Kanesatake Health Centre Inc.
12 Joseph Swan Rd.,
Kanesatake, Quebec J0N 1E0

AHTF Integration Project

ASSESSING, ENHANCING AND INTEGRATING HEALTH SERVICES FOR KANESATAKE

Final Evaluation Report

Submitted by
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Executive Summary

The overall goal of the Integration project was to assess, enhance and create new linkages for services for the Elderly and young children who are the most vulnerable clientele for health services in Kanesatake. Oversight for the project was given by a Steering Committee with representation from each of the project's partners.

Community members were invited to participate on Work Teams. A nurse consultant headed each of the two Integration teams. Each committee had its own terms of reference with clear goals and objectives for continued improvement of services for Elders and young children and their families in Kanesatake. The activities of the Working Teams provided the community with situations of problem-solving with provincial partners which created better understanding. Awareness was created on both sides.

Consistency within the teams was challenged by the change in staff at the CSSS, CLSC, and the community. This led to some confusion as to roles, responsibilities and accountability. It was difficult to keep the process flowing as the committee would have to fill in the details from the last meeting for the new person. It was also difficult for the CSSS to free up staff to sit on the Steering Committee or the Joint Working Teams.

One of the biggest constraints for all aspects of this project was time. It was difficult to complete a project such as this one in the short time available. There was a lack of time to really develop some of the topics. Timelines and waiting for people to respond to the liaison for the project in order to receive required answers to questions that were asked was sometimes challenging. As well, Health Center staff had regular responsibilities that sometimes took them away from the project.

Language was an issue. There are not a lot of bilingual people at the CSSS who could participate in the meetings. Language at meetings or interviews between participants sometimes portions of discussions had to be explained.

The Joint Working Teams and the Coordinator worked together respectfully and everyone felt their opinions were taken seriously. There were people with

many different backgrounds around the table but everyone respected each other, worked well as a team and everyone had valuable contributions

The project coordinator and the consultants encouraged a climate of cooperation during the project. The highly effective project manager provided strong leadership, a climate of transparency and was very dynamic.

The Kanesatake Aboriginal Health Transition Fund Projects benefitted from having the participation of three provincial entities represented on the Steering Committee, the ASSS, the CSSS and Centre Jeunesse. The presence of the ASSS helped to move some of the areas of the project forward. The partnership worked well but was sometimes encumbered by the changes in staffing with the CSSS.

The support of the Steering Committee and the (previous) Executive Director at the Health Center that believed in this project moved this project forward in the beginning. Unfortunately, the H1N1 pandemic, changeover in staff at the CSSS, gaps in the leadership at KHC, and changes to the KHC Board of Directors provided a climate of uncertainty regarding the follow through with the project.

The project has achieved its own objectives by developing ECH and MCH work teams, conducting a gaps assessment of services for Elders and children, developing a work plan to implement its recommendations, providing training to staff, developing protocols and working to bring the in-home support and home and community care programs together.

Awareness levels were raised by the project but the integration of services was not achieved. A culturally appropriate custom of retrieving the placenta was worked out and agreed to, only to be told at the last minute that it was illegal and not permitted.

There was a strong commitment from all of the project partners to carry forward the work that was done through the AHTF project. A Sustainability Plan has been developed to ensure that the work will go forward.

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1. Introduction

1.1 Context

The Aboriginal Health Transition Fund (AHTF) is a five-year initiative (2004 to 2010) which seeks to improve the integration of Federal, Provincial and Territorial funded health systems, adapt existing health programs and services to serve better the needs of Aboriginal peoples (First Nations, Inuit and Métis), improve access to health services, and increase the participation of Aboriginal peoples in the design, delivery, and evaluation of health programs and services. Health Canada has recently received permission to extend all of the AHTF projects until March 2011.

The AHTF provides transitional funding to Provincial and Territorial governments and First Nations, Inuit and Métis organizations and communities in three areas:

- **Integration** - to support First Nations and Inuit communities to improve the coordination and integration between provincial and territorial health systems and health systems within First Nations and Inuit communities;
- **Adaptation** - to support provincial and territorial governments to adapt their existing health programs to the unique needs of all Aboriginal peoples including those in urban and Métis settlements and communities; and
- **Pan-Canadian** - to support cross-jurisdictional integration and adaptation initiatives in three streams: First Nations, Inuit and Métis; capacity funding to national Aboriginal organizations; workshops; evaluation activities; and overall administration of the AHTF.

The Aboriginal Health Transition Fund (AHTF) is a five-year $200-million fund set up in 2005-2006. It was established because there was increasing acknowledgement of the fact that to mitigate differences between the health status of Aboriginal individuals and non-Aboriginal Canadians, coordinated efforts were required on the part of all stakeholders involved in Aboriginal health. The investment allows federal, provincial and territorial governments (FPT) and First Nations governments offering healthcare services and

Aboriginal communities to design new means of integrating and adapting existing health services.

1.2 Background

The project recipient is the Kanesatake Health Center Inc., located at 12 Joseph Swan Road, Kanesatake, Quebec, J0N 1E0. The Health Center was recently incorporated federally, and received its Letters Patent on August 15th, 2006.

The Kanesatake Health Center opened June 3, 1996. The Health Center (KHC) is community-based committed to promoting wellness and harmony within the community of the Kanesatake and its surrounding territories. The KHC endeavors to provide health services that are accessible to all Kanesatake community members regardless of age, race, sex, income, education, lifestyle choices, or religion.

The Health Center believes in a holistic approach to health and well being. It has adopted the belief that all individuals have the right to respectful care and the right to make informed decisions about the care they choose to receive. The mission of the Health Center directs that the staff, in their hearts, through their words and by their actions, endeavor to meet the health and wellness needs of the Kanesatake community, the family, the individual and the unborn child with honor and respect at all times.

The Health Center currently has many programs and services which include but are not limited to the following examples:

- Community Nursing services and clinics;
- Prenatal and Immunization clinics;
- Home and Community Care;
- Outreach for Elders;
- Drug and Alcohol Prevention;
- Youth Council and Youth Group (KYOT);
- Parents and Tots program;
- Environmental programs;
- Prevention programs for healthy living such as tobacco awareness
- Information and Support Groups for Diabetes, HIV-Aids, FASD;

- Mental Health Support programs.

The Health Center also works with the provincial Social Services agency, Centre Jeunesse des Laurentides, to ensure the health and well-being of the Elders who are resident in the Riverside Elders home, and to support Child and Family Services through Health Center programming.

1.3 Integration Project

The Kanesatake Health Center has been approved for two projects under the AHTF initiative, one is an Adaptation Project and the other is an Integration Project. The projects began in August 2009 and will end in March 2011. Both projects are managed by the Kanesatake AHTF Steering Committee.

The Integration Project is to conduct a gaps assessment and to create new linkages for services to the Elders, whether in residence or at home, and services for young children aged 0 – 6 through enhancements to the developing maternal child program.

The overall goal of the project is to assess, enhance and create new linkages for services for the Elderly and young children who are the most vulnerable clientele for health services in Kanesatake.

1.4 Project Partners

The profiles of the partners for the Kanesatake AHTF were as follows:

1.4.1 The Mohawk Council of Kanesatake

The Mohawk Council of Kanesatake (MCK) is the duly elected body with legal powers and authority to govern in Kanesatake and its territory. The Council's jurisdiction covers various public services and programs that are provided to the Community, including the Riverside Elders' Home. The Mohawk Council has delegated the administration of the Health programs and services to the Kanesatake Health Center.

In 2006, the Council (MCK) agreed through Band Council Resolutions to support the incorporation of the Health Center as a mechanism that will allow the expansion and future development of Health Services to the community of Kanesatake. The Mohawk Council of Kanesatake has two permanent positions with voting privileges on the Board of Directors of the Kanesatake Health Center Inc.

1.4.2 CSSS du Lac-des-Deux Montagnes

The Health and Social Services Center (CSSS) of Lac-des-Deux-Montagnes is responsible to maintain and improve the health and well-being of the population of the Municipal Regional Council (MRC) of Deux-Montagnes and the southern sector of the MRC of Mirabel. Further, as a partner, it provides a specific range of services specialized to the population served by the Health and Social Services Center of Ste. Thérèse-de Blainville.

The CSSS ensures that the population of the territory has access to a broad range of health services and social services, in particular services of promotion-prevention, evaluation, diagnosis and treatment, readjustment, support and lodging as well as access to specialized and ultra specialized services.

To do this, the CSSS favours "program services" in order to improve accessibility as well as supporting continuity and a better coordination of the services. The Quebec Ministry for Health and Social Services defines a program as "an entity of services and activities organized with an aim of meeting the needs for the population or the needs for a group for people who share common problems".

Using an interdisciplinary approach, the 2 300 employees, 265 doctors and pharmacists as well as the 180 volunteers collaborate together to achieve the mission of the CSSS in all of its four installations:

Le Centre d'hébergement de Saint-Benoît

Located at Mirabel, the Saint-Benoît Residence offers 75 beds for permanent lodging. It offers in a temporary or permanent way, services for lodging, assistance, support and monitoring as well as services of readjustment, psychosocial, nursing, pharmaceutical and

medical services for adults who have lost their autonomy and cannot remain at home any longer, even with the support of their loved ones. Currently this Residence is being renovated.

Le Centre d'hébergement de Saint-Eustache

The Saint-Eustace Residence offers, in a temporary or permanent way, services for lodging, assistance, support and monitoring as well as services of readjustment, psychosocial, nursing, pharmaceutical and medical for adults who have lost their autonomy and cannot remain at home any longer. There are 192 permanent beds and 3 palliative care beds. In addition, there is a day center and an external service for readjustment.

Le CLSC Jean-Olivier-Chénier

The CLSC offers first line health and social services, of a preventive or curative nature, readjustment or reintegration as well as community organization services. The services of the CLSC are provided at home, school, work and in the community. Psychosocial services and crisis intervention in person or at home are offered 24 hours a day and 7 days a week.

L'Hôpital de Saint-Eustache

With a capacity of 221 beds and 23 stretchers at the emergency clinic, this hospital offers general and specialized care. In 2005-2006, the Hospital of Saint-Eustace received 53.021 visits for the emergency clinic, offered 70,020 external consultations and 27,557 admissions, including 10,802 in short-term care.

Located near highways 13, 15 and 640, the Saint-Eustache Hospital is designated as a "secondary trauma center". Moreover, it acts as a Reference Center for the Québec tracking program for breast cancer. Since 1989, the Hospital of Saint-Eustache is member of the Mother-Child Network that works in collaboration with the University Hospital Complex (CHU) of Sainte Justine. In 2004, it became the second establishment in Quebec to receive the certification "Baby-friendly Hospital" decreed by the World Health Organization (WHO) and UNICEF for the protection, support and promotion of breast-feeding.

1.4.3 Centre Jeunesse des Laurentides-Kanesatake

The Centre Jeunesse des Laurentides is currently mandated by Indian and Northern Affairs Canada to provide social programs to the community of Kanesatake similar to those found in the province, according to the terms and conditions of its funding arrangement, and in compliance with the program objectives and requirements established by the INAC Social Development Program.

The Centre Jeunesse receives funding under the Assisted Living segment of the social program to provide In-Home Support Services to those Elders living at home, as well as funding for Foster Care and Institutional Care. The other segment of the Social Program for Child and Family Services is limited to services resulting from a Youth Protection mandate.

1.4.4 Board of Directors of the Kanesatake Health Center Inc.

The Board of Directors consists of 7 members, some of which are elected and others appointed by the nature of their employment under the Mohawk Council of Kanesatake. The mandate of the Board of Directors is to manage the property and business of the corporation. This is done through its delegation to the Executive Director of the Health Center who is the Chief Administrative Officer of the corporation.

2. Methodology

2.1 Evaluation Overview

Among other things, the evaluation of both projects will address the following general points:

- Progress achieved towards the stated outcomes with reference to the work plans, stated measurement indicators and the logic model included in the integration project;
- Implementation and operation of the adaptation and the integration projects: successes, problems encountered (positive and negative aspects, improvements to be made, etc.)
- Cost effectiveness of the projects in relation to their design and implementation;
- Best practices and weaknesses, what worked and what didn't work and the reasons for this, lessons learned from the projects;
- Relationships between the project partners and ability to mobilize organizations, services and people to contribute to the overall project success;
- Sustainability of the projects in reference to future dialogue and cooperation between the community health services and the provincial health services under the CSSS Deux-Montagnes.

2.2 Objectives

The overall purpose of the evaluation is to collect and organize information on both of the AHTF Projects to determine whether the projects achieved the anticipated results. The objectives are:

1. To provide a summary of the project work – the inputs, activities and outcomes for each project.
2. To determine if each of the projects has met its expectations.
3. To look at the lessons that were learned from each project.
4. To establish what would be the best practices for future projects.

2.3 Logic Model

Inputs

- AHTF funding from Health Canada
- Human Resources from Kanesatake Health Center, Riverside Elders Home, CSSS and Centre Jeunesse

Activities

- Communication & collaboration with partners
- Gaps Assessment for Elders, In-Home Support and Community Care, and Maternal Child Health
- Service enhancement and augmentation, creation of access to services.

Outputs

- Minutes of Steering Committee meetings
- Mobilization and reorganization of local services
- Development of service protocols and policies
- Progress reports, financial reports
- Policy for case management based on the use of a Multi-disciplinary Team
- Manual for Maternal Child Health

Immediate Outcomes

- Open dialogue between Kanesatake services and local representatives of the provincial health and social services system
- Increased awareness and information sharing between services in both jurisdictions
- Increased capacity and training for community health and social services, and for those working for the Elders at Riverside.
- Increased collaboration between community health services and CSSS
- Closer collaboration between In-Home Support and Home and Community Care Programs

Intermediate Outcomes

- Improvement and augmentation of health and social services for Elders resident in Riverside Elders Home, and non-resident in the Elders Home
- Development and enhancement of Maternal Child Health Program
- Integration of In-Home Support and Community Care programs

Final Outcomes

- Improved health programs & services for Elders and young families
- Improved access to quality health programs & services for the Elders and other members of the community of Kanesatake.

2.4 Evaluation Design

The activities involved in the evaluation included:

- Review of existing project literature;
- Review of project work plans and evaluation plans;
- Attendance at project meetings as required;
- Preparation of a questionnaire intended for AHTF Steering Committee members and project partners;
- Preparation of a questionnaire for project work teams;
- Reviewing project minutes and interim evaluation reports;
- Compiling and analyzing information received;
- Preparing a preliminary report for presentation to the steering committee;
- Validating the preliminary report with the steering committee;
- Completing the final report and including the list of recommendations

2.5 Evaluation Questions

The areas that were looked at during the evaluation included:

- Level of collaboration with provincial programs and services (quality of and depth of collaboration);
- Any applied research which has been used, and its relevance and effectiveness;
- Quality of communication between local and provincial organizations and services participating,;
- Any lessons learned from the AHTF activities;
- Extent to which the project fulfilled its objectives and achieved their expectations.
- The likelihood that program benefits will continue after completion without over-burdening local organizations and provincial partners.
- The extent to which local capacity been developed at the individual worker and health service levels, and if so, will it be adequate to sustain the benefits envisaged.
- What have been the overall key challenges, constraints and risks facing the projects?
- Are the management and oversight structures appropriate?

- Has there been shared responsibility and accountability for program results by all the local and provincial partners?
- How effective has been the communication, coordination and cooperation among the program partners?
- What, if any, have been some of the challenges?
- Does the project result make sense in relation to the conditions, needs or problems to which it is intended to respond?

2.6 Challenges

Some of the challenges in conducting this evaluation were:

- The differences in jurisdiction, administrative organization and responsibilities between all of the AHTF project partners.
- Possible differences in language comprehension between community and provincial members of committees.
- Differences in cultural background and orientation.
- Time available to the project partners and stakeholders to willingly respond to the evaluation questions whether by survey or interview.

2.7 Methodologies

The methodologies used in the evaluation included:

- Review of project meeting minutes, documents and other information including any completed AHTF mid-project evaluations for both projects
- Review of any project measures/indicators that have been collected for both projects
- Analyzing collected data and preparing a summary of project inputs, activities and outcomes for both projects
- Development of evaluation tools based on the literature review and the evaluation questions
- Interviews/surveys of project partners and stakeholders using approved evaluation tools in relation to each project
- Compilation and analysis of data collected, reflecting on logic model for integration project
- Development of preliminary reports for approval by the Steering Committee based on evaluation of two projects
- Finalize report based on feedback.

3. Kanesatake Integration Project

3.1 Project Oversight

The partners for this project included:

- Agence de Santé et Services Sociaux des Laurentides (ASSSL)
- Centre de Santé et Services Sociaux Deux Montagnes (CSSSDM)
- Centre de Jeunesse des Laurentides (CJL), Kanesatake Office
- Mohawk Council of Kanesatake (MCK)
- Riverside Elders' Home
- Kanesatake Health Center Inc.

Each of the partners was represented on a Steering Committee which oversaw the entire project. The Steering Committee had specific Terms of Reference which were developed as part of project planning. The committee operated by consensus, and quorum required the presence of at least one of the provincial partners.

Each of the partners was responsible for providing technical support to the project. This technical support consisted of making available technicians who worked on three different teams for each aspect of the project: Elders in Residence and In-Home Support, Maternal Child Health, and a Cultural Team. The teams were composed of community staff and specific technical resources from the CSSS.

3.2 Situation Addressed

Today, in Kanesatake as in other First Nations communities, the community is trying to cope with the multi-generational effects of residential schooling and colonization. Many children from Kanesatake were sent to Shingwauk and Spanish Residential Schools, as well as one or two other schools. This has had consequences for the traditional family unit and on traditional family practices; subsequently, families are more isolated and in greater need of services. The multigenerational trauma has left families without appropriate parenting skills, coping with family violence, alcoholism and addictions and other forms of abuse.

The goal of the MCH program is to improve health outcomes for First Nations women who are pregnant and families with infants and young children who live on reserve. The Kanesatake Health Center wanted to build upon the best practices of the CSSS in this area, along with the strengths of the community's culture and traditions, including support from Elders, and also integrating the spectrum of existing programs such as CPNP, FASD, AHSOR, nursing services, and oral health programs.

The loss of traditional practices and values means that Elders are no longer looked after in the same way. Many are isolated, alone in their homes or left in an Elders' Home without family support. Accessing outside medical, social or physical services has been very difficult due to cultural and language barriers, or transportation issues.

Young children and elders require support services that cannot be provided within the current levels of programming. The Kanesatake Health Center wanted to use the integration project to undertake a gaps need assessment for the Elders in Residence/ Elders' Day Program and for the Maternal Child Health to better address the health and social services needs of these very vulnerable clients.

Decisions regarding clients are made by the individual community services. There was only limited communication with provincial services through the CLSC. There were not any formal mechanisms to integrate community services on behalf of the client or to case manage together. Some shared planning for clients was done informally between the managers of the In-Home Support and the Home and Community Care Programs. There was a need for establishing multi-disciplinary approaches to service provision.

3.3 Project Objectives

The overall goal of the project was to assess, enhance and create new linkages for services for the Elderly and young children who are the most vulnerable clientele for health services in Kanesatake.

The project objectives were:

1. To put in place the project team and administrative structure needed to manage the project.
2. To conduct an assessment of the gaps in service for Elders in Residence, Elders Day Programs and Support Services and Maternal Child Health.
3. To work with the project partners to enhance existing services based on either improving and augmenting services, or integrating access to provincial services into the continuum of health services provided to the community of Kanesatake.
4. To provide training and capacity building to the existing staff members to compliment the enhancement or integration of services; to translate available documentation; and, to provide information and awareness to both milieus (provincial and community).
5. To develop protocols and policies for integrating and sharing services based on the use of a Multi-Disciplinary Team as the methodology for case management.
6. To integrate the two existing community programs, *In-Home Support* and *Home and Community Care* as a means of improving the efficiency and effectiveness of In-Home Medical, Personal Care and Support Services to Elders and other community members.

3.4 Integration Project Activities

3.4.1 Project Structure and Administration

The project oversight was through the Steering Committee. After some difficulty to find the right candidates, a Project Manager, two Nurse Consultants, and later a Culture Attaché were hired.

Three Joint Working Teams were put together, one focused on Maternal Child Health, one focused on Services for Elders and a third focused on Cultural Training and Hospital Liaison (for the Adaptation Project). Community members were invited to participate on the Work Teams.

A nurse consultant headed each of the two Integration teams. Regular meetings of the JWT were held, as well as Coordinators meetings with the Project Coordinator, Nurse Consultants, and the Cultural Consultant. Steering

Committee meetings with the partners were held with the Project Coordinator chairing and recording the minutes.

3.4.2 Gaps Assessment

In September 2009, the gaps assessment began by conducting focus groups with the target populations. The Nurse-consultants designed a grid to organize data from each of the participants. Two technical teams addressed each of these population groups. These teams met from January to May 2010. Both teams included representatives from each of the project partners.

One team addressed Maternal Child Health (MCH) while the other team examined Elders Community Health (ECH). The teams compared programs and services provided by the CSSS Lac des Deux-Montagnes and the territory of Kanesatake in the areas of Maternal Child Health, Home and Community Care, the Assisted Living Program and Riverside Elders' Home.

The AHTF teams met with most of the stakeholders including many in the Kanesatake community. The AHTF teams reported their findings back to all of the stakeholders. The nurses analyzed the information collected by the teams and organized the data into themes. They brought their themes back to the teams and to the community through focus groups. The teams and focus groups agreed on the themes and the recommendations.

The Maternal Child Health (MCH) AHTF team worked on identifying the services offered by the province in comparison with those offered by Kanesatake Health Center. They proceeded to identify the gaps and to develop recommendations for the gaps assessment report.

The Gaps Assessment Report made recommendations for the families of Kanesatake that were designed:

- to increase accessibility to health services;
- to reflect current worldwide best practice in the area of maternal child health; and,
- to provide sustainable results in the quality of life of families in Kanesatake.

The Gaps Report made the following 5 recommendations for MCH:

1. That KHC participate in the society of Obstetricians and Gynaecologists of Canada's Aboriginal Birthing Initiative and work collaboratively with the CSSS to develop an Aboriginal Birthing Strategy.
2. That the KHC formalize its commitment to breastfeeding by becoming the first Aboriginal Baby Friendly Center in North America.
3. That an early childhood intervention program be enhanced by a multidisciplinary team that includes staff members from Kanehsatake Health Center, first-line prevention services, Tsi Rontswa'ta:khwa Early Childhood Center, and Rotiwennakehte/ Aronhiatekha Elementary School to support skill development in children from birth to 6 years.
4. That an ongoing parenting program be developed in collaboration with the KHC and first-line prevention services to respond to the parenting concerns of families in Kanesatake.
5. That the home visitor program be developed in collaboration with the KHC and first-line prevention services to support the health and psychosocial needs of individuals and families in Kanesatake.

The Elders' Joint Working Team examined programs and services for three different clusters of clients.

- Those receiving home care services delivered by the Kanesatake Health Center (KHC) or Centre Jeunesse des Laurentides (CJL) through the Assisted Living Program.
- Those residing at Riverside Elder's Home or serviced by the Ressources Intermédiaires through the local CSSS..
- Those living in residence but requiring more than 3 hours of care each day.

The Elders (ECH) Joint Working Team assessed, and provided suggestions related to the homemakers becoming part of Home and Community Care. They tried to address issues around competence, hiring, orientation of homemakers and the quality care of the elderly at Riverside Elder's home. The team also looked at maximizing the resources available in the community by developing a method to combine the roles of RN's which would enhance services for both Home and Community Care and Riverside.

One of the most glaring gaps for this team was having no overall collaborative professional supervision for people working with clients, families

and groups in the community. The other was the gaps related to the need for transportation (local) for the elderly.

The recommendations made by the Elders Team included:

1. That existing Elder's Center activities be enhanced and increased to include activities similar to the day center at Manoir St-Eustache.
2. That a chronic care facility offering extended services, such as those available in provincial chronic care facilities, be created to meet the needs of Elders in Kanesatake.
3. That palliative care beds and services be added to existing services for Elders in Kanesatake.
4. That increased information be provided to Elders regarding programs and services available to them and other topics of interest such as duties of a public curator and writing a will.

In addition to the recommendations for the Elders and the Maternal Child Health, ten general recommendations were made:

1. A Healthy community advisory committee should be established for the community to decide and take charge of its health.
2. All health and social services should be offered through one structure like other communities that have taken over social services (and the province).
3. Liaison with the province should be formalized so health and social workers know who to speak to at the hospital or CLSC; resources are used more efficiently and clients needs are better met.
4. That a professional, holistic multidisciplinary team approach to client care, under the direction of the professional clinical supervisor, be developed and implemented, with appropriate consent forms, reporting, charting, policies and procedures.
5. Accreditation should be obtained for the Kanesatake Health Center (as the hospital and CLSC recently did).
6. That there be a concerted effort by the Steering Committee and the three committees to hire a physician in order to increase community access to urgent and chronic care, including Riverside Elders Center.
7. A data gathering system for measuring health indicators should be developed for the Kanesatake Health Center (KHC) to assist in program planning, monitoring and evaluation, as per the principles of Ownership, Control, Access and Possession (OCAP).

8. Special funding should be negotiated with INAC and Health Canada so that the community can hire physiotherapists, speech therapists, occupational therapists, dieticians, and other professionals that are part of the CLSC team.
9. Education should be encouraged so that Kanehsatakero:non study nursing, social work, teaching and language training be available in English, French and Mohawk.
10. A family center with extended activities should be created.

The gaps analysis was difficult to undertake as the two systems being compared were fundamentally different and no changes or recommendations could address these fundamental differences. In addition to several gaps arising in comparing the two different systems, the analysis highlighted the limitations faced by the local CSSS.

One limitation is that their resources are quite restricted and meeting the specific needs of such a small population as Kanesatake is not always feasible; another is that they are not designated as a bilingual institution and are therefore not bound to provide services or information in English. For these reasons, the gaps analysis has confirmed that integrating these two systems is not feasible.

Nonetheless, the Joint Work Teams that met throughout the gaps analysis showed that communication is the key. It was the most positive outcome of this process. As a result of these communications and the limitations of the local provincial services, the aforementioned recommendations were made.

The recommendations from the Gaps Assessment Report were approved by the Kanesatake AHTF Steering Committee. The Report was also validated in meetings with community members and the Mohawk Council. The Joint Work Teams then proceeded to work on some of the recommendations that were feasible within the time that was left in the project.

3.4.3 Enhancing and Integrating Services

A Maternal Child Health (MCH) Advisory Committee was formed which includes provincial representation. A Baby-Friendly Policy was approved in March 2011 by the Board of Directors of the Kanesatake Health Center Inc.

A Logo was chosen and a poster for Baby Friendly was launched with each of the community services. All the Health Center staff has been trained in breastfeeding support, and 12 peer support mothers have also been trained.

18 mothers followed a 6 week parenting support workshop series. Educators, daycare staff and family support workers also participated in the training so that the children and parents could receive ongoing support.

To support the recommendation that the community work collaboratively with the CSSS to develop an Aboriginal Birthing Strategy:

- A "Planting Our Roots" information pamphlet was created for the community.
- A procedure for placenta retrieval was drafted for Health Workers.
- An information pamphlet was created and placed in the cultural binder.
- Agreements were drafted to increase collaboration between CSSS Lac-des-Deux Montagnes and Kanesatake Health Center.
- Attempts were made to increase access to English resources.

Although there was collaboration with the Education sector and Daycare on MCH, the last recommendation that an early childhood intervention program be enhanced by a multidisciplinary team required more time and resources and was not feasible with the March 31st deadline.

For the Elders, an Elder's Community Health (ECH) Advisory Committee was formed to oversee the work that was to be done on improving services to the Elders. There was more awareness that there was a need to increase the standard of care, to incorporate best practice guidelines, and to require a clinical supervisor to oversee client care.

Beginning steps were undertaken to promote a change in philosophy in relation to client care: establishing a collaborative work team approach

(similar to multidisciplinary or Inter-professional team approach but with professional and non professional people actively involved).

A temporary measure was undertaken for people at the Elders home to have access to a doctor. This happened as a result of a meeting with the Nurse Manager at the CLSC and explaining the problem. She offered the suggestion for a temporary solution so that the clients at the Elders home can go to see the doctor at the CLSC.

Both Advisory Committees (MCH & ECH) had their own terms of reference with clear goals and objectives for continued improvement of services for Elders and young children and their families in Kanesatake.

3.4.4 Training

The project consultants' team, consisting of the Maternal Child Health Nurse, the Elders Community Health Nurse, the Cultural Attaché and the Project Manager discussed training needs based on the recommendations from the Gaps Assessment Report, as well as the desired outcomes of the project, with the Executive Director of the Kanesatake Health Center Inc. It was decided that the AHTF Projects would offer some training programs in specific areas to benefit:

- Parents and grandparents;
- Health and social service providers within the community of Kanesatake, including some educators;
- Health and social service providers within the province;
- The community at large.

Consultants from the team, or hired as needed, offered training based on the objectives of the training and their own expertise. The main areas of training that were offered between January and March 2011 were:

- Communication training;
- Baby-friendly training;
- Home visitor training;
- Cultural training;
- Community development;
- Inter-professional collaborative approach.

The training programs included (some will be completed later in the spring):

	Title	Overview	Audience
1	"How to talk so kids will listen".	To learn and practice a new language to talk to children that is consistently spoken at home, at daycare, in school and in the community of Kanesatake.	• Parents • Grandparents • Teachers • Educators • Health workers
2	(Adaptation) Project Skennenkowa: A Workshop on Cultural Safety	To increase understanding about cultural safety, the community and cultural practices in Kanesatake among staff at the local CSSS	• CSSS health care workers • nurses, • PABs, • occupational therapists, • nutritionists, • inhalotherapists, • speech therapists
3.	Baby Friendly Training	To facilitate the need to provide those working with mothers and their families the information required to adequately support breastfeeding.	• Nurse • Parents • Grandparents • Health care workers
4.	Healthy Communities Training	To develop an action plan to implement a project that will mobilize the community.	• Community at large
5.	Home visitor training (developed by the ECH Nurse Consultant)	To provide basic information related to caring for people in homes and in residence.	• Health center staff • Homemakers (CJL) • Riverside staff • Community members
6.	Inter-professional Collaboration	To develop a philosophy among the people who are working for community members that	• Health center staff

	Title	Overview	Audience
	(developed by the ECH consultant)	embraces the client as the central focus and all programs and services work together to provide optimal care.	• CJL staff
7.	Health Promotion	To increase understanding of health promotion and how to integrate it in program planning.	• Health Center Staff

3.4.5 Policy and Protocols

Much of the work in policy drafting and protocols was completed in the work of the Maternal Child Health team as described above. They included protocols with the birthing unit of the St. Eustache Hospital for Placenta Retrieval.

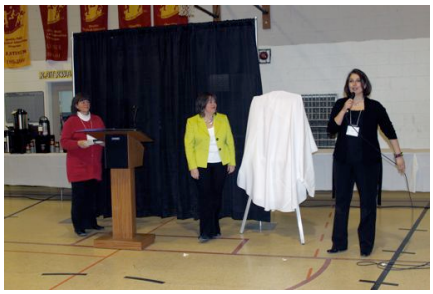
The Nurse-consultant for the Elders Team undertook training on inter-professional collaboration or using a multi-disciplinary approach with clients. The Maternal Child Health Advisory Team and the Elders Community Health Advisory Team represent multi-disciplinary teams created through this project.

3.4.6 Linking Programs

The Joint Working Team for the Elders spent time looking at possible ways to integrate the In-Home Support program and the Home and Community Care programs in a way that would benefit their clients. The Nurse-Consultant worked on an organizational chart that would reflect this integration and also include recommended changes from the Gaps Assessment Report.

3.4.7 AHTF Fair

The Project consultants together with the Joint Working Teams prepared a Community Health Fair featuring the work of the AHTF teams, partners and community services. The new logo and poster for the Baby Friendly Initiative was launched and various presentations were made to inform the community of the work that had been done.



3.4.8 Sustainability Plan

The Steering Committee felt that a sustainability plan would ensure that the project has some continuity after March 31, 2011. The Steering Committee identified a number of areas that must be sustained, and would be part of this plan.

1. The Steering Committee would meet twice per year.
2. The Communication Binder would be reviewed twice per year; this will be part of an overall communication plan to be submitted to the Steering Committee by the Communication Formal Liaison Mechanism group.
3. The Formal Liaison Mechanism Table should be distributed to the Steering Committee as well as to the people whose names appear in the table.
4. The Cultural Training should also be included in the Communication Plan
5. The website address for the cultural training should be included in the orientation package for new employees.
6. Strategic planning with the CSSS should continue.
7. Baby-friendly initiative will be sustained.
8. A summary of these efforts should be written in *Quoi de neuf…?* - the CSSS newsletter.

4. Findings

4.1 Capacity Building and Awareness

The project Steering Committee and the Joint Working Teams had representation from the ASSS (Steering Committee), the CSSS, Centre Jeunesse and from Kanesatake Health and other community services which provided an opportunity to develop a better understanding of the roles and responsibilities of everyone.

The activities of the Working Teams provided the community with situations of problem-solving with provincial partners which created better understanding. Awareness was created on both sides, and for Kanesatake in particular, this awareness involved discovering its place within the region and in relation to what the community has and doesn't have regarding services.

As described in the project, there were a number of training opportunities provided during the project. As well, the development of protocols and agreements required a certain amount of capacity building on both sides.

4.2 Challenges, Constraints and Barriers

The funding was receiving late due to regional delays. The start date of the project work was delayed in order to recruit a qualified project manager and two nurse-consultants. The project team needed more time to use a participatory approach in meeting with community members. All of these factors led to a compressed time frame to carry out the planned activities.

It was difficult to schedule team meetings given the number of individuals and the diversity of working realities for each of the team member. Schedules for meetings or interviews were sometimes difficult and took longer to resolve because of differing operational hours and priorities between partners. Scheduling meetings around very busy people made it very difficult to get together.

Gathering information about the community was a challenge. Information available was often partial or skewed to meet the need for which the information was gathered. Data is not always collected.

Consistency within the teams was challenged by the change in staff at the CSSS, CLSC, and the community. This led to some confusion as to roles, responsibilities and accountability. It was difficult to keep the process flowing as the committee would have to fill in the details from the last meeting for the new person. It was also difficult for the CSSS to free up staff to sit on the Steering Committee or the Joint Working Teams.

It was challenging to compare health programs and services offered in Kanesatake with those offered by the province due to their different missions in addition to the different working realities faced in each community. It was difficult to discuss methods to reduce the gaps through increasing linkages with the local provincial partners when the resources at the local CSSS are already very limited.

One of the consultants stated that not being made aware of all the previous projects that had been completed in the community, and that were related to what they were trying to accomplish, meant that some of the steps could have been avoided since the information (via the reports) was already there. A community health assessment done before the implementation of this project would have provided more insight and set the groundwork for all other future initiatives and directions of services.

One of the biggest constraints for all aspects of this project was time. It was difficult to complete a project such as this one in the short time available. There was a lack of time to really develop some of the topics. Timelines and waiting for people to respond to the liaison for the project in order to receive required answers to questions that were asked was sometimes challenging. As well, Health Center staff had regular responsibilities that sometimes took them away from the project.

Language was an issue. There are not a lot of bilingual people at the CSSS who could participate in the meetings. Language at meetings or interviews between participants sometimes portions of discussions had to be explained.

The Project Consultant Team stated that many saw AHTF as the "fix it" team. Many workers felt that it was the job of the AHTF Team to do the work, versus the stakeholders taking some ownership of the issue or ways to fix the issue.

The reason for this was that most workers involved in the project was very busy just putting out the day to day "fires" and have very limited time to look at the big picture or try to make changes to it. Whereas the AHTF Team hired from the outside did have the time. This limited the opportunity for capacity building within the community services who might have been involved in addressing these issues.

4.3 Collaboration, Communication and Cooperation

There is increased cooperation and collaboration as a result of this project. Having CSSS, CJL and KHC staff all at the "same table" improved communication, understanding, collaboration, and awareness.

The Joint Working Teams and the Coordinator worked together respectfully and everyone felt their opinions were taken seriously. There were people with many different backgrounds around the table but everyone respected each other, worked well as a team and everyone had valuable contributions.

Communication with team members was done by phone, e-mail and meetings. Distance was an issue, but the Project Manager virtually eliminated the distance barrier by using Skype for video and chat conference, as well as file transfers. The inclusion of Skype conferencing as part of the communication system increased the levels of collaboration and communication.

The overall communication for the project was very good. Minutes were taken of all the meetings and made available. All information was provided in writing. The Steering Committee, Consultants, Work Teams and Project Manager communicated often using email. The project communicated a lot with the community using its own Facebook page, and through the Health Center website. In addition, there were flyers sent out in the mail concerning meetings and other project activities.

The project coordinator and the consultants encouraged a climate of cooperation during the project. The highly effective project manager provided strong leadership, a climate of transparency and was very dynamic. The Nurse-consultants proved to be very effective and very capable and the project benefitted from their experience.

4.4 Effectiveness of Partnerships

The Kanesatake Aboriginal Health Transition Fund Projects benefitted from having the participation of three provincial entities represented on the Steering Committee, the ASSS, the CSSS and Centre Jeunesse. The presence of the ASSS helped to move some of the areas of the project forward. The partnership worked well but was sometimes encumbered by the changes in staffing with the CSSS.

The Steering Committee and the Joint Working Groups felt that they were well informed about the stakes and felt very welcome to contribute to the work in progress. Members of the work teams were invited to participate at every step of the process.

4.5 Outside Influences

The support of the Steering Committee and the (previous) Executive Director at the Health Center that believed in this project moved this project forward in the beginning. Unfortunately, the H1N1 pandemic, changeover in staff at the CSSS, gaps in the leadership at KHC, and changes to the KHC Board of Directors provided a climate of uncertainty regarding the follow through with the project.

As well, Health Canada shifted Maternal Child Health (MCH) funding from spending on activities to the development of an operational plan. This direction changed again in February, 2011 and an operational plan was no longer needed, and MCH spending could once again be directed at activities. This shift in direction impacted the direction taken for the implementation of the MCH recommendations.

4.6 Project Outcomes

The project reached many of the immediate Aboriginal Health Transition Fund (AHTF) outcomes for Integration projects. There has been an enhanced awareness among the partners and interveners through capacity building, cooperation and information-sharing.

There has been increased collaboration through the partnership between the Agence des Laurentides (ASSS), the CSSS Deux Montagnes, Centre Jeunesse des Laurentides and the Kanesatake Health Center Inc., as well as with the Mohawk Council. The Board of Directors of the Kanesatake Health Center has recently participated in the Strategic Planning session held by the CSSS.

The project has reached its own objectives by developing ECH and MCH work teams, conducting a gaps assessment of services for Elders and children, developing a work plan to implement its recommendations, providing training to staff, developing protocols and working to bring the in-home support and home and community care programs together.

4.7 Integration of Health Services

The integration of health services in a culturally safe manner is not always feasible as shown in the example from this project. Increasing community and provincial health worker awareness and knowledge on the traditional practice of returning the placenta to the family after birth included the following activities.

- Development of a culturally appropriate placenta kit used by hospital staff to retrieve the placenta.
- Development of documentation, including pamphlet and decision tree for health care workers.
- Training of St. Eustache Hospital Health Care workers on the use of the kit.
- Pamphlet to inform Community Members.

Unfortunately, after the process had been worked out with the provincial representatives on the MCH work team, and contacts had been made with

hospital liaison staff, pamphlets had been made, distributed and inserted into the liaison binders; however, someone who had not attended the meetings informed the MCH Nurse-consultant at the last minute that handing over the placenta to the mother was illegal and the hospital could be fined.

The discussion of this issue is now being raised at the provincial level, both at the Ministry of Health and Social Services and the Environment Ministry. The partners' increased sensitivity to providing culturally safe care has led them to become advocates for the community. They are now working toward changing the laws that are incongruent with the cultural norms of the community they work with.

4.8 Sustainability

There was a strong commitment from all of the project partners to carry forward the work that was done through the AHTF project. The Steering Committee agreed to meet twice a year for the next ten years, and has revised terms of reference to support this pledge. The terms of reference document will be updated in 2013.

A Sustainability Plan was developed for the project. This plan highlighted four main areas for sustainability:

- The committees – three of the committees including: the Steering Committee, the Elders Community Health Advisory Committee, and the Maternal Child Health Advisory Committee.
- The Adaptation Project outcomes;
- The Integration Project outcomes;
- The recommendations from the gaps analysis that was completed early on during the Integration Project.

4.9 Lessons Learned

Some of the lessons learned through this project included:

- There is a need to reorganize services at the Kanesatake Health Center to reflect the intersectorial or multi-disciplinary approaches used in provincial services for Maternal Child Health and for the Elders.

- If the reports and proposals that have been generated in past years had been acted upon, a lot of the funding for this project could have been spent on these previous recommendations.
- There are limits on what we can do in the Health and Social sectors.

- This project was very fortunate to have all of the key persons from all of the partners involved in the project. This enabled the project to move forward especially in the last few months with deadlines looming ahead.
- The project was also very successful because of the inclusion of the community on the working groups, and in information meetings.
- The project was able to move forward because of the decision taken to hire outside for the Project Manager and Nurse-consultants. There were fewer restrictions for these contractual positions. They did not have to put out fires all the time.
- At the same time, this also meant that the expertise derived from the project has not been attached to the community, even though there is a Sustainability Plan in place.

5. Summary and Recommendations

5.1 Summary of Findings

The overall goal of the Integration project was to assess, enhance and create new linkages for services for the Elderly and young children who are the most vulnerable clientele for health services in Kanesatake. Oversight for the project was given by a Steering Committee with representation from each of the project's partners. Community members were invited to participate on Work Teams. Awareness was created on both sides through cooperation and information-sharing.

Consistency within the teams was challenged by the change in staff at the CSSS, CLSC, and the community. This led to some confusion as to roles, responsibilities and accountability. It was difficult to keep the process flowing as the committee would have to fill in the details from the last meeting for the new person. It was also difficult for the CSSS to free up staff to sit on the Steering Committee or the Joint Working Teams.

One of the biggest constraints for all aspects of this project was time. It was difficult to complete a project such as this one in the short time available. There was a lack of time to really develop some of the topics. Health Center staff had regular responsibilities that sometimes took them away from the project.

Language was an issue. There are not a lot of bilingual people at the CSSS who could participate in the meetings. Language at meetings or interviews between participants sometimes portions of discussions had to be explained.

The project coordinator and the consultants encouraged a climate of cooperation during the project. The highly effective project manager provided strong leadership, a climate of transparency and was very dynamic.

The Kanesatake Aboriginal Health Transition Fund Projects benefitted from having the participation of three provincial entities represented on the Steering Committee, the ASSS, the CSSS and Centre Jeunesse. The presence

of the ASSS helped to move some of the areas of the project forward. The partnership worked well but was sometimes encumbered by the changes in staffing with the CSSS.

The support of the Steering Committee and the (previous) Executive Director at the Health Center that believed in this project moved this project forward in the beginning. Unfortunately, the H1N1 pandemic, changeover in staff at the CSSS, gaps in the leadership at KHC, and changes to the KHC Board of Directors provided a climate of uncertainty regarding the follow through with the project.

The project has achieved its own objectives by developing ECH and MCH work teams, conducting a gaps assessment of services for Elders and children, developing a work plan to implement its recommendations, providing training to staff, developing protocols and working to bring the in-home support and home and community care programs together.

Awareness levels were raised by the project but the integration of services was not achieved. A culturally appropriate custom of retrieving the placenta was worked out and agreed to, only to be told at the last minute that it was illegal and not permitted.

There was a strong commitment from all of the project partners to carry forward the work that was done through the AHTF project. A Sustainability Plan has been developed to ensure that the work will go forward.

5.2 Recommendations

The AHTF Integration Project for Kanesatake was extremely successful and has brought a lot of benefits to the community, including the opportunity to become the first Aboriginal certified Baby Friendly Health Center. Therefore, the following recommendations are made to work towards increasing the overall success:

1. The AHTF Project should be extended for another five years so that projects such as the one in Kanesatake can have the appropriate time and resources to increase the levels of awareness and capacity

building to truly create changes in service delivery, professional practice and programming, and to work towards improving access to services.

2. The Integration project in Kanesatake has created some very good training programs as part of the work. Funding should be provided to continue with this development. All of these trainings are complimentary to the programming provided by First Nations Health Centers. There should be an occasion created so that these training programs can be shared with other communities.

3. Funding should be provided so that the Health workers and professionals working at the health center can build more capacity from the project consultants that managed the AHTF in relation to taking over responsibility for extending the work that was undertaken.

4. The necessary resources and support should be provided so that the Kanesatake Health Center can share experiences and provide advice and assistance to other First Nations communities who wish to become accredited as a Baby-Friendly Health Center.

5. Lessons should be learned from the refusal to allow a culturally appropriate custom to be applied (Placenta retrieval) by everyone concerned. Ways and means to avoid getting into situations that have the potential to destroy working relationships should be discussed and elaborated for the future.

6. The CSSS should itself consider how it responded to this situation, given the cultural training that was just provided to the staff. A more appropriate response that provided time to study the issue should have been taken. Health Canada should consider this example when planning future initiatives that require the integration of community and provincial health services.

6. References

Health Canada (2006). "Aboriginal Health Transition Fund Adaptation Envelope", First Nations and Inuit Branch, Health Canada, October 2006.

Health Canada (2008). "Aboriginal Health Transition Fund Evaluation Framework", November 2008.

KHC (2010). "Comparison of Services for Young Children and Elders between the CSSS Lac des Deux-Montagnes and Kanesatake: A Report on the Gaps". Kanesatake Integration Project, KHC, July 2010.