Kebaowek First Nation

Health Plan 2019-2024

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CREDITS

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TABLE OF CONTENT

CHARTS AND TABLES

CHAPTER 1

INTRODUCTION

About the consultant

GRF Recherche/Évaluation was established in 1996 and is based in Quebec City. Claude Rousseau joined the team in 2001 and has been working with the Kebaowek Health team since 2003. He is now an independent consultant, social researcher and consultant specialized in assessment, program planning, population consultation, and training through workshops and support activities. His expertise rests on the anthropological approach, based on language, communication, and culture.

For years, GRF and Claude have been working with indigenous communities all over Quebec. The basis of their working philosophy is to empower their partners for them to concretely benefit from this collaboration, putting forward and sharing any expertise they can offer no matter how modest.

Presentation of the Health Plan document

The actual document is made up of eight chapters plus seven appendices presented in a separate document. The initial part (Chapter 1) is meant to present the way the community's capabilities have been assessed and a summary of the results. Chapter 2 lays out the community mapping while the 3rd chapter presents the Health Services delivery system. In Chapter 4, the reader has a description of the management structure of the Health Services on the reserve territory. Chapter 6 presents the priorities and their original selection process, leading us to Chapter 7 where we present the action plan designed to reach the described goals and objectives. Chapter 8 concludes with the mandatory programs.

Definition of a holistic approach

"Holism" and "holistic approach" are words often used when speaking about the way First Nations members want to address the individual as well as the community's health.

The *Université du Québec en Abitibi-Témiscamingue* (UQAT) explains the concept of holism as the use of the 4 dimensions [*spiritual (soul), mental (head), physical (body) and emotional (heart)]* to address the healing of the individual, who is placed at the centre of his own healing process. The overall process aims to ensure or restore the equilibrium of the individual, which comes through self-esteem, capacity development, and the feeling of security and belonging.[1]

[1] http://web2.uqat.ca/chairedesjardins/documents/CAAVDmai2008FR.pdf. This document is no longer available as registered. The quote comes from the 2013-2018 Health Plan.

Another document about First Nations research that presents the principles of holism complements what is meant by this word which is often used but not always well-perceived through a Western mindset.

"Most traditional Aboriginal world views are planted firmly in the Earth. Aboriginal languages and cultural practices reflect this intimate connection. Traditionally, Aboriginal peoples thought of the Earth and their life on the Earth as an interconnected web of life functioning in a complex ecosystem of relationships (Cohen 2001). Great importance is based on the principle of "balance" in this delicate web of life (Cohen 2001; Kenny 2002). Elders are constantly reminding contemporary Aboriginal people about the importance of keeping our lives in balance.

(…) An Aboriginal world view that not only understands, but embraces change, is often left behind in policy discourse when Aboriginal people are characterized as living in the past."[2]

Holism concerns the individuals and the nations, and their way of thinking.

"Aboriginal knowledge is not a description of reality but an understanding of the processes of ecological change and ever-changing insights about diverse patterns or styles of flux. (…)To see things as permanent is to be confused about everything.

A framework for holistic research (and we add for any holistic approach whatsoever) would include: honouring the past, present and future (…), honoring the interconnectedness of all of life and the multi-dimensional aspects of life on the Earth and in the community (…),honouring the spiritual, physical, emotional and mental aspects of the person and the community (…)"[3]

The challenge now remains in the integration of the holistic mode into the reality of the current organization of health services rooted in a Western model.

Evaluation of the community's capabilities

Method

The current evaluation of the community's capabilities that introduces the planning is essentially based on three main sources of data provision.

The first one, the former Health Plan, is the basic document used to assess the community's capabilities but its data was upgraded during the evaluation process completed in 2017, this being the second source of data.

The evaluation report and the numerous related documents issued for its deployment allowed for the assessment of the course of action of the past 5 years and provided some measure of the changes. The report was presented to the Kebaowek Health Authorities and to Health Canada in September 2017.

Finally, during the consultations carried out for the assessment of the 2013-2018 Health Plan, a survey was distributed within the community in order to collect data about the health status of the community, perceptions, and service appraisals. In order to validate

[2] http://publications.gc.ca/collections/Collection/SW21-114-2004E.pdf (archived document)

[3] Idem

the results of the questionnaire, two focus groups were conducted: one with men, one with women. The questionnaire and the focus groups assessed items such as: general knowledge on health, life habits, community health status assessment, chronic disease status, and health service evaluation.[4]

Benefitting from these consultations with the community and based on their individual work experience with and for the community, the health managers revisited the priorities of the health plan.

Community capabilities weren't just the topic of one discussion among the managers; actually, this stemmed from discussions about the priorities, the community's health status, and even about the programming of the activities themselves. The several ideas and orientations have been summarized into an intelligible form in the current document.

Results

As a summary of the community's capacities, we can say that Kebaowek First Nation is a community that relies on many positive assets.

- The social tissue partly rests on a relatively good employment rate and good income level, some 53% of the households and 40% of the individuals have incomes of over $30,000[5]. The employment rate is a little less than it used to be some years ago (minus 10% from 2009) because of the difficulties of the lumber industry but it still appears to be at a relatively good level.

  Links were established many years ago by the Band Council with Tembec, the #1 employer of the region, and other local lumber industries in order to favor the employment of First Nations members. It paid off and still does by allowing First Nations members to access good jobs without the hindrance of prejudice toward their status.

- The social tissue also relies on a relatively good schooling level since, according to the results to a questionnaire passed in 2017, some 54% of the population completed high school, whereas it is evaluated at less than 10% overall in the First Nations reserves of the Abitibi-Témiscamingue region. The gap between both figures might indicate a bias in the research but it seems to indicate that KFN has more success than others in the schooling of its members.[6]

- Good level of relatively recent infrastructure since the reserve was established in the mid-70s, even if some facilities are definitely aging and becoming too small for their office needs (police station, First Line Services…)

- For the past decades, KFN has more often than not promoted political leadership guided by the separation of politics from the administrative process, allowing the administration to base its actions on more objectively defined long-term goals.

[4] The questionnaire form is presented in an appendix of the *5-Year Evaluation 2013-2018 Health Programs Evaluation, June 2017*.

[5] See Chapter 2, section 2.3.3.

[6] Numbers from 2013-2018 Health Plan. Mentioned document from FNQLHSSC has been archived.

- Kebaowek is located in an overall positive environment where one has an easy access to nature and the traditional activities it entails; not too small a town nearby which provides a good (even if certainly improvable) level of services; a local bilingual context which helps to have real access to these services; a major-sized town (North Bay) not too far away (80 km) where complementary services are accessible as long as you can benefit from a motor vehicle and even if some hindrances exist because of different provincial jurisdictions.

Participation of community members in the planning process

The community's participation in the planning process is more indirect than the other way around. It rests on a long-established process from when it was started around 2003 with the elaboration of the first Health Plan involving the current Health team and consultant.

Focus groups and survey in relation with the community's health status and preoccupations were used each time the Health Plan was renewed. Each year, with few exceptions, the Health team had the opportunity to meet with the population, presenting its priorities and goals, and gathering the community's comments and preoccupations. All these activities have been opportunities to receive comments, mostly constructive, and better understand the community's expectations. This communication is always a central activity directly related to the establishment of sensitive goals and objectives for the Health Centre's action plan.

Though it is seldom consulted by population members, the Health Plan has always been a public document. It is presented to the Band Council, the first representative of the population.

In another type of approach, the Health authorities have had contact with the people managing the establishment process of a *Comprehensive Community Plan.*[7] The main purpose of this communication is to make sure that the Health Centre's goals and objectives do not contradict those of the CCP.

[7] "Sustainable development is the guiding principle of comprehensive community planning." http://kebaowek.ca/CCP.html.

Acronyms used in this document:

CDCM: Communicable Disease Control and Management

CHN: Community Health Nurse

CMSSSTK: Centre multiservices de santé et de services sociaux de Témiscaming-Kipawa, also referred to as « The Hospital »

CPM: Clinical Programs Manager

CPNP: Canadian Prenatal Nutrition Program

CSSSS(TK): former name of a CISSS (Centre intégré de santé et de services sociaux) and former name of the CMSSST-K.

CWPM: Community Wellness Programs Manager

D&CDC: Diabetes & Chronic Diseases Coordinator

EPP: Emergency Preparedness Plan

FLM: First Line Manager

FLS: First Line Services

FNQLHSSC: First Nations of Quebec and Labrador Health & Social Services Commission

HC: Health Centre

HCN: Home Care Nurse

HS: Health Services

ISC: Indigenous Services Canada

KFN: Kebaowek First Nation

KFNHC: Kebaowek First Nation Health Centre

SL&M: Sport, Leisure & Mentoring Coordinator

SAA: Secrétariat aux affaires autochtones (Québec)

WAW: Wellness & Addictions Worker

CHAPTER 2

COMMUNITY MAPPING AND HEALTH STATUS

2.1 Geography

Kebaowek First Nation (KFN) occupies a territory of 21.49 hectares. It is located next to Kipawa, a village of 474 people (2011), at about 10 km north-east of Témiscaming, province of Quebec, a municipality of some 2400 people (2011). The area is the most southern point of the Témiscamingue region, itself part of the Abitibi-Témiscamingue administrative region, in western Quebec, resting on the Ontario border.

The closest cities are North Bay, Ontario, (about 54 000 inhabitants) some 80 kilometers south-west, and Ville-Marie, Québec, (2600 inhabitants) about 90 kilometers north-west and administrative centre of the Témiscamingue region.

The Kebaowek community is the main site of the permanent aboriginal occupation in the TK region.

2.2 Methods used for the assessment of the health needs of the community

Thoroughly explored for the 2013-2018 Health Plan process, the community needs were revisited during the five-year evaluation undertaken in 2017. This was especially done through a survey of 54 questions where a large array of themes were explored: the community's knowledge about health matters, life habits, health issues by gender, assessment of the community's social status, assessment and satisfaction in relation with the health services, individual health status, and comments about the health and social priorities for the coming years.

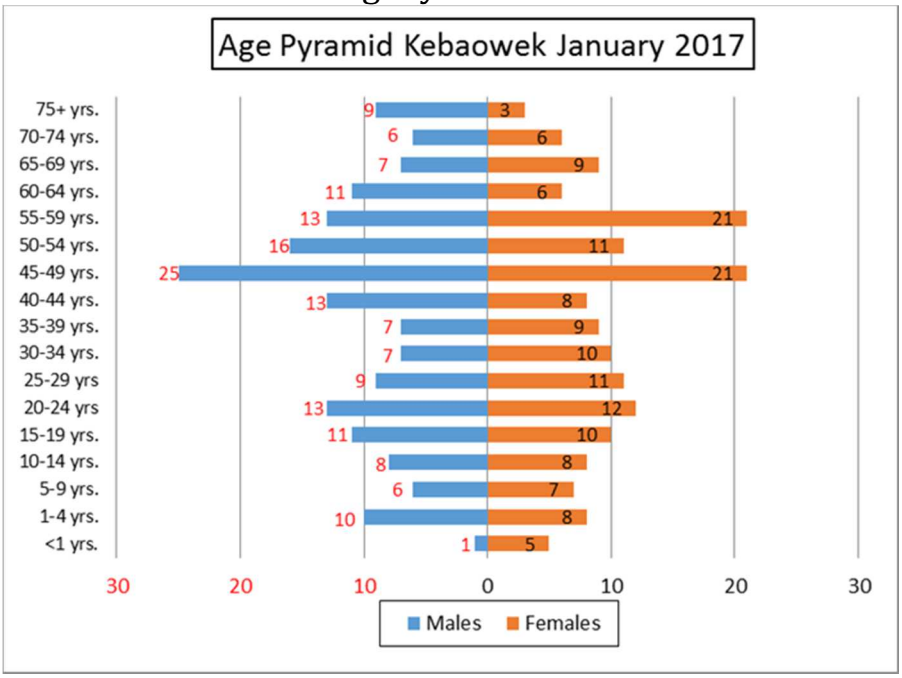
The evaluation report also comprised many tables and charts that provided information on the community health status (such as the description of the causes of consultation) which directly sheds light on the community needs.

Finally, the whole process was completed when the Health team engaged in discussions related to the definition of the priorities, putting forward some facts, comparing those to others, and weighing them to arrive at a consistent and realistic definition of priorities.

2.3 Basic health determinants

2.3.1 Demographic portrait

Chart 1: Age Pyramid Kebaowek



KFN is a non-isolated community of 337 residents; 288 status members (Kebaowek & Wolf Lake Bands); 49 non-status members. Some 89 members who live off-reserve but in the vicinity are currently registered as regular users of the KFN Health Services.

As of January 2017, the population is distributed as follow: less than 1 year of age, 6; between 1 and 4 years of age, 18; between 5 and 19 years of age, 50; from 20 to 60 years of age, 206; 60 years of age and over, 57. (See above Age Pyramid)

According to Statistics Canada from 2006 to 2011, the population numbers of Témiscaming and Kipawa decreased, by 11.6% and 16.1% respectively, whereas the Kebaowek population grew by 5.2%. Note that the Band Council's numbers, which is our base, and Statistics Canada's numbers slightly differ.

About 60% of the students of the English school sector in Témiscaming are Indigenous.

2.3.2 Mother tongue

According to the data of the Health Plan 2013-2018 (the numbers are deemed still valid by the Health workers):

About 96 % of the adult population of KFN use English as the usual language at home.

About 94 % of the population do not speak an Indigenous language.

2.3.3 Employment

Definition: The Work Force population is 15 years of age and over.

Table 1: KFN Work Force Description

WORK FORCE	
N/A	41
Other	44
Disability	2
School	61
Pension	23
Social Assistance	34
Home Care Ass.	14
Retired	16
Kebaowek	71
Tembec	31
	337

- 51% of the workforce is employed, 56% if the Home Care workers are included (66% in 2009)
- 12% of the workforce receive social assistance (13% in 2009)
- 14% are retired or receive an old age pension, or disability benefits (12% in 2009)
- 17% of the work force is still attending school

2.3.5 Housing

There are 52 single dwelling houses in the community.

Gathered from the answers to the 2017 Questionnaire, a typical KFN dwelling is a 3-bedroom household (46%) with 2 (28%) or 3 (30%) people living in it. The household income is over $40,000 (51%).

Incidentally, on a scale of 0 to 5 where 5 is the highest appreciation, 67% of the respondents gave a 4 or a 5 to the "*overall quality*" of their household.[8] The people between 35 and 45 years of age are slightly more critical about it.

2.3.5 Education

According to the results to the 2017 questionnaire, 44% of the respondents did <u>not</u> complete high school.

There is no school within the community. The children go to the G-Théberge school in Témiscaming. On the other hand, many parents take the decision to send their children to North Bay, such a decision being perceived by some as a major problem for the future of the Témiscaming community. It is expected that many of these children will not come back to their original smaller town in the province of Quebec. There is also the perception that more and more children register with the French program of the G-Théberge school.

[8] Question 10: *On a scale of 0 (minimum) to 5 (maximum), how do you assess the overall quality of your housing?*

2.4 Community health status

2.4.1 Causes for consultation

Table 2: Causes of consultation

2014					
Systems	No. of initial cases	% of initial cases	No. of subsequent cases	% of subsequent cases	No. of cases referred
Cardio-vascular	86	18.3%	211	37,5%	7
Dermatologic	74	15,8%	157	27,9%	13
Digestive	16	3,4%	3	0,5%	1
Endocrine	33	7,0%	97	17,2%	1
Locomotive	21	4,5%	2	0,4%	0
Nervous	22	4,7%	7	1,2%	4
Ophtalmology	11	2,3%	3	0,5%	6
E.N.T.	92	19,6%	24	4,3%	27
Reproductive	17	3,6%	13	2,3%	3
Respiratoiry	27	5,8%	12	2,1%	13
Mental Health	8	1,7%	0	0,0%	3
Traumatism	52	11,1%	30	5,3%	13
Urinairy	10	2,1%	4	0,7%	7
TOTAL	469	100,0%	563	100,0%	98

In 2013, the total number of initial cases was 401, and subsequent cases were 701 amongst which 366 were related to the cardio-vascular system.

Probably due to the quality of the services and follow-up, consultation cases seem to steadily increase. The cardio-vascular system is the #2 cause of consultation, E.N.T. being the first, both closely followed by Dermatologic consultations.

The importance of the cardio-vascular system as a cause of health problems also shows in the causes of death on-reserve. It is the second cause of death after the various forms of cancer.

Table 3: Causes of death

Causes of death KFN 2013-2017			
Cause of death	**Men**	**Women**	**Total**
Endocrine, nutritional and metabolic diseases, and immunity disorders	0	0	0
Respiratory system	1	1	2
Ill-defined conditions	0	1	1
Motor vehicle crash	0	0	0
Snowmobile /ATV	0	0	0
Ischaemic Heart disease and Myocardial infarction	2	2	4
Cerebrovascular disease	1	0	1

All other diseases of the circulatory system - unspecified	1	0	1
Lung cancer	0	1	1
Female breast cancer	0	0	0
Neoplasms of unspecified nature	3	3	6
TOTAL	8	8	16

2.4.2 Diabetes status evolution

According to the number of members registered in the KHS Diabetes Program (which does not necessarily encompass all Band members diagnosed with diabetes) the prevalence of diabetes on-reserve was around 11% in 2012 (38 members registered) and around 12% to 15% in 2016 (57 members registered) [See the assumptions for the establishment of this calculation in the *Evaluation Report, Health Plan 2013-2018, Health Priorities - Diabetes Program* section.)

In the Evaluation Report of 2010, the diabetes prevalence rate in the whole Témiscaming/Kipawa area was defined at 4.7%. Statistics Canada in a document of 2008 assesses the overall prevalence of the illness in Canada at 5%[9] as for Diabetes Canada; it estimates the prevalence at 9.3% in Canada in 2015[10].

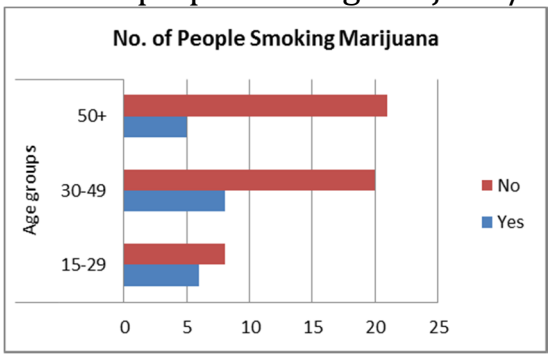
2.4.3 Lifestyle

- Cigarette smoking

Assuming that the sample of respondents represents the whole community of KFN, women smoke significantly more than men, and as a group they seem to smoke more than men do. (Question 19)

- Marijuana smoking[11]

Chart 2: Number of people smoking marijuana/ Age groups



[9] http://www.statcan.gc.ca/pub/82-229-x/2009001/status/dia-fra.htm

[10] http://www.diabetes.ca/how-you-can-help/advocate/why-federal-leadership-is-essential/diabetes-statistics-in-canada. It is not impossible to think that this could prove true if all Canadian communities were as closely monitored as the First Nations are.

[11] Because of the small numbers, we enlarged the age group to protect respondents' confidentiality. The frequency in the use of marijuana appears in *Appendix 8 KFN Population General Picture* in *Evaluation Report of the 2013-2018 Health Plan*

Some 19 respondents (28%) out of the 68 who answered the question said that they use marijuana.

- Alcohol drinking

5% of the respondents claim to have 10 or more portions of alcohol in a week.

- Traditional medicine

The use and interest toward traditional medicine is directly linked with the *Culture* determinant of health as identified by Health Canada.[12]

We explored the community's perception and interest toward traditional medicine through 5 questions, by going from knowledge self-assessment to interest in learning more and degree of utility for the KHS. Details are available in *Appendix 6 Traditional Medicine and Knowledge* of the *Evaluation Report of the 2013-2018 Health Plan*.

Women note a decrease in traditional activity within the community whereas more men tend to see an increase in it.[13]

Though respected by a majority of the community members, traditional knowledge is not seen as a major part of the community's health experience nor do they consider that it has to be addressed as a priority. The strong grip of colonialism may explain or be part of the explanation for this relative unconcern.

2.5 Social adaptation & health status perception

The following figures are meant to deepen the image of the KFN by having a glance at its liabilities column.

Table 4: Major threats to community health as identified by respondents[14]

THREATS	2017	2009
Drug consumption	56	56
Alcohol abuse	23	41
Lack of communication	22	8
Bad eating habits	19	24
Diabetes	16	21
Lack jobs	14	2
Cancer	12	7
Tobacco abuse	10	0
Lack physical act.	9	11
Lack leisure activ.	7	2
Gambling addiction	5	7
Heart disease	3	1
Violence	2	0
Community isolation	2	0
Other	2	1

[12] https://www.canada.ca/en/services/health/determinants-health.html

[13] Question 43: *Based on your perception, would you say that, over the past 5 years, traditional activities (hunting, fishing , trapping, handcraft..) in the community…Have decreased; Have remained the same; Have increased. Survey 2017.*

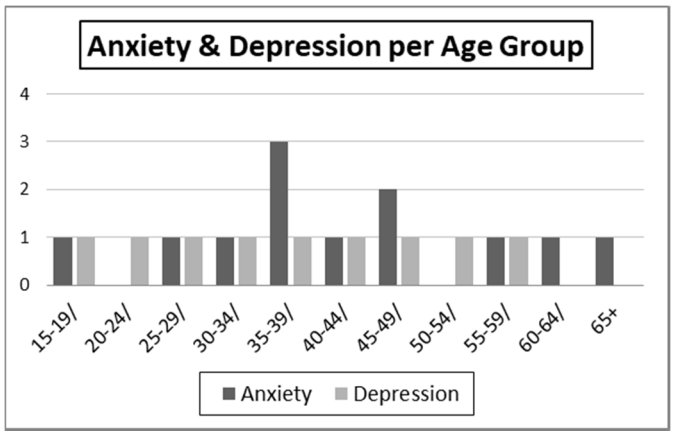
[14] Question 37: *Identify what you think are the 3 most important threats that breach the community health circle? (Check three answers)*

Alcohol abuse is less of a preoccupation than drug abuse, which maintains its high status in the preoccupation scale of the population. Tobacco use rises as a new preoccupation, as well as the lack of jobs, leisure, and communication.

The lack of communication, a complex idea, would benefit from some exploration. Could it mean a socio-political polarization within the community as seems to exist in a large part of the Western World?

Diabetes, may be because it takes much place in the health centre's communication agenda, yields place to cancer as the strongest health preoccupation amongst the population. Besides, cancer is the main cause of death in the community. (See 2.4.1)

Chart 3: Mental health condition treated[15]



Mental health is a rather recent preoccupation within the community. The preceding chart shows that this issue is not meaningless for the social and personal lives of the community members.

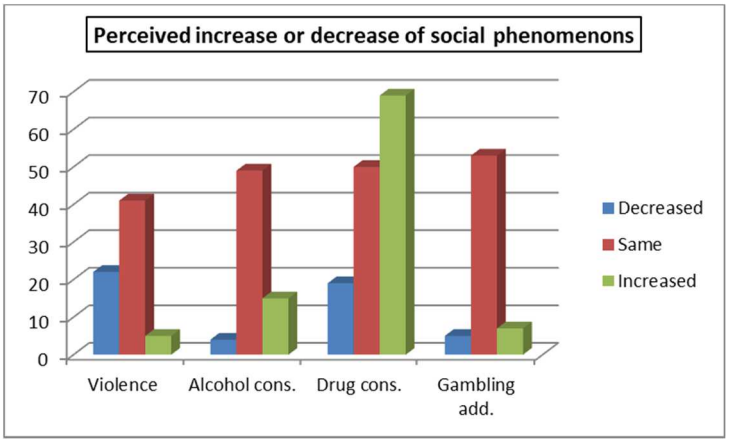
Table 5: Number of "signalements" and "signalements" retained

Year	No. of *Signalements* received	No. of *Signalements* retained	% Retained
2011-2012	20	2	10%
2012-2013	12	4	33%
2013-2014	6	2	33%
2014-2015	21	13	62%
2015-2016	15	7	47%

[15] Question 51: *Within the last 5 years, were you diagnosed or treated for one of these conditions: (select all that apply).* Survey 2017.

Probably because of the small numbers the figure "Number of "signalements" considerably varies from year to year. Table 5 will help identify targets for the action objectives.

Chart 4: Level of increase as a threat (Violence, drug, alcohol, gambling)[16]



In the 2017 questionnaire, the increase of drug use is the only phenomenon largely deemed as increasing, as the others are considered as remaining the same since 2010.

[16] Questions 39 to 42: *Based on your perception, would you say that, over the past 5 years, ……. in the community has decreased, has remained the same, has increased?* Survey 2017.

CHAPTER 3

SERVICE ORGANIZATION

3.1 Fundamental health values

The mission and the values of the Health Services were first defined during the health plan definition process of 2003. Meetings with all the health staff had taken place and such definitions had been thoroughly discussed to establish the services' backbone.

Later on in 2008, the Health Services, assisted by staff members, revised the mission and designed a vision to be incorporated into the 2009 annual report presented to the community. At the same time, the health team added two values to the previous choices.

Recently, an *ad hoc* committee reassessed the mission and the vision for the current health plan and simply modified a few words to clarify the text, otherwise leaving the content as it was.

3.1.1 The mission

To deliver quality Health and Wellness Programs and Services to our members with respect and courtesy;

To empower, promote and encourage healthy lifestyles whereas illness, disease, and addictions no longer threaten our people.

3.1.2 The vision

That our health status in no way sets us apart from the other Canadians in a negative way;

That all members of our Nation live their lives to the fullest in a healthy and holistic manner.

3.1.3 The values

- Respect of others' lifestyle choices

People are the first ones responsible for their own health and they are entitled to make their own choices. It is the responsibility of the Health Centre to give them the proper information but not to interfere in their decisions as long as they don't jeopardized others' health or quality of life.

- Confidentiality

People are entitled to respect of their personal life and privacy. Thus we, Health Workers, will perform our duties while respecting their right to confidentiality.

- Trust

Trust amongst ourselves, the Health Workers and the members of the population are a central axis of our way of working. Such value is completed by the autonomy that we

should each show and the solidarity amongst ourselves that will benefit and help all of us.

- Open to Suggestion (Non-Judgmental)

The Kebaowek Health Centre is not a self-sufficient institution and it doesn't claim to know all the answers: thus listening to others' opinions and using eventual criticisms for the betterment of our services will make up a permanent attitude.

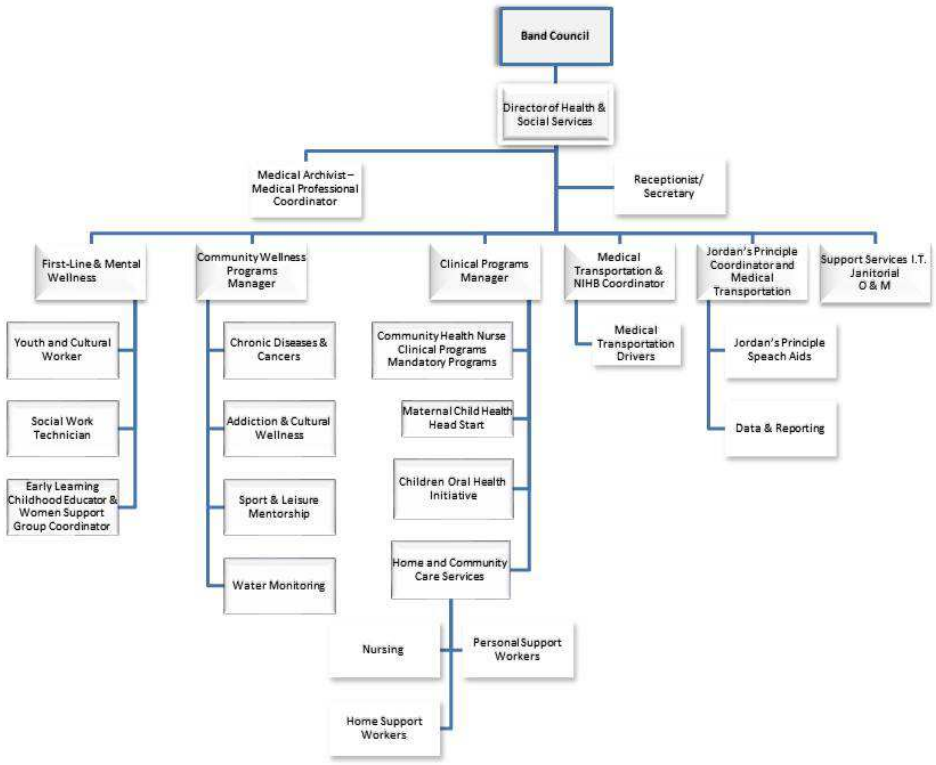
- Caring

We, the Health Workers of Kebaowek, think that we cannot be concerned with the physical and mental health of our community, if we don't care about the people and the conditions they live in.

3.2 Organizational chart - K Health Services

The KHC punctually modify its organizational chart in order to reflect the administrative improvements or arrangements made to enhance the delivery of the services, while being able to manage the numerous administrative tasks. The following chart reflects the reality of the organization as of fall 2018.

Chart 5: Organizational Chart of K. Health Services



3.3 Human resources

KHC rests on the work of 16 health workers and administrative personnel, plus the janitors and medical transportation drivers.

Officers

- Health & Social Services Director
- Clinic Programs Manager
- Community Wellness Programs Manager
- First Line Programs Supervisor

Workers

- Community Health Nurse
- Diabetes & Chronic Diseases Coordinator
- Early Learning Childhood Educator/Women's Support Group Coordinator
- Homecare Nurse
- Jordan's Principle and Data Central
- MCH/HS Worker
- Medical Receptionist
- Medical Transport Coordinator and NIHB Coordinator
- Social Services Technician
- Sports, Leisure & Mentoring Coordinator
- Wellness & Addictions Worker
- Youth & Cultural Worker

The job descriptions are included in Appendix 1.

The Clinic Programs Manager, the Community Wellness Programs Manager, and the First Line Programs Supervisor are under the direct supervision of the Health and Social Services Director.

3.4 Delivery of community services

Prevention is the first mandate of the KHC, which aims at improving community health by offering various forms of primary and targeted health care to the community members, by offering a large array of prevention sessions and by providing support to the community networks.

3.4.1 The Executive Committee

In the 2013-2018 Health Plan, a new managing sector was created encompassing a Clinical Management and a Community Wellness management. A few months later, First Line Services were put in place with a First Line management.

The mandate of these managers was to plan the deployment of the planned activities and to help the workers by eliminating the elements that prevent their effectiveness, to get ready for the up-coming challenges through the development of effective

partnerships, the enhancement of the HC's capabilities, and the development of efficient tools.

In 2018, in order to improve coordination between the three sectors, to help distribute the responsibilities within the administration, and to promote information exchange between services, it was decided to establish an "Executive Committee", its creation included in the 2018-2023 Action Plan. The Executive Committee comprises the three managers and the director of Health & Social Services.

The main mandates of the Executive Committee, as indicated in the action plan, are:

- To supervise the development of any new program, project, or policy;
- To supervise the development of any new tool designed for the evaluation of the activities and objectives;
- To supervise and monitor the administration of surveys or documental research to establish a baseline in order to measure the evolution of indicators;
- To promote and assist in the development of new partnerships within or outside the community.

3.4.2 Community health services

3.4.2.1 Wellness & Addictions

Responsible for delivery of the service: Wellness & Addictions Worker. Full-time employee, under the supervision of the Community Wellness Programs Manager (See job description for more details in relation to tasks).

Locations for delivery: the Wellness & Addictions Worker works at the Centre for walk-in or appointment visits. She is often needed outside the Centre for one-on-one or family interventions in the home, or for leading group activities, workshops, and presentations.

Services: evaluation and assessment for readiness for rehab; set up for referral (treatment, detox, counselling; post-treatment follow-up, and support for aftercare; ongoing support pending treatment; prevention workshops); workshops for community members, for all age groups and through intergenerational activities.

Referral: The client can be referred through other Health Centre workers or he/she can simply decide by him/herself to engage in a healing relationship with the Wellness & Addictions Worker. It is currently a proactive process with no formal entry access. In order to be able to distinguish between individuals who are in an active reorganization of their lifestyle from those who have started but put their personal process on hold, we have decided to treat the individual files as a case load, opening and closing the files under certain conditions.

3.4.2.2 Targeted chronic diseases & cancers

Responsible for delivery of the service: the Diabetes & Chronic Diseases Coordinator. Full-time employee, under the supervision of the Community Wellness Programs Manager.

Locations for delivery: she works mainly at the Centre in her planning activities but she mostly runs her activities outside the Centre such as at the community centre, and will often participate in external activities such as screening or awareness activities.

Services: Technical training for patients during the diabetes clinics; screening clinics in collaboration with the nursing department; management of the lists of individuals registered in Chronic Disease programs; prevention workshops at school and with adults during awareness activities; special events organization; awareness support during other workers' activities; often collaborates with the Sports & Leisure Mentorship who introduces the physical activity component of an activity such as in the Diabetes program.

Referral: The Diabetes & Chronic Diseases Coordinator works in close partnership with the nursing service that will refer the diabetes or chronic disease patients (those who choose to participate) to her for awareness and knowledge transfer, which is part of the work she does in the diabetes and targeted chronic disease clinics.

Table 6: Prevention activities – Chronic diseases

Chronic disease and injury prevention activities	
Physical activity	
Awareness activities related to physical activity (e.g.: Diabetes Walks, Healthy Living Awareness Days)	√
Walking challenges	√
Physical Activities	√
Traditional physical activities (e.g. jigging, dancing, games, snowshoeing, canoeing)	√
Nutrition	
Cooking sessions or classes (including community kitchens)	√
Additional	
Traditional harvesting, food preparation, food preservation (e.g.: berry picking, cleaning fish, canning, etc.)	√
Healthy eating awareness and education (e.g.: health fairs, radio shows, etc.)	√
Community gardens	√
Healthy Food security Boxes	√
Additional	
Diabetes information sessions or workshops	√
Development of resource materials (e.g.: posters, cookbooks, displays, guides, etc.)	√
Injury prevention training and awareness-raising (e.g.: safety committees,	√

tool kits, "A Journey to the Teachings" training, etc.)

3.4.2.3 Sports, Leisure & Mentoring

Responsible for delivery of the service: The Sports & Leisure Mentorship Worker. Full-time employee, under the supervision of the Community Wellness Programs Manager.

Locations for delivery: Based in the Centre for his planning hours, the SL&M Worker mainly has his activities outside, at the community's playgrounds, at the school, or at the community centre.

Services: the systematic organization of outdoor or indoor physical activities for youth on the reserve during after-school hours; supports the physical activity program at school in collaboration with school personnel; inclusion of physical activities within the targeted chronic disease & cancers and the diabetes programs delivery for the benefit of the concerned community members; occasional set-up of adult-targeted physical activity programs or services. The SL&M's function could realistically be described as cross-sector within the health services. His physical expertize is often provided within other programs or services of the Health Services, upgrading these by a physical component oriented toward the promotion of physical activities.

Comments: The mentorship aspect of the worker's mandate refers to the Health Centre's role of promotion of physical activities and good eating habits. Among other ways, it assumes its role by offering youth a role model who delivers his services through personal support, as well as small and larger group activities.

3.4.2.4 Infant & Child Development

Responsible for delivery of the service: the MCH/Head Start Worker assumes a large part of the education and counselling tasks associated with these services. The CHN is responsible for its clinical component. The service is under the supervision of the Clinic Programs Manager. The HCN could also participate if needed.

Locations for delivery: The daycare centre is the main venue for the service delivery. The Health Centre is another usual location especially for administrative tasks. The worker or the nurses will easily do home visits to provide services to the new mother.

Services: prenatal workshops identifying 7 topics (disease, diet, physical activity, medication, self-monitoring, complications & preventive measures, lifestyle); workshops about Foetal Alcohol Spectrum Disorder; linkage with the Head Start and the Brighter Futures programs; 5 periodical visits paid to the parents (mothers) with provision of "packages" adapted to the child development period and meant to provide relevant information and reinforce the verbal teaching provided. Considering the small number of births within the community, these activities are mostly provided on a one-on-one basis.

The MCH/Head Start worker is in close relation with the FL worker, "*Early Learning Childhood Educator*", who regularly comes to the daycare centre within the "*Avenir d'enfant*" program activities. The MCH/HS worker delivers the CPNP program in collaboration with the CHN.

The following tables summarize the MCH/HS worker's and her partners' activities with the children and parental population of the community.

Table 7: Activities - Nutrition

Pre- and Postnatal nutrition activities offered
Nutrition Screening, Education and Counselling
- One-on-one nutrition counselling/education
- Baby food making workshops/classes
Maternal nourishment
- Prenatal Nutrition Program - supplement
Breastfeeding Promotion, Education and Support
- One-on-one breastfeeding support
- Breastfeeding education and support
Supportive Elements that address specific needs of at-risk clients (i.e., transportation, child care, etc.)

Table 8: AHSOR Definition

Aboriginal Head Start On-Reserve (AHSOR)		
Does your AHSOR program offer Outreach/Home-visiting?		No
Is your AHSOR site Centre-based?	Yes	
Is your AHSOR program licensed?	No	
How many full/half days per week does your Centre-based AHSOR program operate?	5	
Is your AHSOR program co-located?	Yes	
If YES, is your AHSOR program co-located with a school or daycare facility?	Yes	

Table 9: AHSOR Activities

AHSOR activities	
Teaching children their First Nation language(s) (e.g., reading a story, teaching letters or numbers, etc.)	√
Traditional ceremonies and activities (e.g., smudging, gathering traditional foods, visits from Elders, etc.)	√
Early literacy skills (e.g., reading to children, singing songs, etc.)	√

Fine and gross motor development activities (e.g., catching a ball, holding a pencil, etc.)	√
Providing healthy foods (snacks and/or lunches)	√
Healthy personal hygiene and dental habits (e.g., teeth brushing, hand washing, etc.)	√
Physical activity (e.g., outdoor play, games, dance, etc.)	√
Linkages (including referrals and collaborations) to professionals and community supports and providers (e.g., housing, education, specialists, etc.)	√
Parent and family support activities	√
Visits from health professionals (e.g., nurses, dental hygienists, others)	√
Safety education and awareness activities, (e.g., playground safety, car seat technician training, car seat use, seat belt use, bike safety, etc.)	√

3.4.3 First Line Services (FLS) & Mental Health Wellness

Responsible for delivery of the service: First Line Social Service Workers (3). Full-time employee, under the supervision of the First Line Programs Supervisor. The titles are: *Early Learning Childhood Educator/Women's Support Group Coordinator, Social Services Technician, Youth & Cultural Worker*.

Locations for delivery: the services are currently dispensed in an office close to the Health Centre, at the daycare centre, and also in clients' homes or in public spaces when appropriate.

Services: the First Line Social Services focus on families, and especially child, youth, and elders. They provide such services as: Family Violence, Food Security (Food Bank), Elder Support (ITMAV), Mini-Pals (parenting skills), Wills & Estates, Victims of Violence. These services are provided by a staff of three workers plus the manager.

Referral: the First Line workers closely collaborate with the daycare workers, the home care nurse and the Sport, Leisure & Mentoring Coordinator. Referrals will also come from these people who are in close relationship with individuals potentially needing services. Any other worker on the team or from outside the Health Centre can refer an individual to the First Line Social Services. The Food Security program (Food Bank) constitutes an important access channel to the FLS.

Suicide prevention is also under the FLS's responsibility.

Table 10: Prevention activities - Suicide

Suicide prevention activities	
Awareness activities (e.g.: increasing knowledge of suicide rates and contributing factors, addressing myths and pre-conceptions about suicide, increasing communication about suicide, and decreasing stigma)	√
Sport, leisure and other activities to engage youth	√
Traditional activities to engage youth (e.g.: land-based activities, cultural practices, skill development)	√
Life skills activities for youth (e.g.: leadership, relationships, problem solving, developing positive coping skills)	√
Training on signs and symptoms and responding to suicidal behaviour (e.g.: ASIST, SafeTalk, Mental Health First Aid, train-the-trainer sessions, CISM)	√
Crisis intervention (e.g.: mobilizing to prevent spread of suicide)	NOT (yet)
Mental wellness promotion and support: Wellness activities teach and promote ways to increase well-being, focusing on positive choices for all, regardless of the risk for mental health issues and addictions.	
Wellness activities promoting mental health (e.g.: parenting skills, self-care, managing stress, positive relationships, emotional and spiritual well-being). Activities may include community celebrations and leisure activities, including physical and social activities.	√
Substance abuse, addictions and mental health activities	
Presentations and workshops aimed at preventing substance abuse	√
Cultural events to support prevention of addictions and substance abuse, as well as awareness of mental health issues	√
Addictions recovery support groups	√
School-based programs to support awareness of substance abuse and addictions	√
Mental health crisis intervention activities (other than those specific to youth suicide prevention)	NOT

3.4.4 Medical Transportation & NIHB

Responsible for delivery of the service: the *Medical transportation & NIHB coordinator* shares her time between these two tasks. Full-time employee under the supervision of the Health and Social Services Director.

Locations for delivery: Health Centre

Services: medical transportation and NIHB management.

3.4.5 Jordan's Principle, Data Central & Accreditation

Responsible for delivery of the service: Jordan's Principle Worker. Full-time employee under the supervision of the Health and Social Services Director.

As pressure from demands has receded in the recent months, she is also assisting the Medical Transportation Coordinator in her task, and devoting her remaining time to her data centralization responsibility for the upcoming implementation of I-CLSC, a data collecting program to be provided by the provincial health system. There is no *job description* related to that specific job.

3.4.6 Training program

In relation to the above-mentioned job summaries and the job descriptions presented in Appendix 1, a training program is established for the duration of the Health Plan, 2019-2024. See Appendix 7.

It is to be noted that besides the listed workshops and trainings in Appendix 7, all employees will also receive training on Research Protocol and on Traditional medicine.

3.5 Confidentiality

Many years ago, KHC adopted a "Protocol concerning the confidentiality and management of client files at the KHC". The protocol completed the confidentiality standard emphasized by the Band Council in its Policy and Procedure Manual:

"*10.8.1 Because of the nature of and their scope of work, some Departments or Activity sectors, such as the Health Center, Social Assistance, Human Resources, Membership and others, collect personal information on their clients. All Directors, Administrators and Employees in particular, entrusted with the personal information on their clients, will abide by the policies, rules and regulations of their respective Departments or Sectors of activities regarding the gathering, the filing and disposal of information for the purpose of their work.*"[17]

Basically this protocol is made up of 14 sections: 1. General; 2. The basic principles concerning the user file; 3. The file's content; 4. The documents required by the Act; 5. The conditions for refusal of treatment; 6. The user file access policy; 7. User file access by a health worker; 8. User access; 9. Information requests over the phone by the user; 10. Access by a third party with the user's explicit authorization; 11. Third-party access without the user's authorization; 12. The distribution of user files; 13. The creation of user forms.

In Appendix 2, the Reader can access the Protocol concerning confidentiality and the Confidentiality form which is to be signed by every health worker in the first days after the hiring.

[17] http://documents.kebaowek.ca/HRPoliciesEmployeesHandbookOctober2011.pdf. P.86.

3.6 Human resources management

It is possible to access the Kebaowek Human Resources Policies on the KFN's Web site. The PDF document is entitled *"Policy and Procedure Manual"*.

The opening sentence of the document reads as follows: *"This Policy and Procedure Manual is intended for the impartial process of Kebaowek First Nation"*[18].

Table of Contents of the Policy and Procedure Manual

- Introduction
- Mission Statement
- Table of Contents
- Section 1 Roles and Responsibilities of Chief, of Council and Management
- Section 2 Definitions
- Section 3 Organization of Work
- Section 4 Vacation, Holidays and Employee Benefits
- Section 5 Allocation of Human Resources
- Section 6 Evaluation of Human Resources
- Section 7 Development of Human Resources
- Section 8 Working Conditions
- Section 9 Travel Policy
- Section 10 Code of Ethics
- Section 11 Harassment in the Work Place
- Section 12 Conflict of Interest Code
- Section 13 Appeal and Complaints Policy
- Section 14 Purchases, Contracts and Tenders Policy
- Section 15 Electronic Etiquette, Security and Procedures
- APPENDICES
    - Appendix 1 Solemnly Declare
    - Appendix 2 Overtime Request Form
    - Appendix 3 Absence Request Form
    - Appendix 4 Benefit Program
    - Appendix 5 Evaluation Form
    - Appendix 6 Salary Scales
    - Appendix 7 Travel Claim
    - Appendix 8 List of Violent and Inappropriate Behaviours in the Workplace
    - Appendix 9 Certificate of Compliance with the Code of Ethics
    - Appendix 10 Meeting with the Appellant Form
    - Appendix 11 Complaint Form
    - Appendix 12 New Employee IT Form
    - Appendix 13 Confidentiality Declaration

The Reader will note that all the elements of a sound and organized Human Resources Policy (working schedule, employee benefits, etc.) are included in the Manual. The Salary Scales introduced in Appendix 6 are actually presented on a separate precautionary document not posted on the Web site. This policy is managed through a

[18] Idem

Human Resources Department within the Band Council administration. It was revised in 2011.

3.7 Professional supervision

In the spring of 2018, Health Canada in junction with University of Montreal and the Centre for Innovation in Nursing Education held a training session presenting the "Professional Development Guide of Quebec First Nations Community Nurses". The training session included support in the development of an implementation plan which end/ purpose / mandate is to implement a competency framework in order to support nurses' specific practice within the First Nation Community. The KFN implementation plan has been created with specific objectives and strategies which have been forwarded to the Health Director for review.

As per the implementation plan, Objective 1 has been completed in the timeframe suggested this year. Thus far, we are on track with objective #2 timeframe ends of 2018 / beginning of 2019 where the KFN guide is to be presented to upper level management and Chief and Council for approval and acceptance and support with implementation and a degree of integration within the HR framework for the Health Center staff.

The action plan is available in Appendix 3.

CHAPTER 4

MANAGEMENT STRUCTURE

Under the flexible funding agreement between Health Canada and KFN, first signed in 2004, the latter receives funding for a certain number of programs, but internally uses its own labels to identify services delivered to the population.

Contribution agreement number: QC700047

Highest type of funding: Flexible

4.1 Initial programs offered

Here is a list of the current programs (2018) financed by the funds providers and their corresponding services as offered by the KHC until recently when the health plan process really got engaged.

Table 11: Programs and services

Funding Program Names	Programs & Services Kebaowek Health Services
Funding: ISC	**Clinical & Mandatory Programs**
Aboriginal Diabetes Initiative	CHN- Nurse Walk-in Clinic services Clinical Prevention & Wellness
Brighter Futures	COHI – Children's Oral Health Initiative (dental hygienist)
Building Healthy Communities	CDC- Communicable Disease Control Hepatitis C STBBI /HIV
COHI – Children's Oral Health Initiative	Immunization
Communicable Disease Control - CDC	**Home &Community Care (HCC)**
Community Based Water Monitoring (Water testing)	Homecare Nurse
Community Primary Care / Nursing	PSW- Personal Support Worker
Environmental Research	HSW- Home Support Worker
Fetal Alcohol Spectrum Disorder	**Infant & Child Development**
Head Start	Maternal Child Health program (MCH)
Home and Community Care	Head-Start Program (HS)
Indian Residential Schools Resolution Health Support Program	Canadian Prenatal Nutrition Program (CPNP) (OLO)
Maternal & Child Health	**Prevention Programs**
Medical Transportation and NIHB Support	Addiction & Wellness

National Aboriginal Youth Suicide Prevention Strategy	Diabetes & Chronic Diseases
National Native Alcohol and Drug Abuse Program (NNADAP)	Sport, Leisure & Mentoring
Prenatal Nutrition Program	Community Based Water Monitoring
Sexually Transmitted Blood Borne Infections – HIV/AIDS/HEPITITIS C	Tobacco Control Strategy
Vaccine Preventable Diseases- Immunization	Nutrition Program (Community Food Security Project)
Youth Solvent Abuse Program	Medical Transportation & NIHB
	First Line Services & Mental Wellness
Funding: INAC	Family Violence Food Security (Food Bank) Elder Support (ITMAV) Mini Pals (Avenir d'enfant) Wills & Estates Victims of Violence
Elder Abuse	Aboriginal Youth Suicide Prevention Program - FQIS
Nutrition (Eating well)	Environmental Health & Safety
Parenting Skills (Mini Pals)	
Funding: Other Sources	
Child Development Support – Avenir d'Enfants (predicted to sunset in fiscal year 2019-2020)	
Fonds Québécois d'initiatives sociales (FQIS) (will terminate at the end of fiscal year 2018-2019 but could be renewed)	
Fonds d'Initiatives Autochtones (FIA III)[19]- under the Community Action component – Healthy Lifestyle Habits. Funding ending March 2022.	

4.2 Health management

The Health & Social Services Director is the first person accountable to the Band Council; he reports to the Council about the scope of the health objectives in compliance with the Council's own objectives, which are indicated in the *Political organization* paragraph of the current section. He will also regularly discuss health issues with the Chief who is the Band Council member responsible for the Health Services portfolio.

[19] http://www.autochtones.gouv.qc.ca/programmes-aide/fia3/FIA-III-WEB.pdf

Furthermore, according to need but usually not less than once a year, the community is invited to information sessions about the band's management, which includes the Health Services. From time to time, Health Services will organize an information session of their own in order to address special issues. These are privileged spaces for the public to voice comments and put forward eventual questions.

Also, there is a formal procedure for client complaints; eventual complaints usually take the form of personal requests to the Health Director or to Band Council members. The complaint process and forms are to be found in *Chapter 13, Appeal and Complaints Policy* of the *Policy and Procedure Manual* of the Band Council, which is available on the KFN's Web site.

4.2.1 Political organization

One chief and three councillors are elected every two years to form the KFN's Band Council. They meet on a very regular basis to, among other things, supervise the management of seven main branches: Health Services, Daycare centre, Police department, Fire department, Land Management, Economic Development & Natural Resources direction, and Migizy gas station[20].

The Band Council's mission statement reads as follow:

"*Political:*

To adequately and transparently represent the members of the community on all government levels and issues according to the direction of its members that will ensure the growth and development of the community.

To promote and protect the collective interest of all Eagle Village First Nation members; through the strength and will of its people and guided by their values, culture and traditions.

Administrative:

To provide equal and fair opportunities to all members accessing programs and services according to established policy and procedures for the betterment of the community."[21]

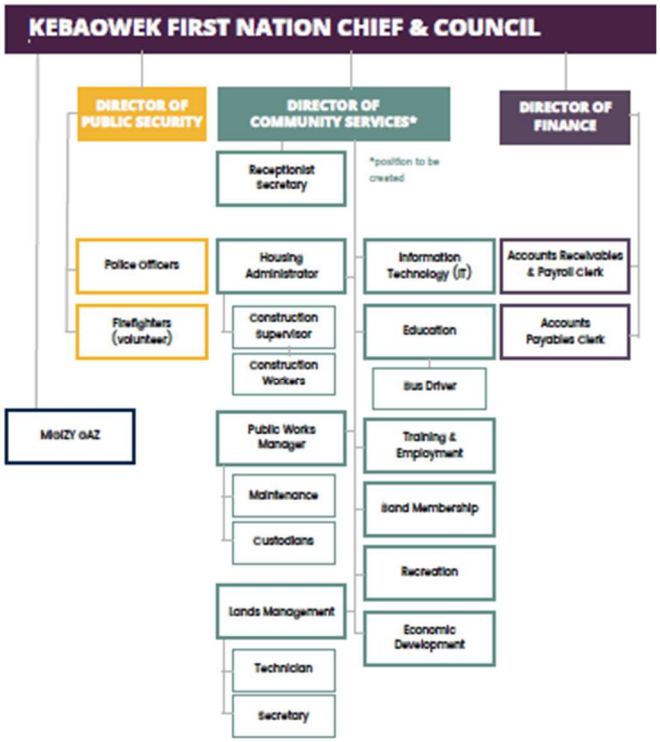
There is currently no general director.

A rather recent agreement between KFN and the Public Security Ministry of Quebec allows a complete renewal of the police force, which consists of one chief and three officers. As for the fire department it is composed of more or less 14 volunteers and one part-time chief. The fire hall, built in 1998, houses one fire truck (pumper).

[20] Migizy gas station is a for-profit facility that provides gas service, convenience store products and fast food restaurant.

[21] http://documents.kebaowek.ca/HRPoliciesEmployeesHandbookOctober2011.pdf

Chart 6: Organizational Chart KFN[22]



4.2.2 Health portfolio mandate in the Band Council

For the past years, the chief, as head of the Band Council, has the responsibility of the health portfolio. His mandate is to supervise the Health Centre provision of services and management in regard to the following articles described in the *Policy and Procedure Manual* of the Band Council presented on KFN's Web site.[23]

« *1.3 Responsibilities of Council*

1.3.5 Envision the development and prosperity of Kebaowek First Nation by setting long, medium and short term objectives including priorities.

1.3.10 Approve operational plans.

1.3.11 Approve annual and multi-year budgets.

1.3.12 Control the efficiency and effectiveness of the Administration."

On the other hand, the program director, such as the Health & Social Services Director, has his own responsibilities under the Band Council authority.

[22] According to Kebaowek First Nation Strategic Plan. http://documents.kebaowek.ca/FINALKFNStratPlan2017.pdf

[23] http://kebaowek.ca/Documents.html

"1.6 Responsibilities of the Program Directors

1.6.1 Under the direction of Council and respecting the policies, orientations and priorities of Council, the Program Director is responsible for the management and administration of the programs and services under the jurisdiction of the Council.

1.6.2 The Program Director is accountable to the Council.

1.6.3 The Program Director is responsible for implementing the Council's decisions.

1.6.4 The Program Director is responsible for serving Kebaowek First Nation members by ensuring their health, well-being and security."[24]

4.2.3 Band Council priorities

Elected for two years in the summer of 2017, the KFN Band Council established four priorities in relation to the vision described earlier: culture, economic development, education, and safety.

The vision: "*To develop into a strong, unified community whereas our Anicinabe rights and ownership to our traditional territory have been acknowledged by all government levels.*

Whereas our community, through economic development, can prosper in a sustainable manner to be self-sufficient."[25]

Over the years, culture has become an important priority in the Health Centre's delivery of services and as a Band Council preoccupation since it has long been established that a well-anchored identity is a health determinant, as identified by Health Canada and supported by ISC.

"*Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services*." [26]

In KFN, the status of the Algonquin language is seriously declining coming very close to a loss. The community is therefore motivating itself to regain some of its cultural fundamentals eventually using more efficient tools in order to more properly address the health issues they are facing daily.

4.3 The challenge of data collecting

For many years, the Health Centre authorities have been aware of the necessity to implement a sound data collecting system in order to better define attendance for

[24] http://documents.kebaowek.ca/HRPoliciesEmployeesHandbookOctober2011.pdf

[25] idem

[26] https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/what-makes-canadians-healthy-unhealthy.html#culture

activities, evaluate their level of popularity on the long term, and better assess the impacts.

A significant step forward was taken when the Health Centre hired a Data clerk whose task was to secure the Centre's data in one central virtual space. The process is in motion but was slowed down by new priorities (Jordan's Principle) and staff shortage.

Efforts are also made by the provincial government and the Commission (FNQLHSSC) to help provide better data collecting tools to the communities. KHC is devoting its energy to the acquisition of i-CLSC, the provincial network of data collecting and report producing. This tool is expected to be an important asset in relation with the data collecting and reporting challenge.

4.4 Tribal Council

KFN is part of the Algonquin Anishinabeg Nation Tribal Council (AANTC), which mainly offers technical services assistance, support with human resources hiring, and research expertise.

"The Council has established two key priorities: the protection and advancement of the human rights of indigenous peoples, particularly those of the Algonquin Nation, and to provide support to the member communities in human resources management, policy, communications and construction."[27]

[27] http://www.anishinabenation.ca/en/

CHAPTER 5

COMMUNITY RESOURCES

5.1 General assets

Kebaowek First Nation is a community that relies on many assets.

A rather good employment rate and consequently a good income level, some 53% of the households and 40% of the individuals have incomes of over $30,000.

55% of the population completed high school.

Constant demographic progression results in the community's expansion and the implantation of new dwellings. This is mostly due to newcomers who are band members on a waiting list to gain a dwelling on the reserve or members of other bands who seek membership.

5.1.1 Inventory check list

In order to present to the Reader a picture as complete as possible of the current Health Centre resources, Appendix 4 presents a recent 2018 Inventory checklist of the Health Centre material resources.

5.2 Infrastructure

Current Facilities

- Administrative building
    - Band Council (upper storey)
    - Health Centre (lower storey)
- Police Station
- Fire Hall
- Community Hall
- First Line Services Building
- Sports grounds
    - Baseball field
    - Skating rink
    - Children's playground
- Municipal garages
  (Bus and loader)
- Maintenance shop
- Storage for Band Office
- Day-Care Centre
- Gas Station and convenience store (Migizy: Community owned)

5.2.1 Liability

In order to demonstrate professional liability and malpractice insurance for healthcare providers/counselors and miscellaneous professionals (excluding doctors), a copy of the general liability contract of the Band Council is available in Appendix 5.

5.3 Partnerships and resources

Beside the competence and dedication of its staff and direction officers, a large part of the Health Services capacities rely on the partnership network and resources they can count on. Some of these partnerships are still requesting development to reach their full potential in the future. We will present these perspectives.

Chart 7: KEABAOWEK Health Center's Chart of Partners

5.3.1 Internal partners:

- Band Council

  As the leading governance institution of the community the Band Council has a crucial role of supervision and assessment over the KFNHC. More details are presented in the community organization section.

- Daycare Centre

  Oriented toward the health, safety and development of the younger part of the population, the Daycare centre has natural links with the Health Center being one of the bases of HS programming. The Daycare building itself is used due to lack of space.

- Public Works

  The Health Centre is located in the same building as the Band Council administration. It developed links with the Public Works mainly over the organization, maintenance, safety and comfort of the Health Centre's physical environment, for the benefit of the employees, patients and visitors. The Public Works department is currently in charge of the EPP management.

- Police Services

  As an intervening institution the police forces of the community developed links with the social services of the Health Centre and its support services for addicts and other individuals affected with temporary or permanent social difficulties.

5.3.2 Public service partners:

- Health Centres in Timiskaming F.N. & Long Point F.N.

  Members of the Algonquin Nation and both located in the Témiscamingue region, these two health centres share many family ties, common social concerns and, eventually, services (at one point, drinking water monitoring for example) with KFN that created links which are significant even if not defined by any protocols or memorandums of understanding.

- CMSSSTK: Centre multiservices de santé et de services sociaux de Témiscaming-Kipawa, also referred to as « The Hospital »

  As the mandate of the KFN is essentially oriented toward prevention, KFN members are standard users of the "*Hospital*". Formerly the second smallest CSSS of the province[28] serving about 3500 people, the once-named *Centre de santé et de services sociaux du Témiscamingue Pavillon Témiscaming-Kipawa* (Pavilion TK) is currently part of the CISSSAT, the main base of which is based in Ville-Marie, about 100 km north of Témiscaming.

  What is still named *Pavilion TK* offers standard first line health services. There are currently discussions between the KFN and the Pavilion TK about improving

[28] In 2011, the CSSS TK merged with the CSSS of Ville-Marie forming the CSSS du Témiscamingue.

their collaboration and exchanging information in order to improve the health services to the population of KFN and avoid grey areas in service delivery.

Table 12: Services offered by the CMSSS TK

First line services (CLSC)

- Perinatal period (regular clientele)
- Integrated services perinatal and early childhood (for vulnerable clientele)
- Child health (including vaccination and early stimulation)
- Youth 5 to 18 years old (health and social services)
- Dental health
- Speech therapy (French only)
- Infectious illnesses
- Diabetes clinic
- Public health for adults and elders (cardiovascular illnesses, tobacco use, cancer, screening)
- Anticoagulant therapy clinics
- Nutrition
- Psychosocial intake
- Psychosocial custody for emergencies during weekends
- Mental health (consultations, respite care/emergency assistance, stress management)
- Occupational health
- Home support (nursing care, home-care service, medical care, respiratory therapy, occupational therapy, social service)
- Support services for disabled persons
- Social services for self-sufficient elderly & sheltered elderly

General medical services (CH)

- Consultations (by appointement, external/emergency clinic)
- Pharmacy
- Labs, radiology & echography
- Hospitalization (6 short-term beds)
- Physical rehabilitation

Long term sheltering services (CHSLD)

- Sheltering (14 long-term beds)
- Respite care/emergency assistance
- Volunteer work services
- Beds in the pavillion (3)

Perspective of development

As far as health is concerned, the CMSSS TK is the main partner of KFN. Significant if not yet formal links have been established between both institutions. Yet the many administrative changes that affect the CMSSS TK management are not simplifying the links between the two institutions. The main communication channels that exist rest essentially on personal links rather than institutional ones.

The reinforcement of the partnership with the "hospital" is a challenge. The designation of 3 managers, whose task, among others, is to develop processes and protocols with partners, is bound to facilitate the development of effective links with our major partners, among which the CMSSSTK has the number one place.

- Municipality of Kipawa

  Kipawa surrounds the territory of the Kebaowek reserve. It is therefore an essential partner as far as land, road and services are concerned, which is more of a concern for the Band Council. Kipawa is also involved in the development of the emergency plan (EPP).

  Development perspective

  There is no formal protocol between KFN or its Health Centre and the municipality of Kipawa but several links bind the people since many inhabitants of the municipality have a band number and many of these people are also regular users of the HC's facilities.

- MRC Témiscamingue

  Provides the waste and recycling matters pick-up services to the community.

  Development perspective

  Since the MRC is an important component of the provincial political organization it is expected that the links between the community and the MRC will increase significantly in the coming years as mining and park development are becoming major issues. Health, mainly through tradition and ways of living, will certainly be part of the preoccupations.

- ISC (Indigenous Services Canada) formerly FNIHB (First Nations and Inuit Health Branch, Health Canada)

  KFN is a reserve as defined in the Indian Act of 1876. Therefore the delivery of health services within the community falls within the ISC's responsibility. New links are being established with provincial health authorities but this matter remains mainly under federal jurisdiction.

  Development perspective

  The links between ISC (Indigenous Services Canada) and KFN are well-defined through the various existing processes, health plan and agreements that develop according to the latter's needs combined with the former's evolving policies.

- Centre Jeunesse de l'Abitibi-Témiscamingue

  The *Centres Jeunesse* are public institutions which have the mandate to provide specialized help to youngsters with occasional or recurring adaptation difficulties and to their families. They also provide help to young mothers and/or parents that have difficulties coping with the realities related to parenthood.

  Development perspective

  KFNHC has now total control (in terms of human and financial resources) over the provision of the local home care services. Having developed its First Line

Services, the Health Centre is now trying to improve the quality and the fluidity of its links with the local Centre Jeunesse in order to play a larger part in the issue of youth safety and child placement. We look forward to developing formal protocols that will allow KFN to have a stronger say in the service delivery to its youth population and the concerned parents.

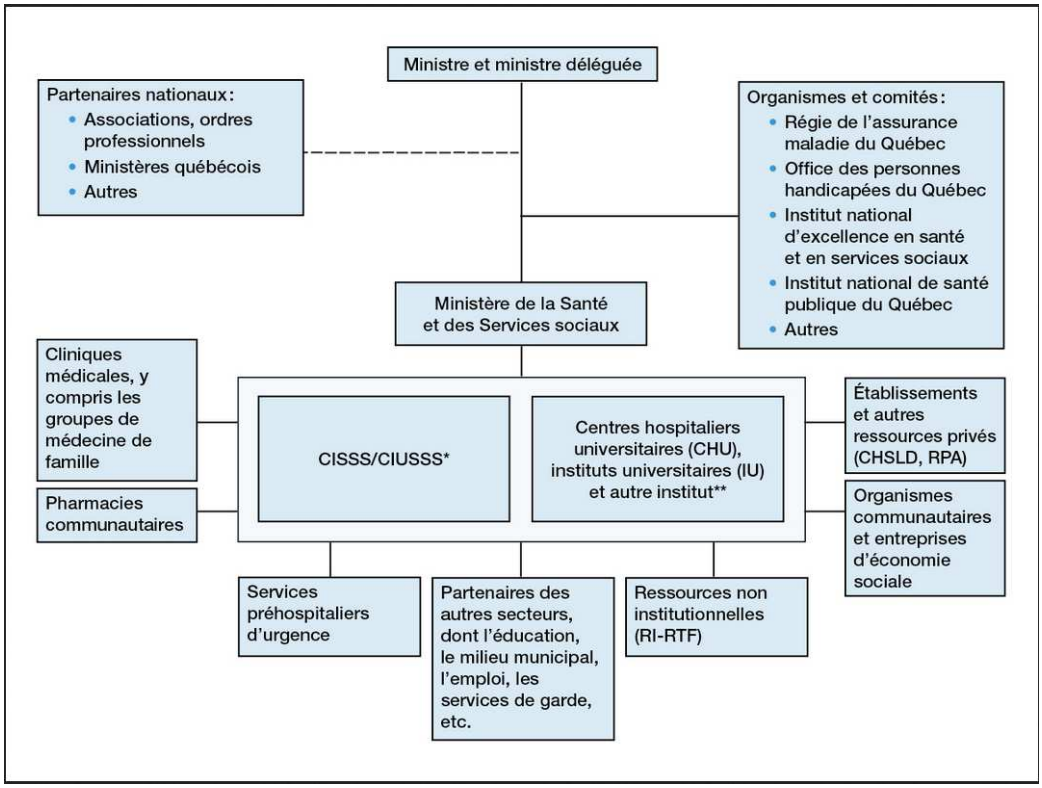
- CISSSAT (liaison officier)

  On the regional level, the Health and Social Service are responsible to coordinate service delivery on their territory. Among other things, they have to develop the general orientations and priorities of their region; they organize public health in their region; they authorize and provide local budgets for service delivery and provide grants to community organizations.

  The CISSSAT monitors and provides expertise to the Quebec health establishments of the region and is in the early stages to provide regular support to KFN. In Abitibi-Témiscamingue one liaison officer is in charge of establishing the link between the CISSSAT and the First Nations communities.

  Chart presents the health and social services organization in the province of Québec, which is under the responsibility of the "*ministère de la Santé et des Services sociaux*".

Chart 8: Health and social services organization in Quebec[29]



[29] http://www.msss.gouv.qc.ca/inc/images/reseau/systeme-de-sante-et-de-services-sociaux-en-bref/graph2-organigramme-systeme.jpg

Development perspective

Links with the CISSSAT are not frequent but they are regular since we encounter openness with its liaison officer. The need for formal protocols does not exist yet but will be considered when the province's health services become more and more of a partner in health services delivery.

- FNQLHSSC (First Nations Quebec Labrador Health and Social Services Commission)

  "The Commission's vision and mission is to promote and monitor the physical, mental, emotional and spiritual well-being of First Nations and Inuit people, families and communities while improving access to comprehensive and culturally-sensitive health and social services programs designed by First Nations organisations that are recognised and sanctioned by local authorities, all the while respecting their respective cultures and local autonomy. The Commission also assists communities that so desire, to set up, develop and promote global health and social services and programs that are adapted and conceived by First Nations organisations."[30]

  In summary, the FNQLHSSC acts as a support service and an expertise provider to the community. It provides the community with studies like the longitudinal survey of 2002 creating sound knowledge bases around the First Nations health and social services.

  Development perspective

  The FNQLHSSC is, and will remain for a long time, an important player in the delivery of health services to First Nations communities. KFN will maintain strong links with the organization but the type of links do not need to be described within any protocol or M.O.U. They correspond to FNQLHSSC mission and are used in such a way.

- Secrétariat aux affaires autochtones

  Le *Secrétariat aux affaires autochtones* (SAA) is the provincial governmental organization that has the responsibility to establish and develop links between the government and the First Nations and Inuit communities for service delivery and development support. In that regard, it is an occasional funding provider to local or regional projects. Since the Aboriginal communities fall under federal jurisdiction, the *Secrétariat* is not yet a dominant player in First Nations development but it is a significant one, whose role is growing.

  Development perspective

  As a result, the formal documents that could exist between KFN and the *Secrétariat* are occasional contracts or funding agreements. There are no foreseeable changes expected.

[30] http://www.cssspnql.com/eng/a-propos/mission.htm

- *Sécurité publique Québec*

  The ministry of *Sécurité publique* has the responsibility of security and police in Québec. It is thus involved in most police actions regarding drug trafficking, which has an impact on the health status of the community and the interventions of the addictions worker. Direct contacts on those matters are exceptional. The *Sécurité publique* is a current partner mostly because of the emergency plan developed in the region.

  Development perspective

  The link exists and it is maintained when required, currently around the development and updating of the emergency plan.

- *Ministère des Loisirs et des Sports du Québec*

  The ministry of *Loisirs et des Sports* has been a fund provider to KFNHC. It helped with allowing the inclusion of sports & leisure activities in the community.

  Development perspective

  At this point, as with the *Secrétariat aux affaires autochtones*, the formal documents that could exist between KFN and the Ministry are occasional contracts or funding agreements.

- *Forum Jeunesse Abitibi-Témiscamingue*

  The *FJAT's (Forum jeunesse de l'Abitibi-Témiscamingue)* mission is to stimulate and guide social actions, which target the youth's benefit and participation to community life. FJAT's mandates are to stimulate consultation amongst youth in order to maximize the impacts of their actions; to promote youth representation amongst local, regional and national institutions; to voice youth concerns and challenges to these institutions; to manage the *Fonds régional d'investissement jeunesse (FRIJ)* fund.

  Development perspective

  The FJAT is an occasional partner in a very specific area. Its role is not expected to increase in the coming years.

5.3.3 Other external partners

- *CMDP (Conseil des médecins, dentistes et pharmaciens)*

  The CMDP is the organization that mainly represents all physicians and other health professionals of the region. Through contacts with the physicians it is an important partner for the KFN. Eventual discussions over a reinforced partnership with the Pavilion will automatically consider the CMDP's concerns.

- *Groupe de médecine familiale*

  The *Groupe de médicine familiale* has a link largely similar to the one of the CMDP since KFN has a partnership with physicians of this group.

- North Bay Native Friendship Centre (NBNFC)

  North Bay Friendship Centre is the closest friendship centre. Very occasional contacts are made with this institution when community member access the NBNFC for services while they are in North Bay.

- Anishinabe long term centre

  Located on Timiskaming First Nation's territory (distance: 125 km) this institution currently received most of the community's elders who need services on a daily basis to compensate their lack of autonomy. It is a well-known resource for community members. It is often considered too far away, putting pressure on the Band Council for the development of closer resources for aging members of the KFN.

- Anishinabe Mikana

  Algonquin group who devotes itself to the "truth and reconciliation" process stemming from residential school trauma. Inspired by Anishinabeg values and traditions, it is also concerned with the intergenerational transmission of values. KFN workers occasionally give support to their activities.

- Ambulance Services

  A regular services used by the KFN's clientele for safe transportation outside the community. No specific contract is required between this service and KFN.

- *Québec en forme*

  Québec en forme, a provincial institution devoted to the development of more active citizens and especially youth, has liaisons officers who specifically work with First Nations communities like KFN. Contacts between this institution and KFN which is in charge of Sports and active life development within the community are done according to opportunities. No current agreement exists between this institution and KFNHC.

- Claude Rousseau GRF, Health Consultant

  Claude Rousseau has been collaborating on several assessments and research documents for the benefit of the KFNHC since 2003.

- Psychologists in Ontario

  Rare resource used by the Health Centre.

- McGill University Medicine Department

  The McGill Medicine Department provides the expertise for the analysis of the retinopathy tests done at the Health Centre.

  Also, always concerned about the importance of enticing young physicians, especially English-speaking ones, to work in the region, KFN developed an informal partnership with McGill University and the FNQLHSSC in order to welcome some of them to pay a 2-week visit to the community to be made aware of the existing possibilities.

Childbirth, surgery and specialized health care are offered KFN to patients mainly in Ville-Marie or, more often because of the linguistic community, in North Bay, ON, which is slightly closer, and offers a wider range of services. For mental health issues, the CISSS in Rouyn-Noranda is the first resource.

Ultimately, Montreal area hospitals provide specialized health services. Social services are under the authority of and delivered by the *Centre Jeunesse*, based in Ville-Marie.

CHAPTER 6

HEALTH PRIORITIES

6.1 Selection of priorities

6.1.1 Process for the selection of priorities

For a significant part, the current Health Centre's priorities consist of a revised version of what had been done during the former process conducted for the 2013-2018 Health Plan.

The selection process was initiated in 2017 shortly after the Health Plan evaluation. Building on a meeting opportunity, the managers' team, administration, and the consultant spent a day analysing the evaluation results, findings, and recommendations.

The process was further processed in an intense work session held in September 2018 were the priorities and goals were established. The action plan was completed in October of the same year.

6.1.2 Criteria for the selection of priorities

In the discussion which took place during the establishment of the 2013-2018 Health Plan, four major factors of selection were retained by the team of workers involved in the definition of priorities.

1. The first item relates the choice of a priority to the number of people affected by the problem and its severity.
2. The second one recognized the link between the problem and the seriousness of its impact on community life.
3. It was then established that the Health Centre's mandate, which was mainly about prevention, and the available resources were to be taken into account.
4. Finally, we felt compelled to take into account the community's preoccupations made known through personal encounters between community members and Health staff, and the results and comments coming from the questionnaire of 2017.

During the fall of 2018, the management team maintained the scope of 4 priorities but renewed the content of these and the overall approaches to each of them.

6.2 The 4 Priorities

The four priorities are:

- *Chronic Diseases & Cancers*

  One of the options mentioned in the evaluation report was the possibility of merging two priorities (*Diabetes and Chronic Diseases*) into one. The Diabetes

priority had been rather well addressed but still maintained a high priority status. On the other hand, it seems time to put more emphasis on the other major chronic diseases affecting the community. And cancers were also very much part of the population's preoccupation to the effect that it was neglected.

- *Mental Health & Addictions*

  Another of the population's preoccupation was Mental Health, which the health team just couldn't disconnect from Addiction, not directly mentioned in the initial priority list but an important underlying aspect of it.

  Over the past years, Mental Health has soared as a health preoccupation in the community and in the Health staff's minds. This preoccupation can no longer be set aside; it is strongly related to the addiction preoccupation. It therefore now inevitably finds its place in the overall prevention mandate of the Health Centre.

- *Community Wellness & Social Development*

  As for the Social Development priority, it appears clearly that, in order to improve the impact of the Health Centre's action, we needed to link the Health Centre's activities to the overall social life of the community and the interactions between individuals and groups. This means the reinforcement of the Health Centre's activities in relation with the various community networks.

- *Better Accessibility (to Health Services)*

  The fourth priority was identified as a process priority. It is meant to put the focus on organizational issues that have been identified and defined as crucial to the development of quality health services for the community's near future.

6.3 Priorities and criteria

The selection process that took place during the previous Health Plan was still significant as a way to measure the importance of the priorities to be chosen. The Health team tried to visualize the "health future of the community in 30 years". This exercise helped by defining real long-term priorities that were subsequently adapted on the shorter term.

It readily appeared that chronic diseases and diabetes were major issues since they strongly affect a growing number of people and their relatives and friends. In the priority definition process initiated in 2017, cancer gained the same level of importance. The link with healthy lifestyle habits followed naturally.

During the 30-year considerations exploring the future of the community, chronic violence was defined as the most long-term disruptive effect upon the population that could be imagined. It was then decided to address its causes, meaning above all, the dependencies that lead to addiction and alcohol abuse. Here again, the linkage between such priorities and healthy lifestyle habits imposed itself.

6.3.1 Axis of intervention

In 1986, the World Health Organization (WHO) presented an array of 5 strategies for health promotion based on the principles that we must take into consideration people's physical, social, and political environments, and enhance individual autonomy and responsibility in order to help people make the proper health choices.

The 5 strategies are:

1. Develop personal skills
2. Build a public health policy
3. Create supportive environments
4. Strengthen community action
5. Reorient health services

In the previous health plans, Strategy 1, *the development of personal skills*, was a large part of the Health services (HS) activities, because somehow it gives importance to each individual of the community and goes in the sense of better lifestyle habits, which has been and still is an essential approach to health.

Strategy 4, *the strengthening of community action*, is an approach that strongly appeals to the HS, especially since the implementation of First Line services. Reinforcing the overall strength of the community networks appears essential to maintain community health, to reinforce the specific identity of the community, and to properly insert HS actions within community life.

The objective becomes the reinforcement of the community and cultural bonds between individuals to enhance their networks and their capability to address health challenges in a proper and timely manner.

Strategy 3, to offer *supportive environments* stems from the same concern, that is to make existing facilities accessible to groups and individuals or implement new tools for them to use and benefit from. The backing of support groups is an example of what the HS will reinforce in its approach in consideration of Strategy 3. Also, the set-up of several screening clinics is a major part of our contribution to the reinforcement of activities under Strategy 3.

Strategy 2, *building a health policy*, somehow requires indirect work from HS. It can hardly be the number one strategy, since it is not part of the HS's mission, but it is an important complement to the other strategies implemented. Thus, in the current Health Plan, part of the Health Centre's efforts are planned to be devoted to local and regional partnership outreach, through regular and significant collaboration. Such relationships could lead toward a common vision of community health and social development that could result in new (and more efficient) health policies.

Which brings us to Strategy 5, the reorientation of health services.

6.3.2 Reorienting Health Services: The necessity of establishing plans and designing programs

The making of a health plan is an extensive process. The reorientation of the HS has been going on for quite some time now and it is still in motion.

In order to be able to fully address the mentioned priorities, conscious that the health team needed to improve some of its operating methods and define proper ways and methods to provide a sound array of health services to KFN's population, the Health team has decided to integrate specific elements into its Health Plan. This integration is to be pursued.

In 2013, the first insight of the programming meetings was the necessity for the Health team to elaborate plans in order to adequately provide the services in light of the population's needs and expectations, and more realistically take into account the available resources. The most significant plan for our population's health is certainly the Diabetes Program: the activities related to this program (plan) are run with regularity; the workers' responsibilities are defined; but the program has yet to be formalized and written down.

It is the kind of administrative/ technical task that is difficult to be addressed by people (workers) used to field work, though it is acknowledged that this is something that must be done to insure that the program keeps rolling smoothly, whatever changes might occur within the HS organization.

The second insight which was gained early during the discussions of 2013 over the priorities is the necessity to add another priority related to the way the KHC will operate in the coming years. This resulted in the Accessibility-to-services priority, as a distinction is made between the availability of services and accessibility to them. A service's mere existence doesn't mean that people feel able/allowed to use it.

In 2018, other insights came up during the discussion. These are not new to the new organizational profile of the HS, meaning the now strongly-implemented new level of organization with the creation of a managers' team of 3 people plus the director.

It appeared clearly that even if responsibilities are properly dispatched amongst them, coordination is a key issue for the programs, activities, and events to be smoothly run with a maximum impact.

After the selection process and definition of priorities, the health team addressed the definition of general objectives (goals), which is summarized in the following table.

Table 13: Priorities, general objectives, and services

1. Priority: Chronic Diseases & Cancers
General objective A) *Delay the onset of complications of diabetes and targeted chronic diseases through the provision of a structured support for all members affected by diabetes*
General objective B) *Reduce the growth of the incidence rate of diabetes within the community through early detection and awareness*
General objective C) *Promote the adoption of healthier lifestyles by creating opportunities to be more physically active and by improving upon individual motivation*
General objective D) *Promote the adoption of healthier lifestyles by creating opportunities to develop better eating habits and by improving upon individual motivation*
General objective E) *Promote access to early intervention on chronic diseases & cancers*

diagnosis by offering early detection opportunities and structured support
2. Priority: Mental Health & Addictions **General objective A)** *Diminish the various form of addictions within the community by providing the necessary support to clients in any stage of recovery* **General objective B)** *Improve the mental health of the community members by offering effective support within (existing and to-be) networks and alcohol & drug free activities* **General objective C)** *Diminish the various forms of violence within the community by strengthening the community links with holistic culturally relevant approaches*
3. Priority: Community Wellness & Social Development **General objective A)** *Reduce the number of placements of children of the community through the development of better knowledge and family networks based on cultural values* **General objective B)** *Improve social development by advocating for approaches that have positive impact on social determinants of health*
4. Priority: Better accessibility to comprehensive health services **General objective:** *Improve our community members' access to all health services within our organization and all other health service providers*
Mandatory Programs • Primary Health Care (Walk-in clinic) • Immunization & Communicable Disease • Environmental Health & Safety (Drinking Water) • Home Care Services[31]

[31] Though the Home care service are now under complete control of the Health Services and are no longer under the Centre Jeunesse's direct responsibility, we consider that it is easier and without consequences to still consider it as a mandatory program in the current document.

Chapter 7

Kebaowek Action Plan 2019-2024

PRIORITY	MENTAL HEALTH & ADDICTIONS
GENERAL OBJECTIVE	A) Diminish the various forms of addictions within the community by providing the necessary support to clients in any stage of recovery

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By the end of 2020 we have defined, written down and implemented a client care process with identification of entering and exiting proceedings to coach interventions with people seeking help to fight addiction	Establish a working group of 3-4 people to define the steps for the implementation of the process	All regional stakeholders involved in the process of recovery from addiction	Executive Committee	Health Team	• For editing tasks • I-CLSC		Early 2019	Group meets regularly and define steps		EC's minutes I-CLSC
	Define and establish the partnerships (including Friendship C. in N.B)						Complete process in 2023	List of meetings with potential partners	List of established partnerships & related agreements	Meetings' minutes and MOU's or the likes
	Coordinate & promote the necessary resources							List of identified resources		EC's minutes
2. By the end of 2020 we have the resources	Offer support for the training of the staff	All staff involved in the addiction recovery process					Process starts in 2020	Existing schedule of trainings		Schedule of trainings

PRIORITY	MENTAL HEALTH & ADDICTIONS
GENERAL OBJECTIVE	A) Diminish the various forms of addictions within the community by providing the necessary support to clients in any stage of recovery

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
and partnerships are established to bridge the gaps between services for those in the recovery process.	Produce and implement the policy	within the community					Complete process in 2023		Existing policies & related MOU's and the likes	

PRIORITY	MENTAL HEALTH & ADDICTIONS
GENERAL OBJECTIVE	B) Improve the mental health of the community members by offering effective support within networks and alcohol & drug free activities

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By 2024 develop community networking through increasing by 15% the overall participation ratio of the targeted groups to family oriented, cultural and recreational activities	Provide the platform for cultural teachings opportunities: crafts, medicines, traditions, craftsmanship	Community: Parents, Extended families, Men, Women, Youth, Elders, Children	FLM	• Recreation Dpt. • CW team • Education Dpt.	• As needed per activity • Contract honorariums • Supplies • Food • Transportation		Permanent develop-ment	Cultural teaching and promotion included in task description of health worker(s)		• Initial survey to fix the current starting point • Listing and stats of the activities
	Define a baseline from previous year data		EC	• CWM • Data staff			Early 2019		Baseline has been established	• Data from data staff • I-CLSC • CBRT
	• Family activities (parents/grandparents /children) • Physical activities • Traditional food harvesting		• CWM • FLM	• HC team • Recreation Dpt. • Education Dpt. • Daycare	• As needed per activity • Contract honorariums • Supplies • Food Transportation		Ongoing. Starts Spring 2019		Increase in the number of events/ overall number of participants to networking activities	
2. Starting in 2019, a team member is participating and	Definition of the work plan amongst First Line Workers	At risk/ vulnerable community members	Executive Committee	• HC Team • Other FN communitie	• As needed per activity • Contract		Starts March 30th 2019	HC work plan		I-CLSC

PRIORITY	MENTAL HEALTH & ADDICTIONS
GENERAL OBJECTIVE	B) Improve the mental health of the community members by offering effective support within networks and alcohol & drug free activities

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
offering outreach support aimed at improving mental health within the community to at least 1 group session or 1 drug & alcohol free activity every 2 weeks	Implementation of the partnerships			s • External Partners	honorariums • Supplies • Food • Transportation		By mid-2019	List of partners with date of agreement and responsible's name		Reports/summaries from meetings with potential partners
3. Reduce the causes of destructive behavior in the community through age group oriented awareness sessions at least twice a year per age group	Monthly Newsletter articles for topics including drinking and driving, prevention, drugs, alcohol, treatment etc.	Community members by age group	CWM	All Band workers	• Clerical support • Mail & distribution resources		Ongoing	Monthly newsletter	Diminution of police statistics related to violence	• Monthly Newsletter • Participation statistics sheets by age group
	Spring Fair Participation with an information booth with addictions and wellness information				• Booth • Documentation		Maintain	Number of people contacted at the Spring Fair		

PRIORITY	MENTAL HEALTH & ADDICTIONS
GENERAL OBJECTIVE	B) Improve the mental health of the community members by offering effective support within networks and alcohol & drug free activities

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	National Addictions Awareness Week Activities		Addiction Worker	Health Team	• Booth • Documentation • Transportation			Number and diversity of groups contacted during the Week		

PRIORITY	MENTAL HEALTH & ADDICTIONS
GENERAL OBJECTIVE	C) Diminish the various forms of violence within the community by strengthening the community links with holistic culturally relevant approaches

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By 2024, decrease social isolation for 80% of the Elders in the community (60 years of age or older) by regularly providing knowledge and support tools for managing their personal situation and by developing good access to support services	Maintain contact with 60 + (Meant to create bonding with Homecare Staff and First Line Services) through : Meals on Wheels, Senior Social, Community Shopping, Elder Abuse Awareness, Home Care, Christmas Baskets Initiatives, Food Security program	People over 60 y. of age	FLM	• Home care • CWM • Nursing team • Health team • Executive Committee (for qualitative evaluation)	• Transportation • Food, traditional and non-traditional • Supplies • Various equipment & facilities		Ongoing	Number of beneficiaries of the initiative	Internal qualitative evaluation to validate the quality of the participation and the decrease of isolation	• Activity summaries • I-CLSC
	Individual support plans as required through various means and regularly programmed activities						By the end of 2019	• Number of individual plans • Increase in the number of activities/ number of participants		

PRIORITY	MENTAL HEALTH & ADDICTIONS
GENERAL OBJECTIVE	C) Diminish the various forms of violence within the community by strengthening the community links with holistic culturally relevant approaches

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
2. By 2024, decrease social isolation for 80% of the vulnerable or at-risk individuals in the community by regularly providing knowledge and support tools for managing their personal situation and by developing good access to support services	Establishment of a list of the targeted individuals. Keep an update						By the end of 2019	Number of beneficiaries of the initiative	Internal qualitative evaluation to assess the quality of the participation and the decrease of isolation	• Activity summaries • I-CLSC
	Provide individual support to the identified individuals through : Meals on Wheels, Community Shopping, Home Care, Christmas Baskets Initiatives, Food Security program, other social activities						By the end of 2019			
3. Starting in 2019, a team member is	Definition of the work plan amongst First Line Workers	FL team		• Sport & Leisure / • Addiction W.			Early 2019	Proceedings document		Proceedings document

PRIORITY	MENTAL HEALTH & ADDICTIONS
GENERAL OBJECTIVE	C) Diminish the various forms of violence within the community by strengthening the community links with holistic culturally relevant approaches

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
participating and offering outreach support aimed at diminishing violence within the community to at least 1 group session or 1 drug & alcohol free activity every 2 weeks	Implementation of the partnerships	Community members					From beginning of 2019	List of partners with date of agreement and responsible's name		Reports/summaries from meetings with potential partners
4. By 2024 reinforce the community links by having provided personalized support to all individuals in the process of	Individual support & referral into the NAADAP network	Individuals in recovery process	Addiction W.	• Nursing • Témiscaming hospital • Health Team • External professionals • Jordan's principle program • FLM	• Transportation • Special room • Teleconference system		Maintain and enhance		Increase number of individuals participating in recovery process	Addiction W.'s files and stats

PRIORITY	MENTAL HEALTH & ADDICTIONS
GENERAL OBJECTIVE	C) Diminish the various forms of violence within the community by strengthening the community links with holistic culturally relevant approaches

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
recovery	Individual support & referral into the psychosocial network	Individuals with psychosocial needs	FLM	• Nursing • Témiscaming hospital • Health Team • External professionals					Increase number of individuals benefiting from psychosocial resources	First Line's files and stats

PRIORITY	COMMUNITY WELLNESS & SOCIAL DEVELOPMENT
GENERAL OBJECTIVE	A) Reduce the number of placements of children of the community through the development of better knowledge and family networks based on cultural values

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. Yearly, 90% of the youth of 0 to 5 years old and parents will be engaged in a continuum of services providing information, support and useful tools for their positive physical, social, intellectual and mental development	Provision to parents of youth 0 to 5 years old with assessment and teaching material related to their children's development, safety, physical integrity and protection. MCH-Head Start-Parent/Child Support Groups – Support within the daycare	Parents of youth 0 to 5 years old	CPM	• Clinic Team • Community Wellness Team	• Supplies • Equipment • Books • Teaching resources		On going	Number of parents reached	Satisfaction measure of the parents	• Activity summaries • Evaluation forms • I-CLSC
	Maintain of an integration calendar of all health team workers into the MCH program to include their respective roles, objectives and program activities	Health Workers	MCH/ Head Start Coord.	HC Team Executive Committee (for quality assessment)			On going	Integration calendar	Qualitative assessment of the effect of the integration calendar	
2. Annually reinforce the parental	Provide monthly newsletter tips/advice from pregnancy onward	Community parents					Ongoing	Articles in the newsletters		Newsletters

PRIORITY	COMMUNITY WELLNESS & SOCIAL DEVELOPMENT
GENERAL OBJECTIVE	A) Reduce the number of placements of children of the community through the development of better knowledge and family networks based on cultural values

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
capabilities of 80% of the parents through supportive approaches and promotion of healthy lifestyle	Monthly family bonding activities	Parents and extended families	FLM	• Recreation Dpt. • Executive Committee (for the activities & planning impact assessment)			Ongoing	Number of parents & families reached through the activities	• Receding of child placement below provincial standards • Qualitative survey amongst parents • Qualitative survey amongst HC Workers	• Activity summaries • I-CLSC • Newsletter archives
	Parenting Education & Skills development through ties developed with MCH & First Line programs			MCH staff			Ongoing			

PRIORITY	COMMUNITY WELLNESS & SOCIAL DEVELOPMENT
GENERAL OBJECTIVE	A) Reduce the number of placements of children of the community through the development of better knowledge and family networks based on cultural values

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	Organize needs based information sessions and resources related to raising healthy children/families. -bullying -sexual violence -vandalism			All health staff			Ongoing	Number of activities organized/ parents reached		
3. By 2024, integrate 60% of the families of the community in a network system allowing support and knowledge	Establishment of an action plan for the definition and implementation of networks centred on nutrition, healthy life style and education	Community families	CWM	FLM				The Action Plan		Actual Action Plan

PRIORITY	COMMUNITY WELLNESS & SOCIAL DEVELOPMENT
GENERAL OBJECTIVE	A) Reduce the number of placements of children of the community through the development of better knowledge and family networks based on cultural values

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
sharing	Organize activities based on nutrition following the Canadian food guide. -Cooking groups -Nutrition information sessions -Access to groceries			FLM	• Transportation • Venue • Supplies				List of the families of the community actively and regularly involved in networking activities	
	Develop a guide for graduating students and parents related to life skills i.e. budgeting, cooking, shopping, stress, time management, study habits, etc.	Parents & graduating students	Executive Committee	• Education Dpt. • Band Council	• Honorarium fees • Transportation • Clerical support		2021	• The guide printed • Number of guides distributed to targeted population	Number of participants	• Activity summaries • I-CLSC
	Sustain a Community Food Security program	Low-income families of the community	FLM	Food Security program Partners	Food, traditional and non-traditional		Ongoing	Number of people monthly using this emergency resource		

PRIORITY	COMMUNITY WELLNESS & SOCIAL DEVELOPMENT
GENERAL OBJECTIVE	A) Reduce the number of placements of children of the community through the development of better knowledge and family networks based on cultural values

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	Family activities that encourage physical activity family bonding & healthy eating	Families of the community	FLM	• Recreation dpt. • Education dpt. • CWM	Transportation		2020	• Number of participants to the activities • Number of activities held monthly		Activity summaries
4. Annually maintain the amount of signalements retained by the "Centre Jeunesse" under 10 through the application of efficient intervention protocols	Establish professional collaboration between voluntary and institutional family services on reserve	*Centre Jeunesse* and other institutions involved in children social care	FLM	• Centre Jeunesse workers & direction • Band Council			To be completed in 2022	Agenda of meetings aiming at a better collaboration between *Centre Jeunessse* and KFN's FL services	MOU or other type of agreement with *Centre Jeunesse*	• FLM's files • Executive C.'s minutes
	Develop an operational protocol for dealing with crisis 0-18 years of age	FL team and collaborators	FLM	• Police Dpt. • Executive C. (for evaluation measures & definition of "crisis" • HC staff	• Documentation • Clerical support		By the end of 2020	The protocols	Qualitative assessment with the concerned workers and other shareholders to validate that the defined protocols are used and	
	Develop a family violence protocol									
	Develop a High-Risk family protocol									

PRIORITY	COMMUNITY WELLNESS & SOCIAL DEVELOPMENT
GENERAL OBJECTIVE	A) Reduce the number of placements of children of the community through the development of better knowledge and family networks based on cultural values

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE: FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	Continue to provide one-on-one psychosocial support	At-risk community members	FLM				Ongoing	Number of interventions	efficient	FL workers' caseloads
5. By 2024, have formal or near-formal partnerships with all identified resources concerned with the community's social and mental health	Meetings to establish or improve the working relationship between CISSSTK, local schools & Kebaowek Health Centre	School age children and parents	Executive C.	• CISSSTK • Schools (3): direction and teachers • CWM • H. Director • CISSS TK • FLM • Education Dpt.	• Transportation • Clerical support		Ongoing	Number & contents of meetings/agreements	MOU's or protocol agreements	Executive C.'s minutes
	Establish partnerships with other First Nations communities and organizations as to share best practices & training resources	Heath Centre	Executive C.	Direction			By the end of 2019	Number of meetings with number of partners	Number of renewed practices coming from external sharing	• Meetings minutes • Executive C.'s minutes

PRIORITY	COMMUNITY WELLNESS & SOCIAL DEVELOPMENT
GENERAL OBJECTIVE	B) Improve social development by advocating for approaches that have positive impact on social determinants of health

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By 2024, 90% of the at-risk school age children of the community (6 to 17 y.o.) are regularly involved in sporting or social activities meant to develop the quality of their social network and reinforce their ability to adopt a healthy lifestyle	Bench mark definition of the "at-risk population"	"at-risk" population regarding diabetes	Executive C.	Data central	Clerical		Early 2019	Data collected	Bench mark measure established	• Data central • I-CLSC
	"Teen Outings" Teen activities that incorporate life skills	Community youth	CWM FLM	H.C. team	• Transportation • Food • Sport equipment • Supplies • Honorarium fees		Ongoing	• Number/type of activities held • Content of the activities • Number of different participants to the activities	Qualitative assessment of the progress done by children of the community in regard of a list of at-risk children establish in 2019 and updated every year	• Activity summaries • Survey with involved workers with at-risk children of the community
	Support for regular physical activities for at-risk youth			• Sport&Leisure • Recreational Dpt.			Ongoing			
	Hunter's Point annual cultural camp: activities and good nutrition animation			H.C. Team			Every year			
	Youth Evening Groups			Executive C. (for supervising assessment tool to measure progress. See indicator column)			Twice monthly			
	Occasional weekend activities						At least 6 times a year			

PRIORITY	COMMUNITY WELLNESS & SOCIAL DEVELOPMENT
GENERAL OBJECTIVE	B) Improve social development by advocating for approaches that have positive impact on social determinants of health

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	According to the schools' calendar activities including sports, and traditional activities such as ice fishing, trapping, etc.			Recreational Dpt.		.				
2. By 2024, develop formal or near-formal partnerships with every identified institutions of the community and outside the community which decisions have an impact on the social determinants of health	List in-community and out-community partners and define approaches	All stakeholders in the overall health condition of the community members	Director	Executive C. Band Council			By the end of 2020	The list	Active collaboration between band Council's and regional institutions on projects and/or activities linked with determinants of health	• Intersectorial meetings' minutes • Executive C.'s minutes • Eventual project results
	Contact the most probably successful partnerships available							Actual agreement		
	Develop two successful partnerships									
	Extend efforts to other partners						By mid-2024	Agenda of meetings		

PRIORITY	BETTER ACCESSIBILITY
GENERAL OBJECTIVE	Improve our community members' access to all health services within our organization and all other health service providers

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCES FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By 2020, the Health Centre will have its own building for service delivery to respond to the growing needs of the community and have the capacity to attract the proper professionals to deliver programs and services	Regular contacts with the Band Council, Health Canada, AANDC and other concerned stakeholders within and outside the community for promotion and financing of the project	Kebaowek community members	Director	• Band Council Band Council's Dpt's • Executive C.	• Transport • Honorarium fees	• Health Centre's surplus • Band Council contribution	By late 2020	Communication documents with stakeholders	New facilities	• Official documents and agreements • Plans of the building
2. By 2022, the Kebaowek Health Centre will have a comprehensive,	Create and implement a data collection system	Health Workers	Executive C.	• Data central • All Health W. • FNQLHSSC • Band admin • Daycare			Completed by 2022	Actual gathering system description document	Outputs & results of the activities can be monitored and communicated for	• Central Data Unit • I-CLSC

PRIORITY	BETTER ACCESSIBILITY
GENERAL OBJECTIVE	Improve our community members' access to all health services within our organization and all other health service providers

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCES FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
functional, efficient and permanent system data gathering for report making and decision making	Give support to staff for data collecting		CWM	Data gathering coordinator			Starting late 2019		decision and feedback	
	Establishment of a standardized planning implementation & evaluation process for activities & events	All Health Workers	Executive C.	All Health Team			By the end of 2019	Standardized forms and summaries		• I-CLSC • Community reports • CBRT
	Establishment of an Executive Committee comprised of the managers and director to take charge of the operationalization and unfolding of the Health Centre action plan in a timely and consistent manner	Health Administration	Direction & Managers				Early 2019	Regular meetings of the Executive Committee		Executive C.'s minutes

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	A) Delay the onset of complications of diabetes through the provision of a structured support for all members affected by diabetes

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By the end of 2019, develop a comprehensive program to give support to all members diagnosed with diabetes	Development of a comprehensive formal protocol (Diabetes Program) encompassing prevention, promotion, detection and all aspects of the treatment plan for members diagnosed with diabetes Definition of a comprehensive strategy to address early detection of diabetes and implementation of a healthy life style within the community	KFN Band members	Executive Committee	• Health C. team • CISSS TK • FNQLHSSC • ISC			By the end of 2019	Actual Diabetes Program	• Implementation of the Diabetes Plan • Number/ proportion of members of the community with diabetes integrated within the Diabetes Program or referred	• The complete Diabetes Guide • Program stats
2. By 2020, all members of the community diagnosed with diabetes will be	Retinopathy Screening Clinics	Community members diagnosed with diabetes.	• CPN • CWPM	• D&CDC • FLM (Meals on Wheels)	• Retinopathy Camera • Laptop • Medical supplies		April each year	Number of people participating to the clinic		• Activity Reports • Retinopathy Report Form • Lab Results • I-CLSC

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	A) Delay the onset of complications of diabetes through the provision of a structured support for all members affected by diabetes

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
integrated in the KFN Diabetes program or referred by our personnel to other health care facilities in order to maintain these people at the lowest level of illness evolution	Nurse consultation; Consultation And Follow up according to identified results or requests	Community members diagnosed with diabetes.	CHN	• CPM • D&CDC • Sports &L. Mentorship	Diabetes resource materials		When initiated by nurse, physician or by client request	• Number of consultations • Number of formal treatment plans • Numbers of referrals		• Activity Reports • Individual Report • I-CLSC
	Foot Care Services	Community members diagnosed with diabetes.	HCN	CPM	Medical foot care supplies			Numbers of foot care patients monthly		• Home care nurse's statistics • I-CLSC
	Quarterly Diabetic Clinics	Community members diagnosed with diabetes.	CPM	• D&CDC • CWPM • CHN • HCN	Medical equipment and supplies		January, April, July and October each year	Participation rate of diabetics at each quarterly clinic	Rate of diabetics whose level of illness remain constant	• Nursing statistics at the KHC and the CISSS-TK. • Activity Reports • Attendance Report • Evaluation Form

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	A) Delay the onset of complications of diabetes through the provision of a structured support for all members affected by diabetes

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	Every year, starting in 2020, every member of the community diagnosed with diabetes not integrated in the KFN specific diabetes programs will be offered to join in	Community members diagnosed with diabetes	CWPM	D&CDC CPM			Every year around April	• List of the non-participants members • List of the non-participants reached	List of non-participants is receding	D&CDC's files (calling list)

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	B) Reduce the growth of the incidence rate of diabetes within the community through early detection and awareness

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By 2024, 50% of the members of the community over 14 years of age will have been checked at least once for their blood glucose level	Baseline to be determined by percentage of the targeted community members who have been tested for diabetes within the last two years	KFN Band members of 14 years old and over	Executive Committee	CPM	• Booth set up • Medical equipment and supplies • Promotional material • Advertising material: invitations, newsletter, posters etc. • Participation incentives		Spring (Health Fair) and Fall (National Diabetes Day) and 2 other open session clinics (To be determined)	• Number of people tested during the screening clinics • Frequency of an individual's participation	Annual increase of participation over the next 5 years	• Baseline Activity Participation Report • Band List • Activity Reports • Screening Clinic Report Sheets • I-CLSC
	Reach out to the non-participating members over the age of 14 years old		D&CDC	• FLM • Health Team						
	Actual screening		CPM							

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	B) Reduce the growth of the incidence rate of diabetes within the community through early detection and awareness

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
2. Yearly, starting in 2019, we will test for diabetes 50% of the adult community members with a special emphasis on those especially at risk because of multiple factors, once every 3 years	Identify the community members especially at risk for diabetes because of family history or other risk factor	Community members including especially at risk for diabetes because of family history or other risk factor	Executive Committee	CPM	• Medical equipment and supplies • Promotional material Advertising material: invitations, newsletter, posters etc.		By fall of 2019	List of the community members especially at risk because of multiple risk factors		Pre- and post-testing lists
	Establish a contact approach and testing schedule		D&CDC							

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	B) Reduce the growth of the incidence rate of diabetes within the community through early detection and awareness

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
3. Starting in 2019, once a year, we will have a measure of the community diabetes incidence & prevalence rates	Calculate the incidence and the prevalence rates of the community based on the members living on-reserve and in the local area	Community members	Executive Committee	• CPM • CHN • D&CDC • Data Central			Starting in 2019	Incidence and prevalence rates defined and established	First, stabilization of the rates Then receding of the rates. These are considered as long term success indicators for the overall goals related to the diabetes component of the Chronic Diseases & Cancers priority	• Clinical data • D&CDC's data • Band list
4. Every year, 80% of the total population will have been specifically exposed to pertinent	Provide diabetes related articles for the monthly community newsletter.	All band members	• D&CDC • D&CDC	• CWPM • CPM • Sports & Mentorship • Sports & Mentorship • CWPM	• Computer with internet access • Diabetes related books and resources • Facilities in Hunter's Point		Monthly according to the newsletter schedule	• Number of relevant articles published • Number of newsletter copies distributed		• Activity Reports • Evaluation Forms • Band List • I-CLSC

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	B) Reduce the growth of the incidence rate of diabetes within the community through early detection and awareness

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
information about diabetes, and the importance of good eating habits and physical activity	Diabetes Youth Summer Camp focusing on Healthy Lifestyle including good nutrition and physical activities	Community members between 6 and 17 years old. 2 groups: 11 yrs and under and 12 – 17 yrs		• CPM • CHN • HCN • Addictions & Wellness • Front Line Services • Environmental Health	• Transportation (van, boats, trucks) • First Aid supplies • Activity supplies		• Two weeks in July of each year + 1 week prep	Number of youth participants per year	Evaluation of satisfaction of workshops and activities	
	Organize two Workshops/ Information sessions related to diabetes	Community members	D&CDC	• CWPM • CPM	• Venue • Guest speakers • Participation incentives • Diabetes related resources • Refreshments and supplies		Two per year	Number of participants		• Activity Reports • Attendance Record • Evaluation Forms
	Organize two diabetes cooking classes and nutrition classes	Community members	D&CDC	• CWPM • CPM	• Community kitchen • Cooking material and supplies • Recipe books • Nutrition resource guide		Two per year	Number of participants		

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	B) Reduce the growth of the incidence rate of diabetes within the community through early detection and awareness

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	"Eldercize" (Exercise group targeting Elders and diabetics of all ages)	Community members with chronic diseases	Sports & Mentor-ship	D&CDC	• Venue • Exercise equipment and supplies		Three times per week (Monday, Tuesday, Thursday) for ten months of the year	Number of participants to each session		• Activity Reports • Attendance Record • Evaluation Forms
	Organize a workshop with all parents about proper portion size and good nutrition.	All parents	D&CDC	• CWPM • CPM	• Venue • Nutrition resources Portion plates and food models		One per year (September prior to school year)	• Holding of the workshop • Number of participants		• Activity Reports • Attendance Record • Evaluation Forms
	Milk Program	School age youth	D&CDC	• CWPM • School Bus Monitor • School Administrator	Refrigerators Milk		Five days a week following the school calendar	Number of students participating		• Activity Reports • Attendance Record • Evaluation Forms

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	C) Promote the adoption of healthier lifestyles by creating opportunities to be more physically active and by improving upon individual motivation

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. Yearly starting in 2019 at least 6 adapted activities sessions will be offered to each age group over 12 years of age to promote physical activities	"Eldercize" (Exercise group targeting Elders and diabetics of all ages)	Community members with chronic diseases	• Sports & Mentor-ship	• D&CDC	• Venue • Exercise equipment and supplies		• Three times per week (Monday, Tuesday, Thursday) for ten months of the year	• Number of participants to each session • Yearly evaluation to be completed by participants	Improvement/ preservation of the level of satisfaction from survey run every year	• Activity Reports • Attendance Record • Evaluation Forms
	Diabetes Youth Summer Camp focusing on Healthy Lifestyle including good nutrition and physical activities.	Community members 12 – 17 yrs	• D&CDC	• Sports & Mentorship • CWPM • CPM • CHN • HCN • Addictions & Wellness • Front Line Services • Environmental Health	• Facilities in Hunter's Point • Transportation (van, boats, trucks) • First Aid supplies • Activity supplies		• Two weeks in July of each year • 1 week prep	• Number of youth participants per year	Improvement/ preservation of the level of satisfaction from survey run every year	• Activity Reports • Evaluation Forms • Band List

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	C) Promote the adoption of healthier lifestyles by creating opportunities to be more physically active and by improving upon individual motivation

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	KASP (Kebaowek After School Program)	Elementary school age children (5-12)	MCH/ Head Start Worker	Sports & L. Mentorship	• Exercise Equipment • Other sporting facilities • Public venues		Twice a month during school time period	Average number of participants/month		• Activity Reports • Satisfaction forms
	"LunchFit": Pilates – yoga – Weight Training	Families	FLM		• Community Hall • Honorarium fees		Twice a week. On going	• Increase and maintain number of participants • Number of events		• Activity reports • I-CLSC
	Family Swim (payment of the fees)	Families	FLM		Témiscaming public pool		On going	• Number of families /individuals participating		Stats related to the reimbursement of the fees
	Daycare Swim	0-5 y.o.	FLM		Témiscaming public pool		Monthly On going	• Number participants • Number of outings		Daycare stats
	Daycare "Fit with Mitch"	0-5 y.o.	FLM	Sport & L. Mentorship	Sport and activity equipment		Once a week On going	• Number participants • Number of events		

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	C) Promote the adoption of healthier lifestyles by creating opportunities to be more physically active and by improving upon individual motivation

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	Development of a new set of physical activities for adults & elders	Adults & elders of the community	Executive Committee	Health Centre team			By the end of 2019	New items of the action plan addressing adults & elders of the community	Implementation of a set of physical activities oriented toward the improvement of the adults' & elders' health	Executive's minutes Activity reports
2. Yearly, starting in 2020, we will measure an improvement of 4% over the global motivation of the population toward physical activity	Define the parameters of the survey to be conduct once a year around Spring Fair over physical activity motivation		Executive Committee	• Director • Eventual external assistance • Health staff	• Eventual external assistance • Paper documents • People to hand out the forms	WG?	End of 2019	Parameters defined	Annual increase of the global motivation percentage	• Survey distribution lists and method • Data documents and analysis
	Write down a survey form						Spring 2020	Survey form established		
	Pass the form, input, analyze and compare the survey data						Yearly from 2020	Analysis of the survey data completed		

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	D) Promote the adoption of healthier lifestyles by creating opportunities to develop better eating habits and by improving upon individual motivation

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. Yearly, starting in 2019, at least 3 adapted activities will be offered for each age group over 12 years of age to promote better eating habits	Provide chronic disease related articles for the monthly community newsletter.	All band members	D&CDC	• CWPM • CPM • Sports & Mentorship	• Computer with internet access • Chronic disease related books and resources		Monthly according to the newsletter schedule	• Number of relevant articles published • Number of newsletter copies distributed		Newsletter archives
	Milk Program	School age youth	D&CDC	• CWPM • School Bus Monitor • School Administrator	Refrigerators Milk		Five days a week following the school calendar	Number of students participating		• Activity Reports • Student List Participation Report Sheet
	Diabetes Youth Summer Camp focusing on Healthy Lifestyle including good nutrition and physical activities.	Community members 12 – 17 yrs	• D&CDC	• Sports & Mentorship • CWPM • CPM • CHN • HCN • Addictions & Wellness • Front Line Services • Environmental Health	• Facilities in Hunter's Point • Transportation (van, boats, trucks) • First Aid supplies • Activity supplies		• Two weeks in July of each year • 1 week prep	Number of youth participants per year	Improvement/ preservation of the level of satisfaction from survey run every year	• Activity Reports • Evaluation Forms • Band List

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	D) Promote the adoption of healthier lifestyles by creating opportunities to develop better eating habits and by improving upon individual motivation

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	Community garden	Community members	FLM	• Angels guardians • Daycare • Health staff • Summer students • Executive Committee (for definition of indicators in relation with groups reached)	Gardening material		From Spring to Fall each year On going	Number of participants	Assessment of the volume of product harvested and distributed within the community /number of different households benefiting from this distribution	To be defined
	Establishment of a policy concerning the management of food within the Health Center's activities	Health Team	Executive Committee	Health Team			By the end of 2019	The policy		Executive Committee's minutes
	Establishment of a calendar of consistent activities regarding the implementation of better eating habits	Health Team	Executive Committee	Health Team			By the end of 2020	The policy		

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	D) Promote the adoption of healthier lifestyles by creating opportunities to develop better eating habits and by improving upon individual motivation

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
2. Yearly, starting in 2021, we will measure an improvement of 4% over the global motivation of the population toward improving better eating habits	Define the parameters of the survey to be conduct once a year around Spring Fair over eating habits motivation		Executive Committee	• Director • Health staff	• Eventual honorarium fees • Paper documents • People to hand out the forms		End of 2020	Parameters defined	Annual increase of the global motivation percentage	• Survey distribution lists and method • Data documents and analysis
	Write down a survey form						Spring 2021	Survey form established		
	Pass the form, input, analyze and compare the survey data						Yearly from 2021	Analysis of the survey data completed		

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	E) Promote access to early intervention on chronic diseases & cancers diagnosis by offering early detection opportunities & structured support

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
1. By the end of 2024, we will engage the women in the community over the age of 21 years in view of having 60% of them seen by a physician to follow the recommended provincial screening standards for cancers and cardio-vascular diseases	Define the parameters of and run a survey to establish a baseline	Female Community members 12 years of age and older	Executive Committee	• Band Membership • Data central	• Paper printer • Team for distribution of the forms • Eventual honorarium fees		Early 2020	Survey and survey passed		• Executive's minute • Data central
	Women's Health Check Clinic: • Screening • Update health info • Pap and mammogram verification • Primary care MD follow up Info session		CPM	• D&CDC • CWPM • CHN HCN CISSS TK	• Venue /booth • Medical equipment and supplies • Health info and resource material		Every March (International Women's Day)	• Number of women screened/ referred/ assisted and identified for follow up during the event • Rate of people participating during the event	Percentage of the women in the community who have been screened and seen by a Md regarding chronic diseases within a period of 2 years	• Activity reports • Band list • Evaluation form • Screening/ health verification form • I-CLSC
	Annual Cancer Awareness Walk		• D&CDC • CWPM (co-responsible)	• CPM • CHN • HCN	• Venue • Guest Speaker • Info table • Promotional material		• September of each year (Breast Cancer Month)	• Number of people participating in the walk. • Number of people attending the information session and information table	• Increased number of participants for the session /walk per year	• Activity Reports • Attendance Record • Evaluation Forms

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	E) Promote access to early intervention on chronic diseases & cancers diagnosis by offering early detection opportunities & structured support

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
	Organize one Workshops/Information Sessions related to chronic disease for each age group over 21 y.o.		D&CDC	• CWPM • CPM • Executive Committee (for the qualitative assessment)	• Venue • Guest speakers • Participation incentives • Chronic disease related resources • Refreshments and supplies		One per year	Number of participants	Evaluation of knowledge and satisfaction of the info session	• Activity Reports • Attendance Record • Evaluation Forms
2. By the end of 2024, we will insure that 50% of the male adults of the community have proper access to doctors and health services according to	Health Check Clinic for all including men: • Screening • Update health info • Primary care MD follow up • Info session	Male Community members 40 years of age and older	CPM	• D&CDC • CWPM • CHN • HCN • FLM	• Venue/Booth • Medical equipment and supplies • Health info and resource material		December (ending "Movember" activities OR June for Father's day / Men's Health Day (to be determined)	• Number of men screened/referred/ assisted and identified for follow up during the event • Number of people participating during the event	Percentage of the men in the community who have been screened and seen by a MD regarding chronic diseases within a period of 2 years	• Activity Reports • Band List • Evaluation Form • Screening/Health Verification Form

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	E) Promote access to early intervention on chronic diseases & cancers diagnosis by offering early detection opportunities & structured support

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
provincial standards	Make aware and individually support men in the process of acquiring a family physician							Number of men assisted in having a family physician		
	Make men aware of the provincial screening standards							Number of men reached for awareness		
	Provide individual support when needed to the men's health card renewal							Number of men assisted in having a medical card		
	Organize one Workshops/Information Sessions related to chronic disease for each age group over 21 y.o.		D&CDC	• CWPM • CPM •	• Venue • Guest speakers • Participation incentives • Chronic disease related resources • Refreshments and supplies		• One per year	• Number of participants		• Activity Reports • Attendance Record • Evaluation Forms

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	E) Promote access to early intervention on chronic diseases & cancers diagnosis by offering early detection opportunities & structured support

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
3. By the end of 2024, all members of the community diagnosed with a targeted chronic disease will be integrated in the KFN Chronic Disease Program or referred by our personnel to other health care facilities in order to maintain these people at the lowest level of illness evolution	Development of a comprehensive formal protocol (Chronic Diseases Program) encompassing prevention, promotion, detection and all aspects of the treatment plan for members diagnosed with a targeted chronic disease or a cancer	KFN Band members	Executive Committee	Health team			By the end of 2024	Actual Chronic Diseases Program(s)	• Implementation of the Chronic Diseases Program • Number/ proportion of members of the community with targeted chronic diseases integrated within the Chronic Diseases Program or referred	• The complete Chronic Diseases Guide • Program stats

PRIORITY	CHRONIC DISEASES & CANCERS
GENERAL OBJECTIVE	E) Promote access to early intervention on chronic diseases & cancers diagnosis by offering early detection opportunities & structured support

SPECIFIC OBJECTIVES	ACTIVITIES	POPULATION TARGETED	IN CHARGE	COLLAB-ORATORS	RESOURCES: MATERIAL	RESOURCE FINANCIAL	DATE	PROCESS INDICATOR	SUCCESS INDICATOR	DATA SOURCE
and to delay the onset of complications	Definition of a comprehensive strategy to address early detection of targeted chronic diseases and implementation of a healthy life style within the community						By the end of 2024 Every year around April	Actual strategy plan & steps	Strategy steps enforced	Nursing and Community Wellness statistics and reports
	Every year, starting in 2022, every member of the community diagnosed with a targeted chronic disease other than diabetes and not integrated in one of KFN specific health programs will be offered to join in	Community members diagnosed with a targeted chronic disease other than diabetes	CWM	• CPM • D&CDC			Starts in 2024 Once a year	• List of the non-participants members • List of the non-participants reached	List of non-participants is receding	• D&CDC's files • Data central • I-CLSC

CHAPTER 8

PRIMARY HEALTH CARE, MANDATORY PROGRAMS AND HOME AND COMMUNITY CARE

8.1 Primary care

8.1.1 Clinical and client Care

Objectives

As described in the First Nations and Inuit Health Program Compendium 2011-2012 and Addendum:

• Provide access to (*urgent and*) non-urgent health services to community members including those who reside in remote/isolated communities where access to health services is not available through provincial or regional health authorities.

• Provide access to coordination and consultation services with other appropriate health care providers and/or institutions as indicated by client needs.

Responsible for delivery of the service: the CHN, with the occasional support of the HCN. Under the Clinic Program Manager's responsibility.

Locations for delivery: Health Centre.

Services

Non-urgent care; coordination and care management; chronic disease aftercare; walk-in clinic as described below; retinopathy testing; foot care (also done within the home care program, at the Health Centre and at home when needed).

Details: walk-in clinic, and clinical support

See the following schedule.

According to the Community Report, for the year 2017-2018, the monthly number of visits to the clinic went from 130 to 350.

In the Health Plan 2013-2018, the indicated monthly number of visits to the clinic varied from 50 to 154 visits.

Table 14: Health Centre opening hours

Kebaowek Health Centre opening hours					
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
8:00 - 12:00	Walk-in clinic (1 nurse)	Walk-in clinic and labs (bloodwork)	Walk-in clinic	Walk-in clinic and labs (bloodwork)	Walk-in clinic
12:45 - 16:00	Walk-in clinic	Walk-in clinic	Walk-in clinic	Walk-in clinic	Closed

Currently, one physician from the CMSSSTK visits the KHC once a month for half a day. This schedule largely depends on the number of physicians, working at the CMSSSTK at a certain time, and their availabilities. She brings her patients' files from the "hospital" and takes them back with her. The follow-up with the patients might take place at the Health Centre or at the "hospital". The nursing staff is not systematically kept informed of the cases' development. This proximity service is a much appreciated service, particularly by seniors.

8.1.1.1 Inventory Control and Handling of Medications

In order to comply with Health Canada's obligation, KHC established a protocol for "Inventory Control and Handling of Medication" to be read in Appendix 6. A separate protocol was also established in relation to "expired medications and bio-hazard material", which is to be found in the same appendix.

8.2 Home and community care

For a few years now, the Home and Community Care Program (HCC) is completely under the KHC management from the hiring of the Home Support and Personal Support Workers to the delivery of the services, the management of the finances and the accountability of the program.

8.2.1 Program overview

The goal of the program is to "Enable individuals to continue to live productive lives in their own homes, while encouraging the continued support of their families and community".

This program should be equally accessible to all the registered community band members of Kebaowek who have a need for health care and/or support services. As the program grows and develops, we hope to be able to offer a full range of preventive, therapeutic, and restorative services as an alternative to institutional care.

Home Care Services is available five days per week, during business hours. For evenings and weekends, we follow the CISSST-K guide for coverage for homecare which is the CISSST-K outpatient clinic.

8.2.2 Management structure

The Home and Community Care Program is managed and administrated at the community level. The KFN Health Centre is responsible for hiring, training and supervising the personnel, administrating the budget, assuring service delivery, and supervising evaluating the program. The following diagram identifies the management structure for the Kebaowek Home and Community Care Program. Council has given full responsibility of program to the Health Director. The qualified workers have been hired to fill each position, as depicted below. The roles and responsibilities of each member of the program will be discussed further in the Essential Services section.

8.2.3 Human resources

For service delivery to occur, as outlined in this plan, the following staff is required for the essential services of the Home and Community Care Program:

- Home Care Nurse / LPN: 5 days per week
- Case Manager : Position assumed by the Clinical Programs Manager
- Personal Support Worker : 8 hours per week (2 days x 4hrs)
- Home Support Workers are provided and managed by the liaison officer or other designated persons funded by AANDC.

Training plan for yearly CPR and First Aid is provided to employees of the Kebaowek Health Centre.

8.2.4 Accessing services

The following illustrates the steps for accessing services in the Home and Community Care Program.

1. Request for Home Care Nursing Services and or Personal Care Services are sent to and received by the Case Manager via telephone (verbal), fax referral or written prescription. Initial contact is made within 48 hours.(excluding weekend and holidays)

2. A physician, a health professional, the patient or a family member, and / or a community member can request an evaluation for homecare services.

3. The patient is evaluated within 72 hours of receiving the request. (Excluding weekends and holidays)

4. A client assessment is completed using the "Initial/Admission Care Pathways Form" or a "Multi-clientele Assessment Form"

The type of services rendered are based the outcomes of the evaluation.

5. Should the patient or family member contest the decision of the Case Manager, the case will be reviewed by the Homecare Committee. Recommendations are made by a Homecare Committee in cases of appeal to reach a final decision on the services rendered.

6. Planning the care to be dispensed. (See Appendix D for an example of a care plan) and individualized visits, when the services of the homecare nurse are required)

7. Service Delivery

8. Re-evaluation of the care and services dispensed to assure that the client's needs are met. (Re-evaluation of acute clients will be done at minimum every 3 months and chronic client re-evaluations will be done at minimum every year or when there is a health status change.)

8.2.5 Essential services

This section describes each element of the essential services in the Home and Community Care Program. These essential elements are based on the Needs Assessments of Kebaowek First Nation and is administrated as previously outlined in the management structure.

8.2.5.1 Management and supervision of the program

Home and Community Care is a program that will be continually changing in relation to client needs, with frequent admissions and discharges. It is therefore very important that it be managed and supervised closely. The Clinical Programs Manager will oversee the program with the cooperation of the Home Care Nurse.

The Health Director will be responsible for the overall programming of health and social services, the budget and staff of the health centre and will be the link between the program and higher management. The Clinical Programs Manager, who reports to the Health Director, will be responsible for the management of the program, and the professional supervision of nursing and personal care worker. Professional nursing supervision will be agreed upon by both the Health Director and FNIHIB Health Canada - regional office.

For now, home support workers will continue to be funded by AANDC and therefore the hiring and supervision of these workers will remain the responsibility of the Social Services.

Our community has established a Homecare Committee. This committee is comprised of the some or all of the following people upon availability; one member of council (not related to the client), the Health Director, the Clinical Program Manager, and one representative from Social Services. The role of the Homecare Committee when required is to re- evaluate a decision rendered by the Homecare Nursing Staff regarding eligibility, level of service, type of service, urgency of service, discontinuation of service or the mix of services provided by the Home and Community Care Program. The Homecare Committee would review all pertinent information in the case and would render a final decision. The home care committee will do so following the policy & procedure with documentation accordingly.

The Home and Community Care Service Delivery Plan is to be reviewed and updated yearly by the Home Care Nurse under the supervision of the Clinical Programs Manager and approved by the Health Director.

The Home and Community Care Policy and Procedure Manual is to be reviewed and updated every year by the Home Care Nurse under the supervision of the Clinical Programs Manager and approved by the Health Director.

8.2.5.2 Managed care

Managed Care in home care services assures that the client receives care that is specific to his/her needs, that it is dispensed by qualified members of health team, and that it is given at the required intervals and for the time needed. The needs of the client will be re-evaluated as needed with changes in status, when the professional deems necessary, and / or at a minimum yearly. It is also essential to establish links with other services that are not available on-reserve in order to eliminate all gaps in services to which the client is entitled. The KFN Homecare Nurse collaborates with the CISSST-K Homecare Nurse for coordination of services as needed.

8.2.5.3 Case management

The position of Case Manager will be full time and will be undertaken by the Clinical Programs Manager.

The Case Manager will have the responsibility to evaluate admissions request and planning discharges. He/she will do so by evaluating the client's needs (using the CarePath Admission and/or Multi-clientele form whichever appropriate). The Case Manager will plan and organize the types of services to be dispensed. The Case Manager, in conjunction with the Homecare Nurse/ LPN will create a care plan with the clients and or their family. The Case Manager will assure quality service delivery, evaluating the care offered and its effect on the client. Re-evaluation of acute clients will be done at minimum every 3 months and chronic client re-evaluations will be done at minimum every year or when there is a health status change.

Homemaker / Home Support Service needs that are identified by the Case Manager or Homecare Nurse are to be forwarded to Centre Jeunesse. The evaluation and set up of such services will be done by the person designated by Centre Jeunesse. Essentially, the Case Manager coordinates the numerous services received by the client at home and ensures that the services are of quality and uniformity. This person will also be the link between all the care providers, hence facilitating communication and preventing gaps and/or overlaps in services.

8.2.5.4 Referrals and linkages to services and other care providers

Linkages to outside services will be an important part of our Home and Community Care Program as our program is very limited. They will help support the community based activities and ensure that the client is receiving the best possible care. Physicians from the local CSSST-K are present and provide services on site at the KFN Health Centre monthly.

The Home Care Nurse will work to maintain the present linkages with the Centre de Santé de Témiscaming so that the client is able to pass from one service to the other without difficulty and that his/her information will follow. At the Centre de Santé Témiscaming, we find such professionals as our Family Physicians, Psychologist, Physiotherapist, Occupational Therapist, Nutritionist, Nurses, etc. These professionals are actively involved in our clients' care when needed and are also able to refer them to other specialists and services when needed.

8.2.5.5 Client assessment

The goal of evaluating the client's needs is ensuring that home and community care services are adapted to the particular needs of the person, either on a physical, mental, emotional, and/or spiritual level. This will be a process that will include the participation of the client and family (or natural care-giver) in identifying the person's health problems and the types of services that will best suit his/her needs.

The client's needs assessment is a task completed by the Case Manager. During the evaluation process, the case manager uses the CarePaths Standard Assessment tool and /or Multi-clientele to collect information on the client's health, autonomy and needs in order to develop a care plan (refer to Appendix B & C). This care plan will outline the client's health/functional needs, the planned care with a description of the role of each caregiver (including the client and his/her family)It will also include the goals of the care and expected outcomes, expected date that the outcomes will be reached and the duration of the services. The plan will also indicate the referrals that have been made to other services.

The care plan will be re-evaluated at minimum every 3 months for acute client, every year for chronic clients and / or as the client's needs or condition changes.

8.2.5.6 Homecare nursing

Homecare nursing is /are services that are delivered by RN or LPN in the client's home. The Home Care Nurse will be under the supervision of the Clinical Program Manager. She/he will be responsible for a number of activities that revolve around the client's care. The nurse's responsibilities include client assessment and care planning with such activities as acute care nursing, medication management, and wound management, teaching clients to care for themselves, and managing chronic illnesses. In addition to these responsibilities the Clinical Programs Manager is responsible for the supervision and teaching of the personal care worker.

To receive home care services a new client needs to be referred by a hospital, a physician (or other health professional) or a request must be made by the client or his/her family or community member. The Case Manager will initiate the assessment process. Then, the services delivered will be based on the client's care plan which was developed based on the needs / conditions of the client identified on the Nurses Initial Assessment.

Home Care Services will be available five days per week, during business hours. During this time, when the Homecare Nurse is absent, the Community Health Nurse or Case Manager will cover homecare nursing services. For evenings and weekends, we will follow the MSSST-K guide for coverage for homecare which is the CSSST-K outpatient clinic.

Professional supervision will be provided by the Health Director and FNIHIB, Health Canada – regional office.

8.2.5.7 Home support services

Home support services will be provided by two types of workers.

Personal care services

The KFN Personal Support Worker is certified in the field of personal care. The role of a Personal Support Worker is to provide personal care according to the care plan. Under the supervision of a registered nurse, these workers assist the client with activities of daily living such as bathing, grooming, dressing, mobilizing, toileting, feeding, taking prepared medications, etc. Kebaowek First Nation Home Community Care Program has 1 Certified Health Care Aide / Personal Support Worker working regular part-time.

The PSW will be made aware of her clients needs and expected duties initially via telephone and with written PSW care plan sheet. (see Appendix I) The PSW is to hand in her visits / task sheet completed every 2 weeks to the Homecare nurse for an update on the clients file. Any changes in the clients status or updates are required to be reported immediately (within the same day) via telephone and in writing within 48hours to the PSW.

Home management

Home management services presently exist in our community. The role of a Home Management Worker / Home Support Worker is to assist the client with tasks such as housekeeping, laundry, meal planning and preparation, shopping, etc. according to the Care Plan.

This service is available through funding from AANDC Adult Care Program. Presently these funds are allocated to the Centre Jeunesse in Ville-Marie. Social Services (from Centre Jeunesse – native division) liaison officer or other designated person in our community (also AANDC funded) is responsible for the hiring, management and supervision of these workers and the services provided.

8.2.5.8 In-home respite services

Presently, this type of service is offered in part by the "ISC" Adult Care Program, but is not available evenings and nights. This type of care is provided to higher need clients who are in the community and require supervision because they can't be safely left alone at home. This service assigns a home support worker to go the home and stay with the client for a period of time (max of 10 hrs/week) or in periodic intervals during the time the caregiver is away from home. The goal of this service is to provide respite to the caregiver so that he/she can continue to care for the client and therefore delay or prevent the need for institutional care.

If needed, for higher needs clients, the Centre de santé de Témiscaming (CMSSSTK) does have one available bed for inpatient respite services.

8.2.5.9 Medical supplies and equipment

Medical Supplies and Equipment are needed to provide good health care in the home and to promote the independence of the client. It is important for the Home and Community Care Program to keep various supplies on hand, so that the support can be provided when needed. At the present time, the Health Centre does have some medical equipment available to be lent out for short-term use by clients. Clients receive medical supplies and equipment as per the assessment and according to the care plan completed by the Case Manager. These supplies and equipment will be kept at the Health Centre and accessed by the Homecare Nurses when needed.

We will continue to lend equipment when needed for short periods of time. At that time the client (or his representative) will sign a loan of medical equipment form.

If any medical equipment is needed by the client for long term use then a prescription is obtained from the physician and the supplies or equipment will be processed thru NIHB and covered as applicable. For equipment not covered thru individual benefits then the option is for the client to purchase the supplies/equipment themselves or the health centre to continue lending the items long term.

Pharmaceutical Services are provided by NIHB.

8.2.5.10 Information and data collection

To adapt the services and programming to meet the constantly changing needs of the community, collection of data and information are imperative. E-SDRT and HR e-HRTT are used to collect and report homecare activities and human resource information. This process is to be completed by the home care nurse.

Monthly statistical reports will be completed and compiled at the end of each year.

Annually, the service delivery will be evaluated, taking into account all requests for service, overall satisfaction of clients and complaints.

Confidentiality**:** The Kebaowek Home and Community Care Program is respectful of, and committed to maintaining the confidentiality of all client information gathered by staff or sent as a referral from other programs and services. Confidentiality of all client information is maintained through a variety of processes and procedures. Client charts are to be stored in a locked unit or in the locked secure achieve room. All employees at the Kebaowek First Nation Health Centre have signed the confidentiality agreement.

8.2.5.11 Supportive services

With the limited budget for our Home and Community Care Program, we will not be able to expand and offer any types of services other than the Essential Services described in this plan.

Periodically, we have access to other supportive and complementary services (i.e. dietician, OT, PT) thru the CMSSST-K when they have them contracted or on staff. We will access these individuals as needed when able.

Responsible for delivery of the service: home care nurse (HCN). Locations for delivery: Health Centre for the preparation of visits and clerical tasks. In the home for the service delivery itself.

8.3 Communicable Disease Control and Management (CDCM)

"Communicable disease control and management programs aim to reduce the incidence, spread and human health effects of communicable diseases, as well as improve health through prevention and health promotion activities, of on-reserve First Nations (…)."

8.3.1 Objectives of the programs

As presented in First Nations and Inuit Health Program Compendium 2011-2012 and Addendum.

8.3.1.1 Vaccine preventable diseases – Immunization Program

• Ensure access to newly recommended vaccines.

• Improve the coverage rates of routine immunizations.

• Improve data and understanding of immunization coverage rates, the incidence of vaccine preventable diseases, barriers to immunization and best practices in implementation.

8.3.1.2 Blood Borne Diseases and Sexually Transmitted Infections (BBSTI) - HIV/AIDS Program

• Increase awareness of BBSTI-HIV/AIDS through improved community-based knowledge development.

• Increase the availability of evidence-based BBSTI-HIV/AIDS interventions.

• Reduce the stigma of BBSTI-HIV/AIDS within communities.

• Promote testing, access to prevention, education and support, and supportive social environments for those vulnerable to and living with BBSTI-HIV/AIDS.

• Increase effective collaboration towards the achievement of a coordinated and integrated response to BBSTI-HIV/AIDS across jurisdictions.

8.3.1.3 Respiratory infections - Tuberculosis (TB) program

• Contribute to reduce the incidence and burden of TB disease in First Nations on-reserve.

• Detect and diagnose TB disease early to eliminate the cycle of transmission among those exposed to infectious cases.

• Provide treatment via Directly Observed Therapy (DOT) to those with active TB disease and latent TB infection to prevent the emergence of drug resistance.

• Support health care workers and communities in the prevention and control of TB disease at the community level.

• Strengthen TB research through collaboration with local, regional, provincial, national and international partners.

8.3.2 Service delivery

Table 15: CDCM Service Delivery

STBBI	Immunization	TB
List of the type of personnel who will provide clinical services linked to CDCM programs.		
KFN has 3 nurses currently working full time; 1 Clinical Programs Manager for Mgmt of all the above mentioned programs with 1 RN as CHN and 1 LPN as HCare / Special Projects Nurse.		

Immunization (childhood vaccines and influenza) primarily assigned under CHN.

STBBI education, prevention and promotion assigned under CHN with Community Wellness Worker

HIV/HepC/STBBI assigned to CHN with Community Wellness Worker. TB assigned under CHN (no activity related to this domain thus far)

Description of activities and clinical services offered:

• testing • diagnosis • treatment • client follow-up • counselling and support services • targeted interventions for vulnerable populations (ex: youth clinics, needle exchange program, outreach services) • referrals and services for the follow-up and treatment of chronic infections (hepatitis C, HIV)	• targeted populations • access to immunization services (school based, on demand, immunization clinics) • vaccines administered (according to the provincial calendar) • type of call back system • cold chain management (equipment and procedures)	• testing • contact tracing • management and follow-up of active cases • procedure for directly observed therapy (DOT)

If the above services are not offered on reserve, identify the providers (ex: CLSC) that offer them, as well as the types of services available to community members.

TB testing /screening is done at the local CMSSS TK

TB test reading / measurements also done at CMSSS TK

Describe the collaborative approach used with the local Public Health Authority (DSP) for the reporting, management and follow-up of cases and contacts:

We may be called upon for assistance with the follow-up process by the local CISSS T-K for MADO but the follow-up is done by them according to the provincial protocol.

• Management and follow-up of index cases • Partner tracing (IPPAP)	• Management and follow-up of cases of vaccine preventable diseases and their contacts	• Management, follow-up and treatment compliance for active tuberculosis

Table 16: List of the mandatory reportable diseases in Québec[32]

Acute flaccid paralysis

AIDS: only if the person gave or received blood, blood derivatives, organs or tissues

Angiosarcome of liver

Anthrax

Asbestosis

Asthma as an occupational disease

[32] http://publications.msss.gouv.qc.ca/acrobat/f/documentation/preventioncontrole/03-268-05.pdf

Babesiosis

Berylliosis

Botulism

Brucellosis

Byssinosis

Chagas disease

Chimicaly caused bronchopulmonary disease

Chimicaly caused disease to the heart, liver, kidney, lung, gastrointestinal or nervous systems

Chlamydia trachomatis infection

Chancroid

Cholera

Creutzfeldt-Jakob disease

Diphteria

Enterococus vancomycin resistant

Encephalitis viral transmitted by arthropods

Epidemical gastroenteritis

Gonococcic infection

Hantavirus Pulmonary Syndrome

Hemangiosarcoma

Hemorrhagic fevers, including:

1. Ebola virus disease
2. Marburg virus disease
3. Other viral causes

HIV infection: only if the person gave or received blood, blood products, tissues or organs

Inguinal granuloma

Invasive infection by Escherichia coli

Invasive infection by Hæmophilus influenzæ

Invasive infection by meningococus

Invasive infection by streptococus A

Invasive infection by Streptococcus pneumoniæ

Legionellosis

Leprosy

Lung cancer due to exposure to asbestos

Lyme disease

Lymphogranuloma venereal

Malaria

Measles

Mesothelioma

Mumps

Paratyphoid Fever

Pertussis

Plague

Poliomyelitis

Psittacosis

Q fever

Rabies

Rubella

Severe Acute Respiratory Syndrome (SARS)

Silicosis

Smallpox

Staphylococcus aureus methicillin resistant

Syphilis

Tetanus

Trichinosis

Tuberculosis

Tularemia

Typhoid fever
Viral hepatitis (ex: VHA, VHB, VHC, VHD)

West Nile Virus illness
Yellow fever

8.3.3 Public education and awareness

Below is a table of all activities run and material used to better inform the KFN members about communicable diseases.

Table 17: CDCM program activities

Communicable Disease Control and Management **Awareness and Education Activities**				
Program and Initiative Areas	National	Regional	Local/community	Number of Activities
HIV/AIDS-Blood Borne and Sexual Transmitted Infections Hepatitis C Initiative	-	-	-Condom distribution -Condom dispensers installed in 3 locations in community Hepatitis C Initiative (related activities and educations resource kits)	4
Tuberculosis	-	-	-	-
Immunization	-	-Posted influenza season awareness posters	-Influenza Posters -Newsletter influenza awareness article -Seasonal influenza	5

			clinics -Prevention & promotion items for influenza prevention	
EPP (Emergency Preparedness Plan)	-	-	-	-
Infection Prevention and Control	-	-	-	-

8.3.4 Capacity development

See Training Plan 2019-2024 in Appendix 7.

8.3.5 Surveillance, data collection and evaluation

Public Health Authority: Direction de la santé publique de l'Abitibi-Témiscamingue (based in Rouyn-Noranda)

8.3.5.1 Communicable diseases; immunization

Communicable disease diagnoses are managed according to provincial bylaws on communicable diseases. However, the Health Centre has never had to proceed with this since this type and level of diagnosis is only done by physicians and/or laboratories at the CMSSSTK.

Immunization is done at the Health Centre, and sometimes at home, on appointment for the younger children. For school age children most of the vaccination is done at school but occasionally the CHN provides the service on appointment, in collaboration with the school nurse.

Table 18: Regular vaccination schedule
List of recommended vaccinations according to age[33]

Age	**Vaccine(s) (French abbreviations)**
2 months	DCaT-HB-VPI-Hib Pneu-C-10 Rota
4 months	DCaT-HB-VPI-Hib Pneu-C-10 Rota

[33] http://www.msss.gouv.qc.ca/sujets/santepub/vaccination/index.php?calendrier_de_vaccination

6 months	DCaT-VPI-Hib
12 months	Pneu-C-10 RRO Men-C-C
18 months	DCaT-HB-VPI-Hib RRO-Var
Between 4 and 6 years of age	dcat-VPI
4th year of elementary school	HA HB VPH
Between 14 and 16 years of age	dcat Men-C-C
Adult age	dcat
From 50 years of age	Dcat ou dt
65 years of age	Pneu-P-23
75 years of age	Influenza (yearly)

8.3.5.2 Immunization, material handling and storage

The protocol referring to the storage and handling of immunization-related products will be found in Appendix 6.

8.4 Environmental Health & Safety (Water Monitoring)

Responsible for delivery of the service: two workers from Land Management, assisted by the Sport, Leisure & Mentoring Coordinator. The activities are under the responsibility of the Community Wellness Programs Manager.

Locations for delivery: the services are planned in the centre but those responsible for them, because of the nature of the activities, are often on the premises in order to collect samples or inspect facilities.

Services

Community-based water monitoring including sampling, quality control analysis and counter control; water plant operation; research (biologist) assistance (occasional).

The same service is provided by the same people to Long Point First Nation.

During the fiscal year 2016/2017, the following sampling and tests were completed.

Table 19: Water Monitoring Stats KFN 2016/2017

KEBAOWEK FIRST NATION	
Samples taken	217
Free Chlorine Tests	180
Total Chlorine Tests	180
Turbidity Tests	164
Monthly Quality Control Tests	12
Boiled Water Advisories	2

8.4.1 Emergency Preparedness Plan (EPP)

By decision of the Band Council, the responsibility of actualization and management of the EPP was entrusted to Public Works under the current interim direction of Mr. Terry Perrier. The title page and the Table of Contents in its latest version is to be found in Appendix 8.

The Health Services didn't receive any request for an active collaboration on this matter.

8.4.2 Community Pandemic Influenza Plan

After evaluation of different options, the Band Council decided to include the Community Pandemic Influenza Plan into the EPP. The Health Centre is to be considered as a partner to it.

The Health Services didn't receive any request for an active collaboration on this matter.

8.5 Children's Oral Health Initiative (COHI)

Objectives

As described in the FNIHB's Program Compendium 2011-2012

• Reduce and prevent oral disease through prevention, education, and oral health promotion.

• Increase access to oral health care

Responsible for delivery of the service: the dental hygienist working in Maniwaki. She receives help from the CHN if needed.

Locations for delivery: Health Centre, Daycare Centre and school; occasionally in the home.

Services

The dental hygienist spends 2 consecutive days every month with children of the community. Services include screenings, topical fluoride applications, placement of dental sealants, alternative restorative treatment, oral health information sessions, and referrals to other dental care professionals for treatments beyond their scope of practice. She also provides information to parents /caregivers and expectant mothers to help children build and maintain healthy smiles from the start.

COHI reached out to children by providing:

- Dental check-up (oral screening)
- Fluoride applications to help prevent cavities
- Education and information regarding oral hygiene
- Sealants to prevent cavities.