KAHNAWAKE COMMUNITY HEALTH PLAN HEALTH TRANSFERRED PROGRAMS

2012 - 2022

Submitted to: Onkwata'karitáhtshera
Steering Committee & Health Canada

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ACRONYMS LISTING

The following is a list of acronyms most commonly used throughout this report and within the logic models.

1.	ACS	Adult Care Services
2.	ADL	Activities of Daily Living
3.	ALC	Adult Living Center
4.	ARBD	Alcohol Related Birth Defects
5.	ARS	Addictions Response Services
6.	ASSS	Agence de la Sante Services Social
7.	ASSTAS	Assoc. Paritatire pou la santé el la sécurité du travail du secteur affaires sociales
8.	BFI	Brighter Futures Initiative
9.	CAEO	Canadian Association for Education and Outreach
10.	CCHSA	Canadian Council of Health Services Accreditation
11.	CHAL	Centre Hospitalier Anna Laberge
12.	CHLP	Communications for a Healthier Lifestyle Program
13.	CHN	Community Health Nurse
14.	CHP	Community Health Plan
15.	CHR	Community Health Representative
16.	CHSLD	Un Centre d'hébergement et de soins de longue durée
17.	CHU	Community Health Unit
18.	CMR	Centre Monte region readaptation
19.	COHI	Children Oral Health Initiative
20.	CPHI	Certified Public Health Inspector
21.	CSST	Commission Santé Security Travail
22.	DS	Direction de Santé Publique
23.	EDC	Executive Directors Committee
24.	EHO	Environmental Health Officer
25.	EHS	Environmental Health Services
26.	EHT	Environmental Health Technician
27.	EPPC	Emergency Preparedness Planning Committee
28.	FNIS	First Nations Information System
29.	FNQLHSSC	First Nations Quebec and Labrador Health and Social Services
30.	HCC	Home and Community Care
31.	HCN	Homecare Nurse
32.	HSS	Health and Social Services
33.	ICADC	International Certification of Alcohol and Drug Counselling
34.	ICCS	International Certified Clinical Supervisor
35.	ILC	Independent Living Center
36.	ISP	Individualized Service Plan
37.	ISW	Inclusion Support Worker
38.	JGH	Jewish General Hospital
39.	KFB & AS	Kahnawake Fire Brigade and Ambulance Services
40.	KMHC	Kateri Memorial Hospital Centre

41.	KSCS	Kahnawake Shakotiia'takehnhas Community Services
42.	KSDPP	Kahnawake Schools Diabetes Prevention Project
43.	KSS	Kahnawake Survival School
44.	KYC	Kahnawake Youth Center
45.	LTC	Long Term Care
46.	MAD Group	Making a Difference Group
47.	MADO	Maladies á declaration obligatory
48.	MAR	Movable Assets Reserve
49.	MCH	Montreal Children Hospital
50.	MCK	Mohawk Council of Kahnawake
51.	MOH	Medical Officer of Health
52.	MOU	Memorandum of Understanding
53.	MSI	Mohawk Self Insurance
54.	MSSS	Ministère de la Santé et des Services Sociaux
55.	MUHC	McGill University Health Center
56.	NIHB	Non Insured Health Benefits
57.	ONQ	Quebec Order of Nurses
58.	PIQ	Protocole d'Immunisation du Quebec
59.	QBCSP	Quebec Breast Cancer Screening Program
60.	QM	Quality Management
61.	RAMQ	Régie de l'assurance maladie Quebec
62.	RVH	Royal Victoria Hospital
63.	SAAQ	Sociéte l'assurance automobile Quebec
64.	SBS	Step by Step Child & Family Center
65.	SCHC	Strategic Community Health Careers
66.	STBBI	Sexually Transmitted Blood Borne Infection
67.	TSC	Teen Social Club
68.	WBC	Well Baby Clinic
69.	WSMI	Westmount Square Medical Imaging
70.	YAP	Young Adults Program
71.	YCJA	Youth Criminal Justice Act

Introduction

This Community Health Plan (CHP) is the third plan developed by Onkwata'karitáhtshera (Kahnawake's one health and social service agency) for the community of Kahnawake. The second CHP was developed in January 2006 and the Heath Transfer agreement expired in March 2011. Onkwata'karitáhtshera was given a one year extension to complete an evaluation process and develop a new CHP. Onkwata'karitáhtshera currently has a Transfer Agreement and wants to enter into a Ten-Year Block Contribution (former Flexible Transfer) funding model for 2012 to 2022. During a meeting in May 2010, there was discussion with members of Health Canada (FNIHB) of a possible ten-year agreement as it would provide long-term stability for both KSCS and KMHC. In addition, the request for a 10-year community health plan encompasses the following considerations:

1. Change is slow and a longer period is needed to affect health changes, attitudes and longstanding lifestyles.
2. Health priorities need longer timeframes to validate changes.
3. Longer timeframes are required so community can retain knowledge and make necessary lifestyle changes.
4. Impacts employee retention – allows for full-time versus contract positions so employees are fully engaged in the process.
5. Need community buy-in to achieve results.

The Community Health Plans submitted in 1998 and 2004 had the following three overarching goals:

- To provide a proactive holistic approach by assuming responsibility and control for determining health priorities and resource allocations for all health and social services.
- To advocate for and promote the health and social interest of all Kahnawa'kehró:non.
- To arrange long-term health and social service planning and strategic frameworks for the priority health needs.

These goals were intended to build capacity within the community to deliver quality health services and develop a structure that would be responsible for establishing long-term goals (between 15 to 20 years) for improving the health of Kahnawa'kehró:non (*the people of Kahnawake).* They also had to integrate with existing planning structures and partnerships within the community.

The second Kahnawake CHP, completed in 2006, reiterated these goals and began to utilize logic models for planning of front line service delivery as there were indicators that results-based management would be a requirement of many funding sources in the future and logic models could serve this purpose. The organizations continue to use logic models as tools for planning and managing their programs and also to plan evaluations. They also provide short- and long-term program goals.

The goals of this CHP, in addition to the overarching goals above, are more ambitious as it reflects the workload involved within integrated systems and information systems management which is essential in the delivery of effective health and social services and was not part of the previous CHP. Also Regional Office has referenced the CHP in their deliberations for funding of community based programs. This indicates the CHP is now playing a role in decision making at the region. This requires more elaborate needs identification than in previous health plans. The plan continues to address the priority health issues, to validate the positive changes to health and well-being in the community, and to acknowledge capacity building within the organizations and the community to meet those needs. Kahnawake has been recognized as a best practice site for its integrated approach to health and social services and KSCS and KMHC have worked diligently to simplify and streamline processes and improve access to services, including those provided by the Province.

The CHP serves as a hub for coordination of health and social services. It must remain flexible and dynamic and as such is considered a living document. This means as more critical needs may emerge in the community and in consideration of funding agreement requirements, Onkwata'karitáhtshera has the responsibility and authority to modify or change the CHP.

Kahnawake submitted a Community health Plan in March 2012, which was accepted by Health Canada; however, Health Canada provided 22 recommendations which should be integrated into the Community Health Plan by March 2013. This work has been completed and this version of the Community health Plan reflects these recommendations.

Community Profile

The Kanien'kehá:ka (Mohawk people) at Kahnawake are the descendants of an ancient people with a rich, vibrant, and unique heritage. The Mohawk territory of Kahnawake is located on the South Shore of the St. Lawrence River, 12 kilometres southwest of the city of Montreal, in the Province of Quebec. The land base of the community is approximately 12,000 acres.

Kahnawake (translated as "by the rapids") was named in 1716 when the community of a few hundred settled along the St. Lawrence River adjacent to the Lachine Rapids. Kahnawake is one of eight communities that make up the Kanien'kehá:ka (Mohawk) Nation spread across the eastern geographical traditional homelands of the Haudenosaunee (Iroquois Confederacy).

Presently, the total community population is estimated at 9,925 persons, with 7,645 people living in the community and 2,272 living outside of the community. Of those living in the community, 43% are under 35 years of age. Those 60+ years of age constitute 20% of the population with females over 80 years old numbering twice as many males (359 vs. 155).[1] Over the past decade, the population has grown consistently with an average of 92 births per year. There has been an average of 48 deaths per year over the past ten years. The community currently has 2,092

[1] Source: Indian and Northern Affairs Canada, Population Statistics Report, Indian Registration System, for 2011/03

households including private homes and multi-dwelling apartments.[2] The on-reserve average household income is $37,153 and the unemployment rate is estimated at 3% to 11%. [3]
The geographic layout of the community is intersected by the Honoré Mercier Bridge into Montreal, provincial highways 132, 138 and 207, the Canadian Pacific Railway, a train bridge and the St. Lawrence Seaway. Transportation is generally by privately owned vehicles, local taxi services or medical transportation. There is bus service provided by an outside company for access off the territory. Air and rail transportation are within 12 kilometres of the community.

The major public services established within the territory are: Canada Post Office, Kahnawake Caisse Populaire (Financial Institution/Bank), Kahnawake Fire Brigade & Ambulance Service, Kahnawake Peacekeepers (Police), Kahnawake Courthouse, Kateri Memorial Hospital Centre, Kahnawake Education Center (directly responsible for four schools and works in partnership with two other schools on the territory), Step By Step Child & Family Center, Kahnawake Shakotiia'takehnhas Community Services, Kahnawake Elders Lodge, Assisted Living Services, Tewatohnhi'saktha(Kahnawake Economic Development Commission), Mohawk Council of Kahnawake, Kahnawake Environment Office, Kanien'kehaka Onkwawen:na Raotitiohkwa (Cultural Center), Kahnawake Sports Complex, and Kahnawake Youth Center.

Some of the above services/agencies come directly under the Mohawk Council of Kahnawake operations and others function under mandated governing Boards of Directors through Mohawk Council Resolutions.

Kahnawake is unique in that the Mohawk Council of Kahnawake (MCK), in an unprecedented action in the early eighties, delegated authority to the organizations under these governing bodies to negotiate and sign funding arrangements directly with Health Canada and the Department of Indian Affairs for the delivery of health and social services. The community of Kahnawake has signed a nation-to-nation agreement with the Quebec Government for funding for the hospital centre. The MCK has also instituted an accountability framework that ensures there is responsible governance with these expanded authorities.

Communication tools used within the community are telephone (emergency fan-out lists), fax, e-mail, organizational electronic e-mail and bulletin boards, internet, web sites, local newsletters, Canada Post, community bulletin boards, signs and posters, community meetings, local newspaper (*The Eastern Door*), community radio station (*K103*), emergency broadcast system, and two community cable television channels. The larger organizations of the community have established their own public relations programs and/or communications units.

Due to its close proximity to Montreal and other surrounding non-Native municipalities, Kahnawake is a highly integrated modern community that is within a short distance of any large

[2] Source: Evaluation of Kahnawake Community Health Plan, P.L. Hawa & Associates, 2010, (Tewatohnhi'saktha, Household Survey, 2005/2006)
[3] Ibid

city amenity. This proximity has been a benefit in some aspects for example quicker access to large hospitals, higher education institutions, recreational services, etc. However, it has also been a factor contributing to negative aspects of the community including diminished Mohawk language and cultural knowledge (Longer standing outside influence), easier access to drugs, alcohol, gambling, increased crime, etc.

Onkwata'karitáhtshera

Onkwata'karitáhtshera (a Mohawk word translated as "*for all the people to be concerned in the area of good health*") is the one health and social service agency that is responsible for overseeing community control over Kahnawake's health. Onkwata'karitáhtshera originally began in 1983 as the Health Consultation Committee (HCC). In 1996, KSCS developed a Health Policy Unit through the Integrated Service Agreement to give technical support to the HCC. The body evolved into Onkwata'karitahtshera with a renewed & expanded mandate acknowledging it as the governing body responsible for the global health and social services for Kahnawake. It is mandated through a Mohawk Council of Kahnawake (MCK) Resolution (MCR #45/1999/2000 - see Appendix A). They provide direction and a leading role in the development of the current CHP and future plans.

Onkwata'karitáhtshera believes in holistic health (including the social, physical, emotional and spiritual well-being of the people).

Its mission is to plan, coordinate, maintain and improve health and social services for all Kahnawa'kehró:non at a community wide level. Onkwata'karitáhtshera serves as the advisory, advocacy and coordinating body that ensures the needs coming out of organizational and community research is addressed where appropriate.

Onkwata'karitáhtshera consists of several community organizations duly mandated under separate resolution by the Mohawk Council of Kahnawake. Onkwata'karitáhtshera currently has 12 seats represented by the following:

- Community Representatives
- Mohawk Council of Kahnawake (Chiefs representing the Health & Social Services Portfolio)
- Kateri Memorial Hospital Centre
- Kahnawake Shakotiia'takehnhas Community Services
- Kahnawake Fire Brigade & Ambulance Service

The goals of Onkwata'karitáhtshera at a community wide level are:

- to assume responsibility and control to determine health priorities and resource allocations for all health and social services within Kahnawake;
- to promote and advocate for optimum health and social services for Kahnawa'kehró:non;
- to plan and manage global health and social services by assuming responsibility and control to determine health priorities.

Onkwata'karitáhtshera meets on a monthly basis. The Executive Committee meets to address pressing issues and sub-committees are formed to assist in the various projects. Presently (in 2011) there are 2 support staff that assist in carrying out all aspects of Onkwata'karitáhtshera operations.

Onkwata'karitáhtshera established a Steering Committee to oversee the development of the current CHP. The Project Steering Committee members are:

- Lynda Delisle, Chairperson
- Linda Deer, Vice-Chairperson
- Susan Horne, Secretary

The current Executive Committee is comprised of:

- Valerie Diabo, Chairperson
- Derek Montour, Vice-Chairperson
- Kelly Ann Meloche, Secretary

The Executive Director of KSCS is the designated Health Director in Kahnawake and has signing authority for documentation. The Steering Committee continues to act in a supervisory capacity in the development of the CHP and in its final approval for presentation to Onkwata'karitáhtshera and Health Canada.

Consultant

Bonnie Kahentineson Jacobs was contracted as Project Coordinator to focus on the 2011 Kahnawake CHP for the transferred health programs in the territory. Work started on the project in July 2011. Ms. Jacobs worked closely with the Steering Committee and organizations to generate and coordinate the information presented in the health plan. Organizational Development Services (ODS), a local consulting service that prepared the previous CHP's for Kahnawake, assisted Ms. Jacobs in researching, writing and fine-tuning elements of the CHP. Additional assistance for this project was received from those involved in the health planning process and was much appreciated. Ms. Jacobs has enhanced her knowledge in her capacity as project coordinator and will continue to apply this experience in future assignments.

Report Layout

Onkwata'karitáhtshera had established overarching goals for the 2006-2011 CHP. These goals are still relevant for Onkwata'karitáhtshera and the current CHP. Three additional priority health needs were identified in the 2010 Evaluation of the Kahnawake Community Health Plan. Four previous priority health needs along with the three new ones will be addressed in the current CHP for those programs under Health Transfer. This plan will continue to be organized at four levels:

LEVEL	RESPONSIBILITY
1. Political	Mohawk Council of Kahnawake
2. Community Development	Onkwata'karitáhtshera
3. Organizational	Kateri Memorial Hospital Centre Kahnawake Shakotiia'takehnhas Community Services
4. Frontline	All Health Transferred Programs in Kahnawake

COMMUNITY HEALTH PLAN COMPONENTS

1. Community Health Priorities and Needs

Community Health Background

The Mohawks of Kahnawake have extensive experience in the governance and management of our health and social services this includes 15 years of experience conducting the required Health Transfer Agreement activities for the community and Health Canada.

In 1998 a comprehensive community health needs assessment[4] was conducted and based on this the first Kahnawake Community Health Plan (CHP) was created. The methodology utilized for the entire project was based primarily on the Participatory Action Research (PAR) model. The PAR approach uses qualitative methods to describe situations and communities; focuses on learning how people actually experience the specific issue or problem and incorporates native values of inclusion and consultation in exploratory research in order to build support and long-term commitment to the action that will come about as a result of the research. A combination of qualitative and quantitative methods was used to carry out the overall Evaluation project including;

- An inventory/audit of services
- Extensive literature review

The research revealed a range of health problems and needs that were affecting the community. Key informants, staff and community members were approached to prioritize in order of importance. The 10 health priorities identified were:

1. Alcohol & Drug Abuse
2. Violence
3. Diabetes
4. Mental Health
5. Cardiovascular Disease
6. Cancer
7. STI's, HIV, AIDS
8. Prenatal/Family Planning & Birth Control
9. Obesity/Poor Eating/Bulimia/Anorexia
10. Accidents & Injuries

Although all of the 10 health priorities were important for the purpose of that report the focus was on the top five health issues. In this report other concerns besides the 10 were also identified by frontline workers and was noted as a **growing concern** and would warrant further research and resources beyond the scope of the report, they were:

Kahnawake Transfer Needs Assessment & Health Plan Final Report to Health Canada august 1998. ODS

Scleroderma	Environmental Health Concerns
Rare Forms of Cancer	Brittle Bones
Alzheimer's	Lupus
Muscular Dystrophy	Physically challenged Children
Prescription Drug Abuse	Attention Deficit Disorder with/without Hyperactivity

In 2003, the CHP was evaluated and in April 2004[5], a new CHP was developed. The evaluation looked at what was realized in the plan and revisited the health priorities and needs. Key informants were consulted to verify whether the health priorities remained the same or had changed. The outcome was that the issues were all inter-related and would be addressed concurrently. The key areas remained the same, however, the ranking changed to the following: Alcohol and Drug Abuse, Mental Health, Diabetes, Violence, & Cardiovascular Disease.

The reader may notice that the top five health priorities from the original 1998 Needs Assessment listing remained relatively the same through the years and more currently the remainder of those issues (6-10) of the ten as various activities were conducted the major health priorities and especially when you take a look at the issues identified in the first needs assessment.

Community Health Priorities

As per the Transfer Agreement requirements and in order to renegotiate the funding agreement an evaluation of the health programs and services was conducted.

In 2010, P.L. Hawa & Associates, an independent contractor was hired to conduct this evaluation[6] of the last Kahnawake CHP. The purpose was to evaluate and update the Plan as it relates to the health services delivered, to assess and evaluate the effectiveness of health programs and services and the indicators by undergoing a consultation with concerned stakeholders.

The consultant used a two pronged assessment which involved individual one on one interviews and the facilitation of-focus groups to gather "common" concerns. Approximately 160 individuals participated in the process.

- Sixty (60) individual interviews were conducted with employees from all organizational levels from both organizations (KSCS and KMHC). The discussions 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.

[5] "2004-2005 Community Health Plan for Health Transferred Programs, April 2004." Organizational Development Services

[6] "Report on the Status of Kahnawake Community Health Plan for Transferred programs, 2010". P.L. Hawa & Associates

- Seven focus groups were also conducted:
  - 2 KSCS employee focus groups
  - 2 KMHC employee focus groups
  - 1 KSCS board of directors focus group
  - 1 family center users group
  - 1 Elders lodge users group

- A survey of community members was also conducted where a stand was set up in the lobby of the Kahnawake Service Complex.

- Also as part of the evaluation a review and update of all logic models was also conducted.

Four basic questions were asked of all participants:

(1) What are the community's main health concerns?
(2) What is your opinion as to how they are being dealt with?
(3) Are there any new challenges in health service delivery or health in general?
(4) How do you think these issues could best be addressed?

Based on the consultations during the evaluation a general consensus emerged from the data regarding the health priorities, for the most part, the priorities remained the same however Learning/Developmental Disabilities as a health priority emerged. The health priorities are as follows:

1. **Substance Abuse/Addictions**
   Expanded from alcohol and drugs to include prescription drugs mainly anti-depressants and pain relief type drugs. This health priority is directly related to the Mental Health priority.
2. **Mental Health Issues**
   It has been reported that health care workers noticed an increase and that now includes younger (adolescent) community members.
3. **Learning/Development Disabilities**
   This health issue consistently arose throughout the consultation as one of the top three challenges facing the community, conditions most identified were Attention Deficit Disorder, Autism, Asperger's and Down Syndrome.
4. **Cardiovascular Disease (hypertension)**
   Gained prominence as an offshoot of diabetes prevention initiative and hypertension is now more frequent as a stand-alone condition (non-diabetes related).
5. **Cancer**
   No one type of cancer was identified cancers were all grouped together.

6. **Diabetes**
   Is being well addressed but it continues to be an ongoing concern.
7. **Obesity**
   Seen as 'catch all' result/consequence of other health conditions such as mental health, substance abuse, cardiovascular disease and diabetes, and the breakdown of the family unit.

Community Health Needs

In July 2011 another Consultant was contracted to develop the Community Health Plan for 2012-2022.
The following activities were done;

- Access and review of organizational documents were i.e. annual reports, internal reports, logic models.
- Review and update of logic models
- Review available community statistics
- To gain feedback and explore Kahnawake's community health priorities and needs in more detail than what was represented in the CHP evaluation report consultations were held with the Onkwata'karitáhtshera Steering Committee, KSCS and KMHC Management Teams using a focus group process. The questions utilized are as follows:
  1. *Identify any Infrastructure needs with KMHC and KSCS to support the new CHP.*
  2. *Are there any concerns, issues or needs not covered in the recent evaluation that must be included in the next CHP?*
  3. *If we rank the 7 health priorities for 2010, what would be the top 3 and why?*
  4. *Which logic models and teams currently addressing which of the priorities?*
  5. *What do we need to adapt or create new logic models for those priorities and teams responsible*
  6. *Which teams will be addressing the 3 new priorities and how?*
  7. *Are there any other community health needs that we need to consider?*
  8. *Are there gaps and/or overlaps in service delivery of the 7 health issues/mandatory programs that need to be considered?*
  9. *Any other comments/feedback?*

- A one-day workshop was held on August 18th, 2011 with KMHC and KSCS to determine health and social services offered in each of the seven health priority areas, as well as to identify any gaps and overlaps in service delivery. The 13 participants consisted of directors and managers from the two organizations. For further details, please see the Gaps and Overlaps/Asset Mapping Workshop section of this plan.

As Mohawks of Kahnawake we believe all health issues are all inter-related and should be addressed concurrently; as such one is not more important than the other. We believe that many of the health issues we see today are the result of a breakdown of the traditional family roles and

responsibilities as well as the increased demands of modern day life on our people. However, if we needed to prioritize, the top three issues they would be:

- **Substance Abuse/Addictions** are still considered the number one issue and are connected to mental health issues.
- **Mental Health** was identified as the second health priority and is often a psychological precursor to the other health issues i.e. obesity is tied into diabetes/cardiovascular disease/cancer.
- **Learning/Developmental Disabilities** may be connected to substance abuse/addictions and there has been a noted increase for services.

However until further evaluation proves otherwise all of the health priority issues will be addressed through health programming and can be seen in the logic models.

As recommended additional statistics are being provided for the reader that will support the health priorities identified. Some statistics are from logic models however the majority of the data is from a report completed in 2010[7] which had the most recent available data on social and health problems (this information was collected at the same time that the CHP evaluation was taking place.

Age Breakdown

The next three charts display the population in various forms which helps provide a different picture of our population.

The following table displays the population breakdown by age in 5 year increments, gender and on/off reserve totals for the 2009 Registered Indian population[8].

AGE BREAKDOWN FOR TOTAL POPULATION IN 5 YR INCREMENTS

AGE RANGE	MALE	FEMALE	ON RESERVE	ON CROWN LAND	OFF RESERVE	TOTAL
0-5	261	220	423	1	57	**481**
6-10	264	248	421	2	89	**512**
11-15	321	324	536	1	108	**645**
16-20	388	341	600	1	128	**729**
21-25	340	340	568	0	112	**680**
26-30	312	289	464	0	137	**601**
31-35	304	265	435	0	134	**569**
36-40	348	301	479	0	170	**649**
41-45	350	404	527	1	226	**754**
46-50	438	413	612	1	238	**851**
51-55	361	415	585	0	191	**776**

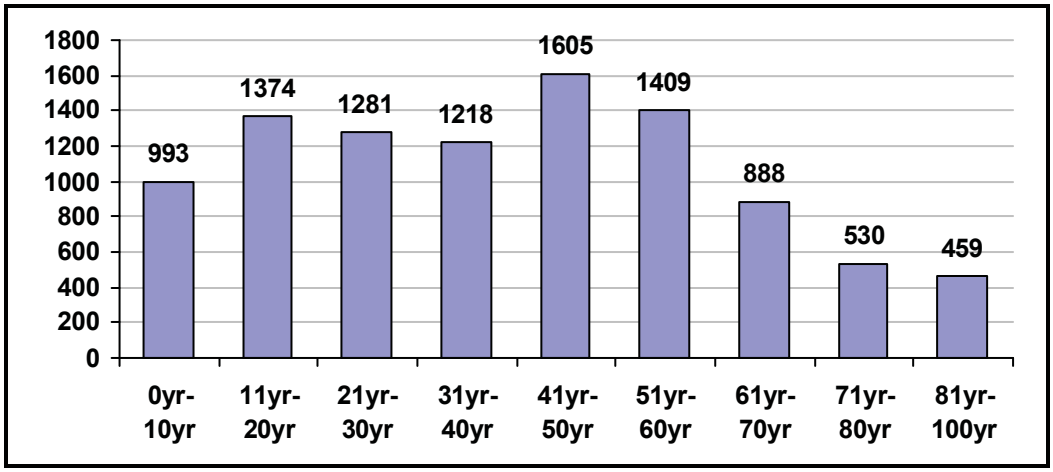
[7]Data sources taken from the KSCS Prevention & Support Services, Kahnawake Child &Family Services (CFS), Enhanced prevention-Focused Approach Action Plans (March 2010).

[8] Source: Population Statistics Report, INAC Indian Register System for December 2009

56-60	296	337	466	0	167	**633**
61-65	200	280	347	0	133	**480**
66-70	160	248	301	0	107	**408**
71-75	111	171	229	0	53	**282**
76-80	84	164	186	0	62	**248**
81-85	57	141	150	0	48	**198**
86-100	77	184	202	0	59	**261**
TOTALS	**4682**	**5105**	**7556**	**7**	**2224**	**9787**

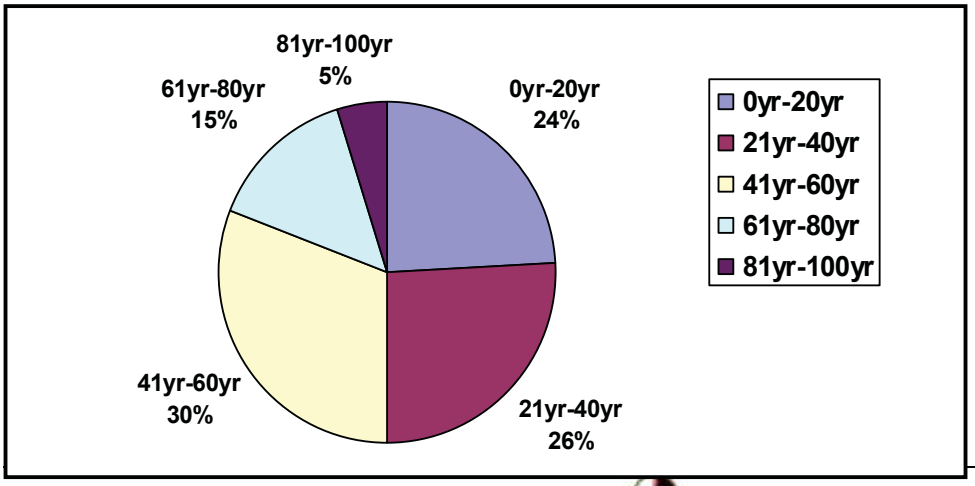
The following bar chart depicts the 2009 population in ten (10) year age increments for the total number of persons within that age group for both on and off reserve.

POPULATION CHART IN 10 YR INCREMENTS



The following pie chart shows the percentage of the population by twenty (20) year age groups for the total population which includes both off and on reserve numbers. When the data is displayed in this format one can see that the largest grouping is the 41-60 year olds making up 30% of the population followed closely by the 21-40 year age group with 26 % and 24% being the 0-20 year old age group.

PERCENTAGE OF POPULATION IN 20 YEAR INCREMENTS



One of the interesting items noted for Kahnawake's population is that more than half (56%) of the population is aged 21-60 years of age.

Birthrate

The number of births each year is collected by the Community Health Unit (CHU) of the KMHC. The CHU receives birth notices from hospitals in the surrounding area based on the mother's postal code (indicating Kahnawake). The CHU then uses this information to provide newborn home visits.

The birth rate over a five year period is shown in the table below along with a further breakdown of the number of births to teen mothers (13-19 years old). The average birth rate for years 2005-2009(on reserve) has been 92 births per year.

KAHNAWAKE BIRTHRATES

Year	Total # of Births	# Born to Teen Mothers	% Born to Teen Mothers
2005	77	9	12%
2006	95	15	16%
2007	97	11	11%
2008	91	13	14%
2009	100	20	20%

The birthrate based on statistics maintained by INAC over the last ten years for the total population (both on and off reserve) on average has been 99.4 births per year.

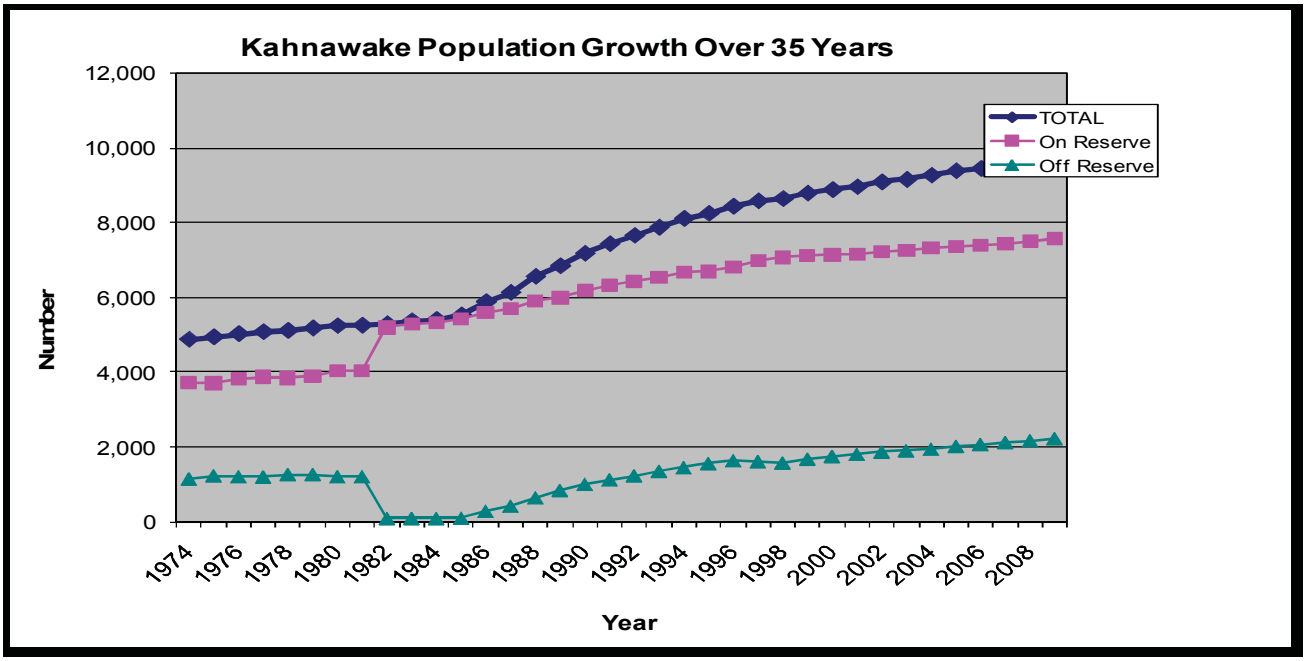
In 2009, there seemed to be a significant increase in the percentage of total births born to teen mothers (20%). It remains to be seen if this will be a future trend.

Kahnawake Population Growth

The graph below illustrates the total population for the last 35 years[9]. The community has had a steady growth rate in total population from 4,868 in 1974 to close to 9,787 people by 2009 (totals for both on and off-reserve). Kahnawake's' population over the last 35 years has more than doubled.

KAHNAWAKE POPULATION GROWTH

[9] Source: INAC, Indian Register (Total Population Counts) 1974 to 2009.



KMHC Diabetes Education Program Data[10]

	Prevalence (all cases)	Incidence (new diagnosis)					
at end of Aug 2011		**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Type 1	11	0	0	0	0	0	0
Type 2	503	23	25	40	25	11	24
transfer	n/a	5	5	6	2	1	1
IFG	120	11	16	25	6	6	14
IGT	23	1	2	1	1	0	0

Transfer meaning clients previously with Impaired Fasting Glucose (IFG) or Impaired Glucose Tolerance (IGT).

24-hour Ambulatory Blood Pressure Monitoring

	2009-10	2010-11
New Referrals	111	56
Monitored	81	45
Did not arrive for appointment	8	2
Cancelled	5	0
Refusal	2	0

KMHC Diabetes & Hypertension Data[11]

Screening programs		date	# of sessions	# registered/ referrals	# of participants	New DM	BP @ risk or have hypertension
Diabetes & hypertension	booths	2010-2011	21	n/a	500+	0	60%

[10] These two tables are from the Diabetes Education Logic Models submitted in the 2012-2022 CHP
[11] This table is taken from the Adult Prevention Program Logic Model submitted in the 2012-2022 CHP

Psychological Services

Review of financial records specifically for Psychological Cases/Services helped to identify the top problem issues seen by Psychological Services at KSCS. Percentages of the total amount spent on Adult and Child psychological cases were used to identify the top ten issues/problems for years 2007, 2008 & 2009.

TOP 10 ADULT & CHILD PSYCHOLOGICAL CASES BASED ON % SPENT IN TOTAL BUDGET

Period ending Mar 2007		Period ending Mar 2008		Period ending Mar 2009	
Cases	%	Cases	%	Cases	%
1. Depression	.22	1. Behavioural	.20	1. Depression	.20
2. Behavioural	.17	2. Depression	.19	2. Behavioural	.18
3. Anxiety	.11	3. Anxiety	.16	3. Family Therapy	.13
4. Sexual Abuse	.10	4. Adjustment Reaction	.07	4. Anxiety	.10
5. Adjustment Disorder	.07	5. Sexual Abuse	.07	5. Parental Capacity	.09
6. Family Therapy	.06	6. Family Therapy	.05	6. Adjustment Reaction	.08
7. Parental Capacity	.06	7. PTSD	.04	7. Anger Management	.05
8. Personality	.04	8. Parental Capacity	.03	8. Personality	.04
9. Self Esteem	.03	9. Personality	.03	9. Sexual Abuse	.04
10.Grief	.03	10.Self Esteem	.03	10.PTSD	.03

KSCS Addictions Services

- The Addictions Response Team (ARS) has documented a noticeable increase in clients with a substance abuse problem (alcohol and/or drugs) who are also being prescribed psychiatric medication and/or analgesics. It is important to note the issue is not the use or abuse of prescription drugs in Kahnawake, but the noticeable increase in psychiatric medications being prescribed and people with dual diagnosis.
- The two most prescribed categories of psychiatric drugs are Antidepressants and Benzodiazepines/Anti-Anxiety. This finding coincides with the general observations at KSCS that the top two presenting mental health issues clients seek treatment for are depression and anxiety.
- The interpretation of these findings is limited for a number of reasons. It is not possible to determine causes of the increase in the prescriptions for psychiatric medications or analgesics. For most of these drugs there is no way of knowing the specific purpose/intent of the doctor who prescribed it. It is also known that in Canada, 95% of psychiatric medications are prescribed by family physicians (not psychiatrists). Many of the drugs are used broad spectrum to treat a multitude of conditions. For example antidepressants are used to treat more than just clinical depression. For this reason we cannot say that there is an increase in clinical depression in the community based solely on the increase in antidepressants prescribed however it is nonetheless important to continue to monitor.

KSCS Suicide Statistics

The following chart reflects a four month period (April 2011 to august 2011) from the Family Services Prevention Status Intakes

Gender	0-12	13-19	20-49	50+	Suicidal Ideation	Attempt	Other	Completion	Total
Male	0	2	4	1	7	1	2	0	7
Female	0	3	3	1	7	1	0	0	7
Total	**0**	**5**	**7**	**2**	**14**	**2**	**2**	**0**	**14**

The following are numbers were drawn from the Status Meeting Minutes.

	April 2009 to March 2010		March 2010 to Feb 2011	
	Male	Female	Male	Female
Suicide Ideation	12	13	10	16
Attempts	1	2	2	1
Other (cutting, hot line)	0	3	0	5
Completed	1	0	2	0
Total	**14**	**18**	**14**	**22**

Kahnawake Fire Brigade & Ambulance Service Statistics

The **total calls** in the chart are made up of other categories as well and therefore the number reflects all of the calls received for that year. Mental Health calls were described as self-inflicted wounds, depression, suicide and abnormal behaviour.

MOST COMMON KFB & AS CALLS & RESPONSE #'S FOR A PERIOD OF 5 YRS

Category	2005	2006	2007	2008	2009
Cardiac	n/a	n/a	93	150	138
Respiratory	n/a	n/a	108	113	143
Road Accidents	n/a	n/a	83	105	99
Trauma	n/a	n/a	215	253	219
Mental Health	n/a	n/a	55	69	49
Total calls:	**1158**	**1160**	**1175**	**1252**	**1352**

Peacekeepers (PK) Statistics

The Kahnawake Peacekeepers are the police service who respond to emergencies and are responsible for maintaining peace within the territory. The Peacekeepers maintain their own statistics in a database. The table below is a general list of the types of crime or other calls that they responded to over a 3 year period.

PEACEKEEPERS RESPONSE GENERAL CALLS/CRIME #'S

Types of Calls	2007	2008	2009
Alarms	539	425	420
Assault	99	106	150
Break and Enter	18	32	37
Counterfeit Money	12	11	9
Disturbing the Peace	6	7	12
Drugs	18	34	31
Execution of Warrants	115	107	130
Fraud	28	23	17
Impaired Driving	68	72	58
Mischief	93	127	90
Motor Vehicle Accident	356	258	276
Public Assistance	307	298	326
Robbery	3	10	13
Theft	73	84	69
Theft of Motor Vehicle	20	14	18

It is important to note that the PK's respond to all calls within the territory of Kahnawake, and the numbers include service to many non-community members. For example, the number of motor vehicle accidents and public assistance calls is likely elevated due to the fact that Kahnawake has major highways intersecting the community and a large number of commuters travelling through the territory each day.

Learning and Developmental Disabilities

Given that learning and development disabilities was highlighted as a priority for the community, further discussion with the Kahnawake Education Center ensued to gather statistics related to this situation. According to the Kahnawake Education Center, Kahnawake had an enrolment of 771 on reserve children with 249 children with an identified special need.

ON RESERVE ENROLMENT #'S FOR KAHNAWAKE SCHOOLS[12]

	Karonhia-nonha	Kateri	Indian Way	Karih-wanoron	Survival School (KSS)
Nursery	32	14	4	4	-
Kindergarten	25	23	5	6	-
Gr.1	23	36	5	1	-
Gr.2	18	24	4	6	-
Gr.3	26	35	9	5	-
Gr.4	12	26	6	3	-
Gr.5	27	39	6	2	-
Gr.6	27	37	8	3	-
Gr.7	-	-	-	-	47
Gr.8	-	-	-	-	64
Gr.9	-	-	-	-	57
Gr.10	-	-	-	-	60
Gr.11	-	-	-	-	42
Totals	**190**	**234**	**47**	**30**	**270****

**includes 7 students from Kanesatake

The number of special needs students per school is as follows:

- Kateri has 112 special needs
- Karonhianonha has 11
- KSS has 126 special needs

Each category will be listed by the top 5 difficulties encountered.

Elementary School Gr. K4 thru Gr. 6	Middle School Gr. 7 & 8	Secondary School Gr. 9-11
1) Moderate to Severe Learning Difficulties 2) Mild Learning Difficulties 3) Mild Behavioral Difficulties 4) Behavioral Difficulties and Specific Learning Difficulties or Significant Academic Delays and 5)Specific Language Disorders	1) Moderate to Severe Learning Difficulties 2) Behavioral Difficulties and Specific Learning Difficulties or Significant Academic Delays 3) Mild Behavioral Difficulties 4) Moderate to Severe Behavior Difficulties and 5) Developmental Disabilities	1) Moderate to Severe Learning Difficulties 2) Behavioral Difficulties and Specific Learning Difficulties or Significant Academic Delays 3) Moderate to Severe Behavioral Difficulties 4) Mild Learning Difficulties 5) Mild Behavioral Difficulties

[12] Source Kahnawake Education Center

Organizational Needs

In August and October 2011, consultations were held with the Onkwata'karitáhtshera Steering Committee, KSCS and KMHC Management Teams to gain feedback and explore Kahnawake's community health needs in more detail than what was represented in the CHP evaluation report. These facilitated groups were asked to take a look at what additional organizational infrastructure is needed within these community organizations to support the new CHP and to identify concerns, issues and needs that were not covered in the recent evaluation and that must be included in the CHP. The remainder of the group work was to prioritize health issues and determine logic models to address the priorities.

Analysis of data from the consultation revealed a large number of needs and additional resources that would greatly enhance the level of service currently being offered by community health organizations. These needs could be categorized within the following general areas: Global, Health Service, and Infrastructure. Each of these categories is broken down further in the charts below.

The **Global Need** for a fully functional Onkwata'karitáhtshera Secretariat is placed first as this item is viewed as an integral piece to ensuring that the remaining health priorities and needs are fulfilled. It is important to note that for the Health Service and Infrastructure categories, the needs that fall within each have not been placed in any particular order. It is not possible without further consultation to say that one need is more important than another within each category, as each is of significant importance to the managers and directors who are working in these areas.

GLOBAL NEED (TO SUPPORT ALL OTHER HEALTH NEEDS)

Onkwata'karitáhtshera Secretariat (Governance Support)

A fully functional Secretariat would work to ensure the health priorities are addressed and results are achieved. Due to the unique community structure and having a local hospital (a situation that does not exist with most other First Nations) the workload in community health is much heavier. The current management structures of the different community health organizations are experiencing extreme workload burden in trying to meet the needs of coordinating the CHP, the increasing demands by Health Canada in terms of reporting and accountability and at the same time integrating with the Provincial Health System. Additional manpower for coordination is critical. As previously noted there are presently only 2 support staff that assist in carrying out all aspects of Onkwata'karitáhtshera operations including support to the numerous subcommittees.

An operational diagnostic report on Onkwata'karitáhtshera prepared by P.L. Hawa & Associates in 2010 indicated that "*there exists a need for a fully functioning, independent Onkwata'karitáhtshera, aligned to its original objective – that is to act as Kahnawake's primary health commission."* It is also recognized within this report that Kahnawake is in need of a strong centralized structure to provide oversight and long term service policy direction. In order to accomplish this, it is estimated that funding in the area of $300,000 annually is necessary to meet the needs of such a Secretariat.

The following is a breakdown of the various components of this need.

Need	Description	Cost
Staffing & Human Resources	3 to 4 staff positions to support the overall administrative and coordination support to Onkwata'karitáhtshera through the operation of a Secretariat. Onkwata'karitáhtshera Secretariat would be responsible to ensure health priorities are achieved. Some initial responsibilities identified for these positions include but are not limited to: ▪ Developing strategic frameworks for each of the health priorities (major goals) by bringing stakeholders together (including federal and provincial	$275,000 annually

	representatives) ▪ Assist Onkwata'karitáhtshera table with planning (conducting action research). ▪ Research both internally and externally to assist Onkwata'karitáhtshera with decision making, and to create briefs on the research conducted. ▪ Oversee files for the various subcommittees and assist with decision making.	
Operations	Includes space rental, utilities, equipment and supplies.	$25,000 annually

Health Service Needs can be described as those health services that are required to enhance the existing services in the community. While Kahnawake has many health services, it is known that some gaps exist and the population would be better served if these gaps can be filled.

The following chart elaborates on Kahnawake's Health Service Needs:

HEALTH SERVICE NEEDS (ENHANCEMENTS TO EXISTING SERVICES)

	Need	Description	Cost (Salaries do not include benefits and prerequisites)
a.	Integration of mental health programs/ services	Mental health programs and services are offered through both KSCS and KMHC. An integration of the two would improve collaboration/quality of service by utilizing the successful Home and Community Care integration approach e.g. case management and personnel in one locale.	To be determined
b.	Nutritionist dedicated to community initiatives	In light of Obesity identified as a new health priority, the workload and demand for community nutrition services will increase creating the need for an additional nutritionist at KMHC on a part time (4 day) basis. A nutritionist was hired in 1988, with the specific objective of introducing nutrition education to the schools. Since 2000, the community has benefited from the services of an additional nutritionist who has been funded on a yearly basis through	$78,326 annually

		ADI (Aboriginal Diabetes Initiative). The objectives in community nutrition are to create healthy eating environments for children at school, at home and in the community; and to serve as a nutrition resource and support community efforts to promote a healthy lifestyle and reduce the top health problems in the community. Nutrition education is promoted in the community through health and nutrition events, presentations to community groups, and nutrition classes and activities in the schools. The community nutritionist is also a resource for schoolteachers and community organizations, and develops and implements nutrition projects and programs.	
c.	Clinical Psychologist	The addition of 1 full-time Psychologist at KSCS is needed to address the health priority need of mental health issues. Currently there is no psychologist in place to facilitate or manage overall psychological cases i.e. to ensure there is a comprehensive strategy in place to efficiently coordinate services. In 2010-2011 there was a 27% increase (165→210) from the previous year (2009-2010) in psychological services. The top problem issues consistently identified were behavioural, depression, parental capacity and anxiety.	$70,470 annually
d.	Addictions Clinical Supervisor	The addition of 1 full-time Addictions Clinical Supervisor at KSCS is needed to solidify the existing Addictions Response team and deal with increasing mental health issues which, in most cases, identifying dual diagnosis. Addictions has been identified as the number one health related problem in our community for many years, and more recently highlighted as the number one health related problem in the last 2 Community Health Plans. When analyzing the ARS team's combined workload, we must take into account	$88,349 annually

		both on-going cases they have been providing service to, as well as new cases within the current fiscal year. The following data is reflective of 11 months of service (does not reflect any new cases for the month of March 2011). ▪ a total of 130 different requests for addictions response service within fiscal year 2010-2011, with 74 clients being newly assigned in that year, this works out to an average of 32.5 cases per worker ▪ age range of clients varied between 13 years old to 67 years old. ▪ of these 130 clients, 84 clients (65%) had alcohol as their primary drug of choice and 55 clients (42%) had cocaine as either their primary or secondary drug of choice. This indicates that many clients do not present with a single substance addiction, which can complicate detoxification, treatment and/or follow-up. ▪ of the 130 clients, 61 (47%) have a known or suspected concurrent mental health disorder. With almost half the clients in the past year with a known or suspected mental health disorder, this definitely complicates the detoxification, treatment or follow-up process, but also demands an increase in time and resources to effectively create change. KSCS' approach to address addictions problems within the community is multi-tiered, multi-disciplined and involves both prevention activities and intervention activities. The current team that provides direct intervention services to clients requesting support for addictions recovery is comprised of 4 Addictions Response Services (ARS) Workers. A consultant was contracted in the past to work with this team and had been instrumental in the following areas; developing the capacity of the individual ARS staff members, raising awareness of addictions recovery techniques and issues for all of KSCS and providing quality direct clinical supervision. However it has been identified that there is the need to have a full time Addictions Supervisor in place. Given how far the services have advanced and its successes along with the steady number of requests for services, an Addictions Supervisor in place to continue the work that the consultant had started would be the best	

		option.	
e.	Mental Health Nurse	The addition of 1 full-time mental health nurse is needed considering the rapid increase in the number of intakes by mental health nursing since 2006. This position would be full time, including replacement costs. There has been an overwhelming 240% increase in intakes from 2006 to 2011 for clients that require a mental health nurse in their care. The numbers of referrals are as follows: 2006: 1 2007: 3 2008: 3 2009: 14 2010: 18 2011: 24 in a 6 month period.	$102,803 annually
f.	Volunteer Coordinator	There is an increasing need for volunteers to assist community health programs such as providing support/escort services to community members (for example, home care clientele) to medical appointments in/outside of the community. The cost involved would be the increase from a part time to a full time position. Presently working part time (2 days per week) does not give enough time to effectively organize volunteers. Volunteers also need support and supervision with the volunteer coordinator present. From 2005-2006 (558.25 hours) to the present 2011 (2210.1 hours), there has been a 34% increase in volunteer hours (1,652 hours).	$39,307 annually
g.	Physician Recruitment and Retention Strategy -	The physician incentive fund needs an increase of 38% or $64,600 annually. This strategy/fund was established in 2005-2006 as KMHC was experiencing great difficulty in recruiting and retaining physicians; this problem was attributed to the overall shortage of physicians allowed to work in the Province and the inferior billing rates a physician receives in a hospital out-patient clinic such as KMHC versus private practice. As far back as 2005, KMHC has had to decrease the number of evening clinics and day clinics were also understaffed with at least one morning per	$64,600 annually

		week without a physician which continues today. This situation plays havoc with access to and continuity of care for community members, especially those with chronic illness. To turn things around, the community implemented the physician incentive fund of $170,000 annually and provided physicians financial incentives based on each physician's commitment to work in the community. The fund amount has remained the same since 2005. KMHC is proposing increased funding based on inflation and the fact that the strategy has been successful. Looking back, KMHC has experienced retention of 5 of the 11 physicians present in 2005 and were able to retain 5 of the 8 physicians recruited since then. The full benefits of this strategy were somewhat mitigated by the fact that we had six overlapping maternity leaves, 4 out of 6 of these physicians were back as of September 2011.	
h.	Strategic Community Health Careers Program	With the upcoming expansion of KMHC, there will be a significant increase in the demand for nurses and other health care workers in Kahnawake. There is a nation-wide shortage of nurses and other health professionals and Kahnawake is not immune. To meet this challenge, the Kahnawake Education Center, Tewatohnhi'saktha Employment & Training Division and KMHC formed a partnership with the goal of strengthening our health care workforce. Strategic Community Health Careers (SCHC) was initiated in September 2010 to maximize the opportunities presented by existing and expanding health careers in the community. Through this collaboration, SCHC is being pro-active in promoting health career awareness to students at both the high school and elementary levels, and in providing academic and financial support to post-secondary students in health career programs. To recruit students and provide support in their academic endeavours, SCHC has been working closely with Champlain College, St-Lambert, which has a new Nursing Program starting this Fall, and preparatory courses were offered at Kahnawake Survival School (KSS), through John Abbott College, to give prospective students an opportunity to upgrade academically and ensure they have the credits needed to enter Nursing or other health programs. Tutoring was provided as needed. Eight of these students have been accepted into Champlain's	$40,000 annually

		Nursing Program. Other program events included setting up an information booth on the project at the 2011 KSS Career Fair and upcoming presentations are planned for high school students at the Kahnawake Library and KSS, as well as an interactive display for younger students at the Kahnawake Youth Center. SCHC will continue to provide important information to the community, encourage students, and support their efforts as they venture into their studies and training that will prepare them to be part of a vital health care force. Plans are also underway to offer scholarships to students enrolled in health career programs. Given the above, we want to continue with this valuable partnership; to also involve KSCS and to include the promotion of the social work profession. As well, provide financial support for the program for at least the next five years; i.e. $40,000 annually.	
i.	Preconception Health Program	Enhancement is needed to the KMHC Preconception Health Program with a part-time 1 day/week community health nurse and overhead costs. The missing aspect of care is individual counselling. With the promotion of preconception health, messages would include a contact at KMHC for any questions or concerns. Physicians would be encouraged to refer anyone needing counselling.	$20,044 annually
j.	Prenatal Clinic Nurse	An increase from 1 day/week to 2 days/week is needed for the prenatal clinic nurse. KMHC presently has a physician that delivers at Centre Hospitalier Anna-Laberge (CHAL) which is the nearest hospital to Kahnawake that delivers babies. Previously, KMHC clients would see physicians in Chateauguay that delivered at CHAL. Last year, a KMHC physician did 254 (65.8% of all prenatal visits done at KMHC) prenatal visits. So far this year, in 7 months, she has done 230 prenatal visits. KMHC also has two other physicians who see prenatal clients. To improve health outcomes for all moms and babies who come for prenatal appointments, KMHC wants all prenatal clients to be able to see a specialized prenatal nurse.	$20,044 annually
k.	Well Baby Clinic Enhancement	Increased accessibility to the Well Baby Clinic by 1 day/week is needed; this clinic is presently offered 3 days/week.	$20,044 annually

		KMHC is experiencing a notable increase in the number of babies that are being delivered by physicians who also work at KMHC. This has resulted in an increased number of families bringing their newborns for follow-up care at the KMHC Well Baby Clinic (WBC). For example, in 2004-2005 there were 798 WBC visits and in 2009-2010 there were 938 visits, It is becoming increasingly difficult to provide timely appointments with the present level of service. This is especially important for the 1 month visits that would have been followed up with the physician that delivered the baby (previously in Chateauguay).	
l.	Diabetic Foot Clinic	There is a need to institute a permanent Diabetic Foot Clinic that would operate 2 days per week. The costs would include salary & overhead. This clinic started as a project with Aboriginal Diabetes Initiative Funding due to non-insured health benefits cutbacks in podiatry. From 2009-2010 to 2010-2011, there has been a 38% increase (39 to 54) in the number of clinics held, a 32% increase (124 to 164) in the number of patients receiving care and a 40% increase (316 to 444) in the total number of visits.	$40,088 annually
m.	French Language training	Intensive French Language Training is critical and necessary for Kahnawake organizations under Onkwata'karitáhtshera. The primary languages used in Kahnawake are historically Kanien'keha (Mohawk language) and English, while the community is surrounded primarily by the French language. Kahnawake as an English speaking First Nations community in Quebec is faced with a major challenge to participate as a full partner with the provincial health and social services system. Senior management is expected to interface with their provincial counterparts and stay abreast with health issues within the province. As the majority of the existing health forums are presented primarily in French, Kahnawake managers have been marginalized in the past. The same holds true for any legislation impacting health and social services. The law is presented bilingually; however, all supporting and resource documents are in French only. This creates service delivery limitations as was demonstrated in the Pandemic Response and Planning. The Kahnawake Aboriginal Health Transition Fund Evaluation Report 2011	$46,380 (for 6 people). Replacement salary costs to be determined

		reinforced this finding and recommended increasing Manager/Director fluency in the French language through access to French language training as a means to combat this issue. It is our understanding that an employee of the provincial and federal government could be mandated to attend an intensive language course for which they would be required to take a leave of absence from their full time position. The French Language training would be best suited for staff positions under the umbrella of Onkwata'karitáhtshera and its member organizations, targeting upper management. In addition to compensating a staff member while attending full time training there would be the supplementary financial cost of backfilling these positions. Any language training should be staggered over several years by sending one senior manager to attend training at a time and then waiting a year before sending another to training. McGill University School of Continuing Studies offers a full time Intensive French Language program comprised of five levels which upon completion a successful student will receive a Certificate of Proficiency in French. The cost of the program for all five levels and application fee is $ 7,730.00 per person x 6 people for a total of $46,380.00.	

Infrastructure needs can be described as the basic physical and organizational structures needed for the operation of the community, or the services and facilities necessary for an organization to function. It can be generally defined as the set of interconnected structural elements that provide a framework supporting everything else. For Kahnawake, the infrastructure needs include the physical assets such as information systems and technology infrastructure (which are essential tools), as well as the new facilities and resources which will allow for greater community responsiveness to long standing health needs.

The following chart elaborates on Kahnawake's health infrastructure needs:

INFRASTRUCTURE NEEDS (INFORMATION SYSTEMS & TECHNOLOGY)			
	Need	**Description**	**Cost**
a.	Electronic health records (Logibec for health systems)	The introduction of an electronic health record (EHR) system within KMHC, as well as the teaching of the use of such technology, is a huge and complex project, albeit an inevitable one, as an EHR will be the standard in health-care delivery in the near future. At this point, KMHC does not have an updated dollar figure to implement such a system. It is believed there will be a province-wide deployment. In the past, KMHC has been quoted $700,000 to pursue the system on its own.	$700,000
b.	Database system with resources (developmental & maintenance)	It is often challenging to strategize and plan prevention/intervention services effectively when critical information (trends, incidence, prevalence, population profiles) is limited or not available. Many community organizations are data rich but information poor; meaning the data is there but no one dedicated to its compilation, analysis and interpretation. Sifting through files (computer and hard copy) and collating the data takes a lot of time because it has to be done manually. The majority of human resources are targeted to frontline services and their support there is little or no time left for the compilation of data generated. There is also an ever increasing demand to collect and analyze statistical information to justify funding. Without the available human and technical resources to manage the data systems, the existing data serves no one. When services can successfully and consistently identify ways to improve a program by determining what works, what doesn't work and why, they can actually reduce costs and reallocate resources to prevention efforts or other identified areas of need. KSCS and KMHC are two different facilities with different needs, however both need to improve, synchronize and coordinate the management information system(s)	$1,000,000+

		currently in place so planning efforts are provided with compiled, analyzed and interpreted data. Doing so will result in the following long term outcomes: • Increased use of meaningful data analysis in decision-making re: policies, programs and services. • Planning and reporting practices well integrated and consistent throughout the organizations. • Improved prevention and support services that will ultimately lead to addressing the priorities identified in the CHP. • Statistics to support the above. It is anticipated that a project this size will require a number of human resources over a long term but more specifically one full time statistician/evaluator/ researcher and database consultant(s) to work with internal subject matter experts. Depending on the research (needs assessment) a pre-packaged or tailored database system can be purchased; however, this will also require an upgrade of the current system in place and possibly a new server. The costs could easily fall within the range of 1 million dollars.	
c.	Software licenses for computer programs	There is a need for licensing upgrades for word processing & e-mail, presentation software, and an upgrade to the server. For KSCS, every employee should have a licence for software; presently this is not available for all staff. An upgrade to the basic Microsoft Office 2010 (word, excel, power point, outlook one note and publisher) would need licenses at approximately $498 per computer. For KMHC staff under transfer, the cost would be $6,972. Communications would also need special programs by Adobe called Design Standard and Master Collection totalling $9,097. There are 60 (46 KSCS and 14 KMHC) employees who are salaried under Health	$38,977 approximately Needs at KMHC are $3000 per year for message system licenses and approximately $3000 every five years for software licence updates.

		Transfer (the CHP).	
d.	Smart board with videoconferencing	KSCS currently does not have a Smart Board or Videoconferencing capabilities. KSCS has to access the use of these resources through the few other organizations in the community, some of which have service charges. The advantages of having a Smart Board are numerous. Lessons and presentations can be prepared well in advance and reused and updated as needed. The ability to combine sound, video, interaction and Internet gets and keeps the attention of participants more than traditional media. The interactive whiteboard works with any program loaded or available on the host computer. Some applications commonly used with the Smart Board are Microsoft PowerPoint, Excel, Word, and AutoCAD. Uses include teaching, training, conducting meetings, and delivering presentations. Video conferencing is a communications technology that integrates video and voice to connect remote users with each other as if they were in the same room. Each user needs a computer, webcam, microphone, and broadband internet connection for participation in video conferencing. Users see and hear each other in real time, allowing natural conversations not possible with voice-only communications technology. Video conferencing helps save time and money on travelling and housing costs by bringing people face-to-face virtually. Many prominent universities have adopted video conferencing as an educational tool to be used in conjunction with online courses. KSCS does a lot of work with, and for the community, and both the smart board and video conferencing tools will definitely provide staff the capabilities to do their work more efficiently and effectively. Furthermore KSCS will also be able to offer these resources to the many community members, organizations/agencies that already use our facilities. For example, from 2005 to 2008, there were on average 163 room bookings with more than 5,000 people a year coming into the organization (numbers do not include internal staff room bookings). There has been a decrease in room usage externally over the years due to other organizations within the	Smart board (approximate cost $15,000) Video-conferencing (approximate cost $30,000 plus annual fees)

		community incorporating space for meetings and trainings; however KSCS still has been averaging well over 100 room bookings per year with over 3700 people using our facilities. Both tools would enable the following: • provide staff up to date resources when offering training to community members or other remote communities • staff to participate in online training sessions themselves without the added time for off-site training and additional expenses • offer other organizations/agencies and community members access to these resources • be used in day-to-day operations, as well as in any emergency response situations that may arise within the community i.e. pandemic	

INFRASTRUCTURE NEEDS – FACILITIES & RESOURCES (NEW)			
	Need	**Description**	**Cost**
a.	Mental health facility/resources for acute care	The shortages faced in all acute care hospitals at this time also affect Kahnawake's mental health clients. The two main hospitals that KMHC sends patients to are Centre Hospitalier Anna-Laberge (CHAL) and the Montreal General Hospital (MGH). Both these hospitals have a limited amount of acute care mental health beds which are usually full. When this occurs, community members have to be assessed quickly in an emergency room and are usually discharged prematurely. As a result, these persons often end up back in the emergency room after discharge, at their physician's office at KMHC or in trouble with the law. If KMHC had a facility in the community to receive the client back after an ER visit or admission to CHAL or MGH hospitals, these patients would receive a treatment plan for after care in their own community.	To be determined

b.	Foster care facility for adults with limited mental capacity (Alzheimer's, dementia)	A foster care facility would meet the needs of people with early dementia or Alzheimer's that are staying long term at KMHC but do not require hospitalization. Their families have no other option open to them to deal with this type of illness. These patients require a closed facility because they may wander. It is estimated that approximately 39 individuals may fit into this category currently. This number includes people who may already be in existing facilities but would do better in foster care. Considering that such a facility usually houses approximately 10 people, the number of 39 potential residents proves that there is definitely a need. At present there is no facility to meet the needs of this population so they are put on the list for Long Term Care at KMHC when they do not necessarily have to be in a hospital. Statistics show that 20% (2,096) of the population are 60 years of age and older and represents the group likely to require this type of specialized care.	To be determined
c.	Facilities and resource personnel for severely disabled/ handicapped	KSCS provides support services to individuals and their families living with developmental delays and special needs through Assisted Living Services (ALS). Through a team of case workers, needs are assessed, a service plan is developed and clients are linked to services appropriate to their needs and abilities. Resources utilized within ALS include the Young Adults Program (YAP), the Teen Social Club (TSC), Inclusion Support Workers (ISW), and ALS Case Workers. In the 1990's the province closed most of the residential care facilities that were taking care of individuals with special needs. At that time many of Kahnawake's community members were relocated back on reserve with their families and the support of KSCS. Some of those same individuals are now living with aged parents who are voicing growing concern and anxiety over who will care for their children when they are no longer able. The responsibility and concern is shared by KSCS/ALS. Although these clients are presently receiving the maximum amount of available services, this is inadequate to address their growing need for care. Specifically, these individuals have significant developmental delays; all are non-verbal and about half have physical disabilities that make them dependent for meals and	To be determined

		general personal care. At this time Kahnawake lacks a residential type facility to care for this special needs population. Outside resources are extremely limited and KSCS lacks the financial resources to pursue outside placements on an individual, case by case basis. ALS Client Statistics: - On-Reserve Clients: 44 - Respite Services: Weekends: 5 Summer Camp Respite: 4 - Off- Reserve Placements: 4 - Receiving Inclusion Support Service: 17 - YAP Participants: 17 - TSC Participants: 8 - Families Requesting Residential Placement: 8 Kahnawake has always maintained responsibility for its people. This is historically and culturally supported through our commitment to the seven generations ahead. Current community resources and funding agreements however do not make it possible for the placement on reserve of our most vulnerable population. In fact, our current funding agreements also make it cost prohibitive to place these high need clients off-reserve as well. Although it is reasonable and logical to expect that this clientele had the right to receive services on-reserve comparable to those living off-reserve, the present reality is much different.	
d.	Adult Wellness Clinic	A feasibility study for an Adult Wellness Clinic will be completed by March 31, 2012. It is anticipated that this new program would require a full-time chronic disease management nurse, administrative support and overhead.	Full time nurse: $89,813 annually

		It is anticipated that the Clinic would offer clients the opportunity to meet with a Community Health Nurse after each doctor's visit where teaching, promotion and prevention activities would occur, based on the client's individualized needs. This approach would not only support the needs of well adults but would enhance the continuity of care of clients suffering from chronic diseases. Out-patient clinics presently average 35 to 50 clients per day.	Full time administrative support: $46,737 annually

Gaps and Overlaps / Asset Mapping Workshop

A one-day "Gaps and Overlaps / Asset Mapping" workshop was held on August 18th, 2011 with KMHC and KSCS to determine health and social services offered in each of the seven health priority areas, as well as to identify any gaps and overlaps in service delivery. The 13 participants consisted of directors and managers from the two organizations. It was determined that strategic frameworks for each of the health priorities need to be developed in order to make linkages. The process should begin at the start of the next fiscal year (April 2012). Facilities to house aggressive mental health clients, foster care for older adults with early Alzheimer's/dementia, and a treatment center were identified as gaps. A consistent gap was the need for a database for health and social services, and appropriate resources for data analysis.

The second component of the workshop was an asset mapping process to identify community and positive aspects in Kahnawake that will aid in the planning and delivery of health programs. The information generated from the workshop will help in continuing to address the health priority areas in the most efficient manner possible, and also to developing key partnerships in the community. They also examined the opportunities, supports and sustainability, as well as any barriers and challenges. Evaluation results indicated that it was important for key leadership of Onkwata'karitáhtshera to come together and discuss what is being done at all levels in the organizations to ensure collaboration. Within the time frame allotted, it was a good start but there is a need for follow up sessions at Onkwata'karitáhtshera to fully explore the issues. Overall, the information emanating from the session will be useful data in future community health planning. A comprehensive report was compiled and forwarded to Onkwata'karitáhtshera. A copy of the Gaps & Overlaps/Asset Mapping report is located in *"Kahnawake Community Health Plan"* as Appendix O.

In addition to the above mentioned workshop, Kahnawake undertook a process to identify all the numerous partners within the community, within the provincial health care system and within the government level. It is of prime importance that these partnerships are presented in a usable format and the nature of the collaborations be explained, so that the information can be used to create a more comprehensive community health plan. Further discussion regarding Assets and Resources will be described later in the Community Health Plan in the section regarding Management and Delivery of Primary Health Care and in appendix R.

Key Findings

Key findings from the evaluation and analysis of the workshop sessions are highlighted below:

- 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. It is believed that the increased dependency is the result of a breakdown of the family unit as well as the increased demands of modern day life.

- Health care workers have experienced 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 (adolescent) community members.

- In the 2010 evaluation, Learning/Development Disabilities 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's and Down Syndrome were the conditions most often identified.

- Current projections in Kahnawake indicate that there exists a need for, and could easily utilize, a 10-bed residential care facility for individuals with developmental delays. At present, the cost to house 4 developmentally delayed individuals off-reserve, amounts to approximately $486,000 annually. It is recommended that KSCS look further at the operational and associated costs of establishing and staffing our own residential care facility.

- During the consultations, several community health needs that warrant consideration are suicide, STIs, Alzheimer's/Dementia, and Safety – Accidents/Injuries (all ages). Although not currently classified as trends, these areas continue to be of concern. In the area of suicide, from March 2010 to February 2011, of 26 individuals who exhibited suicide ideation, there were three attempts and two completed suicides. In the previous year, there was one suicide. For every 1000 people, there are 0.29 completed suicides a year. The community also noted an increase in cutting episodes (self mutilation) particularly among females.

- Parenting issues were identified as a significant trend that continues to impact families. Some of the concerns that continue to emerge in the community were the loss or absence of parental skills, less parental involvement with children in activities and lack of parents taking responsibility for their children. Within the services of KSCS, parenting assistance is offered through the Parenting Program at the Family & Wellness Center.

- Because of the ageing population (20% in the 60+ age category), it was found that during the screening of 500 participants for diabetes and hypertension in adult prevention, 60% of participants were at risk or had hypertension. Prevention and programming need to continue efforts for this segment.

- Kahnawake continues to have a challenge in finding English language material and documentation provided by the Provincial government. This limits community members from accessing/benefiting from services provided by Quebec because they are unable to understand the French material. Translation resources made available to the community would benefit access to health services and health resources from the province. As well, receiving health care services in the English language in the province can be challenging in some cases. These issues were identified with federal and provincial partners during the

Aboriginal Health Transition Fund project in 2010. This is a process that will be looked at by all parties. Although there is a demonstrated desire by all stakeholders to address these issues, access is a critical need that requires manpower in terms of advocacy. Further to this, Kahnawake has been involved in a Health Services Integration Funds (HSIF) project related to English speaking services.

- From the Gaps/Overlaps workshop it was determined that strategic frameworks for each of the health priorities need to be developed in order to make linkages. The process should begin at the start of the next fiscal year (April 2012). Facilities to house aggressive mental health clients, foster care for older adults with early Alzheimer's/dementia, and a treatment center were identified as gaps. A consistent gap was the need for a database for health and social services, and appropriate resources for data analysis.

- Gathering statistics within and for Kahnawake has always been a challenge and there are many reasons and the need for a data base and resources for consistent data analysis also remains to be a reoccurring need. Currently (2011/12) at the Onkwata'karitáhtshera table an Information Systems Sub-Committee was formed and tasked with looking at outside sources for accessing statistics on a consistent basis for the community. Please refer to the logic model pertaining to Data Mining for further information regarding this initiative. Concurrently KSCS got an opportunity (financial & human resources) to also work on its own Information Systems Management (ISM) project with the objective to outline what type of information system KSCS needs to establish in order to access internal data efficiently and effectively in order to carry out its mandate.

Health Programming Based on Health Priorities

Kahnawake's goal is to integrate all health related programs through integrated logic models, regardless of the funding sources or organization, in an effort to contribute to a more holistic approach to health. We believe this approach has a better chance to further impact health.

Logic models are used to describe this health programming. The health programming should describe the continuum of health interventions to include promotion, prevention, intervention and re-adaptation activities. It should also target all population groups within the community.

Kahnawake has realigned all organization of services and subsequent logic models to be directly in line with respective health priorities. This realignment is described below.

LOGIC MODELS

Since entering transfer, all parties involved in the process have at one point or another went through varying degrees of learning which still continues today. There is an underlying force which drives all involved from frontline staff to the members of Onkwata'karitáhtshera, to continually strive to better meet the health needs of our community. The evolution of the logic models is one aspect that illustrates this.

There are three approaches to logic models;

- Theory Approach Models emphasize the theory of change that has influenced the design and plan for the program. Sometimes they have additional parts that specify the problem or issue addressed by the program, describe the reasons for selecting certain types of solution strategies, connect proven strategies to potential activities and are built from the "big picture".
- Outcomes Approach Models focus on the early aspects of program planning and attempt to connect the resources and/or activities with the desired results in a workable program. These models often subdivide outcomes and impact over time (short term (1-3 yrs), long term(4-6 yrs) and impact 7-10 yrs)) that may result from a set of activities.
- Activities Approach Models pay the most attention to the specifics of the implementation process. They link that various planned activities together in a manner that maps the process of program implementation.

Initially the logic models used in the Health Canada Accountability Framework were used as a reference. Over the years, training and research on logic models were accessed and applied always with the drive to become more efficient and effective.

In June 2011, the Onkwata'karitáhtshera CHP Steering Committee sent in a copy of the draft logic models developed to date to the First Nations and Inuit Health Interdisciplinary Team (FNIHIT) for review and feedback. Comments and recommendations were only received mid September which impacted the timelines the community was working with. In addition, there was also some misunderstanding/miscommunication as the reviewers thought that what was being sent to them was Kahnawake's entire Community Health Plan. Nonetheless, all efforts were made to ensure that the managers overseeing the programs whom submitted the logic models take the recommendations provided and make any necessary modifications.

In the Kahnawake Community Health Plan, our logic models address the seven identified priorities as our main priorities and we have restructured all the logic models to strengthen and streamline them. In addition, we have added an overarching goal, strategy and rationale are assigned to each priority, as recommended by Health Canada.

Health Priorities

1. Addictions
2. Cancer
3. Cardio Vascular
4. Developmental Disabilities
5. Diabetes
6. Mental health
7. Obesity

The logic models below cover contributing services that support the Community Health Plan. We have added a general goal, strategy and rationale for each and they are linked with each individual priority.

8. Multiple Support Priority
9. Primary Health
10. Home and Community Care
11. Health Management

It is the intention of Onkwata'karitáhtshera to implement sub committees for each priority with a mandate to assess the gaps, links and an inventory of services for each area. Their role will be to also review each of the logic modules to determine if the choices of indicators are focused on outcome as opposed to process and to ensure they have SMART objectives.

Logic models are arranged, in alphabetical order, by Health Priority:

1. ADDICTIONS
   a. ADDICTIONS
   b. ADDICTIONS RESPONSE SERVICES
   c. CHILDREN'S DRAMA
   d. IN SCHOOL PREVENTION PROGRAM
   e. MAKING ADULT DECISIONS
   f. OUR GANG

2. CANCER
   a. CANCER
   b. ADULT PREVENTION
   c. CANCER CARE
   d. ENVIRONMENTAL HEALTH SERVICES

3. CARDIO VASCULAR
   a. Cardio Vascular
   b. Adult Prevention

4. DEVELOPMENTAL DISABILITIES
   a. Developmental Disabilities
   b. Assisted Living Services
   c. Fetal Alcohol Spectrum Disorder (FASD)

5. DIABETES
   a. Diabetes
   b. Diabetes Education
   c. KMHC Operations

6. MENTAL HEALTH
   a. Mental Health
   b. Healing & Wellness Lodge
   c. KMHC Social Service Worker
   d. KYC Outreach
   e. Nobody's Perfect
   f. Parenting & Family Center
   g. Shakotisnien:nens Support Counsellor
   h. HCN Tertiary Prevention

7. OBESITY
   a. Obesity
   b. Adult Prevention

8. MULTIPLE SUPPORT PRIORITY
   a. Multiple Support Priority
   b. Brighter Futures
   c. Communications
   d. KMHC Operations
   e. KSCS Administration & Operations

9. PRIMARY HEALTH
   a. Primary Health
   b. Child Injury Prevention
   c. CHU – Breastfeeding Support
   d. CHU – Newborn Home Visits
   e. CHU – Prenatal Clinic
   f. CHU – Prenatal to Toddler Data & Statistics

g. CHU – Well Baby Clinic
h. HIV
i. Preconceptual Health
j. Reportable Diseases
k. School Health – Elementary Schools
l. School Health – Survival School
m. Staff Health
n. Volunteer Program

10. HOME & COMMUNITY CARE
    a. Home & Community Care Services
    b. Home Care Nursing – End of Life Care
    c. Home Care Nursing – Home Hospital
    d. Home Care Nursing – Tertiary Prevention
    e. Home Care Program

11. HEALTH MANAGEMENT
    a. Health Management
    b. Home Care Nursing – Data & Stats
    c. Home Care Nursing – Skills Development
    d. Human Resources
    e. Recruitment & Retention of Health Care Professionals
    f. Risk & Quality Management

2. Health Management Structure

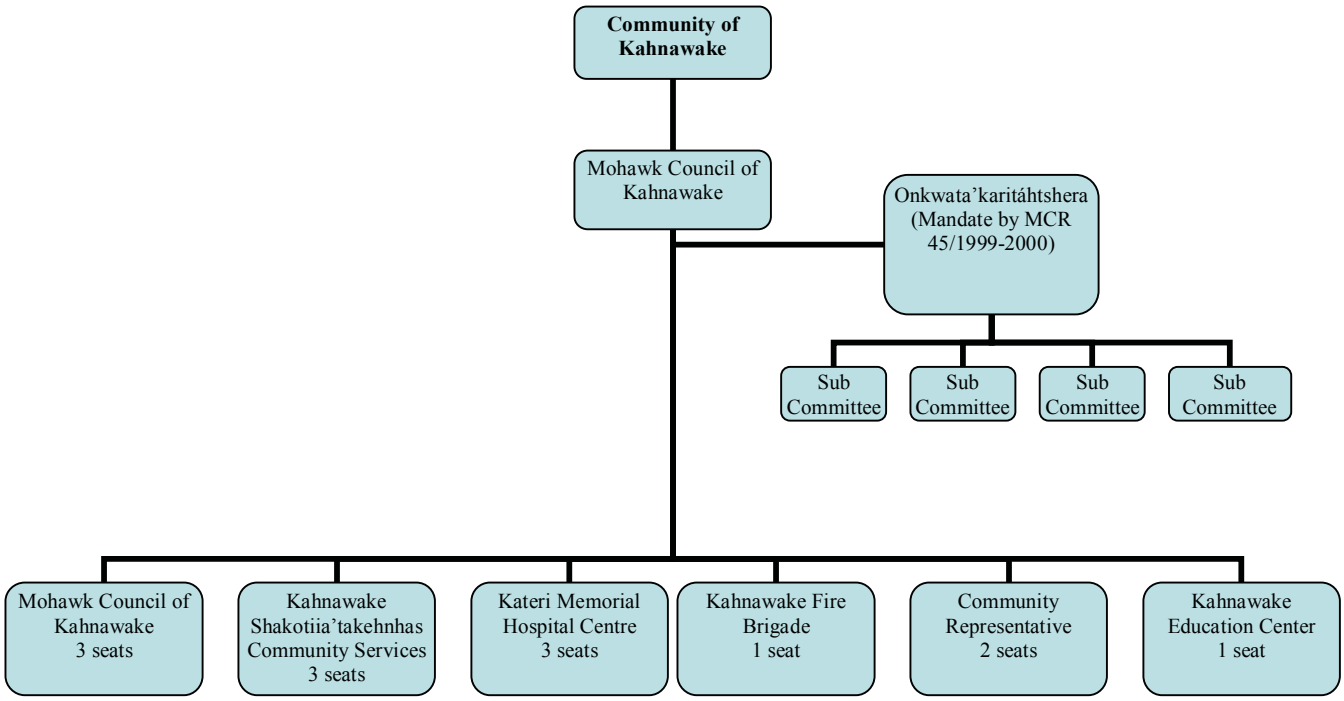
Authority & Accountability

The Mohawk Council of Kahnawake (MCK) has through council resolutions delegated authority to various community organizations for governing and providing services. Each of these organizations has established a board of directors comprised of community members. These boards operate under constitutions and bylaws. The MCK has established a quality improvement and accountability framework to support these delegated authorities.

In the health and social services sector, health directors determined the community would benefit from a more formal structure for planning and coordination. Onkwata'karitáhtshera, Kahnawake's one health authority, was created for this purpose and also receives delegated authority via MCK resolution. Member organizations still remain autonomous and responsible for specific service delivery through their governing boards of directors and accountable to MCK through annual reports and audits, but they participate on Onkwata'karitáhtshera to ensure programs are planned and coordinated effectively. MCK also has portfolio chiefs who are assigned seats on all delegated boards in the community, including Onkwata'karitáhtshera. Community/Elders also have a seat on

and advise Onkwata'karitáhtshera. The work and decisions of Onkwata'karitahtshera and its members are continously aligned to the attainment of the Community Health Plan (CHP).

Onkwata'karitáhtshera Composition



The Kahnawake Fire Brigade & Ambulance Service (KFB & AS) has a separate contribution agreement with Health Canada to provide medical transportation service to the community. This includes transportation for medical appointments and emergency ambulance transport. This is a non-insured health benefit and KFB signs a separate agreement with Health Canada.

Both KSCS and KMHC have their own governing boards with delegated authority from the MCK. KSCS and KMHC have developed individual strategic frameworks and conducted strategic planning activities prior to entering into Transfer. The frameworks for the two organizations include their respective:

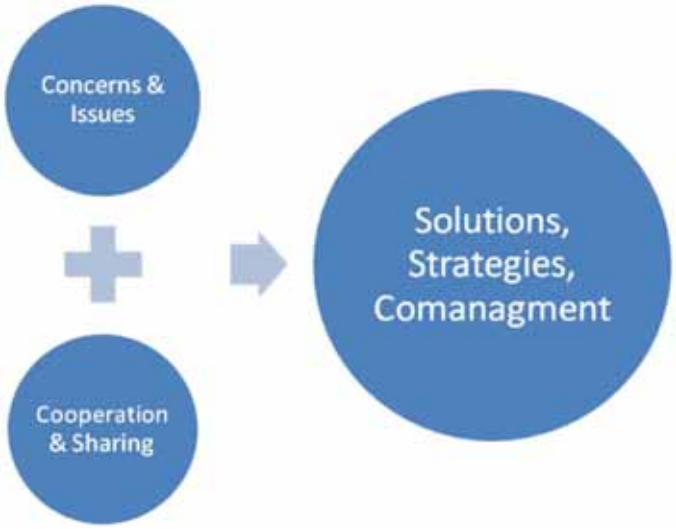
- Vision
- Mission
- Goals
- Values
- Levels of Responsibility

Both organizations have conducted realignment activities and updates to ensure there is constant development and upgrading of the frameworks to ensure community needs are met.

In order to provide the reader with a visual image of KSCS and KMHC management and accountability structures the organizational charts are provided on pages 52 and 53.

Relationships

Member organizations have similarly established cooperative partnerships with each other that are guided by Memoranda of Understanding (MOU). These MOUs outline the nature and key elements of the partnerships. Regular meetings at a management / professional level are held to address needs specific issues of mutual interest/concern and in specific instances relative to the Community Health Plan.

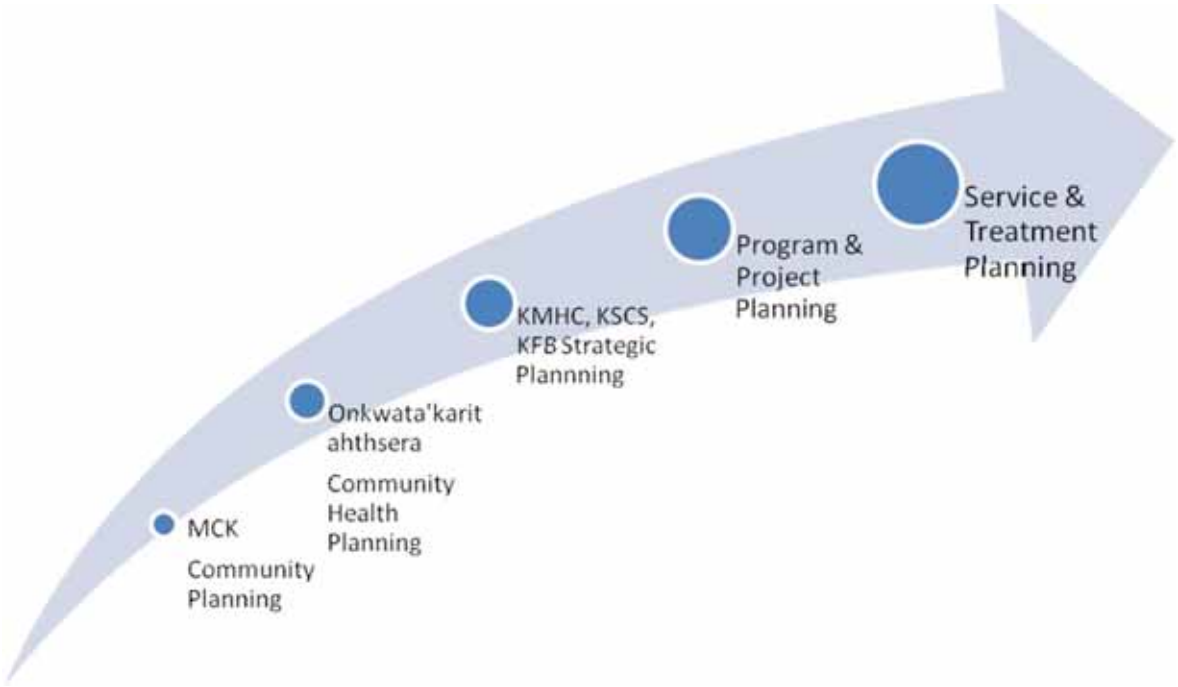


Onkwata'karitáhtshera has established standing sub committees who are responsible for developing frameworks and strategies to address health issues and priorities indicated in the community health plan. The sub committees include community members and groups. They are involved in planning and community mobilization efforts. Their terms of reference include alignment to the Community Health Plan.

Member organizations also have established committees and working groups for specific initiatives designed and aligned to assist in realization of the Community Health Plan.
Job descriptions under Health Canada funded programs are also aligned to the realization of the Community Health Plan.

Community Planning Levels

There are also different levels of planning and coordination that take place in the community intra and inter organization. Action research is conducted and used in determining needs, priorities and resource allocation. Information is shared and there is cross participation of community organizations in planning activities. Planning conducted by member organizations is aligned to the realization of the Community Health Plan.

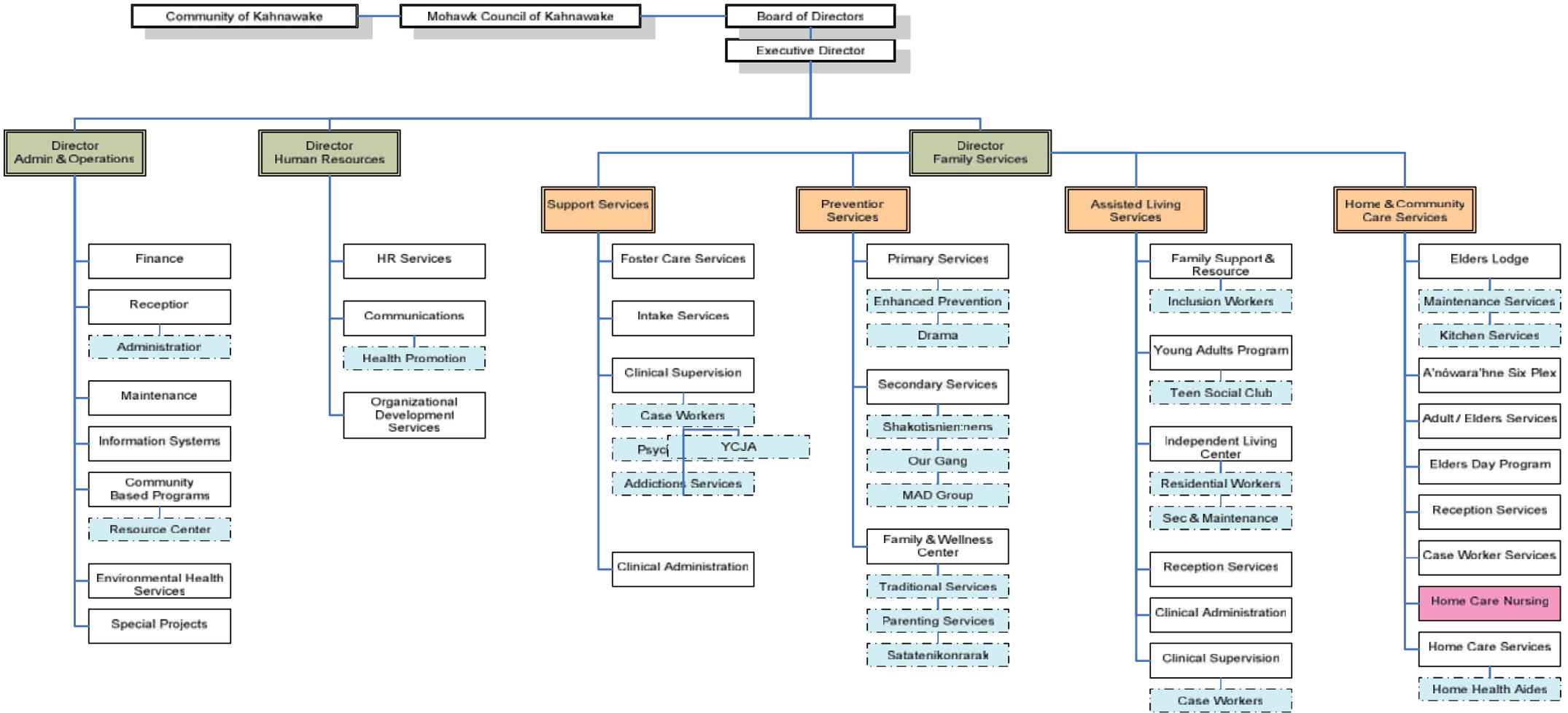


Community Health Plan Monitoring

Onkwata'karitáhtshera meets on a monthly basis and the agenda involves:

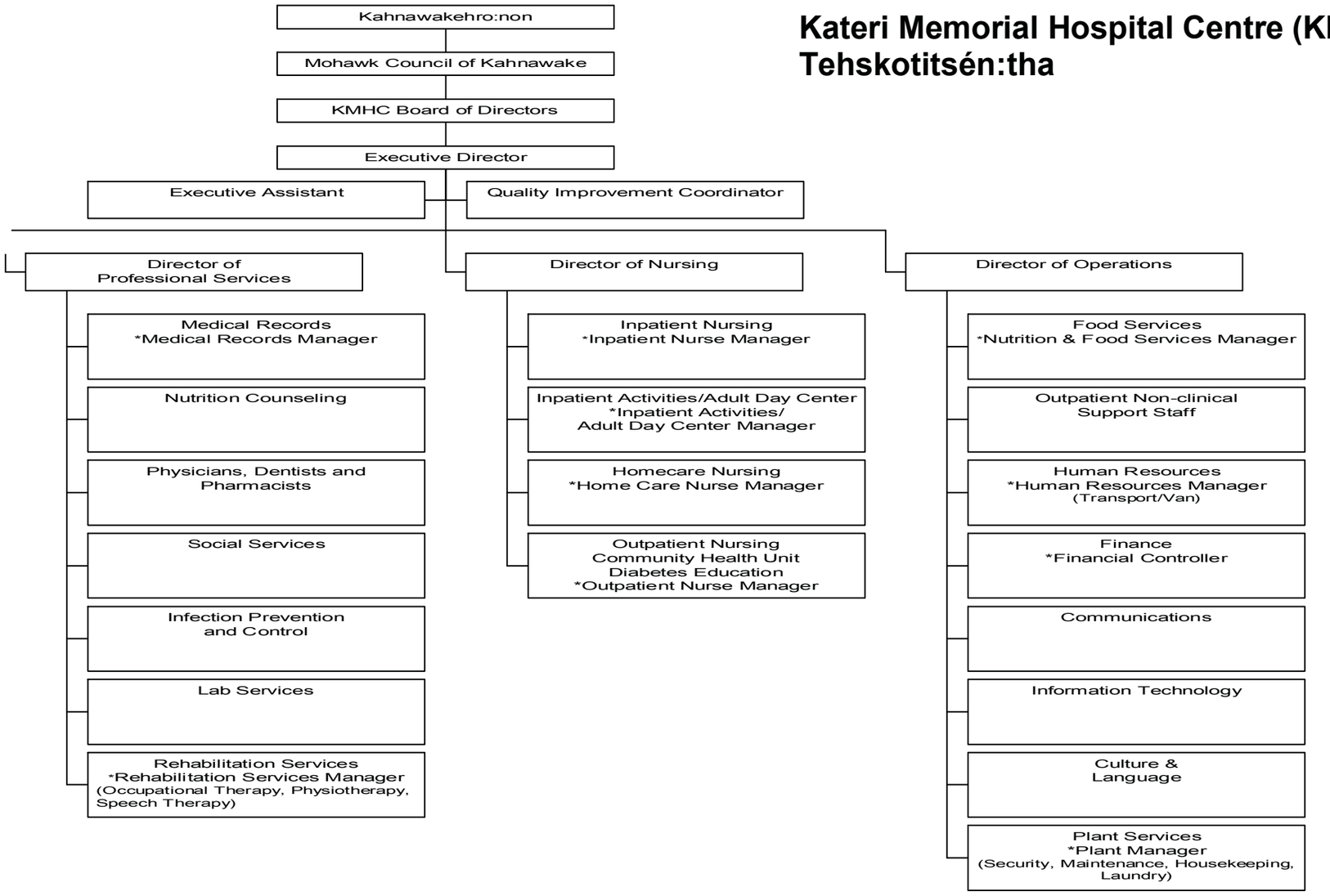
- emerging health trends that are flagged by member organizations
- organizational updates
- CHP coordination, alignment, reporting
- subcommittee development, reporting, advising

Please review PowerPoint presentation "Exploring Partnerships". This document was developed for and used during the duration of the Kahnawake Aboriginal Health Transition Fund Project. The information in this document provides a picture of Health and Social Services in Kahnawake from the past to present and is an ideal supplement to the above information. This PowerPoint presentation has been previously submitted with the original Community Health Plan.



Kahnawake Shakotiia'takehnhas Community Services Organigram Updated February 28th, 2013

Kateri Memorial Hospital Centre (KMHC)
Tehskotitsén:tha



Communications

Communications involving health and social services in most cases are initiated or flow through Onkwata'karitáhtshera. It comprises membership from organizations in the community entrusted with health care in any form. It is up to the individual organization to ensure that important information reaches all levels of the organization and the community.

In Kahnawake, a body of community organization directors exists called the Executive Directors Committee (EDC). This committee has representation from Kahnawake Shakotiia'takehnhas Community Services, Kateri Memorial Hospital Centre, Kahnawake Fire Brigade and Ambulance Service, Mohawk Council of Kahnawake, Kahnawake Youth Center, Step by Step Child and Family Center, and Tewatohnhi'saktha, Kahnawake Economic Development Commission. Issues discussed at this table are of concern to the organizations but are not necessarily health related.

KSCS

In KSCS, internal communication is initiated in numerous forms. All regular full-time employees have computer access and their own internal e-mail accounts in Microsoft Outlook. Memos can be sent electronically. Staff receive daily updates and notices via the Info Line located in the Outlook program, which is continuously updated, and the KSCS communications protocol common (G) drive, which provides immediate electronic access to data and stores all documents that are required reading. All employees also can access the "Weekly Bulletin," an online internal newsletter published for staff. For staff working out of satellite offices, the same information is forwarded to them via e-mail messaging. These satellite offices (Family & Wellness Center, Environmental Health Services, Children/Teen Drama Project, Our Gang, MAD Group, Assisted Living Services, and Home and Community Care Services / Turtle Bay Elders Lodge) all have MOU's with the Communications Unit. Communications is presently in the process of creating an Intranet site for the organization.

All requests for media access (print, video, air) must be routed through the Communications Unit. An alternative communications tool for staff is the organization's bulletin board located in a main hallway. Staff has free access to posted information for all to read. KSCS produces an annual report to the community. Team meetings and management meetings are held regularly. KSCS also holds All Staff meetings. These meetings are usually scheduled on a quarterly basis, however, can be mandated at any time by KSCS management on an as needed basis.

KSCS produces a health and wellness newsletter, *Aionkwatakari:teke*, six times each year and is distributed throughout the community. KSCS is also an active participant in putting an Emergency Broadcast system into operation for Kahnawake. A message board is located in the Services Complex building that delivers general information to the community. KSCS finalized development of their website – www.kscs.ca which was launched in September 2011.

KMHC

Communications has evolved at KMHC and now implements the latest technology into everyday life. Each staff member who requires an e-mail address is provided one, along with a workstation and access to the internet. E-mail can be accessed at a workstation, via webmail and even via Blackberry. All KMHC staff has access to a computer with the latest office technology software and hardware available. In addition, all Senior Managers, Information Technology technician, Communications Officer and the transportation employee have been designated a KMHC Blackberry that allows these key staff members to be informed and available 24/7. This technology has proven to be important during flu outbreaks, boil water advisories, and ensures that important and timely information is available to staff and the community at a moment's notice.

An internal website is also available to all staff and contains links to various learning videos, medical information as well as other pertinent information. The need for further development of this site has been established by the amount of requests to post information as well as the type of requests. The internal site now houses all Human Resources postings for internal-external positions, as well as recipes from Nutrition and Food Services. The need to develop this site from a purely static site to a dynamic site has been made evident and is taken into consideration for further growth.

Additionally, an internal grapevine has been established and has been in use for approximately two years. It is an electronic bulletin board like system and is a virtual hub of important information such as press releases, external communications as well as vital information that is circulated instantaneously through this system. The external website – www.kmhc.ca contains information about the departments and day-to-day operations.

"*The Well*" is a monthly/bi-monthly newsletter that is produced in-house with input from all departments and staff. The Outpatient Department has a television in the waiting room with a DVD player to show information videos to the public. Several in-house information pieces have been shown.

The Annual Activities Report is available to the community through the internet in PDF and copies are also available upon request and in strategic locations in the community. This is done in an effort to be more environmentally friendly. The majority of publications for education and information are culturally relevant and more familiar to community members. There is an effort to implement the Kanien'keha language and culture into all materials produced.

A Smart Board is available for all staff and located in the boardroom of the hospital. It allows staff to participate in online webinars and training sessions, and staff can also make dynamic presentations. Videoconferencing equipment is also available on site.

The organization regularly utilizes local radio, newspaper and television to transmit appropriate information to the community. The MCK television show, Kwatokent TV (KTV) shown on local cable, is one of the venues that is used to distribute information to the community. KMHC has a

segment called *The KMHC Pulse* that is taped and anchored by staff. KMHC has reported on H1N1 pandemic, what to do to avoid the flu and passed on information re: Strategic Health Careers.

Job Profiles

The KSCS positions (job titles) funded under Health Transfer are identified in the chart below. Range of salaries and detailed job descriptions for all KSCS positions are located in Appendix C. All positions funded by Health Canada are identified in the General Information block of the job description.

Job Family	Working Title	KSCS Job #
Administration	Receptionist	A1
	Administrative Assistant I	A2
	Administrative Assistant II	A3
	Administrative Assistant III	A4
	Executive Assistant	A5
Communications	Communications Correspondent	C1
EHS	Environmental Health Technician	EH1
	Environmental Health Officer	EH2
Facilities	Maintenance / Security Worker	FC3
Front Line Services	Prevention Worker	FLS6
	Support Counsellor	FLS7
	Addictions Worker	FLS12
	Drama Project Coordinator/Artistic Director	FLS13
	Health Programs Liaison	FLS14
	Addictions Clinical Supervisor	FLS16
Human Resources	Human Resources Generalist	HR2
Information Services	Information Systems Technician	IS2
Management	Team Leader	MG2
	Director – Human Resources	MG6

The KMHC positions (job titles) funded under Health Transfer are identified in the chart below. Range of salaries and detailed job descriptions for all KMHC positions under Transfer are located in Appendix D.

KMHC Job Titles	
CHU Manager	Information Technician
Nutritionist	Financial Assistant
Community Health Worker	Language & Culture Coordinator
CHU Nurse	CHU Administrative Assistant
Breastfeeding Support (CHW)	Quality Improvement Coordinator
Homecare Nurse Manager	Social Service Worker
Homecare Nurse	Dental Hygienist
DPS Administrative Assistant	Volunteer Coordinator

As suggested in the Community Health Plan recommendations, R-3 and R-20, the following reflects the planned revisions to the job descriptions, to be in line with the new health programming:

KMHC Senior Managers' job description summary section; i.e. ED, DON, DPS and DOO:

*At the community level, the **Director** participates in the development of a community health plan, which identifies the community's health priorities. He/she also ensures that programs and services are developed, implemented and regularly evaluated, which address the health priorities which fall within his/her scope of responsibility. Note: For the ED, we can say "....which fall within the scope of responsibility of the hospital centre."*

KMHC Managers' job description summary section, ten Managers:

*The **Manager** ensures that he/she has a sound knowledge of the community health plan, which identifies the community's health priorities. He/she participates in the development, implementation and evaluation of programs and services which address the priorities which fall within his/her scope of responsibility.*

Employee job descriptions under Transfer, 17 employees:

*The **employee** ensures that he/she has a sound knowledge of the community health plan, which identifies the community's health priorities. He/she ensures that a program plan is developed, implemented and regularly evaluated which addresses the health priority(ies) which fall within his/her scope of responsibility.*

The above planned revisions are to be realized in consultation with the Director, Manager and Employee at the time of annual performance appraisal.

All of the job descriptions for the two organizations with positions funded under Health Transfer address the following areas:

- Roles & Responsibilities for position
- Qualifications for position
- Identify lines of supervision
- Experience required for each position

Personnel Policies

The personnel policy for both KSCS and KMHC address the normal hours of work, group employee benefits provided, hiring and probation period, job criteria, employee ethics, confidentiality, and disciplinary action. The policies are utilized for all staff members of each organization. A copy of the KSCS Personnel Policy is located in Appendix E and a copy of the KMHC Personnel Policy is located in Appendix F.

Both organizations have salary ranges that identify the entry level to maximum amount for all job descriptions. Charts have been prepared that identify the salary ranges for all positions covered under Health Transfer, these are located in Appendices C (KSCS) and D (KMHC).

Complaint and Conflict Resolution Mechanisms

KSCS

The KSCS Personnel Policy outlines the process whereby an employee may file a complaint in relation to employment. In the event the employee is dissatisfied with the outcome of the complaint a grievance procedure is available for working towards a resolution. The first level of the process includes providing a written grievance to an employee's immediate supervisor within an appropriate time frame. The supervisor has 14 days to respond to the written grievance.

The second level is for the Human Resource Generalist to convene a grievance committee comprised of two managers, not including the direct supervisor of the employee. The committee may interview the employee and any other person involved prior to making a recommendation in a timely manner. The grievance committee will render its recommendation within 14 days. Should the employee be dissatisfied with the grievance committee's recommendation, he/she may bring the grievance to appeal within following seven days.

The third level in the process is for an employee to make an appeal to the Executive Director. The Executive Director may interview the employee and any other person that can provide clarification of the situation. He/she will render a decision within 14 days. In the event all of these steps have been exhausted and an employee wishes to pursue his/her grievance further, the employee can go to final arbitration.

A copy of the KSCS personnel policy is included in Appendix E, Sections 20-1 and 20-2 details the grievance process and arbitration.

KMHC

The KMHC Personnel Policy and Procedure outlines the process for complaints from an employee. The process includes completing an employee complaint form by the direct manager. An investigation into the complaint is conducted in a timely manner and a decision rendered within 14 days into the validity of the complaint, action is taken to address the concern and action is taken to prevent such an event from reoccurring. Completed reports are reviewed by the Executive Director and maintained on file.

If an employee is dissatisfied with the outcome of the employee complaint process, the employee can file a grievance. The first step in the grievance process is again between the employee and manager. In the event this is unsatisfactory to the employee the second step is a grievance committee. The grievance committee is comprised of four employees to review pertinent information and conduct interviews, if necessary, for clarification on the situation. The committee will issue a written decision, or recommendation concerning the grievance to the employee and

Manager, within a timely manner, approximately 14 days.

Should the employee still be dissatisfied, the next step is to forward the written grievance to the Executive Director within a seven day time period. This Executive Director has the option of the formation of an ad hoc review committee to further assess the grievance. This committee would consist of one Board Member, the Executive Director and three non-management staff members. This is the final level in the grievance process. A copy of the KMHC Personnel Policy is included in Appendix F, Sections 23.0 and 24.0 detailing the Grievance Process.

KMHC also has a User's Complaint Process. The rights of KMHC users include that each person has the right to responsible, confidential and diligent examination of his/her complaint. Complaints may be verbal or written sent to the attention of the Executive Director. Verbal complaints are to be converted to written format using the complaint form. The acknowledgement and decision on said complaint is determined by the Executive Director or by the Director of Professional Services when complaints concern physicians, dentists or pharmacists. A written response is sent to the user within 45 days of receipt of the complaint. A copy of the KMHC User Complaints Policy and Procedures is located in Appendix F.

Kahnawake Health Care Professions Law

A law for the regulation of Health Care Professions within the territory of Kahnawake was enacted by MCR #59/2004-2005 in November 2004 and amended by MCR #09/2005-2006 in February 2006. This law requires every person providing professional health care services to patients within the territory of Kahnawake to hold either a valid private permit or be employed or associated with a community organization that holds a valid permit issued under the law. The law was established to preserve and promote the highest quality health care services at reasonable cost within Kahnawake. Onkwata'karitáhtshera is the administrative body overseeing this law. A copy of the Kahnawake Health Care Professions law is located in Appendix G.

3. Management and Delivery of Primary Health Care

KMHC

The out-patient services at KMHC provide primary health care to the community. They are provincially funded services. It is often the first contact most community members have to health care. The out-patient clinic is staffed with 2-3 nurses Monday to Friday and 1 nurse on Saturday. The clinic is open Monday to Friday from 9:00- 17:00 with an evening clinic 1-2 times a week depending on physician availability. The services provided by the nurses include:

- Laboratory services (blood and urine tests, EKG, etc.). Specimens are sent to Centre Hospitalier Anna Laberge for analysis.
- Health teaching regarding acute and chronic conditions
- Nursing procedures (medication administration i.e. oral, injections, IV, aerosol; ear irrigation; etc.)
- Dressings

- Health/chronic disease monitoring (blood pressure, glucose, respiratory status monitoring)

During holidays, evenings, weekends, clients needing medical advice are encouraged to call Info-Santé. Those needing medical services are directed to present themselves at medical clinics in surrounding communities or to the emergency room.

Kahnawake is fortunate to have 10 physicians, 3 specialists (paediatrician, neurologist, and psychiatrist), an optometrist and a dentist who work at KMHC. Physician visits generally include but are not limited to physicals, chronic disease management, diagnosing and treating minor illnesses, minor surgery (suturing), referrals to specialists (at KMHC and elsewhere). Specialists see clients through referral only. All reportable diseases are sent to the Direction de Santé Publique at the Agence de Santé et Services Sociaux Montérégie.
The rehabilitation department offers physiotherapy, occupational therapy and speech therapy. There are 2 physiotherapists (full-time), 2 occupational therapists (1 full-time and 1 part-time), and 1 speech therapist (1 day a week). Rehabilitation services are delivered to out-patients and in-patients Monday to Friday.

Because Kahnawake is situated so close Montreal and the neighbouring community of Chateauguay, the clients are often referred to specialists and hospitals in surrounding areas. For emergency services, clients are often transferred by ambulance to other hospitals (i.e. Centre Hospitalier Anna Laberge, McGill University Health Centers, Jewish General Hospital, Montreal Children's Hospital, etc.) after careful assessment and immediate care that can be provided at KMHC. Clients needing admission for short-term illness that do not need a tertiary care hospital are admitted to KMHC in-patient department. KMHC also has 33 long-term beds within the facility to accommodate those who can no longer function without 24 hour supervision/care.
Clients are also referred to services within KMHC and the community. Some services at KMHC include: dietician (1 full-time, 2 part-time), diabetes nurse educator (part-time), rehabilitation services, foot care (ADI project), optometry, adult day center, homecare). Within the community, the services offered may include: social services, psychologist, addictions counsellors, traditional healing lodge, etc. Clients needing treatment for substance abuse are referred to an addictions counsellor at KSCS who then will find placement in a treatment center.

The Community Health Unit works closely with the Out-Patient Department (OPD) at KMHC in many ways. Some examples are as follows: prenatal clients are referred for blood tests for blood type and will receive WinRho for Rh negative moms. Families often call the Community Health Nurse because their children are not well. Based on telephone triage, clients are given recommendations, are referred to another health care center (Montreal Children's Hospital) or are referred to the OPD to see a physician. Babies seen in the Well Baby Clinic will see the physician as part of their visit. Children are often referred to specialized services at KMHC such as the ophthalmologist, optometrist, dentist, paediatrician or dietician.

The travelling road show, an outreach screening program for hypertension and diabetes, will refer clients to the OPD for follow-up for high blood pressure or elevated blood glucose levels.
Kahnawake Survival School (KSS) youth clinic has physicians from KMHC working with residents from the Hertzl Family Practice to provide medical services with the School Nurse. The school

nurse also works in the OPD, which is advantageous when she needs to refer KSS clients to a physician urgently.

The Diabetes Nurse Educator (DNE) works in the OPD. Clients who are diagnosed with diabetes or pre-diabetes will be referred to the DNE for education about the diabetes and its complications, medications, insulin initiation, glucose monitoring and many other co-morbidities. She often sees clients prior to their visit with the physicians to assure any screening for complications is done. She will also work closely with the physicians to adjust medications in a timely manner to get optimum blood glucose management. She will also address concerns about her clients with the OPD nurses and the physicians as needed. The DNE also does 24-hour blood pressure monitoring for hypertension as well any education needed for prevention and controlling hypertension.

Activities for the prevention of illness and injury and health promotion are carried out primarily by the Community Health Nurses. Although, if circumstances warrants, i.e. a child has been injured or has repeated infections, the clinic nurse may advise the family how to prevent further injury or how to reduce risk of infection within the home and school.

If trends are identified by the clinic nurses (i.e. increased gastro, ATV accidents), the Community Health Nurse/workers will often start a disease or injury prevention campaign to educate the community, often in conjunction with community partners.

KSCS

The first point of contact for community members and non-community members seeking information, services, or to make a report on a child or family at risk, is the role of the Intake Worker. The majority of the intakes are requests from community members for services for themselves and/or their family members. Some of these requests come in the form of referrals from their doctors. When this happens, the individual will receive a call from the Intake worker so as to get some basic information from them about the situation and what services they feel would benefit them the most. Sometimes the Intake worker will also call the physician to inquire about the referral and get more information. Individuals seeking support counselling will then be directed to one of KSCS' in-house support counsellors to begin their sessions immediately. Individuals requesting psychological counselling will be referred to one of KSCS' support counsellors for a further assessment and then referred out to a psychologist.

If an individual requires immediate assistance, the Intake worker will bring the information to a supervisor who will assign a worker to handle the situation right away. There is always a worker assigned to deal with emergencies that arise throughout the day. This person is called the "Roster Worker." When a report of a child at risk comes in, the Intake worker will consult with one of the Youth Protection Clinical Supervisors so as to determine whether the call requires immediate intervention or not. If so, the Intake worker and the Youth Protection clinical supervisor will meet to give the Youth Protection "Roster" worker all of the information.

In both situations, if other service providers are needed to assist in assessing and intervening with the situation (i.e. the Peacekeepers, hospital staff, ambulance, other KSCS staff, school personnel,

etc.), the Intake worker will contact them and inform them of the situation. Once the worker has gone out, the Intake worker can also be of assistance as a link back to KSCS with updates, etc.

If the report does not require immediate attention, then the Intake worker will record all of the information and bring it to a collective team meeting the following day for assignment to a worker. Every morning at 8:30, the Intake team meets to discuss the cases that have come in the day before along with any on-call reports. This is where the assignment of cases takes place for appropriate follow-up.

Assets and Resources

Based on the management and delivery of primary care services outlined in the above for both KSCS and KMHC , one gets a sense that there are numerous partners not mentioned that each organizations taps into when delivering services to community members. To truly get an appreciation of what assets and resources exist, an inventory was conducted with each organization. The data was extensive and a diagram would not have done justice therefore the information was put into a chart format.

A listing of services with descriptions is provided prior to each Asset/ Resources Classification/Identification Chart.

For the purpose of this report the charts in this main document provide only a snapshot. More detailed descriptions are provided in appendix R. The charts have been created using Excel spreadsheets so that management can sort the information to meet their needs depending on their query. This tool is a foundation (work in progress) which can be further developed, added to and refined in the future.

The charts that follow display the assets and resources that KSCS, KMHC and KFB &AS use and/or draw upon to help function in the duties that they perform. Each organization is presented separately as they differ slightly from one another with regards to the presentation of information within the charts. The categorization and formatting of the charts are consistent and as follows:

- Services of a particular organization can be found on the left hand side of the chart and follow the sequencing of the organigrams provided from each organization on pges 52&53
- Sixteen (16) Asset/Resource Classifications (general categorizations) can be viewed on the first row at the top of the chart. The assets and resources identified by the services were classified based on their primary area of activity within one of the 16 classifications, there are some however that operate in multiple areas.

1. **Clinic:** a facility often associated with a hospital or medical school, that is devoted to the diagnosis and care of outpatients i.e Eye clinics, Dentists, CLSCs etc. Some clinics may also have been classified under the hospital classification.
8. **Hospital:** an institution that provides medical, surgical, or psychiatric care and treatment for the sick or the injured and may if necessary provide lodging.
9. **Legal Service**: includes organizations and groups that work to protect and promote

2. **Committee:** a supportive system of sharing information and services among individuals and groups having a common interest.
3. **Community Organizations:** (sometimes known as community-based organizations) are sometimes non-profits that operate within a single local community; a social unit of people that is structured and managed to meet a need or to pursue collective goals.
4. **Consultant**: experienced professional who provides expert knowledge, most often for a fee. He or she works in an advisory capacity only.
5. **Education**: category includes organizations and activities administering, providing, promoting, conducting, supporting and servicing education. This includes: primary and secondary education organizations; organizations involved in other education (that is, adult/continuing education and vocational/technical schools); and organizations involved in research (that is, medical research, science and technology, and social sciences) and organizations and activities related to higher learning i.e. universities, business management schools, law schools and medical schools.
6. **FN Government/Administration:** any First Nation government organization or administrator i.e. band offices, Assembly of First Nations, First Nations of Quebec and Labrador Health and Social Services Commission, Onkwata'karitáhtshera etc.
7. **Government Service/Agency:** any government office, service or agency i.e. Health Canada, INAC, MSSS, RAMQ etc.
8. civil and other rights, offer legal services, and promote public safety i.e. lawyers, mediators, ADR, police etc.
10. **Professional Association:** (Business / Industrial Relations & HR Terms) a body of persons engaged in the same profession, formed usually to control entry into the profession, maintain standards, and represent the profession in discussions with other bodies.
11. **Shelter & Residence**: a building serving as a temporary refuge or residence, i.e. Native Women's Shelter, group homes, foster homes etc.
12. **Social & Recreational Organization:** are a diverse group or organization devoted to amateur sport and physical fitness, organizations that provide recreational facilities of various types, recreation and leisure clubs, and service clubs such as the Lions or Kiwanis.
13. **Spiritual/Arts & Culture:** category includes organizations promoting religious beliefs and administering religious services and rituals, longhouse which is the traditional way of life and includes organizations and activities in general and specialized fields of arts and culture.
14. **Supplier:** a person or business that serves as a source for goods and services.
15. **Treatment Center:** a licensed facility that specializes in the evaluation and treatment of drug addiction, alcoholism and associated disorders. This center may provide residential treatment, partial hospitalization treatment or outpatient treatment services.
16. **Volunteer Service/Organization**: one which relies on occasional or regular volunteers for its operations, and may or may not have paid staff.

- For each organization's chart the reader will be able to see how many assets/resources a service area has in each classification area in the chart marked by a number in parenthesis (#). For more details the reader will be able to look in the appendices. The reader will also be able to discern if that asset/resource is internal meaning not within their own organization however within the community of Kahnawake. All other asset/resources have been labelled external. In some cases they may qualify as both.

KSCS

The following are descriptions of the services within KSCS, and they are listed in the order as seen in the KSCS organigram. Regardless of the source of funding all services were asked to partake in this activity.

Services	Service Details
KSCS Operations	*The operations team contributes administrative, financial and management services to all client service teams. Our services have an impact on their success in carrying out their objectives to address the CHP priorities, goals and strategic vision of KSCS.*
Finance	Provides invoice payment, payroll processing of staff on a weekly payroll, financial budgets and reporting and year end audit preparations.
Reception	Provides day and evening (weekends when required) assistance.
Administration	Provide support to each of the integrated client services teams
Maintenance	Ensure clean workspaces, repairs and safety checks are performed at all buildings.
Information Systems	Address computer needs of all main office and satellite operations.
Community Based Programs	Supports community-based and community delivered programs, initiatives and strategies that collectively aim to improve the health outcomes and reduce health risks in three targeted areas: Children and Youth; Chronic Disease and Injury Prevention; Mental Health and Addictions. Provide up to date information to all Kahnawake health and social service decision makers about the continuous changes to the non-transfer health care programs. Provide administrative and technical support to Onkwata'karitáhtshera. Administer Health Canada's non-insured health benefits program, FASD, HIV/AIDS, ADI, Maternal Child Health Programs, and coordinate Brighter Futures Initiative.
Environmental Health Services (EHS)	Activities primarily concentrate on identifying, monitoring and mitigating health hazards in the physical environment. This responsibility has been divided into the following concentration areas: Water quality, Waste disposal, Food safety, Health hazard investigations, Air quality, Communicable disease control, Building safety, Occupational health and safety.
First Nations Health and Social Services	Provides audio/visual and printed prevention resources to our community and other Aboriginal nations in Quebec.

Resource Center	
Human Resources(Large HR team)	*Comprised of HR, ODS and Communications each brining unique talents and responsibilities to help KSCS realize its strategic framework and raise the standard of services within KSCS.*
HR Services	Provide support to the board, management, and staff regarding recruitment, hiring, benefits, policy, performance management, training transition and succession planning.
Communications For A Healthier Lifestyle	Ensures there is a consistent flow of information going out to the community. To address the health and social priority issues identified in Kahnawake's CHP.
Promotion/Education	Ensures that timely and focused promotion and education activities address the health and social priority issues identified in Kahnawake's CHP.
Organizational Development Services (ODS)	A First Nations consulting and training business which operates within KSCS as internal/external consultants.
Family Services	*Encompasses four major areas of services within KSCS which is Support Services, Prevention Services, Assisted Living Services and Home and Community Care Services each with a specific focus.*
Family Services: ***Support Services***	*Provides a multi-disciplinary team approach to assisting community members in quality intervention services in the areas of addictions, psychological services, and youth protection.*
Foster Care Services	Secure appropriate caring foster homes to assist families in need. Provide support and training to foster parents.
Intake Services	Receives all calls for services, provide immediate support to clients when necessary and to refer clients to appropriate KSCS Prevention and Support resources.
Youth Protection	To receive all reports of children being at risk, investigate allegations of child abuse, to include abandonment, neglect, psychological abuse, physical abuse, sexual abuse, and serious behaviour disturbances and provide follow-up to address the risk.
Psychological Services	To screen, assess and make recommendations for referral for individuals, couples and families who are referred to or requesting psychological support. To provide support and consultation to related services, programs, projects and activities in the area of psychology.
Addictions Services	Our goal is to help individuals break free from addictions and learn new ways of coping with life's many challenges, services include: screenings and assessments done by trained professionals; individual outpatient treatment; individual, couple and family counselling; family interventions; referrals to withdrawal management centres, residential treatment centres and other appropriate resources; referrals to internal services and after care services.
Youth Criminal	Assists in facilitating the process for youth who have been involved in the

Justice Act (YCJA)	justice system.
Family Services: ***Prevention Services***	*The team is made up of from different sub-teams whose goals vary in relation to the community's needs. The greater team is comprised of Shakotisnien:nens Support Counsellors (traditional and S5), MAD group, Our Gang, Parenting, and Family Violence Prevention.*
Enhanced Prevention	Plans, prepares and facilitates prevention campaigns, programming and training in relation to family violence and addiction prevention.
Drama	Promotes the performing arts and through the process of rehearsals and presenting theatre and music events, provide a venue where children, teens and adults practice and experience the basic human values of responsibility, caring, pride trust acceptance, sharing and self-esteem.
Our Gang	Provides after school program to children between the ages of 6–12 years. (Grade 1 to 6) The group meets each day, from September to June, to teach Kahnawa'kehró:non children social/life skills in a fun and safe environment. The program covers five different themes throughout the year including: group inclusion/relations, self awareness, understanding relationships, decision making as it affects one's life, and the world around us.
MAD (Making A Difference) Group	Is a youth leadership program for adolescents age 12-17 years that meets twice a week on Tuesday and Thursday nights from 6:00 P.M.-9:30 P.M. MAD Group provides youth with the chance to learn more about themselves and others while interacting in a safe environment. Members learn social life skills in a fun and productive way as well as being offered employment opportunity through our MAD Dishes rental service.
Traditional Services	The traditional component of the Family and Wellness Center provides a variety of support services to enhance and or to heal the individual person, using both natural and spiritual realms of Iroquois teachings.
Parenting	Provides and promotes programs and services which will enhance parenting skills for Kahnawa'kehró:non mothers and fathers.
Satahtenikonarak	To provide information and education to individuals and community organizations, by providing trainings and support regarding fetal alcohol spectrum disorder (FASD), healthy sexuality, HIV/AIDS, and suicide awareness
Family Services: ***Assisted Living Services (ALS)***	*Provides members of the community with special needs client centered services to enhance the quality of life of individuals living with a disability in order to reach their full potential. Is comprised of the Independent Living Center (ILC) and Family Support and Resources Services (FSRS). The ILC is a residential program for community members living with mental health issues. FSRS includes the Family Support Caseworkers, Young Adults Program, the Teen Social Club, and Lifeskills Support Workers.*
Family Support &	This team is comprised of Caseworkers who work with individuals, families,

Resources Services (FSRS)	and other professionals, to assess needs and develop a service plan. Services available include Lifeskills Support Workers, the Young Adults Program (YAP) and the Teen Social Club (TSC). The programs provide services to promote inclusion and work towards enhancing the quality of life for our clients.
Lifeskills Support	Provide support / respite for families and individuals as determined through assessment and service plans.
Young Adults Program (YAP)	A day program for adults, aged 19 and over, with physical and/or developmental disabilities. The YAP offers basic academic activities and programming to provide lifeskills, inclusion, recreation and social integration.
Teen Social Club (TSC)	An after school program for individuals aged 12-18 years, who have physical and developmental disabilities. Programming is offered to enhance life skills, to promote socialization and to provide recreational outings.
Independent Living Center (ILC)	A residential program for community members living with mental health issues. The ILC focus is to foster and maintain independence and quality of life for Kahnawa'kehró:non living with mental health issues in a structured and supportive environment that promotes wellness and social integration.
Family Services: ***Home and Community Care Services (HCCS)***	*To foster and maintain independence and quality of life for adults, elderly, and handicapped Kahnawa'kehró:non. We provide home and community care service which includes home care nursing, case workers, home care services, meals on wheels, and the activity program operating out of TBEL. Contrary to belief, HCCS does not just provide service to the elderly, though they are our main clientele. We also service a large number of people between the ages of 45-65.*
Turtle Bay Elders Lodge (TBEL)	Is a residential elders institution, constructed based on National Building Codes and maintained under the National Fire & Safety Codes that provides a continuum of care to elders within the community that addresses health and social needs.
Adults and Elders' Services	Offers information and liaison services for: income security programs, disabilities, civil status, estate planning and management, and Commissioner of Oaths and other services as required.
Elders Day Program	The program is targeted to elders or individuals in need of socialization access to activities and a meal in a central location. Programming enhances the independence of elderly Kahnawa'kehró:non by providing information, assistance, healthy programs, and activities to residents and other elderly in the community.
Case Worker Services Elders Caseworker	Elders' Case Workers provide casework; care planning and service delivery to the elderly population of Kahnawake with social issues.
Home Care Services	The homecare team (Home Care Nursing, Home Health Aides) works with

	families to provide: Medications Assistant: Assist clients with medication compliance in accordance with Law 90. Personal Care: For people with loss of autonomy who require cueing or help with daily bathing and/or dressing. Meal Preparation: Work in conjunction with Meals on Wheels. In Home Respite: Scheduled care provided for those who are not safe to be left alone, to give family members occasional breaks. Escorts: To provide medical escorts only when family is not available. Provide assistance for shopping, and errands when family is not available. Domestic Services: Help with basic household chores, usually provided on a weekly basis, based on assessments.

* the Director of Family Services was just recently hired therefore was not included in this activity and will not be identified in the charts.