Aboriginal Health Transition Fund Sustainability Plan

Beyond March 2011

Ensuring the maintenance of the Aboriginal Health Transition Fund outcomes

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AHTF Sustainability Plan

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Background

In 2004, Health Canada introduced the Aboriginal Health Transition Fund to reduce the gaps in health between Indigenous people and other Canadians. In 2009, Kanesatake applied and was funded for two projects: the Integration Project and the Adaptation Project.

The Integration Project, entitled **"Assessing, Enhancing and Integrating Health Services for Kanesatake",** intended to examine services for Elders and for Maternal Child Care in the community, analyze the gaps compared to provincial services and enhance and augment services following the analysis of the gaps. The enhancement and augmentation was to occur by integrating with existing provincial services, where appropriate.

The Adaptation Project, entitled: **"Cultural Adaptation of Pre-Hospital, In-Hospital and Post-Hospital Services and Liaison for Kanesatake"**, aimed to increase understanding and awareness among staff at the local provincial services about services and cultural practices in Kanesatake. This project also sought to develop a working culturally sensitive model for care between provincial services and community services.

All project partners were represented on the Steering Committee, which oversaw the projects from beginning to end. The partners on these projects are:

- Board of Directors of the Kanesatake Health Center Inc.
- Centre de Santé et de Services Sociaux (CSSS) du Lac des Deux-Montagnes
- Mohawk Council of Kanesatake
- Agence de Santé et de Services Sociaux (ASSS) des Laurentides
- Centre Jeunesse des Laurentides – point de service Kanesatake

Project Outcomes

The Integration Project and Adaptation Project intended to enhance existing services, increase awareness, increase access and provide more continuous care for community members.

The original project proposals outlined a number of outcomes that were expected for each of the projects.

The outcomes for the Integration Project were to:

- Increase support services to Riverside Elders' Home, including day center activities and physical services, through protocols established with provincial partners;

- Access local, integrated and effective MCH program based on First Nations culture;
- Enhance the quality of social support to mothers through the creation of a home-visiting program;
- Provide more efficient client care through the development of a case management intervention service for families;
- Improve the continuum of community health services for Elders and young children and their families.
- Provide capacity building and increased awareness of existing programs both locally and provincially.

The outcomes for the Adaptation Project were:

- The development of a working culturally sensitive model between the CSSS and Kanesatake for service delivery and hospital care that includes various protocols for client transfer before and after hospitalization.
- An understanding and awareness by hospital staff of the health services and cultural practices of the community of Kanesatake;
- Enhancement of the role of the liaison staff attached to emergency, maternity and medical services to include referral to appropriate community services, and to the inclusion of culturally sensitive approaches.
- An understanding by community members of the role of the hospital liaison staff
- The development of protocols for services between the community and the CSSS hospital, clinics and other agencies.

This document will outline the actual outcomes of the projects and introduce the plan for maintaining these outcomes so that the long-term objective of improving the health status of Indigenous peoples is attained.

Overall goal

The overall goal of the sustainability plan is to maintain the outcomes, goals and products that were developed through the Aboriginal Health Transition Fund projects and to institutionalize the process by incorporating these into the Kanesatake Health Center Inc. work plan for the purpose of improving the health outcomes of Kanehsetakehro:non.

Areas for Sustainability

This sustainability plan will highlight four main areas for sustainability:

- The committees;
- The Adaptation Project outcomes;
- The Integration Project outcomes;
- The recommendations from the gaps analysis that was completed early on during the Integration Project.

The Committees

The AHTF projects in Kanesatake required the formation of four committees. Three of the four committees have agreed to carry on beyond the end of the projects in order to ensure full integration of services. Each committee has 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 aforementioned documents are accessible online at www.kanesatakehealthcenter.ca/ahtf.

The Steering Committee

The Steering Committee, as previously stated, was assembled to represent each of the partners on the project. They were mandated to oversee the project from its' inception to its' full implementation. However, the Steering Committee has agreed to continue meeting for the next 10 years to continue the integration of community-based partnerships and linkages that work together to improve health and social outcomes. Their terms of reference will be revised in 2013.

The Elders Community Health Advisory Committee

The ECH Advisory Committee includes representation from all partners and community services working with Elders or persons losing their autonomy in the community. Their mission is to ensure that the health and social needs of this population are met. They will also oversee the implementation of the recommendations that arose as a result of the gaps analysis.

The Maternal Child Health Advisory Committee

The MCH Advisory Committee includes representation from all partners and community services working with young children and their families. Their mission is to ensure that the health and social needs of this population are met. They will also oversee the implementation of the recommendations that arose as a result of the gaps analysis.

Adaptation Project Outcomes

The actual outcomes of the adaptation project include:

- Creation of a cultural/information team to oversee objectives.
- Collaboratedwith Tsi Ronterihwanónhnha Language and Cultural Center to ensure cultural appropriateness of deliverables.
- Assembled group of Elders to oversee creation of cultural training.

- Creation of website, pamphlets and other documents to inform about services available in Kanesatake.
- Presentations at local CSSS on programs and services available in Kanesatake.
- Cultural training presented to staff at local hospital and CLSC to increase awareness about the community and the culture – 120 trained in person.
- Cultural training placed online to train staff at local CSSS – 117 trained.
- Cultural training website to be included in orientation package of new employees of CSSS.
- Developed culturally appropriate model for pre-hospital, in-hospital and post-hospital care.
- Harmonization of services through increased understanding and communication between CSSS and Kanesatake Health Center.
- Began discussions about developing protocols that are culturally relevant (ex: regarding placenta).
- Began discussions to have liaison staff from hospital present information in the community – will likely occur in April or May.
- Created binder to serve as communication tool for community of Kanesatake in all pertinent departments at hospital and CLSC.
- Board of Directors of Kanesatake Health Center participated and will continue to participate in strategic planning of CSSS.
- Information meetings within community to inform about new protocols.

A number of the aforementioned outcomes have already produced results. For example, the evaluation forms collected following the cultural training indicate that there is already increased awareness and understanding among CSSS staff about Mohawk culture.

However, several outcomes will not yield results in the short term, but require a concerted effort by all partners for the outcomes to yield positive results in the future.

Integration Project Outcomes

The actual outcomes of the Integration Project include:

- A committee (the Steering Committee), which is composed of a representative from each of the partners, was created to oversee the entire project.
- This committee has agreed to remain in place until 2019 to ensure ongoing communication and that the work begun through the AHTF project continues.
- The community was consulted to find out what the gaps were from their perspective – in following with a participatory approach.

- Two Joint Work Teams were created that included all the partners on the projects.
- An assessment of the gaps in services was conducted and a report with recommendations was written.
- Based on the recommendations, a work plan was developed that included work to be completed before the end of the project and work to continue after the end of the project.
- Among some of the specifics of the work plan, based on comparison with provincial services, these are the objectives that the AHTF has reached or is working toward:
    - Created an intersectoral committee (including all the partners mentioned above as well as other services within the community) to oversee all objectives of the Maternal Child Health portion of the project including: completing the 10 steps toward becoming a Baby-Friendly Certified Health Center (Steps 1 and 2 complete at the time this document was written); working on an operational plan that will include case management and a home visiting program similar to the one available at the local CSSS; offering parent training and ongoing support;
    - Offered training and capacity building for staff and community in Healthy Communities Initiative;
    - Created an intersectoral committee to oversee all the objectives of the Elder's portion of the project including: creating home visitor/home maker/orientation training program, writing protocols and policies based on an Collaborative Work Team model for client care;
    - Developed a Formal Liaison Mechanism with local CSSS to ensure continuous and harmonized service to clients by formalizing the links that were created through the AHTF Integration Project. In addition to improved access to care for clients, increasing communication between the two organizations will lead to greater understanding, information sharing with regards to best practice and an occasion to share training opportunities.
    - Organized information sharing sessions between partners to introduce protocols for follow up of clients in Maternal Child Health, Home and Community Care and Residential care.
    - Assessed feasibility of integrating two existing programs and proposed and presented ways of making this integration successful.

Recommendations Resulting from the Gaps Analysis

1. That a Healthy Community Advocacy Committee be formed to implement the World Health Organization's (WHO) Healthy Communities Initiative and create subcommittees as needed. It would ensure that recommendations are implemented and that there is accountability to the people of Kanesatake. In addition, this Committee would lobby the

Mohawk Council of Kanesatake and other governmental organizations to address issues regarding NIHB, housing and transportation.

2. That the liaison mechanism between the community of Kanesatake and the CSSS du Lac-des- Deux-Montagnes be formalized.
3. That the health and social programs at Kanesatake be reorganized into a single organizational structure, based on Mohawk cultural values and customs. This new structure must include the KHC, Riverside, the Assisted Living Program, first-line prevention services, and any new programs for health and wellbeing in the community must fall under the direction of a professional clinical supervisor with a separate operational director.
4. That there be an ombudsperson for clients as well as employees.
5. 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.
6. That a data gathering system for measuring health indicators 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).
7. That there be a liaison person working out of a liaison office to support families and health care workers to navigate local and provincial resources.
8. 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.
9. That the KHC obtain accreditation.
10. That the restructured health and social services agency in Kanesatake lobby Health Canada and Indian and Northern Affairs Canada (INAC) for the creation of a Therapeutic Services Fund to increase timely access to Anglophone professionals (such as a dietician, occupational therapist, respiratory therapist, physical therapist) that can be hired as needed to support client care and community health promotion initiatives.
11. That KHC participate in the Society of Obstetricians and Gynecologists of Canada's Aboriginal Birthing Initiative and work collaboratively with the CSSS to develop an Aboriginal Birthing Strategy.
12. That the KHC formalize its commitment to breastfeeding by becoming the first Aboriginal Baby Friendly Center in North America.
13. That an early childhood intervention program be enhanced by a multidisciplinary team that includes staff members from Kanesatake 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.

14. 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.
15. 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.
16. That existing Elder's Center activities be enhanced and increased to include activities similar to the day center at Manoir St-Eustache.
17. 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.
18. That palliative care beds and services be added to existing services for Elders in Kanesatake.
19. That there be increased information 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.
20. That a plan for capacity building be developed that would include:
    a. Incentives for current workers to further their education, and
    b. Incentives for students to pursue studies in health and social sciences, including, but not limited to, nursing, social work, midwifery, and teaching, and
    c. Language training in French and Mohawk, and
    d. A mentorship program.
21. That a family center be created.

The Sustainability Plan

The following table summarizes the expected outcomes, as outlined in the original project proposals, the actual outcomes and the work that has been done to date. In addition, the table identifies the actions that must continue to sustain the outcomes that have already occurred and to move forward those that have not been completed. **The actions remaining category must be included in the Kanesatake Health Center Inc's work plan to ensure follow through**. In addition, specific people, or groups of people, have been identified to follow the progress of each item.