Overview

Originally named the Healing Lodge, the Family & Wellness Center (FWC) Traditional Counseling services are a core component of KSCS Prevention, and is located in a facility with a large and beautiful garden, separate from KSCS's main building. The team consists of Traditional Support Counselors, who work with clients and groups to enable healing, and to encourage healthy lifestyles through promotion, prevention and wellness activities.

Services encompass and address:

- Traditional counseling
- Grief counseling
- Spirituality
- Family preservation
- Healing
- Upstream prevention
- Healthy lifestyle
- Stress management
- Anxiety
- Depression
- Self-esteem

Using traditional cultural and spiritual teachings, the team aims to provide a variety of support services to enable healing. Programming focuses on spirituality, as it's a major gap in the present system. The team actively works in collaboration with health and social care partners across Kahnawà:ke, to incorporate the dimension of spiritual care within care plans.

Excerpt from Morgan Kahentonni Philips' 2010 thesis entitled "Understanding Resilience Through Revitalizing Traditional Ways of Healing in a Kanien'kehá:ka Community":

"What is unique about the counselling programs at the Family and Wellness Center is that counselling sessions and treatment programs have no specific set time limit. For example, one session could last up to three hours instead of the normal 60-minute session visits to the psychologist or psychiatrist. Clients are encouraged to experience the healing at a pace which is comfortable to them. The mind and body is given time to adjust to behaviour and lifestyle changes that the client may be working to achieve. He [Family and Wellness Center Shakotihsnié:nenhs/Spiritual Helper] stressed the importance of knowing, and perhaps relearning, that embedded in each of us through our traditional teachings, "we all are our own healers". The spiritual helper's role is to guide the client to listen more carefully to our physical bodies as well as our mind and spirit.

They [the client] become the teacher, and I become the student", he says. The client is taught to work through their issues by teaching the spiritual helper about themselves. This is important for him when looking at the difference between clinical and traditional approaches to healing.

The intake process at the Family and Wellness Center is one example as the process is much shorter and less bureaucratic. A client simply calls the receptionist, chooses one of the traditional helpers/counselors, and makes an appointment. Counselling and treatment can begin even within the week. He believes that it is very important to have clinical education as well as experience when working with clients although, he warns, often-times clinicians often "get caught up in their title." The fact is there's always got to be doctors, psychiatrists, so on and so forth, but there's always got to be traditional people too and to understand an individual... Respectfully, I'd say people generally like to say hello, 'I'm Dr. so and so', or 'hi, my name is Louie and I'm a clinical psychologist', or 'I'm a forensic psychologist' . . .but I just look at the human being.

General health related challenges he sees faced by the community include diabetes, cancer, complications that accompany these diseases, sexual abuse, violence, low self-esteem and depression. "In a nutshell their fire is low, because their spirit is left in the past when they were assaulted or traumatized."

Team-based service delivery model

The team's Traditional Support Counselors offer one-on-one counseling for clients, to assess needs and co-develop individualized service plans. Group activities are also offered. Support can be given through traditional approaches, as well as contemporary delivery methods, including referrals to needed health and social services.

Various Indigenous frameworks are available and are wholistic in approach, providing direction on how to attain more balance and interconnectedness. They are analogous to a pilot's gauge or ship's compass, providing direction towards healing, health and wellbeing. The team service delivery models build on Kashwéntha (the Two Row Wampum theory) and Two-Eyed Seeing framework, to effectively bridge Indigenous science and knowledge systems with Western ones, for the benefit of the client.

> *"[Regarding] Kashwéntha: Being educated in both worlds means that you have the best of both. For centuries, Indigenous peoples worldwide have had their own psychiatrists, psychologists, doctors, pharmacists and spiritual advisors. Relearning our own languages is an important part of this process because many of our teachings are contained within phrases that cannot always been translated to another, and if done so, it loses some of its meaning." ~ Excerpt from Morgan Kahentonni Philips' thesis (Understanding Resilience Through Revitalizing Traditional Ways of Healing in a Kanien'kehá:ka Community, 2010).*

To address trauma and grief in the community, the program offers grief workshops (Ase:sasatonhet: Starting a New Life Grief Support Group), which is now an integrated program within the FWC.

The FWC works in close collaboration with other partners from the Prevention program, to offer special services, such as those for teens with mental health and behavioral risk and problems; for example:

Special project: Teen Healing Camp (2021)

Problem statement: KSCS has an increase at intake as well as for individual support and psychological services for teens in Kahnawà:ke who present with anxiety, depression, self harming behavior and suicidal ideation and suicide attempts.

Target group/population:

- Teens who are currently receiving services though KSCS ages 12-17 years old, by referral only. The participants will identified by the ARS, YP, Support and Psychological Workers at KSCS who have been working with the individual youth and their families

Addressing:

- Mental health: anxiety disorders, depression, complex trauma, anger management (mood and behavior regulation)
- General psychosocial problems: family violence (child abuse and intimate partner violence), suicide, grief and loss
- The social problem that we would be addressing is anxiety, depression, self-harm, suicidal ideation & suicide attempts amongst the Teen population
- Multidisciplinary team approach
- Primary Prevention Team, Traditional Support Team, Support Services (rovers & monitors), Traditional Healers and Art Therapist, Bus driver.

Description: The 1st camp goal is to provide an intensive virtual day camp for the week of July 12-16 for present KSCS clients. The camp would provide traditional Haudenosaunee teachings from a Healer who will focus on easing anxiety, depression and suicidal thoughts by increasing their coping skills utilizing traditional approaches to healing. The virtual day camp, loosely based on the medicine wheel will focus on the spiritual quadrant in the morning (9am-12:00pm) and then will reconvene in the afternoon for art therapy, traditional singing, crafting and will close off with a fun field trip. The second goal will be to provide another camp that will be opened to community youth ages 12-17 in the month of August, for the week of 9-13. This full week intensive camp will consist of the traditional team, as well as the other Haudenosaunee knowledge keepers who will provide teachings on spirituality & grounding, Creation Story with an emphasis on suicide prevention, art therapy, roles & responsibilities and will also end with a fun trip. The same afternoon activities, crafting, seed & Aton:wa songs, and a fun physical activity.

The project had a completed logic model and activity report, including indicators.

The program is in the process of formulating a clear vision and goals, which has been a challenge due to management turnover in past years. Further communication, direction and guidance from senior governance levels are required to ensure alignment of vision and goals. The program aims to develop a clear vision of how traditional counseling services fit in within the system, the community and their place in the traditional world and healing.

The FWC traditional counseling program could benefit from the support of traditional healers (which they had access to in the past), who have knowledge, expertise, skills and abilities in the domains of traditional healing and traditional medicine. Therefore, the service presently focuses on traditional counseling, rather than on medicines, ceremony or sweats (for safety concerns). The team also has limited Kanien'kéha language skills, which could otherwise benefit the service delivery. Furthermore, the team could benefit from further resources and training, to effectively and appropriately serve children and youth.

There are also some challenges related to referrals from the addictions services. For clients to benefit from the traditional counselling services, they really need to have their substance use issues under control (to ensure the necessary state of mind), since the service focuses on the spiritual domain.

Communication, collaboration and coordination

The Traditional Counseling program is keen to continue strengthening and formalizing its collaboration with KMHC Traditional Medicine, particularly in relation to the domains of traditional teachings, language and ceremony.

The team are also continuously working to enable and encourage collaborative multi-disciplinary team care planning, in partnership with health and social care services across Kahnawà:ke.

Program-specific CHP input

Due to cross-cutting trauma, there is a major need for the development of a family healing center focusing on the entire family, including children, teens and adults. Families would all learn the same materials from different angles, which enables them to discuss and use the knowledge at home. Presently, there is the grief group, but a dedicated and comprehensive multidisciplinary family healing center is needed.

The vision is for a non-judgemental family healing service, that incorporates culture and language in a sensitive and effective manner, as well as traditional philosophies. The center should use a multi-disciplinary and multi-professional approach, leveraging innovative approaches that addresses a wide range of needs, including complex ones associated with addictions, psychology, behavioral health. For upstream prevention, a special focus on children is required, with trained and knowledgeable professionals. Ultimately, a community-based approach that engages families and the community is needed. It should focus on preserving the family unit, incorporating culture and traditional values, with a focus on improving the overall health and wellbeing of the community.

5.8 Jordan's Principle

Highlights

- CHP health priorities: Early childhood wellness; mental health and wellness.
- An important service with a focus on enabling access to needed health, social and educational services for vulnerable and marginalized children and families.
- Significant effort into community engagement, and promoting awareness and collaboration with educational, health and social services from across Kahnawà:ke and neighboring jurisdictions.

Overview

Jordan's Principle is a principle and legal requirement that ensures there is substantive equality and that there are no gaps in publicly-funded health, social and education programs, services and supports for First Nations children (0-18 years) (18). The First Nations Child and Family Caring Society (Caring Society) has advocated alongside the Assembly of First Nations (AFN) for more than ten years to ensure that First Nations children do not face barriers to getting the services they need. Other groups joined in and together took Canada to the Canadian Human Rights Tribunal (Tribunal) to improve child and family services for First Nations children. In 2016, the Tribunal ordered Canada to fully implement Jordan's Principle, resulting in a federal government announcement that it would comply with the Tribunal ruling so that First Nations children receive necessary care first and then the various levels of government or departments involved will figure out who pays for it.

Jordan's Principle covers public and private services such as mental health, special education, dental, physical therapy, medical equipment, physiotherapy and more. Jordan's Principle goes above and beyond the normative standard for non-Indigenous people in Canada in cases where doing so would ensure culturally appropriate service provision, support substantive equality or be in the best interest of the child.

Honouring Jordan River Anderson (19)

Jordan's Principle is named in memory of Jordan River Anderson, from Norway House Cree Nation in Manitoba.

Jordan was born in 1999 with multiple disabilities and stayed in the hospital from birth.

When he was 2 years old, doctors said he could move to a special home for his medical needs. However, the federal and provincial governments could not agree on who should pay for his home-based care.

Jordan stayed in the hospital until he passed away at the age of 5.

In 2007, the House of Commons passed Jordan's Principle in memory of Jordan. It was a commitment that First Nations children would get the products, services and supports they need, when they need them. Payments would be worked out later.

Today, Jordan's Principle is a legal obligation, which means it has no end date. While programs and initiatives to support it may only exist for short periods of time, Jordan's Principle will always be there. Jordan's Principle will support First Nations children for generations to come.

This is the legacy of Jordan River Anderson.

The concept of "substantive equality" is important, in that it reflects and encompasses the following:

- Self-Determination (First Nations are in the best position to make decisions for themselves and their First Nations)
- Culture and Language (Culture and language is the foundation for First Nations health and wellbeing, therefore, programs, products and services must be culturally-appropriate and responsive)
- Wholistic Approaches (Wholistic needs of children must be met and historical and cultural factors, such as Indian Residential Schools and colonization, must be understood as continuing to impact the wellbeing of First Nations)
- Structural Interventions (Barriers within all systems must be challenged so the needs of First Nations children are met)
- Non-Discrimination (Regardless of where a First Nations child lives, they must have equal access to health, social, and educational services)

Table 3: Jordan's Principle – descriptive statistics (2019/2020)

Total number of children served who live on-reserve	60
Total number of children served who live off-reserve	3
Total number of children referred to regional Jordan's Principle focal point for Service Access Resolution funding	76 (60 applications were approved, 16 sent to the national level for review and refused)
Types of service/support received through service coordination	After School Daycare Program Art Therapy Behavior technician Laptop and Assistive Technology Neuropsychological Assessment Orthodontics, Osteopath Services Psychoeducational Assessment Psychological Assessment Specialized Car Seat Specialized Summer Camp Speech Therapy Transportation Tutoring Services

Service delivery model

To ensure clients have better access to services via Jordan's Principle, Onkwata'karitáhtshera has a full-time coordinator for the Jordan's Principle initiative as of 2019, with the job title of "Health Programs Liaison for Jordan's Principle & Non-Insured Health Benefits (NIHB)". The liaison provides a critical support function to First Nations children and families in accessing supports through Jordan's Principle. In addition to providing navigation support through the Jordan's Principle application process, the liaison also has in-depth knowledge of the other services that may be available at the community level and would be of benefit to the child to ensure a continuum of supports and services.

The Health Programs Liaison has developed a series of informational resources for parents and guardians, as well as educational, health and social services and providers within and external to Kahnawà:ke. The resources describe Jordan's Principle and services offered, as well as detailed instructions on how to prepare and submit applications for funding or reimbursement.

The Health Programs Liaison directly supports families and guardians who require additional assistance, particularly those who are vulnerable and marginalized. The liaison also works closely with the provincial focal point's program officers, to ensure that applications are processed, and to follow up and resolve any processing issues that may arise. These functions are important, since complex administrative processes can deter families. If applications are rejected, or if reimbursement is delayed, families may delay or forego care.

Furthermore, coverage varies between Quebec Medicare, NIHB and Jordan's Principle, causing disparities, confusion and complications. All of these issues negatively impact vulnerable and marginalized families the most.

KSCS' Financial Department has been instrumental in supporting the Liaison with the significant increase in workload, with applications nearly tripling over the past four years. The previous knowledge and experience of the Liaison with the Non-Insured Health Benefits (NIHB) program also enhanced their ability to provide services to families requesting support through Jordan's Principle. Furthermore, the Liaison's years of experience working in the community in the health and social services system provided an opportunity to network with health professionals, and to enhance their understanding of the NIHB system, especially for orthodontic requests.

Implementation challenges have arisen, in cases when the government does not comply with court orders. Furthermore, the Health Programs Liaison compiles information regarding gaps in service availability, such as a lack of external resources for families seeking English services for assessments, and a lack of resources for referrals to external respite services in English services.

Funding and access to orthodontic services requires attention and assessment, as NIHB applications have been rejected in the past. Upon rejection, families are directed to submit applications via Jordan's Principle, which had tightened approval criteria, requiring supporting documentation from a mental health professional or a teacher attesting to the mental health effects of orthodontic problems. This may deter families from addressing legitimate children's orthodontic problems, affecting vulnerable families the most (e.g. setting up appointments with psychologists). Applications have been recently approved, but the criteria remain relatively unclear and require more transparency.

Community engagement

Community engagement is a high priority that is actively addressed by the Health Programs Liaison. The Liaison has developed a community communications plan to promote Jordan's Principle to families, and continuously networks with organizations such as schools, daycares, health and social services centers, both within and external to Kahnawà:ke. Individual meetings are set up with relevant stakeholders, including directors, managers, health professionals, principals, teachers and support staff.

Promotions are conducted using a variety of methods, including billboard advertising, local radio, ads in the local newspapers, social media and distribution of posters and handbooks at site visits. Detailed community engagement activity reports are integrated into the program's annual reports to KSCS.

The meetings (particularly with school staff, counsellors, social services and healthcare professionals) has led to substantial increases in referrals to Jordan's Principle, and utilization of Jordan's Principle by families has nearly tripled over the past 4 years. There has been a significant increase in families accessing Jordan's Principle through referrals from schools, daycares, physicians and self-referral through public promotion of Jordan's Principle in the community.

The Liaison continues to network and engage with community organizations in Kahnawà:ke, including:

- Step by Step Child and Family Center (SBS), to identify needs of children and to ensure there are no duplication or gaps in services provided for children;

- Kahnawà:ke Shakotiia'takehnhas Community Services (KSCS), including networking with intake workers and social services;
- Zoom meetings and conference calls with New Frontiers School Board to discuss protocols and reporting for Kahnawà:ke students funded through Jordan's Principle;
- Website, social media, and direct mail promotions with local and non-local schools for Kahnawà:ke students;
- Posters for Jordan's Principle displayed throughout the community, created specifically for Kahnawà:ke families.

Communication, collaboration and coordination

The Health Programs Liaison works closely with KSCS' Financial Department, as has a very strong rapport with the Regional Program Officers for Jordan's Principle in Quebec, who are perceived to be responsive and collaborative. However, when files are sent to the national level for review by the Minister, there is a long wait (anywhere from 4 to 11 weeks), as well as additional delays for the official letter for parents to submit an appeal. This has not worked well for clients waiting for an answer, and does not align with Jordan's Principle. The existence and intent of this initiative is to alleviate wait times for services, however, this does not occur when a file is escalated to the national level.

The Health Programs Liaison has developed and maintained strong working collaborations with educational, health and social care organizations within and external to Kahnawà:ke. A particularly strong working relationship has been developed with Step by Step Child and Family Center (SBS). The Early Childhood Wellness Sub-committee was a useful way to promote Jordan's Principle, and promote collaboration with other programs/services. Jordan's Principle and partners at Onkwata'karitáhtshera used to share data; it would be beneficial to develop mechanisms to restart the sharing of data between these teams.

Participation and cooperation of some of the community's educational, health and social services could be improved. For example, some schools are perceived to be reluctant, due to a variety of reasons. Administratively, they may not want to be overrun by application requests. They may also be apprehensive of being perceived not to meet quality or performance standards (i.e. if a school has a lot of referrals, it may appear to reflect poorly on their performance, in relation to meeting needs).

Some healthcare providers used to have negative experiences with the NIHB program for dental and orthodontic services. However, they are now largely receptive to Jordan's Principle, because the Health Programs Liaison has alleviated concerns regarding payments. Applicants have commented that health and social care providers are now familiar with Jordan's Principle and the process of providing supporting documents.

To improve communication, collaboration and coordination, the following activities and actions have been suggested:

- Increased networking activities with other coordinators;
- The development of a coalition/ regional committee for coordinators, including regional focal point officers;
- Conference calls for coordinators on a regular basis;
- Training and information on substantive equality;

- Training and information on urgent situations, if parental authorization and supporting documents are not immediately available.

Evaluation, performance and quality

The Health Program Liaison submits a detailed annual report to KSCS, which provides statistics and qualitative data and information regarding activities and key functions. Included in the annual reports are:

- Statistics regarding applications, approval rates, and service utilization (by type)
- Detailed qualitative information:
    - Description of activities undertaken to reach out and identify potential service coordination clients to improve the situation for families living in Kahnawà:ke;
    - Examples of how the relationships built across health and social systems and levels of government facilitated better access for clients and how the knowledge gained from this function will help improve access for future clients;
    - Description of opportunities used to build cultural competency within the broader health and social systems or provide culturally appropriate and safe care for clients;
    - Qualitative information on achievement of objectives and activities, including as appropriate, successes, barriers, challenges, future needs, etc. including any success stories of families served;
    - Barriers, challenges and future needs
    - Success stories (i.e. services delivered, by type)
    - Improvements noted in children
    - Comments from healthcare providers and parents

Jordan's Principle could benefit from the development of an updated evaluation framework, to enable systematic and longitudinal evaluation and quality improvement activities. Data is presently collected in MS Excel (basic descriptive statistics regarding applications and types of services requested). Data collection and analysis can potentially be improved by transitioning from the MS Excel spreadsheet to a properly designed database.

The program relies on both formal and informal family feedback and comments regarding services, particularly from those using in-home services for children with special needs and respite services. Feedback to date indicates that families are highly satisfied (e.g. "you're saving families"). It is perceived that access to services such as orthodontics, as well as child assessments (e.g. Individual Education Plan or IEP Assessments), and coverage of tuition and French tutoring has improved the performance of children in school, as well as the overall health and wellbeing.

Culture and language

Children have continued to access the services of an Indigenous Art Therapist in the community. The art therapist considers the impacts of multigenerational trauma and residential schools on attachment, identity, and overall wellness. Through a play-sensory and narrative approach, the children can express themselves through painting and storytelling based on their own culture.

This is an important aspect of the child's identity as they can explore their culture through different forms of art.

The delivery of the Circle of Security® parenting program is also tailored to the cultural needs of this community and is offered to parents. This program runs for 10 sessions and covers attachment, emotional regulation, and parenting interventions for children of all attachment styles. It provides the parents with teachings from an Indigenous perspective in developing parenting and co-regulation skills to support the child's emotional development at home.

Further assessment is required to ensure families going through Jordan's Principle have access to culturally safe and appropriate services, both within and external to Kahnawà:ke.

5.9 Child And Youth Wellness (KSCS)

Highlights

- CHP health priorities: early childhood wellness; mental health and wellness; substance abuse/addictions
- Conducts comprehensive risk assessments to develop individualized service plans, in collaboration with families (where possible) and other programs (e.g. mental health and substance use).
- Strategic orientation and focus on family preservation, with an increasing focus on upstream prevention, and leveraging community assets and resources.
- Recognizes the need to focus on trauma-informed service design, delivery and evaluation. Due to the context of intergenerational trauma, and the complex nature of the program and its target populations, longitudinal outcomes-oriented evaluation designs are required.
- The program is interested in promoting collaboration and co-interventions with other programs, and is increasingly focusing on upstream prevention.
- The program is working to decolonize the approach to Youth Protection, and to increase alignment with Indigenous family values.

Overview

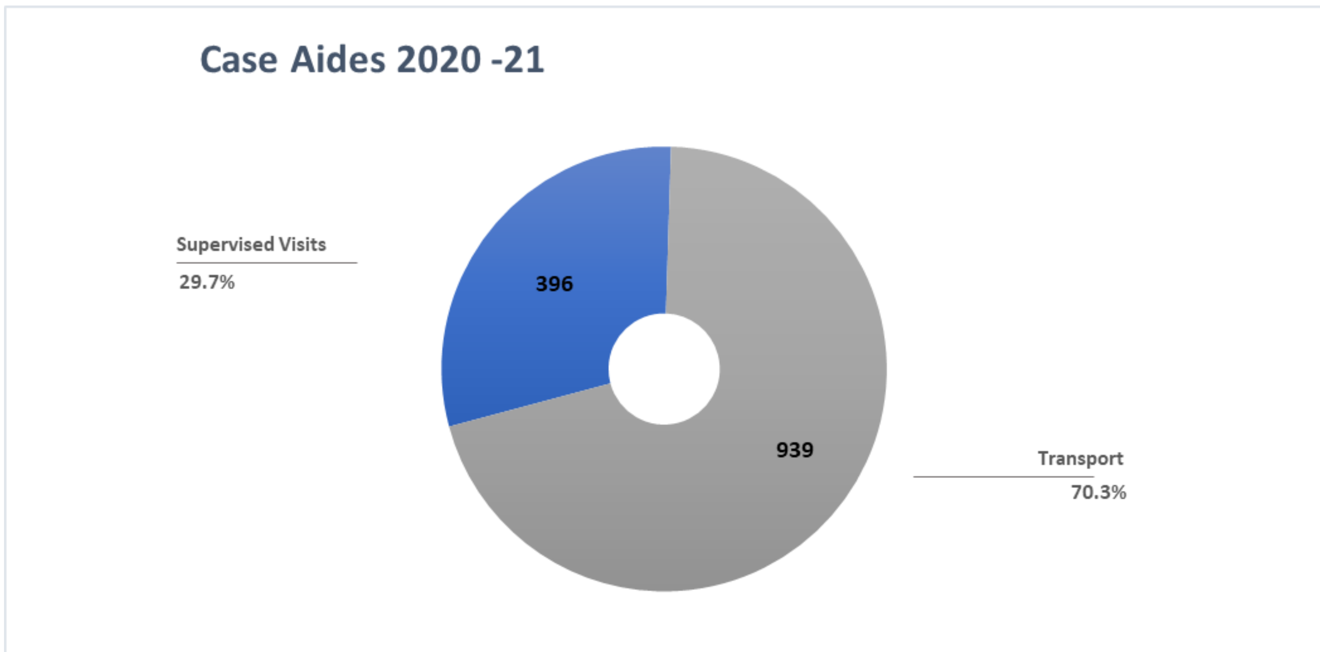
The KSCS Child and Youth Wellness program is mandated to receive and investigate allegations of potential risks to children and youth, which are defined as situations that compromise their safety, security and/or development. These include allegations of abandonment, neglect, psychological abuse, physical abuse, sexual abuse, and serious behaviour disturbances.

With a focus on enabling, maintaining and promoting family preservation (when possible) and upstream prevention, the program offers customized support services to assist in resolving the risk within various situations. Individualized service plans are developed to meet the needs of each child and their respective families. These plans are reviewed and modified over time, based on the progress of the file and the changing needs of the client.

The primary goal is always the preservation of the family unit and maintaining the child within their family system. When that is not feasible, it is common for extended family to step forward to care for the child(ren). However, staying with family is not always possible and foster care homes, group homes and case aides are required to meet the needs while the service plan is carried out.

The program prioritizes placements with family members, and has successfully assessed and transitioned all kinship homes to become kinship Foster Homes. Kahnawakehró:non provide the majority of our foster homes. Despite the COVID-19 pandemic, the program's front-line staff were available to provide ongoing 24/7 service.

Chart 2: Case Aides descriptive statistics 2020-2021



Team-based service delivery model

The program's multidisciplinary team-based service delivery model is comprised of clinical supervisors, clinical teams, case workers, foster care workers and case aides. The clinical supervisors are well established and stable in their roles, and have good working relationships with each other, and their respective team members. However, the program continues to face challenges in relation to maintaining the front-line team, due to a variety of issues which have been exacerbated by the COVID-19 pandemic, including staff shortages, medical leaves, turnover and recruitment challenges.

The management team are interested in reviewing the program's organizational structures and processes, to identify opportunities to update and redesign service delivery models, and to clarify and optimize organizational boundaries, and team roles, functions and tasks. A particular area of focus is to explore mechanisms to improve multidisciplinary teamwork and collaboration.

The program's present processes are relatively well established, using standardized assessment tools to conduct comprehensive risk assessment and situational evaluations. These assessments and evaluations encompass all articles of abuse under the Protection Act, from when a child is signaled, enabling the development of an individualized service plan. The standardized assessment tools and forms are integrated within Penelope case management software (this includes evaluations of signalement, individual assessments, annual reassessments of homes and foster care). With a focus on comprehensiveness and accuracy, the risk assessment and situation evaluation incorporate the child's perspective, if the child is old enough and capable of providing a version. Interviews are also conducted with different family members when possible, with a focus on situational and contextual factors.

When appropriate, team members will attempt to work with the family to come to an agreement in relation to the development of a plan to address the risks identified. Often, this entails close collaboration with the KSCS Mental Health/Wellbeing and Addictions program team. Based on the assessment of risks and needs, referrals are made to various programs and services, both within (e.g. KMHC, KSCS) and external to the community.

When staying with the family is not possible, foster care homes or group homes meet needs while the service plan is carried out. The Youth Support worker provides individual support for youth (15–25) who have been or are a part of the foster care/group home systems. In 2020/21, there are an average of 32 children in approximately 22 Tsi Ionteksa'tanonhnha homes (regular foster homes, kinship foster homes, and kinship care) each month. Case Aides provided 396 supervised visits and 939 transportation services for families.

Communication, collaboration and coordination

The program is responsible for ensuring that appropriate referrals are made to health and social services across the entire system, to address all major risk and needs identified by the assessments conducted. This entails referrals to programs and services within the community (e.g. KSCS, KMHC), but also external to Kahnawà:ke.

However, communication, collaboration and coordination with these referral partners face significant challenges and barriers, and require attention. The barriers and challenges stem from a variety of factors that require further investigation and assessment, and may include: organizational / structural barriers; informational barriers (e.g. privacy and data sharing limitations); and social factors associated with fear of involvement with complex Youth Protection cases. Therefore, the design and implementation of co-interventions with other programs and services are challenging. Organizations that report serious incidents sometimes fail to follow through, or choose not to continue collaborating on cases.

Due to the complex and sensitive nature of the program, there is an ongoing need to improve mechanisms for communication, collaboration and coordination, to ensure alignment, effectiveness and efficiency. Upstream prevention is essential, because once a case is referred to Youth Protection, collaboration becomes extremely challenging due to the strict protocols and legal standards that must be enforced.

Community engagement

Overall, there is reluctance from the community to interact or engage with the Youth Protection program, due to fear of getting involved, especially in light of the sensitive and complex nature of the program and cases. It is important to identify approaches and mechanisms to sensitively address these issues.

Child, youth, family and foster care experience

Due to the sensitive and complex nature of the program and cases, it is extremely challenging to design and implement mechanisms to engage children, youth, families or the community, or to elicit and garner their feedback and input in relation to the program. Therefore, there

are presently no systematic mechanisms to collect, analyze or leverage input or feedback for evaluation and/or quality improvement.

However, during meetings, staff do provide feedback (their own, as well as what they hear/receive from children, youth and/or families) in relation to service design, policies and processes/practices, as well as the status of all ongoing cases.

Evaluation, performance assessment and quality improvement

The program collects and stores data in Penelope case management system, and statistics regarding service delivery and utilization are compiled by the program and KSCS' Research & Systems Administrator. Examples of data fields collected are highlighted below:

Table 4: Data fields collected relating to the Quebec Youth Protection Act Articles

Article (Quebec Youth Protection Act)	Description
38a	Abandonment
38 B (1) i	Neglect (of child's basic needs)
38 B (1) ii	Neglect (of child's physical or mental health)
38 B (1) iii	Neglect (of supervision/support, schooling)
38 B (2)	Neglect (serious risk)
38 C	Psychological ill treatment
38 (d) (1)	Sexual abuse
38 (d) (2)	Risk of sexual abuse
38 (e) (1)	Physical abuse
38 (e) (2)	Risk of physical abuse
38 (f)	Behavior

Other program statistics include:

- Client demographics (age, sex, gender)
- # of transports (to foster homes, institutions, others)
- Supervised visits (# of visits, # of clients)
- Service volumes

The program could benefit from the development of updated evaluation frameworks, quality improvement (QI) frameworks, assessment tools and performance indicators. Without these frameworks and tools, it is challenging to assess or evaluate the performance and quality of the programs/services.

Apart from the voluntary services component, evaluation of Youth Protection programs is extremely difficult both conceptually and operationally. This is due to the sensitive nature of the program, and challenges associated with attempting to standardize the quantification of complex

risk variables, especially within the context of inter-generational trauma. It is important to explore both the potential of leveraging data fields within existing risk assessment forms, and to identify potential frameworks and tools that can be adapted, such as the National Child Welfare Outcomes Indicator Matrix (20). A scoping review of the scientific literature and publications from other Indigenous communities could enable identification of potential tools and frameworks that could be adapted for Kahnawà:ke.

Due to the context of intergenerational trauma, and the complex nature of the program and its target populations, evaluation design must also be longitudinal, to assess long-term outcomes (i.e. to assess success in relation to *"stopping or breaking the cycle"*). Presently, the program does conduct proxy

assessments of performance, using metrics such as the numbers of cases which are closed and are not reopened. However, long-term outcome metrics and longitudinal multi-generational metrics are required, to create a portrait of youth protection outcomes from a multi-generational lens. Such metrics would enable assessment of whether the present systems and programs are making an impact on multi-generational trauma, and whether the community is on the path to healing. This also aligns with the program's increasing focus on upstream prevention, and recognition of the importance of family preservation and intergenerational healing.

Culture and language

The team is aware that the program needs to continue to decolonize its approach to Youth Protection, and that even the Quebec Youth Protection Act, in terms of how it is executed, should be decolonized - at least in terms of practices. The Western Codes of Ethics which underpins the Act do not always align with Indigenous values.

The program is interested in engaging with, and leveraging the knowledge, wisdom and experience of more Elders in family conferencing. Furthermore, the program could potentially benefit from an Elders Council approach, prior to resorting to outside courts. Such an approach, if properly and sensitively designed, may help create a sense of accountability and ownership for all stakeholders involved, and the community at large.

5.10 Mental Wellness and Addictions (KSCS)

Highlights

- CHP health priorities: Mental health and wellness; Substance abuse/addictions
- Increasing focus on harm reduction approaches, integration of individuals with mental health conditions and substance use/addictions issues within the community, family preservation and goal-oriented care.
- The program provided essential community mental health functions to mitigate and address the impact of the pandemic on the mental health and wellbeing of the community, as well as to address increased risks of substance use.
- Increasing understanding, training and education within the team in relation to Indigenous trauma, particularly due to the effects of colonization and inter-generational trauma.
- Complex clients with mental health and/or substance use often use a multitude of health and social services, both within and external to the community. Coordination, communication and data sharing between various programs/services is presently challenging.
- The landscape of mental health and substance use/addictions services across Kahnawà:ke is significantly fragmented and siloed. The development of robust and coordinated systems for these health and wellbeing domains is required.

Overview

The KSCS Mental Wellness and Addictions program provides multidisciplinary team-based services, focusing on Kahnawakehró:non and their families as the single most important stakeholder, with an emphasis on family preservation. The program consists of collaborative services, namely:

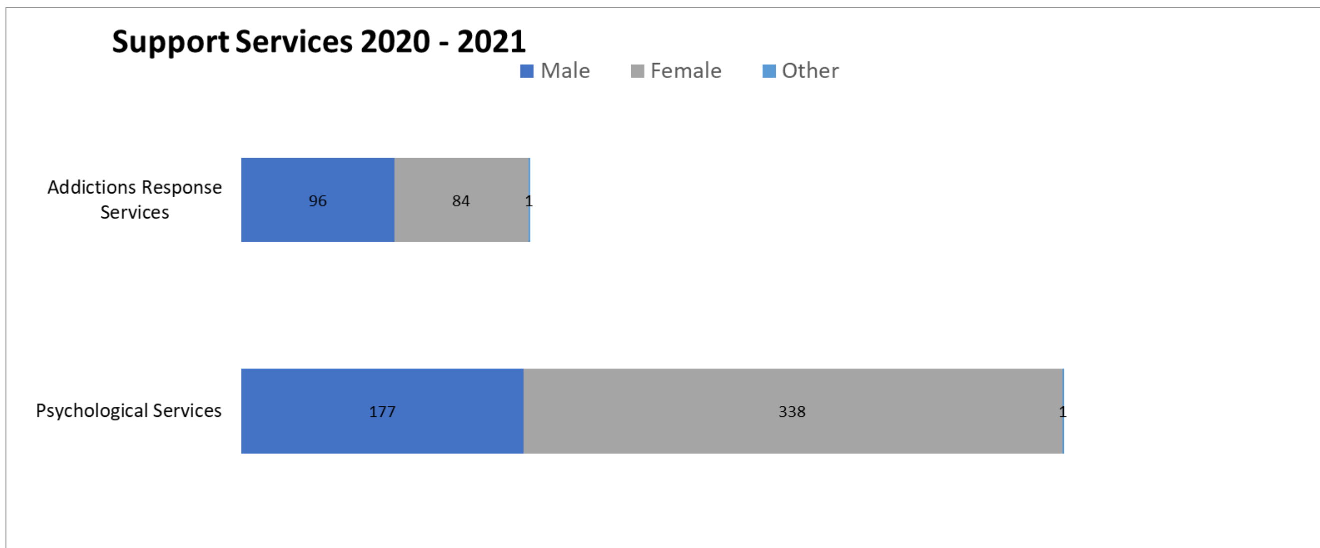
- Addictions response services (ARS)
- Psychological services
- Secondary prevention
- Intake
- After-hours response services.

The ARS provides a comprehensive set of client and family-oriented services, such as individual addictions counselling and consultation (screening and assessment, along with addictions support and referrals to needed health and social care services), couples and family counselling and intervention (upon request from family members), as well as education, support and counselling for clients and families dealing with addictions and concurrent mental health issues, and a variety of group sessions.

Psychological services provide positive psychosocial support for clients, couples and families (screening, assessment, treatment and referral functions), psychological consultations for related programs and services, as well as support groups.

After-hours emergency response service works in close collaboration with the Kahnawà:ke Peacekeepers and other critical partners such as Kahnawà:ke Fire Brigade (KFB), to provide emergency response services for social emergency situations that occur within the community on a 24-hour, 365-day-per-year basis.

Chart 3: Support Services descriptive statistics 2020-2021



Team-based service delivery model

The program's multidisciplinary and multi-professional team-based service delivery model is comprised of support counselors, addictions/prevention workers, after-hours response workers and psychologists. The program's processes and functions are relatively well developed and standardized for intake, assessment, counselling, treatment, referral and follow-up functions.

Intake first conducts a brief assessment (via phone or in person if required or desired), which informs what level of service the client and/or family will be referred to. For example, clients may be assigned to a KSCS support counsellor, or referrals may be made internally or externally to psychologists of psychotherapists, along with other needed health and social services.

In the past, the assessment process leveraged standardized assessment tools more often; for example, support counselors have used standardized assessment tools such as the SA45 (Symptom Assessment–45, an assessment tool that prompts an individual to rate the degree of distress arising from psychiatric symptomatology). However, for in-house counselling, the available standardized assessment tools are sometimes not perceived to be useful or culturally appropriate.

Presently, most assessments are qualitative in nature; however, different service providers still leverage a variety of standardized assessment tools, depending on their discipline. Data from the assessments are all inputted into Penelope, KSCS' case management software, along the client's history, and relevant diagnoses/diagnostic codes.

Service planning puts a focus on cultural sensitivity, as well as creating a sense of community belonging and integration for the individual. The program is increasingly shifting its team-based service delivery model towards harm reduction approaches (e.g. promoting Naloxone kits, which are available at pharmacies and distributed for free, no questions asked). Furthermore, the team are increasing their knowledge and skills to address the potential needs of children and youth, as this is a growing concern in the community.

Communication, collaboration and coordination

Based on needs identified in the assessment process, support counsellors connect and refer clients to health and social care resources and services in and out of the community, such as rehabilitation, inpatient treatment facilities, withdrawal management hospital services, detox services and support groups such as Alcoholics Anonymous and Narcotics Anonymous.

Complex clients with mental health and/or substance use often use a multitude of health and social services, both within and external to the community. Data sharing between various programs/services is a challenge, and is presently limited due to privacy and technical reasons (i.e. different information systems, depending on organization). This causes issues in relation to the sharing of information regarding the same client, limits coordinated care planning functions, or even the ability to disclose what programs/services the clients are accessing, or if referrals are successful. Furthermore, various psychological services and assessments are covered by differing funding sources (e.g. NIHB, Jordan's Principle), requiring careful attention to coordination and follow-up mechanisms.

Overall, the landscape of mental health and substance use/addictions services across Kahnawà:ke is fragmented and siloed. The development of robust and coordinated systems for these health and wellbeing domains is required.

Community engagement & awareness

The program and in-house communications team leverage local media (e.g. radio, newspaper) to engage with the community, as well as hosting community events, and are regularly present at school events. The program also leverages social media (e.g. Facebook) to engage with the community, posting videos to inform the community regarding the types of services available, and how to access them. The program was also active on Kahnawà:ke 911 to promote Let's Talk, which is accessible by phone call or text. Furthermore, the program provides information regarding online and virtual resources, such as Hopeforwellness.ca and Wellness Together Canada Helplines.

The program engages with the community to encourage daily self-screening for mental health symptoms (e.g. anxiety, sadness, hopelessness, sense of personal safety), as well as self-screening for increases in personal or family substance and alcohol use, as well as the impact of increased use. The program also promotes self-care for caregivers, to protect and promote mental health and wellbeing, and to mitigate and address burnout.

Client, family and/or caregiver experience

Through team meetings, the multidisciplinary staff provide ongoing feedback regarding issues they identify, or comments they have received from clients and/or families. A recurring theme

that requires further investigation and assessment pertains to clients indicating that they do not feel comfortable due to the institutionalized feeling of the building and office spaces. The present space is very institutional, and is not perceived to be warm or culturally appropriate (e.g. lack of appropriate space for ceremonies or smudging). There is a need for new settings, that make clients feel more at home and comfortable, including a garden space for ceremonies and to be close to nature.

The team is interested in developing robust mechanisms to systematically elicit and collect feedback or input from clients, families and the community, for ongoing evaluation and quality improvement purposes.

Evaluation, performance assessment and quality improvement

Assessment and evaluation of quality of care at the client level occurs via meetings between the clinical supervisors and support counsellors, whereby all cases are reviewed weekly or biweekly. At the program level, descriptive statistics of service utilization are collected, assessed and discussed periodically. Examples of descriptive statistics are provided below.

Addictions Response Services data

Table 5: Presenting problems, disaggregated by gender (ARS data, 2021/22). Data is also available disaggregated by age. Note: data quality has not been validated.

Presenting problem	Female	Male	Total
Alcohol	48	79	127
Cocaine	12	30	42
Marijuana	19	26	45
Opiates	2	10	12
Benzodiazepine	3	2	5
Gambling	0	0	0
Crack	2	3	5
Speed	4	2	6
No specified drug	0	0	0
Mental health	0	0	0
Anger	0	9	9
Crystal meth	0	0	0
Other	10	3	13
Entourage (a program to assist families in understanding challenges a person with addictions/ their loved one is facing)	14	1	15

Table 6: Service type (ARS data, 2021/22). Data is also available disaggregated by age and/or gender. Note: data quality has not been validated.

Service type	Total
Group counseling	0
Traditional / addictions	0
Urine toxicology	0
Outreach	0
Consultation	2
Family intervention	3
Treatment request	4
Section 84	4
Other services	6
Detox	7
Aftercare	11
Education	17
Crisis intervention	33
Addictions counseling	48
Treatment plan and follow-up	58
Support	59
Assessment	104
Total	**356**

Table 7: Referrals to internal resources (ARS data, 2021/22). Data is available disaggregated by age and/or gender. Note: data quality has not been validated.

Internal resource	Total
Other support groups	0
Self help	1
Outpatient treatment	2
Detox	4
Shelter	4
Hospital	6
Other	8
Residential treatment	17
Total	**42**

Table 8: Referrals to external resources (ARS data, 2021/22). Data is available disaggregated by age and/or gender. Note: data quality has not been validated.

Service type	Total
Assisted living services	0
Support – youth protection	0
Prevention – Sataenikonrarak worker	0
Home and community care	1
FWC parenting services	2
Prevention – Shakotisnien:nens counsellor	3
FWC traditional services	13
Support – psychological services	16
Total	**35**

Psychological services data

Table 9: Number of people having accessed psychological services through KSCS, by year and sex. Note: data quality has not been validated.

	2017/18	2018/19
Female	128	201
Male	58	109
Total	186	310

Table 10: Examples of referrals to external psychologists and psychotherapists from KSCS Psychological Services, by type of presenting problem (NIHB program). Note: data quality has not been validated.

Presenting problem	2017/18 (# of referrals)	2018/19 (# of referrals)
Anxiety	24	23
Depression	19	15
PTSD	8	11
Family therapy	7	11
Gender dysphoria	5	6
Marital difficulties	4	3

To optimally leverage these available statistics, a systematic approach to evaluation and quality improvement needs to be further developed. Presently, two related logic models do exist: the addictions logic model (developed in 2013) and a Kahnawà:ke mental wellness and addictions logic model (developed in 2017). However, it is unclear how or to what extent the team are aware of these logic models, and whether or how they have been used for evaluation functions.

Due to the lack of systematic adoption and use of standardized assessment tools within the program, data analysis for evaluation purposes (e.g. pre/post health status/outcome assessments) is limited. However, sometimes when referrals are made to external service providers (e.g. with contract service agreements via NIHB), reports are generated regarding care processes and outcomes (e.g. goal attainment scores).

There is a desire to measure and assess client experience and satisfaction using validated survey tools, which are appropriately designed and validated for the complex population(s) being served. The program could also benefit from staff and team experience surveys, to assess factors such as team climate, staff wellbeing, motivation and burnout, to garner ongoing feedback regarding program design, and to improve overall team and program performance. The program is interested in leveraging evaluation frameworks, approaches and tools that enable the measurement and assessment of health and wellbeing from Indigenous perspectives.

Culture and language

The management and team are aware that the program still largely functions within a Western model, and are keen on continuing to explore ways to decolonize its design/framework and approach. However, there is increasing understanding, training and education within the team in relation to Indigenous trauma, particularly due to the effects of colonization and inter-generational trauma. Many staff are members of the community, and are on a healing journey in which it is critical to reconnect with language, identity and culture. Therefore, the program has dedicated staff to the committee at KSCS responsible for Tsi Niionkwarihò:ten ("Our Ways").

5.11 Assisted Living Services (KSCS)

Highlights

- CHP health priorities: Mental health and wellness; Early childhood wellness; Substance abuse/addictions.
- An interdisciplinary team-based approach that leverages a sophisticated hub and spoke service delivery model. The client, family and case worker are the hub, with spokes connecting to all required services, within and external to Kahnawà:ke.
- The multidisciplinary team leverages standardized assessments and case management approaches, and works in close collaboration with clients, family and caregivers to conduct wholistic person-oriented assessments, and develop individualized care plans.
- The focus is on empowering people with disabilities and increase their autonomy and self-advocacy abilities. Individuals are assisted to develop life management skills and competencies, to improve quality of life for individuals and their families, and to integrate the individuals within the community (as active, autonomous and engaged society members).
- Physical space is a major constraint that presents significant challenges to the team, clients and families. The space is limited in size, and the current configuration and design of the space is not well suited to meet the present or increasing future needs of the clients or the community.
- The present ILC wait list is an indication of the needs in the community that need to be urgently met. Furthermore, there is a need for other models of care (e.g. intermediate care) to meet the needs of individuals that do not meet the mandate of the ILC.

Overview

The Assisted Living Services (ALS) program provides a comprehensive range of team-based services for families and individuals living with special needs, as well as individuals living with severe and persistent mental health conditions. The ALS program consists of the Family Support and Resources (FSRS) program and the Independent Living Center (ILC) (21).

The Family Support and Resources Services (FSRS) program provides services for families and individuals living with special needs. The aim is to provide individuals and families with access to information and support, to empower people with disabilities and increase their self-advocacy abilities. Individuals are assisted to develop life management skills and competencies. The FSRS program includes:

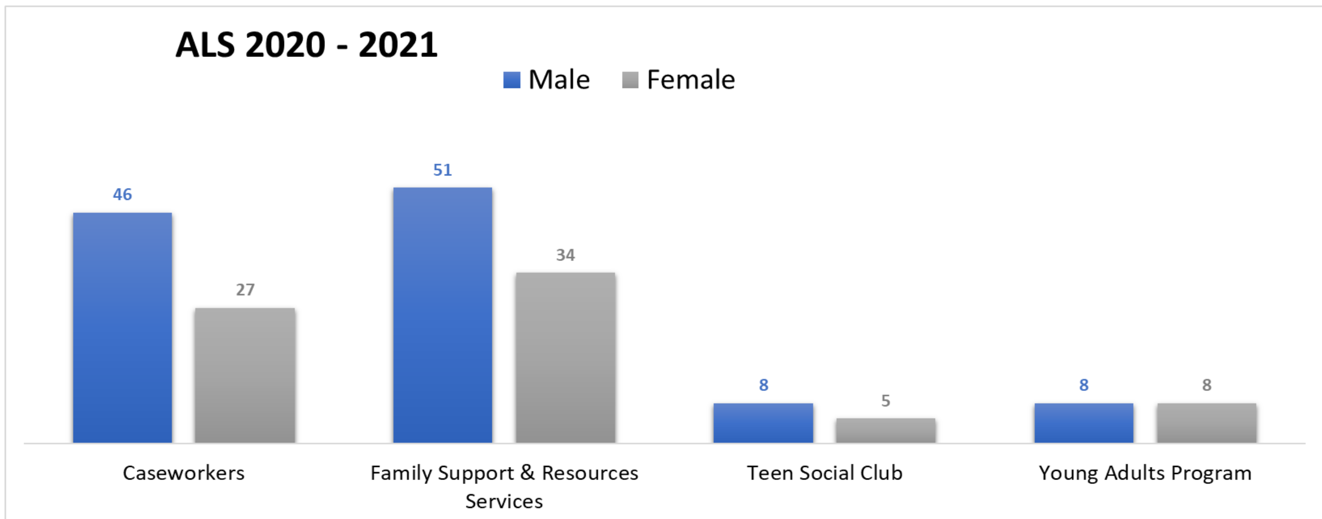
- The Teen Social Club (TSC), which provides services to special needs Kahnawakehró:non ages 13+. It runs as an after school program (autumn to spring) for individuals with special needs and developmental and physical disabilities, providing life skills and social supports with a focus on social integration. During the summer, the TSC operates as a day program.
- The Young Adults Program (YAP), which is a day program for individuals with developmental and physical disabilities (ages 21+). The program provides individuals and families/caregivers life skills and social supports that focus on social integration in Kahnawà:ke and the surrounding communities.

Figure 3: Young Adults Program Fun Fair (2016)

The Independent Living Center (ILC) is a 12 bed residential resource providing a safe, structured and supportive living environment for individuals with severe and persistent mental health conditions. Residents have access to an interdisciplinary mental health team that includes Case Workers, Life Skills Workers - and when needed - mental health nursing, physicians, pharmacists and psychiatrists. The ILC aims to:

- Build on the individual's assets.
- Provide the life skills, care and supports, to enable and maximize autonomy and independence for individuals (either within the ILC or in the community).
- Integrate the individuals within the community (as active, autonomous and engaged society members)
- To improve quality of life for clients and their respective families.

Chart 4: ALS service utilization statistics 2020-2021



Team-based service delivery model

The ALS program consists of a multidisciplinary and multi-professional team that works collaboratively with individuals and families with complex needs. The program's scope encompasses neurological, cognitive, and developmental disabilities and intellectual challenges and needs. Services – particularly those of the FSRS – always extend to individuals and their respective caregivers and/or families (when possible, depending on individual family situations). The extended ALS team includes clinical supervisors, social workers, case workers and life skills workers, who work in close collaboration with mental health nursing, primary care physicians, pharmacists and psychiatrists.

The multidisciplinary team works in close collaboration with the individual and family to comprehensively assess global needs, to identify biopsychosocial assets, deficits and/or needs, and to ensure that all required supports and services are put in place (for both the individual and the family), including referrals to all relevant services.

The team uses a rigorous and comprehensive needs assessment approach. Assessment is an ongoing and indefinite process, as needs continuously evolve and change with this vulnerable and complex population over time. The needs assessment is wholistic and longitudinal, and consists of several standardized tools, including:

- **The Multiclientele assessment tool (OMEC)** (Appendix section 5), which operationalizes the medical model to assess physical and psychological needs. It is a comprehensive assessment tool that identifies deficits as well as levels of autonomy, and identifies the need to build upon strengths to address deficits.
- **The Evolutive assessment tool** (Appendix section 6), a derivation from the OMEC, is performed for progressive assessments over time, usually every 6-12 months, or depending on needs when there are significant changes in health status.
- **The KSCS psychosocial assessment tool** (Appendix section 7), which was developed in-house by a KSCS multidisciplinary team. The psychosocial assessment tool enables the team and case workers to assess and address psychosocial aspects of health and wellbeing. This is extremely important, especially for individuals with high levels of mental health and

psychosocial complexity who present with problems of compensation-decompensation over time, as a function of the levels of stress encountered in their lives.

The needs assessment process is therefore:

- Comprehensive
- Wholistic
- Biopsychosocial and person-oriented
- Balanced (i.e. balancing identified deficits with an assets perspective)
- Family-oriented (In the case of the YAP and TSC, the comprehensive assessment is conducted along with the families, taking ~ 4 hours)
- Longitudinal and ongoing

Based on the needs assessments, goals are developed in conjunction with the clients and families, followed by recommendations and a treatment plan. The plan links the client and/or family with various members of the multidisciplinary team, and enables referrals to required services, including traditional and spiritual services, as well as respite services for caregivers and families.

The program uses a hub and spoke care delivery model. The client, family and case worker are the hub, with spokes connecting to required services, within and external to Kahnawà:ke. The case worker brings the multidisciplinary team together to discuss the clients needs (e.g. home care nursing for medication, activity/day program for isolation or a 1:1 support worker, addictions workers for substance use issues). Together, the team develops a plan for the individual, which is also sent to the family (when possible). The approach is further outlined below:

- The Individual is assessed as a whole person, from which a multi-service intervention and/or treatment plan is devised, in collaboration with the client and/or family.
- A multidisciplinary and multi-professional team-based care planning approach is used. This incorporates clinical supervisors, social workers, case workers, life skills workers, as well as close collaboration with mental health nursing, home health aides, primary care physicians, psychiatrists, pharmacists, occupational therapy (OT), physiotherapy (PT), speech language pathology and psychoeducators.
- To ensure longitudinality of primary care, the team closely collaborates with physicians and nurses from KMHC. One nurse is attached to the ILC program, following the treatment plans longitudinally. All ALS clients are attached to primary care.
- Psychiatry and medication management are coordinated via a mental health nurse liaison (who is part of the home care nursing team), who is the key link between clients, physicians and psychiatrists at KMHC.

Physical space is a major issue that presents significant challenges to the team, clients and families. The ALS program team work mainly from the ILC building, which is a satellite building of KSCS. The space is limited in size, and the current configuration and design of the space is not well suited to meet the present or increasing future needs of the clients or the community. For example, the ILC does not have a dedicated activity area; rather, activities are conducted in the kitchen. The COVID-19 pandemic exacerbated these issues, and highlighted the need to address the ALS program's space-related requirements, to ensure that services can safely expand to meet the increasing needs in the community. The present ILC wait list is an indication of the needs in the community that need to be urgently met.

The ILC has a specific mandate to serve a specific population, and is not designed or resourced to serve a large population of people who need somewhere to go for housing or social support. Presently, there are misunderstandings and misperceptions across the community and health and social care services, that the ILC is a social placement.

To properly assess whether an individual potentially meets the ILC's admission criteria, the following questions are also considered:

- Does the person fit well within the ILC?
- If the ILC helps one individual, does it upset the other residents? The ILC is a delicate environment, with clients who are highly vulnerable and complex. If the ILC brings in a person that does not fit the main criteria, the ensuing disharmony that may ensue would distress the present residents, and adversely impact their health, wellbeing and safety.

It is also important to note that weekend services (especially activities) need to be expanded and improved, due to limited HR availability, affecting services to clients who are at high risk of experiencing loneliness and isolation.

Community engagement

The ALS team organize and participate in community and sporting events to build awareness of the program, and to engage its clients, families and the wider community. For example, during the summer, in conjunction with the community's softball league, the ILS, YAP and TSC set up hot dog stands and sold raffle tickets, and participated in playing the game along with the league's team players. On a more informal basis, all members of the community – including youth and young adults – are also encouraged to interact and spend time with clients of the ALS program.

Communication, collaboration and coordination

There are challenges presented by the differing models of care between the medical model and psychosocial model. The ALS team recognize that the medical and psychosocial teams bring different perspectives, which are both valid and valuable. However, it is important to recognize that clinicians see the clients for relatively short encounters, while the ALS team spend much more time with them, observing their behaviors and challenges over long periods of time.

To align both medical and psychosocial perspectives, and to enable better coordination and collaboration, open and ongoing discussions and conversations are required. Mechanisms could include more frequent team meetings and email correspondence, which the ALS team promotes.

Due to the ongoing and frequent changes in the status of clients, as well as medication changes, there are issues with communication with other programs and services. For example, sometimes physicians change prescriptions without informing the ILC team. Physicians and/or pharmacists may forget to liaise with the nurse, who is responsible for medication management at the ILC. Therefore, it may take some time to become aware of medication changes, if the ILC nurse is not informed. Medical changes can have a strong impact on the wellbeing of ILC residents. Two-way

communication with other programs and services is therefore problematic. There is a perception that the ALS team sends information out to other programs and service providers, but often does not receive information back.

Furthermore, MYLE EMR and ALS' case management systems are not interoperable, limiting communication and data sharing. The medical system (nursing and physicians) use MYLE EMR, whereas ALS is presently paper based and is transitioning to Penelope EMR.

Client, family and caregiver engagement & experience

The team takes time to engage and work closely with families (especially in the case of the YAP and TSC), to build awareness and understanding of the roles and functions of the team, the goals of the services, and how the ALS program has helped other families in other situations.

Family engagement at the ILC can challenging for various reasons. For example, ILC clients can be quite old, so their elderly siblings are often unable to visit (due to age-related issues). However, the team does arrange for birthdays and other events such as galas, and invite family members and caregivers (these activities had to be halted due to the pandemic).

Evaluation, performance assessment and quality improvement

Team meetings are routinely conducted with clients and their families to assess satisfaction with services and activities, as well as their state of health and happiness. A proxy indicator of satisfactory performance and success is ongoing and open communication with the clients. If the client can always communicate their preferences, likes and dislikes openly, the team perceives that it is working in the right direction.

Client participation in community activities is a sign of engagement and success, as it indicates that they are not isolated; rather, that they are integrated and present in daily life. Examples include linking clients with the KYC weight room, or planting tobacco. These are "small things for us, but big things for the clients".

Families of clients in the TSC and YAP express their joy in seeing their kids participate in activities, especially when seeing activities they never thought were possible (e.g. horse riding, or being hired for a job). Families express that it is a very high value service that is essential to their well-being as a family unit. The TSC and YAP are involved with Community Health Plan Initiatives (CHPI), such as the Painted Ponies and Golden Horses projects.

There exists opportunities to develop more systematic approaches, methodologies and tools for comprehensive evaluation and quality improvement, with a focus on activation, wellbeing and health outcome domains. Detailed cross-sectoral CHP logic models for Developmental Disabilities and Mental Health were developed in 2013; however, it is unclear how or if the logic models were used.

For data collection, charting by the ALS team is paper based. The team is planning to transition to Penelope case management system, to document digitally. The Multiclientele assessment tool is in the process of being digitized as a form in Penelope; however, presently it is scanned and entered into Penelope.

Culture and language

Culture and language are sensitive topics, especially with individuals who have experienced many forms of trauma. Therefore, culture and language are integrated into programming in a sensitive and nuanced manner, based on the interests and needs of the clients and families. This includes traditional arts and crafts (participation is optional). Tsi Niionkwarihò:ten ("Our Ways") also provides many resources, and the ALS program leverages many resources including DVDs, dictionaries and books, and supports residents and clients interested in participating in festivals (maple, strawberry) and traditional, cultural and language activities.

> *"The Tsi Niionkwarihò:ten Program and Coordinators have reintroduced me to language and culture that I have lost touch with throughout the years. The program has supported me by offering Kanien'kéha sessions, singing groups, workshops with guest speakers, ex: Introduction to the Great Law, The Creation Story, and much more that are on-going throughout the year. Tsi Niionkwarihò:ten has been implemented into the Young Adults Program and Teen Social Club in many ways by our dedicated staff. Many of the participants have the knowledge and enjoy demonstrating what their strengths are. Our programming has been promoting awareness by incorporating the Ohén:ton Karihwatéhkwen, festivals, music/singing and by using Kanien'kéha, our language, every day. We encourage our participants and staff to continue practicing tsi niionkwarihò:ten."*
>
> **~ YAP/TSC Team Leader**

Program-specific CHP input/recommendations

Mental health and wellbeing within the context of special needs and disabilities are significant issues, that need to be priorities. Furthermore, there need to be clear strategic cross-sectoral plans in relation to caring for the aging and frail elderly population – particularly those with disabilities and special needs – including aging caregivers.

Effective cross-sectoral initiatives are required to integrate populations with special needs and disabilities into the community, and to promote all forms of necessary accessibility and community awareness. This includes meaningful integration of individuals within the community, including vocational opportunities at early ages, so they participate in work activities. Some individuals are able to perform tasks and duties, and provide services. Participating in work activities helps individuals feel empowered and engaged, as valuable members of society, making a positive contribution to the community.

5.12 Connecting Horizons

Highlights

- CHP health priorities: Early childhood wellness; mental health and wellness.
- A community-based group working to advocate for the needs of individuals with special needs, and their families living in Kahnawà:ke.
- The organization focuses on individuals and families that were already isolated, and severely impacted by the pandemic.
- The Connecting Horizons report "Supporting individuals with special needs and their families: a community needs assessment" highlighted limitations with awareness, community engagement, funding, staffing, service availability and program quality, as well as support worker skills and knowledge.

Overview

Connecting Horizons is a community-based group working to identify, and respond to, needs of individuals with special needs, and their families living in Kahnawà:ke (22). The group is comprised of individuals with special needs, parents and caregivers of individuals with special needs, along with representatives from community organizations (including the Mohawk Council of Kahnawà:ke (MCK), Step by Step Child & Family Center (SBS), Kahnawà:ke Fire Brigade (KFB) and Kahnawà:ke Shakotiia'takehnhas Community Services (KSCS), Tewatohnhi'saktha, First Nations Human Resources Development Commission of Quebec (FNHRDCQ) and the Kahnawà:ke Education Center).

Through consultations, Connecting Horizons continues to build grassroots initiatives to understand the needs of families and individuals living with disabilities, and increases awareness to engage leadership, community members and other organizations to support its mission to help meet those needs.

Service delivery model

After many years of functioning in an informal grassroots manner, Connecting Horizons has succeeded in securing funding from the Community Initiatives Fund (CIF) and KSCS. Leveraging these supports, and governed by a volunteer Oversight Committee, Connecting Horizons continues to increase its advocacy and partnership capacity.

The team now includes an Advocacy Coordinator, who is responsible for a wide range of functions, including: enabling community engagement and dialogue regarding gaps in services and special projects, launching community-wide awareness campaigns, and strategic plan development and implementation. To meet the increasing needs in the community, and increased scope of work, Connecting Horizons will require further support and resources in terms of volunteers and staffing (e.g. communications, operations, administration).

Connecting Horizons collaborated with KSCS the Centre for Research on Children and Families (CRCF) at McGill University on an important study entitled "Supporting individuals with special needs and their families: a community needs assessment" (July 2014) (23). Funding was secured via the Social Sciences and Humanities Research Council (SSHRC) Partnership Grant titled Building Research Capacity (BRC) with First Nations and Mainstream Youth Protection Services in Quebec. The study was comprehensive, and provided insights into the following themes:

- Personal and professional support networks
- Awareness of services
- Service efficacy:
  - Service strengths
  - Quality of programming
  - Service availability and helpful services
  - Service provider knowledge and skill
  - Family engagement and involvement
  - Understaffing
  - Availability of out-of-home living residences
  - Accessibility/mobility in the community
  - After-hours services
  - Transportation services
  - Suggestions for services
- Service plan involvement
- Community involvement

Excerpt of the Connecting Horizons report, entitled: "Supporting individuals with special needs and their families: a community needs assessment" (July 2014) (23)

"The assessment found that individuals with special needs experienced a range of disability types and corresponding special needs, and thus required a range of services. Participants were able to share rich information regarding their personal and professional support networks, which could potentially be built upon to improve the lives of individuals with special needs and their families. Participants also highlighted a number of strengths and limitations regarding current service availability and quality, and provided concrete suggestions for improvement in a number of areas such as program availability, program quality and support worker skills and knowledge.

As with many health and social services, financial and staffing resources are seen as lacking, which likely contribute to many of the limitations noted by participants. During the interviews, some participants expressed appreciation for the opportunity to be involved in this needs assessment, for having their voices heard, and noted that the development of effective services takes time. However, some, who have been involved in discussions for decades on the lack of services for people with special needs and their families felt their dreams have not yet been realized. There is a sentiment from some participants that nothing has nor will ever change. To move towards positive changes, participants called on service providers to open their doors, be more transparent, and create a culture of information sharing. Participants overwhelmingly want to feel their voices are heard, to see concrete improvements to existing services, and meaningful efforts to increase awareness of the needs of individuals with special needs across the whole community."

The community needs assessment that was performed in 2014 requires updating. It is recommended that reassessment should be systematic and periodic (e.g. every 5 years at a minimum), to properly identify and assess changing needs of vulnerable populations in the community.

In October 2021, Connecting Horizons published its Strategic Plan (2021-2024), which highlights its three main strategic orientations:

- **Engagement:** Through consultations, Connecting Horizons continues to build grassroots initiatives to understand the needs of families and individuals living with disabilities, and increases awareness to engage leadership, community members and other organizations to support its mission to help meet those needs.
- **Collaboration:** Building on existing collaborations with MCK and the Executive Directors' Committee, Connecting Horizons participates on boards of other organizations, develops partnerships, and shares the needs to increase funds for its operations and services for people within the community while creating an accessible continuum.
- **Promotion:** Using existing media within the community as well as social media, Connecting Horizons promotes itself and the people it works with to increase understanding of people living with disabilities and their inclusion in all.

Community engagement

Connecting Horizons' team and the Advocacy Coordinator actively engage with the community, and its educational, health and social care organizations using a variety of mediums, such as radio, email, documents and social media.

Although the larger organizations (e.g. the PeaceKeepers, MCK) know about Connecting Horizons, the smaller community-based organizations sometimes are unaware of its existence or key functions. To improve community engagement, awareness and access to its services, Connecting Horizons could benefit from an accessible and visible storefront.

Connecting Horizons is keen to work with the community's health and social care organizations to increase its visibility, while at the same time trying to champion the cause of vulnerable and underserved "invisible" populations. Connecting Horizons' Strategic Action Plan highlights some key functions relating to engagement and promotion, including:

- Conducting an updated needs assessment to identify the gaps in services in Kahnawà:ke through a community-wide consultation with all families and individuals living with disabilities;
- Organizing regular meetings to reflect on inclusion and Connecting Horizons' projects with leadership, persons living with disabilities, and volunteers to maintain engagement
- Engaging with funders (new and existing) in reflecting on how their projects can support Connecting Horizons' mission.
- Creating a communications plan, and adding communications resources to the team (e.g. a communications officer)

To promote awareness and transparency, Connecting Horizons suggests that health and social care organizations in the community arrange "open house" days, when members of the public can tour the buildings and meet the teams, to learn about their services, functions and goals, and to ask questions and provide input and feedback (e.g. similar to the open house hosted by KMHC recently).

Communication, collaboration and coordination

Communication and collaboration with the health and social care organizations in the community has often been challenging. The program continuously attempts to engage and communicate with other programs and services, who are not always responsive. This includes requests for meetings, information requests, or responses to requests to address potential access and/or safety issues identified within facilities. Barriers to communication and collaboration may include factors such as: bureaucratic processes, organizational siloes, lack of clarity regarding accountability, and lack of responsiveness.

Connecting Horizons is developing plans to improve collaboration and strategic alignment with other cross-cutting programs that focus on similar populations, such as Jordan's Principle. Connecting Horizons is keen on engaging with, and opening channels of communication with the Boards of Directors of the community's educational, health and social services organizations. Establishing mechanisms to enable information sharing and engagement within the context of Board meetings (e.g. adding topics as agenda items for Board discussion and deliberation) would be beneficial.

Program-specific CHP input

It is recommended that the CHP focus on people with disabilities, and their families. The scope of the present CHP did not sufficiently encompass the real scope of special needs and disabilities. Furthermore, it is important for the CHP to frame priorities from the perspective of the human being who is using the services (i.e. person-orientation) and their families (i.e. family-orientation), rather than being framed from the perspective of the ones providing services (i.e. service-oriented perspectives).

5.13 Home & Community Care

Highlights

- CHP health priorities: Cross-cutting.
- An extensive multidisciplinary and multi-organizational program that provides comprehensive clinical and psychosocial home care services, including chronic disease management, palliative care and mental health nursing, in homes in the community and across various institutional settings, such as Turtle Bay Elders Lodge, KMHC programs and Assisted Living Services.
- An area of high performance is that of same or next day access to services, and virtually no wait list, which ensures that clients and families with needs are able to access services without delay. The entire team is very responsive and agile, and is able to rapidly and collaboratively develop and implement service plans.
- The home care nursing program also always attempts to maintain equal or higher standards of performance than all outside CLSCs, which was clearly demonstrated through the excellent results of the latest accreditation. The accreditation process is particularly useful, functioning as a comprehensive and periodic assessment and evaluation of nursing services.
- An upstream structural factor that presents challenges to teamwork – particularly in relation to communication, collaboration and coordination – stems from the fact that KSCS and KMHC are separate organizations with distinct governance, funding, management, organizational cultures, policies, accountability mechanisms, visions and mandates. The staff from each organization are from various disciplines and professions, as well as different requirements in terms of legal standards, directives, protocols and reporting and accountability requirements.
- The HCC program experiences significant challenges relating to short-staffing, recruitment and retention. Staff (e.g. nurses) are stretched and have to sometimes prioritize between essential work (e.g. case management vs task work to maintain essential services).
- The pandemic had a particularly severe impact on the isolated frail elderly, and the providers caring for them. The resilience of the team must be recognized. The burnout and trauma felt by everyone affected requires a healing journey.

Overview

The Home and Community Care (HCC) program consists of an joint partnership between KMHC Home Care Nursing program and KSCS' Home and Community Care Services (amalgamated in 1999). The program provides comprehensive clinical, psychosocial and home care services, including chronic disease management, in the community and across various settings, including (but not limited to) homes, Turtle Bay Elders Lodge (TBEL), KMHC long and short-term care programs, and the Assisted Living Services (ALS) program. The multi-professional team is comprised of nurses (including mental health nurses), home health aides (PAB technical certification), case workers and social workers.

The program aims to promote independence, prevent complications of pre-existing health conditions, address acute care needs, delay the onset of disease, promote a healthy lifestyle, encourage wellness and enhance quality of life while ensuring safety. One of the key goals of the program is to assist Elders to remain in their homes for as long as possible, before having to move to next levels of care, such as long-term care. However, it is important to note that the program serves many age groups, including adults below the age of 65, who require chronic and complex care.

Scope of services

The HCC program encompasses the following levels and domains of care:

- **Home care supports:** the home care team works in collaboration with families to provide the following services:
    - Medication assistance: Assist clients with medication compliance in accordance with Law 90.
    - Personal Care: For people with loss of autonomy who require cueing or help with daily bathing and/or dressing.
    - Meal Preparation: Work in conjunction with Meals on Wheels to ensure clients have at least one good meal per day.
    - In Home Respite: Scheduled care provided for those who are not safe to be left alone, to give family members occasional breaks.
    - Escorts: To provide medical escorts only when family is not available. Provide assistance for shopping, and errands when family is not available.
    - Domestic Services: Assistance with basic household chores, usually provided on a weekly basis, based on assessments.
    - Adult and Elders Services Counsellor: offers information and liaison services for income security programs, disabilities, civil status, estate planning and management, and provides Commissioner of Oaths and other services as required

- **Home hospital (level 1, acute care focus):** focuses on providing nursing care to patients on a short-term basis (usually 3 months or less. They can be readmitted to Home Hospital/ Short Term Care if their health issue has not resolved within the 3 months). Homecare Nursing receives referrals for these patients after they've had surgery, a medical procedure or upon discharge from an acute care hospital which requires follow up. Nursing care is provided to

these patients as well as teaching to the patient and their caregivers to assist them to care for themselves in their homes. In Home Hospital the majority of patients are seen for wound care (including specialized treatments, dressing changes & clip/suture removal), injections, IV therapy and management, blood tests, catheter care as well as a wide variety of nursing interventions. The major goal in this area is for patients to return to their previous level of functioning following surgery, a medical procedure or a short-term illness in an appropriate time frame. Clients who are admitted to Home Hospital are initially assessed using the short-term OMEC, which ensures that the patient receives the appropriate care they require in a coordinated manner.

- **Tertiary Prevention Care (level 2 care):** focuses on assisting patients to stay at home as long as possible by maintaining their current level of functioning and preventing further deterioration from their pre-existing conditions. It has been identified that this patient group are persons who may be experiencing a loss of autonomy; therefore, the goal is to promote, maintain or improve their independence. The focus is on promoting autonomy while fostering patient/family/caregiver participation. Examples of the work includes: monitoring patient's health condition, health promotion, teaching, facilitating health care management, networking with other health and social care providers, and coordinating care. One of the goals in this area of care is to identify priority areas early and to intervene (implement services) in a timely fashion. This approach also contributes to patients requiring less acute care interventions and making all efforts to delay their need for long term care. The aim is to assist the patient to feel as well as possible and reach their optimal level of health. All patients in Tertiary Prevention Care are assigned a case manager (in most cases a nurse or case worker).

- **Mental Health nursing:** Tertiary Prevention encompasses mental health nursing, which addresses the needs of patients who are experiencing mental health Issues. While the primary mandate of the nurses was to address the needs of patients who fall into the category of severe and persistent or who are experiencing psycho-geriatric issues, the role of the mental health nurse has broadened to include patients who may have mild to moderate mental health issues. Nursing care for this patient population also focuses on activities geared towards prevention and maintenance. This includes promoting autonomy, by assisting patients to maintain or improve independence, preventing deterioration and assisting to improve these patient's quality of life.

- **Activity program:** The HCC Activity Program is a combination of the Adult Day Center of KMHC and the Activity Program at TBEL, which amalgamated to create the HCCS Activity Program. This program conducts a day program where persons can participate in a variety of activities. A wide variety of clients attend the program, which runs from 8am to 4pm, Monday to Friday, as well as weekends and evenings for special activities. Participants include the residents of the TBEL, Homecare Patients & clients of HCCS. The program is open to any client which requires increased social interaction or daytime respite. Referrals to the activity program can come from a variety of sources, the same applies to any program within HCCS. Initial Assessments are done by the Recreational Therapist in collaboration with the participant's Case Manager as well as other members of the activity team. The Activity Program meets the different needs of participants, including stimulation of mind, body and

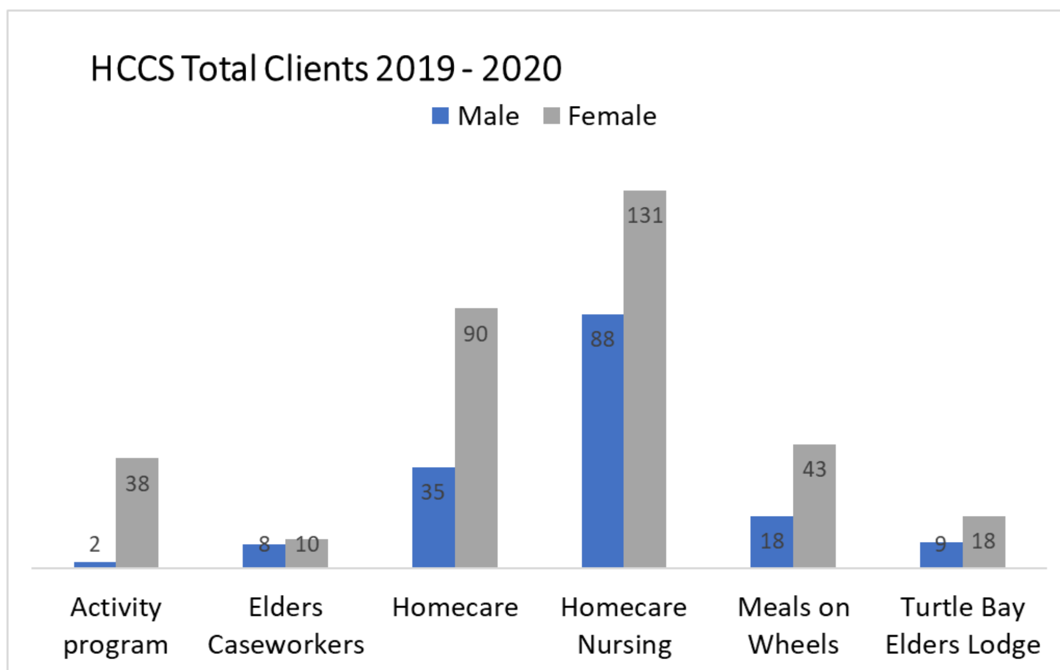
spirit and providing social interaction. The program also provides respite to families, who need assistance and support to care for their loved ones at home. An Activity Department Nurse provides nursing care to the participants of Activity Program at TBEL.

- **End-of-Life Care / Palliative Care (level 4 care):** focuses on managing symptoms, promoting comfort, coordinating care, providing teaching and support to the patient, families and caregivers. The program's concept of end of life care has broadened in the last few years to include a wide spectrum of chronic conditions such as COPD, diabetes, muscular dystrophy, end stage renal failure as well as a number of other chronic conditions.

End of life care / palliative care is a very challenging and rewarding area of homecare nursing, and is continually evolving; therefore, the program strives to stay up to date with current practices. The program continues to explore new ways of providing the best possible care to patients in their homes.

This area can be one of the most rewarding for nurses as they find great comfort in being able to help the patient and family in their last and final days. The aim is to assist patients and their families through the patient's dying process in the comfort of their home.

Chart 5: HCCS descriptive statistics 2019-2020



Team-based service delivery model

The HCC program is led by a home care nursing manager (from KMHC) and a home and community care manager (from KSCS), who have a strong and well-established collaborative working relationship:

The KSCS Home And Community Care Services component of the HCC program is led by a home and community care manager with 34+ years of experience in Kahnawà:ke's health and social services. The manager has been with the HCC program since its inception, and is involved in regional and national First Nations community initiatives and projects. The manager leads a

large home and community care team, including home health aides, case workers and social workers.

The Home Care Nursing (KMHC) component of the HCC program is led by a manager with many years of clinical, administrative and managerial nursing experience across many departments at KMHC (e.g. inpatient, outpatient, home care). The nursing manager has a very large scope of responsibilities, encompassing home care nursing, management of the activity program at TBEL and overseeing mental health nursing across the community.

The multidisciplinary and multi-professional HCC team is comprised of nurses, PABs (Préposé(e) aux bénéficiaires, similar to Personal Support Workers), home health aides, social workers and case workers. The team use a comprehensive and integrated case management approach, with standardized processes and tools for intake, needs assessments, Integrated Service Plans (ISPs) and referrals. The team focuses on addressing the wholistic needs of complex clients (i.e. clinical and psychosocial needs), and pulls in all necessary and relevant community resources, to enable independence and autonomy of the client. The team also emphasizes family engagement, to empower families to take on and share responsibilities.

A description of the integrated HCC program case management approach

New referrals are assigned to either KMHC or KSCS teams, depending on the needs and context of the client (i.e. either a nursing case manager for clinical problems, or a social worker/case worker if problems are more social). The KMHC and KSCS teams work closely together to avoid duplication (e.g. in relation to assessments), to improve patient experiences and quality of care.

If the client requires home care services, the case manager would conduct the assessment using the OMEC/Multiclientele, which is a comprehensive and wholistic assessment that incorporates the client's perspective. It allows for comments to be incorporated by the assessor, and enables identification of deficits and what resources/ assets are available to help the person overcome them. It also enables identification of what services are required to be put in place to help overcome deficits/handicaps. The OMEC also has a special section that identifies if there are family/relatives and how involved they are in the care.

Once needs and resources are identified, the case manager completes an internal referral form and a request for services (i.e. referral to various service components like nursing, home care). To ensure alignment and service quality, the HCC team use the same standardized tools, which include the OMEC, Evolutive and ISP. Assessments are integrated into Penelope case management system and/or scanned into MYLE EMR. Collaborative care planning is enabled by the ISPs, which is integrated into both MYLE EMR and Penelope case management systems. Every 6-12 months, or upon major changes in health status, an evolutive assessment is conducted.

Community engagement

Further community engagement and awareness activities are required, as community members often expresses confusion regarding the respective roles, responsibilities and functions of KSCS and KMHC home care services. To address this confusion, staff have to actively answer questions and triage inquiries and requests to the appropriate team members.

Communication, collaboration and coordination

Home and community care clients are often highly complex (clinically and psychosocially), with chronic health and social needs requiring access to diverse services both within and external to Kahnawà:ke. Communication, collaboration and coordination are therefore essential functions of the HCC team, and are recognized as organizational priorities.

The management and front-line team continue to develop mechanisms and processes to improve internal communication between the HCC team, and to minimize bureaucracy and duplication of key functions (e.g. intake, assessment and care planning). The front-line HCC teams from KMHC and KSCS are increasingly comfortable working together as a cohesive team, and are often communicating directly and setting up joint meetings, without always going through their respective managers. To facilitate communication and meetings between the HCC team, staff are increasingly leveraging MS Teams.

The HCC team leverages collaborative case management systems and ISP meetings, to bring family members and relevant service providers together, to ensure alignment and clarification of roles and functions. These meetings are particularly important within the context of complex clients with multimorbid chronic disease, mental illness and end of life / palliative care. In the case of mental illness, the mental health nurses work closely with psychiatrists, and provides expertise in relation to coordination with family physicians. However, there continues to be a need to improve linkages with other health and social services within the community (e.g. prevention services).

The nursing manager also attempts to link with neighboring CLSCs (Centre Local de Services Communautaires), particularly in relation to enabling cross-learning and knowledge exchange. Nurses within the KMHC team have worked at other CLSCs, bringing their knowledge with them to the team. This knowledge is important, as the HCC program strives to maintain equal or higher standards of performance than all outside CLSCs. Due to this high level of performance, many sister First Nations communities draw upon the HCC program for guidance and support.

Client, family and caregiver experience

Client satisfaction surveys were used by Home Care Nursing. Furthermore, the accreditation was a very useful process, as it involved families and clients and elicited their feedback, ensuring that their voices were heard.

Much of HCC evaluation relies on one-on-one discussions and conversations. However, there is a risk of bias, due to clients and families fearing that negative feedback would affect service delivery or service quality.

It is important to note that there are many social barriers to engaging with some families, (e.g. dysfunctional extended families). Caregiver burnout is also a major problem, and requires sharing of responsibilities between various members of families, which may cause issues or not occur at all.

The home care nursing manager is often informally referred to as the complaints department, and follows up on every call, asking for feedback and following up regarding the outcomes. The manager presently documents issues that are brought forward, as well as what course of action was taken.

Evaluation, performance assessment and quality improvement

The Home and Community Care team collects various types of statistics, including:

- Home visits
- Intake statistics, by type
- Active client caseload statistics (volumes, age, gender)
- Service hours, by type
- Case management services (examples include case conferences, charting, consultations with family members, consultations with physicians, establishing linkages/liaison, hospital discharge planning, initial assessment, intake, reviews/assessments, in-home respite)
- Nursing services: Foot care, health teaching, medication administration, monitoring for therapeutic intervention, nursing treatments and procedures, therapeutic care, wound management
- Personal care: bathing/toileting/oral care/skin care/hair care/dressing; direct observation therapy/transfer skills, feeding, foot and nail care, mobilization, rehab exercises
- Professional therapies: mental health consultation, nutrition counseling, occupational therapy, physical therapy, podiatry, speech therapy
- Admissions, readmissions
- Primary reason for home care services (by gender and age)
- Sources of referral

Examples of some of these statistics are provided below:

Chart 6: HCCS service hours descriptive statistics 2020-2021

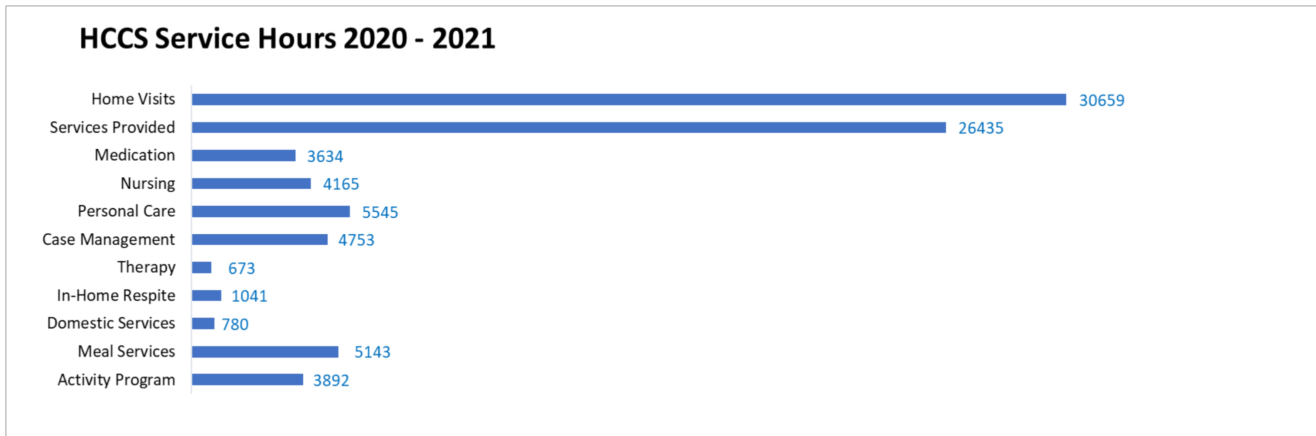


Chart 7: HCCS intake descriptive statistics 2020-2021

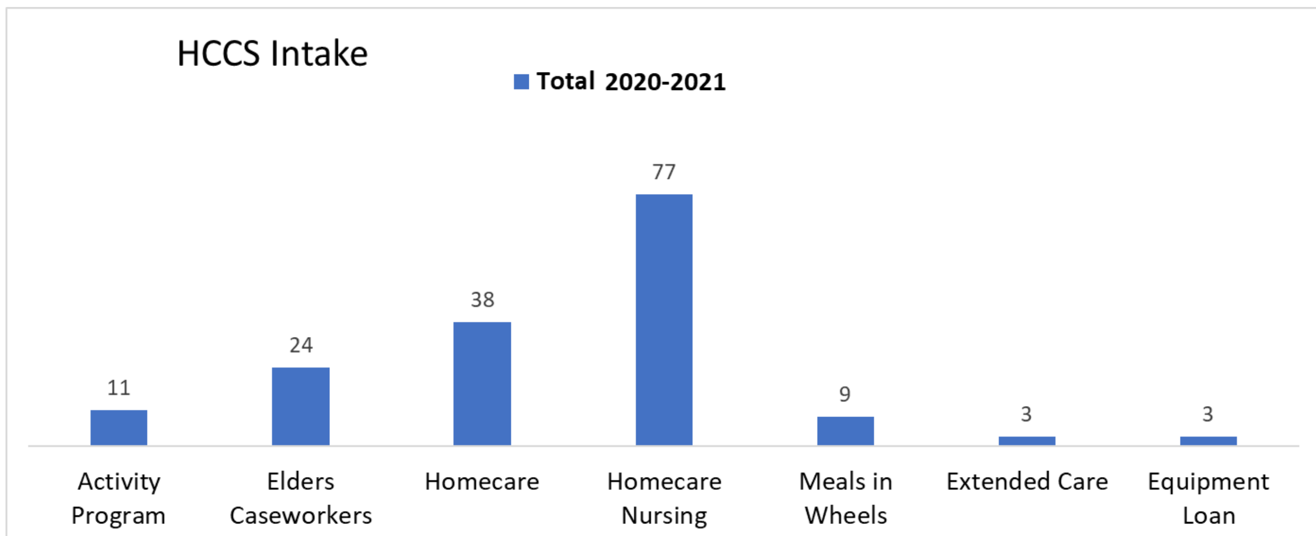


Table 11: Example of mental health nursing statistics (new referrals, and # of clients cared for). Note: data quality has not been validated.

	2016/17	2017/18	2018/19
New referrals	21	19	14
Clients followed	54	54	55

The HCC program recognizes the need for further support and resources to enable robust and ongoing evaluation, performance assessment and continuous quality improvement (CQI) functions. The team has little opportunity in terms of time or resources to conduct evaluation, CQI, self-reflection or team building exercises. A 25-page logic model for home and community care and home care nursing was drafted in 2013. However, it is unclear to what extent, or how,

this logic model was used. The upcoming Home and Community Care Needs Assessment Project will shed some light on many of the challenges that are experienced.

An area of clearly high performance is that of same or next day access to services, and virtually no wait list, which ensures that clients and families with HCC needs are able to access services without delay. The entire team is very responsive and agile, and is able to rapidly and collaboratively develop and implement service plans.

The Home Care Nursing program also always attempts to maintain equal or higher standards of performance than all outside CLSCs, which was clearly demonstrated through the results of the latest accreditation. The accreditation process is particularly useful, functioning as a comprehensive and periodic assessment and evaluation of nursing services. KMHC's Quality Improvement, Risk Management and Innovation team supports the nursing team with accreditation functions and audits, enabling alignment with best practices, and to attain the highest benchmarks.

The KMHC Home Care Nursing program also submits an annual report, which reports on:

- Key annual objectives
- Responsibilities to fulfil
- Quality Improvement (QI) activities
- Organizational and service delivery challenges
- Success and accomplishments
- Training and workshops
- Meetings, working groups and committee membership
- Recommendations

The home care nursing program has identified the following quality improvement (QI) activities for the upcoming year:

- Ensure nurses resume filling out Incident Reports (IRs) in a timely manner (the pandemic and transition to MYLE EMR presented challenges in relation to completing and documenting IRs).
- Implement protocols to identify trends reflective on the IRs received.
- Implement tools to improve communication between nurses themselves, as well as nurses and other service providers, including families.
- Continue to adjust services to address all the directives related to COVID-19 pandemic (this will include ongoing training to staff to ensure they are providing care in line with all the directives).
- Continue to collaborate with the MYLE Team to improve all processes within MYLE EMR.
- Continue to improve medication reconciliation compliance. The pandemic negatively affected medication reconciliation functions, due to short-staffing and competing priorities (i.e. delivery of essential care vs medication reconciliation processes such as audits).
- Catch up on performance appraisals for nurses, and incorporating cultural competency frameworks.

The management team also has an open-door policy, to maintain continued communication with the team, and to encourage them to candidly share both positive and negative feedback. The nursing manager maintains a front-line and hands-on clinical presence as well, to support the nursing team when short-staffed, and to maintain visibility and presence.

Data and information systems

During the pandemic, MYLE EMR and Penelope case management system were deployed by KMHC and KSCS, respectively. Prior to these systems, the HCC program used an MS Access database, which was good for queries of client information, but problematic for finding detailed longitudinal information (e.g. encounter notes), charting, and conducting and reviewing assessments (e.g. the OMEC and/or Evolutives could not be pulled up easily).

The new web-based systems that are in place are very promising; however, there is a very steep learning curve for both teams, and the timing of implementation and adoption was not optimal during the pandemic. Implementation, training and change management functions, which are essential to ensure effective use of these systems, was very challenging during the first two years of the pandemic.

The KSCS and KMHC teams continue to learn and adapt to MYLE EMR and Penelope case management systems. The systems have improved communication between the HCC team members and the other health care professionals within KMHC and KSCS, and has reduced the need to rely on faxes and paper documents, particularly in light of the staff working at satellite sites such as TBEL. The organizations are working on continuing to integrate the paper assessment tools into both MYLE and Penelope, as digital forms.

The fact that the KMHC and KSCS teams each use different systems (MYLE EMR and Penelope, respectively) presents challenges to teamwork and collaborative care planning. Furthermore, the systems are not interoperable, hindering the efficient and effective sharing of information relating to the same client being cared for. Management are forced to learn both systems, and to toggle between them, due to the lack of interoperability. Clients have two records that do not automatically sync, and there are legal and confidentiality barriers to having team members access both systems.

Finally, it is recognized that the masses of HCC data being generated and recorded by both KSCS and KMHC teams are not being properly and comprehensively analyzed, to guide and inform functions such as planning, evaluation or QI on an ongoing basis.

Governance, organizational and service delivery challenges

An upstream structural factor that presents challenges to teamwork – particularly in relation to communication, collaboration and coordination – stems from the fact that KSCS and KMHC are separate organizations with distinct governance, funding, management, organizational cultures, policies, accountability mechanisms, visions and mandates. The staff from each organization are from various disciplines and professions, as well as different requirements in terms of legal standards, directives, protocols and reporting and accountability requirements. Staff from the two organizations also have differing holidays, benefits and schedules, which can result in conflict and/or resentment. These upstream factors result in challenges downstream, particularly in

relation to multi-professional teamwork, coordinated front-line service delivery, and the conduct of organizational functions such as accreditation.

Mental health nursing is a very large and important program (especially post-pandemic), requiring its own programmatic entity (but not necessarily removed from home care nursing, overall). Many programs offer various types of mental health services across the community; however, the services are not well aligned or coordinated. Each program uses differing approaches, with limited integrated case management functions. Although there are attempts at collaboration, many of the mental health services operate as siloes. This is something that the Mental Health development team will aim to address.

It is important for KSCS programs (e.g. the ILC and TBEL) to continue to have a clinical connection with KMHC, for direction and support relating to medical/clinical matters. The mental health nurses provide support to these organizations, to ensure that the complex medical needs of the clients are effectively and safely met (particularly those with dual diagnoses, and concurrent mental health and addictions).

The HCC program experiences significant challenges relating to short-staffing, recruitment and retention. Staff (e.g. nurses) are stretched and have to sometimes prioritize between essential work (e.g. case management vs task work to maintain essential services).

Families can and should take up and share more responsibilities with the teams, particularly in relation to engaging with care planning and care. There is an incorrect perception that the responsibility entirely lies with the HCC team.

Presently, the Meals on Wheels program uses the TBEL kitchen. However, that kitchen is not equipped or designed for that purpose. The KMHC kitchen may better equipped and resourced to make better quality meals and meet dietary requirements. One option is that the preparation and cooking of meals to be conducted at KMHC, with the HCC team continuing to deliver the meals.

The lack of snow removal from home driveways and entrances was noted to often a problem, and presents a high risk of injury for clients, families, caregivers and staff.

Culture and language

Staff are encouraged to participate in cultural activities within KSCS and KMHC, as well as other cultural activities across the wider community.

Home care and nursing in particular are very intimate and personal. Nurses must have good technical clinical quality of care skills, but also must have a clear and deep understanding of the community, how it functions, its idiosyncrasies and its values. This is difficult to teach – often, they learn as they go along, making mistakes, and learning from them.

A project was started in 2014 with Indigenous Services Canada and the University of Montreal, in relation to a competency framework for nurses (since most nurses were Francophone or foreign). The nurses knew the clinical technical aspects of nursing, but did not know the people or how to interact with the community. At the time, communities – particularly remote ones in Quebec – felt disrespected, and felt oppression coming back, in terms of outsiders teaching the community how to care for themselves. The competency framework was to culturally sensitize people, and was an excellent tool, but was not implemented in Kahnawà:ke. The Home Care Nursing manager wants to implement this framework, to culturally sensitize staff and ensure cultural competency and safety.

Program-specific CHP input

- It is important to focus on enabling cultural safety, and to implement cultural awareness, sensitivity and competency training and standards for staff.
- It is important to understand, assess and address upstream structural/system issues that impact teamwork and service delivery – and to explore mechanisms of alignment between KSCS and KMHC at macro (system) and meso (organizational) levels.
- A comprehensive system for mental health and wellbeing needs to be developed, with clear programs, services, mandates, functions and accountabilities. The present mental health response (e.g. mental health nursing) was largely created in response to address severe and persistent mental illness needs, demonstrated by crises, in terms of ambulance and police calls, rather than robust population-level statistics. However, post-pandemic, the services are now being inundated by referrals/presentations of anxiety and depression. It is challenging to address these needs effectively before they become worse, with the current fragmented service delivery landscape, and with the lack of timely and accurate epidemiological and healthcare statistics. Mental health and addictions are high priorities, along with violence. Families are overwhelmed and in crisis, and family violence, in particular, has worsened.
- Human resource recruitment and retention is extremely important, with a need to focus on primary care, especially getting patients attached and rostered. There are not enough family physicians, and nurses are undervalued. Nurse Practitioners (NPs) can fulfil an important role, and are urgently needed.
- There is a lot of data, but it needs to be properly analyzed to be used effectively.
- Pandemic preparedness and clear planning mechanisms need to be improved and streamlined, as soon as possible, so services are not disrupted and team dynamics are not negatively affected. Also, it is important to always engage with the front-line service people in the trenches, to inform decision making at senior and executive levels.
- It is important to use a Social Determinants of Health (SDH) lens to understand the clinical manifestations/symptoms of illness and disease, which have roots in intergenerational trauma. Social determinants such as housing are a very high priority (including housing shortages, housing instability, unsuitable/unsafe housing without adaptive equipment). The CHP needs to focus on providing the required resources, adaptive equipment and how to properly set up homes (e.g. beds, ramps, accessible and safe showers/tubs, stairs, linens, PKs, snow removal, lack of phones/internet). Food security and proper nutrition, particularly for vulnerable populations and families, also require attention.
- The community needs new comprehensive models of care to meet present needs that are overlooked or neglected, such as shelters, drug addictions centers, detox beds, temporary women's and Elders shelter for domestic abuse. Elder abuse is presently not being addressed well.
- The CHP priorities are all related, but in the 2012-2022 plan there was little attention in terms of how to connect those domains, and how they are interrelated. They all go back to Social Determinants of Health, which can be used as the overarching framework for all the health priorities. Furthermore, the CHP needs to be person-oriented, with a focus on upstream prevention and SDH, and not just tackling the symptoms.

5.14 Turtle Bay Elders Lodge (TBEL)

Highlights

- CHP health priorities: Cross-cutting.
- A case study of exemplary teamwork during the pandemic. In response to the pandemic pressures, the team self-organized and worked collaboratively to develop mechanisms for multidisciplinary teamwork, communication and coordination. Regular individualized integrated service plan (ISP) meetings were conducted, involving clients, families, caregivers and all relevant staff and support workers.
- Rather than hierarchy, the team focuses on working to maximum scope of practice. Meetings are high task, low maintenance, and focus on what needs to be done urgently. Team members leave meetings with clear plans and functions/task lists that must be conducted.
- Care encompasses both clinical and psychosocial orientations, with special attention to isolation and loneliness, mental health and social needs. The team leverages talking circles with residents, to promote engagement, and to identify, discuss and address psychosocial needs.
- There are significant structural limitations and design issues with TBEL as a facility. For example, there is no adaptive bathroom, no handicap accessible bathrooms, and areas of Lodge also not easily accessible for clients with disabilities. It is also perceived that there is a need to expand the facility, to accommodate large numbers of people who are predicted to need the service, in the near future.
- Some team members are not comfortable working with complex clients (e.g. with significant mental health issues and concurrent disorders), and lack the necessary training, background and/or experience to address complex health needs.
- TBEL is also affected by gaps in services for issues relating to homelessness, housing instability, social crises, abuse and those requiring intermediate care (i.e. care for individuals who are too complex for home care, the ILC or TBEL, but do not require the intensity of service at long-term care). TBEL has also functioned as intermediate care for clients with higher needs who can not live autonomously; however, this is outside of its mandate, driven by a lack of beds for that level of care in the community or surrounding institutions.
- The pandemic had a particularly severe impact on the isolated frail elderly, and the providers caring for them. The resilience of the team must be recognized. The burnout and trauma of everyone affected requires a healing journey.

Overview

The Turtle Bay Elders Lodge (TBEL) is a residential Elders institution, providing health and social care supports to enable Elders to live semi-autonomously within a salutogenic community-based environment. TBEL has 25 beds, including several extended care rooms with extended care beds for those who require additional care. Most rooms are equipped with a kitchenette, private bath and access to a garden space and gazebo. An interprofessional team, comprised of nurses (including mental health nurses), home health aides (PABs), food services staff, case workers, social workers, maintenance and security staff provide TBEL residents with team-based care and supports.

Team-based service delivery model

The service delivery model at TBEL is underpinned by a multidisciplinary team-based case management approach. In response to the pandemic pressures, the entire team self-organized and worked collaboratively to develop mechanisms for teamwork, communication and coordination. Regular individualized and integrated service plan (ISP) meetings were conducted, involving clients, families, caregivers and all relevant staff and support workers.

This approach represented a major advance towards improving team-based care. In the past, the team was relatively siloed and hierarchically organized based on professional or disciplinary background (e.g. medical vs psychosocial models). Team meetings were generally not inclusive, and did use a multidisciplinary approach. Due to the pandemic pressures and short-staffing, the team self-organized to ensure that all members maximally contributed to the limits of their scope of practice – even exceeding respective job descriptions, within safe parameters.

The team feels accountable for the wellbeing and health of the residents. Therefore, to avoid delays to care, staff were proactive and collaborative. For example, while the team were waiting for an ISP meeting, they would step into whatever role was necessary (e.g. clinical, social, housekeeping, domestic services), to ensure that care was safely and properly provided, and that needs were addressed.

Team meetings were organized to be "high task – low maintenance", focusing on important tasks and functions that needed to be done urgently. Team meetings were self-directed, productive and focused on problem-solving. The team was agile and problem-oriented, focused on developing effective and efficient solutions without delays. During meetings, everyone was on the same page – focusing on wholistically identifying and assessing the health and wellbeing needs of the client, and collaboratively developing clear plans of action outlining required tasks, functions and responsibilities.

By removing professional hierarchies, each team member's disciplinary perspective and contribution was valued, and team members worked maximally to their scope of practice. This includes incorporating the perspectives of food services, which has valuable insights into the

dietary and eating habits of residents, to help identify clients at risk. Therefore, every disciplinary and professional area was engaged and involved. The team respected everyone's respective roles and expertise, and adapted quickly to changing situations.

The team developed clear accountability and follow-up mechanisms. Responsibilities were delegated based on consensus, and every two weeks, updates are given and notes are shared. Communication was always ongoing between the teams, as evident by shared email threads.

The multidisciplinary approach ensured that both clinical and psychosocial orientations were incorporated, with special attention to isolation, loneliness, mental health and the social needs of clients as human beings. The team arranged talking circles with residents, to promote engagement and to identify, discuss and address psychosocial needs.

Communication, collaboration and coordination

TBEL's strengths stem from its experienced multidisciplinary team, and their corporate knowledge and nuanced understanding of the community. It is important that senior management and executive levels regularly engage with, and seek the advice of this front-line group of experts – particularly in relation to informing planning and decision-making processes.

The issue of proper communication and responsiveness to information requests between home health aides and nursing needs to be addressed. There were perceptions that information was not always being promptly shared, for privacy considerations (refer to Section 5.13). The management team agrees that all front line team members should share information, as required and necessary.

Staff do have access to MYLE EMR or Penelope case management systems, so they can view intakes, who the assigned case worker is, ID numbers, assessments and care plans. However, the lack of interoperability between the systems is a barrier to effective and efficient communication and coordination.

Family and caregiver engagement

Family engagement and involvement is often difficult, particularly in relation to sharing responsibility (even when signing an OMEC/Evolutive). The team perceives that it is important to leverage traditional values, particularly in relation to caring for family members – especially Elders. Another issue that arises is that Elders often do not want to burden or bother their families, which limits the ability to engage with them. Other times, there are burned bridges and dysfunctional families.

The team plans to develop a "how to guide" for family members of residents, that will outline and clarify their respective roles and how they can meaningfully contribute and engage.

Pre-pandemic, TBEL used to arrange family days with BBQs. The team plan to resume these activities, to enable staff to engage and get to know the families.

Evaluation, performance assessment and quality improvement

TBEL requires further resources and attention to evaluation, as an organization. Staff are busy with operations and delivering care; therefore, there is little time for self-reflection, evaluation or quality improvement.

Presently, the team leverages several approaches to evaluation:

- Team members review charts, records and notes, to ensure that functions (e.g. intake, assessments, service plans) are complete, and to ensure all goals are being addressed and met.
- Team members leverage feedback from residents, family members, and other team members and organizations (e.g. hospitals), to evaluate performance. This encompasses both positive and negative feedback.
- Resident participation rates in activities are noted (e.g. attendance of cultural or art events), to ensure residents are engaged and active.

The KMHC Home Care Nursing team also leverages the following approaches to evaluation and quality improvement (QI):

- KMHC's Quality Improvement, Risk Management and Innovation team supports the nursing team with accreditation functions and audits, enabling alignment with best practices, and to attain the highest benchmarks.
- Accreditation encompasses client and family feedback, which provides valuable insights into their respective experiences.
- Filling incident reports (IRs), and analyzing IR data to enable quality improvement (QI) functions.

Organizational and service delivery challenge

There are significant structural limitations and design issues with TBEL as a facility. For example, there is no adaptive bathroom, no handicap accessible bathrooms, and areas of Lodge also not easily accessible for clients with disabilities.

Financially, TBEL needs to carefully allocate funding and manage its budget to remain solvent. Human resources, maintenance, renovations, and equipment are costly. It is perceived that there is a need to expand the facility, to accommodate large numbers of people who are predicted to need the service, in the near future. Presently, the team is strategic and creative, to overcome limitations and barriers.

Some team members are not comfortable working with complex clients (e.g. with significant mental health issues and concurrent disorders), and lack the necessary training, background and/or experience to address complex health needs.

TBEL is also affected by gaps in services for issues relating to homelessness, housing instability, social crises, abuse and those requiring intermediate care (i.e. care for individuals who are too complex for home care, the ILC or TBEL, but do not require the intensity of service at long-term care). In the past, TBEL has functioned as a shelter for community members experiencing homelessness, though it does not have a mandate to address housing issues, and also had a social bed for crisis situations (e.g. abuse, not just for Elders). TBEL has also functioned as intermediate care for clients with higher needs who can not live autonomously; however, this

is outside of its mandate, driven by a lack of beds for that level of care in the community or surrounding institutions.

Furthermore, it is important to note that existing residents of TBEL experience significant declines in health and wellbeing status over time (e.g. cognitive and functional decline, and increasing frailty). TBEL is their home, and staying there as long as possible, with support, is important. However, once these residents become too complex, there are limited options in the community for their care.

The absence of intermediate care models in the community is problematic, and has resulted in TBEL having to accept and care for individuals who do not fit their mandate. Although there is an admissions process with criteria, the admissions committee is often presented with applications with very limited information. In some cases, information regarding the complexity of the client is actually withheld. Furthermore, there is a very high need in the community, with a long wait list; therefore, with limited information, it is difficult to make informed decisions on who to admit.

Due to the significant need of individuals and families, TBEL often has to admit individuals who do not fit the mandate of the organization, resulting in scope creep, and potentially compromising the safety of residents and staff. The sustainability of TBEL's service delivery model is therefore at risk, as needs are only increasing. In the interim, the team has to prioritize its tasks. The present situation is unsustainable, since a few people in Lodge are very high risk and not independent, requiring 24/7 care and ongoing security presence. Furthermore, if a client becomes palliative, TBEL has to provide that service, since Lodge is their home. Due to increased complexity and intensity of needs, and insufficient staffing ratios, there is a risk of serious accidents for both staff and clients.

Culture and language

For the TBEL team, culture and language are not subjects, but ways of life. The staff have significant experience with the community, and are all dedicated to the community, culture and language. The staff recognize that know Kanien'kéha language is so precious, so when they conduct activities, they often incorporate language and culture. When there was no pandemic, the children from the school would do an exchange, where they would talk to the Elders – the team are looking to restart this.

KMCH Traditional Medicine and KSCS Tsi Niionkwarihò:ten are involved and consulted, and residents have access to the Language And Culture Coordinator. The community garden is leveraged, for tobacco and ceremony such as tobacco burning, and the Lodge participates in festivals (e.g. the strawberry and harvest festivals) and in songs and dancing. The Lodge has lots of books and materials in Kanien'kéha, and support activities such as crafts (e.g. beadwork, beaded birds) and host guest speakers.

Many language and culture activities and initiatives got interrupted by the pandemic, which is planned to resume soon. Staff were taking community language classes, with the intention to use the language in the workplace.

Program-specific CHP input

- It is important to address the need for intermediate care models in the community (i.e. the gap between home care, TBEL, the ILC and long-term care). It is also important seriously assess the need for foster homes for Elders in the community.
- Along with (or even before) a CHP, an Employee Health and Wellbeing Plan is needed. A healthy and happy care provider is needed, for high quality and humanistic care to be provided.
- Practical initiatives and investments that allocate resources to the programs delivering person-oriented care for complex populations are needed. This includes supports to recruitment, retention, training, staff wellbeing, and a community human resource development strategy.
- The CHP also needs to look at what is working well, and not just problems, and to build on successes and strengths. It should not just take a deficits approach, but rather an assets-based and salutogenic approach. This means recognizing, identifying and supporting what works, rather than reinventing the wheel.

5.15 Tehsakotitsén:tha Short Term Care (KMHC)

Highlights

- CHP health priorities: Cross-cutting.
- A high performing multidisciplinary and multi-professional team providing Short Term Care (STC) services to the community, across a range of functions including post-surgery recovery and convalescence, palliative care, pain management and medication management.
- Processes (e.g. wait list, admissions, care planning, discharge) are well established and under continuous review. Decision-making processes are multidisciplinary team-based, and involve the client and family/caregivers (when possible).
- Strong working collaboration with other programs - especially home and community care, TBEL and LTC - to ensure seamless client experiences.
- Strong basis of audits, quality assurance and risk management, with an increasing focus on evaluation and continuous quality improvement.
- Actively working to expand scope of services and staff competencies to encompass mental health and substance use, and to support other parts of the system (e.g. outpatient care, hospitals).

Overview

Short-Term Care (STC) is a subdivision of Inpatient Care Services at Tehsakotitsén:tha Kateri Memorial Hospital Center (KMHC). The STC program aims to provide the highest level of care using a multidisciplinary team-based approach. The program offers a comprehensive range of short-term care services, including post-surgery recovery and convalescence, pain management, palliative care and medication management. The program focuses on the treatment of acute medical conditions, healing, discharge planning and enabling a return to autonomous, independent living.

Figure 4: Tehsakotitsén:tha Kateri Memorial Hospital Center (KMHC)

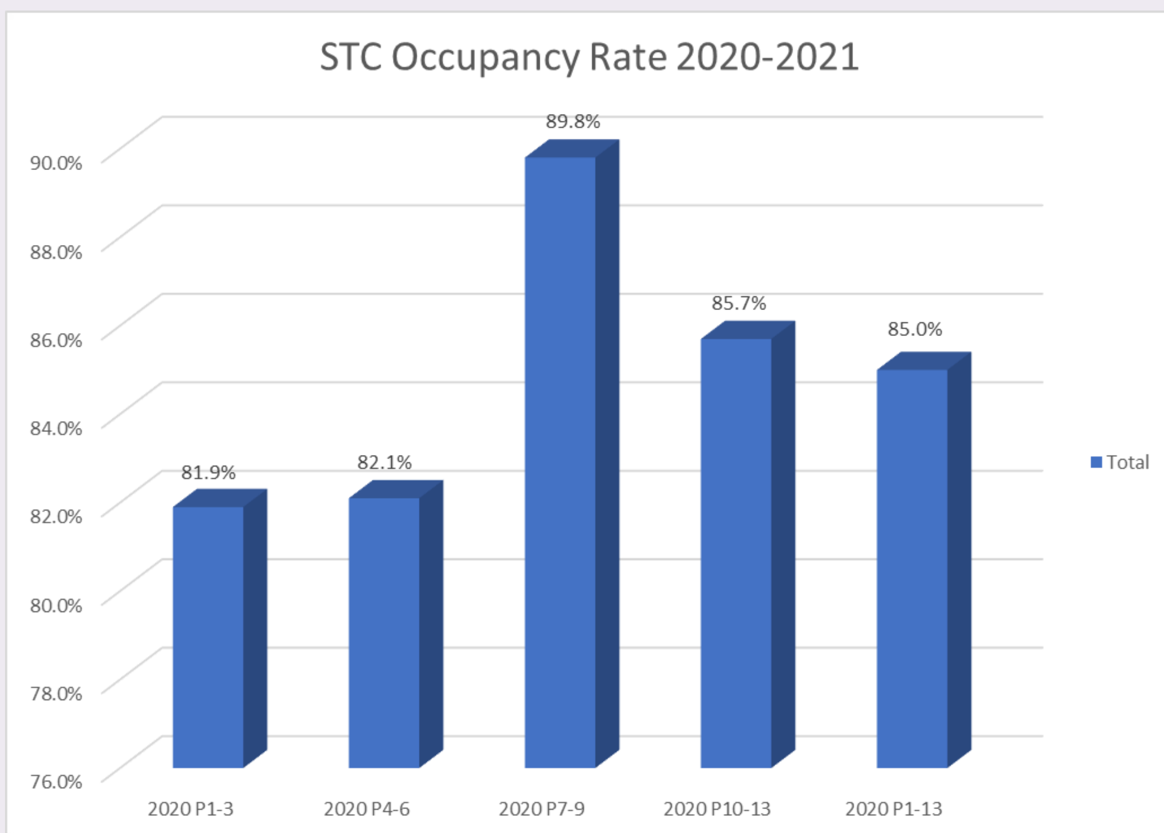
Team-based service delivery model

The Short Term Care (STC) program aims provide the highest level of care using a multidisciplinary approach. The program presently has 10 beds, with plans to increase to 15 in the future. Services for STC clients are directed towards treatment of acute medical conditions, medication management/adjustment, end of life care and discharge planning; whether it be to their home, to Turtle Bay Elder's Lodge (TBEL) or to Long Term Care (LTC) placement at Kateri Memorial Hospital Centre (KMHC). Decisions are based on assessments and discussions with the client, their families and the multidisciplinary team.

Descriptive statistics: Short term care (2020-21)

- Admissions: 31
- Discharges: 33 (13 who were admitted to STC were discharged to home or to the Elder's Lodge; 2 clients signed out against medical advice; 12 admissions to STC were discharged and readmitted to LTC; 1 client was discharged to another hospital)
- Deaths: 5

Chart 8: STC occupancy rate statistics 2020-2021



Note: Loss of autonomy (LoA) and the need for a geriatric assessment account for higher lengths of stay in STC.`

The team is comprised of 20 permanent employees, 13 of which are Kahnawa'kehró:non. The team includes 8 Registered Nurses (RNs), 5 PABs, 2 Ward Clerks (who also assist with admissions, intake and discharge), a Social Worker, a Volunteer Coordinator, a Physiotherapist (PT) and an Occupational Therapist (OT), and has continuous access to physicians. Staff are also shared with KMHC's LTC program, including speech and language therapy and nutritionists.

RNs are responsible to update the PAB care plans based on the Therapeutic Nursing Plans, and in collaboration with the PABs. The communication between the RNs and the PABs is open and honest, as each respect the role of the other. The STC RNs and the PABs have an excellent working relationship in which they communicate well with each other and work well together in order to provide the highest quality of care to the clients.

Social Work also support the completion of assessments (e.g. OMECs and/or Evolutives), to assess client needs upon admission. In 2020/21, 68% of admissions had an OMEC and/or Evolutives completed.

KMHC's Social Service Program provides support and counselling to STC clients and their families, with social workers acting as liaisons for clients. In 2020/21, the Social Service for STC had 31 newly admitted clients, and the Social Worker had a total of 800 interventions (a 23% increase over the previous year) .

The Volunteer Program also provides effective and efficient involvement of the volunteers to complement the STC program's services. However, for 2020/21, the volunteer program was not functional due to the pandemic. The volunteer coordinator was re-assigned to work with the activity staff on a designated unit and to provide one on one social visits to clients under isolation.

The STC team is actively working towards increasing the scope of the service, to encompass mental health, addictions, and to support other parts of KMHC, particularly the Outpatient Clinic. The STC program has been offering services for clients with mental health problems, working with the Douglas Mental Health Institute for evaluations and medication adjustments.

Key functions, such as wait list management, intake, care planning, medication reconciliation and discharge are generally standardized, and continuously improving.

Wait list and admissions processes are well designed, and continue to be developed and optimized. There is careful follow-up every week to identify and assess who needs a bed, and who was ready to be admitted. Working closely, the management team assesses needs updates the short-stay wait list and links to the admissions process.

Discharge processes are well designed, and continue to be optimized. A multi-disciplinary team-based approach to discharge is used. Discharge meetings take place with clients, family, Home Care Nursing and the STC multidisciplinary team in order to plan for a safe discharge home.

In 2020/21, 64% (18/28) patients who were discharged from KMHC had a discharge meeting prior to their discharge date. The team also conducts weekly multidisciplinary meetings (including the nurse, social worker, dietician, OT and PT) to discuss the status of patients, their plans, progress to date, and possibilities for discharge. This is followed by setting up meetings with families and necessary services (e.g. home care), to arrange services and plans for safe discharge.

Communication, collaboration and coordination:

The STC program's key functions (e.g. intake, admissions, medication reconciliation, care planning and discharge) require high levels of inter- and intra- organizational communication, collaboration and coordination.

Internally, the team's communication (particularly between RNs and PABs) is strong, and the team uses a collaborative approach to care planning that values all disciplinary and professional perspectives.

The wait list management and admissions processes requires high levels of coordination. The team closely with home care clients, the home care team and caregivers to assess needs and prioritize clients for admission. The team also works closely with hospitals (e.g. Anna Laberge), and the STC team's physicians work closely with the hospital physicians to decide on admissions, and to ensure needs can be addressed.

There are sometimes challenges with coordination with admissions from home care nursing due to the EMR, particularly because the paper form that was used (for content like general health status, patient details, medications, blood tests, lab results, etc.) have not been transferred over to MYLE EMR. For now, it is recommended to return to the paper format of the form until the form is digitized and integrated into MYLE.

Admissions from other facilities (e.g. from outside the community) require high levels of coordination. Often, there are challenges with information gaps regarding the health status and medical information of the patient. Facilities are asked to fax over a document which provides the main types of information that is required; however, this process needs to be strengthened.

The STC team has also been working in close coordination with the Douglas Mental Health Institute for evaluations and medication adjustments, for patients with mental health issues.

The team would like to increase collaboration with the KMHC Outpatient clinic and hospitals (e.g. Anna Laberge and Jewish hospitals), to enable patients to directly access short-term care if required, and to offload stress from the rest of the system. This would offer a safer and more effective step-down service, rather than having patients directly discharged home without the care they require.

Discharge processes are collaborative, with a strong focus on coordination to ensure patient safety and continuity of care. The team conducts weekly multidisciplinary meetings, to discuss the status of patients, their plans, progress to date, and possibilities for discharge. For patients that can be discharged, meetings are set up with the relevant step-down services (e.g. home care, Elders Lodge) and families/caregivers, to set up services and plans for discharge, including transport.

Discharges or transfers to KMHC LTC are generally well organized, with the teams ensuring smooth transitions and transfer of information/data. The STC program has developed a transfer of care form for clients who are discharged from STC and are to be admitted to LTC. Along with using the form at the discharge meetings, STC invites the LTC Social worker and the Team Leader to the STC discharge meeting prior to admission to LTC. Gaps still exist, which are being addressed using huddles and team meetings.

The STC team also maintains close communication with home care nursing using MYLE EMR, and collaborates with KMHC's Traditional Medicine program and community-based faith services, particularly for the spiritual needs of palliative/end-of-life patients.

A significant challenge relating to collaboration and coordination, is that many health and social care organizations both within and external to Kahnawà:ke (particularly hospitals) do not have a clear idea of STC's mandate, model of care, scope of service or its admissions criteria and processes. Often, the program is confused for LTC or rehabilitation. The program is planning to work with KMHC's communications team to develop a short video tour of the unit, explaining what the unit does as well as the admissions process. It may also be beneficial to incorporate actual tours of the facility, and to arrange meetings of external stakeholders with the team, during tours.

Family engagement

Through family meetings and the involvement of the STC multidisciplinary team there is an increased awareness of how the program works, and the role of services in providing safe, effective and timely care.

In order to maintain client and family centered care as well as keeping in mind the restrictions on visitation during the pandemic, STC reached out to the families with weekly updates and with assisting clients connect to FaceTime in order to see their love ones.

Patient, family and caregiver experience

KMHC's Quality Improvement, Risk Management and Innovation (QIRMI) team had developed a client experience survey, which encompassed the major components/aspects of care, including palliative care. This was distributed in a sensitive manner, with a prepaid envelope for families to return the survey from the comfort of their home, and at their own time.

The client experience survey (Appendix section 8: STC client experience survey) encompasses various aspects of care during short stays, with a special section for palliative care (i.e. responsiveness to needs, comfort, communication, overall experience, etc). The QIRMI team assesses the feedback and provides "grades", which are returned to the team, which then proceeds with quality improvement work.

Evaluation, performance assessment and quality improvement

Performance appraisals of staff and management are conducted, to identify strengths as well as areas for improvement. 85% of the STC staff had performance appraisals completed in 2020/21.

The STC program conducts systematic and regular incident reports (IRs) and audits (Appendix section 9: STC audit forms), encompassing important domains of care and quality, including:

- Quarterly audits for medication reconciliation, as well as upon admission and discharge.
- Identification bracelet audits.
- Allergy bracelet audits.
- Environmental audits (e.g. walking aids by bedsides).
- The QI team provides assessments of results, as well as a grid that the team uses to assess performance and perform QI work.

The STC program collects, reports and uses key statistics for ongoing quality improvement (QI), including:

- Assessment and care plan statistics (e.g. % of patients with completed OMECs, evolutives)
- Social service program indicators (e.g. total number of interventions and # minutes spent)
- Inpatient activity program (participation and time spent)
- Volunteer program stats
- Client experience statistics (from the client experience survey, described in the section above)
- Risk statistics:
    - Medication errors, by type and year
    - Medication omissions reported
    - Dose/rate incidents reported
    - Medication events on time of administration
    - Falls, by type
    - Occupancy rates
    - Admissions, discharges (and location) and deaths.
- CliniBase software is also used to monitor and assess performance indicators such as admissions, length of stay (LOS), and discharges.

Accreditation is conducted every four years is performed, with the support of KMHC's QIRMI team. The STC team meets regularly to ensure that accreditation standards are continuously adhered to.

Team feedback is elicited during the multidisciplinary meeting discussions, as well as emails, and are largely informal in nature. The team is looking to formalize and structure the process, and incorporate team feedback as a core component of future team huddles.

The STC team also continuously participates in educational and training activities to improve competency, knowledge and quality of care:

- Palliative and End of Life Care
- Advanced Palliative and End of Life Care
- Évaluation et approche clinique de la maladie de Parkinson
- K-GEM, Kanien'kehá:ka Growth and Empowerment Measure
- LTC Cultural Change
- Alzheimer Communication with Teepa Snow
- Aging with Rights Ending Elders Abuse in Canada
- Développer des plans de traitement créatifs et innovateurs avec vos patients en perte d' équilibre et troubles neurologique

Data systems

MYLE EMR has been implemented as part of a pilot project; therefore, the team has been providing input and feedback regarding its functionality and performance. Presently, there are issues with some of the modules such as the prescribing module, as well as challenges with reviewing progress notes. Furthermore, there is inconsistency between staff members across teams, in terms of how they use MYLE to communicate. Therefore, the team still relies on phone calls and emails. However, there are very positive aspects to the EMR as well, in terms of accessibility of data and improving standards of care.

Issues relating to MYLE functionality and use are addressed as they come up, and the company Medfar Solutions is working closely with KMHC on a continuous basis to improve on the use of the software for a 24-hour service. An audit is planned to take place at the beginning of the new fiscal year in order to receive feedback from the nurses and the other professional disciplines who use MYLE. The implementation of MYLE in STC was well received by the multidisciplinary team and with concerns being addressed as they arise, the use of an EMR can prove to be a safe and effective tool to enable quality of care.

Organizational and service delivery challenges

The STC program experiences some resource constraints, particularly in relation to equipment such as missing beds (or beds taken to serve LTC). Further ceiling lifts are needed, to ensure the safety of both clients and residents.

Recruitment and retention are challenges, particularly in relation to nursing. The team considered including LPNs, but that would require RN oversight and presents limitations. It is recommended that more should be done in relation to promoting awareness of what KMHC is across the region, and to engage with students who are close to graduation.

The hiring of new physicians to work in STC and the changes in the way the physicians would do rounds were met with challenges, and required an adjustment period, as each physician had their own ideas as to how things should work.

Culture and language

All agendas, minutes of meetings and memos are written with the date and greetings in Kanien'kéha Signs on the units are written in Kanien'kéha.to identify the areas. Staff members are also encouraged to attend cultural activities, and the monthly Tobacco Ceremonies.

Program-specific CHP input/recommendations

There is a gap for patients who don't have a family physician (i.e. unattached/unregistered to primary care), who are accessing the outpatient clinic. For some of those clients who require supports, short-term care can address their medical issues (e.g. supporting patients requiring medication adjustments).

Short-term care is looking to expand its scope and capacity, to support other parts of the system such as the outpatient departments, hospitals and addictions services. The team is also keen on exploring addictions training, to provide supports for that population if possible.

The short-term care unit will continue to support LTC, and to support families that are burned out.

5.16 Tehsakotitsén:tha Long-Term Care (KMHC)

Highlights

- CHP health priorities: Cross-cutting.
- A multidisciplinary client-oriented program that strives to mimic home conditions and lifestyle, to ensure comfort and well-being of residents.
- Comprehensive individualized clinical and psychosocial services, including wound care, palliative care, medication management, recreation, day programs. Various standardized assessments are conducted by the multidisciplinary team, including skin assessments, falls risk assessments, ADLs/function, diet, medication reconciliation.
- Excellent communication and collaboration with home and community care and short-term care, resulting in smooth transitions for long-term care clients upon admission. Close collaboration with other programs and services, such as Traditional Medicine and Assisted Living Services.
- The LTC program, with the support of KMHC's Quality Improvement, Risk Management & Innovation (QIRMI) team, conduct a large range of audit, risk management, safety and quality improvement activities.
- Staffing continues to be an issue, with difficulties to fill open postings. There are also multiple staff on sick leaves, which affects operations. Although there were many postings and active recruitment, all the positions needed in order to open the remaining LTC beds were not filled.

Overview

Long Term Care (LTC) is a subdivision of Inpatient Care Services at Tehsakotitsén:tha Kateri Memorial Hospital Center (KMHC). The mission and philosophy of LTC is to provide the highest level of care to residents, using a multidisciplinary approach.

The services that are available to LTC residents include: nursing (RNs, LPNs, nursing aides), physiotherapy (PT), occupational therapy (OT), nutrition, palliative care, respite care, speech language pathology, traditional counselling, recreation therapy and social services. The multidisciplinary team works collaboratively with residents and their families, to develop truly Individualized Care Plans (ICPs). Care plans are developed and followed to enhance the residents stay at KMHC while focusing on autonomy, dignity and comfort.

Descriptive statistics – Long term care (2020/21)

- Admissions: 11 (from KMHC Short term care; no admissions directly from home)
- Respite admissions: 16
- Deaths: 11 (10 at KMHC, 1 at a hospital)

Team-based service delivery model

LTC is able to accommodate and care for 47 residents and one respite client at full capacity, and will be increasing its capacity to 58 beds after the expansion is complete. The services that are available to LTC residents include; nursing (RNs, LPNs and nursing aides), physiotherapy (PT), occupational therapy (OT), nutrition, speech language pathology, traditional counselling, recreation therapy and social services. There has also been an increase in availability from 2 LTC physicians, allowing for better coverage and increased continuity of care for our residents.

There are approximately 81 employees that work in Inpatient Care, 37 of whom are Kahnawakehró:non. The multidisciplinary team composition includes: one nurse manager, one team leader, 13 RNs, 11 LPNs, 40 PABs, 2 ward clerks, one social worker, one recreation therapist, 4 activity workers, an administrative assistant, a physiotherapist (PT), an occupational therapist (OT), a speech language therapist, a physical rehabilitation therapist, TRPs (thérapeutes en réadaptation physique, a rehab assistant and a nutritionist.

The restructuring of services at KMHC (i.e. the separation of Inpatient Care Services into STC and LTC programs) was done to ensure that there are multidisciplinary teams dedicated to every service area. For LTC this showed an obvious benefit as the participation of professionals at Individualized Care Plan (ICP) meetings increased, and the wait time decreased after referrals were sent. Furthermore, there has been a marked increase in activities on evenings, weekends and holidays, a decrease in wait time when consulting the multidisciplinary team, and an improvement in the ability of the team to meet with residents and families on a regular basis.

The Life History for the Long Term Care Admissions form is used to reflect on who the person was during their lifetime (e.g. their occupation, family status, interests, hobbies, etc). Having the residents/families meet with staff to fill out this paper, it provides an opening for communication between the resident and the staff, once completed it would be kept in the bedroom of each resident.

Figure 5: Long term care welcome package

Medication Reconciliation is conducted on admission to LTC and upon return of residents from other institutions. LTC continues to be successful with Medication Reconciliation; however, it may become a challenge when there is more LTC residents being admitted from home rather than STC.

Various standardized assessments are conducted by the multidisciplinary team upon admission, and are updated annually or when there are changes in resident health status. Assessments include (but are not limited to), OMECs, evolutives, wound and skin assessments, falls risk assessments, function and Activities of Daily Living (ADLs), and diet. Results are brought forward and discussed during team meetings, and inform the development and/or updating of ICPs.

The multidisciplinary team works together with the resident and their families to find what is uniquely meaningful to each resident in order to develop Individualized Care Plans (ICPs). Care plans are developed and followed to enhance the residents stay at KMHC while focusing on autonomy, dignity and comfort. Clients are regularly asked if their needs are being met, and if there were any gaps or issues in relation to the services provided.

Advanced Care Planning (e.g. updated Levels of Care forms) is conducted with the physicians, residents and families. LTC also has a medication management program, which is a collaboration between the pharmacists, physicians and Anna Laberge hospital. The LTC program also has arrangements with the foot care program at KMHC for weekly services.

Rehabilitation services, including physiotherapy (PT) and occupational therapy (OT) are integrated into LTC. The PT and OT are able to provide a comprehensive range of rehabilitation services, including working with clients with chronic pain, and to address the prevention and treatment of pressure sores.

The palliative care team is always striving to stay up to date to with current practices and to offer the best quality of care to LTC residents. KMHC has develop a great partnership with schools, such as John Abbott College, who will provide a training on Advanced Concepts and Principles in Palliative Care to KMHC Inpatient and Homecare nurses.

The dietician and speech and language therapist are engaged to discuss risk situations and coordinate plans for specific residents at risk, and to update protocols such as that for dysphagia. The Speech Language Pathologist assessed 22 LTC residents in 2020/21. 28 swallowing evaluations were completed and 43 follow up re-assessments. Two residents were seen for speech and language issues post CVA or other condition. Other activities completed by the Speech Language pathologist were meeting with McGill professors to coordinate stage for Speech Language Pathology students, May Speech and Hearing Month activities for staff and meeting with dietary staff for a trial of new thickener.

The LTC social service program, staffed by social workers, provided services to fifty-eight Long Term Care residents; as compared to last year in where there were fifty-three. There were a total of 1,212 interventions for a total of 60,310 minutes. This has increased from last year as there has been more consistency with social workers this year. The social workers roles include, but are not limited to, arranging Individualized Care Plan (ICP) meetings with the residents/families, developing the care plans from the meetings, preparing assessments for the public curator as needed, updating the evolutives and OMECs for the residents and offering support to residents and their families.

The LTC Activity program hosted four festivals this past year; Mid-Winter, Maple, Strawberry and Harvest. Other activities that are hosted by activity staff are; singers, choirs, Irish dancers and pet therapy. The program provides activities on a daily basis which include; morning exercises, card games, bingo and memory word games. The residents are taken on outing trips which include but are not limited to shopping, bingo at the Golden Age Club and Turtle Bay Elder's Lodge, trips to the Marina, restaurants and apple picking. There was increase in the amount of participation from LTC residents this past fiscal year; this is due to the fact that there was an increase in the Activity program staffing. Two new activity aides started on January 27th, 2019 with the goal to increase activities on evenings, weekends and statutory holidays.

Table 12: Long term care residents (time and participation analysis for activities)

	2018/19	2019/20
Time (minutes)	805,342	1,045,590
Participation	9,218	10,662

Communication, collaboration and coordination

LTC has very strong communication and collaboration with home and community care (HCC), as well as Short-Term Care (STC), resulting in smooth transitions for long-term care clients upon admission (i.e. sharing of history, needs, medications, preferences, behavioral patterns, and contextual/family factors).

The LTC team collaborates closely with KSCS services, to provide respite care for home and community care clients and caregivers, and collaborates with KSCS Assisted Living Program for younger LTC clients (e.g. with developmental delays, Down Syndrome) who need to access the Young Adults Program (YAP). The LTC team also works closely with KMHC Traditional Medicine, to ensure residents have access to their services.

During the pandemic, to address staffing shortages, the LTC program collaborated various partners such as the Red Cross, as well as nursing staff from the Outpatient Department and from the Community Health Unit (CHU).

The LTC program encourages our staff to take an active part in the various committees within the hospital (e.g. Staff Health, Risk and Quality, Infection Prevention and Control, CPR, Fire and Safety, Pharmacology, Long Term Care Accreditation Team, Falls/Restraints, Information Management).

Client and family engagement

The LTC program has created a Welcome Package that is given to all new LTC residents and families. The booklet is beautifully designed and was admired by staff, residents and families. The package will continue to be distributed with additions and modifications made as needed.

LTC is always looking to increase resident and family involvement. Some ways that have been successful are through the Individualized Care Plan meetings (annually), inviting families to activity events and inviting a family member to sit on the LTC Accreditation Team.

Evaluation, performance assessment and quality improvement

The LTC program, often with the support of KMHC's Quality Improvement, Risk Management & Innovation (QIRMI) team, conduct a large range of quality improvement (QI) activities and initiatives, including:

- Medication reconciliation: Medication Reconciliation is being done on admission to LTC and upon return of our LTC residents from other institutions. LTC continues to be successful with Medication Reconciliation; however, it may become a challenge when there is more LTC residents being admitted from home rather than STC.
- Falls and restraints committee: The Falls Collaboration Committee and the Restraints committee continue to meet as concerns arise on an individual basis. Most of the meetings take place as team huddles rather than formal meetings. The huddles include physiotherapist, occupational therapist, Team Leader, Nurse Manager, PABs, and nurses. The team collaborates and puts in place a plan for the resident to meet their individual needs. This approach seems to be working to address the safety concerns for our residents in a timely manner. Families are also invited to attend these meetings for their input and feedback.
- Mistreatment prevention: The prevention of mistreatment continues to be a main quality improvement activity and a required organizational practice for Accreditation. Awareness of elder abuse is promoted on a yearly basis and staff are educated to report instances of abuse.
- CAP training: The manager of LTC is a CAP trainer, which is training on how to deal with disruptive and aggressive behaviors in residents. This is beneficial as education and huddles with staff can be held to discuss challenging behaviors in the residents admitted. The challenge is with manager being the trainer and time constraints. Because of time contraints, the full 2 day training was not given to staff this year. Having another trainer in LTC would be beneficial as there are many new staff who would benefit from this training.
- Treatment Administration Records.

The LTC program also collects, reports and uses statistics from its various service areas; for example:

- Admissions, discharges and deaths
- Social service / social worker program statistics (# of interventions and time spent)
- Activity program and recreation statistics
- Inpatient activity program
- Participation statistics re activity type and time spent
- Speech language pathology statistics re assessments and conditions.
- Risk situation and Incident Report (IR) statistics:
    - Medication events (errors and omissions) and consequences
    - Falls, severity
    - Admissions, discharge and death statistics
- Educational and training statistics for the multidisciplinary team

The LTC program also leverages participative observation and one-on-one conversations, to assess the state of services and observe resident participation and engagement in activities. The team receives and responds to emails and calls from families and caregivers, to discuss issues, and promptly responds to inquiries and complaints.

The management team engages with staff to discuss staff experiences and satisfaction, and to receive feedback, constructive criticism and suggestions. Performance appraisals are also periodically conducted for all staff.

The LTC team is interested in working with KMHC's QIRMI team, to restart conducting the resident and family experience and satisfaction surveys, including for palliative care

Organizational and service delivery challenges:

Staffing continues to be an issue as even with multiple postings there remain RN, PAB, LPN, OT and TRP positions that are not filled. There are also multiple staff on sick leaves, this is felt the most with nurses in Long Term Care. Although there were many postings and active recruitment, all the positions needed in order to open the final ten (10) LTC beds were not filled.

Activities need to be further increased during weekends and evenings, as residents do experience loneliness during those periods.

Choosing who would be a priority to admit to the new LTC beds proved to be a challenge as there were 40 clients waiting, 14 declared priority, with only ten new beds.

Culture and language

LTC continues to integrate Kanien'kehá:ka culture within Inpatient Care in various ways. Some examples include:

- Hand hygiene signs are written in Kanien'kéha
- April activities are centered on Cultural Awareness
- Staff members are encouraged to attend the Monthly Tobacco Burning Ceremonies
- Every Friday morning, Kanien'kéha language classes are held to teach staff members

KMHC has worked on protocols for a variety of situations to allow our patients/residents to be able to go with Tekanonhkwatsherane:ken (Two medicines working Side by Side) to cultural and traditional health appointments at various locations within Kahnawà:ke for healing purposes.

To continue to support integrating Kanien'kehá:ka culture within Inpatient Care the following has been instituted:

- Upon entering the two Long Term Care units there are stop signs placed at the elevators encouraging everyone to wash their hands written in Kanien'kéha.
- All agendas, minutes of meetings and memos are written with the date and greetings in Kanien'kéha.
- Staff members are encouraged to attend the Monthly Tobacco Burnings.

- Staff members are encouraged to attend various presentations, festivals and workshops that are offered.
- Three staff members attend weekly sessions with Calvin Jacobs.
- Festivals are help with the activity staff for residents and staff are encouraged to attend and participate.
- Signs on the units are written in Kanien’kéha.to identify the areas.
- Two Long Term Care staff members area attending Kanien’keha classes in spots designated for Kateri Memorial Hospital.

Program-specific CHP input/recommendations

There is a need for an intermediate model of care, between home care and long-term care (e.g. a 24 hour support service, perhaps mainly staffed by PABs). There is a long wait list for LTC; however, many people do not need to be in long-term care if an intermediate model of care is available to meet their needs.

5.17 Tehsakotitsén:tha Outpatient Clinic Services (KMHC)

Highlights

- CHP health priorities: Cross-cutting.
- The Outpatient Clinic provides a comprehensive range of team-based outpatient care services, encompassing primary care, ophthalmology, pediatrics, nursing, laboratory nurses, laboratory support staff, pharmacy and dentistry.
- Wellness nurses provide comprehensive and longitudinal chronic disease management and medication management for a range of conditions, including diabetes, hypertension, cardiac conditions and chronic obstructive pulmonary disease (COPD). The nursing team works closely with mental health nurses, who act as a liaison with family medicine and psychiatry, to provide comprehensive care and supports for clients with persistent and severe mental illness.
- The Outpatient Clinic conducts ongoing quality activities, particularly in relation to its nursing and laboratory services.
- The Outpatient Clinic experiences issues associated with short-staffing, and challenges with recruitment. It has been very challenging to recruit and retain full-time professional staff from most disciplines, particularly nursing. For example, primary care is encountering challenges, primarily due to staff shortages. The after-hours and weekend clinic offerings are limited, and there are many community members who are currently not registered to a family physician.
- The performance of primary care services can potentially be improved by delegation of non-clinical tasks and responsibilities to non-clinical and administrative support staff, if they develop the competencies and abilities to effectively conduct these tasks. This would enable clinical teams (e.g. physicians, nurses) to generate efficiencies, and to focus on essential clinical functions and quality of care.

Overview

The mission of Tehsakotitsén:tha Kateri Memorial Hospital Centre’s (KMHC) Outpatient Clinic is to provide safe, wholistic, family centered, primary and preventive care for clients. The Outpatient Clinic provides professional and auxiliary services to meet the ambulatory needs of the community, encouraging respect, pride and professionalism from all staff members

The services are part of an expansive program, encompassing primary care, ophthalmology, pediatrics, nursing, laboratory nurses, pharmacy and dentistry. The clinic provides a comprehensive range of services relating to Community Health Plan (CHP) priorities, particularly in relation to chronic disease management and medication management.

Figure 6: Artwork at KMHC, commissioned by local artists (24).

Team-based service delivery models

The Outpatient Clinic provides a comprehensive range of team-based outpatient care services, encompassing primary care, ophthalmology, pediatrics, nursing, laboratory nurses, laboratory support staff, pharmacy and dentistry.

Wellness nurses provide comprehensive and longitudinal chronic disease management and medication management for a range of conditions, including diabetes, hypertension, cardiac conditions (e.g. coronary artery disease) and chronic obstructive pulmonary disease (COPD). The nursing team works closely with mental health nurses, who act as a liaison with family medicine and psychiatry, to provide comprehensive care and supports for clients with persistent and severe mental illness.

Pharmacists also have an increasing role in light of the physician shortage, and are able to renew medications, order blood tests, conduct follow-ups and help manage patients with chronic conditions such as diabetes, hypertension and renal disorders.

The community has access to specialized services such as pediatrics and pediatric assessments on-site (for complex cases such as neural deficits, ADHD, autism), as well as access to optometry (diabetic eye screening funded via CHPI Aboriginal Diabetes Initiative) and ophthalmology. The ophthalmologist has expertise in pediatric ophthalmology, thereby providing comprehensive assessments for children. Dentistry is offered on-site once a week – providing exams, cleaning, X-rays, and general dental services covered by NIHB (although NIHB funding is restrictive on crowns, root canals and orthodontics referrals).

Nine physicians offer comprehensive and longitudinal primary care services, which are provincially funded services. Primary Care Services has worked on active recruitment and retention strategies; therefore, in the past 5 years, there have been significant increases in physician morning (+26%), afternoon (+28%) and evening (+32%) clinics. The nurses also provide comprehensive primary care services, including:

- clinical procedures (medication administration i.e. oral, injections, IV, aerosol; ear irrigation; dressings, etc)
- laboratory services (blood and urine tests, EKG, etc.), with specimens sent to Centre Hospitalier Anna Laberge for analysis
- chronic disease management

- medication management
- health education regarding acute and chronic conditions
- health/chronic disease monitoring (blood pressure, glucose, respiratory status monitoring)

Other programs and services such as the Community Health Unit (CHU), community outreach screening programs, social services and school youth clinics often refer clients to the Outpatient Clinic for a variety of primary care and chronic disease management services.

The Outpatient Clinic's primary care services also maintain a list of clients who are not registered to a primary care provider (i.e. "unattached" patients). Clients on the list are assigned a vulnerability code, which enables prioritization for attachment based on vulnerability and complexity.

Table 13: Physician visits in Outpatient Care (2019/20)

Period	Appointments	Patients	Regular visits	Emergency	Saturday clinic	Evening clinic	WBC	Phone consults
1	942	903	679	104	55	57	47	
2	984	932	688	114	56	77	49	
3	925	870	673	108	31	70	43	
4	789	752	533	101	38	69	48	
5	817	780	539	127	65	29	57	
6	945	904	681	125	29	57	55	
7	1013	953	725	112	46	87	43	
8	948	904	627	107	58	92	64	
9	869	831	593	103	70	60	43	
10	819	790	515	131	75	58	40	
11	925	888	644	110	55	59	57	
12	887	852	572	125	40	87	63	
13	682	668	406	84	34	44	32	80
Total	**11545**	**11027**	**7875**	**1451**	**652**	**846**	**641**	**80**

Communication, collaboration and coordination

Teamwork, communication, collaboration and coordination within and between the nursing and physician teams are very strong. For clients with persistent and severe mental illness, mental health nurses provide coordination of care, and act as a liaison with family medicine and psychiatry.

MYLE EMR has been a very effective tool in relation to enabling real-time communication and collaboration for the multidisciplinary team, supporting coordination of care for clients.

Furthermore, offsite team members, such as home care nursing, can access MYLE EMR, which has been very beneficial for teamwork, care planning, communication and efficiency.

The multidisciplinary team, including pharmacists, can access patient records via the Dossier Santé Québec (DSQ), to view updated content such as bloodwork, testing results, medications and vaccinations.

However, the sharing of information between KSCS and KMHC is limited, due to privacy and technical factors (i.e. MYLE EMR and Penelope case management systems are not interoperable). This is frustrating for teams from both organizations, and limits teamwork, coordination and shared care planning for complex clients using both services.

Client, family and caregiver experience

A patient experience survey has been developed, encompassing the continuum of service delivery (covering the totality of experience, from admission to discharge: from the phone call, booking appointments, to their experience at the front desk, and the experience with the physician and/or nurse).

The survey has been put on hold for the past few years, but the team are looking at the logistics of implementing it in the near future. One potential implementation mechanism is a module in MYLE EMR, which can leverage patients' email addresses or phone numbers to send automated links to surveys via email and/or text, upon discharge.

Evaluation, performance assessment and quality improvement

The Outpatient Clinic conducts ongoing quality activities, particularly in relation to its outpatient clinic (particularly nursing) and laboratory services.

Quality activities (outpatient clinic):

- Audit for TNP and wound care sheet development for clients needing regular follow for dressings.
- Review processes in OPD with regards to nursing/physician visits.
- Work with consultants regarding review of the functioning of the OPC clinic.
- Work with the team to implement MYLE EMR.
- As a continuous effort to offer safe delivery of care, the team conducts a weekly verification of equipment and medications stock, including the emergency room cart.
- Pneumovax vaccines were offered during the influenza vaccine campaign and continue to be offered throughout the year.
- Clients are actively triaged at the door for fever and cough. Those affected are directed to the respiratory etiquette area in the waiting room. Those presenting with a rash are directed to isolation rooms designated for this purpose. Since there is only one room and no negative pressure room, mandatory cleaning is needed between client use (additional OPD housekeeping hours improves the availability of this room).

- Implementation of EClinibase, an administrative management software, for Outpatient Care Nurses to schedule patients.
- At the request of the physicians, an OPD subcommittee has been initiated to discuss issues in the clinic with physicians, nurses, reception, MRD, administration.

Quality activities (laboratory services):

- Activities to maintain zero incidence of phlebitis.
- Development of processes to review and update the policies and procedures pertaining to laboratory services.
- Reviewing the processing of results, to reduce gaps in processes to assure best follow-up of results.
- Using a continuous quality improvement (CQI) approach, laboratory services conduct audits to monitor the quality standards of processes, and implement new practices to reduce and prevent errors (e.g. auditing cytology results, PAPs).
- To lessen the misidentification of patients, lab requisitions and cytology requisitions are stamped with Medicare cards, which lessens the error of misidentification of patients. With the collaboration of our physician, the team encourages clients to actively take part in the steps in the identification process.
- Physicians are advised to instruct their patients to see a nurse or the lab secretary if they are given a lab requisition. This system is efficient because clients receive proper instructions for the tests ordered and thus receive the containers for their specimens to be collected. This system does lessen the anxiety level of the patients when they come for their lab test. Patients are also requested to come in on the lab test days of their physician, to assure that their physician will receive the results the following day

As per the section above, the patient experience survey has been put on hold for the past few years, but the team are looking at the logistics of implementing it in the near future. One potential implementation mechanism is a module in MYLE EMR, which can leverage patients' email addresses or phone numbers to send automated links to surveys via email and/or text, upon discharge.

Program and service delivery challenges

The Outpatient Clinic experiences issues associated with short-staffing, and challenges with recruitment. It has been very challenging to recruit and retain full-time professional staff from most disciplines, particularly nursing. For example, primary care has been struggling, primarily due to staff shortages. The after-hours and weekend clinic offering is very limited, and there are many community members who are are currently not registered to a family physician.

In November 2022, KMHC announced that four physicians are joining its family medicine team. Furthermore, KMHC has launched a pilot project – the KMHC Access Clinic- to support community members with a chronic medical condition, such as diabetes, heart disease, chronic lung disease and mental illness, who do not have a family physician.

Furthermore, there is a need for more non-clinical and administrative support staff with competencies and abilities to function at higher levels, that the multidisciplinary clinical team (e.g.

physicians, nurses) can delegate non-clinical tasks and responsibilities to. This would generate efficiencies, and enable clinicians to focus on essential clinical functions and quality of care.

In addition to increasing the capacity and competency of support staff and integrating them within the multidisciplinary team, it is important to ensure that spaces are appropriately designed (i.e. fit for purpose), and that equipment and information technology (IT) are properly functioning.

Culture and language

Most of the nurses are from the community, and are encouraged to pursue their interests in culture and language. This includes educational opportunities to learn about the language and culture through programs, and working closely with KMHC Traditional Medicine.

The team works with KMHC Traditional Medicine to understand medication interactions with traditional medicines, and to incorporate traditional medicine and traditional approaches to care planning with Western medicine. Traditional medicines being used are incorporated into the client's MYLE EMR record.

KMHC Traditional Medicine also works closely with prenatal team, to incorporate welcoming ceremonies, and to integrate with pregnancy and labor services. Traditional Medicine also works with the diabetes program, as well as with psychology, providing traditional counseling.

It is important to recognize that the team come from diverse backgrounds - that the community itself is not a monolith. Respect for diversity and mixed cultural backgrounds is essential. It may be beneficial for QI days (i.e. "Set Days") to be developed, or educational sessions, for all staff in relation to promoting diversity, respect, bringing back traditional values and promoting cultural sensitivity.

Program-specific CHP input

When onboarding new physicians or staff, KMHC attempts to discuss cultural sensitivity and safety, to enable new team members to perceive various conditions (e.g. mental health, addictions, obesity) within the context of what the community has experienced (i.e. multi-generational trauma, residential schools). Further cultural sensitivity and safety education and training are required for all the clinical and social disciplines and professions.

There is a need to accurately measure and assess updated incidence/prevalence rates for various conditions listed as priorities in the CHP (e.g. developmental delays, cancer), to validate subjective perceptions on epidemiological matters. It is also important to leverage data being generated by MYLE EMR, to measure and assess epidemiological patterns in the community.

There is a need to focus on mental health and addictions, and to resolve the current fragmentation in mental health and addictions services.

It is important to focus on violence, and particularly family violence, as a major CHP priority.

5.18 Tehsakotitsén:tha Community Health (KMHC)

Highlights

- CHP health priorities: Cross-cutting.
- Extensive community-oriented programs and services, ranging across the entire lifespan (preconception to death). Services include: preconceptual health, prenatal, newborns, maternal health, developmental screening, immunization, well baby visits, child injury prevention, adult prevention, chronic disease management, cancer, tobacco, STIs, reportable diseases, dentistry and podiatry.
- CHU teams extensively collaborate and coordinate activities with a broad range of health, social and educational services within Kahnawà:ke. CHU services work particularly closely with KSCS programs and schools (e.g. KSCS prevention, youth protection, foster care, school nurses, child injury prevention, bullying, STI awareness).
- CHU is keen on strengthening its collaborative working relationship with KSCS's social care services, due to increasing social-related needs of the community. There is also a potential need for a teen health clinic, offering teens comprehensive services; therefore, CHU's management is exploring the possibility of designing and incorporating a teen clinic (perhaps close to the pediatric and obstetrics unit).
- The program's respective services conduct evaluations, which are often guided by detailed logic models and evaluation frameworks including performance indicators. Presently, evaluation capacities are limited. The scope of evaluation is very large, as each service area is unique with different mandates, service delivery models, target populations and data sources.

Overview

Tehsakotitsén:tha Kateri Memorial Hospital Centre (KMHC) Community Health is an extensive community-oriented program, encompassing a comprehensive range of services across the entire lifespan (preconception to death). The services address most Community Health Plan (CHP) priorities, and include: preconceptual health, prenatal care, maternal health, well baby visits (2,4, 6, 12, 18, 24, 36 months), breast feeding support, developmental screening, child injury prevention, adult prevention, chronic disease management, diabetic eye screening, cancer support, tobacco reduction, school health, staff health, sexually transmitted infections, reportable diseases, dentistry, dental hygiene and foot care.

The Community Health Unit (CHU) long-term goals are to:

- Continue to provide and maintain high-quality mandated responsibilities.
- Continue to develop and provide culturally relevant interventions aimed at promoting the well-being of Kahnawakehró:non.
- Continue to develop structures for prevention of disease and health promotion that are supported with current research findings

- Empower community members and groups to promote health and well-being in the community at large.
- Encourage and promote collaboration amongst community organizations.
- Become more grounded in the community (through location of the services and hiring more Indigenous staff).

Service delivery models

KMHC Community Health is comprised of an extensive range of services, that predate and often exceed the health priorities identified in the Community Health Plan (CHP). The program works in close collaboration with many of Kahnawà:ke's health, social and education services, and leverages various funding streams, such as the Aboriginal Diabetes Initiative Funding, to provide services for clients with advanced chronic disease, such as diabetic foot care.

Community health provides the community with important family-oriented services. The programs and services for newborns, children and mothers are particularly relevant and important, particularly in light of data that indicates that a significant proportion of babies born in Kahnawà:ke were born to teenage mothers, which is several times higher than in the Montérégie region or the province. Furthermore, a significant proportion of babies in Kahnawà:ke were born to a mother who had not completed high school, compared to the region and province(source: Onkwaná:ta Our Community, Ionkwata'karí:te Our Health' Portrait, Volume II , forthcoming).

Figure 7: Tehsakotitsén:tha Kateri Memorial Hospital Center

The list below provides a high level description of some of the major services that KMHC's Community Health program offers to the community. Comprehensive descriptions and descriptive statistics for all of these services are reported in the CHU's Annual Report.

Service	Goals
Newborn home visiting	• To decrease morbidity associated with early hospital discharge of neonates and their mothers. • To provide all first-time mothers, and mothers at risk, with an initial home visit to assess the physical state of infant and mother, as well as the environment/ social factors to ensure for the well-being and safety of both. Mothers at risk include those who had cesarian sections, adolescent mothers, and those flagged as at risk. • To assess for risk of post-partum depression and suicide in moms. • To provide follow-up via home visit or clinic visit for breastfeeding babies until they regain their birth weight.
Well baby program	• To ensure that children (0-4 years) receive early access to assessment, diagnosis, treatment, immunization and referral.
Preconceptual health	• To increase knowledge of pre-conceptional health issues among future parents in Kahnawà:ke.
Prenatal clinics and classes	• To provide quality care to the mother and her unborn child. • To provide the mother and birthing partner with information and techniques to make the birthing process as safe and comfortable as possible. • Prenatal classes cover topics such as: labor support, relaxation and breathing techniques, stages of labour, breastfeeding, community resources and how to develop a birth plan. Traditional services include a segment on traditional medicines, welcoming ceremonies for the newborn, naming ceremonies, and traditional teachings. • In an effort to address post-partum depression, the Edinburgh Post-Partum Depression Scale has been reviewed and nurses are administering it to all moms at the one month visit.
Lactation consultant program	• To promote breastfeeding as a primary health prevention strategy. • To assist women and families to meet their breastfeeding goals. • To maintain/improve (a) the breastfeeding initiation rate of 80%, and (b) the breastfeeding duration rate of 80% at six months. The main activities in this program are: • Responding to any clients needing breastfeeding assistance both inside/ outside of work hours (shared with Breastfeeding Support Worker (BSW); • Planning events for National Breastfeeding Week with the (BSW); • Co-facilitating monthly breastfeeding support group meetings with the BSW and; • Educating colleagues as to the most recent updates in breastfeeding and incorporating BPG into the workplace.

Service	Goals
Ontstaronhtha (breast-feeding promotion program)	• To promote & support breastfeeding as the number one choice for feeding of all newborns. • To increase breastfeeding initiation rate to 80%. • To increase breastfeeding duration at 6 months to 80%. • To promote awareness of breastfeeding as an important measure for health promotion & disease prevention.
School health	The goal in school health is one that will lead to a healthy lifestyle in adulthood – all areas of well-being are examined and all nursing programs are directed to these areas of health – physical, emotional, social, developmental and environmental, with western and traditional medicine considerations. • To identify, assess and address student health problems. • To ensure a safe and healthy school environment. • To provide information/programs to students to enable them to make healthy choices. • To control & prevent communicable diseases. • To have good collaborative working relationships with other organization members. • To promote healthy behaviours & lifestyle choices by providing students with quality health care, accurate information & adequate support services on their turf, on their time and on their terms. • To continue to encourage responsible self-care behaviour among KSS students. • To continue to develop & provide a high quality, culturally relevant school health program.
Elementary schools	Program areas include: • Staff-in-service (Bloodborne Diseases/ medication policy, EpiPen, Epilepsy/ seizure first aid, CPR) • Student health (Vision Screening, Health & Safety Meetings, First Aid kits, Student illness/injuries/consults, communicable diseases) • Vaccines (Twinrix, Gardasil) • Classes (handwashing and infection prevention; sexual abuse prevention and boundaries [Gr. 1]; anaphylaxis/EpiPen [Gr. 4]; Puberty [Gr. 5]; Sexuality [Gr. 6])
Kahnawà:ke Survival School (KSS)	Programs and activities include: • Youth wellness clinic (STI screening, vaccination, nursing consultations) • Health education, sexuality, risky behaviors
Assisted Living Services (Young Adults Program and Teen Social Club)	• Sensitization to health care in general • Act as liaison / resource as needed • Health Education (hygiene, nutrition, sun safety, sexuality, etc.)

Service	Goals
Staff health	• To promote & support breastfeeding as the number one choice for feeding of all newborns. • To increase breastfeeding initiation rate to 80%. • To increase breastfeeding duration at 6 months to 80%. • To promote awareness of breastfeeding as an important measure for health promotion & disease prevention.
Adult prevention	To provide wellness activities to Kahnawakehró:non that: • Reduce barriers to physical activity in at risk populations • Reduces their risk of chronic/preventable illness • Increases access to health education and opportunity • Provides/facilitates tools for self-care • Reduce morbidity and mortality-related to preventable risk factors for chronic disease • Provide screening opportunities for at risk population • Reduce tobacco related morbidity and mortality • Promote freedom from smoking • To provide awareness of links between smoking & tobacco related illness to smokers and non-smokers • To reduce risk of chronic illness and disability related to work place hazards/ practices in tobacco production industry The programs meet the goals of reducing barriers to physical activity and through formal, informal and impromptu opportunities. The goal of increasing access and opportunity to health education targeted specifically women's health and heart health issues. Health education topics focused on self care, risk awareness and reduction, active living, and wellness activities. Examples of programs include: screening (diabetes, hypertension), reduction of chronic preventable illness/progression of disease, osteoporosis, lifestyle and wellness, lifestyle modification, individual support, smoking cessation.
Cancer	• To reduce the incident/mortality of cancer among Kahnawakehró:non by disseminating prevention and awareness information that is current, culturally relevant, effective in enhancing understanding of all aspects of cancer, and effective in improving knowledge, attitudes and behaviours. • The Cancer Support Nurse participates in the Onkwata'karitahtshera Cancer subcommittee, as well as the cancer support group that meets monthly. The nurse shares new research information, answers questions about the medical system, the human body and how it functions, lymphedema, medications, treatments, self-care tips, resources and whatever their needs may be. Psychologists help participants deal with grief. • Programs include: skin cancer, smoking cessation, tobacco prevention, breast cancer, cancer screening, general cancer prevention/healthy lifestyles.

Service	Goals
HIV/AIDS awareness and prevention	• To provide awareness & prevention information in the community (Teens & Adults) that will ultimately reduce risky sexual behaviours and sensitize to a social issue.
Alcohol Related Birth Defects	• Our mission is to eliminate ARBD in the community and to care for those affected by ARBD, and to ensure that mothers no longer drink during their pregnancy and we no longer see ARBD in our community.
Child injury prevention	• To reduce the morbidity and mortality associated with childhood injuries. • The service includes a Child Injury Prevention Worker (CIPW). Participation in the Child Safety Network which includes Kahnawà:ke Peacekeepers, Kahnawà:ke Fire Brigade, Kahnawà:ke Youth Center, Animal Protection, Community Protection Unit, and CHU. Programs include: child passenger safety (car seats), babysitter training course, fall prevention, trampoline safety, school bus safety, rail safety, child passenger safety technician training, Halloween safety, holidays safety.
Reportable diseases	• To prevent the spread of disease in Kahnawà:ke. Through the Healthy Sexuality Education that takes place at Survival School and the Youth Wellness clinic, the goal is to increase education regarding STI's and their prevention.
Children's oral health initiatives	• To continue to offer the COHI program services in Kahnawà:ke schools and daycares. • To provide dental screenings, fluoride varnish, sealants and dentals referrals to participants in schools, daycares and homes. • To promote oral health practices to pregnant women, parents and caregivers of young children, organized groups and community at large • To provide support to the teachers with the class tooth brushing program. • To reduce the rate of dental disease in babies and children. • To reduce the number of children who require dental treatment under general anesthesia. • To prevent dental disease through education.
Diabetes education, wellness nurse, nutrition	Services provided include: • Disease management education and counseling for clients living with chronic disease. • Provide support to client coming for physician appointments to help in their continued self-care of their chronic diseases. • Interdisciplinary education with the nutritionist for clients living with diabetes. • Clinical case management as needed. • Individual education for blood monitoring and general disease management. • Providing education and information resources in hospital. • In-patient visits as needed. • 24 hour ambulatory blood pressure monitoring

Service	Goals
Nutrition	• To offer quality outpatient clinical nutrition care and counseling • To improve response time in providing OPC nutrition counseling to referred clients • To continue to improve our diabetes care program in collaboration with the diabetes nurse educator and medical staff • To share our client-centered diabetes care model "At Peace with Diabetes" with other First Nations • To serve as a nutrition resource and support community efforts, to promote a healthy lifestyle and reduce the top health problems in the community • To provide nutrition education activities to Kahnawà:ke school children with a focus on traditional foods, and in collaboration with Kanien'kéha lessons • To promote familiarity and comfort with traditional foods, while enhancing food preparation skills, through cooking workshops • To provide seasonal food activities for clients of Kahnawà:ke's Assisted Living Services
Foot care	• To prevent foot ulcers and assess for risk factors i.e. neuropathy. • Process: provide foot care and foot assessments to people living with type 2 diabetes at least annually
Diabetic eye screening	• To provide diabetic eye screening for diabetic retinopathy to patients living with type 2 diabetes.

Communication, collaboration and coordination

As evident by the descriptions of the service delivery models, the CHU teams extensively collaborate and coordinate activities with a broad range of health, social and educational services within Kahnawà:ke. CHU services work particularly closely with KSCS programs and schools (e.g. KSCS prevention, youth protection, foster care, school nurses, child injury prevention, bullying, STI awareness).

CHU is keen on strengthening its collaborative working relationship with KSCS's social care services, due to increasing social-related needs of the community. There is also a potential need for a teen health clinic, offering teens comprehensive services; therefore, CHU's management is exploring the possibility of designing and incorporating a teen clinic (perhaps close to the pediatric and obstetrics unit).

It is important to also note that the inability to share client files (due to privacy and confidentiality requirements), and the lack of interoperability between MYLE EMR and Penelope case management system present some challenges to collaboration and coordination of care. Examples of CHU's collaborations and referrals across Kahnawà:ke include:

- Well Baby Clinic (WBC): Referrals are made based on need to several services including: Ophthalmology, dentist or dental hygienist, Step by Step Child and Family Center, pediatrician, Montreal Children's Hospital, audiologist for routine newborn screening or older children where there is a concern. The Well Baby Clinic (WBC) nurses also hold meetings with KSCS Social Services team to assess what each service provides and how to manage complex social situations.

- The Pre-natal clinic team works with KMHC Traditional Medicine, to include welcoming ceremonies for the newborn, naming ceremonies, and traditional teachings.
- The Breastfeeding Promotion program and baby friendly support group coordinates several activities. The Child Injury Prevention worker went to present on the importance of proper installation of car seats and checked some of the participants' car seats. The nutritionist discussed the introduction of solid foods and gave information on planning healthier meals for the family. Jordan's Principle staff provide information regarding applying for reimbursement/payment for needed services.
- School health works with all the elementary schools (e.g. Karonhianónhnha, Indian Way, Karihwanoron, Step by Step) and Kahnawà:ke Survival School (KSS).
- Supporting KSCS' Assisted Living Services, specifically the Young Adults Program (YAP) and Teen Social Club (TSC).
- The Staff Health program supports the major programs and services within KMHC.
- The Child Injury Prevention Worker (CIPW) holds babysitting courses at the Kahnawà:ke youth Center (KYC) after school and on weekends. The CIPW participated in several collaboration meetings including the KSDPP Wellness meeting, the Parks and Recreation meeting, Family Wellness meetings about future campaigns, the Regional Survey results, and the Spirit of Wellness planning meeting.
- The Children's Oral Health Initiative (COHI) program is provided in Kahnawà:ke's (4) Schools and (3) Daycares.
- The Community Health Unit works closely with the OutPatient Department (OPD) at KMHC in many ways. Some examples are as follows: prenatal clients are referred for blood tests for blood type and will receive WinRho for Rh negative moms. Families often call the Community Health Nurse because their children are not well. Based on telephone triage, clients are given recommendations, are referred to another health care center (Montreal Children's Hospital) or are referred to the OPD to see a physician. Babies seen in the Well Baby Clinic will see the physician as part of their visit. Children are often referred to specialized services at KMHC such as the ophthalmologist, optometrist, dentist, pediatrician or dietician. The Wellness Nurse works in the OPD. Clients who are diagnosed with diabetes, pre-diabetes and chronic disease will be referred to the Wellness Nurse for education on complications, medications, insulin initiation, glucose monitoring and other co-morbidities.

Client and family experience

The management team is interested in exploring options to restart client experience surveys, potentially using MYLE EMR's module that enables automated texts and/or emails to patients upon discharge.

In the interim, CHU's various services (e.g. vitality and fitness programs) collect client feedback as part of their evaluation processes. Cancer care also used patient satisfaction surveys and feedback from the cancer support group). The team also monitors discussions and comments of various Facebook groups (e.g. breastfeeding program).

Evaluation, performance assessment and quality improvement

KMHC has a QI team (Quality Improvement, Risk Management and Innovation, or QIRMI) that supports evaluation, QI and accreditation activities across the organization.

The program's respective services conduct evaluations, and report some of the results in CHU's annual report to KMHC. The program evaluations are often guided by detailed logic models and evaluation frameworks, which include defined performance indicators.

Results of the evaluations, mainly qualitative data, but also including descriptive statistics (e.g. demographics, service utilization, outputs and outcomes) are included in CHU's annual report to KMHC. The evaluations use mostly qualitative approaches, and the program is keen on formalizing the evaluation approach through the use of updated logic models, standardized assessment tools and leveraging clinical and administrative datasets for quantitative evaluation, including for statistical and epidemiological analyses.

Presently, evaluation of CHU's program areas falls largely on the manager, which limits the ability of the program to conduct comprehensive and rapid cycle evaluations. The scope of evaluation is very large, as each service area is unique with different mandates, service delivery models, target populations and data sources. The manager is focused on operations, and due to the intense workload, can not allocate sufficient time for the development of the logic models, or to conduct comprehensive, rigorous or updated evaluations.

Culture and language

One of the CHU's key stated goals, is to continue to develop and provide culturally relevant interventions aimed at promoting the well-being of Kahnawakehró:non.

The CHU program actively integrates culture within its service offerings, particularly those focused at pediatric and youth populations. For example, culture is increasingly being integrated in prenatal services, particularly through midwives who bring traditional perspectives. The prenatal team also works with KMHC Traditional Medicine, to include welcoming ceremonies for the newborn, naming ceremonies, and traditional teachings.

The Well baby program's literacy program gives books to all babies 2 months to 2 years at their Well Baby Clinic (WBC) appointment, including books in Kanien'keha. Parents continue to be thrilled to see that their very young babies are interested in the books as demonstrated in the WBC. The nurses provide more information to parents about the importance of how to read to their children. One nurse involved in a special project to develop three Kanien'keha board books for babies.

5.19 Tekanonhkwatsheranéːken: Two Medicines Working Side By Side, Tehsakotitsén:tha Traditional Medicine (KMHC)

Highlights

- CHP health priorities: Cross-cutting.
- The program was developed incrementally and inductively over a period of many years, in response to needs that were not being addressed (major gap in traditional medicine and traditional healing approaches). For ~14 years, it was considered a pilot project
- Tekanonhkwatsheranéːken (Two Medicines Working Side by Side) transitioned being from a pilot project, to a full-time operational program with fulltime positions and an operating budget.
- The program aims to seamlessly incorporate traditional medicine into all other programs at KMHC - the "two medicines working side by side" philosophy and approach. Therefore, there is a very strong emphasis on collaboration and coordination with programs and services within KMHC, and across other health and social services within the community.
- To ensure that the community is served in a harm reduction approach, there is a need for organizations to further leverage the program and to direct resources and efforts to improve overall cultural safety within all health, social care and educational organizations – including a focus on cultural awareness, sensitivity and competency.

Overview

Tekanonhkwatsheranéːken (Two Medicines Working Side by Side, Tehsakotitsén:tha KMHC Traditional Medicine) provides comprehensive services focused on taking care of the body, mind and spirit – keeping individuals independent, healing the mind, and to provide a sense of peace. Services encompass traditional medicine, spirituality, healing, cultural teachings, rituals, ceremonies, language, prevention, healthy lifestyles, and educational, training and orientation activities. A key aim is to seamlessly incorporate traditional medicine into all other programs at Kateri Memorial Hospital Centre (KMHC), using the "Two Medicines Working Side by Side" philosophy and approach.

Tekanonhkwatsheranéːken Descriptive statistics (2020/21)

- # referrals: 60
- # Prenatal clients: 2
- # Palliative Care/End of Life Care clients: 2
- # Couples: 1
- Youth (15-24 years): 4 (3 female, 1 male)
- Adults (25-64 years): 48 (40 female, 8 male)
- Seniors (65 years and over): 8 (5 female, 3 male)

Program and services

Through many years of grass-roots dedication, passion and advocacy, the program has evolved to address community needs relating to traditional healing and traditional medicines. The initiative existed for many years as a pilot project, conducting workshops, educational sessions, cultural activities and ceremonies. In 2021, after approximately 13 years as a pilot project, Tekanonhkwatsheranéːken was formalized as a full time KMHC operational program, with three positions and an operating budget.

The program's staff have many years of combined knowledge and experience in both traditional and Western (allopathic) approaches, including work experience in rehabilitation, short-term care, long-term care, nursing, community mental health (including persistent and severe mental health issues) and cancer care. This combined knowledge and experience are essential to attaining the goal of seamlessly incorporating traditional medicine into all other programs at KMHC, using the "two medicines working side by side" philosophy and approach.

The team includes a Tekanonhkwatsheranéːken Traditional Medicine Services Co-ordinator, a Language and Culture coordinator and a Traditional Medicine Support Worker. The combined team has extensive combined experience; for example, the Language and Culture coordinator is a faithkeeper in the Longhouse of the Haudenosaunee, and is a traditional drummer and singer, and performs ceremonies and traditional healings. The coordinator does Ohénːton Karihwatéhkwa (Opening Prayer) over the intercom Monday-Friday at KMHC, as well as the monthly Tobacco Burning Ceremony, which all KMHC staff are welcome to attend.

At the inception of the program, the team formulated an Elders Committee, for guidance and support, and to develop and implement the vision. The team works with Traditional Elders and Medicine People, gaining knowledge about the tradition and culture of Haudenosaunee people. They maintain a close and ongoing collaboration and cross-learning with healers from Akwesasne, who had already developed a Healing Center, and who had experience and knowledge with traditional medicine. The staff worked with the Elder medicine person from Akwesasne for a period of approximately 10 years, to gain knowledge and experience with traditional medicines.

The end of KMHC's Expansion and Renovation Project enabled the team to realize their goal of offering traditional medicine as an Outpatient service. The team now have two dedicated areas for the Traditional Medicine Unit, placed alongside our Western Medicine model, including a consultation office and a training room. Additionally, Traditional Medicine has direct access to one of our healing gardens where monthly tobacco burnings are held, as well as other service-related activities. The Unit is presently staffed with individuals prepared to provide a culturally appropriate, community-based, wholistic health program.

In addition to the offices, a retractable awning was installed just outside the Unit's patio doors to the courtyard, which has enabled the team to have a garden atmosphere with a shaded sitting area to meet with people. Furthermore, a beautiful and meaningful Turtle art installation was created in the courtyard.

Figure 8: Turtle art installation by Megan Kanerahtenha:wi Whyte

The program aims to keep individuals independent, healing the mind and spirit, and to provide a sense of peace. The assessment process is person-oriented, starting with the individual's own perceptions and feelings on what their respective needs are, along with whatever they can share with the team, due to the major issues with trauma encountered in the community over many years.

The staff act only as a guidance system, listening to and respecting the individual's stories, and providing as much relevant information as possible, to inform the individual's own decision-making process, as an autonomous human being.

The team also relies on inclusive traditional healing approaches, such as talking circles and group activities. Many individuals do not present for physical ailments and / or conditions; rather, they require support and guidance relating to emotional, behavioral and/or mental issues.

Often, individuals are referred from other health and social care providers; therefore, the team liaises with the referring clinical teams to obtain an accurate and comprehensive overview of the

client's condition and issues. The team works gradually and incrementally with the individuals, to make sure they are not overwhelmed.

Tekanonhkwatsherané:ken staff also collaborates with multidisciplinary KMHC teams on care planning for complex clients. Tekanonhkwatsherané:ken staff work as a team with physicians, nurses and mental health professionals to ensure a wholistic approach to care, that incorporates somatic, psychosocial, emotional and spiritual domains.

Referrals to other services are conducted after careful communication with the client, to ensure mutual understanding and buy-in. The team also expedites access to services, if required. These include any services that individuals may be able to benefit from (e.g. KMHC health care services, KSCS social services, diabetes nurse educators, psychological services). The team attempts to pull in all relevant and necessary resources that may benefit the individual, if they desire.

The development of Tekanonhkwatsherané:ken as a program is an evolution and progression, in tandem with the team's own healing journeys. These healing journeys continue to inform the design and delivery of the service.

Communication, collaboration and coordination

The Tekanonhkwatsherané:ken team works extensively with health, social care and educational partners, within and outside of Kahnawà:ke.

The team work closely with all major KMHC programs, to ensure that traditional approaches are appropriately incorporated into service delivery models. For example, close collaborations with KMHC's Well Baby Clinic (WBC) prenatal team, to include welcoming ceremonies for the newborn, naming ceremonies, and traditional teachings. The team also enables other KMHC programs to have an understanding of the chemistry of phytochemicals, to ensure the safe use of traditional medicines, and to enable staff to identify potential contra-indications with other medications, or side effects. The team also collaborates with KMHC dieticians, to incorporate traditional foods.

The program supports the Re-Awakening the Body, Mind and Spirit workshop series and educational presentations to outside partners, such as with Dr. Kent Saylor, McGill University, Dawson College and others. The team support numerous organizations with cultural awareness and safety educational presentations, in the health and social care professions, as well as school health programs. An example is the culture orientation and traditional medicine presentation to 60+ McGill 2nd year medical students through Dr. Kent Saylor, Indigenous Health Professions Program.

The team also offers group workshop and presentations to community partners at KSCS (e.g. Tsi non:we Ahsonhni:iohake, Family and Wellness Center Traditional Counseling, Mental Wellness and Addictions, Tsi Niionkwarihò:ten), to invite their clients to attend the Re-Awakening the Body, Mind and Spirit workshop series. The team work closely with the Family and Wellness Center, on initiatives such as the grieving workshops, providing spiritual supports and resources. Traditional medicine (KMHC) and Traditional Counselling (KSCS) have related but distinct areas of focus, with somewhat different underpinning philosophies and approaches. Further communication and alignment between the two groups would possibly be beneficial.

The team also maintain close collaborations and cross-learning activities with healers from sister communities such as Akwesasne – an excellent relationship that goes back many years – that strengthens knowledge and experience relating to Haudenosaunee ways, traditions, medicines and ceremonies.

Evaluation, performance assessment and quality improvement

The program submits an annual report to KMHC, which includes descriptive statistics of service delivery, descriptive evaluations of functions, activities and services, and qualitative data and testimonials of the experiences of clients, as well as partners from health, social care and educational settings (e.g. feedback regarding workshops and collaborations).

Program and service delivery challenges

The program was developed incrementally and inductively over a period of many years in response to needs that were not being addressed, related to domains such as traditional healing approaches and traditional medicine. Traditional medicine was understood to be alive and vibrant, but largely hidden. It was important to incorporate it into all aspects of health and social care in the community.

For approximately thirteen years, the program was considered a pilot project, relying heavily on the personal advocacy and perseverance of the staff, without adequate supports, resources or recognition. Staff were dedicated to the pilot project approximately one day a week, which was insufficient to meet the needs of the organization or the community. Furthermore, over time, with older staff retiring, there was a loss of language and traditional knowledge in the organization, which presented a major problem.

A major challenge facing the team related to changing the mindsets and attitudes of staff working within health and social services. There was very limited cultural awareness, cultural sensitivity and cultural competency, as well as a general lack of engagement and/or buy-in from various stakeholders (e.g. some clinicians were initially reluctant and skeptical, and did not understand or recognize the value of traditional medicine, which disrespected and alienated the community and clients and families of KMHC).

Over the years, the program's staff have gone through their own healing journeys, which has continuously informed the development of the program's design and services.

Program-specific CHP input

Presently, there is a need to increase and improve engagement at Board levels, both at KMHC and at Onkwata'karitáhtshera levels. The program should be given proper attention and backed up by resources to ensure its long-term sustainability, especially in light of Truth and Reconciliation, and calls to action.

Furthermore, to ensure that the community is served in a harm reduction approach, there is a need for organizations to further leverage the program and to direct resources and efforts to improve overall cultural safety within all health, social care and educational organizations – including a focus on cultural awareness, sensitivity and competency.

Organizations should proactively engage with the community, and ensure they always have a pulse on the community's realities, challenges and needs. The community and staff still have challenges with accepting and integrating culture, due to the trauma and ongoing colonization.

Therefore, it is very important to consult with people who have knowledge and lived experience, such as the Traditional Medicine team and people within the community.

It is also important to recognize that there's very little cultural awareness or cultural integration at governance levels beyond the community (e.g. at the ministry level), which need to be meaningfully addressed with these partners.

5.20 Kahnawà:ke Fire Brigade & Ambulance

Highlights

- CHP health priorities: Cross-cutting.
- An extensive range of services, including fire suppression, evacuation procedures, fire protection, fire prevention, fire inspections, alarm functions, testing of emergency plans, building codes compliance, emergency medical response and ambulance service.
- A significant proportion of calls pertain to community paramedicine type services - particularly for elderly, vulnerable populations, clients with special needs/disabilities and pediatrics/newborns. A significant proportion of these calls are for psychosocial needs, and are no-transports.
- There are individuals who are extremely high/frequent users of services (i.e. frequent callers to the ambulance for non-emergency situations, related to social, emotional or behavioral needs/problems).
- The team work closely KSCS, to ensure that clients are connected to needed health and social services. However, communication, collaboration and coordination mechanisms need to be further strengthened.
- The service's quality program generates Patient Care Record (PCR) reports, which includes data related to: demographics, transports/no transports (refusals), Clinical codes/presenting problem, Protocols followed, Pick up location, Transport location (by hospital), Inter-hospital transports (non-emergency), COVID-19 status and Mental health related calls.

Overview

The Kahnawà:ke Fire Brigade and Ambulance serves the community in areas of fire suppression, evacuation procedures, fire protection, fire prevention, fire inspections, alarm functions, testing of emergency plans, building codes compliance, emergency medical response and ambulance service. Daily tasks include responding to calls for assistance for both fire and medical emergencies, conducting fire safety inspections, training of personnel, providing safety information to community members, and responding to mutual aide calls.

Team-based service delivery model

Kahnawà:ke Fire Brigade & Ambulance is comprised of ~ 45 members, consisting of 17 paramedics, some cross-trained in fire and ambulance. The whole operation of KFB is overseen by an Executive Board of five members. The Department is led by 7 Officers, ranging from Chief, Captain and 4 Lieutenants. The firefighters are entirely a volunteer group, and are equipped with 7 well equipped fire vehicles (majority with one pump), a water tanker, a Utility Task Vehicle (UTV), a well equipped First Response Officers vehicle, and a hazmat trailer.

The ambulance service operates under the guidance of their own Medical Director, and is comprised of four teams of two, who are paid. The service is run by Primary Care Paramedics (PCPs), and operates 24/7, 365 days a year (two ambulances from Monday - Friday (8am-4pm); after-hours run by volunteers, with an on-call calendar). The ambulance service also responds outside of Kahnawà:ke to assist with patient care when requested.

Figure 9: Kahnawà:ke Fire Brigade and Ambulance

A significant proportion of calls (estimated to be approximately a quarter of calls) pertain to community paramedicine type services - particularly for elderly, vulnerable populations, clients with special needs and/or disabilities, and pediatrics. A significant proportion of these calls are for psychosocial needs, and are no-transports.

There are also individuals who are very high/frequent users of services (i.e. frequent callers to the ambulance for non-emergency situations, related to social, emotional or behavioral needs/problems). The team work closely with KSCS, to ensure that clients are connected to needed health and social services.

Table 15: Kahnawà:ke Ambulance call volumes, by type. Mental Health calls were described as self-inflicted wounds, depression, suicide and abnormal behaviour.

	Type of call	2016	2017	2018
	Total # of calls	1308	1247	1220
1	Abdominal pain	89	88	74
2	Allergy	20	23	15
3	Animal attack	3	2	5
4	Assult	28	17	18
5	Non-T Back Pain	21	17	14
6	Respiratory	103	96	102
7	Burns	1	6	3
8	Inhalation/dangeours	2	1	3
9	Cardiac arrest	13	11	12
10	Chest pain	101	92	90
11	Choking	4	5	1
12	Seizure	20	10	13
13	Diabetic	9	8	11
14	Drowing/Diving	2	2	0
15	Electrocuted	1	1	2
16	Eye problem	6	2	3
17	Fall	92	89	99
18	Headache	17	20	9
19	Cardiac problem	25	26	28
20	heat/cold	1	4	3
21	Hemm/Laceration	39	40	41
22	Inaccessible accident	0	0	0
23	Overdose	22	21	17
24	Pregnancy	7	2	2
25	Psychiatry	22	30	32
26	General sickness	211	264	309
27	Weapon/Firearm	0	0	1
28	CVA	2	9	12
29	MVA	96	87	57
30	Trauma	124	100	129
31	Unconscious	23	18	34
32	Unkown	56	55	11

The KFB also oversees the Medical Transportation operations, which consist of 7 vehicles and 13 employees. During the pandemic, Medical Transport was essential in the delivery of home meals for the elderly and vulnerable, and also for maintaining a service for medical appointments.

Communication, collaboration and coordination

KFB is one of 22 fire departments that are part of a mutual aid system with shared radio frequencies and operating protocols. The team also collaborates closely with the Peacekeepers, Emergency Management Services, and the community's health and social care services (particularly KSCS for home care and social work services, KMHC programs and services), and nearby hospitals, such as Anna Laberge Hospital. However, communication, collaboration and coordination mechanisms need to be strengthened with health and social care partners.

Client experience

Client feedback is largely obtained via informal mechanisms, particularly one-on-one conversations during or after service delivery.

Quality Assurance

Patient Care Records (PCRs) data is analyzed for quality assurance functions, with data tracked to ensure that care aligns with standards and protocols. The following are specific data fields collected for each ambulance call:

1. Date
2. Call time
3. Age
4. Sex
5. Number of no transports (refusals)
6. Clinical codes/presenting problem (Appendix section 10)
7. Protocols followed (see attached list)
8. Pick up location
9. Transport location (by hospital)
10. Inter-hospital transports (non-emergency)
11. COVID-19 status
12. Mental health related calls

5.21 Peacekeepers

Highlights

- CHP health priorities: Mental health and wellness; substance abuse/addictions.
- The Peacekeepers are a proactive and forward-thinking police service, that focuses on community-orientation, upstream prevention, social determinants of health, community engagement, education/awareness, transparency, de-escalation through empathy and communication, and close collaboration with educational, health and social services.
- Preparing to implement the DARE program (Drug Abuse Resistance Education), an educational program in schools that seeks to prevent use of controlled drugs, membership in gangs, and violent behavior.
- Dedicate significant resources into proactive activities related to upstream prevention, community engagement, promoting transparency, and close collaboration and coordination with educational, health and social services.
- The Public Relations Officer focuses on community engagement, information sharing, liaison and coordination functions with educational, health and social services, as well as campaign activities
- Misinformation is a major problem that needs to be addressed, especially due to social media.
- Transparency needs to always be at the center of all initiatives, to build trust with the community, and to humanize the service and its staff.

Overview

Established in 1979, the Kahnawà:ke Peacekeepers are possibly one of the only First Nations police services in North America that is staffed entirely with First Nations people (~35 Officers). The Peacekeepers provide professional, proactive law enforcement and emergency/crisis response services to the community of Kahnawà:ke, enforcing Band bylaws, The Criminal Code of Canada and the Quebec Highway Safety Code (25). The Peacekeepers are a proactive and forward thinking police service, that focuses on community-orientation, upstream prevention, social determinants of health, community engagement, education/awareness, transparency, de-escalation through empathy and communication, and close collaboration with educational, health and social services.

Figure 10: PeaceKeepers website (https://Kahnawà:kepeacekeepers.ca/)

Team-based service delivery model

The Peacekeepers are comprised of a team of ~35 Officers, including Operations staff and a dedicated Public Relations Officer, performing functions relating to community engagement and liaison with educational, health and social services. The Peacekeepers perform law enforcement and emergency/crisis response functions (including suicide intervention), but also dedicate significant resources into proactive activities related to upstream prevention, community engagement, promoting transparency, and close collaboration and coordination with educational, health and social services.

Due to the social and community aspect of their work, Officers have been referred to as "informal social workers, 50% of the time".

Types of calls	2017	2018	2019
Alarms	337	363	246
Assault	81	79	67
Break and enter	14	7	12
Custody dispute	6	8	8
Assist KSCS	37	20	26
Drugs	37	42	41
Execution of warrants	113	127	84
Fraud	44	52	25
Impaired driving	56	73	48
Mischief	40	30	13
Motor vehicle accident	307	248	203
Public assistance	322	363	333
Robbery	1	5	5
Theft	38	48	41
Theft (motor vehicle)	7	6	10

The Peacekeepers are preparing to implement the DARE program (Drug Abuse Resistance Education), an educational program in schools that seeks to prevent use of controlled drugs, membership in gangs, and violent behavior. The Peacekeepers also design and implement several prevention initiatives, including firearm safety. The Peacekeepers provide the community with information and educational programs re legality of weapons, and have implemented a buyback program for firearms that have been classified as prohibited.

An example of the Peacekeeper's community-based approach, and focus on empathy, communication and collaboration was highlighted in a Global News article entitled "How Indigenous policing works in Kahnawà:ke" (July 15, 2020):

"Their approach is trying to be collaborative, trying to settle down the situation so it doesn't have to turn into violence." Delormier insisted that all police officers in other forces should treat their patrol area, even in the city, as a small community, and learn about the residents. That's what he likes about where he works. "It's the ultimate accountability," he said, "to police where you live." Delormier explained that understanding the societal conditions and history that can lead to someone breaking the law helps build empathy. That and knowing the people he and his colleagues arrest, he added, who may include family members, means they tend to use less force and spend more time de-escalating a situation. Former Peacekeeper and current member of the Mohawk Council of Kahnawà:ke Gina Deer agreed. "I used to tell people 'I have eight hours to talk,'" she smiled. "'My shift is eight hours — we can stay here, if you'd like.' And people think about that, you know?" Deer pointed out that sometimes they don't even charge an individual for minor infractions resulting from a dispute, if the involved parties choose to use an alternative dispute resolution process to settle differences. "Because sometimes that's all you need," Deer noted, "is to be heard and to understand the other person's perspective of things."

Community engagement

The Peacekeepers have a dedicated Public Relations Officer, focusing on community engagement, information sharing, liaison and coordination functions with educational, health and social services, as well as campaign activities (e.g. press releases, social media, videos, police station tours for students, radio, newspaper, website). Public relations activities encompass a wide range of topics, from emergency management to water safety and preventative activities.

The Public Relations Officer leverages social media, continuously creating fun videos to answer questions from the community (similar to a Q&A format), with a focus on prevention, safety and community wellbeing. The Peacekeepers website is always updated with new and interactive content, to engage the community, and maintaining transparency and openness. Examples of website content include:

- Videos - fun Q&A style for a variety of priority topics
- THE PK FILES: A weekly review of Peacekeeper activity
- Photo gallery
- Community events

Figure 11: Snapshot of PeaceKeepers YouTube channel

There is a need to improve awareness and understanding (across the community's citizens and organizations) regarding the legal parameters of the Peacekeepers (particularly in relation to their powers, functions and roles), as well as the value the Peacekeepers contribute to the community. The community are not always knowledgeable in terms of the actual parameters of the law, and what is illegal.

Communication, collaboration and coordination

The Peacekeepers have strong collaborative working relationships with KSCS, KMHC, KFB, schools and other community-based organizations. Maintaining these relationships is enabled by the public relations and operations team members. For example, the Peacekeepers have a direct line to call KSCS social work, with 24/7 access, for cases that need to be referred.

A derivative benefit of the close collaborative relationship with the educational, health and social care organizations is that it improves the Peacekeepers' visibility with the community. In terms of coordination, information sharing and communication, there is room for improvement. The officers perceive that they are good at sharing information out, but often information does not stream back to the Peacekeepers from the other services.

Statistics are compiled by the Peacekeepers, and are periodically shared with KSCS (e.g. drug files, assaults, impaired driving), and upon request (e.g. recently, a data request from KSCS was fulfilled, in relation to suicides, mental health and crisis interventions). However, there is potential benefit to set up consistent meetings between the main organizations in the community to share aggregate statistics, to garner a comprehensive understanding of population health needs. However, time is limited, and staff and resources need to be dedicated to such an initiative.

Culture and language

The Kahnawà:ke Peacekeepers are possibly one of the only First Nations police services in North America that is staffed entirely with First Nations people, the majority of whom are Kahnawakehró:non and community members.

Program-specific CHP input

Peacekeeper data indicates that there must be a strong focus on mental health and wellbeing, as well as substance use, both in the clinical sense, but mainly also from an upstream prevention perspective - looking at housing, poverty, family relations, the social determinants. Furthermore, violence

(particularly family violence) and abuse are major problems, as well as social media's negative influence and impact on youth.

Misinformation is a major problem that needs to be addressed, especially due to social media. Transparency is another major domain that needs to always be at the center of all initiatives, to build trust with the community, and to humanize the service and its staff.

The Peacekeepers recognize the importance of addressing the social determinants of health, and agree that health and social services must be appropriately resourced to address the intensifying social, mental health and substance use needs of the community. This would enable the police to refocus more on the crisis/emergency response and law enforcement functions, roles and tasks that they are trained for.

5.22 Tsi Niionkwarihò:ten (Our Ways, KSCS)

Highlights

- CHP health priorities: Cross-cutting.
- There is increasing recognition of the well-established link between language and culture as mediators and manifestations of wellness, and significant healing forces for Onkwehón:we. It is therefore important to consider it as a priority health and wellbeing domain.
- Tsi Niionkwarihò:ten staff extensively collaborate with partners within and external to Kahnawà:ke, encompassing health, social care and educational organizations. Furthermore, Tsi Niionkwarihò:ten maintains close contact with other organizations and programs focused on culture and language, and are focused on increasing alignment between these stakeholders.
- Important culture and language-related programs and services were disrupted during the pandemic, demonstrating the need to invest resources to ensure their sustainability.
- The 2018/19 Tsi Niionkwarihò:ten report contains detailed organizational recommendations that are generalizable, and can potentially be adapted to other settings across the community.

> *"There needs to be more of you being that we are such a large organization. You have a big job to tackle considering it is only two staff in the Tsi Niionkwarihò:ten department. We are lucky to have that support within our organization and that learning our language and culture is not only designated to work hours. We need to keep this up I think, it's important now more than ever. The pandemic really has people down." ~ feedback from Tsi Niionkwarihò:ten program participant*

Overview

Tsi Niionkwarihò:ten is vital for KSCS and the entire community, since language and culture are key indicators of community wellness. The program offers Tsi Niionkwarihò:ten awareness, support and community networking functions, with an emphasis on educating staff on topics around Kanien'kehá:ka ways and language. This is in order to ensure staff have an understanding of Tsi Niionkwarihò:ten, and to enable programs and services to comprehensively and seamlessly integrate Kanien'kehá:ka traditions, principles and values.

The Tsi Niionkwarihò:ten program's strategic objectives encompass:

- Improving understanding of Kanien'kehá:ka tsi niionkwarihò:ten among staff at Kahnawà:ke Shakotiia'takéhnhas Community Services (KSCS) in order to demonstrate the integration and development of tsi niionkwarihò:ten standards and principals within K.S.C.S. programs, projects, and services.
- Evaluating program development and implementation of report recommendations.
- Enhancing and creating opportunities for involvement in collaborative efforts (internal and external), in order to share resources and to support integration of tsi niionkwarihò:ten in a variety of areas.
- Providing training and educational opportunities to KSCS staff and community.
- Fostering a KSCS team approach to integrating tsi niionkwarihò:ten programming and services through relationship, trust building, and social activities.

Background

The Tsi Niionkwarihò:ten Program developed as a result of the Kahnawà:ke Shakotiia'takéhnhas Community Services (KSCS) 2016-2019 Strategic Plan. Based on feedback and discussions with staff and community members, Tsi Niionkwarihò:ten (Our Ways) has been cited as being an important theme that needs to be given priority in the planning of programs, and services. This was emphasized in Strategic Objective #3, which outlined organizational expectations in terms of programs and services to guarantee that there is an effort to ensure Tsi Niionkwarihò:ten values, principles and traditions are at the heart of all work. KSCS Strategic Objective #3 is to:

- Foster & accelerate active Kanien'kehá:ka ways of doing things, including more use of our language.
- Strengthen our understanding of our Kanien'kehá:ka ways, language and culture.
- Incorporate Kanien'kehá:ka ways in everything we do. This means increasing the use of our language and culture in everyday living and in the standard practices of our services.

The present KSCS Tsi Niionkwarihò:ten Committee traces its roots back to the KSCS Language Committee, which commenced activities in 2000, as a result of the desire to promote and support the Language Law.

It is important to also note that since 2008, KSCS staff have been participating in the language and cultural sessions offered by the Mohawk Council of Kahnawà:ke (MCK) Tsi Niionkwarihò:ten Tsitewaháhara'n Center. Each year, KSCS was provided one seat for a first-year candidate to participate and commit to the five year program. Each year, new and returning students made applications to the K.S.C.S. Tsi Niionkwarihò:ten Committee and their supervisors to participate in the training sessions. In 2017, the Executive Director accepted that full training hours are available to full time staff participants.

Tsi Niionkwarihò:ten Coordinators support the program, offering Tsi Niionkwarihò:ten educational, support and community networking functions. A key role is to educate KSCS staff on topics around Kanien'kehá:ka ways and language, to ensure staff have an understanding of tsi niionkwarihò:ten (our ways) and to provide inspiration for enhancing programs and services with Kanien'kehá:ka traditions, principles and values at their core.

Tsi Niionkwarihò:ten – staff awareness and engagement

Over the years, the coordinators have gathered information and input from KSCS staff through engagement sessions, focus groups and surveys, to assess levels of awareness of tsi niionkwarihò:ten. The findings of these activities provide valuable insights into the present state of staff awareness and tsi niionkwarihò:ten integration in programming.

For example, a 2018 survey of 72 staff (with a 40% participation rate) reported:

- A participation rate of 59%, among responders who indicated that they had participated in any KSCS Tsi Niionkwarihò:ten Committee trainings/activities/presentations.
- Regarding "challenges influence your ability to participate in Tsi Niionkwarihò:ten activities offered by KSCS":
    - 62% of staff cited heavy workloads as a barrier to their participation in tsi niionkwarihò:ten training or activities;
    - 46% cited that "timeframes don't fit my schedule"
    - 24% cited a lack of awareness or promotion of activities as a key barrier to participation
    - 11% say that they "don't feel comfortable"
    - 0% stated that they feel unwelcome
- Regarding factors that would further assist staff in their development and ability to develop to incorporate Tsi Niionkwarihò:ten in their respective area of service:
    - 68.75% staff respondents expressed a need for more training in order to develop their ability to incorporate tsi niionkwarihò:ten in their service areas
    - 34.38% need to see the relevance of incorporating tsi niionkwarihò:ten into their jobs.
    - Personal motivation was also cited as an issue with 29.69% of respondents
    - Supports from coworkers and supervisors at 26.56% and 23.44% respectively
- 95.31% of staff respondents stating that they would be "interested in learning more about tsi niionkwarihò:ten topics."

Excerpt from the 2018 Tsi Niionkwarihò:ten Special Project Final Report (related to the staff survey results):

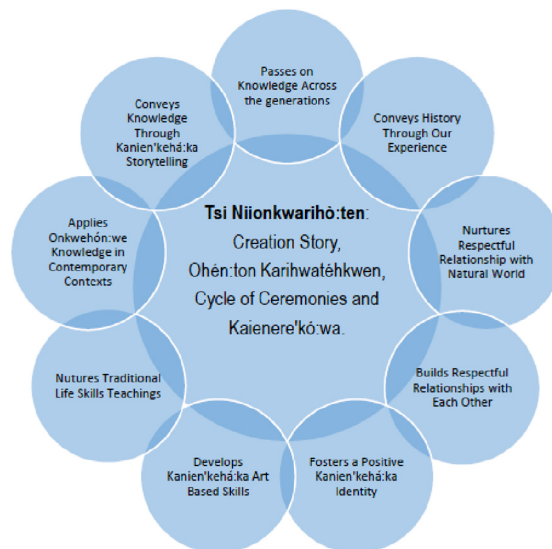
As stated in the staff survey, many staff are challenged with making the time to participate in tsi niionkwarihò:ten training and activity sessions. It is important for staff to be aware of the topics and teachings that provide the content for Kanien'kehá:ka ways of doing things. However, this can't be accomplished if they don't see it as an integral part of their work. Without ongoing education and awareness staff are hard pressed to recognize how tsi niionkwarihò:ten topics, and ways of doing things can be inspired to make changes to programming and services. These type of activities also need to be valued by all-staff from workers to management in order to accomplish our strategic goals and not viewed as extra or detrimental and time consuming activities that get in the way of our "real jobs".

In order for Shakotiia'takéhnhas Community Services to actively demonstrate value of our language and culture, we then need to review our programs and services at the team level with managers and staff members taking responsibility for the development and assessment of programming and services towards this end. The Tsi Niionkwarihò:ten Program Coordinator along with the continued assistance of the K.S.C.S. Tsi Niionkwarihò:ten Committee can assist in education and coordination of learning activities, but in the end each staff member in the context of their teams need to pick up the ball in order to do their part.

KSCS Tsi Niionkwarihò:ten Program Curriculum and Training Plan

The Kahnawà:ke Education System developed a framework for their Tsi Niionkwarihò:ten Curriculum. The nine elements of the framework have provided a guide to the KSCS Tsi Niionkwarihò:ten Coordinators and Committee for KSCS staff training and education since 2017.

Figure 12: Kahnawà:ke Education System Tsi Niionkwarihò:ten Curriculum framework (authored by Kahtehrón:ni Stacey).



A key goal of the program is "to improve understanding of Kanien'kehá:ka tsi niionkwarihò:ten among staff at Kahnawà:ke Shakotiia'takéhnhas Community Services (K.S.C.S.) in order to demonstrate the integration and review of tsi niionkwarihò:ten standards and principles within K.S.C.S. programs, projects and services".

In developing training geared to the various needs and interests of KSCS staff it was important to determine how we could encourage all staff to get involved in training and also be transparent and respectful when promoting sessions that are for Onkwehón:we/Kanien'kehá:ka only. Two streams of training were envisioned, and the program will strive for a balance of the two: one for all staff, and another exclusively for Onkwehón:we staff.

Stream 1 - Tsi Niionkwarihò:ten Training sessions offered to all staff:

- Includes information and content at a "Beginners" level and for all staff. This includes On-Boarding sessions (scheduled as needed). Additionally, this may include basic language instruction; introduction to the Creation Story, Ohén:ton Karihwatéhkwen, Cycle of Ceremonies, Kaianerehkó:wa (Great Law), social events (ex. socials, plant identification and cooking); special training as scheduled such as decolonization/ indigenization, and intergenerational trauma.

Stream 2 - Tsi Niionkwarihò:ten Training sessions offered to Onkwehón:we staff:

- Includes more in-depth content that may be appropriate for Onkwehón:we staff only. These sessions would overlap with Stream 1, as staff involved may also participate in all sessions related to Stream 1. Stream 2 would be more specific to culturally sensitive materials such as, protocols and practices for medicine making, traditional speeches, Midwinter, Harvest, Maple, Strawberry and other Ceremonies. As well, even more in depth for specific staff related to the work that they do such as, traditional sweats and ceremonial speeches, moon ceremony etc. In order to participate in the MCK Language and Culture Program, staff must be Onkwehón:we.

Tsi Niionkwarihò:ten onboarding

In response to the pandemic, the Tsi Niionkwarihò:ten onboarding presentation was developed a completely online version that staff could complete on their own schedule. In response to a request from Psychological Services, the Tsi Niionkwarihò:ten onboarding presentation was also revamped for use with the external service providers that KSCS refers clients to. This presentation covers an overview of Kanien'kehá:ka, Kahnawà:ke's cultural and historical context, the Tsi Niionkwarihò:ten program and committee at KSCS, the role of Kanien'kehá:ka ways, language and culture within KSCS' strategic plan, and an introduction to cultural safety.

Culture and language resources

The Tsi Niionkwarihò:ten coordinators maintain an inventory of culture and language resources within KSCS, and across the community. These include:

- Kanien’kehá:ka Cultural Resources in Kahnawà:ke
- Cultural centers
- Online videos and resources
- Tsi Niionkwarihò:ten and Health Care
- Language resources
- History
- Books and readings

KSCS Tsi Niionkwarihò:ten activities and events

KSCS continues to strive to incorporate Tsi Niionkwarihò:ten language, culture and values in daily work. Some examples outlined in the 2018 Tsi Niionkwarihò:ten Special Project Final Report include:

- Community socials for Prevention Program activities (Spirit of Wellness Month) and the use of the language in promotion and education activities.
- Ohén:ton Karihwatéhkwen at meetings and the creation of the staff Ohén:ton Karihwatéhkwen project (DVD packet, 2018).
- Tsi Niionkwarihò:ten Community Networking meetings.
- Collaboration with Mohawk Council of Kahnawà:ke Tsi Tewahahara’n Language and Cultural Center. (Continued representation of K.S.C.S. staff seats in programming).
- Collaboration with the Cultural Center for Tsi Niionkwarihò:ten Awareness Month.
- Onkwatakaritátshera Traditional Approaches Sub-Committee representation.
- Medicine Walks and Collaborative Training with Kateri Memorial Hospital Center.
- K.S.C.S. Traditional Support Counsellors, sweats and Residential Schools support.
- K.S.C.S. Tsi Niionkwarihò:ten Committee. Ongoing planning for education and awareness on the Cycle of Ceremonies and language activities for K.S.C.S. staff (2000 to present).
- Tehontatrò:ris Cultural Awareness sessions in the month of April started in 2016.
- K.S.C.S. Tsi Niionkwarihò:ten Special Project Coordinator pilot project and program development (2017-2018).
- Training and K.S.C.S. Personnel Policy changes have been adapted and encouraged to reflect tsi niionkwarihò:ten (e.g. Policy revisions effective Oct. 2, 2017: Traditional Ceremonies (14.4), Bereavement Leave (15.2) and the Ratiwennahní:rats Leave of Absence (15.7))

KSCS Tsi Niionkwarihò:ten program survey 2021 – Pandemic version

In 2021, the KSCS Tsi Niionkwarihò:ten Program Survey (Pandemic version) was developed and deployed. This online staff survey gathered implementation data, determined priorities for programming considering working through a pandemic and helped us better understand where

the Tsi Niionkwarihò:ten program should focus its efforts. One of the questions was on what staff have been doing to integrate Tsi Niionkwarihò:ten into services they provide. Examples of staff initiatives and activities include:

- Applying cultural teachings in counseling work
- Use of Creation Story themes (sky world, darkness, sky woman falling, Great Law & condolence teachings with individual counselling and groups sessions
- Ohén:ton Karihwatéhkwen used in team meetings
- Adding Kanien'kéha to outgoing communications products (Facebook posts, newspaper ads, Christmas cards, etc.)
- Using Kanien'kéha in new psycho-social assessment tool
- Encouraging clients to use natural medicines for self-care (ex: smudging, cedar baths, etc.)
- Using our language with clients who can speak/understand
- Teaching of seasonal traditional stories such as felt board on wáhta & discovery of maple water
- Ohén:ton Karihwatéhkwen felt board in use since 2018, clients participate by placing pictures on felt board
- Making traditional foods with clients – bannock demonstration
- Calling bingo numbers in Kanien'kéha
- A mini cultural library has been set up for staff to use for programs
- Considering/incorporating language and culture when assessing funding opportunities/ projects
- Advocacy for policy change to reflect our cultural practices
- Teaching staff to use digital keyboards to facilitate ease in typing accents, helping lower the barrier of effort when adding Kanien'kéha to their posts, emails, and digital correspondence
- Incorporating learning from workshops-better able to understand those individuals who come in and speak of their cultural beliefs and practices
- Using smudging/ sprays to cleanse negative energies. Use of herbal teas.
- Use of songs and other tools to help connection with body, emotions, and spirit

Communication, collaboration and coordination

As exemplified by the examples above, the Tsi Niionkwarihò:ten program extensively collaborates with partners within and external to Kahnawà:ke. It's activities are not limited to KSCS staff; rather, they are cross-cutting, - encompassing health, social care and educational organizations. Examples of recent collaborative activities are highlighted below:

- Internal events (2020/21/22)
    - Kanien'kéha Sessions and language requests
    - Staff educational events (Corn Harvesting & Braiding, Tree Identification and Fire Making with Iontionhnhéhkwen Wilderness Skills, Wáhta teachings)
    - Staff wellness activities (sharing circles, moon ceremonies, snowshoe club sessions)

    - Traditional Wellness Videos
    - Staff onboarding sessions (Tsi Niionkwarihò:ten Committee Meetings, Tsi Niionkwarihò:ten Program Coordinators meetings, Informal staff support meetings, Suicide Prevention session planning meeting)
    - Kanien'kehá:ka Growth and Empowerment Tool
    - Special Requests for Tsi Niionkwarihò:ten Content (Cultural Safety, cultural videos, Prevention and Support requests to participate in events (ex. Spirit of Wellness Month, Winter Carnival, Pink Shirt Day, Teacher Support Sharing Circles, Parenting Team What's for Lunch show)
    - Promotional Activities (Traditional Dress Day photo contests, Aionkwatakariteke newsletter articles, Facebook live recordings with What's for Lunch, Mother Language Day mini Kanien'kéha lesson, Pink Shirt Day kiosk at schools)
    - Tsi Niionkwarihò:ten Resource Library
- External events (2020/21/22)
- Meetings (Tewahará:tat Tsi Niionkwarihò:ten Language and Culture Network, Tewahará:tat Tsi Niionkwarihò:ten Special Meetings e.g. Cultural Awareness Month Addictions Panel, Mentorship Project)
- Training (KSCS staff participation in Mohawk Council of Kahnawà:ke Tsitewaháhara'n Language and Culture Program, Special Request for Suicide Prevention Training at KMHC)
- Special Events/Requests (Tsi Niionkwarihò:ten Program Coordinators reassigned to Emergency Food Basket from April 2021 to September 2021, Tsi Niionkwarihò:ten Program Coordinators facilitated Staff Support Sharing Circles for the Education System, Tsi Niionkwarihò:ten Program Coordinators participated in Winter Carnival and Holiday Parade)

The program coordinators also attend community language & culture network meetings, to maintain alignment with grassroots groups, KOR Language & Culture Center, MCK Language & Cultural Training Center and Kahnawà:ke Collective Impact (which has various cultural, language & wholistic health priorities).

2016 CHP mid-term evaluation recommendations: Progress and areas requiring attention

The Tsi Niionkwarihò:ten program provided feedback regarding the culture and language-related recommendations in the 2016 mid-term CHP evaluation report (section 4.5), particularly in relation to whether recommendations were addressed, and areas requiring further attention. The following is a summary of feedback regarding the content of the CHP mid-term evaluation:

- The recommendations have not been fully followed through. Rather than focusing on how to entrench Kanien'kehá:ka culture and values at a higher Onkwata'karitahtshera level (across all health priority areas), it seems that it was able to roll down to the individual organizations in different ways.
- Culture and language was not established as a health priority with its own committee (over and above the original 7 priorities). It is not entirely clear how and to what extent culture and language have been integrated into program.

- Onkwata'karitahtshera did have a traditional approaches Sub-committee made up of representatives from the member organizations, which was working on how to better share resources and work towards improving and expanding traditional services for the community. This sub committee operated from approximately 2013 to 2018 when it was put on hold. Perhaps it is time to revisit the feasibility of gathering again.
- To achieve recommendation 7 for integration of language and culture across all health priorities, there needs to be some form of "cultural wellness" action team dedicated to this task. Ideally this team would be made up of individuals with a love for tsi niionkwarihò:ten and a strong desire to see it flourishing within the community. There needs to be those already incorporating tsi niionkwarihò:ten within their work/their lives (stakeholders engaged in culturally based programming), Managers and Directors who are dedicated to supporting this vision, and as suggested others such as elders and cultural experts/knowledge keepers.
- Cultural safety guidelines for health & social services in Kahnawà:ke would be extremely helpful. We also need training to go with it. Cultural safety is an area of interest to the Tsi Niionkwarihò:ten program, and has already been requested for training.
- Research dedicated to how Haudenosaunee ways could be best integrated into programs and services while respecting the diverse needs of community members is needed. This a challenge at organizations such as KSCS. Along with increasing the level of tsi niionkwarihò:ten education of staff, it is important to look at how each person can translate that education into action within their work (everyone is at different levels of comfort and skill to do this). Surveys in the community and outcomes of many reports highlight the need for better integration and list what people want to see but we do not have a concrete plan for achieving it. Presently, KSCS still offers mostly mainstream or "western" health services. It is important to learn from places where western and traditional knowledge has been successfully integrated at all levels. Page 52 of the mid-term evaluation report points this out - the main two known services to seek traditional methods of wellness support are KSCS's Family & Wellness Center (traditional support counsellors) & KMHC's Traditional Medicine unit. Both of these services are limited in capacity (small numbers of staff), and their reach is limited to clients who a) know about what they offer, and b) express interest or activity seek out such services. It is important to improve their reach, capacities and capabilities.

Tsi Niionkwarihò:ten Final Report (2018-2019): Organizational and coordinator-level recommendations (progress and areas requiring attention)

The Tsi Niionkwarihò:ten coordinator provided input regarding the organizational and coordinator-level recommendations in the 2018/19 Tsi Niionkwarihò:ten report, particularly in relation to whether recommendations were addressed, and areas requiring further attention (26). Many of the organizational-level recommendations are potentially generalizable, and can be adapted to other organizations and settings across the community (see Appendix Section 11).

5.23 KMHC Quality Improvement, Risk Management And Innovation)

Highlights

- CHP health priorities: Cross-cutting.
- A particularly strong and comprehensive evaluation and continuous quality improvement infrastructure (CQI) is being developed and supported by the high performing Quality, Risk Management and Innovation (QIRMI) team. The work encompasses important domains related to risk management, safety, accreditation, patient experience, MYLE EMR, CQI, Knowledge Translation and Exchange (KTE) and innovation.
- KMHC was "Accredited with Exemplary Standing", the highest designation with Accreditation Canada. Out of 1,193 standards that were evaluated, KMHC met or exceeded the requirements of 98.99%.
- KMHC is now focused on expand the organization's focus and activities from quality assurance and accreditation, to also encompass evaluation and Continuous Quality Improvement (CQI).
- It would be beneficial for the QIRMI team to work with other health and social care organizations, to arrange cross-learning sessions and Knowledge Translation and Exchange (KTE) mechanisms. This would enable the sharing of knowledge and experiences relating to various approaches to evaluation and QI on an ongoing basis, and enable alignment and promote innovation and best practices.

Overview

The Quality Improvement, Risk Management and Innovation (QIRMI) service at Tehsakotitsén:tha (KMHC) aims to promote and enhance the quality of care and services provided to users and families. The program partners and collaborates with all service areas at Tehsakotitsén:tha, supporting all members of the organization including staff, managers, directors and board members on activities relating to quality improvement (QI), risk management and innovation:

Quality Improvement entails assisting the organization in continuous quality improvement initiatives by:

- Identifying areas for improvement that are related to user and family safety
- Enhancing excellence through staff safety training
- Ensuring best practices and quality standards are maintained and applied
- Promoting and facilitating teamwork across services at Tehsakotitsén:tha

Risk Management entails promoting and developing safety culture, while supporting the organization in:

- Being proactive in identifying risks of users and families
- Highlighting weak links or gaps in our organizational processes
- Reviewing and analyzing incidents and accidents that have occurred
- Mitigating a risk and/or prevent recurrence of the incident/accident
- Providing information regarding risk and quality management activities

Innovation entails increasing the efficiency and efficacy in all processes in the organization by:

- Assessing and adapting processes using proven healthcare approaches
- Facilitating the implementation of automated database reporting systems to increase accessibility of information
- Applying the latest healthcare innovations and advancements

Program and services

The Quality Improvement, Risk Management and Innovation (QIRMI) team is comprised of:

- Manager
- Administrative assistant
- Nurse Advisor
    - Responsible for reviewing and approving clinical protocols or decisions
    - The Nurse Advisor also supports outlining the roles and responsibilities of RNs, LPNs and Home Health-Aids within KMHC, with the goal of having all the professionals work to the top of their scope of practice, and to improve staff engagement and retention
- QIRMI Advisors
- QI and communications agent

The functions of the team members are outlined and integrated into the QIRMI program's logic model. The QIRMI team's key functions and activities relate to the following domains, and are described further in the sections below:

- Enhanced communications
- Staff orientation
- Continuous education
- MYLE EMR
- Patient experience
- Accreditation
- Safety and integrated risk management
- Continuous Quality Improvement (CQI)

Enhanced Communications

The QIRMI team dedicates significant resources and time towards communications activities. The focus relates to improving community and staff awareness of the QIRMI team's role and functions, and how they relate to all programs and services within Tehsakotitsén:tha. Communications also encompass KTE (Knowledge Translation and Exchange) functions, to ensure staff awareness, engagement and alignment across the entire organization.

Examples of key communications functions include:

- "Coffee with QI" video series
- The ''Did you know" advertisement campaign, providing information to the community and staff, to build awareness and counter misinformation regarding organizational policies and processes. Furthermore, to provide general news, updates and information regarding access to information and services.
- Positive updates: supporting the Executive Director and Communications Officer
- Simplified reporting and communication of evaluation findings and data (e.g. surveys, audits results, etc.) for staff and the wider community
- QIRMI team annual report

Figure 13: "Coffee with QI" QIRMI team video series snapshot

Staff orientation

The QIRMI team supports general staff orientation functions, with topic encompassing:

- Cultural Awareness
- Fundamental Kanien'kéha
- Our vision, mission & values
- Strategic orientations, programs & services
- Onkwaná:ta Our Community,
- Onkwata'karí:te Our Health (Regional Health Priorities)
- Research ethics in Indigenous communities
- Infection Prevention & Control (IPAC)
- Tsi ní:ioht tehsì:teron (homelike environment)

- Fall prevention & least restraints policy
- Privacy & confidentiality in healthcare
- Safety culture, reporting risks & accreditation
- Workplace violence prevention
- Emergency response measures
- Wellness Initiatives
- Retirement planning
- Computer training
- Committees and how to get involved
- Suicide prevention
- Ethical decision making framework
- Social media policy
- Mistreatment of older adults

The QIRMI team are looking into offering future sessions through an online learning platform where more topics can be added, and whereby staff can be trained when they start, versus only one session per year. In the meantime, the QIRMI team is gathering all the content for the topics to be presented in the new online platform, piloting it with few employees, and preparing a proposal for senior management.

Continuous education

The QIRMI team supports continuous education for KMHC staff, through a variety of functions and activities:

- Staff Excellence Training (SET) Days: These include sessions for all employees, as well as specific sessions for clinical staff. Topics (all-staff sessions) include: Accreditation, the Strategic Plan, Falls, Microsoft 365, Committees, Staff Health & Wellness, Reporting Risks & Disclosure, Respect & Communication. Topics for clinical SET Days include: PSP on IV Iron, Point of Care Risk Assessments, Anaphylaxis, Disclosure, Mental Health, and Palliative Care from a Traditional Medicine Perspective. Generally, there is positive feedback from staff for the training days, along with feedback regarding future topics for inclusion for future trainings.
- Supporting Nursing Director and Nursing Clinical Managers to ensure all nursing staff receive: updates and links training for OIIQ and OIIAQ accredited hours; refresher of collective orders (during clinical SET days), rights for medication administration; implementation of the Safety Medication Administration Vest
- Refresher training on Safety Culture

MYLE EMR

The QIRMI team providing KMHC teams with supports and updates relating to MYLE EMR. A MYLE EMR pilot is focused on ensuring optimization and standardization of processes and

workflows, the development of policies and procedures, as well as audits (focusing on patient chart access, to ensure confidentiality). The MYLE EMR agent provides support relating to technical issues, quality control, forms, profile settings and audits. The team is also working with Medfar to develop custom dashboards.

Patient experience

The QIRMI team supports a wide range of activities relating to measuring, assessing and improving the patient experience at KMHC. Key projects include:

- Patient reported experience measurement (PREM)
  - Survey design, deployment, analysis and reporting
  - Examples include the KMHC Outpatient Service patient experience survey
- Users Committee
  - Functions include supporting the following: inpatient newsletter and reminder of users' rights; food menu with pictures for residents; art project for inpatients; support community on respecting their rights and complaint process; surveying KMHC services
- Ombudsman
  - Development of new role and responsibilities of the Ombudsman (Service Quality and Complaint Commissioner) on retainer, similar to ethicist agreement.
- Development of the Patient and Family Advisory Council (PFAC)
  - Patient-Family Advisory Councils (PFAC) promote patient and family engagement with the healthcare team to improve the quality and delivery of care. Patients and families provide diverse perspectives and lived experiences that may not have been previously considered in clinical and organizational decision-making. The PFAC facilitates two-way communication and collaboration between the patients and hospital regarding everyday operations, program development, and develops strategies and interventions to improve patient care. PFACs meet monthly to discuss patient and family experience. Strategies and advice developed by the PFAC will be taken into consideration and may be implemented into organizational policies and structure. At KMHC, the PFAC will offer families and patients greater access to the internal and external operations of the organization. PFAC members will be involved in general reviews, decision-making, and project implementation, among other areas. The council will provide members with a wholistic vision of KMHC's challenges, realities of the decision making and implementation, and show what is involved in maintaining some of the projects that are alive and thriving at KMHC.
- Mistreatment policy
- Complaint process
- Volunteering Program (expansion to the entire organization, not just inpatient services)

Accreditation

As part of KMHC's commitment to patient safety and quality healthcare, the organization had its fifth Accreditation Survey with Accreditation Canada between November 29 – December 2, 2021. The survey is an important stage of the four year accreditation cycle. KMHC reviews organizational practices, and compare them to the standards of excellence in the following areas:

- Governance
- Leadership & Risk Management
- Infection Prevention & Control
- Medication Management
- Home Care
- Long-Term Care
- Short-Term Care
- Primary Care and Community Health

The QIRMI team is composed of specialists who act as facilitators for the accreditation process. The QIRMI team guides all KMHC teams in relation to understanding and addressing accreditation standards and processes, providing knowledge, and assisting teams with meeting benchmarks and best practices.

KMHC facilitates self-assessments (e.g. Governance functioning, worklife pulse, patient safety, culture organizational self-assessment [e.g. Aboriginal Integrated Primary Care]), creates action plans and works to improve areas where needed. Monthly accreditation meetings are held, to review the results from patient experience surveys, prioritizing red flags and updating action plans). The following goals are set for KMHC teams:

- identify relevant evidence to your standards set
- identify gaps (issues, challenges) and communicate them to the right instances
- know how to bring back constructive feedback and evidence to the Team
- develop and update actions plans according to priority (red, yellow, green flag)

The QIRMI team receives feedback from the accreditation surveyors, and works with staff to improve processes and practices.

In 2021, KMHC was "Accredited with Exemplary Standing", the highest designation with Accreditation Canada. Out of 1,193 standards that were evaluated, KMHC met or exceeded the requirements of 98.99%. Despite challenges related to the pandemic and staffing issues, the surveyors commended KMHC's staff and Board for being "truly motivated by community, [and] focused on quality".

The QIRMI team is focused on shifting the organizational culture, from an emphasis on accreditation, to move towards encompassing and focusing on Continuous Quality Improvement (CQI).

Safety and integrated risk management

The QIRMI team conducts comprehensive safety and integrated risk management functions, including ongoing measurement, assessment and reporting activities: The work encompasses:

- Quarterly Reports including the following risk event statistics:
    - Client incidents and accidents (by type, severity and service area)
    - Falls (by type and severity)
    - Medication events (by type and severity)
    - Diagnostic tests (by type and severity)
    - Medical devices
    - Treatment events (by type and severity)
    - Materials, equipment or personal effects (by type and severity)
    - Abuse, assault, harassment or intimidation
    - Sentinel events
- Quarterly reporting of performance and quality indicators
    - Accessibility (wait lists and wait times, by service area)
    - Safety (non-clinical events, workplace violence)
    - Worklife (staff incidents and accidents, by type and service area)
    - Client-centeredness (processes, clinical and professional aspects)
- Presentations to: Management/Senior Management, Board of Directors, Oversight Committee
- Patient Incidents/Accidents processes: analyzing trends, investigations, debriefs, recommendations, prioritization
- Organizational risks: complaints, investigations

The QIRMI team has also supported the development of a comprehensive Patient Safety Action Plan, which focuses on the following goals and objectives (for 2021/22):

- Create a culture of safety within the organization
    - Strengthen and reinforce the process of event investigation and disclosure to provide safer care to clients
    - At least one patient safety related prospective analysis is carried out and appropriate improvements are implemented as a result
- Ensure the safe use of high risk medications
    - Ensure that high-alert medications are managed safely
    - The availability of high-risk medications is limited to ensure they are not available in patient service areas.

- Reduce the risk of health-care associated infections and their impact across the continuum of care
    - Compliance with accepted hand hygiene practices is measured and hand hygiene education is provided to all staff
- Identify and mitigate safety risks inherent in the patient population
    - Emergency and disaster preparedness

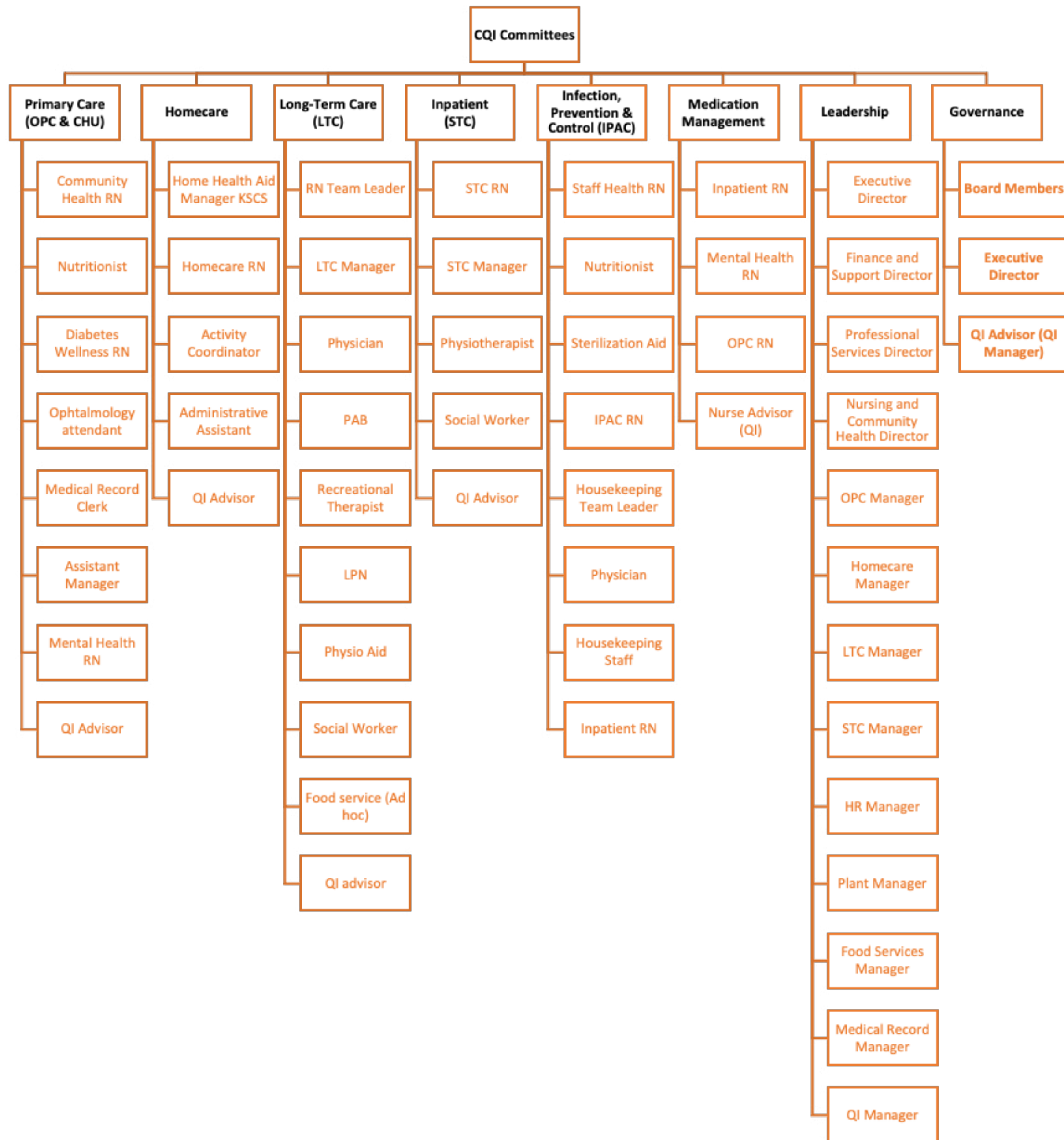
The QIRMI team also works with KMHC manager and directors, to develop and operationalize Action Plans, and to assess performance via the development of indicator frameworks and dashboards.

Continuous Quality Improvement (CQI)

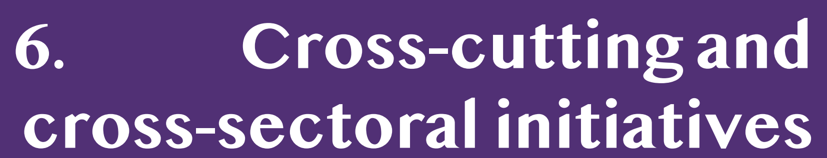
The QIRMI team facilitates and supports the development and work of KMHC's Continuous Quality Improvement Committees (CQICs), in accordance with Accreditation Standards [Figure 14]. The CQICs have replaced the Risk and Quality Management Committee (RQMC). KMHC's CQICs include:

- Primary Care CQIC
- Homecare CQIC
- Long-Term Care CQIC
- (Inpatient) Short-Term Care CQIC
- Infection Prevention and Control CQIC
- Leadership CQIC
- Governance CQIC
- Medication Management CQIC

Figure 14: CQIC organizational structure



These CQICs worked hard all year evaluating the standards, conducting audits and assessment, and creating action plans. The QIRMI team hopes to incorporate more risk management and LEAN management approaches moving forward, while ensuring alignment across all the different areas in the hospital. The QIRMI team also meets regularly with Tekanonhkwatsherané:ken (Two Medicines Working Side by Side) to learn, collaborate and get feedback on QI projects.



6. Cross-cutting and cross-sectoral initiatives

6. Cross-cutting and cross-sectoral initiatives

This section provides descriptions and analyses of programs and initiatives that often leverage cross-sectoral collaborations to address CHP priorities, as well as other population health needs in Kahnawà:ke's. These initiatives include:

- The Community Health Plan Initiative (CHPI)
- Kahnawà:ke Collective Impact (KCI)
- Wellness Action Team (WAT)

6.1 Community Health Plan Initiative (CHPI)

The Kahnawà:ke Community Health Plan Initiative's (CHPI) goal is to address the priority health issues, and provide Kahnawakehró:non with opportunities to design, develop, and participate in projects to address health and social issues in the community (27).

Community members, community groups, and multi-disciplinary committees including health, social, education, and recreation sectors who submit projects that include the elements of:

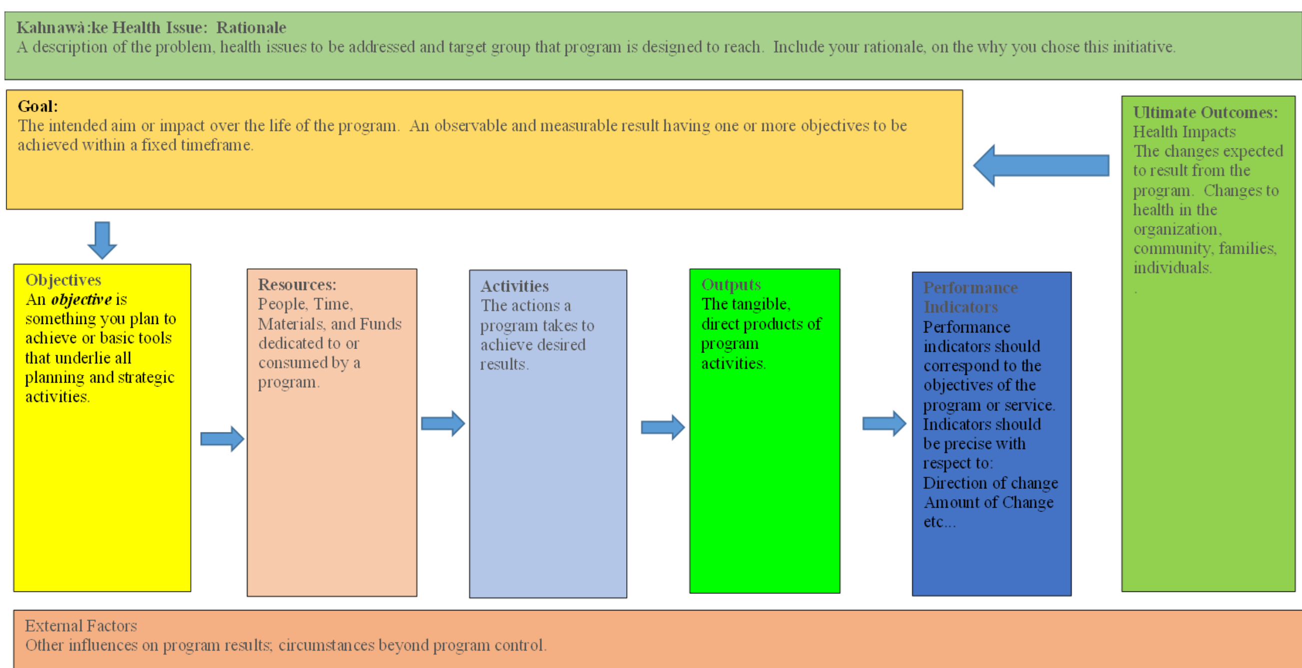
- Care and treatment,
- Prevention, promotion and education
- Lifestyle supports

Projects must demonstrate how they will address and benefit two or more areas of Kahnawà:ke's health priorities:

- Mental Wellness: Mental Health Issues & Substance Abuse/Addictions
- Chronic Disease: Diabetes, Cardiovascular Disease (hypertension), Obesity
- Early Childhood Wellness: Learning/Developmental Disabilities
- Cancer

Since 2016, 74 diverse CHPI projects by health care, social services and educational organizations have been funded and successfully implemented. All projects include logic models, and upon completion, have had evaluations completed. The CHPI logic model template is shown below:

Figure 15: CHPI Logic Model template



CHPI projects address the health priorities for various age groups, using a wide range of health, social and educational issues and activities. For example, 2020/21 the following organizations received CHPI funding, for projects addressing Cancer, Chronic Disease, Early Childhood Wellness and Mental Wellness & Addictions priority areas. All projects integrated logic models, and complete evaluation reports upon closing of the project, as per the CHPI's requirements.

Table 17: CHPI Logic Model template

Organization	Funded project(s) 2020/2021
Kahnawà:ke Education Center	Encore Sistema
Kahnawà:ke Youth Center	Community Events Community Fitness Healthy Nutritional Snacks
Kanien'kehá:ka Onkwawén:na Raotitióhkwa Language and Cultural Center	Tóta tánon Ohkwá:ri
Kateri Memorial Hospital Centre	Diabetic Eye Screening At Peace with Diabetes Tekanonhkwatsherané:ken/Two Medicines Working Side by Side
KSCS / Teen Social Club	Painted Ponies
KSCS / Young Adults Program	Golden Horses
Oná:ke	Kahnekanó:ron
Skawenni:io Tsi Iewennahnotahkhwa Kahnawà:ke Library	Children's Literary programs for Intrinsic Well-being
Skawenni:io Tsi Iewennahnotahkhwa Kahnawà:ke Library	Pilot Project – Health and Wellness Collection
Step by Step Child and Family Center	Moving: Toward Healthy Lifestyles

The CHPI projects are highly successful in terms of:

- Engaging grass-roots organizations and programs with the CHP
- Improving awareness relating to the community's health priorities
- Promoting alignment of community-based strategies and initiatives with the CHP
- Enabling cross-sectoral collaboration
- Strengthening evaluation capabilities (e.g. learning how to develop a logic model, evaluation design and implementation)
- Promoting grass-roots innovative approaches to addressing population health and wellbeing priorities

It would be beneficial to arrange annual forums, for CHPI participants to come together and share knowledge and experiences and successes. This would enable Knowledge Translation and Exchange (KTE), cross-learning, collaboration and promote innovative approaches developed through the CHPI.

6.2 Skátne Teionkwaká:nere - Kahnawà:ke Collective Impact (KCI)

Kahnawà:ke Collective Impact (KCI) is a long-term grassroots movement and collaborative approach towards positive community change (28). The aim is to foster greater collaboration across organizations and groups in the community to address social and economic issues, and to support positive change that nurtures a thriving Kanien'kéhaka community rooted in a connection to culture, identity and traditions.

This process enables the community to work together on identified priorities and create action plans. KCI's Steering Committee was formed to provide guidance on the work to be undertaken through the Collective Impact process. The Steering Committee learned about the work that various community organizations were championing, and through community engagement sessions and Open House events, narrowed an initial list of 17 community priorities down to six for possible collective action:

Food sovereignty:

This priority focuses on the right to food which is sufficient, safe, secure, healthy and appropriate to use and share in a socially and environmentally safe and sustainable way.

A Kahnawà:ke Food Sovereignty survey conducted in March 2021 found that:

- 74% of respondents agreed or strongly agreed that "participating in the food sovereignty initiative helped improve my mental wellbeing"
- 63% of respondents agreed or strongly agreed that "participating in the food sovereignty initiative was a valuable cultural experience"
- 74% of respondents agreed or strongly agreed that "participating in the food sovereignty initiative gave me an opportunity to learn new things"
- 79% of respondents agreed or strongly agreed that "participating in the food sovereignty initiative was a valuable wellness experience"

Language and culture mentorship program:

This program will build language fluency in the community by placing Masters (First Language Speakers) with Apprentices (Individuals with a strong desire to learn Kanien'kéha) in an immersion setting on their own time, pace, and schedule but meeting a 300-hour target in six months.

Wholistic health and wellness initiative:

This priority is aimed at providing young adults with the freedom to learn and create their own group-driven, and individually-respecting, one-year program in "Preparation for Life." At the initial Skátne Teionkwaká:nere Collective Impact Event there was an overall agreement that young people have a right to a clean (addiction-free), healthy (mental and physical), safe/secure (emotional, physical and relationships) community with many opportunities for physical activity, healing, and support from the entire community.

There was agreement that all community members have the right to healthy spirits, numerous lifestyle opportunities, freedom from alcohol and drug symptoms and addictions, opportunities for healing from past trauma, and freedom from mental, sexual, and physical violence. In order to live healthier lives and avoid transference, community healing was emphasized to address the effects of colonization, residential schools, and multi-generational trauma. There was also support for the promotion, integration, and support for traditional healing therapies grounded in our culture.

Furthermore, three Kahnawà:ke youth (21-29) will be sent to Sharm El Sheikh, Egypt for the global climate negotiations – also known as COP27. The conference dates are November 7-18, 2022. This initiative is supported by Kahnawà:ke Collective Impact, the David Suzuki Foundation, Climate Reality Project, and the Foundation of Greater Montreal.

Economic development strategy:

The need for an economic development strategy was identified through prior community feedback. Currently, the community needs a global economic strategy or guidelines to ensure culturally relevant ventures/investments in line with community values. There is also a desire for an economically independent community with high employment rates, educated community members, a strong sense of identity and more community owned and operated businesses which are aligned with community values.

Tewatohnhi'saktha (Kahnawà:ke's Economic Development Commission) is therefore a strategically important KCI partner. Tewatohnhi'saktha's mission is to stimulate and enhance Kahnawà:ke's economic growth by investing in people and businesses. Its vision is a self-sustained community that creates well-being and prosperity for seven generations in accordance with Kanien'kehá:ka cultural values.

Tewatohnhi'saktha mandate:

- Workforce Development – to enable individuals to acquire knowledge, skills and attitudes for gainful employment or improved work performance and providing employers with an effective means to communicate and meet their demand for skills to decrease the number of unemployed and under-employed community members.
- Business Retention & Expansion – to ensure that businesses located within Kahnawà:ke maintain and expand (as measured by increasing the number of individuals employed) their operations within the Territory.
- Entrepreneurship & Business Services – to provide entrepreneurs with access to developmental loans and other financial contributions, training, mentoring and the technical assistance they need to start-up and expand their business.
- Economic Development Marketing and Tourism – to market the overall community, individual properties or sites, or specific programs or policies for the purposes of attraction, retention, and expansion of businesses, increasing the number of tourists, and improvement of the community's image locally, nationally, and internationally.
- Economic Policy Advisory – to provide research and analysis of how economic policy, commercial regulations, and macroeconomic trends could impact Kahnawà:ke's economy and businesses.

Kahwa:tsire family resource:

Parenting is key to family success in all areas of identity and culture, health and wellness, education and learning and more. This is an initiative to develop a New Parent Resource Kit that provides expecting parents with information about cultural teaching, and existing resources, tools, and support groups in the community.

6.3 Wellness Action Team (WAT)

The Wellness Action Team (WAT), previously called the ‘Covid-19 Mental Wellness Action Team’ (a subcommittee of the Covid-19 Task Force), had its roots in the pandemic response. However, it quickly evolved to comprehensively address the wholistic physical, mental, emotional and spiritual needs of the community. The name was changed focus on Wellness, to better reflect a wholistic understanding of wellness as more than the absence of disease (e.g. COVID-19).

The WAT encompasses many organizations within the community, who meet regularly (usually monthly) to share knowledge and resources, and to identify needs and ways to collaboratively address them using a community-based approach. The team works together to support resiliency and wholistic wellness in the community, in response to the pandemic.

Figure 16: WAT group Jamboard session

The team includes community members and staff from KSCS prevention, mental wellness and addictions teams, KSCS and KMHC Home and Community Care, KEC, MCK (including sports and recreation and communications), KYC, Tewatohnhi’saktha, Step by Step Child and Family Center, Kahnawà:ke Collective Impact, New Frontiers School Board, KMHC Public Health and Kahnawà:ke Peacekeepers. In addition to planning health and wellness activities, the WAT developed trauma informed training that ties into the larger history of trauma to the community.

The WAT has a well-developed project logic model for evaluation, which includes the following performance indicators and outcomes:

Table 18: Wellness Action Team indicator framework

Performance indicators	Funded project(s) 2020/2021
• % of participants reporting a meaningful change (increase) in their awareness of mental, emotional and spiritual health • % of participants reporting a • meaningful increase in their coping skills, especially towards pandemic impacts • % of participants feeling more resilient • % of participants feeling their mental, emotional and spiritual health is increased, during/after the campaign as compared to before • # of participants who reached out to someone else for mutual support • The importance of connecting with others and self-care is as prevalent in messaging as physical • safety messages.	• Reduce wholistic wellness negative impacts of the Covid-19 pandemic • Increased resilience • Increased coping skills • Increased feelings of connectedness • Reduced stigma surrounding wellness issues during the Covid-19 pandemic • Connecting with others and selfcare

The WAT developed and deployed a community health/wellbeing survey, to understand the state of health and wellbeing in the community and to assess needs, particularly within the context of the pandemic. The survey focused on the concept of "wholistic wellness": the idea that different areas of our health are in balance, interconnected, and affect one another. There four areas of health and wellness are stated as:

- Physical health (Our body)
- Emotional health (Our feelings)
- Mental health (Our mind)
- Spiritual health (Our spirit)

The results of the WAT survey will be reported very soon, providing much-needed data regarding the community's needs, access to mental health services, pandemic impact on health (physical, emotional, mental and spiritual), and overall self-rated health status.

In addition to providing extremely important data, the WAT survey was an example of productive and successful cross-sectoral collaboration. To build upon the WAT's success, and to support its development, it is important to create supporting structures and improve clarity regarding respective roles, responsibilities and accountabilities.

7. System-level performance

7. System-level performance

To address the evaluation question (#2) relating to the performance of programs, services and initiatives, an analysis of the generalized system-level findings related to the following strategic domains of the evaluation framework are presented:

- Organizational needs
- Service delivery models
- Access
- Teamwork
- Communication, coordination and collaboration
- Community engagement
- Client, family and caregiver experience
- Evaluation, performance assessment and quality improvement
- Data infrastructure
- Data analytics, business intelligence and health informatics
- Pandemic impact and response
- Culture, language and identity
- The Community Health Plan (CHP)
- A Community Wellness Plan (CWP)

7.1 Organizational needs

Highlights

- Organizations, programs and services are continuously adapting and evolving to meet the increasing biopsychosocial needs of the community (in scope, complexity and intensity).
- The Health Portraits (Volumes 1 and 2 [forthcoming] of Onkwaná: ta Our Community, Onkwatákarí:te Our Health) provide useful evidence of the increasing complexity of population health needs of Kahnawakehró:non.
- Several programs and services have indicated that their resources need to be expanded, upgraded and/or updated, to effectively meet the increasing needs of the community.

Health, social care and educational programs and services across Kahnawà:ke are continuously adapting and evolving to meet the increasing health and wellbeing needs of the community. These needs are increasing in scope, complexity and intensity (particularly in terms of service utilization), spanning all biopsychosocial health and wellbeing domains (e.g. somatic, psychosocial and socio-environmental), as well as spiritual needs.

The Health Portraits reports (Volumes 1 and 2 [forthcoming] of Onkwaná:ta Our Community, Onkwatákarí:te Our Health) provide detailed data and analyses of the increasingly complex population health needs of Kahnawakehró:non (29,30). By leveraging a variety of data sources, the Health Portraits provide insights into the prevalence, incidence, impact and trends of priority health domains. Examples of significant population health and wellbeing needs and challenges include:

- Early childhood and family wellness (e.g. high numbers of babies born to teenage mothers and new concerns, like the upward-trending rates of Attention Deficit / Hyperactivity Disorder [ADHD] and Autism Spectrum Disorder).
- Mental wellness and mental illness (e.g. anxiety, depression, suicidality – particularly in youth)
- Violence
- Substance use and addictions (including alcohol abuse)
- Cardiovascular chronic illness and disease (e.g. diabetes, hypertension)
- Tobacco use and smoke exposure

Organizations across Kahnawà:ke have worked to meet the increasing needs of the community, through the redesign and/or expansion of programs and services. A notable example is KMHC's expansion project, which renovated and expanded the facility, increasing bed capacity by close to 70%, and incorporating medical imaging (X-ray) and Traditional Medicine to its outpatient services. The additional Inpatient Care Beds in both short-term care (STC) and long-term care

(LTC) brought the total number of beds to 73 (15 STC and 58 LTC). The project also enhanced and expanded infrastructure and /or services such as physiotherapy, occupational therapy, adult day center/inpatient activities, kitchen, admission, archives, medical records, administration, training and conference rooms and outpatient clinics.

However, several programs and services have indicated that they have “outgrown” their space, and also emphasized that their resources need to be expanded, upgraded and/or updated to meet the increasing needs of the community.

Organizational resource needs mainly relate to the following domains:

- Physical space (design, maintenance, repairs, renovations, expansions)
  - It is also important to note that social distancing requirements during the pandemic often exacerbated existing challenges related to insufficient physical space, which sometimes limited service delivery and/or compromised safety.
- Equipment (availability, maintenance, repairs)
- Information technology (IT) and data infrastructure (functionality, training, support, trouble-shooting)
- Management and administration (availability, knowledge, practices and skills)
- Human resources (recruitment, retention, training and education)

If additional funding and/or human resources are limited, staff have indicated that there are areas where program and service efficiency can be enhanced through cost-effective measures, such as:

- Ensuring that existing equipment and technology are functional and routinely maintained
- Redesigning multidisciplinary teams to maximize scope of practice, and to delegate more tasks to non-clinical staff (e.g. receptionists, administrative staff) through proper training

7.2 Service delivery models

Highlights

- There is increasing standardization of multidisciplinary team-based service delivery models, particularly in relation to professionalization, and the use of standardized assessments, guidelines, protocols and processes.
- Organizations across Kahnawà:ke are continuously redesigning their programs and services, to ensure accessible, effective, efficient, equitable and culturally safe service delivery.
- However, depending on program or service, there is significant variability and sometimes ambiguity in relation to the use and implementation of standards, as well as the availability of updated logic models and/or service delivery model descriptions.

Across Kahnawà:ke's health, social care and educational organizations, there are increasing efforts and initiatives to standardize multidisciplinary team-based service delivery models, particularly in relation to the formal use of assessment tools and standardized protocols, guidelines, processes and workflows.

The standards used by some programs and services sometimes meet or exceed provincial guidelines and levels, and are sometimes adapted and/or redesigned to be culturally safe and contextually appropriate. For example, KMHC was "Accredited with Exemplary Standing", the highest designation with Accreditation Canada. Out of 1,193 standards that were evaluated, KMHC met or exceeded the requirements of 98.99%. Home and Community Care (HCC), Assisted Living Services (ALS) and Step by Step Child and Family Center (SBS) also use standardized tools and processes for team-based service delivery, as do other organizations and programs across the community.

However, depending on program or service, there is significant variability and sometimes ambiguity in relation to the use and implementation of standards. For example, the key functions of some programs (e.g. relating to admission, needs assessment, case conferencing, care planning, coordination, referrals, follow-up and discharge) could benefit from increased standardization, to ensure consistency of client experiences and quality of care.

A lack of standardization – particularly in relation to the use of standardized assessment tools – also limits the ability of programs and services to conduct systematic assessments and evaluations of performance and quality of care. However, it is important to note that programs and services often do not have access to culturally appropriate or valid assessment tools. Efforts to leverage, develop and validate culturally appropriate assessment tools are ongoing, and need to be supported and promoted.

Furthermore, there is significant variability between programs and services, in terms of the availability of updated logic models and/or service delivery model descriptions (e.g. that should include details of standardized workflows, processes and/or Standard Operating Procedures [SOPs]).

It is important to note that organizations and teams across Kahnawà:keare continuously striving to redesign their programs and services, to ensure effective, efficient, equitable and culturally safe service delivery.

The focus of program and service redesign often encompasses:

- Self-determination (particularly, via decolonizing and Indigenizing values, frameworks and approaches)
- Trauma-informed service delivery design, implementation and evaluation
- Cultural awareness, sensitivity, competency and safety (and integrating these domains in performance appraisals and client experience measurement)
- Integrating the principles and approaches of Tsi Niionkwarihò:ten (Our Ways) into all aspects of design, implementation and evaluation
- Re-orienting services (i.e. towards person-orientation and family-orientation, vs service-orientation)
- Leveraging Social Determinants of Health (SDH) frameworks
- Orienting service design and evaluation towards achieving health and wellbeing outcomes

7.3 Access

Highlights

- Kahnawà:ke's health, social care and educational organizations recognize the importance of enabling low-barrier access to services, and are often actively working to address access-related challenges and barriers that limit participation by community members and families. The use of technology (e.g. virtual and tele-services) has been broadly implemented across many Kahnawà:ke organizations.
- Virtually all services record, monitor and assess utilization and participation rates, often disaggregated by demographic variables. Programs such as home and community care are extremely high performing, with same or next-day services, and virtually no wait list.
- It is challenging to reach some vulnerable families, particularly those with special needs. Furthermore, there are significant challenges to engage teens (particularly those with anxiety, depression and/or who have unhealthy home environments) and enable their participation.
- The lack of transportation limits access to services for lower income families.
- Some organizations (e.g. those serving frail elderly and or special needs clients) require additional and/or upgraded resources, particularly in relation to physical space, staffing and equipment.
- Timely access to primary care services is challenging; furthermore, a significant proportion of Kahnawakehró:non not being attached/registered to a family physician.
- There are gaps in service delivery, particularly in relation to services for teens, intermediate care (i.e. between home and community care and long-term care), mental health and substance use.

Kahnawà:ke's health, social care and educational organizations recognize the importance of enabling low-barrier access to services, and are often actively working to address access-related challenges and barriers that limit participation by community members and families. Virtually all services record, monitor and assess utilization and participation rates, often disaggregated by demographic variables.

A particularly high performing program is the Home and Community Care program, which ensures same or next-day access to services, with virtually no wait list. The team is proud of this stellar example of high performance, and are proactive to ensure that essential services are delivered, even within the context of emergencies such as the pandemic.

Educational organizations pay special attention to ensuring low-barrier and equitable access to educational services. Step by Step Child & Family Center (SBSCFC) has a strong multidisciplinary team that is able to meet the needs of children and families with high levels of biopsychosocial complexity, through the provision of highly inclusive and comprehensive services.

Organizations focused on upstream prevention, such as Kahnawà:ke Youth Center (KYC), KSCS parenting services and the Whitehouse, ensure that programming is inclusive and open to all families. However, the teams are cognizant that it is challenging to reach some vulnerable families, particularly those with special needs. Furthermore, there are significant challenges to engage

teens (particularly those with anxiety, depression and/or who have unhealthy home environments) and enable their participation. A lack of transportation also limits access and participation in programming. Programs at the KYC can also benefit from additional staff with the necessary knowledge and expertise to meet the needs of children with high levels of psychosocial and mental health complexity, such as behavioral technicians. Programs focused on the psychosocial needs of teenagers are required, including teen healing.

Some organizations have indicated that additional and/or upgraded resources are required, particularly in relation to physical space, staffing and equipment. For example, TBEL has structural limitations as a facility, with no adaptive bathroom, no handicap accessible bathrooms, and areas that are not easily accessible for handicapped clients. Space and staffing are also limited, which limits the ability to address the long admissions wait list. This brings to light the need to develop service delivery models, to address unmet needs in the community, relating to intermediate care models (i.e. between home and community care and long-term care), supportive housing and shelters, and substance use services.

Connecting Horizons is a community-based group working to identify, and respond to, needs of individuals with special needs, and their families. The team continuously identifies limitations regarding current service accessibility, availability and quality, and provided concrete suggestions for improvement in a number of areas such as program availability, program quality and support worker skills and knowledge. As with many health and social services, financial and staffing resources are seen as lacking, which likely contribute to access challenges for individuals with special needs.

KMHC community health services – particularly those targeting infants, children and maternal health – are highly focused on ensuring access and participation. However, the outpatient clinic primary care is encountering challenges, primarily due to staff shortages. The after-hours and weekend clinic offerings are limited, and there are many community members who are currently not registered to a family physician.

Jordan's Principle ensures there is substantive equality and that there are no gaps in publicly funded health, social and education programs, services and supports for First Nations children (0-18 years). Jordan's Principle covers important public and private services such as mental health, special education, dental, physical therapy, medical equipment, physiotherapy and more, and ensures that children and families – particularly those with special needs and vulnerabilities – are able to access these services.

7.4 Teamwork

Highlights

- Virtually all health, social care and educational programs and services across Kahnawà:ke increasingly leverage multidisciplinary team-based approaches, incorporating a comprehensive array of professions and disciplines.
- The development of high performing teams require further dedicated supports and resources (administrative and technical) by their respective organizations.
- Team members often have difficulties reconciling the various perspectives of differing professions and disciplines (e.g. biomedical vs psychosocial), and do not always understand the various professional standards, legal designations or scope of practice of different team members.
- Ongoing proactive assessments of team experience and staff motivation are necessary, to ensure the optimal function and performance of teams.

Virtually all health, social care and educational programs and services across Kahnawà:ke increasingly leverage multidisciplinary team-based approaches. Teams often incorporate a comprehensive array of professions and disciplines, integrating clinical and psychosocial models and perspectives.

Multidisciplinary teams work on a variety of functions, initiatives and governance levels that often exceed team-based approaches to front-line service delivery and care for individual clients. This includes teamwork at macro cross-sectoral levels (e.g. Community Health Plan Sub-Committees) and meso organizational levels, encompassing a range of functions such as community engagement, prevention activities (e.g. Wellness Action Team), accreditation, evaluation and quality improvement (QI).

Although multidisciplinary team structures, processes and dynamics are maturing and under continuous development (both formally and informally), they generally require further dedicated supports and resources. There is also variability in terms of if, how, and to what extent teamwork development is formally resourced and supported by their respective organizations.

Multidisciplinary teams often have difficulties reconciling the various perspectives of differing professions and disciplines, and their respective models of care (e.g. biomedical vs psychosocial). Furthermore, different professions and disciplines often do not properly understand the various professional standards, legal designations and obligations of each team member.

Multidisciplinary teams require ongoing support in relation to increasing awareness regarding the respective scope of practice of individual team members, and how to optimize teamwork through appropriate sharing and delegation of responsibilities

Systematic assessments of team performance also need to be conducted periodically. Examples of standardized assessment tools include that Team Climate Inventory, which assesses the following dimensions of teamwork performance and experience (31):

- **Vision** refers to the shared motivation of the team toward common goals and objectives
- **Participative safety** refers to the degree to which the environment is encouraging, promotes interaction and participation, and is psychologically safe
- **Task orientation** refers to a shared attitude for self and team-level appraisal, communication, and accountability
- **Support for innovation** relates to the team attitudes toward innovation and change and their support for new ideas
- **Trust**
- **Communication**

It is also important to note that staff within teams across the community exhibit very high levels of **intrinsic motivation**, especially from the perspective of **social purpose** (32). The high levels of staff intrinsic motivation should be considered valuable assets to teams and organizations, that should be recognized, protected and supported. The concept of intrinsic motivation is premised on the theory that humans have an inherent desire to direct their own lives, and to progress and improve in areas that matter, while serving something larger than themselves individually. Studies have indicated that intrinsic motivators enhance any level of financial motivator, and contribute to improved individual and team performance.

7.5 Communication, coordination and collaboration

Highlights

- There is universal consensus across Kahnawà:ke organizations regarding the need to proactively work together, specifically in relation to meeting the health and wellbeing needs of the community.
- Communication, collaboration and coordination functions are particularly critical to ensure the continuity and quality of care for individuals with complex needs, who require services from multiple organizations (e.g. the frail elderly, individuals with concurrent mental health and substance use disorders, individuals with special needs, and individuals with multimorbidities and chronic illness and disease).
- It is important to note that extensive formal and informal mechanisms relating to the communication, collaboration and coordination do exist within and between the community's various programs and services.
- The Wellness Action Team (WAT) survey is a strong example of successful cross-sectoral collaboration, that should be supported.
- However, several types of structural barriers limit communication, collaboration and coordination functions and activities (e.g. governance, organizational, professional, disciplinary, IT and personal factors), that should be addressed.

There is widespread consensus across all Kahnawà:ke organizations regarding the value and importance of the functions of communication, collaboration and communication. Furthermore, there is universal recognition of the urgent need to meaningfully work together, specifically in relation to meeting the health and wellbeing needs of the community.

"The coordination of care for Indigenous [Peoples] has been recognised as critical in addressing Indigenous patients' needs, for example in relation to navigating the health system, providing essential information and communication and ensuring cultural safety… The World Health Organisation (WHO) developed a framework on integrated people-centred health services (IPCHS) recommending a fundamental shift of health systems from being disease focused to people-focused. This approach promotes equity in access to healthcare, is responsive to people's needs, and strengthens the capacity of health systems. The framework identifies the primary drivers of continuity and coordination of care. Continuity of care promotes an environment to develop ongoing relationships that support seamless interactions between service providers within and across sectors that enable coordination of care.

Continued on the next page

> Care coordination can be viewed as a broader strategy to improve care by bringing together providers and professionals to meet service users health needs and delivering integrated, person-centred care across settings. Together, continuity and coordination of care are vital to deliver quality care and are likely to be important in improving [outcomes] for Indigenous patients”.
>
> Source: de Witt A et al. **Communication, Collaboration and Care Coordination: The Three-Point Guide to Cancer Care Provision for Aboriginal and Torres Strait Islander Australians**. Int J Integr Care. 2020 Jun 8;20(2):10. (33)

However, there is recognition of challenges and barriers relating to these functions, and widespread fragmentation between and within the community’s organizations. These perceptions are often articulated by the common narrative relating to “operating in siloes”.

These perceptions are often accurate, and are validated by data and client experiences – particularly in relation to their impact on continuity of care. However, it is important to note that formal and informal mechanisms relating to the communication, collaboration and coordination exist within and between the community’s various programs and services. Most teams dedicate significant resources and energy to network and work together, often using inductive collaborative approaches to solve mutual problems.

A particularly strong example of successful cross-sectoral collaboration is the Wellness Action Team (WAT), which encompasses many organizations within the community who meet regularly to share knowledge and resources, and to identify needs and ways to collaboratively address them using a community-based approach. The team works together to support resiliency and wholistic wellness in the community, in response to the pandemic. The WAT successfully jointly developed and deployed a community health/wellbeing survey, to understand the state of health and wellbeing in the community and to assess needs, particularly within the context of the pandemic.

It may be beneficial to map the complex ‘web of interconnections’ (formal and informal) between and within the community’s programs and services. This mapping could serve as a basis for streamlining, improving and standardizing communication, coordination and collaboration functions and activities.

Furthermore, increasing the visibility and transparency of existing productive collaborations is critical, particularly in relation to improving community experiences and perceptions of Kahnawà:ke various organizations – particularly the health and social services.

Several types of challenges and barriers affect communication, collaboration and coordination functions and activities, including:

- Governance factors (differing Board compositions, jurisdiction, accountability, legal frameworks)
- Organizational factors (differing strategic orientations, visions, missions, mandates, priorities, organizational and administrative policies, management and HR policies)

- Disciplinary factors (e.g. differing biomedical vs psychosocial worldviews; prevention vs treatment vs harm reduction approaches; speaking different disciplinary and professional "languages"; hierarchies)
- Professional factors (differing legal designations, scope of practice, standards, skills, ethics frameworks and accountabilities)
- Staff knowledge and skills
- Lack of IT interoperability (e.g. MYLE EMR, Penelope case management system)
- Software platforms (e.g. differing use of various software, such as MS Office suite, MS Teams)
- Organizational culture (different organizational cultures and historical contingencies)
- Personal factors (attitudes, mindsets, biases, trust, emotions, etc)

Communication, collaboration and communication functions are particularly important in relation to programs and services serving highly complex individuals and populations, who use a multitude of services both within and outside of Kahnawà:ke. People with high levels of biopsychosocial complexity (e.g. the frail elderly, individuals with concurrent mental health and substance use disorders, individuals with special needs, and individuals with multi-morbidities and chronic illness and disease) require careful coordination between service providers, to ensure continuity, quality and safety of care.

Therefore, effective and efficient communication, coordination and communication functions are particularly important for programs such as Home and Community care, Mental Health and Substance Use/Addictions. As shown in the program-level evaluations, mechanisms to improve these functions, and overall alignment of structures and processes within these programs, are required. These programs are presently undergoing evaluations, to assess their present state in relation to these functions, and to identify mechanisms and strategies to improve performance of these functions.

It is important to note that the present configuration and design of these programs are influenced by historical contingencies and structural factors, such as governmental policies and funding streams. These macro-level factors have resulted in fragmentation and gaps within these programs. It must also be noted that the leadership, management and service delivery teams address these issues by continuously developing strategies, mechanisms and processes to enable alignment and coordination, to ensure continuity of care, and positive client experiences and quality of care.

7.6 Community engagement

Highlights

- Programs and services all conduct community engagement activities, which encompass a range of approaches and strategies, from service-specific activities to broad cross-sectoral initiatives.
- Although there is universal consensus regarding the relevance, value and importance of community engagement, there is no commonly agreed upon definition of the concept.
- Often, there is a lack of clear, comprehensive and systematic strategies for planning, implementing and evaluating community engagement functions.
- There are significant challenges in relation to meaningfully and sensitively engaging individuals and families with access challenges, vulnerabilities, special needs and/or highly impacted by trauma.
- It is also important that stakeholders work together to ensure alignment of community engagement strategies, initiatives and activities.

In general, community engagement is widely understood by Kahnawà:ke organizations, programs and services to encompass the processes of people working together to affect positive change, with objectives relating to enabling community awareness, participation and empowerment.

Community engagement activities benefit from the fact that a significant proportion of staff are Kahnawakehró:non and community members. Programs and services all conduct community engagement activities, which encompass a range of approaches and strategies, from service-specific activities to broad cross-sectoral initiatives (e.g. Collective Impact, Wellness Action Team).

Although there is universal consensus among all Kahnawà:ke organizations, programs and services regarding the relevance, value and importance of community engagement, there is no commonly agreed upon definition of the concept. Community engagement is understood, designed and implemented in various ways, depending on the stakeholder and the population it targets and/or serves. Therefore, there is significant variability in how, and to what extent, organizations, programs and services engage with the community.

Overall, most organizations, programs and services lack a clear, comprehensive and systematic strategy for community engagement, and do not consistently or systematically evaluate community engagement functions and activities. It would be beneficial to capture and assess feedback and input of participants during such events, to have a pulse on the perceptions, realities and needs of the community. This information would be valuable to ensure that programs and services are proactively designed, to effectively and appropriately meet the health and wellbeing needs of the community.

Furthermore, ongoing feedback would help provide a balanced picture of the reality of the community's perceptions regarding services, to balance narratives and accounts disproportionately amplified through social media, but that are not necessarily reflective of the complete picture.

There is recognition that despite general success in meeting the "mainstream", there are significant challenges in relation to meaningfully and sensitively engaging individuals and families with access challenges, special needs and/or highly impacted by trauma (sometimes referred to as high-risk, vulnerable and/or marginalized groups). Within the context of Kahnawà:ke, it is particularly important to develop and implement sensitive approaches to engage with individuals and families that are highly impacted by various forms of trauma. This includes (but is not limited to) trauma relating to the impact of multi-generational trauma, physical abuse, sexual abuse, various forms of violence, bullying, intimate partner trauma and grief.

It is also important that organizations, programs and services work together to ensure alignment of community engagement strategies, initiatives and activities. This would enable productive collaboration, improve community perceptions of programs and services, and reduce the risk of duplication and/or overlooking important segments of the population. Furthermore, stakeholders should explore the possibility and feasibility of working together to collect, analyze, share and act upon input and feedback from the community.

7.7 Client, family and caregiver experience

Highlights

- There is widespread agreement regarding the relevance, value and importance of measuring, assessing and using client, family and/or caregiver experience data.
- There exists significant variability in how (content, mechanisms, frequency) and to what extent experience data is collected and used (e.g. for quality improvement).
- It is important to note that there are significant ethical, conceptual and technical challenges associated with designing appropriate and culturally safe approaches and tools.
- Dedicated technical and administrative supports and resources are required to support functions associated with experience measurement and assessment and quality improvement.

A universal domain of quality frameworks – Western and Indigenous – for all domains of human social activity (e.g. healthcare, social services, education) relates to assessing and improving the client experience. The concept has been expanded to incorporate the family and/or caregiver experience, in recognition of the importance of family-orientation of programming and service delivery.

There is broad recognition and consensus across most programs and services in Kahnawà:ke of the relevance, value and importance of measuring, assessing and using client, family and/or caregiver experience data. Furthermore, there are ongoing efforts and projects related to these important functions.

However, there is significant variability in how (content, mechanisms, frequency) and to what extent experience data is collected and used (e.g. for planning, program design, quality improvement). Within most programs and services, experience data is often anecdotal, based on interpersonal conversations during or after service delivery.

Standardized Patient Reported Experience Measure (PREM) surveys have been developed and deployed within some programs; for example within KMHC, with the support of the Quality Improvement, Risk Management & Innovation (QIRMI) team. The organization is exploring the feasibility of incorporating PREMs within MYLE EMR, to automatically send text messages and/or emails with links to surveys for patients and/or families to complete upon discharge.

KMHC is also developing their Patient-Family Advisory Council (PFAC), which promotes patient and family engagement with the healthcare team to improve the quality and delivery of care. The PFAC meets routinely to discuss patient and family experience. Strategies and advice developed by the PFAC will be taken into consideration and may be implemented into organizational policies and structure.

It is important to note that there are significant ethical, conceptual and technical challenges associated with designing appropriate and culturally safe approaches and tools. The

incorporation of domains relating to cultural competency, sensitivity, and safety, along with respect and stigma within experience assessment tools are essential, due to the impact of colonialism and multi-generational trauma. Furthermore, there is often discordance between Indigenous worldviews and understandings of health and Western biomedicine.

Furthermore, it is very challenging to capture experience data from complex and vulnerable populations (e.g. individuals presenting with differing levels of distress, limited literacy, high burdens of illness and disease, complex psychosocial needs, limited resources and abilities, and weak motivational profiles).

Dedicated technical and administrative supports and resources are required to support tool design and validation, systematic data collection, analysis, reporting, change management (technical and culture change), and quality improvement (QI) functions.

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7.8 Evaluation, performance assessment and quality improvement

Highlights

- Since the 2012 Community Health Plan (CHP), many resources, efforts and initiatives have been dedicated to evaluation, performance assessment and quality improvement functions. For example, a particularly strong example is KMHC's Quality, Risk Management and Innovation (QIRMI) team.
- However, there remains significant variability and weakness across most organizations, in terms of capacities, resources and competencies related to evaluation, performance assessment and quality improvement.
- Teams often exhibit significant difficulties developing and using robust logic models. Often, logic models lack a strategic orientation (focusing on workplan tasks rather than functions) and are not tied to measurable performance indicators.
- To promote and enable evaluation, performance assessment and QI, it would be beneficial for health, social services and educational organizations to arrange cross-learning and Knowledge Translation and Exchange (KTE) mechanisms.

There is widespread recognition across all Kahnawà:ke organizations, programs and services of the relevance, value and importance of evaluation, performance assessment and quality improvement (QI) functions.

Since the 2012 Community Health Plan (CHP), many resources, efforts and initiatives have been dedicated to these functions. Examples include the development of logic models by the CHP Sub-Committee teams in 2013 and 2016, as well as evaluations of the Community Health Plan Initiative (CHPI) projects.

Furthermore, there are organizational units, teams and programs across the community dedicated to evaluation, performance assessment and QI functions. Examples include:

- KMHC Quality, Risk Management and Innovation (QIRMI) team.
- KSCS Research & Systems Administrator, who supports a range of data analytics and Business Intelligence (BI) functions for KSCS programs and services
- Kahnawà:keFire Brigade and Ambulance Service Quality Assurance Program
- Analysis and reporting of Ambulance Patient Care Record (PCR) data
- Step by Step Child and Family Center Quality Program and Cultural Curriculum

A particularly strong and comprehensive evaluation and QI infrastructure is being developed by KMHC, specifically the Quality, Risk Management and Innovation (QIRMI) team. KMHC scored extremely highly in their latest Accreditation, and is now focused on transitioning the organization's focus and activities from quality assurance and accreditation, to encompass evaluation and Continuous Quality Improvement (CQI).

However, these remains significant variability across most Kahnawà:ke organizations, in terms of evaluation, performance assessment and QI functions, particularly in relation to:

- Resource supports (e.g. administrative and technical)
- Capacities, competencies and capabilities
- Approaches (e.g. qualitative, quantitative)
- Implementation (e.g. systematic, well managed implementation of evaluation and QI activities)

Most organizations, programs and services in Kahnawà:ke do not have robust and comprehensive systems enabling evaluation, performance assessment or QI. They often face significant conceptual and operational challenges related to:

- Development and use of evaluation frameworks, logic models, performance indicators and QI frameworks
- Outcomes-oriented performance assessment and evaluation
- Data sources, data entry, data quality, assessment tools, data standards
- Quantitative data and statistical analysis
- Development and implementation of QI frameworks and approaches
- Standardized reporting

It is important to highlight that organizations such as KSCS and KMHC have and continue to invest significant effort into enabling their teams to develop logic models. However, logic models are often developed as ends in and of themselves, rather than being developed as tools for self-reflection, evaluation and quality improvement (QI). Logic models tended to be developed in response to organizational requirements, such as in response to the 2012 CHP and the 2016 mid-term CHP evaluation, or CHPI (Community Health Plan Initiative) applications. It is unclear if, how and to what extent the various logic models were used for evaluation and QI purposes.

The logic models also tend to be very lengthy and lack a strategic orientation – focusing on tasks rather than functions. In their present form, most are detailed workplans rather than logic models. Furthermore, there tends to be a lack of clear and measurable set of accompanying indicators (particularly those focusing on outcomes and impact), and are not explicitly tied into action planning, evaluation or quality improvement functions. This was highlighted in the mid-term CHP evaluation's recommendation #5, which stated *"We recommend that the four subcommittees update their logic models to include process and impact indicators and their associated data sources. Subcommittees should identify key outcome indicators that can be measured over the next five years" (12).*

To promote and enable evaluation, performance assessment and QI, it would be beneficial for health, social services and educational organizations to arrange cross-learning and Knowledge Transfer and Exchange (KTE) mechanisms. This would enable the sharing of knowledge and experiences relating to various approaches to evaluation and QI on an ongoing basis. Such mechanisms would enable alignment of evaluation, performance assessment and QI strategies between organizations and programs within the community, and promote knowledge, innovation and best practices.

7.9 Data infrastructure

Highlights

- There is widespread recognition by staff of the value and importance of data systems that have been deployed, such as MYLE Electronic Medical Record (EMR) at KMHC and Penelope Case Management System at KSCS.
- Organizations are providing ongoing supports and resources to enable the optimal use of these data systems, and to support required change management functions.
- The lack of interoperability between MYLE EMR and Penelope case management system is problematic, as both organizations frequently care for the same client.

Health and social services organizations across the community have invested in the deployment of data systems, to support their respective operations. Notable examples include:

- MYLE Electronic Medical Record (EMR) at KMHC
- Penelope Case Management System at KSCS
- Kahnawà:ke Ambulance Patient Care Record (PCR)

There is widespread recognition by staff of the value and importance of these data systems, particularly in relation to the following functions:

- Charting/coding
- As data repositories
- Conducting queries
- Off-site access (for satellite sites, home care)
- Enabling team-based care functions (e.g. communication, interdisciplinary care planning, integrated service planning, health status and needs assessments, follow-ups, etc)

Both KSCS and KMHC are addressing (via dedicated resources and initiatives) the following issues:

- Significant design challenges, as the software needs to be configured, designed and optimized for use across different programs and services
- Significant implementation, training and change management challenges (exacerbated by the pandemic)

To enable the successful deployment and use of these systems, ongoing supports and resources are critical, particularly in relation to:

- Digitization of forms
- Module development, workflow alignment and optimization
- Communications and training
- Data quality
- Record management and confidentiality

Staff (front line to senior management) recognize that the lack of interoperability between MYLE EMR and Penelope case management system is problematic. Presently, the lack of interoperability between the systems presents significant challenges related to data and information sharing, reinforcing organizational siloes, adding to fragmentation in workflows, and inefficiencies (e.g. double charting). Technical solutions and/or the development of process workarounds are required to address these issues.

7.10 Data analytics, business intelligence and health informatics

Highlights

- Various organizations, programs and services across Kahnawà:ke are collecting and storing masses of client data.
- Organizations recognize the importance of transforming this data into useful information for effective and efficient decision-making functions across all levels of governance (e.g. policy, planning, organization, management, evaluation, quality improvement, frontline care/service delivery).
- Strong examples of the successful use of multi-sourced data are the 'Onkwaná:ta Our Community, Ionkwata'karí:te Our Health' Portraits (Volumes I and II). The Health Portrait reports leveraged multi-sourced data to provide useful population health statistics. A valuable data source was the 2015 Regional Health Survey, which provided rich insights into the community's needs, experiences and health and wellbeing status.
- To move towards the vision of developing learning systems, it is critical to dedicate resources and investments towards advanced data analytics, business intelligence (BI) and health informatics functions.

Various organizations, programs and services across Kahnawà:ke are collecting and storing client data. In an effort to transform this data into meaningful information, investments and resources are being directed towards advanced data analytics and business intelligence (BI) functions. Examples of teams supporting these functions include:

- KMHC Quality Improvement, Risk Management and Innovation (QIRMI)
  - Program and service-specific performance indicator dashboards
  - MYLE EMR dashboards
- KSCS Research & Systems Administrator
  - Penelope case management system analytical reports for KSCS programs and services
  - Tableau dashboards (business intelligence and data visualization)
- Kahnawà:ke Fire Brigade and Ambulance Service Quality Assurance Program
  - Patient Care Record (PCR) statistics

Overall, data analytics and business intelligence functions across all organizations are at early formative stages of development, and require much higher levels of support and improvement.

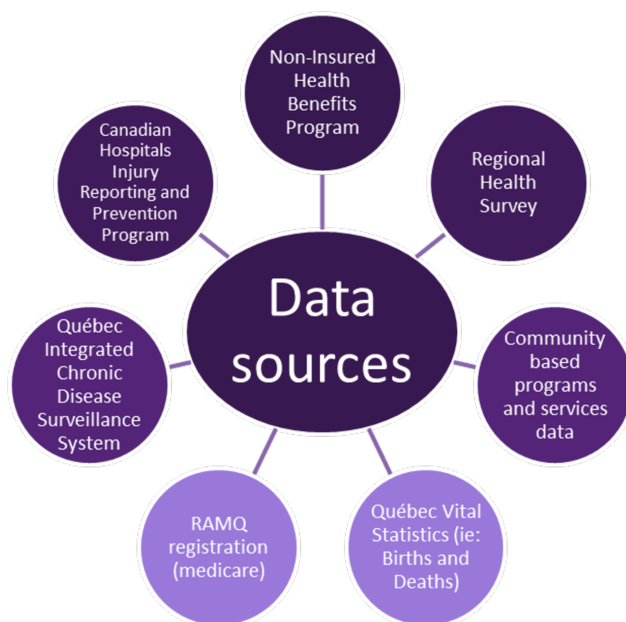
There is consensus across stakeholders regarding the value and importance of leveraging and analyzing available data to enable key functions, particularly in relation to:

- Governance, decision-making, planning and accountability
- Population health management
- Epidemiological, health surveillance and public health functions
- Business Intelligence (BI)
- Quality assurance, audits and accreditation
- Performance assessment, rapid-cycle evaluation and QI

To maximize the value of existing data generated from across the community, and neighboring jurisdictions (e.g. from health and social care, educational institutions, emergency services, hospitals, mental health facilities, social services), it is important to explore the feasibility of linking the various datasets. This idea was proposed in the 2016 mid-term CHP evaluation as well. Data linkage would enable advanced analytics and population health management functions, and help build a robust and comprehensive picture of the health and wellbeing of the population.

Particularly strong examples of the successful use of multi-sourced data are the 'Onkwaná:ta Our Community, Ionkwata'karí:te Our Health' Portraits (Volumes I and II) (29,30). The Health Portrait reports leveraged the following data sources, to provide a comprehensive, valuable and in-depth analyses of Kahnawà:ke population health statistics:

Figure 17: Summary of key data sources included in Volume 2 of Onkwaná:ta Our Community, Ionkwata'karí:te Our Health (30)



The Regional Health Survey, conducted in 2015 in collaboration with the First Nations of Québec and Labrador Health and Social Services Commission (FNQLHSSC), was a particularly valuable source of rich data regarding the community's health and wellbeing, experiences and utilization of health and social services. 616 community members answered questions about a wide range of health and social issues, including chronic diseases, health and social challenges to the community and data relating to habits, behaviours, feelings, experiences, support networks, community connectedness and other root causes that can lead to health or to illness for individuals, and that can influence their quality of life (29).

7.11 Pandemic impact and respone

Highlights

- Staff demonstrated admirable levels of resilience, courage, selflessness, and empathy during the pandemic, and worked collaboratively to ensure continuation of service delivery.
- Staff demonstrated high levels of intrinsic motivation, particularly a sense of social purpose during the pandemic.
- Organizations provided a number of supports for staff, to protect and promote their health and wellbeing, and to ensure the continuation of service delivery and teamwork.
- Along with signs of staff resilience, the symptoms and indicators of burnout were also widespread.
- Change management was challenging, particularly due to high levels of uncertainty and the rapid rate of change.
- Programs and services also often struggled to maintain essential services, due to several factors that caused staffing shortages. Many essential functions (e.g. performance appraisals, evaluation, team-building) had to be postponed, to focus on maintaining essential service delivery.
- The Wellness Action Team (WAT) is an example of a successful cross-sectoral collaboration effectively assessing and addressing the wholistic health and wellbeing needs of the community, particularly within the context of the pandemic. The WAT has surveyed over 400 community members to assess needs and health status, and has compiled an inventory of over 120 activities across the community, focusing on health and wellness within the context of the pandemic.
- Kahnawà:ke demonstrated highly successful community-wide mobilization in response to the pandemic, reflecting high levels of solidarity, and effective communication, coordination and collaboration.

Teams from across all Kahnawà:ke organizations, programs and services demonstrated admirable levels of resilience, courage, selflessness, and empathy during the pandemic. Often, the teams worked collaboratively and with little guidance, to develop grassroots strategies to ensure the continuation of service delivery. Staff demonstrated high levels of intrinsic motivation, particularly a sense of social purpose. Team members often bonded and formed strong relationships, to support each other and to develop innovative mechanisms to cope with the ongoing and ever-changing pressures related to the pandemic. Staff demonstrated high levels of agility, often responding to changing requirements and needs with an open mind, flexibility and creativity – and working to the maximum of their respective scope of practice and abilities.

Staff were often provided a variety of organizational supports, such as

- Staff appreciation events
- Employee Assistance Programs
- Sick days and wellness days
- Mechanisms to enhance staff knowledge, skills and availability to respond to the pandemic
- Managerial and administrative supports
- Personal Protective Equipment (PPE)
- Training (e.g. Infection Prevention and Control/IPAC)
- Structural, organizational and workflow redesign for IPAC
- Virtual technologies
- Team building exercises

Along with signs of staff resilience, the symptoms and indicators of burnout were also widespread, including:

- Emotional and physical exhaustion
- Depersonalization
- Demotivation
- Anxiety and depression
- Trauma

The teams were confronted with myriad challenges, risks and problems related to the pandemic and pandemic response. Change management, particularly in relation to the socialization and implementation of public health directives, protocols and workflow revisions, was extremely difficult. Despite organizational and community-level pandemic response alignment efforts (e.g. via the pandemic Task Force and public health), the rate of change was extremely high, and the content of directives was sometimes confusing, particularly in situations when different information was being presented to the teams from differing sources. Furthermore, there was often a very high level of uncertainty, in terms of interpretation of guidance or directives, as well as a lack of information at times.

Programs and services also often struggled to maintain essential services, due to factors such as staffing shortages, staff being redirected to other services, staff having to do multiple shifts, staff

having to choose one facility to work from (e.g. staff of long-term care facilities), and/or dedicate essential resources and/or space towards the pandemic response (e.g. setting up COVID units). Organizations had to rapidly deploy technologies, which presented significant challenges associated with change management and staff training, along with IT design, configuration, optimization and trouble-shooting.

The Wellness Action Team (WAT) is an example of a successful cross-sectoral collaboration that focuses on assessing and addressing the wholistic physical, mental, emotional and spiritual needs of the community. The WAT meet regularly (usually monthly) to share knowledge and resources, and to identify needs and ways to collaboratively address them using a community-based approach. The team works together to support resiliency and wholistic wellness in the community, in response to the pandemic. The WAT has recently surveyed 412 community members between May and July 2022, to understand the community's needs and experiences during the pandemic. Furthermore, the WAT has compiled a list of over 120 activities by organizations across the community, focused on health and wellbeing within the context of the pandemic.

It is also important to highlight the community-wide mobilization in response to the pandemic. This mobilization demonstrated high levels of solidarity, and effective communication, coordination and collaboration. The various aspects and outcomes of the community mobilization during COVID is presently being studied by researchers (for Kahnawà:ke in particular, because the response was highly successful, particularly in comparison to other communities both First Nation and otherwise). Further understanding of the mobilization could provide useful insights that could be generalized in relation to other mobilization efforts (e.g. for education and prevention, such as chronic disease prevention).

7.12 Culture, language and identity

Highlights

- There is increasing recognition of the well-established link between language and culture as mediators and manifestations of wellness, and significant healing forces for Onkwehón:we. Culture and language are therefore often directly integrated into organizational Strategic Plans and programming.
- Collaboration and alignment between the various culture and language programs in the community need to be further strengthened. The Wellness Action Team's (WAT) work on enabling collaborations integrating tradition and culture programs and activities is a good example.
- Culture and language-related programs and services were disrupted during the pandemic, demonstrating the need to invest resources to ensure their sustainability.
- Culture and language, along with cultural safety and competency frameworks need to be systematically integrated across all levels of governance, from leadership to programming and service delivery.

There is widespread recognition of the self-evident value and need to comprehensively and meaningfully integrate culture and language within all levels of organizational governance, leadership, programming and service delivery. There is increasing recognition of the well-established link between language and culture as mediators and manifestations of wellness, and significant healing forces for Onkwehón:we. Culture and language are therefore often directly integrated into the Strategic Plans of health, social services and educational organizations. Examples include:

- KSCS 2016-2019 Strategic Plan Objective #3 ("To foster & accelerate active Kanien'kehá:ka ways of doing things, including more use of our language; to strengthen our understanding of our Kanien'kehá:ka ways, language and culture; to incorporate Kanien'kehá:ka ways in everything we do. This means increasing the use of our language and culture in everyday living and in the standard practices of our services") (34)
- Tehsakotitsén:tha (KMHC) 2013-2019 Strategic Plan Objective #3 (Implement Traditional Medicine services). In the future Strategic Plan, "To deepen Kanien'kehá:ka ways of working" is planned to be integrated into all four of the organization's strategic orientations

Significant resources, efforts and initiatives are dedicated by various organizations across the community to culture and language. Examples include:

- Tewahará:tat Tsi Niionkwarihò:ten Language and Culture Network
- Kanien'kehá:ka Onkwawén:na Raotitióhkwa Language and Cultural Center (KORLCC)
- Tsi Niionkwarihò:ten Tsitewaháhara'n Center (Kanien'kéha Language and Culture Training Program)
- Kahnawà:ke Education Center's (KEC) Tsi Niionkwarihò:ten Program, and culture and language programming at Kateri School, Kahnawà:ke Survival School, and Karonhianónhnha Tsi Ionterihwaienstáhkhwa Language Immersion School.
- Tehsakotitsén:tha (KMHC) Tekanonhkwatsherané:ken (Two Medicines Working Side by Side, Traditional Medicine Program)
- KSCS (Tsi Niionkwarihoten ("Our Ways"), Tsi Niionkwarihò:ten Committee , Traditional Counseling Program, Whitehouse prevention programs)
- Step by Step Child and Family Center (SBSCFC) Quality Program Cultural Curriculum framework.
- Kahnawà:ke Youth Center (KYC) cultural programming
- Kahnawà:ke Collective Impact (e.g. language and culture mentorship program)

Special highlight: Kanien'kehá:ka Onkwawén:na Raotitióhkwa Language and Cultural Center (KORLCC)

Established in 1978, the Kanien'kehá:ka Onkwawén:na Raotitióhkwa Language and Cultural Center was created to preserve and enrich the language and culture of the Kanien'kehá:ka of Kahnawà:ke (35).

The mission of Kanien'kehá:ka Onkwawén:na Raotitióhkwa, a vital and dedicated catalyst for community change, is to lead and support all Kahnawakehró:non to practice, maintain, respect, renew, and enhance Kanien'kéha language, beliefs, values, customs and traditions through the development, delivery, and sharing with all peoples, cultural and educational activities which will ensure the continued existence of our present and future generations as Kanien'kehá:ka. (May 13, 1997: Kanien'kehá:ka Raotitióhkwa Cultural Strategic Planning Session)

Programming and projects include:

- Kanien'kéha Ratiwennahní:rats: A 2-year Adult Language Immersion Program offered by the Kanien'kehá:ka Onkwawén:na Raotitióhkwa Language and Cultural Center
- Museum and Welcoming Center
- Resource library
- Tóta tánon Ohkwá:ri puppet show (a CHPI supported project), which aims to promote and foster Kanien'kéha oral proficiency abilities for viewers, to create awareness of the following health priorities in Kahnawà:ke; mental wellness, substance abuse/addictions, cardiovascular disease, diabetes, obesity and cancer, to write the show in a way that the characters are firmly rooted in Haudenosaunee culture and values and that is inclusive for all children in Kahnawà:ke.
- Public programming, including: cultural workshops, annual events and community classes
- The Kahnawà:ke Beadwork Oral History Project seeks to collect, preserve, and share our community's stories and records related to this important dimension of local history and contemporary life.
- Ontkahthóhtha' all-Indigenous art fair

Figure 18: Sun safety video (source https://www.korKahnawà:ke.org/multimedia)

The Kahnawà:ke Cultural Arts Center Capital Campaign is a multi-million dollar fundraising campaign to construct a new facility for the Kanien'kehá:ka Onkwawén:na Raotitióhkwa Language and Cultural Center (KORLCC), Turtle Island Theatre and a Tourism Visitors Center. This is a community partnership between KORLCC, Turtle Island Theatre, Kahnawà:ke Tourism and the Mohawk Council of Kahnawà:ke. The community impact focuses on language revitalization, cultural development, museum exhibits, performing arts (theatre, concerts, lectures, presentations) and education.

Collaboration and alignment (strategic and operational) between the various culture and language programs in the community need to be further strengthened, as well mechanisms to promote ongoing cross-learning and engagement between the stakeholders. The various programs bring diverse, philosophies, perspectives and approaches, which is a potential strength that should be leveraged through improved mechanisms for communication, cross-learning and collaboration.

A good example of collaborations focused on tradition and culture is the Wellness Action Team (WAT). The WAT plans to structure messaging and activities to address a gap in the spiritual component of pandemic response and give culturally relevant ways of healing and maintaining mental and emotional health. Its communications campaign will highlight existing traditional wellness activities and online resources such as videos from KOR, and Tsi Niionkwarihoten collaborations with the KSCS Staff Wellness Activities Project.

Another example of collaboration is Tewahará:tat Tsi Niionkwarihò:ten Language and Culture Network, which aims to bring key people together who work in the field and/or share the same interest and passion of language and culture revitalization. The intent is to discuss ideas and develop strategic plans for language and cultural initiatives, to enable collaborative planning and activities that foster the vision of Kanien'kéha tánon' Tsi Niionkwarihò:ten in Kahnawà:ke.

A cross-sectoral Traditional Approaches Sub-Committee (Tehoterihwaienawà:kon) operated between 2016-2018, with the mandate incorporate traditional approaches into existing health care services to Kahnawakehró:non. Reporting to the subcommittee were the KMHC/KSCS Traditional Medicine Working Group; its purpose was to review the existing documentation and protocols in place, as well as to identify new issues of mutual involvement and service delivery, to find service delivery agreements assuring optimal use of resources, identify new opportunities for joint service delivery, and pilot new initiatives when determined feasible. It is important to revisit the feasibility of regrouping and planning new strategic activities.

The sustainability of cultural and language-related programs and services are important, particularly during challenging times and crises. During the pandemic, the staff of some of these programs were redeployed to other services (e.g. to Emergency Food Services), severely disrupting their operations. This is problematic, as culture is a mediator of wellness and a significant healing forces for Onkwehón:we. Contingency plans should be put in place to ensure the continuous functioning of these programs during emergencies, and these programs should be recognized as a fundamental component of emergency response. Furthermore, culture and language programs have limited human resources and support, which affect their sustainability and ability to provide effective and comprehensive services.

Cultural competency frameworks and cultural safety also need to be systematically integrated across all levels of governance, from leadership, to programming and service delivery. Resources such as the National Aboriginal Health Organization's Guidelines for Practicing Cultural Safety may be useful, and could be adapted to the Kanien'kehá:ka context. The content of these concepts and frameworks should be integrated as essential components of strategic planning, staff performance appraisals, as well as client and family experience assessments.

It is important to note that KSCS' Tsi Niionkwarihoten program provided detailed organizational level recommendations (Appendix Section 11), that are comprehensive and can be generalized and adapted (to a large extent) to all organizations across Kahnawà:ke (e.g. health care, social care and social services, educational institutions). These recommendations complement the strategic recommendations outlined in this report.

7.13 The Community Health Plan (CHP)

Highlights

- There is insufficient quantitative data to statistically measure the direct impact of the CHP on the specific health priorities, or to assess trends in performance and outcomes over time.
- However, there is clear evidence and sufficient data that the large array of programs and services directly address all of the health priorities, and beyond – extending to population health needs across the entire lifespan – from pre-conception to death.
- Conceptually, the next iteration of the CHP needs to be health outcome, wellness and wellbeing oriented, rather than focused on specific diseases, illnesses or conditions. Furthermore, it should integrate Indigenous and Kanien'kehá:ka wholistic understandings of health, wellness and wellbeing.
- The CHP had limited integration of performance indicator frameworks, to enable ongoing rapid-cycle evaluation, performance assessment and quality improvement.
- The CHP had several operational and implementation challenges, related to Knowledge Translation and Exchange (KTE), as well as the lack of ongoing evaluation and reporting.
- There was significant variability in the performance of the CHP Sub-Committees, as well as the experiences of their respective members. Most were found to functioning at early developmental stages, rather than being high performing.

Similar to the findings of the 2016 CHP evaluation, there remains insufficient quantitative data to accurately measure the impact (especially from a statistical perspective) of the CHP on the specific health priorities, or to assess trends in performance and outcomes over time (12).

However, there is clear evidence and sufficient data that the large array of programs and services directly address all of the health priorities, and beyond – extending to population health needs across the entire lifespan – from pre-conception to death.

Overall, there was consensus among interviewees that the CHP – from the perspective of identifying health priorities at the community level – is beneficial and useful. Furthermore, existing data (e.g. the Health Portraits Volumes I and II) largely support and validate the relevance of the CHP health priorities (29,30). Therefore, existing policies, programs and services should continue to address these community health needs.

Conceptual limitations

However, the CHP is widely perceived to have several conceptual limitations, related to the following domains:

- The CHP needs to be more (health) outcome oriented, and should integrate Indigenous and Kanien'kehá:ka wholistic understandings of health, wellness and wellbeing.
- The CHP is oriented around specific diseases, illnesses and conditions, rather than being person-oriented. Person-orientation is important, in light of concepts such as multimorbidity and complexity.
- The CHP's biomedical orientation needs to be further balanced with a psychosocial orientation.
- The CHP tends to be perceived as having a treatment/intervention focus, rather than on health promotion, upstream prevention and early intervention.
- The CHP's deficits/problems/weaknesses-orientation needs to be balanced with an assets/strengths orientation.
- The CHP's health priorities need to be tied together within a social determinants of health framework.
- The CHP's needs to incorporate wellness and wellbeing domains.
- The CHP had limited integration of performance indicator frameworks, to enable ongoing rapid-cycle evaluations, performance assessment and quality improvement functions
- The CHP's health priorities were not sufficiently defined and contextualized, to be effectively integrated and operationalized through collaborative programming.

Key operational challenges and limitations

The operationalization and implementation of the CHP is also widely perceived to have encountered several constraints, challenges and limitations, particularly in relation to the following factors:

- The general state of awareness of the content of the CHP is very limited across most organizations and governance levels, including management and front-line staff. Awareness was particularly limited for newer staff, as there was significant variability whether and/or to what extent the CHP was incorporated into onboarding sessions and/or orientations within various organizations. Often, the CHP was leveraged in a more simplistic, targeted and selective way, to obtain funding for specific projects and/or initiatives.
- The 2016 mid-term CHP evaluation recommendations (#8 and #12) specifically addressed these issues. It is important to recognize that ongoing community and organization-wide Knowledge Transfer and Exchange (KTE) functions are extremely resource intensive, and that Onkwata'karitáhtshera had limited resources that could be dedicated to these functions and activities.
- There were no ongoing, systematic evaluations (e.g. annual) of performance and progress in relation to the CHP and its priorities. This was also highlighted in Recommendation #12 of the

mid-term CHP evaluation, which read: "We recommend that Onkwata'karitáhtshera produce a regular report on the Community Health Plan, including summaries of activities related to the health priorities and integrating data from all organizations involved in delivering programs and activities under the CHP".

CHP Sub-Committees

Seven CHP Sub-Committees were established by Onkwata'karitáhtshera, to conduct several functions related to the health priorities, including:

- Assessing gaps and links
- Developing an inventory of services for each priority
- Strengthening logic models to be outcomes-focused, and to have SMART objectives
- Developing frameworks and strategies to address CHP health priorities

The Sub-Committees began meeting in 2014, and were usually chaired by Onkwata'karitáhtshera members. As of 2020, the Sub-Committees were:

- Ahsatakariteke (Chronic Diseases)
- Cancer Health Priority
- Data Mining
- Early Childhood and Family Wellness
- Mental Wellness and Addictions Priority
- Tehoterihwaienawà:kon (Traditional Approaches)
- Tobacco Control Subcommittee (between 2016-2018)

Despite general agreement regarding the value and importance of bringing staff together from various organizations to address health priorities, there was significant variability in the performance of the Sub-Committees, as well as the experiences of their respective members (36). The results of this evaluation seem to somewhat validate the Onkwata'karitáhtshera Subcommittees Interview Project's findings, which indicate that the Sub-Committee structure seemed to work for about half of the Sub-Committees, and that Terms of Reference and logic models were developed and implemented to varying extents.

The Sub-Committees developed a number of logic models relating to the health priorities; however, overall, logic models seemed to be developed as ends in and of themselves, rather than being developed as useful tools for self-reflection, evaluation and quality improvement (QI). It is unclear if, how and to what extent the various logic models were used for evaluation and QI purposes.

The logic models also tend to be very lengthy and lack a strategic orientation – focusing on tasks rather than functions. In their present form, most are detailed workplans rather than logic models. Furthermore, there tends to be a lack of clear and measurable set of accompanying indicators (particularly those focusing on outcomes and impact), and are not explicitly tied into action planning, evaluation or quality improvement functions. This was highlighted in the mid-term CHP evaluation's recommendation #5, which stated *"We recommend that the four subcommittees*

update their logic models to include process and impact indicators and their associated data sources. Subcommittees should identify key outcome indicators that can be measured over the next five years" (12).

The majority of Sub-Committees were found to functioning at early developmental stages (i.e. forming/re-forming, storming and norming), whereas only a few were found to be performing or high performing. Some Sub-Committees did not have a well-formed Terms of Reference, and lacked clarity and agreement regarding their respective vision, purpose, scope, goals, functions, activities, expectations, timelines and accountabilities.

Furthermore, their operations were constrained due to a lack of allocated or protected time dedicated to members, for participation in the Sub-Committee meetings. The importance of incorporating non-senior management staff within the Sub-Committees was perceived to be important, as senior management often have extremely busy calendars, making scheduling very challenging.

7.14 A Community Wellness Plan (CWP)

Highlights

- There is general consensus regarding the importance of shifting the strategic focus from individual diseases, illnesses and conditions, and to move towards domains of wellness, wellbeing and health outcomes. Furthermore, it is essential to integrate Indigenous and Kanien'kehá:ka wholistic understandings of health, wellness and wellbeing.
- To shift the strategic orientation of the CHP towards a "Community Wellness Plan" (CWP), a number of principles, concepts and orientations could be considered for guidance.
- The CWP should integrate a comprehensive outcomes-oriented performance framework. This common framework would enable all Kahnawà:ke stakeholders to align efforts and collaborate to achieve commonly desired health, wellness and wellbeing outcomes. The framework's process indicators would clearly reflect the functions and activities of the respective stakeholders, and the outcome indicators would enable ongoing measurement and assessment of the performance and quality of services.
- Existing data largely support and validate the relevance of the seven CHP health priorities. However, Kahnawà:ke stakeholders suggested that additional health, wellness and wellbeing domains should be considered, defined and assessed for inclusion, using comprehensive engagement strategies.

> *The 2016 mid-term CHP evaluation recommended (#7d): "Considering changing the name of the CHP to "Community Wellness Plan" to better reflect a Kanien'kehá:ka understanding of wholistic wellness" (12).*

As highlighted in the previous section (under "CHP conceptual limitations"), there is general agreement regarding the importance of shifting the strategic focus from individual diseases, illnesses and conditions, and to move towards domains of **wellness, wellbeing and health outcomes**. Furthermore, it is essential to integrate Indigenous and Kanien'kehá:ka wholistic understandings of health, wellness and wellbeing.

The next iteration of the CHP should be reconceived as a "Community Wellness Plan" (CWP), incorporating the following key **principles, concepts, and orientations**.

- **Principles:**
  - Inclusivity and engagement (whereby the CWP is developed as a co-construction by stakeholders from across Kahnawà:ke)
  - Self-determination (developing a CWP that reflects Kanien'kehá:ka worldviews, values and concepts of health, wellness and wellbeing)
  - Transparency (in all structures and processes, with ongoing systematic evaluation, performance assessment and reporting)
  - Accountability (shared accountability for health outcomes)
  - Teamwork and collaboration
  - Data-driven governance and decision-making

- **Concepts (and frameworks):**
  - Indigenous and Kanien'kehá:ka concepts and frameworks of health, wellness and wellbeing. For example, building on the six components of wellness (i.e. Inner Peace, Empowerment, Social Network, Safety, Land and Cultural Identity) conceptualized in "The Wellness of Our Nations" report (7).
  - A population health approach, leveraging social determinants of health (SDH) frameworks to tie health, wellness and wellbeing domains together
  - Cultural safety (incorporating concepts of cultural awareness, sensitivity and competency)
  - Tsi Niionkwarihò:ten
  - Continuous learning systems and innovation (the CWP must have integrated evaluation, performance assessment and indicator frameworks, to enable rapid-cycle evaluation and Continuous Quality Improvement (CQI))
  - Knowledge Transfer and Exchange (KTE)

- **Orientation:**
  - Outcomes-oriented (health, wellness and wellbeing outcomes)
  - Health promotion, upstream prevention and early intervention
  - Person-orientation (vs service orientation)
  - Family-orientation (with a focus on family wellness, preservation and healing).
    - **Note:** This domain is particularly important. Thorough engagement of all community and organizational stakeholders is needed, to align concepts and definitions, and to jointly co-construct a family wellbeing, preservation and healing vision and strategy. It is also important to build upon existing foundational work by the various health, social and educational organizations in the community (e.g. the Kahnawà:ke Child & Family Services (CFS) Plan Enhanced Prevention – Focused Approach Action Plans (2020) and KSCS Family Preservation Approach Special Project (2018)) (37).

A Community Wellness Plan (CWP) outcomes-oriented performance framework

The principles, concepts and orientations highlighted above should be operationalized using a ***comprehensive outcomes-oriented performance framework***. This common framework would enable all Kahnawà:ke stakeholders (e.g. from health care, social services and educational organizations) to align efforts and work together to achieve common CWP objectives relating to the health, wellness and wellbeing outcomes of all Kahnawakehró:non, which are defined by Indigenous and Kanien'kehá:ka wholistic concepts and worldviews.

The framework's process indicators would clearly reflect the functions and activities of the respective stakeholders, and the outcome indicators would enable ongoing measurement and assessment of the performance and quality of services, particularly in relation to effectively meeting population health needs and improving experiences. The performance framework would therefore enable clarity, transparency and ongoing performance assessment, evaluation and quality improvement.

It would be beneficial to leverage existing work relating to the development and implementation of Indigenous performance frameworks. Examples of potentially useful indicator frameworks, tools and resources include:

- First Nations Population Health and Wellness Indicators (2019-22, FNHA)
- The Wellness of Our Nations report (7)
- Alberta First Nations Indigenous Health Indicators (38)
- National Child Welfare Outcomes Indicator Matrix (NOM) (20)
- Swinomish Indian Tribal Community Indigenous Health Indicators (39)
- International Group on Indigenous Health Measurement (IGIHM) resources (40)
- First Nations of British Columbia Measuring Wellness: An Indicator Development Guide for First Nations (8)
- Cultural Connectedness Scale (41)
- K-GEM Kanien'kehá:ka Growth and Empowerment Measure (42)
- Ktanaxa Nation Community Plan indicators (43)
- Aboriginal Children's Health and Wellbeing Measure (ACHWM) (44)

Health, wellness and wellbeing priorities

The findings of this evaluation largely align with recommendation #9 of the 2016 mid-term CHP evaluation, which stated: "We recommend maintaining the seven health priorities identified through community consultation prior to 2012, while working to obtain and gather the data needed to assess the accuracy of the health priorities and update them accordingly in 2022" (12).

Existing data (e.g. the Health Portraits Volumes I and II [forthcoming]) and the results of this evaluation largely support and validate the relevance of the seven CHP health priorities (29,30):

- Addictions
- Cancer
- Cardiovascular
- Developmental Disabilities
- Diabetes
- Mental health
- Obesity

However, it may be beneficial to reframe some of the chronic illness and disease priorities, as prevention and promotion domains. For example, cardiovascular/hypertension and obesity could be reframed as functional areas around which systems could be developed, such as:

- Avoidance and cessation of commercial tobacco use
- Supporting physical activity
- Supporting healthy diets
- Ensuring access to primary care

This would ensure a broader focus that encompasses other priority conditions in the community, that could otherwise be overlooked (e.g. COPD, which has a high prevalence, and is associated with high utilization of healthcare and poor health outcomes). Furthermore, such an approach addresses the fact that a significant proportion of the community with chronic illnesses have co- or multi-morbidities.

Additional health, wellness and wellbeing domains require consideration, assessment and further conceptualization and definition through comprehensive engagement strategies. These include (in no particular order):

Potential priority health, wellness and wellbeing domains for consideration and assessment:

- Culture, language and identity
- Family wellness and healing
- Violence (including family violence, Elder abuse, lateral violence, bullying, racism, social media violence, shelters)
- Mental health and wellbeing (reiterating the importance of developing comprehensive and robust coordinated systems that address mental health and wellbeing across all age groups)
- Primary care (with a focus on access and quality of care)
- Social determinants of health (e.g. housing instability and supports, food insecurity, poverty/income security, unemployment)
- Teen/youth health and wellbeing (including behavioral, mental and sexual health)
- Injuries
- Harm reduction (integration within the Addictions/substance use domain)
- Aging (including aging caregivers, social inclusion/isolation, supporting healthy aging at home, intermediate care models, Elder adoption)
- Expanding upon "Developmental Disabilities" to encompass broader special needs (i.e. beyond Attention Deficit Disorder, Autism, Asperger's and Down Syndrome)
- Staff health, wellness and wellbeing
- Climate change
- Happiness

Volume II of the Onkwaná:ta Our Community, Ionkwata'karí:te Our Health Portrait, that is due to be published soon, will provide useful data and evidence in relation to: 1) mental health and wellness, 2) injury and injury prevention and 3) early childhood and family wellness. Data from the Health Portrait report can partially inform and support evidence-based decision-making, particularly in relation to the inclusion and prioritization of some of the domains outlined above.

8. Impact on health priorities

8. Impact on health priorities

This Section addresses the third evaluation question, relating to the impact of the Community Health Plan (CHP) on the health priorities. Similar to the findings of the 2016 CHP evaluation, there remains insufficient quantitative data to statistically measure the impact of the CHP on the specific health priorities or supporting areas, or to assess trends in performance and outcomes over time.

However, there is clear evidence and sufficient data, including program and service-level descriptive statistics, that the large array of programs, services and cross-sectoral initiatives directly address all health priorities, and beyond – extending to population health needs across the entire lifespan – from pre-conception to death.

Important cross-sectoral initiatives such as the Community Health Plan Initiative (CHPI) projects, CHP Sub-Committees, the Wellness Action Team (WAT), Skátne Teionkwaká:nere - Kahnawà:ke Collective Impact (KCI) and Jordan's Principle directly address all or most of the seven health priorities. The teams participating in these cross-sectoral initiatives are increasingly developing their respective evaluation functions, with a focus on assessing their performance and impact on wholistic health and wellbeing outcomes (i.e. across physical, mental, emotional and spiritual domains).

Furthermore, organizations, programs and services across the community continuously design, plan and implement large numbers and types of activities addressing the CHP priorities of:

- Mental health and wellness
- Substance abuse/addictions
- Chronic disease (including diabetes, cardiovascular disease, hypertension and obesity)
- Early childhood wellness (including learning and developmental disabilities e.g. Attention Deficit Disorder, Autism, Asperger's and Down's Syndrome)
- Cancer

Key examples of activities by organizations, programs and services in relation to the health priority areas are described in the sections below.

8.1 Mental health and wellness

Mental health and wellness are universally recognized by all Kahnawà:ke organizations to be extremely important and urgent priorities; therefore, most programs and services incorporate these domains in various forms within their strategic plans, functions and/or activities.

Notable examples include (in no particular order):

- Kahnawà:ke Youth Center (KYC) provides a comprehensive range of family-oriented upstream prevention programs and activities, focused on promoting healthy and active lifestyles, social inclusion and community involvement. KYC's CHPI projects are also designed to make positive contributions on mental health and wellbeing.
- Step by Step Child and Family Center (SBSCFC) provides comprehensive upstream prevention and early intervention for children and families. These functions include a focus on mental health and wellbeing, and pay special attention to children with developmental disabilities and special needs. The organizational leverages developmental screens, wholistic assessments and individualized education plans. There is significant focus on social acceptance, enabling awareness and preventing and addressing stigma, and supporting children's physical, cognitive, language and socio-emotional development. SBSCFC closely collaborates with health and social services across the community, and leverages a multidisciplinary team-based approach, including physiotherapy, occupational therapy, nutritionists, speech and language therapy, psychology and inclusion specialists.
- Whitehouse prevention programs for children, teens and youth, such as Onkwanèn:ra, A:se Tahonatehiarontie and violence prevention. Programming is family and community-oriented, and includes topics related to healthy lifestyles (mental, physical, social and spiritual wellbeing), healthy decision making, social activities, social connections, enabling positive self-esteem, healthy sexuality, suicide prevention, depression and anxiety, healthy relationships, culture and language programming, bullying and social media.
- Family Wellness Center (FWC) Traditional Counseling provides traditional healing and spirituality services to address mental health and wellbeing issues. Furthermore, the program addresses trauma and grief in the community through grief workshops (Ase:sasatonhet: Starting a New Life Grief Support Group), which is now an integrated program within the center. Additionally, the program provides services such as teen healing camps for youth the community who present with anxiety, depression, self harming behavior and suicidal ideation and suicide attempts. The program therefore addresses mental health (anxiety disorders, depression, complex trauma, anger management, mood and behavior regulation), and general psychosocial problems such as family violence (child abuse and intimate partner violence), suicide, grief and loss.
- Tekanonhkwatsheranè:ken (Two Medicines Working Side by Side, KMHC Traditional Medicine) provides comprehensive services focused on taking care of the body, mind and spirit – keeping individuals independent, healing the mind, and to provide a sense of peace. Services encompass traditional medicine, spirituality, healing, cultural teachings, rituals, ceremonies, language, prevention, healthy lifestyles, and educational, training and orientation activities. A key aim is to seamlessly incorporate traditional medicine into all other programs at KMHC, using the "Two Medicines Working Side by Side" philosophy and approach.
- Jordan's Principle enables access to mental-health related services for children, particularly those with vulnerabilities and/or special needs. Examples include art therapy, behavior

technician, neuropsychological assessment, osteopath services, psychoeducational assessment, psychological assessment, specialized car seat, specialized summer camp, speech therapy and tutoring services.

- KSCS Child and Youth Wellness: with a focus on enabling, maintaining and promoting family preservation (when possible) and upstream prevention, the program offers customized support services to assist in resolving the risk within various situations (abandonment, neglect, psychological abuse, physical abuse, sexual abuse, and serious behaviour disturbances). Individualized service plans are developed to meet the needs of each child and their respective families.
- KSCS after-hours emergency response service works in close collaboration with the Kahnawà:ke Peacekeepers and other critical partners such as Kahnawà:ke Fire Brigade (KFB), to provide emergency response services for social emergency situations that occur within the community on a 24-hour, 365-day-per-year basis.
- KSCS Addictions Response Services (ARS) provides education, support and counselling for clients and families dealing with addictions and concurrent mental health issues, and a variety of group sessions.
- KMHC mental health nursing provide services to many KMHC program areas, including Long-term care, Short-term care, as well as Home and community care and Assisted Living Services. In addition to providing mental health services, they act as an important liaison with family medicine and psychiatry services, to provide comprehensive care and supports for clients with mental health conditions, including persistent and severe mental illness.

Challenges – mental health and wellness services

Several significant challenges relating to mental health and wellness require further attention, and are starting to be addressed by organizations in the community.

A Mental Wellness and Addictions CHP Sub-committee was established; however, it did not make much progress. A lengthy CHP mental health logic model (2012/13) was drafted, but it is unclear if, how or to what extent it was used to evaluate programs and/or services.

The development of an aligned and comprehensive system for mental health and wellbeing is extremely important. The scope and intensity of mental health needs in the community is very large, particularly due to multi-generational trauma, and has been exacerbated by the pandemic. These are very difficult and sensitive problems, that the community is often not comfortable talking about, due to stigma and shame. Violence (particularly family violence and sexual violence) in the community is perceived to be rising. The impact on all age groups is severe, particularly for teens and youth who are presenting with problems relating to behavioral issues, anxiety, depression and suicidality.

Engaging teens to participate in programming is a very big challenge, particularly in relation to reaching vulnerable teens with high levels of anxiety and depression. Youth are often on the streets, due to a lack of suitable alternatives to keep them productively occupied. This is particularly problematic for vulnerable youth from unhealthy homes, who need a safe and salutogenic space, that offers them the support needed. Upstream preventative-oriented programs and services such as youth mentoring are urgently needed.

Presently, many stakeholders and programs are involved in providing mental health-related services, but they are often fragmented and piecemeal, using different approaches, and not leveraging proper case management approaches. Despite some collaboration, the stakeholders are often working in isolation. The focus tends to be on severe and persistent mental illness, with insufficient attention to upstream prevention and/or early intervention for less severe conditions.

Mental health and wellbeing requires champions, and a proper system of mental health must be developed, with clear and aligned programs, services, mandates, processes and accountabilities. The design of such a system requires the use of updated and accurate epidemiological and healthcare statistics, which are presently largely insufficient to inform effective decision-making.

It is important to integrate robust mechanisms for routine and systematic evaluation, to assess the performance and quality of programs, with a focus on health outcomes.

Furthermore, it is important for organizations to start collaboratively addressing upstream and social determinants of health, through multi-sectoral strategies – focusing on domains such as poverty, housing instability, employment and social inclusion.

8.2 Substance abuse/addictions

Substance abuse and addictions are largely recognized to be increasingly important issues in the community that were exacerbated by the pandemic, as reflected by the dangers of the opioid crisis (e.g. fentanyl). The impact on families and the entire community are well recognized, as is the need for a multi-sectoral and comprehensive approach. The increasing prevalence of concurrent disorders (i.e. co-occurring mental health and addictions) present significant challenges to existing services. Presently, a number of organizations address substance abuse and addictions through their programming, ranging in functions from prevention to intervention:

- KSCS Mental wellness and addictions, and particularly the Addictions Response Services (ARS) provide comprehensive client and family-oriented services, such as individual addictions counselling and consultation (screening and assessment, along with addictions support and referrals to needed health and social care services), couples and family counselling and intervention (upon request from family members), as well as education, support and counselling for clients and families dealing with addictions and concurrent mental health issues, and a variety of group sessions. The pandemic also severely impacted clients and families dealing with substance abuse. The team created a dedicated Facebook page called Ensa'nikonhriióhake (your mind will be good/well) to share timely information about the services offered by ARS, harm reduction, recovery tips, and prevention initiatives. The team offered virtual recovery support groups and worked closely with partners at the Centre hospitalier de l'Université de Montréal, Centre intégré de santé et de services sociaux (CISSS) de la Montérégie-Ouest, and the Kateri Memorial Hospital Centre in the critical area of opioid overdose prevention and awareness.
- KSCS After-hours emergency response service works in close collaboration with the Kahnawà:ke Peacekeepers and other critical partners such as Kahnawà:ke Fire Brigade (KFB), to provide emergency response services for social emergency situations that occur within the community.
- Whitehouse prevention programs such as A:se Tahonatehiarontie program, which upstream prevention services for teens and youth focusing on healthy lifestyles (mental, physical, social and spiritual wellbeing), healthy decision making, social activities and social connections, positive self-esteem, addictions and mental health.
- The Peacekeepers are preparing to implement the DARE program (Drug Abuse Resistance Education), an educational program in schools that seeks to prevent use of controlled drugs, membership in gangs, and violent behavior.
- Substance use and addictions services are increasingly being integrated into many KSCS and KMHC programs, including Home and community care and Short-term care.

Challenges – substance abuse and addictions services

A Mental Wellness and Addictions CHP Sub-committee was established; however, it progress was limited. A CHP addictions logic model (2012/13, revision in 2014) was drafted, but it is unclear if, how or to what extent it was used to evaluate programs and/or services.

The importance of integrating the concepts and approaches of harm reduction are increasingly important within health and social services organizations. Furthermore, it is important to socialize

these concepts with the organizations and the wider community, to build awareness, and to address issues related to stigma and to enable acceptance and social inclusion. Organizations are considering and/or implementing various harm reduction approaches and services, such as naloxone and drug testing kits, needle exchange programs, and safe injection sites. It is important to have comprehensive services in the community, to ensure that Kahnawakehró:non do not have to leave Kahnawà:ke to receive services, which puts them at risk, particularly in relation to cultural safety and the lack of a supportive social and/or community network. However, it is a challenging culture shift, both for organizations and the wider community.

The increasing prevalence of concurrent disorders also reaffirms the importance of alignment between mental health and substance use/addictions services, and to ensure coordination and person-orientation of care through mechanisms such as case management and joint care planning meetings.

It is important to integrate robust mechanisms for routine and systematic evaluation, to assess the performance and quality of programs, with a focus on health outcomes.

Similar to mental health, it is important to address upstream social determinants, such as poverty, housing, employment and social inclusion. Furthermore, parenting and family preservation are extremely important priorities, especially in relation to vulnerable families experiencing problems with substance use, mental health, social problems, poverty, food and housing instability and violence.

8.3 Chronic disease

Chronic illness and disease are of significant relevance and importance to the community, and are being addressed by a multitude of programs and services across Kahnawà:ke. The Health Portraits reports (Onkwaná:ta Our Community, Ionkwata'karí:te Our Health) provide useful data regarding the prevalence of conditions such as diabetes, cardiovascular disease, hypertension and obesity. Co- and multi-morbidity are frequent with chronic conditions, and emphasize the importance of having person-oriented preventative and primary care services. Organizations and programs offering services related to chronic illness and disease include:

- Kahnawà:ke Youth Center (KYC) provides a comprehensive range of family-oriented upstream prevention programs and activities, heavily focused on promoting healthy and active lifestyles, physical activity and nutrition, and address issues related to obesity, cardiovascular diseases and diabetes.
- Whitehouse primary prevention programs such as Onkwanèn:ra and A:se Tahonatehiarontie offer prevention programs for children and teens related to healthy and active lifestyles and nutrition.
- KMHC Community Health offers extensive community-oriented programming that directly addresses chronic illness and disease. These services include chronic disease management, nutrition, diabetic eye screening, tobacco reduction, and school and staff health.
- KMHC Outpatient Clinic Services provide safe, wholistic, family centered, primary and preventive care for clients, particularly in relation to chronic disease management and medication management. Wellness nurses provide comprehensive and longitudinal chronic disease management and medication management for a range of conditions, including diabetes, hypertension, cardiac conditions (e.g. coronary artery disease) and chronic obstructive pulmonary disease (COPD). Pharmacists also have an increasing role in light of the physician shortage, and are able to renew medications, order blood tests, conduct follow-ups and help manage patients with chronic conditions such as diabetes, hypertension and renal disorders. Other programs and services such as the Community Health Unit (CHU), community outreach screening programs, social services and school youth clinics often refer clients to the Outpatient Clinic for a variety of primary care and chronic disease management services.
- KMHC Outpatient Clinic Primary Care services: Nine physicians offer comprehensive and longitudinal primary care services, which are provincially funded services. Primary Care Services has worked on active recruitment and retention strategies; therefore, in the past 5 years, there have been significant increases in physician morning (+26%), afternoon (+28%) and evening (+32%) clinics. The nurses also provide comprehensive primary care services, including:
    - clinical procedures (medication administration i.e. oral, injections, IV, aerosol; ear irrigation; dressings, etc)
    - laboratory services (blood and urine tests, EKG, etc.), with specimens sent to Centre Hospitalier Anna Laberge for analysis
    - chronic disease management
    - medication management
    - health education regarding acute and chronic conditions
    - health/chronic disease monitoring (blood pressure, glucose, respiratory status monitoring)

Other programs and services such as the Community Health Unit (CHU), community outreach screening programs, social services and school youth clinics often refer clients to the Outpatient Clinic for a variety of primary care and chronic disease management services. The Outpatient Clinic's primary care services also maintain a list of clients who are not registered to a primary care provider (i.e. "unattached" patients). Clients on the list are assigned a vulnerability code, which enables prioritization for attachment based on vulnerability and complexity.

Kahnawà:ke Schools Diabetes Prevention Project (KSDPP)

The Kahnawà:ke Schools Diabetes Prevention Project (KSDPP, which began in 1994) mission is to prevent type 2 diabetes through the promotion of healthy eating, physical activity and wholistic wellness for present and future Kahnawakehró:non and for other Indigenous communities (45)This is achieved by designing and implementing school, family and community intervention activities. KSDPP conducts community based participatory research on these activities, and trains community intervention workers and academic and community researchers. KSDPP is committed to report all research results first to the community, then to wider lay and scientific audiences. KSDPP's vision is to empower community members to care for their personal and family health through continual improvement of its unique diabetes prevention model based on Kanien'kéha values. KSDPP collaborates with all community organizations on a shared vision of diabetes prevention activities that reach all community members.

While KSDPP's program of activities is anchored in evidence-based theories of behavior and community change, the core of KSDPP's actions are based on Kanien'kehá:ka values and traditions, and a wholistic view of health which incorporates the physical, emotional, mental and spiritual dimensions of life, true to a Haudenosaunee perspective of wellbeing (45,46).

KSDPP continues to develop its research model based on the experiences of Kahnawakehró:non, staff and researchers in a partnership between Kahnawà:ke and universities. The research model is shared with other Indigenous communities and all involved with diabetes prevention. KSDPP trains a significant number of Indigenous people in diabetes prevention intervention and research activities.

KSDPP's style of governance is based on Kanien'kehá:ka values, which involve consensus in decision-making and a collective vision for the community. KSDPP's Community Advisory Board (CAB) consists of Kahnawakehró:non volunteers from different sectors of the community. CAB members meet regularly to oversee the project, influence decision making, give feedback, and ensure that the needs of the community are addressed. Some of CAB's main tasks so far have been the creation of the Vision Statement and a Code of Research Ethics, which describes how

the Community Advisory Board, Community Researchers, and Academic Researchers could work with one another in a respectful manner.

KSDPP has been involved in a number of CHPI projects over the past several years, such as:

- Implementation of the Kahnawà:ke Schools Diabetes Prevention Project program of activities
- Iakaonhnhiióstha ne Taionré:ren
  Racers for Health
- Free Kahnawà:ke Family Skating
- Get Fit
- Living with Diabetes Men's Education Program
- Yoga for Diabetes Prevention
- Sadie's Walk

KSDPP has also actively participated in the Onkwata'karitáhtshera Ahsatakariteke ("To be well") subcommittee since 2014 (formerly called the Chronic Disease subcommittee), including the Physical Activity Initiative (PAI).

KSDPP provides yearly research project updates through its annual plan, submitted to Onkwata'karitáhtshera Health and Social Services Research Council and publicly available on its website (45,47). The annual report highlights completed and ongoing research projects, funding applications, graduate/undergraduate research trainee projects, and other research-related networks and activities.

As of 2021, 74 publications have been successfully completed through work with KSDPP. All research has been approved by the KSDPP CAB and Research Team respecting the KSDPP Code of Research Ethics.

Challenges – chronic disease services

A Chronic Disease (Ahsatakariteke) CHP Sub-committee was established, but its progress was rather limited, apart from a Physical Activity Initiative. CHP logic models for cardiovascular conditions, diabetes, obesity, diabetes and "primary health" (2012/13) were drafted, but it is unclear if, how or to what extent they were used to evaluate programs and/or services.

Ensuring timely access to comprehensive and high quality primary care services is extremely important for the longitudinal care of patients with chronic conditions. KMHC's Outpatient Clinic primary care services experiences issues associated with short-staffing, and challenges with recruitment. It has been very challenging to recruit and retain full-time professional staff from most disciplines, particularly nursing.

The performance of primary care services can be improved by developing stronger teamwork mechanisms. For example, there is a need to integrate more non-clinical and administrative support staff with competencies and abilities to function at higher levels, that the clinical team (e.g. physicians, nurses) can delegate non-clinical tasks and responsibilities to. This would generate efficiencies, and enable clinicians to focus on essential clinical functions and quality of care.

Access to primary care also presents significant challenges. For example, the after-hours and weekend clinic offerings are limited, and there are many community members who are currently not registered to a family physician.

8.4 Early childhood wellness

Many organizations in Kahnawà:ke provide family-oriented programs and services related to early childhood wellness, often exceeding the scope articulated in the CHP (i.e. beyond learning and developmental disabilities such as Attention Deficit Disorder (ADD), Autism, Asperger's and Down's Syndrome). It is important to note, however, that the specific conditions articulated in the CHP have indeed been found to be relevant and important by the Health Portrait report (Onkwaná:ta Our Community, Ionkwata'karí:te Our Health) (29,30). High numbers of babies born to teenage mothers and concerns like the upward-trending rates of ADD and autism which are likely to continue in coming years.

Many of these organizations have highly sophisticated service delivery models that focus on upstream prevention and early intervention, and that focus on comprehensively addressing the medical and psychosocial needs of children and their respective families, as well as on social inclusion.

- Step by Step Child and Family Center (SBSCFC) provides comprehensive upstream prevention and early intervention for children with developmental disabilities and special needs. The organizational leverages developmental screens, wholistic assessments and individualized education plans. There is significant focus on social acceptance, enabling awareness and preventing and addressing stigma, and supporting children's physical, cognitive, language and socio-emotional development. SBSCFC closely collaborates with health and social services across the community, and leverages a multidisciplinary team-based approach, including physiotherapy, occupational therapy, nutritionists, speech and language therapy, psychology and inclusion specialists.
- Whitehouse prevention programs such as Onkwanèn:ra and A:se Tahonatehiarontie provide inclusive programs that enable children and teens with developmental disabilities and special needs to participate.
- The Family Wellness Center (FWC) Parenting team provide parenting services for clients that have children with neuro-behavioural differences and developmental delays.
- Jordan's Principle enables access to services for children, particularly those with vulnerabilities and/or special needs. Examples include art therapy, behavior technician, neuropsychological assessment, osteopath services, psychoeducational assessment, psychological assessment, specialized car seat, specialized summer camp, speech therapy and tutoring services.
- Connecting Horizons is a community-based group working to identify, and respond to, needs of individuals with special needs, and their families living in Kahnawà:ke. The group is comprised of individuals with special needs, parents/caregivers of individuals with special needs, and representatives from community organizations. Through consultations, Connecting Horizons continues to build grassroots initiatives to understand the needs of families and individuals living with disabilities, and increases awareness to engage leadership, community members and other organizations to support its mission to help meet those needs. CHP focus on people with disabilities, and their families.
- Although going beyond the scope of early childhood wellness, the Assisted Living Services (ALS) program provides a comprehensive range of team-based services for families and individuals living with special needs, as well as individuals living with severe and persistent mental health conditions. The ALS program consists of the Family Support and Resources

(FSRS) program and the Independent Living Center (ILC). The FSRS program incorporates the Teen Social Club (TSC) and Young Adults Program (YAP). The TSC provides services for individuals with special needs and developmental and physical disabilities, providing life skills and social supports with a focus on social integration. The YAP is a day program for individuals with developmental and physical disabilities. The program provides individuals and families/caregivers life skills and social supports that focus on social integration in Kahnawà:ke and the surrounding communities.

- KMHC Outpatient Clinic: the community has access to specialized services such as pediatrics and pediatric assessments on-site (for complex cases such as neural deficits, ADHD, autism). The ophthalmologist has expertise in pediatric ophthalmology, thereby providing comprehensive assessments for children.
- KMHC Community Health: an extensive community-oriented program, encompassing a comprehensive range of services across the entire lifespan (preconception to death). Services for early childhood wellness include preconceptual health, prenatal care, maternal health, well baby visits (2,4, 6, 12, 18, 24, 36 months), breast feeding support, developmental screening.

Challenges – early childhood wellness

An Early Childhood and Family Wellness CHP Sub-committee was established, but had limited progress apart from activities relating to the development of a resource kit and services diagram, and work on the Kahnawà:ke Early Learning and Child Care Framework (ELCC). CHP logic models for developmental disabilities and Fetal Alcohol Spectrum Disorder (FASD) were drafted in 2012/13, but it is unclear if, how or to what extent they were used for evaluation of programs, services and activities.

The scope of early childhood wellness articulated in the CHP should be expanded to other special needs populations, beyond a focus on specific conditions scope articulated in the CHP (i.e. beyond learning and developmental disabilities such as Attention Deficit Disorder, Autism, Asperger's and Down's Syndrome). Volume II of the Health Portrait (Onkwaná:ta Our Community, Ionkwata'karí:te Our Health' Portraits (30)), which will soon be published, does expand upon the CHP's scope, providing a comprehensive picture of:

- Demographics
- Home and learning environments and family circumstances of children
- Parents' economic and educational context
- Using Kanien'kéha
- Healthy pregnancies and healthy kids (including factors that are harmful during pregnancy, such as smoking, alcohol, gestational diabetes, low birth weight, preterm birth, high birth weight)
- Breastfeeding
- Infections and vaccine-preventable diseases
- Health conditions in children
- Access and barriers to healthcare

- Self-rated health status
- Common conditions and health concerns

Volume II of the Health Portrait (forthcoming) provides striking statistics pertaining to children and family context, that emphasizes the urgent need to focus on early childhood and family wellness (30). For example, data indicates that a significant proportion of babies born in Kahnawà:ke were born to teenage mothers, which is several times higher than in the Montérégie region or the province. Furthermore, a significant proportion of babies in Kahnawà:ke were born to a mother who had not completed high school, compared to the region and province (source: Onkwaná:ta Our Community, Ionkwata'karí:te Our Health' Portrait, Volume II).

The evaluation also found that upstream prevention services often lack the resources to provide effective services for children with learning and/or developmental disabilities or special needs. For example, behavior technicians should be integrated into prevention teams, to ensure effective service delivery.

The pandemic had a particularly negative impact on populations with special needs, that already were isolated pre-pandemic. Furthermore, access to vital and essential services was limited, having devastating impacts on the health and well-being of special needs populations and their respective caregivers and families (e.g. the impact on the long-term development of children with special needs). The impact and needs of these populations, in light of the pandemic, need to urgently be assessed and addressed.

The Connecting Horizons report "Supporting individuals with special needs and their families: a community needs assessment" highlighted limitations with current service availability and program quality, as well as support worker skills and knowledge. Furthermore, financial and staffing resources should be reviewed, to ensure sustainability of services. There to ensure that families and individuals with special needs have their voices are heard, to see concrete improvements to existing services, and meaningful efforts to increase awareness of the needs of individuals with special needs across the whole community.

8.5 Cancer

It is reassuring that cancer rates in Kahnawà:ke are not higher than in neighboring jurisdictions; however, cancers are serious concerns and are a leading cause of morbidity and mortality globally. 2015 data from the Health Portrait report (Onkwaná:ta Our Community, Ionkwata'karí:te Our Health) indicates a breast cancer screening rate of 79%, cervical cancer screening rate of 78%, and colon cancer screening test rate of 57%. 15% of people aged 12 and over in Kahnawà:ke smoke, and 40% are former smokers (29).

The Cancer Health Priority CHP Sub-committee's purpose was cancer prevention and intervention, with a focus on long-term projects and using the Medicine Wheel as a basis for cancer care. However, the effectiveness of the Sub-committee was not optimal, and its activities were put on hold in 2019.

Several cancer-related programs are available in the community, that provide a range of services mainly related to prevention and cancer support. Notable examples include:

- Upstream prevention programs at Kahnawà:ke Youth Center (KYC) and the Whitehouse provide programming related to sun safety, healthy nutrition, physical activity and healthy lifestyles. The KMHC tobacco reduction strategy (which also incorporates vaping) focuses on prevention and enabling people to stop smoking.
- KMHC's Community Health cancer program aims to reduce the incidence and mortality of cancer among Kahnawakehró:non by disseminating prevention and awareness information. The Cancer Support Nurse participates in the Onkwata'karitahtshera Cancer Sub-committee and attends the monthly cancer support group, where the nurse shares new research information, answers questions about the medical system, the human body and how it functions, lymphedema, medications, treatments, self-care tips, resources and whatever their needs may be. It helps the nurse get greater insights of their personal experiences. The psychologist was brought in to help participants deal with grief, as many members died in a short time period.

Table 19: KMHC Community Health Unit cancer program statistics

Year	Clients (#)	Interactions (#)	Hours (#)
2016-17	30	157	114
2017-18	32	266	190.5
2018-19	44	316	206
2019-20	35	359	176

9. Recommendations

9. Recommendations

A workshop was held on October 18-19, 2022 to conduct a content validation and prioritization exercise, relating to recommendations that were drafted. The workshop included a variety of participants from organizations and groups from across Kahnawà:ke, including Onkwata'karitáhtshera, MCK, KSCS, KMHC, KFB, KYC, SBS, Connecting Horizons and the PeaceKeepers.

Using a group activity, participants assessed the content validity and priority status of the draft recommendations. Using a content validity scoring and feedback template (Appendix Section 2), workshop participants rated each of the recommendations for:

- Clarity
- Relevance
- Essentiality
- Importance
- Urgency

Workshop participants were also requested to complete an online survey (confidential and voluntary), to individually score the draft recommendations for their content validity and priority status (Appendix Section 3). This exercise enabled triangulation of results from the workshop, and to ensure that individuals had a safe and confidential space to provide candid feedback (particularly for individuals that did not feel comfortable or safe voicing differing perspectives within a group setting). The survey thereby served as a mechanism to ensure that all voices are heard.

Fourteen strategic recommendations were drafted, through analysis and incorporation of feedback from the content validation and prioritization workshop and survey, as well as subsequent validation with Onkwata'karitáhtshera team members. The list of 14 strategic recommendations are provided below (Table 20), and linked to the respective evaluation framework domains.

It would be beneficial for subsequent prioritization exercises be conducted with community stakeholders, to update the prioritization scores (importance and urgency). Furthermore, to enable the successful operationalization and implementation of the recommendations, it is critical to conduct thorough stakeholder engagement activities, and to collaboratively develop Action Plans to ensure stakeholder agreement regarding definitions, and strategic alignment.

Table 20: Strategic recommendations

Domain	Strategic recommendation	Related notes, operational recommendations and/or action items
Organizational needs	(1) That programs and services proactively assess organizational needs, to identify gaps in resources, knowledge, practices and/or skills.	• Refer to Section 7.1 findings and analyses. • Organizations should work with their respective programs and services to develop organizational needs assessment guidance documents. Guidance documents provide structured approaches for organizational needs assessments and define key areas for attention. Programs and services should provide input regarding the final content and frequency of organizational needs assessments. • It is important that mechanisms (e.g. action plans) are developed, to ensure that findings from organizational needs assessments are properly addressed. Prioritization (survey results, **pre-revision):*** • Importance: 76.9% very important, 23.1% somewhat important • Urgency: 30.8% very urgent, 61.5% somewhat urgent *** Note:** *Prioritization (importance and urgency) scores of some of the recommendations are included in the table. It is important to note that these scores – derived from the workshop survey – are not statistically significant (n=14). Furthermore, they specifically pertain to the recommendations prior to their final revision. However, the scores were included if the recommendation was not perceived to be heavily revised. The complete scores (content validity and prioritization) are included in [Appendix Section 3].*

Domain	Strategic recommendation	Related notes, operational recommendations and/or action items
Human Resources	(2) That health, social and educational (technical and vocational) organizations collaboratively explore the development of a recruitment and internal talent development strategy, to ensure the long-term sustainability of Kahnawà:ke's health and social services systems.	• Refer to Sections 7.1 & 7.2 findings and analyses. • Training, educational, and experiential opportunities not only for youth, but any individuals interested in pursuing a career in a health or social care related field. This should be done with clear incentive and financial support. It is important to invest in supporting the next generation of health & social services workers in Kahnawà:ke.
Service delivery models	(3) That all service delivery models have mechanisms that ensure core standards are periodically reviewed and updated.	• Refer to Section 7.2 findings and analyses. • Definition of "standard": Standards are explicit statements of expected quality in the performance of health, social care and/or educational activities. Standards contain technical specifications or other precise criteria designed to be used consistently, and may take the form of rules, procedures, definitions, guidelines, protocols, regulations or statements of expected outcomes, among other formats. • "Core standards" are those that pertain to fundamental service delivery functions, rather than specific tasks. • Prioritization (survey results, pre-revision): • Importance: 84.6% very important, 15.4% somewhat important • Urgency: 7.7% very urgent, 76.9% somewhat urgent, 15.4% not urgent

Domain	Strategic recommendation	Related notes, operational recommendations and/or action items
Communication, collaboration & coordination:	(5) That Kahnawà:ke explores steps towards alignment of health and social services at governance, organizational and administrative levels, to enable integration of service delivery and coordination of care for all Kahnawakehró:non.	• Refer to Section 7.5 findings and analyses. • Related operational recommendations / action plan items: • 5a-operational) That organizations work together to identify and address the challenges, barriers and risks for inter- and intra-organizational communication, coordination and collaboration. This also encompasses organizations external to Kahnawà:ke (e.g. hospitals, mental health facilities, educational institutions, etc). • 5b-operational) That Kahnawà:ke health and social care organizations work together to identify, assess and address service delivery gaps and fragmentation of care, particularly for the following conditions and/or populations: frail elderly, mental illness, substance use, chronic illness/ disease, and special needs. Prioritization (survey results, pre-revision): • Importance: 69.2% very important, 23.1% somewhat important, 7.7% not important • Urgency: 23.1% very urgent, 53.8% somewhat urgent, 23.1% not urgent

Domain	Strategic recommendation	Related notes, operational recommendations and/or action items
Community engagement	(6) That organizations, programs and services work together to develop and align strategies for ongoing community engagement, including a focus on sensitively engaging individuals and families with access challenges, special needs and /or highly impacted by trauma.	• Refer to Section 7.6 findings and analyses. • There is no commonly agreed upon definition for "community engagement", and the concept has been understood and implemented in various ways by different stakeholders in Kahnawà:ke. It would be beneficial for stakeholders to work together, to discuss their ways of conceptualizing and defining the concept, and to align their various strategies of community engagement. • It is important to leverage Haudenosaunee, Kanien'kehá:ka and First Nations perspectives approaches to community engagement.
		• It may also be beneficial to leverage the World Health Organization's (WHO) handbook for community engagement: ▪ Leverage the WHO definition of community engagement: "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes". The WHO conceptualizes community engagement as both a process and an outcome. ▪ Leverage the WHO checklist for developing a community engagement strategy. • It is important to develop and implement sensitive approaches to engage with individuals and families that are highly impacted by various forms of trauma. This includes (but is not limited to) trauma relating to the impact of multi-generational trauma, physical abuse, sexual abuse, various forms of violence, bullying, intimate partner trauma and grief. • Prioritization (survey results, pre-revision): • Importance: 92.3% very important, 7.7% somewhat important • Urgency: 30.8% very urgent, 61.5% somewhat urgent, 7.7% not urgent

Domain	Strategic recommendation	Related notes, operational recommendations and/or action items
Client, family & caregiver experience recommendation	(7) That organizations, programs and services develop and implement systems for the collection, analysis and use of client, family and /or caregiver experience data on an ongoing basis.	• Refer to Section 7.7 findings and analyses. • It would be beneficial for organizations, programs and services to work together, to ensure alignment of strategies and approaches, as well as to explore opportunities for sharing information and joint action. • Organizations should ensure that technical and administrative supports are in place, to enable functions relating to tool design, data collection, data analysis, reporting and continuous quality improvement. • It is important that mechanisms (e.g. action plans) are established, to ensure that findings are effectively and efficiently acted upon. Prioritization (survey results, pre-revision): • Importance: 69.2% very important, 30.8% somewhat important • Urgency: 30.8% very urgent, 61.5% somewhat urgent, 7.7% not urgent
Evaluation, performance assessment & quality improvement	(8) That organizations, programs and services develop robust systems for evaluation, performance assessment and quality improvement, that integrate Indigenous and Kanien'kehá:ka frameworks.	• Refer to Section 7.8 findings and analyses. • Key functions include the development of evaluation frameworks/logic models, continuous quality improvement (CQI) frameworks, indicator frameworks (e.g. KPIs), evaluation design, evaluation management, assessment tool development and validation, data collection, data analysis, reporting and Knowledge Translation and Exchange (KTE). Prioritization (survey results, pre-revision): • Importance: 69.2% very important, 30.8% somewhat important • Urgency: 30.8% very urgent, 53.8% somewhat urgent, 15.4% not urgent

Domain	Strategic recommendation	Related notes, operational recommendations and/or action items
Data & information systems	(9) That Kahnawà:ke organizations, particularly health and social services, develop and implement robust data and information systems strategies.	• Refer to Section 7.9 and 7.10 findings and analyses. • It is recommended that the data and information systems strategies should consist (at a minimum) of the following domains: • Data sources: supporting the deployment, optimization and "meaningful use" of electronic medical records (EMRs) and case management systems. • Data sharing: developing data-sharing agreements and protocols, to identify what data (individual and population level) can be shared, how it can be shared, and related logistical considerations, including data governance, OCAP principles, data privacy and confidentiality, funding streams and accountabilities. • Data management: developing a robust and integrated strategy for data management. This encompasses functions related (but not limited) to: data governance, database management, data warehousing, data integration, data quality, and data integration and interoperability.
		• Data analytics and business intelligence: developing infrastructure and resources to support data analytics and business intelligence functions. This is to ensure that data is transformed into meaningful information for informed decision making, at all governance levels (clinical, organizational and system levels). This includes developing organizational competency and capacities related (but not limited) to: advanced statistics, predictive analytics, indicator measurement, dashboarding and data visualization. • Health informatics: developing a robust health informatics strategy, focusing on defining and enabling key epidemiological, public health, population health management and clinical informatics functions.

Domain	Strategic recommendation	Related notes, operational recommendations and/or action items
Staff wellbeing	(10) That organizations continue to prioritize staff health and wellbeing by periodically assessing staff wellbeing, motivation and burnout, and ensuring that staff have low-barrier access to wellness supports and services..	• Refer to Section 7.11 findings and analyses. • Organizations, programs and services should jointly develop mechanisms to consistently and periodically assess staff wellbeing, motivation and levels and risks of burnout. These mechanisms can leverage various approaches and methods, including the adaptation and use of standardized assessment tools as well as qualitative methods. • It is important to be proactive, and to carefully monitor trends over time. • Organizations should continue to encourage staff to access support services such as the Employee Assistance Program (EAP), and to address issues relating to potential stigma staff encounter or perceive, that hinder seeking support. • It is important that to be proactive, and to carefully monitor and assess trends over time. Furthermore, mechanisms (e.g. action plans) should be established to ensure that findings from assessments are properly addressed. • Prioritization (survey results, pre-revision): • Importance: 92.3% very important, 7.7% somewhat important • Urgency: 61.5% very urgent, 38.5% somewhat urgent

Domain	Strategic recommendation	Related notes, operational recommendations and/or action items
Culture & language	11) That organizations continue to develop and implement strategies and action plans relating to the integration of Kanien'kehá:ka culture and language within all levels of governance, including macro system and policy levels, senior administration, programming and service delivery..	• Refer to Section 7.12 findings and analyses. • Strategies should ensure the sustainability of culture and language programs, via the allocation of necessary supports and resources. • Organizations should continue to develop internal practices and policies that support Tsi Niionkwarihò:ten ("Our Ways") integration at all levels of governance (i.e. macro/policy, meso/organizational and micro/clinical/front-line levels).
Culture & language	(12) That organizations continue to develop and implement strategies relating to trauma-informed service delivery and cultural safety.	• Refer to Section 7.12 findings and analyses. • Cultural safety lies upon a continuum of care that involves the concepts of cultural awareness, sensitivity, and competence. Although analytically distinct, they are interrelated and mutually constitutive. Therefore, it is important that strategies approriately integrate all four of these concepts. • It is important to implement cultural competency frameworks, and to integrate cultural competency within performance appraisals. • It is important to integrate concepts from cultural safety, competency, sensitivity and awareness within client/family/caregiver experience measurement activities. Prioritization (survey results, pre-revision): • Importance: • Urgency:

Domain	Strategic recommendation	Related notes, operational recommendations and/or action items
Community Wellness Plan (planning & development)	(13) That stakeholders from across Kahnawà:ke co-develop a Community Wellness Plan premised on mutually agreed upon principles, concepts and approaches, with a focus on health and well-being outcomes.	• Refer to Sections 7.13 and 7.14 findings and analyses. • It is important that the CWP integrate a comprehensive outcomes-oriented performance framework. This common framework would enable all Kahnawà:ke stakeholders to align efforts and collaborate to achieve commonly desired health, wellness and wellbeing outcomes. The framework's process indicators would clearly reflect the functions and activities of the respective stakeholders, and the outcome indicators would enable ongoing measurement and assessment of the performance and quality of services. Prioritization (survey results, pre-revision): • Importance: 76.9% very important, 23.1% somewhat important • Urgency: 46.2% very urgent, 38.5% somewhat urgent, 15.4% not urgent
Community Wellness Plan (Health, wellness & wellbeing priorities)	(14) That Onkwata'karitáhtshera continues working with all relevant partners to gather and analyze data from available sources, to update the health, wellness and wellbeing priorities.	• Refer to Sections 7.13 and 7.14 findings and analyses. Prioritization (survey results, pre-revision): • Importance: 76.9% very important, 23.1% somewhat important • Urgency: 23.1% very urgent, 76.9% somewhat urgent

10. Bibliography

10. Bibliography

Note: Some internal organizational documents are not included below, for privacy and/or confidentiality requirements

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11. Appendix

11. Appendix

The Appendix Sections below can be accessed digitally using the following weblink:

https://drive.google.com/drive/folders/1nX3QVPTbelxHvPtRIyN8-bGMqpIlYX2U?usp=share_link

Appendix Section 1: Evaluation matrix

Appendix Section 2: Content validity scoring template

Appendix Section 3: Content validity and prioritization results

Appendix Section 4: 2016 CHP Evaluation (Niska) recommendations

Appendix Section 5: Multiclientele Assessment Tool documents

Appendix Section 6: Evolutive Autonomy Profile

Appendix Section 7: KSCS Psychosocial Assessment tool

Appendix Section 8: KMHC Client Experience Survey (Short-Term Care)

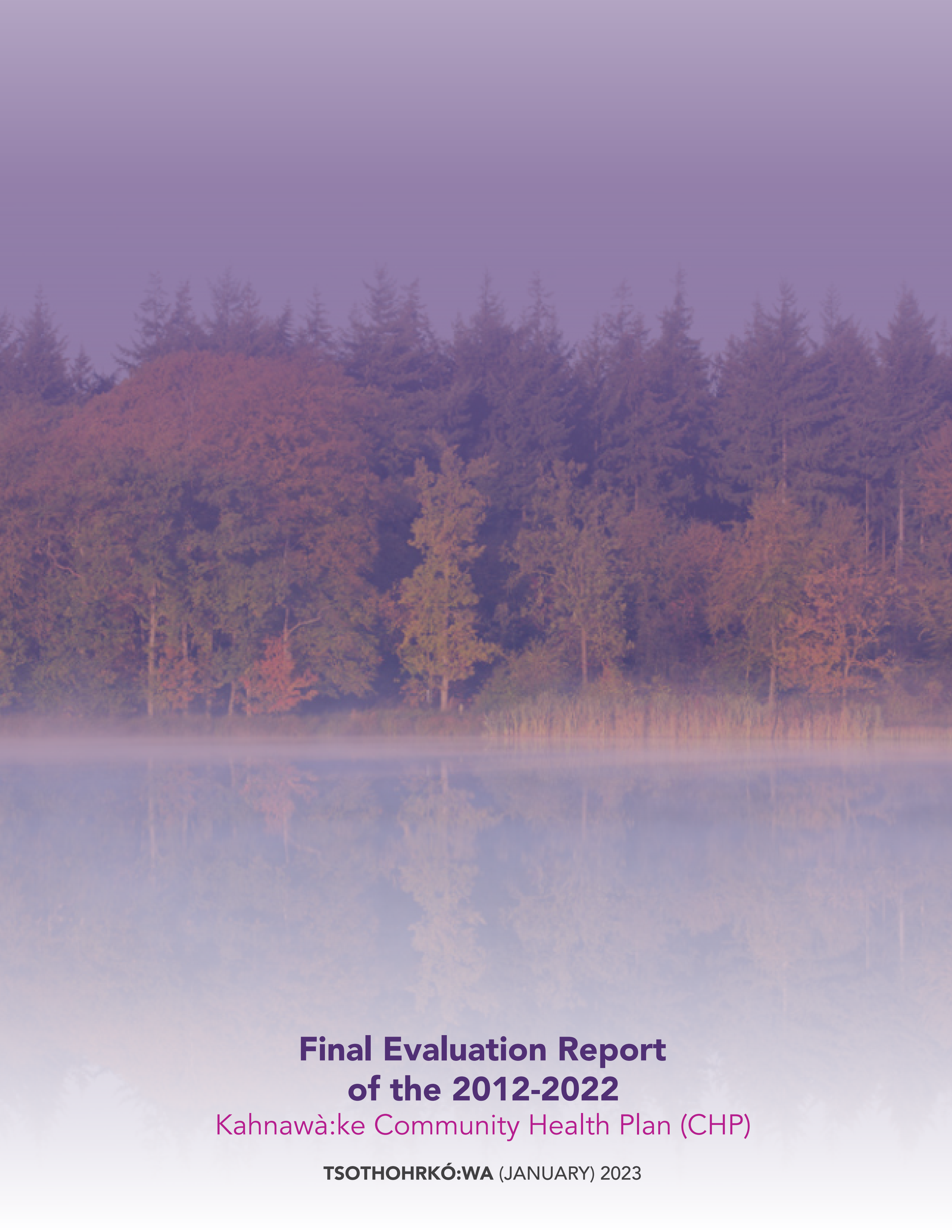
Appendix Section 9: KMHC Short-Term Care audit forms

Appendix Section 10: Kahnawà:ke Fire Brigade and Ambulance Service Patient Care Report (PCR) Data Fields, Protocols and Codes

Appendix Section 11: Tsi Niionkwarihò:ten Final Report (2018-2019) updated notes

Appendix Section 12: Pandemic impact and response (examples from various organizations, programs and services)

Appendix Section 13: Erratum



Final Evaluation Report of the 2012-2022

Kahnawà:ke Community Health Plan (CHP)

TSOTHOHRKÓ:WA (JANUARY) 2023