Home and Community Care Services

Service Delivery Plan

Community Name: Kahnawake

Date: July 2012

Program Vision, Philosophy, Mission Statement, Demographics

INTRODUCTION

This report provides an update to Kahnawake's Community Health Plan for programs which fall within the scope of the Health Transfer Agreement.

Onkwata'karitahtshera, Kahnawake's Health Commission mandated the review and analysis of the Health Plan to independent, third party consultants with 15 years experience in the evaluation and assessment of high profile projects and organizational/Quality management.

The content and format of this report respects the guideline entitled *"Evaluation Quinquennale du Plan de Sante – Guide a l'intention des consultants, May 2010"* provided by Health Canada representatives.[1]

Every effort has been made to address each requirement detailed in the Guideline.

I. COMMUNITY PROFILE

A. Socio-demographic Portrait[2]

i. *Geographics*

Kahnawake is a 12,000 acre Mohawk community located 10 kilometres southwest of Montréal. Its strategic location renders it accessible by varied routes including three provincial highways, the Honore Mercier Bridge in addition to a commercial train bridge, and the St. Lawrence Seaway. Despite its urban location, there is a limited public transportation network and the community must therefore rely on its own resources, for example - to transport community members by Medic transport to various Montreal Island health care facilities[3]. Additionally, although the community is not isolated geographically and is but a short distance from the center of Montreal, the fact that the

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[1] Presented to Kahnawake by Mme Michelle Deschamps (Health Canada) in June 2010.

[2] Note: "Kahnawake does not participate in Statistics Canada's census so the community does not have readily available statistics on its economy, employment rate, poverty level, and average income. The information that is available is limited and only used by community organizations for internal planning purposes". Source: Extract from KSCS internal document.

[3] For the period April 1, 2009 to March 31, 2010 there were 21,961 off territory medical appointments for a total of 14,402 clients.

community speaks primarily English lends to a feeling of isolation especially in relation to accessing services and information.

ii. *Population*

Kahnawake's population levels continue to grow at consistent levels with an average ninety-two (92) births per year and an average forty-eight (48) deaths per year over the past decade[4]. In 2009, Kahnawake on reserve births reached its second highest level in a decade at 100 births[5]. Currently, 49% of the on reserve population is 39 years of age and older; close to 20% are aged 15 and under: and 20% are 60+. (Note: For more detailed data, please see Attachment 37 – "Indian Register Population by Individual Age, Sex and Residence, 2009" also for general information and comparative purposes: "Statistics Canada – Aboriginal Population Profile from the 2006 Census")

Population[6]		
Number of persons within the community	**Number of persons outside the community**	**Total**
7 645	2 224	9 869

iii. *Income levels*

The on- reserve average household income is $37,153.[7] The community's unemployment rate is estimated at between 3% to 11%.[8] Another indicator that may be useful in painting the economic profile of the community, is the number of community members who receive Social Assistance. The Social Development Unit of the Mohawk Council of Kahnawake, maintains general data based on the number of Social Assistance cheques issued per year.

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[4] Source: KMHC. 2000:44, 2001:48, 2002:44, 2003:57, 2004:46, 2005:46, 2006:48, 2007:57, 2008:55, 2009:40.
[5] Resource DIAND: On reserve births in 2006 were102.
[6] Resource: Indian Register as at December 31, 2009.
[7] Source: Kahnawá:ke Economic Development Commission (August 2009).
[8] Ibid.

Social Assistance[9]					
	2005	2006	2007	2008	2009
Total Cheques Issued	5,797	5,821	6,340	6,631	7,018
Monthly Average of SA Recipients	483	485	528	553	585

iv. *Community Resources*

Kahnawake's community resources are equivalent to those one would find in a typical, modern suburban community. However, unlike today's "neighbourhoods", Kahnawake residents have the added benefit of living in a close-knit community where the value of working for the common good is of paramount importance. The spirit of the idiom: "it takes a village", is evident in the numerous community initiatives: from Harvest Fairs, Mohawk Miles, picnics and outings, to children's firemen "camps" and the travelling Diabetes Awareness "road show" to name but a few. With some exceptions, it can be stated that the community has successfully achieved a level of self-sufficiency.

Many tangible resources are available to the Kahnawake community, including:

- Kateri Memorial Hospital Centre (KMHC) – Accredited by the Accreditation Canada Canadian Council for Health Services Accreditation
- Kahnawake Fire Brigade & Ambulance Service
- Kahnawake Peacekeepers
- Several on reserve schools[10]:

  Karonhianonha School
  Pre-Kindergarten to Elementary 6
  Enrollment: 189 (2008-2009)

  Kateri School
  Kindergarten to Elementary 6
  Enrollment: 286 (2008-2009)

  Kahnawake Survival School
  Secondary 1 to 5
  Enrollment: 280 (2008-2009)

[9] Social Development Unit (SDU): MCK (August 2010).
[10] Government of Canada: INAC – Kahnawake Community Profile http://www.ainc-inac.gc.ca/ai/scr/qc/aqc/prof/Kahnawake-eng.asp

Step by Step Child and Family Center
Pre-Kindergarten and Kindergarten
Enrollment: 168 average

Kahnawake Learning Center
Secondary 2 to 5
Enrollment: Fluctuates

Indian Way School
Pre-Kindergarten to Secondary 1
Enrollment: 19 average.

Karihwanoron Mohawk Immersion
Up to 6 years old
Enrollment: 23 average

- Kahnawake Shakotiia'takehnhas Community Service (KSCS) (support/prevention)
    - Family and Wellness Center (parenting and traditional approaches)
    - Turtle Bay Elders Lodge – Tiosehrohon Tsiiontientahkwa
    - Assisted Living Services (disabled/socially handicapped)
    - Home and Community Care (homecare)
- Kahnawake Cultural Center – Kanien'kehá:ka Onkwawén:na Raotitióhkwa
- Kahnawake Sports Complex
- Kahnawake Youth Center
- Tsi-iehwistaientahkwa Caisse Populaire Kahnawake (Financial institution)
- Canada Post branch office
- Pharmacies (independently owned)
- Dental Office (independent professional)
- Old Malone Medical Center (includes a General Practitioner, Chiropractor, Optometrist, Podiatrist)
- Library
- Local Radio Stations
- Local Newspaper
- Cable TV stations
- Mohawk Council of Kahnawake – Band Council
- Hydro Quebec office

v. *Education*

Community wide, detailed, "education" level data is not available. However, general, limited, information is available for those currently employed within the health and social services delivery programs in Kahnawake under the health transfer agreement.

Graduate Degree - Masters (9)

• Nursing - 1
• Arts - 3
• Business Management - 1
• Social Work - 4

Bachelor Degree (51)

• Nursing - 15
• Liberal Arts - 2
• Applied Science - 1
• Business Management - 1
• Social Work - 11
• Social Science - 2
• Human Relations - 1
• Arts - 16
• Education - 1
• Political Science - 1

University Certificate (31)

• Management - 1
• Education - 2
• Teaching - 1
• Social Work - 6
• Arts - 2
• Applied Human Science - 1
• Community Service - 16
• Family Life Education - 2

Professional Education Diploma (28)

• Home Care - 16
• Secretarial - 10
• Social Work - 1
• Special Care - 1

Diploma of Collegial Studies (DEC) (43)

• Nursing - 15
• Addictions - 3
• Special Care - 1
• Computer Science - 1
• Social Work - 8
• Early Childhood Ed. - 1
• Human Relations - 1
• Arts - 2
• Social Science - 6
• Journalism - 1
• Police Tech - 1
• Other - 3

Ministry of Education Certificate (5)

• Teaching - 2
• Professional Organization - 1
• Gerontology - 1
• Home Care - 1

Certifications & Diplomas (10)

• Systems Administrator - 1
• Diabetes Educator - 1
• PAB (Orderly) - 1
CPR - Yearly
• Secretarial - 3
• Wellness Coach - 1
• Non-violent Crisis Intervention Instructor - 1
• Nursing - 1
• Fitness Leader - 1

Other (3)	
• Vocational Program (Home Care) - 1	• Other (Home Care) - 1
• Secondary School Diploma (General Secretary) 1	First Aide

As stated above, there are several English pre-kindergarten, elementary and secondary schools within the Kahnawake territory. Some of the educational institutions offer Mohawk (including Mohawk immersion program) and French as second language instruction. Students also attend off-reserve public schools in nearby Chateauguay or various private schools on the island of Montreal. Kahnawake is located within a 20 minute drive from two important downtown English universities (McGill and Concordia) and English CEGEP (Dawson College).

vi. *Economic Resources*

Tewatohnhi'saktha is Kahnawake's Economic Development Commission. Founded in 1999, its mission is to stimulate and enhance Kahnawake's economic growth and "to create jobs, wealth, and self-sufficiency for the Mohawks of Kahnawake"[11]. Since 2004, the organization also acts as a business incubator by providing: training to community members; access to funding to entrepreneurs; as well as promoting economic initiatives with a view to expanding opportunities beyond the Kahnawake territory. "Kahnawake has recently refocused its efforts on expanding the development of the economy through initiatives to promote small businesses and integrate key regional industry sectors, notably information technology, trade and tourism"[12].

"Economic activities are rather varied, and include: several retail and service businesses; a few manufacturing companies and a small degree of natural resource development. The reserve is home to most of the services found in cities: food stores, filling stations, pharmacies, hunting and fishing supply, gift shops, sportswear and sporting goods, hardware, florist, construction materials, restaurants, golf clubs, travel agency etc.

[11] See Tewatohnhi'saktha website: http://www.kedc.biz/about_us.php
[12] Source: Extract from internal KSCS document.

Services include: secretarial, dry-cleaning, housecleaning, plumbing, welding, electricity, furniture-making, carpentry, decoration and interior design, etc.

General contractors in carpentry, excavation, cement-laying, masonry, petroleum products and asphalting, transportation, livestock breeding, quarry, etc."[13]

vii. *Community Challenges*

Kahnawake is a close-knit, independent community, which is on the whole cognizant of the need to keep pace with present-day challenges while remaining true to its cultural heritage However, Kahnawake's strength also underlies the community's challenge(s).

The fact that the primary language is almost exclusively English isolates the community from its dominantly French neighboring communities. More importantly, from a health service delivery perspective, the fact that most, if not all, Quebec Health agencies' communication is provided solely in French creates an important challenge for Kahnawake. From understanding forms, to requirements, to special program and initiative directives, organizations tasked with delivering global health and social services within Kahnawake must generally rely on outside assistance which results in either significant time delays, translation costs and/or "missed opportunities" altogether. Until recently, the community was somewhat fortunate in that it successfully built relationships with individual government agency employees who provided general guidance in English. However, most of these employees have recently been transferred to other government agencies or have retired – as these actors "move-on", it becomes a greater challenge to continually orient new partners and to establish and build a solid working relationship between all parties Interviews with Kahnawake health and social service employees revealed a marked level of apprehension about the future of communication strategies with their provincial and federal counterparts.

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[13] Source: http://www.ainc-inac.gc.ca/ai/scr/qc/aqc/prof/Kahnawake-eng.asp

Education presents an interesting dichotomy within the community and more specifically within the Kahnawake organizations responsible for health and social service delivery. On one front, the community (and the organizations) advocates the importance of attaining a higher education as a benefit for both the individual and the community – yet, some employees believe that these accomplishment(s) are not always afforded the consideration they merit with relation to advancement within the organization(s). The emerging challenge is to reconcile the vision of those who attain post-secondary education with those whose knowledge and experience is gleaned primarily from "on the job training". For all intents and purposes, these two groups speak a different language; have a different understanding of terminology and view approaches and solutions through a different spectrum (*i.e.* clinical versus social approach). The situation is no different from what most organizations face, where "up and comers" must make a place for themselves and struggle to be heard. However, this very average struggle is especially significant in Kahnawake as it seeks to attract and maintain native professionals in an increasingly competitive market.

The on-reserve tobacco industry combines a number of challenges for the community. It was one of the most identified issues in both individual interviews and community focus groups and has engendered heated debates within Kahnawake, specifically as it relates to the health and future well-being of the community. For example, many highlighted the inconsistency between the presence of the industry with the anti-smoking message/program promoted by Kahnawake health organizations. Further, high paying work attracts young adults to the industry and away from pursuing a higher education. Kahnawake health service professionals are concerned that any future constriction within the industry could possibly result in increased future mental health and addiction issues as tobacco industry workers experience (and learn to cope with) a significant drop in lifestyle. The Mohawk Council of Kahnawake on behalf of the community is making concerted efforts to address these challenges. Recent

initiatives were undertaken to formalize the industry and render it more socially responsible. This has resulted in the creation of the Kahnawà:ke Tobacco Association (KTA).[14] Together with the local band council (Mohawk Council of Kahnawake – MCK), initiatives are underway to find solutions that will balance the community's economic needs with its future health and social needs.[15]

B. Organizational Management

There are four (4) main organizations responsible for the delivery of health and social services to the Kahnawake community. Onkwata'kariatahtshera (Onkwa), Kahnawake Shakotiia'takehnhas Community Services –(KSCS), Kateri Memorial Hospital Centre (KMHC) and the Kahnawake Fire Brigade and Ambulance Service (KFB).

i. Onkwata'kariatahtshera (Onkwa)

The organization is responsible for overseeing and directing health service delivery initiatives within the community. In its role as Kahnawake's "Health Commission" (One Health Agency), Onkwata'kariatahtshera (Onkwa) looks at the "big picture", and is the umbrella for the individual organizations which provide services, primarily KSCS and Kateri Hospital (KMHC). Summarily, Onkwa is driven by its mission statement.

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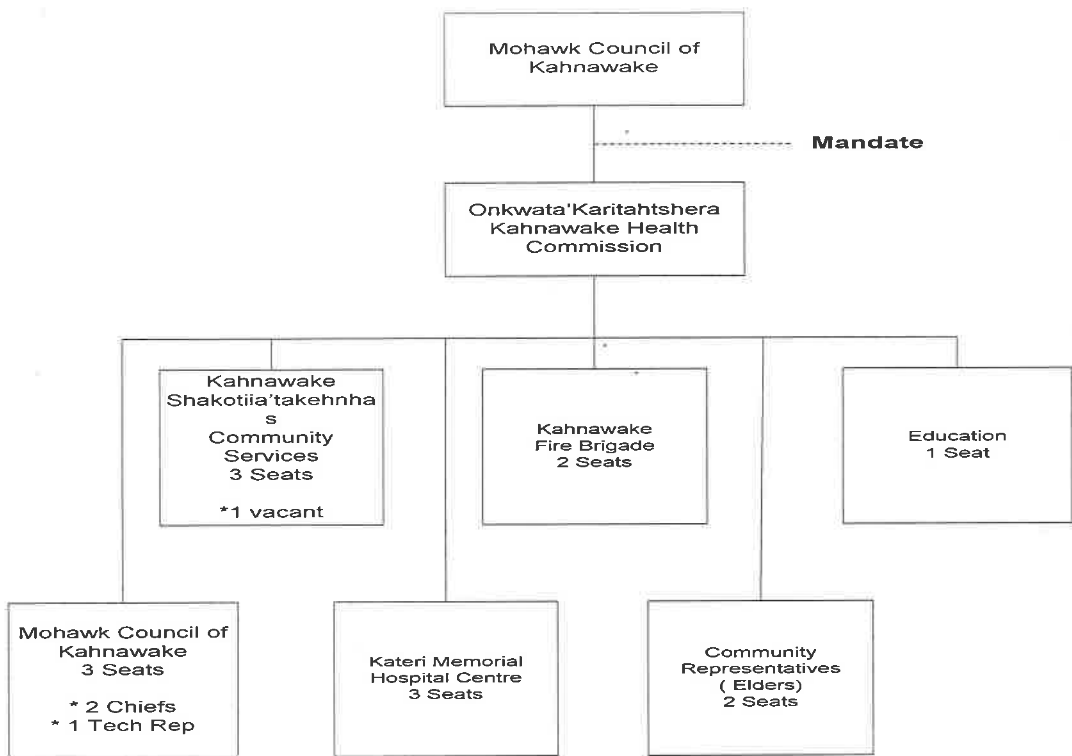
[14] Source KTA website: http://www.kahnawaketobaccoassociation.com
[15] "MCK, Kahnawà:ke Tobacco Association Support Regulation of Industry "Tsi Nahóten Karihwanákere No'nenk News Release (Kahnawake – 16, Kenténha/October 2009) http://www.kahnawake.com/news/pr/pr10162009b.pdf



Mission

Onkwata'kariatahtshera is the responsible body that oversees Kanien'keha:ka control of Kanien'keha:ka health.
Onkwata'kariatahtshera believes in holistic health. We believe in the social, physical, emotional and spiritual well-being of our people.
Our mission is to plan, maintain and improve health and social services for all Kahnawa'kehró:non.

In addition, Onkwa has identified its goals and responsibilities as follows:

- Assume responsibility and control to determine health priorities;
- Resource allocations for all health and social services;
- Promote and advocate for optimum health and social services for all Kahnawa'kehró:non;
- Plan and manage global health and social services;
- Maximize existing resources in health and social services;
- Support community health and social services programs and activities
- Create a greater awareness and understanding of each person's responsibility in health and social services;
- Clarify mandates and unify community direction in health and social services.

In essence, Onkwa's role is to promote, enhance and oversee the health service delivery process(es) in an efficient and effective manner throughout Kahnawake, but its most important task is to ensure cohesion in Health Policy. It is through this global perspective that Onkwa allocates discretionary resources to specific health initiatives and oversees the general administration of non-discretionary dollars.

The organization's authority is founded in a resolution enacted by the Mohawk Council of Kahnawake (MCK) which explicitly delegates the Band Council's control over health policy and services to Onkwa.[16] Onkwa represents a cross section of the local organizations which have a direct and/or indirect impact on health service delivery to the community at large.[17] Onkwa also has an Executive Committee, comprised of representatives from the major organizations such as, Fire/Ambulance (KFB), KSCS and KMHC.

Until recently, the Commission was provided with the services of a Director of Policy[18] through KSCS whose role was one of intermediary/liaison between various government agencies and Kahnawake health service organizations. More specifically, the Director position evaluated and interpreted the effects and opportunities of upcoming federal and provincial government initiatives and their impact on local service delivery and health policy with a view to long-term planning. The effects of this vacancy are slowly being felt in numerous areas of the organizations.

ii. Kahnawake Shakotiia'takehnhas Community Services (KSCS)

The first thing one notices when reviewing the KSCS Organizational Chart is the size and complexity of the organization.

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[16] Mohawk Council Of Kahnawake Resolution (MCR 25/1997-1998)

[17] Onkwa membership includes: 3 representatives of KMHC; 3 representatives of KSCS; 3 representatives of the Mohawk Council of Kahnawake - MCK, (2 Chiefs, 1 public administration); 2 representatives of the Fire Brigade/Ambulance Service; 2 Community Representatives (Elders).

[18] From an organizational reporting perspective, the Policy Director as well as the Policy Unit falls within the jurisdiction of KSCS. See KSCS Organizational Chart below.

Kahnawake Shakotiia'takehnhas Community Services Organigram

- Community of Kahnawake
  - Mohawk Council of Kahnawake
    - Board of Directors
      - Executive Director
        - Executive Assistant
        - Special Assistant
        - Director of Family Services
          - Manager Prevention Services
            - Prevention Services
              - Coordinator Secondary Prevention Team
                - Our Gang Facilitators / Shakotiiaten'nikens Support Counselors
              - Primary Prevention Workers / MAD Group Facilitators / Sel:atenikonrarak Worker / Child / Adolescent Prevention Worker
              - Coordinator Support Services
                - Healing/Wellness / Healing / Wellness Admin Support / Parenting Facilitators
            - Admin Assistant Supervised by Manager Support Services
          - Manager Home and Community Care Services
            - Home and Community Care Services
              - Coordinator Home Care Services
                - Home Care Services Assistant
                  - Home Care / Personal Care Workers / Homemakers / Specialists
              - Coordinator Elders Day Program
                - Elders Day Program Assistant
              - Adult and Elders Services Counselor
              - Case Workers
              - Kateri Memorial Hospital Centre / Homecare Nurses / Administrative Component
              - Admin Assistant
                - Reception / Greeters Services
              - Turtle Bay Elders Lodge
                - Maintenance / Security Workers
                - Kitchen
          - Manager Support Services
            - Support Services
              - Foster Care Resource Worker
                - Case Aides
                - Intake Worker
              - Coordinator Clinical Support
                - Psychological Admin Support
                - Clinical Supervisors
                  - Psychological Services / Case Workers / Addiction Workers / YOJA Worker
          - Manager Assisted Living Services
            - Assisted Living Services
              - Family Support & Resource Coordinator
                - Young Adults Program Facilitator
                  - Inclusion Workers
                - Caseworkers
              - Admin Assistants
                - Maintenance / Security Workers
              - Residential Workers / Weekend Animators
        - Director of Human Resources
          - Coordinator Organizational Development Services / ODS Lead Consultant / ODS Consultants
          - Human Resource Administrators / Human Resources Executive Assistant
          - Coordinator Communications Services / Communications Correspondents / Promotion Educators
        - Director of Operations
          - Coordinator Financial Services
          - Coordinator Administration Secretarial Services
            - Admin Assistants Archives / Records
          - Manager Info Systems
          - Coordinator Reception/Greeter Services
          - Maintenance / Construction
          - Maintenance / Cleaning Services
          - Environmental Health Officer / Environmental Health Services Technicians
          - Coordinator-Community Based Programs
            - Community Organizer
            - Researcher / Film Librarian

Last revision February 02, 2010

Note: The "Policy Unit" no longer exists when compared to that of the previous 2006 Health Transfer Report submission.

Over the past few years, the organization has undertaken several initiatives with a view to streamlining processes while placing a premium on creating team based approaches – within both the organization as well as its partner local organizations.[19] These types of cooperative initiatives are especially important when, as previously stated, funding structures lend themselves to a "silo management" structure. KSCS' present more streamlined structure is a marked improvement from that presented at the time of the last Health Plan Evaluation. The introduction of a case management approach coupled with MOU type committees has had a positive impact. It may be beneficial for the organization to also review its management processes, literally flowchart major processes (for a start) in order to identify opportunities for streamlining specific tasks, reduce bureaucracy and increase efficiency.

This said, KSCS' challenges can be viewed through the spectrum of its stated Vision and Mission statements (the same may be said of KMHC as addressed below).

> ***Vision***
>
> Tekaienawa:kon – To continue to strengthen our participation by working hand in hand with our community in renewal of Mohawk cultural values. The community has responsibility for its well being and our role is to assist.
>
> ***Mission***
>
> Our goal, with the assistance of a team of caring people, is to encourage a healthier lifestyle through promotion, prevention and wellness activities that strengthen pride, respect and responsibilities of self, family and community as Mohawks of Kahnawake

As is very often the case with most organizations, both statements rely on "feel good", abstract notions rather than quantifiable objectives. They define the "what we are", without providing a performance measure - of when & how these ideals will be achieved. Organizations, especially service organizations, need to ask themselves the questions: At which level do we define "success"?; How do we know we've succeeded? Today, Vision & Mission statements have evolved and become a "management tool" used to gauge performance. While it may not be necessary to insert quantifiable objectives within these

[19] For example, the Memorandum of Understanding Committee (MOU) between KSCS and KMHC.

statements, a separate supporting document/plan defining tangible goals should be considered.

KSCS has established regional links with outside health organizations, primarily for training, education and information purposes. Some employees attend external seminars and then share the information with their colleagues at monthly sessions. Links include major regional hospitals such as nearby Anna Laberge Hospital, and the Douglas Mental Health University Institute. The Douglas is an especially important local resource as health service delivery organizations such as KSCS and KMHC face a growing number of mental health issues and challenges. It should be noted that some links and resources were introduced by means of employees' own initiatives and/or personal connections with the resource organization(s). Instead, these links should be organization driven, formalized and more systemic.

Although employees are encouraged to attend outside training, there is no clear long-term "Training Plan" for the whole of the organization. The annual Plan should identify specific training requirements/needs for a group of employees within a particular program and/or position and function. Employees need to gain knowledge from different sources, be exposed to varied ideas in order to identify the mix of approaches that may work best for Kahnawake. The monthly formal/informal employee training/information sharing sessions are important and useful, but they at times only provide that one employee's view and interpretation of the information.

The increasing challenges and complexity in health and social service delivery requires a continuous, and timely, updating of skills. There is undoubtedly a financial reality to funding cross- the- board increases in training. KSCS should perform a full cost/benefit analysis and define a training priority plan for both the short and long term.

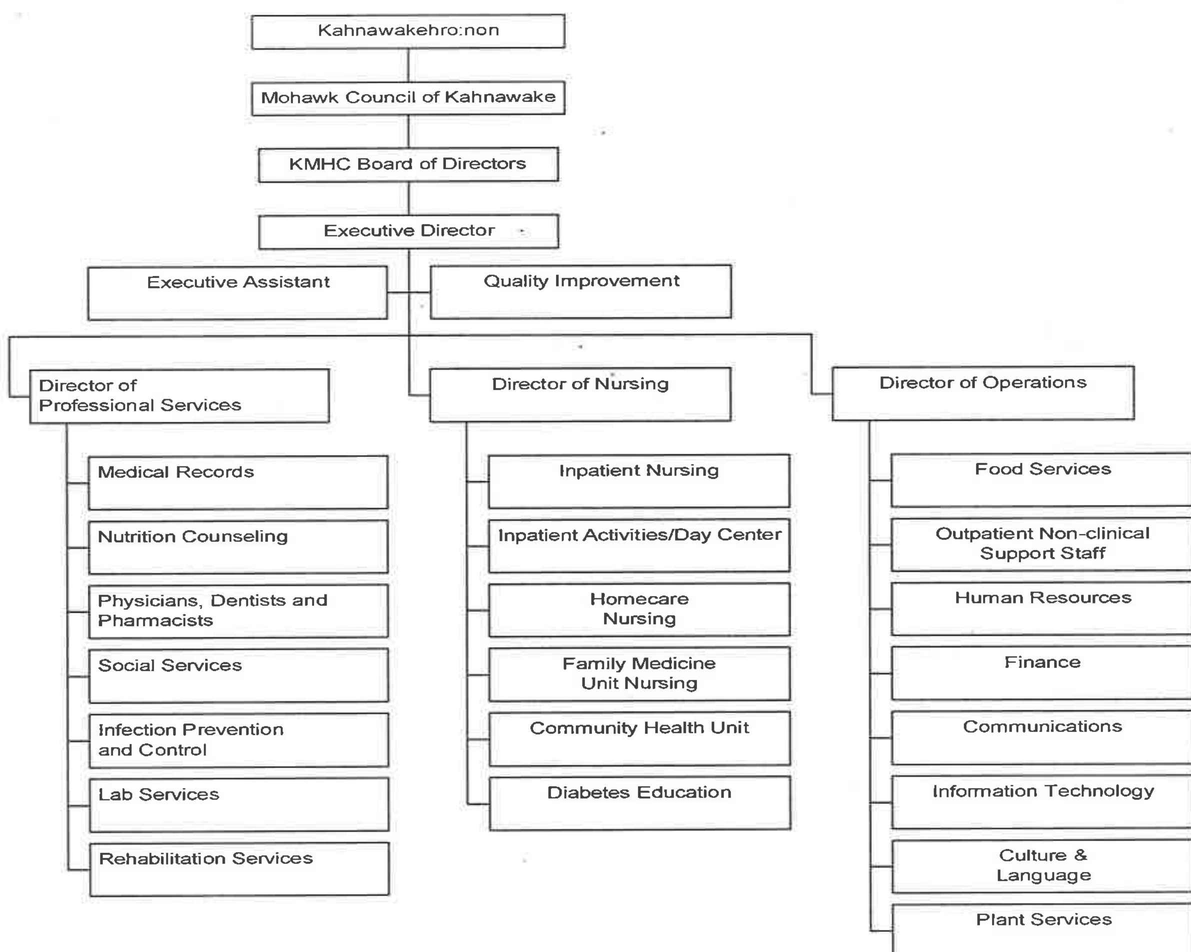
One common theme which emerged from one-on-one interviews with employees - at all levels of the organization - is the need for program performance metrics and analysis. The idiom "*you can't manage what you can't measure*" is apt in this situation. The organization has a reasonable approach to data collection but does not actually analyze the data it has collected. It is therefore difficult to gauge in objective terms, whether a particular program and/or approach has successfully met its objective. For example, Prevention Workers spend much effort doing the rounds of schools and setting up booths

to sensitize adolescents to the issue of teenage pregnancies. The organization collects data as to the number of students they approached or heard the message, but they do not have the data as to the number of teen pregnancies for a given year. Yet, this is the one true measure that would indicate whether the message/program was successful or whether modifications are required. In fairness, this data is available through another department within Kateri Memorial Hospital (KMHC), but not systemically available to KSCS. Such examples are common throughout the organization(s) .

A proposed solution is to create a Policy Unit specifically for Onkwa (it was at one time under KSCS), and to make the Policy Unit responsible for collecting and analyzing data from both KSCS and KMHC. As an independent organization and one that is tasked with overseeing Kahnawake's global health policy/initiatives, Onkwa should also be responsible for collecting and analyzing data from all major health service delivery organizations. This will ensure that gaps and overlaps in overall health policy are identified and resolved and will result in a more cost effective and efficient implementation of health initiatives. The centralization of data collection and analysis will assist the organizations in overcoming the challenges posed by the current silo structure, by effectively eliminating the information gaps described in the example above.

iii. Kateri Memorial Hospital Centre (KMHC).

Kateri Memorial Hospital Centre (KMHC) obtained its first accreditation from "Canadian Council on Health Services Accreditation" in 2006. It was again successful in 2009 - receiving an "Accreditation with Report" with minor recommendations which it will need to address prior to the next scheduled survey in 2012.



In 2001, with ever increasing demands for the institution's services, KMHC undertook the initiative to renovate and expand the current facility. As of today, the hospital has "completed the preliminary plan phase that required [KMHC to] work with project architects and engineers to further fine-tune plans. The project [has undergone] extensive analysis by the Corporation d'hébergement du Québec. Many recommendations were made and acted upon; a process that entailed [more effort] than anticipated. [By the end of 2009, KMHC] was preparing [its] submission to the Quebec Treasury Board for approval for the next phase; the development of final plans/specifications and construction. [KMHC should] be in a position to begin the long-awaited project [in 2011]."[20]

[20] Kateri Memorial Hospital Center; 2009-2010 Annual Report ("A Message from the Executive Director").

Couched in the good news of the expansion project is the reality that more resources will be required to operate the facility and meet the increasing demand for its services, especially in areas such as elder care. Similar to the phenomena experienced by health service organizations throughout Quebec and Canada, both KSCS and Kateri Hospital suffer from a shrinking pool of health professionals. The challenge is greater for Kahnawake organizations as they seek to attract Mohawk candidates. A partnership was developed with Ottawa University, wherein Kahnawake became an English education distance site. This allowed for college educated nurses to pursue nursing degrees. Although this program has ceased, the gap was filled by the DEC-BACH Program, which now offers direct access from a CEGEP nursing program to an English university nursing program (i.e. McGill University). Another program was then offered within the community with the aim of preparing community members for CEGEP nursing programs – this program has produced thirteen (13) graduates. Some of these students have, or are presently, pursing university level nursing degrees. Hospital management is cognizant of this growing human resource challenge and have recently begun discussions with two community partners and several educational institutions with the objective of reviving a similar initiative aimed at promoting health careers in general.

In terms of Health Transfer programs, KSCS and Kateri Hospital share responsibilities for the Homecare Nursing and Home and Community Care program. The organizations have experienced some success in finding solutions to overcome the barriers (i.e. terminology, confidentiality, co-management of the team) this shared responsibility has created.[21] However, the fact that employees in the different organizations speak a "different language" (due to different academic or because the nature of service delivery is different) and do not share the same understanding for specific terms/jargon - does result in the creation of an additional barrier.

> ***KMHC Vision***
> KMHC is a centre of excellence. We support Onkwehson: to use and develop all the gifts given to them by the Creator.
> We strengthen our community's health and well being by delivering quality health that respond to the needs of the community.

[21] For example, the MOU Committee.

KMHC is a haven of comfort and support to families who share with us in the care of their loved ones.
KMHC is recognized as a role model to First Nations and other communities for our ability to successfully develop and deliver holistic services and programs by incorporating both contemporary medical practices and traditional Kanien'kehaka practices.

KMHC Mission
We are a team dedicated to strengthening the health and well being of Onkwehson: a by providing, in partnership with others, quality and holistic services that respond to the needs of the community.

Similar to KSCS, the success of the organization's Mission and Vision statements can not be quantifiably assessed. Additionally, the "data rich – analysis poor" scenario described above, is not confined or limited to KSCS. KMHC suffers from a similar weakness but to a lesser extent, as it must comply with provincial and federal reporting requirements in addition to Accreditation requirements and, unlike KSCS, it employs a Quality Improvement Coordinator who carries out some data analysis. The fact the current analyst speaks both French and English certainly helps KMHC communicate with outside regional health and social services groups and provincial counterparts. However, the sheer volume of data that *should* be analyzed cannot be managed by one person working on a part time basis.

Kateri Hospital, KSCS and the Kahnawake Fire Brigade have access to – and established relationships with a number of outside resources including:

- Department of Indian & Northern Affairs (INAC) – National Level
- First Nations Child & Family Services
- AFN – Assembly of First Nations
- Health Canada – FNIHB First Nation Inuit Health Branch
- FNQLHSSC – First Nations Quebec & Labrador Health & Social Services Commission
- Ministere de la Sante et des Services Sociaux (Quebec)
- Agence de la sante et des services sociaux de la Monteregie
- RAMQ
- Batshaw Youth & Family Centre
- Laurentides Social Services
- CSSS Jardins Roussillons (Anna Laberge Hospital)
- Quebec Order of Nurses
- Jewish General Hospital

- Montreal General Hospital
- Royal Victoria Hospital
- Montreal Children's Hospital
- Accreditation Canada
- AQESSS (Association of Quebec Health and Social Services Establishments)
- Corporation d'hebergement du Quebec

C. Administrative Processes and Consideration

i. Confidentiality Standards

The Medical Records Department of Kateri Memorial Hospital Centre is the conduit for client/patients' medical information. It manages, maintains and provides client medical information to both the requesting client and/or responsible healthcare professional(s). KMHC has established internal procedures based on the requirements of external regulations.

KSCS also respects a "confidentiality" protocol, although this is mainly based on an individual signed proclamation/commitment to the effect that the worker will adhere to internal rules with respect to maintaining information/data confidentiality.

Ironically, this respect for "confidentiality" creates barriers between the organizations which often share the responsibility for a client. In fact, one may question whether the organizations' reluctance to share information is legitimately based on respect for the rules of confidentiality or an expression of the individual organization's need to assert its territory. It is recommended that the organizations collaborate in order to collectively define/develop and implement an information sharing protocol that will both respect legal confidentiality principles while ensuring that the focus remain on the clients' overall needs.

ii. Client Complaints/Conflict Resolution, Feedback Processes

Kateri Memorial Hospital Centre has an established "Users Committee", which has recently undergone a self-evaluation. By means of a defined and documented process, clients, and/or their families, may submit their concerns/complaints to KMHC

management and the User's Committee. These comments are logged and tracked by KMHC until the point of resolution. This information is shared with members of the Users' Committee within the limitations of "Confidentiality" concerns. Members of the Users' Committee believe they should be afforded a role where they may carry an influence as to consequence.

KSCS has adopted a documented Client Complaint process. In addition, KSCS uses the same process to address individual employee conflict resolution issues - as described within the KSCS Personnel Manual. As a service provider, KSCS should develop a process to review and analyze complaints in order to identify areas for improvement.

iii. Human Resources and Human Resource Planning & Training

Both KMHC and KSCS will face similar resource/knowledge and experience challenges as senior executives and critical mid-level management personnel prepare to retire within the next 1 to 2 years. Neither organization has formalized a succession plan.

The nature of KMHC and KSCS leads the organizations to different approaches in terms of human resource development and training. Kateri Memorial Hospital is staffed with personnel who are required by their Professional Associations to attend specific training each year. In addition, the organization performs annual analysis/trending from different information sources such as incident/accident reporting in order to determine and plan for specific and/or cross organizational supplemental training needs. A Findings Report detailing how the training needs were addressed is submitted to the KMHC Board and management annually

KSCS develops/identifies its own training requirements and programs as per service delivery needs i.e. psychologist, social workers (caseworkers), certified Addiction Counsellors, Environmental Health Officers/Technicians, managers etc.. As previously discussed, KSCS does not have a formal "Training Plan" *per se*. Rather, the organization gleans "training requirements" from the annual employee evaluation process. As such, the training schedule is not a result – or reflective of - an analysis of impending and upcoming "skill needs" analysis but rather a "reaction" to employees' individual needs and preferences. These differences in training exacerbates the communication challenge between both organizations.

Both KSCS and KMHC have their individual Personnel Policy Manual which addresses standard human resource issues such as probationary periods, conflict resolution process, vacation periods etc.

The organizations also have detailed job descriptions for all positions, including those funded through Health Transfer. KSCS launched a job description validation/update and wage parity project two years ago. These documents are currently in the final approval phase and the organization plans on releasing the new documents shortly.

iv. Professional Oversight

Kateri Memorial Hospital Centre (KMHC) is ultimately responsible for the oversight of health professionals. In accordance with regulations, registered professional nurses report directly to a Director of Nursing who holds a Bachelor of Nursing degree from a Canadian recognized educational institution.[22] In addition, KMHC also employs a Director of Professional Services (Board Certified Physician), whose primary responsibilities are the oversight of all medical-type professionals working within KMHC (physicians, dentists, occupational therapists, pharmacists, physiotherapist, etc.).

Kahnawake Shakotiia'takehnhas Community Services is responsible for the oversight of social service workers, clinical supervisors, psychologist/psychological services and health promotion/prevention workers. In accordance with the Ministry of Health and Social Services regulations, the social workers, caseworkers etc., are supervised by a Clinical Supervisor who is appointed and approved by the Centre Jeunesse de la Montérégie.

In 2004, the Mohawk Council of Kahnawake adopted a "Healthcare Professions Law" in order to effectively monitor and bring oversight to healthcare providers within the territory.[23] The law requires independent professionals and organizations that employ health professionals to apply directly for – and obtain a permit – to practice/provide healthcare services within the community. Although the Director of Professional Services (within KMHC) has the ultimate responsibility for oversight for professionals working in the hospital centre, the Community Based Programs Coordinator, within the KSCS

[22] KMHC nursing staff are members of the Quebec Order of Nurses.
[23] Mohawk Council Resolution (MCR #59/2004-2005) – November 2004.

organization (but whose authority stems from Onkwa), is responsible for issuing and maintaining permits for all other professionals approved by the Onkwa Health Professionals Law Committee. In essence, the process requires the involvement/intervention of three (3) separate organizations (KMHC, KSCS, Onkwa). This process can be rationalized and streamlined by, as previously suggested, making Onkwa an independent organization with true healthcare oversight responsibilities.

v. Environmental Health & Safety Officer

The Environmental Health and Safety Officer holds a recognized Certificate in Public Health Inspection. The officer is responsible for the oversight of all public health related activities (water quality tests, air quality tests, food service inspections, wells and septic tanks) within Kahnawake and Tioweroton.

vi. Emergency Planning

Kahnawake's Emergency Preparedness Plan is a well thought-out and detailed program that would certainly be the envy of most small (and mid-size) communities. The Plan is the result of a community and organizations' wide effort. The Mohawk Council of Kahnawake's (MCK), Community Protection Unit (CPU) is the primary driver and custodian of the overall plan.

The Kahnawake community recognizes the increased risks associated with its geographical location. In as much as the location is ideal in terms of access to Montreal facilities, the presence/proximity of the St. Lawrence Seaway, Canadian Pacific Railroad (commercial), Trudeau International Airport, and the Mercier Bridge - a main artery linking the island of Montreal to the South Shore also serves to increase the risk to the community.

In April 2009, the World Health Organization declared the world-wide threat of an H1N1 pandemic. "One day later after the initial declaration, Kahnawake Influenza Pandemic Planning Committee (KIPPC) met for the very first time. The Committee was comprised of members from the [Mohawk Council of Kahnawake] MCK, KSCS, [Kahnawake Fire Brigade] KFB and KMHC. KMHC took the lead and coordinated activities in

conjunction with KIPPC."[24] The different organizations came together and produced information pamphlets which were distributed throughout the community; set-up information telephone lines; KMHC also set-up vaccination clinics and made appearances on Kahnawake local television and radio programs. More than half of the members of the Kahnawake community received the vaccination, for a total of 4,212 vaccinations.

Kahnawake's Emergency Preparedness Plan stands as a shining example of the community's vigilance and the way organizations can come together for the common good. Perhaps its success is due to its "close knit" community mentality/approach and/or a solid plan or leadership. Irrespective, in the face of a global health threat – the Plan worked. Kahnawake should share its expertise and successes with other native and non-native communities alike.

II. HEALTH SERVICE PROGRAM EVALUATION

A. Health Priorities

The information as to the community's and organizations' current health priorities was gleaned as described in Section V – Assessment Approach.

The 2006-2007 Kahnawake Health Plan report identified the community's, then, health priorities as follows[25]:

Priorities as of 1998

- Alcohol and Drug Abuse
- Violence
- Diabetes
- Mental Health
- Cardiovascular Disease

Priorities as of 2003

- Alcohol and Drug Abuse
- Mental Health
- Diabetes
- Violence

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[24] Kateri Memorial Hospital Center: Annual Report 2009-2010, p.15.

[25] See page 186 of "Kahnawake Community Health Plan for Health Transferred Programs, 2006-2007, Report, January 2006."

- Cardiovascular Disease

Priorities 2010

Although each group and/or individual prioritized health concerns differently, based on their own perspective – a general consensus emerged:

- Substance abuse/Addictions
- Mental Health Issues
- Learning/Developmental Disabilities
- Cardiovascular Disease (Hypertension)
- Cancer
- Diabetes
- Obesity

Substance Abuse/Addictions

Participants felt that the issue/scope of substance abuse has expanded from alcohol and drugs to include prescription drugs mainly anti-depressants and pain relief type drugs. As such, this health priority is directly related to the second priority, Mental Health. The majority of respondents believe that the increased dependency is the result of a breakdown of the family unit as well the increased demands of modern day life.

Mental Health Issues

Health care workers have noticed a significant increase in the number of mental health related issues and clients requiring mental health and social services. They are especially concerned that the profile of those requiring health and social services has changed and now includes younger (adolescents) community members.

Learning/Developmental Disabilities

The issue came as a surprise as it had not formed part of the previous lists, yet in the 2010 evaluation it was consistently placed within the first three health challenges facing the community (irrespective of the focus group or individual interviewee). Attention Deficit Disorder, Autism, Asperger and Down Syndrome were the conditions most often identified.

Cardiovascular Disease
Interestingly, the issue gained prominence as an offshoot of the Diabetes Prevention initiative. Although, hypertension is now more frequent as a standalone condition (non diabetes related).

Cancer
Participants could not name one particular/specific type of cancer, but rather grouped all cancers under the same heading.

Diabetes
The large majority of respondents believed that the challenge of Diabetes is being well addressed due in large part to the success of the Diabetes prevention initiatives though it continues to be an overarching concern.

Obesity
Was seen as the "catch-all" result/consequence of other health conditions such as mental health, substance abuse, cardiovascular disease and diabetes. Additionally, the majority of participants attributed the rise in obesity to the breakdown of the family unit.

B. Health Programs' Content

i. *Mandatory & Community Health Programs*

As with the previous Health Plan report of 2006, the organizations continue to work with "Logic Models" as a means to plan activities, identify objectives and responsibilities and document performance. Each mandatory/community health program that forms part of the Community Health Plan has a related Logic Model. Efforts have been made to streamline and focus the information contained within these Models.
The models are included in this report in order to provide requisite details of activities undertaken in support of specific programs. With very few exceptions, the Models do not identify "quantifiable measures" for success. The organizations are cognizant of the need to transition from a "narrative type" Model to one that may be used more as a "management planning tool". The transition should be relatively easy as the organizations are already "data rich" – they already collect most of the data required to form the basis of solid analysis/performance measurement.

The reader may refer to the Logic Models appended to this report as follows:

- **Attachment 1** Onkwata'karitáhtshera (Health Commission – Health Policy)

Kateri Memorial Hospital's Community Health Unit (CHU) is an important player in the delivery of mandatory health programs. The Unit is ultimately responsible for the management and delivery of the communicable disease initiatives.

- **Attachment 2** Reportable Diseases (Includes Communicable Diseases program information as well Provincial requirements for reporting).
- **Attachment 3** Well Baby Clinic (Includes Immunizations).
- **Attachment 4** School Health (Includes Immunizations).
    - All Schools
    - Kateri School & Step by Step Child & Family Centre
    - Karonhianonhnha School & Indian Way School
    - Kahnawake Survival School
    - Karihwanoron

- **Attachment 5** Environmental Health Services

  Environmental Health Services program has a direct impact on public health issues as they report, monitor and manage issues such as water, waste water, public building safety, food services, and workplace safety. The unit is an active participant in Kahnawake's Emergency Preparedness Plan.

Community Health programs are appended as detailed below:
Note that Attachments 6 to 19 represent programs which fall primarily within the responsibility of KSCS.

- **Attachment 6** Alcohol/Drug Addiction
- **Attachment 7** Brighter Futures Program
- **Attachment 8** Brighter Futures
    - Community Youth/Family Recreation Outreach Project" – Kahnawake Youth Center
    - Drama Project

    - "Our Gang" After School Life Skills Program
    - Weekend Teen Activities Project
- **Attachment 9** Communications for a Healthier Lifestyle
- **Attachment 10** Healing & Wellness Lodge
- **Attachment 11** Healthy Sex & Sexuality
- **Attachment 12** Human Resources
- **Attachment 13** Education System & KSCS Prevention Programming
- **Attachment 14** Education – "Making Adult Decisions" (MAD)
- **Attachment 15** Fetal Alcohol Spectrum Disorder (FASD)
- **Attachment 16** Men's/Women's Anger Management Groups
- **Attachment 17** Operations: Administration, Finance, Information Systems, Maintenance and Cleaning Teams
- **Attachment 18** Parenting – Family & Wellness
- **Attachment 19** Suicide Prevention

Attachments 20 to 36 are programs where the primary program responsibility(ies) is held by Kateri Memorial Hospital or is shared with KSCS.

- **Attachment 20** Adult Prevention
- **Attachment 21** Alcohol Related Birth Defects
- **Attachment 22** Cancer Care
- **Attachment 23** Child Injury Prevention
- **Attachment 24** Breastfeeding Promotion Program
- **Attachment 25** Homecare Program
    - End of Life Care
    - Home Care Nursing: Home Hospital
    - Home Care Nursing: Tertiary Prevention
    - Home Care Nursing: Staff Training
- **Attachment 26** Lactation Consultant Program (International Board Certified)
- **Attachment 27** Newborn Home Visiting
- **Attachment 28** Operations' Support
- **Attachment 29** Preconceptional Health

- **Attachment 30** Prenatal Clinics & Classes
- **Attachment 31** Recruitment & Retention of Health Care Professionals
- **Attachment 32** Risk and Quality Management
- **Attachment 33** Social Service Worker (KMHC)
- **Attachment 34** Staff Health
- **Attachment 35** Volunteer Coordination Program
- **Attachment 36** Diabetes Education Program

III. HEALTH PROGRAM IMPLEMENTATION

By reviewing the individual program Logic Models appended to the report, it is evident that steps required to achieve program objectives have been identified and a process has been adopted to reach their respective objectives.

As addressed in the previous Report (2006-2007), the organizations recognize that an important challenge is how to effectively implement programs and initiatives in the silo-type Health Canada funding structure for the two major organizations, KMHC and KSCS. As previously discussed, the organizations have made efforts to bring processes more in line with a "horizontal" management approach. This is especially true for programs that are shared between KSCS and KMHC (i.e. Homecare and Homecare Nursing).

As the silos now exist, it is difficult for any evaluation to get an accurate "overall" view with regard to program implementation. The organizations should continue to work together and focus their efforts on developing horizontal processes. This should be accomplished using cross-functional Task Forces who should "return to basics", that is flowchart current processes in order to identify gaps, overlaps and barriers to efficient implementation. Indeed, the need to simplify and streamline current processes and responsibilities was a recurrent theme that emerged from the one-on-one interviews with employees.

Further, although there is an abundance of data in relation to program performance, these are not available in a form that would allow a quantitative assessment of individual program performance. However, by qualitative measures, programs are in fact implemented as described within the Logic Models.

IV. RESULTS EVALUATION

As previously discussed, the organizations are "data rich – analysis poor". With very few exceptions, the majority of employee respondents identified the lack of (individual) program analysis as an impediment to effective program evaluation. They view the ability to perform/rely on "quantitative analysis" as an important management tool. Individual programs must work towards a system where performance measures are based on objective quantifiable versus subjective measures. Without a defined baseline, there is a sense that everyone is "working hard" but are uncertain as to the "real" impact/results of their efforts. The Logic Models are an excellent means to document program objectives and tasks; however their weakness as a management tool is evident in the content of the final column "Health Impact", which generally contains narratives rather than quantifiable objectives.

The current Health Plan appears to address the community's health priorities as identified through the focus groups and one-on-one interviews. However, two distinct points should be reviewed.

The first, the lack of programs/resources allocated to address what the community has identified as an emerging priority: "learning disabilities and developmental delays". Participants identified the need for additional services including: general information clinics; services for the (mainly) school-age children (, coping strategies); support groups for parents.

The second, the Assessment teams' conclusion that it may be useful to re-evaluate the actual scope of FASD within the community in order to ensure that the organizations' efforts and focus are commensurate with the health threat. This may be a "chicken before the egg" type argument, but, at this point - and in light of the data that is available (including local health professionals' opinion(s)), it would appear that FASD is not as common within Kahnawake as was previously believed.

V. ASSESSMENT APPROACH

Following a "by invitation" Call for Tender process, Onkwata'karitahtshera, Kahnawake's Health Commission mandated the review and analysis of the Community Health Plan to independent, third party consultants in order to ensure objectivity in the reporting of evaluation results. The evaluation process was launched in March 2010 and was completed in June, 2010.

A two-pronged assessment approach was adopted. The process involved individual, "one on one" interviews with all organizational levels of health service delivery employees, in addition to facilitating focus groups in order to garner "common" concerns. Through this combined approach, approximately 160 individuals shared their opinions.

With Kahnawake Health Commission's consent, the individual interviews were performed under strict respect for the rules of confidentiality. It was felt that employees would be more at ease and forthcoming if they received assurances that the opinions and information they shared could not be directly attributed to them. The interviews lasted between two to three hours each. Approximately 60 individual interviews were conducted, with a cross section of both organizations (KSCS and KMHC). The discussion(s) centered on the individual employees opinions with respect to the current Health Plan activities, responsibilities, perceptions as to strengths and weaknesses of the current approach and future health and organizational challenges.

Seven focus groups were held, representing a cross section of the community, these included two KSCS employee focus groups; two KMHC employee focus groups; one KSCS Board of Directors focus group; one Family Centre users group; one Elders Lodge users focus group and one "community at large" survey group where a stand was set-up in the lobby of the KSCS building and passers-by where interviewed. The same four basic questions were presented to each group as well as the survey interviews. These, including a summary of the most common responses are detailed below:

1. What are the community's main health concerns?
   - Mental Health issues
   - Increased levels of developmental/learning disabilities/delays (autism, ADHD, Asperger etc)
   - Addictions (Drugs, including prescription drugs, alcohol, gambling)

- Diabetes
- Cardiovascular Disease
- Cancer

2. What is your opinion as to how they are being dealt with?
    - Need to develop expertise within the community
    - Health & social services programs are working in silos and are therefore less effective within the community
    - Need for issues to be addressed “holistically”
    - The KMHC Diabetes Education program is exemplary

3. Are there any new challenges in health service delivery or health in general?
    - Emergence of a two-tier system (pay/no-pay)
    - Challenge to keep skills updated/current (health professionals)
    - Learning disabilities (including new challenges for schools/teachers)
    - Health Canada Non-insured health benefits cutbacks

4. How do you think these issues could best be addressed?
    - Develop training programs addressing developmental delays (including, advocacy, promoting awareness, assistance for parents)
    - Need to assess effectiveness of health programs objectively (collection & use of statistics)
    - Reclaim “traditional values”
    - Increase communication between health service delivery organizations within Kahnawake (work collaboratively rather than in “silos”)
    - Adapt the model of the successful KMHC ”Diabetes Education Program” to new challenges

VI. ASSESSMENT TEAM

Firm Profile

P. L. Hawa & Associates is a firm focussed on excellence in the assessment, design and delivery of programs, on results-based management, and on the need for efficient and effective processes to achieve results. This approach integrates strategy, people, resources, processes and measurements to improve decision-making and drive continuous improvement.

The firm's approach focuses on:

(1) working with people to get the right design early in the process;

(2) clearly identifying outcomes and performance measures to support learning and improvement;

(3) assessing processes against established "best practice" standards;

(4) designing efficient community and business processes that facilitate implementation and generate results, and

(5) developing a balanced program for reporting performance.

Developing effective and accountable organizational systems is a core part of the service offering.

As the adage states: "Experience Matters". Clients benefit from the professionals' wide range of experience acquired from their work with both large and small organizations, private and public, non-profit and profit driven. This wealth of expertise allows the professionals to propose innovative solutions to entrenched challenges. The fact that the firm is neither a direct or indirect stakeholder in Onkwata'karitahtshera allows for an impartial and objective view of the Organization and its programs.

3.2 Project Team

Paola L. Hawa (Project Manager)

Me. Hawa offers a unique combination of Legal and Operations development, management and audit experience. She brings 20 years of experience leading small and large scale cross-organizational process assessment and audit,

regulatory compliance, restructuring, risk assessment, legal liability prevention, organizational change and Quality management improvement initiatives. Ms Hawa has successfully lead, developed, designed and implemented hundreds of Organizational Development projects, as well as trained stakeholders in Process Definition and Internal Audit. She is known for her excellent strategic and business acumen and strong focus on results. Attentive to detail, she is able to evaluate the broad impacts of issues and effectively manage change. Ms Hawa is fully bilingual.

Monica Thibault

Ms. Thibault was a co- facilitator for the project. She is an experienced facilitator and Health Promotion professional who is known for her warmth and community building capacity. She has 20 years experience in leading the design and implementation of a number of community, stakeholder and Health and social services consultations and work group processes; applying a range of group work techniques, and facilitating focus groups. She has extensive experience in producing Logic Models in support of various Community Health and social services. She is experienced in the use of learner-centered, St-FX, train-the-trainer, Paulo Freire approaches, and has functioned as team lead in Community Health Promotion Services at several Community Health Centers. She has also coordinated and facilitated sessions in the development of community capacity building for a number of organizations including Aboriginal client groups, New Canadian associations and federal government departments. Ms. Thibault is fully bilingual.

Julie Blais Comeau

Ms. Blais Comeau is a training program developer, educator, facilitator and workshop leader with a contagious passion for service excellence and social justice. She has over 20 years experience in conducting needs assessments and information sessions and the achievement of training objectives. She has delivered group specific customized presentations and facilitation sessions to government departments and organizations, retail leaders, various tourism sectors and school boards. Having held the positions of manager, training manager and

human resources manager, she has a solid understanding of and promotes what it takes to exceed internal and external service delivery benchmarks and client needs assurance. Ms. Blais Comeau is frequent presenter at the Federal School of Public Service and a training consultant for the University of Ottawa's Center for Organizational Development and Learning. Since 2001, she has successfully contributed to Service Excellence Certification for public and private clients. Ms Balis Comeau is fully bilingual.

Program Overview

Home and Community Care Services has been in existence in Kahnawake since 2000. When the First Nations and Inuit Home and Community Care program was being launched, the program in Kahnawake was in the early stages of a strategic planning effort in homecare. Interestingly, the community's process integrated well with the front end activities of the new initiative. The national initiative provided Kahnawake with the much need resources to conduct the research, planning, development and implementation of a more effective service. The program service delivery utilizes a case management approach by providing clients coordinated care. This is achieved via an integrated approach to client care that includes a case manager, the client, family members, and other service providers as needed. This ensures that clients receive well individualized, coordinated, and appropriate care.

OUR MISSION

"We will create a circle of care that ensures dignity and respect and are cornerstones to maintaining Kahnawakero:non in their homes. Our circles of care will include a wide range of professionals, clients and their families. We promote health and wellness while providing quality health care".

OUR PHILOSOPHY

The Kahnawake Homecare Team (KHT) believes that independence is an essential part of health and wellness. Fostering and maintaining that independence needs support from many people and services.

Our circle of care is focused around our clients and their needs. This approach requires a well rounded and coordinated team that is committed to maintaining, promoting and practicing Kanien'Kehaka values of respect, responsibility, sharing and caring

By practicing new traditional ways of "taking care of our own" we can help Kahnawakehro:non live as healthy and independently as possible.

Involving our clients and their families as partners preserves their dignity and ensures our traditional practices of "everyone has a voice".

We accept that strong partnerships are based on honest communication mutual trust, and maintaining confidentiality. These relationships can be further strengthened if we are prepared to learn from our past to improve homecare for the next seven generations.

OUR VISION

Our clients are appreciative of the services and tender loving care they receive because they and their families are involved in the decisions, planning and delivery of their care.

The KHT includes clients, their families, a range of staff and professionals with various talents, abilities, resources and competencies that are used to meet the needs of the clients.

Clients and their families see themselves as true members of the homecare team, are aware of their responsibilities and exercise their independence to the best of their ability.

The team is deeply committed and dedicated to mission and values of homecare services and feel deeply rewarded and satisfied in their work.

Members of the KHT are confident in their capabilities to deliver services to Kahnawakero:non. This confidence stems from strong orientation, training and development in specialized health care for homecare.

Continuity of care is ensured to clients and backlog of work is prevented because each position within the homecare team has backup or replacement.

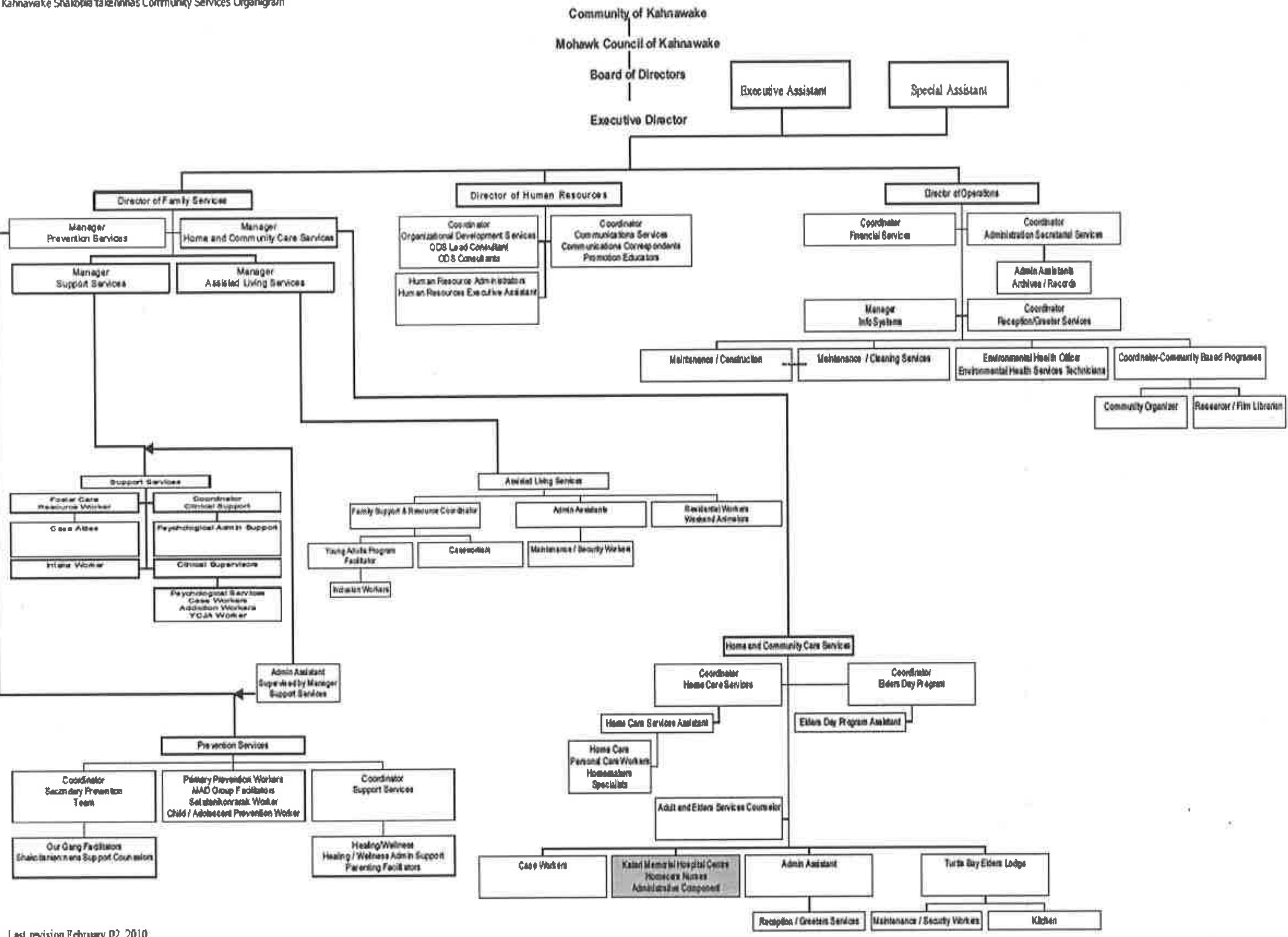
Equipment, materials and resources necessary to the homecare team are accessible to the territory of Kahnawake.

Service partners of the KHT respect, are impressed and appreciative of the structures, operations and working protocols of the homecare team because they are a model to others in the homecare field.

Management Structure

Home and Community Care Services is a part of Kahnawake Shakotiia'takehnhas Community Services. The following organigram of KSCS provides a visual of the set-up and accountability.

Kahnawake Shakotiia'takehnhas Community Services Organigram

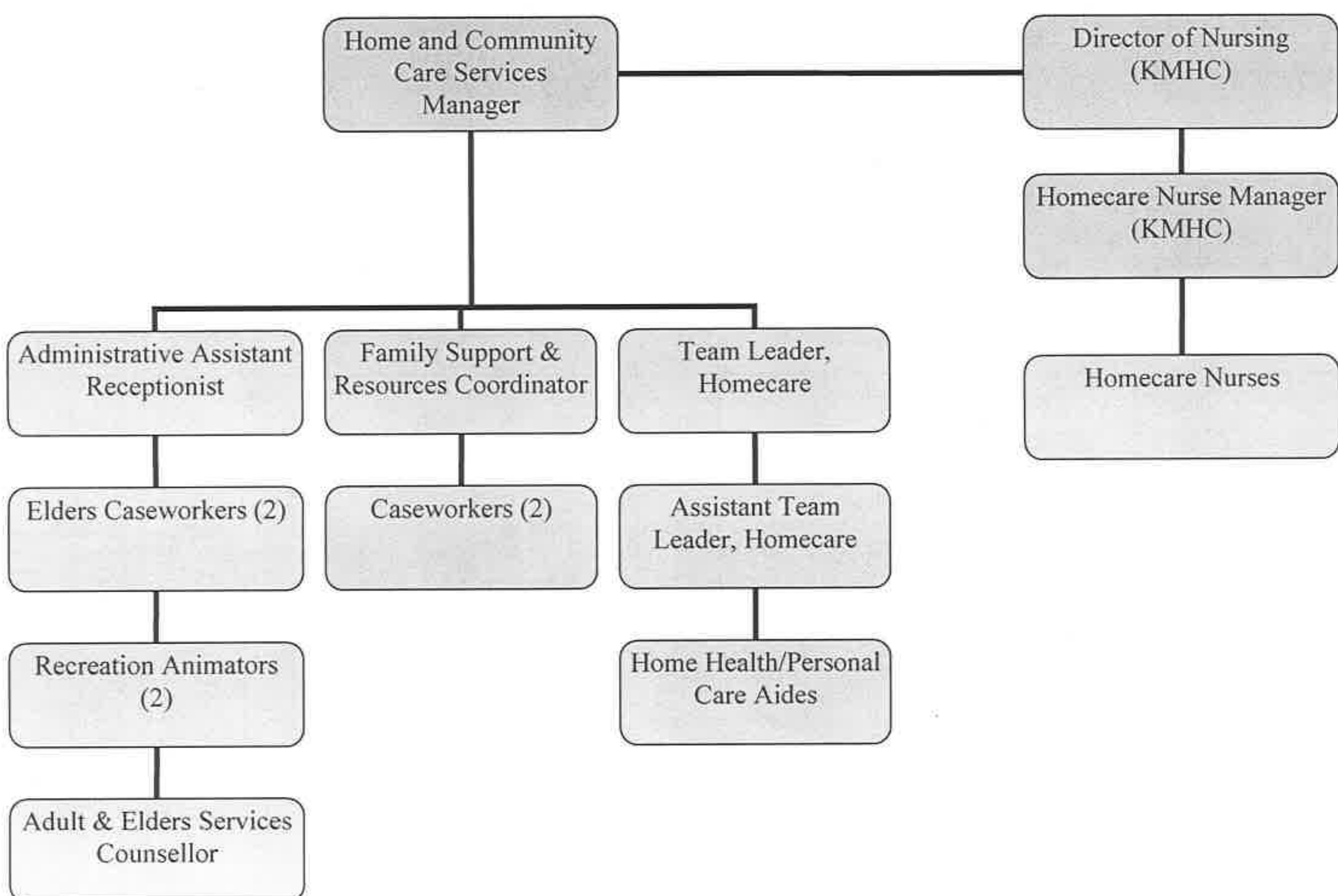


Last revision February 02, 2010

The governing body for KSCS is the Board of Directors mandated through the Mohawk Council of Kahnawake. The Board of Directors is responsible for the development of policies, the direction of the organization and the supervision of the Executive Director.

The Executive Director of KSCS makes decisions regarding the program periodically but is responsible for the management and administration of the global organization and therefore answerable to the Board of Directors.

The Home and Community Care Services program is one of the several programs within the KSCS organization.. It is managed by the Manager of Home and Community Care Services who reports to the Executive Director. The Manager of HCCS and the Homecare Nurse Manager are responsible for the general requirements of the Homecare program and its management. The relationship between the Manager and the Homecare Nurse Manager operates as a collaborative one. The following organigram will further illustrate the management structure.



The Home and Community Care Services program is joint managed by two managers working for 2 separate organizations. The manager for Home and Community Care is employed by KSCS while the manager for Home Care Nursing is employed by KMHC. There exist a Memorandum of Understanding (M.O.U.) between the two organizations

MEMORANDUM OF UNDERSTANDING
(M.O.U.)

BETWEEN

KAHNAWAKE SHAKOTIIA'TAKEHNHAS
COMMUNITY SERVICES

Herein represented by its Executive Director
(Herein referred to as "K.S.C.S.")

AND

KATERI MEMORIAL HOSPITAL CENTRE
TEHSAKOTITSE'N:THA

Herein represented by its Executive Director
(Herein referred to as "KMHC")

WHEREAS K.M.H.C. recognized by the Mohawks of Kahnawake Council and Le Governement Du Quebec in the 1984 Government to Government agreement as a non-profit community hospital centre for the Mohawks of Kahnawake.

WHEREAS K.M.H.C. is mandated by the Mohawk Council and sanctioned by the Ministry of Health Quebec to provide and offer health services such as:

- Out patient and minor emergency care
- Long term care
- Nursing care
- Community health services

WHEREAS the 1984 agreement states that:

"That the Aboriginal Nations have the right to have and control such institutions as may correspond to their needs in matters of culture, education, language, health and social services as well as economic development;"

WHEREAS K.M.H.C. is involved in developing as part of Onkwa'takaritáhtshera's network of care, services, and facilities to meet the changing health and social service needs of Kanawa'keró:non;

- Care of clients requiring long term or low acuity short term inpatients services
- Care of clients requiring outpatient services
- Community health services

WHEREAS K.S.C.S. is responsible for the funds received from the Federal Government for the provision of a continuum of health and social services;

WHEREAS both parties have the ability to enter into agreements;

CONSEQUENTLY, both parties agree to the following in order to:

- Focus their efforts to maximize the quality of services to the community of Kahnawake;

- Facilitate the work of the administrative and service delivery level of both organizations by sharing information.

1. K.S.C.S. AND K.M.H.C. COLLABORATION PROCEDURES:

a) FACILITIES:
K.S.C.S. and K.M.H.C. agree to discuss the use of facilities of each organization for joint initiatives;

b) PROMOTION & EDUCATION:
K.S.C.S. and K.M.H.C. agree to do joint planning to strategize collaboratively in delivering the promotion and education to the shared client groups in the most effective manner and utilizing shared human and financial resources;

c) PROGRAMMING:
K.S.C.S. and K.M.H.C. agree to do strategic planning on shared client groups including evaluations every three (3) years to create and develop programming targeted to the community in which resources, human and financial will be utilized;

d) ADDITIONAL FACILITIES AND STAFF:
K.S.C.S. and K.M.H.C. agree to do strategic planning on shared client groups, the need for additional facilities, human resources and shared identified training to accommodate the emerging needs. Program funding will have to be approved by each organization's Board of Directors;

2. JOINT PLANNING:
Joint planning will include K.S.C.S. and K.M.H.C. providing data on needs for common target groups determining priorities.

Developing plans to meet the needs and identifying resources needed to realize the plan.

Who should be involved in the plan
- Staff;
- Managers;
- Board;
- Stakeholders.

The planning cycle will coincide on the existing fiscal year of April to March.

3. JOINT MANAGEMENT:
K.S.C.S. and K.M.H.C. agree to a joint management process of staff in the following areas and as defined/outlined in the attached annexes:
a) Homecare / Homecare Nursing
b) Mental Health Services
c) Teen Clinic, Drop In Center
d) Kahnawake Independent Living Services
and any other new programming that will result from the joint planning will be addressed through on-going collaboration.

Joint management will consist of the designate from K.S.C.S. and K. M.H.C. and they will be responsible for the day to day supervision of the designated staff as agreed to in each area of joint service delivery annexed to this agreement

Should additional management issues arise, the Director of Client Services of K.S.C.S. and Appropriate Directors of the Kateri Memorial Hospital Center will need to resolve the issue.

Should the issue not be resolved at that level, it will be brought to a joint working group comprised of the Executive Directors of K.S.C.S. & K.M.H.C. and a board member from each organization to resolve the issue.

4. **ADMINISTRATIVE PROCESS:**
   The joint management will meet once a month to review programming and financial issues and prepare quarterly reports to senior management and respective Boards.

   Senior management of KMHC and KSCS will meet on a quarterly basis to review reports and overall function.

5. **FINANCIAL CONSIDERATIONS:**
   K.S.C.S. and K.M.H.C. agree to pool their financial resources when applicable based on the result of joint planning.

6. **DURATION:**
   This M.O.U. shall take effect as of April 1, 2003, and shall automatically be renewed year to year unless one of the parties signifies to the other, in writing, at least three months before the agreement expires, its intention to amend, to append or to terminate.

   Should either party fail to conform to the obligations deriving from this M.O.U., either party may terminate after having given notice to the other, in writing, to correct, within a reasonable lapse of time, the irregularities indicated in such notice.

THE PARTIES HAVE SIGNED:

Linda Deer — September 26, 2003
FOR K.S.C.S. — **DATE**

Lynda Belisle — September 26/2003
FOR K.M.H.C. — **DATE**

NewKMHCMOU2003.doc

Program: HOMECARE PROGRAM

Goal	To Provide In Home Support to Community						
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/Dates**	**Indicators**	**Data**	**Health Impact**
To provide clients coordinated care using case management	Initial Assessment Reassessment every 6 months Integrated Service Plan meetings with client, family & service providers	Client & Family/Caregiver	HCCS Manager HCN Manager Case Managers (Case Workers & Home Care Nurses)	Ongoing	Clients access appropriate services in timely manner	Access Database Intake Stats Stat Hours of Service	No duplication of service Clients receiving well individualized, coordinated & appropriate care
To assist clients post-surgery/hospitalization with activities of daily living and instrumental activities of daily living	>Washing >Dressing >Grooming >Meal Preparation >Housekeeping >Laundry >Errands & Groceries	Post Hospitalization and clients with limited ADLS	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	Clients have needs met at home with assistance of Home Health Personal Care Aides	Stat Hours of Service Request for Services Stats	Clients rehabilitate or are able to remain living at home longer vs being place in a long term care facaility
To provide short term assistance to new mothers with c-section, multiple births, or high risk pregnancy	Housekeeping / Laundry Meal Preparation Groceries / Errands	New Mothers	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	Mothers carry pregnancies to term Improved post op wound healing	Stat Hours of Service Request for Services Stats	New mothers are able to cope at home and provide care for newborn infant

					Mothers cope better, experience less stress therefore improved family adjustment		
To provide clients with escort to medical appointments when no family member is available	Escorts to appointments & therapies	Clients with decreased mobility Clients with decreased mental status	Home Care Team Leaders Home Health Personal Care Aides	As needed	Clients able to attend appointments as scheduled	Request for Escorts Stats	Ensures access to health services and attendance to medical appointments
To assist disabled & elderly with loss autonomy to remain in their homes	Housekeeping/Laundry Assisting with medications Assisting with personal care Meal preparation Escort for trips outside the home	> Elderly > Disabled	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	Number of Elders & Disabled remaining at home with support	> Stats > Hours of Service Request for Services Stats	Clients rehabilitate or are able to remain living at home longer vs being place in a long term care facaility
To provide respite to families for clients who require constant supervision	In Home Respite	Elders with loss of autonomy / Alzheimers /Dementia	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	# of families caring for clients	Request for Services Stats > Stats > Hours of Service	Clients rehabilitate or are able to remain living at home longer vs being place in a long term care facaility Prevents caregiver burnout

Home Care Nursing - End of Life Care

Goal	To provide end of life care & support to the patient, their family and/or caregivers						
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**
To assist & support patients, families/caregivers while providing end of life care	Provide coordinated care in the home. Use Case Management System which would include all team members such as: Patient, family, caregivers, Nurses, MD's, HHA, OT, PT, Clergy, Traditionalists, etc. (whoever is involved in pts. Care) Link patient and/or family/caregivers with appropriate resources.	End of Life clients, their families & caregivers	Home Care Nurse Manager Home Care Coordinator	Evaluate yearly at end of fiscal year for Annual Report	Total # of end of life care/ palliative care referrals (25). # of clients who chose to die at home (6). # of client's who had to be admitted to hospital as a result of lack of resources or support in the home (1)	Feedback from families (use short questionnaire) ***must create questionnaire** Stats, flow sheets.	Clients will receive the be possible end of life care in their homes. Families and Caregivers w feel confident and support while caring for a loved o Patient, family and caregi will have increased ability cope with a difficult situat Community will become aware of our services and may consider using our services in the future as opposed to having to be hospitalized. More palliative care at ho frees up more hospital bed thus leaving room for clie who require more acute ca
To provide adequate symptom management for palliative care clients	-Regular patient Assessment -Liaison with physicians, specialists as well as any other professional health care providers -Providing appropriate pain control measures	End of Life Patients and their family/caregivers	HCN'S Home Care Nurse Manager	Evaluate yearly at end of fiscal year for Annual Report	Total # of end of life care/palliative care referrals (25). # of clients who chose to die at home (6).	Pts. Chart Statistics, flow sheets	Adequate symptom management results in pat being able to remain in th homes. Pt. being able to stay in th own environment with the

	-Addressing basic patient needs such as nutrition, respiratory status, hydration status, elimination patterns, skin integrity, rest & activity, solitude & social interaction.				# of client's who had to be sent out to acute care hospital as a result of being unable to achieve adequate symptom management (1).		loved ones makes this experience more private, dignified and comforting t all parties involved. Whei is comfortable caregivers : able to rest in the comfort their home. Adequate symptom contrc decreased the need for pt. be transferred or admitted hospitals (Pt. Comfortable
To provide aftercare and support to families & caregivers after the loss of a palliative care pt.	To provide initial phone call when we are informed that the person has died To send a sympathy card to the family the week following the death To check in with the family and caregivers (both formal and informal) to see how they are coping afterwards and link them with appropriate services if necessary (2 weeks after the funeral)	Family members and Caregivers Staff (Debriefing often necessary for staff after difficult loss)	HCN & Home Care Coordinator Technician in Administration (Homecare Nursing)	April 1st, 2012.	# of families that were contacted by Homecare Program (11). # of families that were went sympathy cards by Homecare Program (5) # of families that were referred to other services (1).	Stats, flow sheets, check lists.	Family & caregivers feel a sense of comfort that HCC services team is also concerned about them and only about the person whc just passed away. Community has confidenc services of HCCS

Home Care Nursing: Tertiary Prevention

GOAL	To use a client centered approach to assist them to achieve their optimal level of health and prevent further complications due to their pre-existing health concerns						
OBJECTIVES	**MAIN ACTIVITIES**	**TARGET GROUP**	**TITLE RESPONSIBLE**	**CALENDAR/ DATES**	**INDICATORS**	**DATA**	**HEALTH IMPACT**
For clients to maintain or improve their current health status	Routine nursing visits based on the pts. individual health needs Ongoing monitoring (assessment) of client's health condition which includes the following interventions: Dressing Changes (Diabetic Ulcers, Chronic Wounds) Blood Glucose Monitoring Vital Signs Blood Tests Foot Care etc. *Weight* Prevention & Health Promotion Activities (Flu Shots, *Pneumovax Shots)* *Facilitating health care management via education & counselling re: Weight Management, Healthy Eating, Addressing Addiction Issues which include food addictions* (with clients & caregivers). Continue to use case management system to ensure that pt. receives coordinated	Tertiary Care Clients	HCN Manager Home Care Nurses	Ongoing but evaluated every year at the end of the fiscal year, April 1st.	Total # referrals to Tertiary Prevention/Long Term Care Homecare during fiscal year (70) Frequency of visits required on admission. *# of patients requiring acute care interventions (unscheduled nursing or doctor's visits)* *# of patients requiring transfer to off reserve hospitals.* *# of patients requiring acute care admissions to KMHC (due to deterioration of condition, complications or non-compliance)* (Next Year)	Stats, flow sheets Pt. file (ie.evolutives)	Good percentage of client: health will be stable Coordinated, appropriate c at home with less duplicat of services Increased client participati in their care plan Increased family/caregive participation in patient's c plan Improved client outcome Complications found earl therefore patient able to b treated in their homes. Results in decrease need f acute care hospitalization. When patient received adequate care, support anc resources in the home the are able to stay at home longer and avoid the need premature admission for L

	care and is able to access all available resources						
To prevent further deterioration of their disease process or to decrease the adverse symptoms r/t their disease process (ie. Diabetes, Cardiovascular Disease)	Routine nursing visits based on the pts. Individual needs Ongoing monitoring (assessment) of client's health condition which includes the following interventions: Dressing Changes (Diabetic Ulcers) Blood Glucose Monitoring Vital Signs/*Routine Weights* Blood Tests Foot Care etc. Prevention & Health Promotion Activities *which include addressing lifestyle issues such as; Healthy Eating, Physical Activity and Addictions* Teaching and facilitating health care management (with clients & caregivers) Continue to use case management system to ensure that pt. receives coordinated care and is able to access all available resources	Tertiary Care Clients	HCN Manager Home Care Nurses	Ongoing, assessed every fiscal year by April 1st	Total # referrals to Tertiary Prevention/Long Term Care Homecare during fiscal year (70). Total # of complications ie. Wound infections, new wounds (spontaneous), CHF, Chest Pain, uncontrolled Blood Glucose etc. (Next Year) # of admissions to KMHC (Next Year). # of admissions to acute care hospital (Next Year). # of years in program before admission to LTC (average number is 7 years) Longest pt. stayed in program was 10 years	Stats, flowsheets	Optimal symptom management in this client group results in the following; Decreased need for *acute care interventions from nu or physicians (emergency visits in OPD)* Improved symptom manag ment and early interventio Decrease need for acute c hospitalizations Tertiary Care Clients achi their optimal level of healt *Improved quality of life*
Utilization of Therapeutic Care Plans (TNP's). Utilization of Integrated	Implement *TNP's as directed by the OIIQ and ensuring that ISP'S are implemented as agreed upon by all parties. To implement standardized	Tertiary Care Clients	Homecare/Mental Health Nurses & Case Managers	Ongoing, but evaluation at the end of every fiscal year by April 1st	Total number of Homecare Nursing Patients with TNP done (126 out of 152=83 %). Total number of Homecare Nursing	HCCS data base. Nursing stats, flow sheets and patient files.	*Improved communication between nurses* *Patients priority needs clearly identified* Clients are more confident

Service Plans (ISP's) will ensure improved coordination of care for all home health tertiary clients (this would include "activities of exception")	nursing interventions geared to the needs of the tertiary care client. *To obtain information regarding standardized nursing intervention via aqesss (program has been available for all Native Communities in Quebec by April 1st, 2010, in French *Only, we are currently waiting for English Translations)*				Patients who have an ISP done (Blair has this #). Total number of patient Kardex's that include standardized nursing interventions (aquess or other recognized source) (Next Year)		managing their illness or situation knowing that the have comprehensive plans place (which they took pa creating). Increased client & family/caregiver participa in their care Client satisfaction r/t care education they receive. Client receive coordinated care
To ensure that the care that clients receive by the HHA'S, Family and any other nonprofessional is monitored and guided by trained professionals (Nurses, Physicians) and that non-professionals feel confident and supported when providing care. ie. Direction sheets for activities of exception, *Care Maps	***Ongoing*** 'Practical' Follow-up on education provided to HHA by HCCS Coordinator and Home Care Nurses when required ***Implementation*** of 'direction sheets' for activities of exception. ***Implementation*** of Care Maps for clients receiving care from Home Health Aids	Tertiary care clients Family, HHA and any other non-professional caregiver	HCN Manager & HC Coordinator	Ongoing, evaluate at the end of every fiscal year by April 1st. (All patients receiving assistance from HHA will have direction sheet)	Client Satisfaction questionnaire's completed with sufficient amount of Homecare Clients # of incidents related to "Activities of exception" # of clients who receive services from a HHA who have a direction sheet (Next Year). # of incident reports involving HHA's (9)	Results of Client Satisfaction Questionnaire's filled out Incident reports of errors in medication and/or activities of exception involving HHA, family and all non-professional caregivers Incident reports r/t collaborative effort between nurses & HHA.	-Patient Safety issues improved as a result of us implementing changes ba on the types of incidents t we see concerning the collaboration between nu and HHA or informal caregivers.
Develop a client satisfaction questionnaire for HCCS clients	Investigate different questionnaires, test and finalize Review tools that	Tertiary care clients	HCCS Manager HCN Manager	April 1st, 2012	Questionnaire results	Completed questionnaires	Services will be more clie driven

	already exist and customize it to our needs					Compilation and analysis of questionnaire data	Will help identify areas of improvement
Develop a worker satisfaction questionnaire for all workers within HCCS *(simulate Work life Pulse Questionnaire from accreditation)*	Review tools that already exist and customize it to our needs	All employees of HCCS	HCCS Manager HCN Manager	April 1st, 2012 Develop tool used at KMHC and adapt for HCCS. Conduct by April 1st, 2012.	Questionnaire results	Completed questionnaires Compilation and analysis of questionnaire data	Reponses will help addres issues and concerns voice employees of HCCS Satisfied workers provide better client care
Mental Health To stabilize, improve & maintain mental health clients	Perform Initial Mental Health Assessment Assess medication needs both oral and injections. Refer to psychiatry or any required discipline Work with clients Case Manager on ISP plans ie, attending other appts. (Assist to develop treatment plan, ISP) Consult & work with family members as well as support workers Meet with pts. on regular basis or as needed Meet with Mental Health Team on regular basis Liaison, Consult, Intervene & Educate	Severe & Persistent Mental Health Clients	Homecare Nurse Manager Mental Health Nurses Mental Health Team Steering Committee	Ongoing	Total number of MH Patients (will calculate Monday) # of clients at ILC followed assisted with medication by HHA (8 out of 11) # of incident reports r/t non compliance (3) # acute hospitalizations (Next Year) # of crisis interventions ie. Outbursts, disputes. (Next Year) # Mental Health Patients who have Case Manager or Primary care worker involved in their care (Next Year) # of Mental Health Patients who have a Nurse as their Case	*Pt. Progress notes* *Stats*	When a person's mental health improves their over health is more likely to improve Mental Health Clients become more productive members of their commun Improved family situation which contributes to overa community health Less hospitalizations of th clients decreases the risk f nosocomial infections, les changes to medications, m stable community care Improved communication between all service provid improved coordination of care.

					Manager # of cancelled appointments.		
To ensure early diagnosis & intervention for our psycho-geriatric patients	*Initial Psycho-geriatric assessment done by Homecare (Mini-Mental) or Mental Health Nurse* *Refer patient to specialized memory clinic for a more thorough assessment* *Implement appropriate treatment plan ie. Medication, Day Programs, Respite, Long Term Care Placement*	*Psycho-geriatric patients*	*Homecare Nurse Manager* *Mental Health Nurse* *Home Care Nurse* *Physician*	*Ongoing*	*# of mini-mental exams done indicating memory issues* *# of referrals to Mental Health Nurse for assessment* *# of referrals to memory clinics*	*Stats*	*Early intervention in this area results in better patie outcomes ie. Pt. starts Da Program and becomes familiar with hospital environment, results in be transition to hospital whe eventually requires long te care.* *Early implementation of p for patient reduces potenti for caregiver stress and burnout.*
To maintain or improve the level of functioning of persons who have learning/developmental disabilities	*Collaborate with Case Manager and caregivers to develop long term plan this clientele.* *Provide nursing care and follow up to patients* *Provide support and follow-up to patients, their families and care*	*Persons with learning/develop-mental disabilities*	*Homecare Nurse Manager* *Homecare Nurses* *Mental Health Nurses*	*Ongoing*	*# of referrals for persons with learning/developmental disabilities*	*Stats*	*We have been seeing our number of referrals increa in this area partly due to t fact that this particular patients population is agi and so are there parents* *Many of these patients wil requiring long term placement within the next years because their aging parents are no longer stro or well enough to take car them.*

GOAL	To provide home care nurses with the skills required to provide quality care.						
OBJECTIVES	**MAIN ACTIVITIES**	**TARGET GROUP**	**TITLE RESPONSIBLE**	**CALENDAR/ DATES**	**INDICATORS**	**DATA**	**HEALTH IMPACT**
To develop physical assessment skills related to various disease processes ie. C O PD, Diabetes, CRF, CHF etc.	- In-service education - Workshops, Conferences, Training	Nurses	Home Care Nurse Manager	Yearly (April 1st, 2011) *first list	# of trainings, workshops, conferences nurses participated in throughout fiscal year.	List of training that nurses participated in within the fiscal year	Improved assessment skill will lead to improved response when patient is showing signs of decompensation
To refine skills in completing Therapeutic Nursing Plans (TNP's) ie.refresher, f/u training	-TNP Training -Individual practical learning experiences	Nurses	Home Care Nurse Manager	April 1st, 2011 (Arrange f/u training session)	# of nurses who attended TNP training and refresher.	AUDIT of pts. Files by HCN Manager (Check pts. Files to see if anyone still does not have a TNP completed)	Clear direction for other nurses (availability), departments and services (HHA) More appropriate care Continuity of care between nurses
To fine tune skills in Case Management	-Informal follow up, education, coaching and support (In-house) -Ensure that any new nurse hired by Homecare has formal Case Management Training	Nurses	Home Care Nurse Manager Home Care Coordinator	April 1st, 2011	# of nurses who have received formal OMEC (Case Management) Training and refresher	AUDIT of pts. Files to see if all Case Management documents are up to date.	Pt. receives individual, appropriate coordinated care. Appropriate use of available resources
To develop skills in providing care according to a standardized 'wound care protocol'	-Arrange for Basic Wound Care Training for all Homecare Nurses -Implement "standardized wound care prototcol" in Homecare	Nurses	Home Care Nurse Manager	June 2011	# of nurses who have attended formal wound care training	Attendance lists	Improved patient care, improved wound care management, comfort and quality of life for patients Increased consistency in wound care management in our program

								\ t c k v p t
To improve skills in providing symptom management care for end of life care patients.	-Protocol development by home care nurses -Review "Standardized Nursing Methods" already in practice (aqsss) -Ongoing education for nurses	Nurses	Home Care Nurse Manager Risk & Quality Management Coordinator (KMHC)	April 1st, 2011	# of trainings, workshops, conferences specifically r/t end of life care that the nurses participated in throughout fiscal year	Attendance lists HCCS data base	More comfort through the dying process for client and family	F i s c

Home Care Nursing: Home Hospital

GOAL	To provide safe and efficient care *on a short term basis*						
OBJECTIVES	**MAIN ACTIVITIES**	**TARGET GROUP**	**TITLE RESPONSIBLE**	**CALENDAR/ DATES**	**INDICATORS**	**DATA**	**HEALTH IMPACT**
To *assist client to address an acute health care issue (this includes post-hospital care)*	Follow-up and continued interventions post – hospitalization, *treatment or procedure* which includes: a global assessment, treatment, procedures and interventions ie. vital sign, dressing changes, suture removal, client teaching etc.	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing	Total # of referrals to Home Hospital/Short Term Care within fiscal year (54) # of Home Hospital patients who had more than 1 admission to Home Hospital within fiscal year (4 and 2 of those pts. had 3 admissions) # of complications ie. Infections (none this year) # of complications that resulted in readmission to hospital (Next Year). *# to KMHC* *#to CHAL or outside hospital* *# of pts. admitted to Tertiary Prevention after being referred to Home Hospital*	Stats, flow sheets, patient files, HCCS Data Base	Appropriate health outcon Improved health status Home Hospital return to baseline in appropriate tir frame *High risk pts. identified ar ensured follow-up*
To ensure that clients receive	Prompt referral to appropriate	Home Hospital	Home Care Nurse	Ongoing	# of incident reports r/t	Incident reports	Appropriate health outcon

care promptly when there is a change in their status	professional/establishment	clients	Manager and Nurses		delay, mistake or lack of care. (20, but majority were pharmacy errors that the nurses picked up)		*when patients receive the appropriate care in a time fashion* Clients receive the best ca possible
To ensure that clients receive care using a client centered approach	Clients receive a thorough global assessment of their needs using the short form Multiclientele	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing	# of home hospital clients evaluated with this form (Short Term Assessment) within 48 hours of admission to program vs total number of clients admitted for short term care. (Blair) # of TNP Forms completed **within 48** hours of admission to program. (Next Year)	HCCS Data Base Audit of pt. files	Pt. centered care ensures t the pts. Individual needs a met Team approach ensures th all pts needs are addressed Pt. receives well coordinat care Treatment requirements ai clear
To reduce the incidence and spread of super bugs amongst Homecare care clients.	Patients will be screened upon admission into our program when transferred from an outside hospital Pts. will be screened when transferred to another area of care ie. KMHC, respite, active or LTC. Implementation of Infection Prevention Control measures within the pts. Home Staff & family (caregivers) education regarding infection control measures Pt. teaching	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing, evaluated at end of each fiscal year by April 1st	# of persons who are MRSA or ERV positive when they are admitted into our program. (we probably have this number) # persons who became MRSA or ERV positive following treatment in our program. (None)	Registrar of positive clients Pts. chart Flow sheets	Appropriate infection cont measures will decrease the spread of super bugs

To identify high risk "Short Term Care" (Home Hospital)clients who may need to be admitted into the Tertiary Prevention component of our program ie:obesity, learning disabilities/development delays	*Pt. assessed using Short Term OMEC*	*High Risk Short Term Care Clients*	*Homecare Nurses Homecare Nurse Manager*	*Ongoing*	*#of pts. admitted to Tertiary Prevention after being admitted to Home Hospital*	*Flow Sheet Intakes*	*Increased number of pts. v will receive the care they requires*

Essential Services

Program Management & Supervision

The Kahnawake Home and Community Care Program has a Homecare Coordinator to oversee the service delivery of the Homecare program.

The professional supervision for the Homecare Nurses comes from the Homecare Nurse Manager who is responsible to the Director of Nursing at the Kateri Memorial Hospital Centre (KMHC) who in turn is responsible to the Executive Director of KMHC who in turn is responsible to the KMHC Board of Directors.

Managed Care

Case Management

The case management for the clients is the responsibility of their assigned Case Manager working in collaboration with the other service providers, both internally and externally to Home and Community Care Services. This entails carrying out the clients needs assessments, care planning, co-ordination of services, provision of planned services, evaluation of client plans provided and client responses to the care provided.

The Homecare nurses are responsible for the co-ordination of medical supplies, services and equipment.

Referrals and Linkages to Services and Other Care Providers

The Case Manager will work collaboratively with:

- KSCS Prevention & Support
- Physicians
- KMHC Inpatient Department
- KMHC Rehabilitation Services
- Medical Transportation
- Assisted Living Services
- Young Adults Program
- KMHC Social Services Worker
- KMHC Day Center

and any outside service providers for a smooth transition.

The relationship with these service providers is maintained though a variety of activities such as meetings, workshops, case conferencing, training and the co-development of the Home and Community Care Services Strategic Framework.

Client Assessment

A client can easily access the program through a variety of ways. The client will have the final decision on whether of not he or she will receive services. The Case Manager will be responsible for carrying out the client assessments. The Multiclientele Autonomy Assessment will be utilized to conduct these assessments. All applicants will pass through a case study review by the appropriate member of the Home and Community Care Services team and the immediate supervisor. The client will need to meet eligibility criteria. Upon approval a Individual Service Plan will be drawn upon based on the client needs assessment. The ISP will include the duration, frequency, duties and participation of the client in the performance of tasks or medical needs. Services will not exceed three months however, extensions may be granted if indicated in the evaluations. Clients chronically ill, handicapped or elders and in need will be re-evaluated or assessed every six months.

Homecare Nursing

The Homecare Nursing team will provide health care assistance in three categories:

1. Tiertiary Prevention: includes teaching, vitals signs, medication preparation/administration and physical assessment.
2. Home Hospital: includes dressings, evaluation, medication, injections, crisis intervention, i.e. client's or caregivers' dressings, IV hydration (boluses), IV antibiotics (maximum 2x/day).
3. End of Life Care: includes oxygen, hydration, medications and supportive care for families, counselling, support workers and pain control.

The Homecare Nurses provide services based on a 35 hour workweek. The Homecare Nurses work a flexible schedule when clients require weekend assistance. Client services are available on weekends based on client needs and care plans.

The Homecare Nurses drive their own vehicles and will be compensated for mileage accrued to tend to clients. A monthly claim form is required for payment of mileage.

The supervision of the Homecare Nurses will be the responsibility of the Director of Nursing of the KMHC. In addition, the Director of Nursing responsibilities include providing supervision, professional training, development and support of nurses.

The Homecare Nurse Manager and the Director of Nursing will work on the enhancement and monitoring of policies and procedures.

Home Support Services

Personal Care Services

The personal care services will be based on the individual needs of the clients indicated form the homecare client needs assessment. The staff hired will be trained and utilized accordingly by the Homecare Team Leader and assigned to the appropriate client. The personal care services offered will be occasional escorts (when medically appropriate) to essential services, bathing, shaving, dressing, mouth

care (excluding health reasons), assistance in daily living and providing social emergency assistance. Ongoing education methods will be utilized as prevention in the areas of the predominant health problems facing the community members.

Home Management

The Home Support Workers will provide services that will be co-ordinated by the Homecare Team Leaders. The home Support Workers will provide domestic duties such as:

- Preparing meals
- doing laundry
- helping individuals get around and shop
- in home respite
- Security checks on home and client
- performing light housekeeping duties
- do social visits

In-home Respite

Respite will be provided to family caregivers who care for clients who requiring constant supervision.

The respite will be provided in home allowing the caregiver to attend to personal self care.

The goal is to maintain the client in their home longer vs. being place in along term care facility. It will provide the caregiver with the require respite to prevent caregiver burnout.

Medical Supplies and Equipment

Information and Data Collection

KSCS	Budget	April,1,2012	to March,31,2013		
cost center	5210	HCC	1st,quarter	2nd,quarter	3rd,qua
Revenue		Budget,12 months	April-June	July-Sept	Oct-De
Home and Community Care service delivry		1600909	400227	400227	400
Revenue	**Total**	1600909	400227	400227	400
Expense	**units**				
Salaries	30 staff	1194403	298601	298601	298
benefits		216487	54122	54122	54
salary & benefits	**subtotal**	1410890	352723	352723	352
operation cost share		14601	3650	3650	3
program costs		12000	3000	3000	3
Capital		0	0	0	
Van operation		13800	3450	3450	3
training		11600	2900	2900	2
travel		26700	6675	6675	6
Administration cost share		111318	27830	27830	27
	subtotal	190019	47505	47505	47
	Total year	1600909	400227	400227	400
	surplus(defecit)	0	0	0	

First Nations and Inuit Home and Community Care Program

eHRTT Application

Cor

HR Staff

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Delete Row(s) / Supprimer rangée(s)

Note: Mandatory columns are marked in red.

English / Français | Sort / Trier | Calculator/Calculatrice | Help / Aide

Staff Information						
Surname	First Name	Employee Id	Start Date (yyyy/mm/dd)	End Date (yyyy/mm/dd)	Leave Type	
A	B		D	E	F	
Horne	M	H223	2000/05/26			Administra
Zachary	P	H226	2000/09/14			Program S
Diabo	S	H544	2001/10/01			Personal C
Lahache	H	H545	2001/10/08			Personal C
McComber	W	H981	2011/10/08			Personal C
Ross	S	H267	2011/08/01			Program S
Horn	T	H166	2002/05/22			Administra
Brascoup	V	H531	2002/06/02			Personal C
Phillips	A	H552	2002/07/02			Program S

Alfred	D	H553	2002/07/15			Program S
Lahache	D	H556	2002/11/18			Personal C
Marsh	E	H555	2002/11/18			Personal C
McComber	K	H554	2002/11/18			Personal C
Lahache	L	H563	2003/01/06			Personal C
Montour	P	H548	2003/06/02			Program S
Phillips	C	H638	2003/07/15	2012/01/01	T	Program S
Mayo	W	H976	2005/09/05			Personal C
Proulx	C	K838	2005/10/10			Registered
Curotte	J	H935	2006/01/30			Personal C
McComber	L	H637	2006/07/24			Personal C
Rice	L	H802	2006/07/31			Personal C
Charles	C	H433	2006/11/20			Program S
Kinsella	B	H251	2007/02/19	2011/03/23	P	Personal C
Armstrong	B	H280	2007/09/10			Administra
O'Connor	J	H210	2007/11/19			Program S
Kezar	E	K938	2007/12/10			Registered
Pelletier	L	K915	2008/07/11			Registered
Samayoa	J	H266	2009/06/15	2011/10/01	T	Program S
Phillips	T	H524	2006/12/01	2011/10/21	P	Personal C
Grohe	W	H975	2009/09/18	2011/12/15	P	Personal C
Diabo	A	H273	2010/02/15	2012/01/27	P	Administra
Chahal	K	H1003	2010/04/19			Program S
Diabo	H	H1009	2010/05/31			Personal C
Curotte	K	H1023	2010/07/05	2011/11/01	P	Personal C
McComber	L	H1012	2010/07/19			Program S
Mekdeci	R	H1059	2012/01/16			Personal C
Rice	L	H546	2001/10/01	2012/03/01	P	Personal C
Douglas	S	H532	2002/06/03	2012/03/01	P	Personal C