Kahnawake Community Health Plan
2012-2013

RATIONALE	This health issue has consistently been identified in previous health plans as a priority issue and continues into our next health plan. Cardiovascular diseases often go untreated which leads to increased challenge to provide intervention.
GOAL	To reduce the incidence of cardiovascular disease in Kahnawake.
STRATEGY	To create a comprehensive prevention, intervention and support spectrum of services for cardiovascular disease.

OBJECTIVES	Main Activities	Target Group	Title Responsible	Calendar/ Dates	Indicators	Data	Health Impact
To reduce the risk of Cardiovascular diseases within Kahnawake through collaboration of community organizations (Logic Model to be developed)	Establish a working group to focus on the cardiovascular health priority.		Onkwa	Ongoing	# of meetings Terms of reference Objectives	Sub committee reports	Improved and efficient service delivery
	Inventory existing services which impact cardiovascular disease.		Working Group	Ongoing			
	Identify gaps and overlaps and implement service delivery activities to address this priority		Working Group	Ongoing	# of protocols, agreements, MOU, policies		A measurable decrease in drug/alcohol abuse in Kahnawake
To provide wellness activities to Kahnawa'kehro:non that reduces barriers to physical activity in at risk populations, reduces their risk of chronic/preventable illness, increases access to health education and opportunity, and provides/facilitates tools for self-care. (Adult Prevention)	To provide physical activity opportunities to at risk adults (40+)	At risk 40+ adults	Community Health Nurse, Fitness Leader	Sept../May	Attendance sustained and increased Evaluation	Attendee numbers- Increased number returning- - Evaluations	Participants demonstrate improvement Level of health maintained/improved i.e. ↓ obesity, ↓ WC, improved BP and glucose control, etc.

	To provide physical activity opportunities to at risk adults (20 - 30)	20-30 yrs	Community Health Nurse, Fitness Leader	April/June	April/June Sept./Dec.	Returned surveys Evaluation results	Activities which meet the expressed needs of the target group in order to improve their wellness. Level of health maintained/improved i.e. ↓ obesity, ↓ WC, improved BP and glucose control, etc. Prevention of diabetes, heart disease, cancer, etc.
	To provide physical activity opportunities to at risk adults (inactive adults)	Inactive adults	Community Health Nurse, Fitness Leader	Oct-Nov-ADI proposal-Ballroom Dancing Line Dancing	36BRD # of attendees Evaluation	Evaluation results	Willingness to explore new avenues to activity
To reduce morbidity and mortality related to preventable risk factors for chronic disease. (Adult prevention)	To provide screening, or educational opportunities for at-risk groups for Heart Disease	Adult population.	CHU Nurse	February November May/June	Visits to booths -500+ Demonstrated awareness of risk factors Number of requests	Radio talk show, article in KSCS newsletter. Number of screenings-60% of those screened during ambush opportunitys had hypertension, or had risk factors for hyperstension Number of requests for assessment/work-shops-	Decreased number of undetected heart health risk factors.

	To provide awareness, or educational opportunities for at-risk groups for Diabetes	Adult population with preventable risk factors.	CHU Nurse	May June November	Increased demand for screening opportunities.	Number of screenings 5 Number of requests for workshops- Number of requests for assessment	Decreased number of undetected diabetic/IFG persons in community.
	To provide educational opportunities for at-risk groups for Osteoporosis, to promote prevention, and screening	Women 25+	CHU Nurse	Oct. / Nov.	Increase demand for more info or related information.	Number of requests for workshops- Number of requests for assessment-referral or information	Reduced numbers of complications – for example fractures related to osteoporosis.

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Goal	Reduce tobacco related morbidity and mortality.							
Objectives	**Main Activities**	**Target Group**	**Responsible Contact**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**Review**
To promote freedom from smoking	To provide opportunities for behavioural change. Counselling & Support	Adult smokers	CHU Nurses	April – March	Increased number of consultations	3 referrals (2 from Physio dept)	Reduced number of tobacco related illnesses.	Reminder letter to new M.D.'s re consultations. - Done
	Promote governmental strategies * "Quit to Win"-(on line support), Clear the Air Campaign	All smokers	CHU	April-March	Increased number of individuals participating in strategy.	Anecdotal	Reduced number of tobacco related illnesses.	Distributed posters to community – done on-line so hard to evaluate number of participants.
	To promote use of motivational interviewing related to smoking cessation for nurses	Health care Community	CHU Nurses Director of Nursing	April – March	Improved skills in the implementation of Clinical Practice Guidelines (CPG).	Anecdotal	Decreased number of clients resistant to change.	Reminders to OPD nursing re: to ask 'smoking questions'. - Ongoing
To provide increased awareness of links between smoking & tobacco related illness in smokers and non-smokers.	To produce the following communications: Articles 2x/yr. Visual displays Pamphlet, & Radio	Smokers living / working with non-smokers and non-smokers	CHU Nurses	April – March	Increased number of smoke free households	Anecdotal	Increased number of individuals from populations with tobacco related health issues who quit tobacco. Increased numbers of adults displaying positive role model to children, teens, peers.	Consider PSA in local paper regarding availability of smoking cessation consultations. Develop/explore additional/alternative support systems – Updated.
	To promote the 'Clean the air campaign"	Community	CHU Nurse	April-May	Increased number of smoke free households	number of presentations	Reduced number of visits related to 2nd & 3rd hand smoke exposure – ear infections, asthma, COPD.	Weedless Wednesday Kickoff Breast Feeding Support Group

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Goal	To provide wellness activities to Kahnawa'kehró:non-non that reduces barriers to physical activity in at risk populations, reduces their risk of chronic/preventable illness, increases							
Objectives	**Main Activities**	**Target Group**	**Responsible Contact**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**Review**
To provide physical activity opportunities to at risk adults (40+)	Continue Vitality Activity Program - Provide health education - Monitoring for safety - Design program incorporating cardiovascular, weight training and flexibility - Encourage/facilitate in community wide activities, i.e. Sadie's Walk, Mohawk Miles - Advertise/actively recruit - Evaluate at year end	At risk 40+ adults	Community Health Nurse, Fitness Leader	Sept../May	Attendance sustained and increased Evaluation	Attendee numbers- Increased number returning- - Evaluations	Participants demonstrate improvement Level of health maintained/improved i.e. ↓ obesity, ↓ WC, improved BP and glucose control, etc.	DDiscussion seasonal health issues i.e. balance/ice/falls /heat/hydration/stress/holidays/ injury related to dancing. Number of attendees sustained – new clients attending
To provide physical activity opportunities to at risk adults (20-30 years)	Research, design and undertake a survey to determine needs for physical activity; Hawas Stroller Fitness Plan and implement innovative activity for the target group Monitor for safety Provide health relevant health education Evaluate quantitative/ qualitative	20-30 yrs	Community Health Nurse, Fitness Leader	April/June	April/June Sept./Dec.	Returned surveys Evaluation results	Activities which meet the expressed needs of the target group in order to improve their wellness. Level of health maintained/improved i.e. ↓ obesity, ↓ WC, improved BP and glucose control, etc. Prevention of diabetes, heart disease, cancer, etc.	Despite having negotiated indoor opportunity it became increasing difficult to continue program at this time due to its cost ineffectiveness. Scheduled air time ads, as well as newspaper ads, and a visit of solicitation to BFSG Have had 3 phone calls in January 11 inquiring as to start date of next program. To be determined.

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Objectives	**Main Activities**	**Target Group**	**Responsible Contact**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**Review**
To provide physical activity opportunities to at risk adults (inactive adults)	Develop a seasonal activity to introduce a new skill Determine availability of venue and equipment Advertise and recruit Research promotional educational materials	Inactive adults	Community Health Nurse, Fitness Leader	Oct-Nov-ADI proposal-Ballroom Dancing Line Dancing	36BRD # of attendees Evaluation 35	Evaluation results	Willingness to explore new avenues to activity	Program initiated in Jan 2011, anecdotal evidence-people report unwillingness to this sort of activity at social clubs due to smoke environment

Goal	To reduce morbidity and mortality related to preventable risk factors for chronic disease.							
Objectives	**Main Activities**	**Target Group**	**Responsible Contact**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**Review**
To provide screening, or educational opportunities for at-risk groups for Heart Disease	Heart Health: Blood pressure screenings Display board Newspaper article Workshop/booths Individual risk assessment Counselling	Adult population.	CHU Nurse	February November May/June	Visits to booths -500+ Demonstrated awareness of risk factors Number of requests	Radio talk show, article in KSCS newsletter. Number of screenings-60% of those screened during ambush opportunitys had hypertension, or had risk factors for hyperstension Number of requests for assessment/work-shops-	Decreased number of undetected heart health risk factors.	-Increase to partner up with community activities. -to continue to Increase access to unserviced population

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To provide awareness, or educational opportunities for at-risk groups for Diabetes	Diabetes: Blood glucose screening booths Display boards Workshops	Adult population with preventable risk factors.	CHU Nurse	May June November	Increased demand for screening opportunities.	Number of screenings 5 Number of requests for workshops- Number of requests for assessment	Decreased number of undetected diabetic/IFG persons in community.	Well educated community re: diabetes. - people ask informed questions.-changed venue of road show to march to co-incide with nutrition month
To provide educational opportunities for at-risk groups for Osteoporosis, to promote prevention, and screening	Osteoporosis: Display boards Articles Pamphlets Workshops	Women 25+	CHU Nurse	Oct. / Nov.	Increase demand for more info or related information.	Number of requests for workshops- Number of requests for assessment-referral or information	Reduced numbers of complications – for example fractures related to osteoporosis.	Anecdotal evidence to support i.e. two falls □ fractures. 2 falls without fracture, 1 with fracture