Final Evaluation Report for the 5 year Interim Evaluation

Kahnawá:ke Community Health Plan 2012-2022

Onkwata'karitáhtshera

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Thank you | Niá:wen,
Chakda Yorn, Harry Cummings, Bridget Hall, Ariella Orbach, and Émanuèle Lapierre-Fortin

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Executive Summary

Project Overview

Onkwata'karitáhtshera serves as the advisory and coordinating body for health and social services in the community of Kahnawá:ke. It is responsible for the development, implementation, and evaluation of the 2012-2022 Community Health Plan. The 2012-2022 Community Health Plan identifies the health priorities of Kahnawá:ke and describes how the various programs and services offered by Kateri Memorial Hospital Centre and Kahnawá:ke Shakotiia'takehnas Community Services address those health priorities. The Community Health Plan includes those programs and services funded under the 2012-2022 Health Funding Consolidated Contribution Agreement between Health Canada and Kahnawá:ke.

As part of the 2012-2022 Health Funding Consolidated Contribution Agreement, Onkwata'karitáhtshera committed to conduct a summative evaluation at the mid- and end-points of the funding period. In 2017 and 2022, Onkwata'karitáhtshera will submit evaluation reports to Health Canada, and in 2022, it will renegotiate the health transfer agreement.

The purpose of this mid-point evaluation is to address the formative and summative evaluation questions outlined in the 2012 Community Health Plan Evaluation Plan.

The questions addressed by this evaluation are:

1. Did the activities listed in the Community Health Plan take place?
2. Did participants benefit from the programs and services provided?
3. Are the priority health needs and problems the same or have they changed?
4. What was the impact of the Community Health Plan to the health priorities identified in the last evaluation?
5. Is the current information system and data gathering methods sufficient to meet the data needs to inform the summative evaluation and annual review process?

Methodology

In consultation with Onkwata'karitáhtshera, the evaluation team developed a series of evaluation sub-questions to address the five key evaluation questions. The following data collection methods were used to address these evaluation questions:

- A review of organizational documents (e.g. annual reports);
- Twenty-three key informant interviews with staff of main Community Health Plan partner organizations;

- Five focus groups, one with each of the four health priority subcommittees and one with a group of service users (clients);
- A stakeholder workshop with 35 Community Health Plan stakeholders from across the community;
- A recommendation prioritization exercise with the Onkwata'karitáhtshera executive committee and secretariat.

Findings

The evaluation results show that progress has been made in completing the activities linked to the seven health priorities of the Community Health Plan. In addition, most of the organizational needs that were identified in the Community Health Plan have been at least partly addressed.

The findings also indicate that the current programs and services are benefitting those who use them. More community outreach is needed to reach the most vulnerable and ensure that all community members are accessing programs and services to the extent that they should. It was also noted that some further improvements could be made to enhance the benefits of services.

There is a general consensus that the current health priorities reflect the major issues faced by Kahnawa'kehró:non. However, it was noted that better statistical data would help determine the accuracy of the health priorities. Some changes to the priorities were evoked, notably to reconsider violence as a health priority.

The findings indicate that continued and increasing inter-organizational collaboration and coordination are important for ensuring effective implementation of the Community Health Plan. The findings also indicate that increased promotion of the Community Health Plan to frontline staff and to the wider community could be of benefit. It was noted that the Community Health Plan would benefit from increased integration of Kanien'kehá:ka culture, language, and a holistic approach to wellness.

There was insufficient quantitative data to measure the impact of the Community Health Plan on the health priorities. Insufficient coordination of data collection and storage among programs and organizations limits the ability to assess the overall impact of the Community Health Plan. The monitoring and evaluation tools (e.g. logic models) are not used to the extent that they could be, and there are no annual reports for the Community Health Plan as a whole. However, significant advances have been made through efforts such as data mining and the centralization of data management and analysis at Kahnawá:ke Shakotiia'takehnas Community Services.

Overall, good progress has been made over the past five years, providing a solid foundation on which to continue building from 2017-2022. In particular, it was noted that the current Community Health Plan is widely seen as a living, working document used to inform the planning and delivery of programs and services, and that the creation of the four health priority subcommittees has contributed in a significant way to enhancing inter-organizational collaboration. These successes should be acknowledged and celebrated as the next steps for continual improvement are discussed.

Recommendations

The following are summaries of the recommendations that emerged from the evaluation:

1. We recommend that Onkwata'karitáhtshera identify the data needs for the Community Health Plan in the upcoming years.

2. We recommend that Onkwata'karitáhtshera develop a data-sharing protocol to identify what data can be shared, how it can be shared, and any other logistical considerations.

3. We recommend that Kahnawá:ke Shakotiia'takehnas Community Services and Kateri Memorial Hospital Centre continue working to enhance the client experience and to ensure that a full continuum of care is available and accessible for all Kahnawa'kehró:non, by making incremental improvements to inter-organizational coordination and collaboration.

4. We recommend that Onkwata'karitáhtshera continue to promote the Community Health Plan as a practical tool and resource for staff.

5. We recommend that the four subcommittees update their logic models to include process and impact indicators and their associated data sources.

6. We recommend that Onkwata'karitáhtshera consider implementing regular community-wide collaborative planning sessions with Kahnawá:ke Shakotiia'takehnas Community Services, Kateri Memorial Hospital Centre, and other key stakeholders to encourage collective decision-making and prioritization.

7. We recommend that Onkwata'karitáhtshera build on successful culturally-based health initiatives at Kahnawá:ke Shakotiia'takehnas Community Services and Kateri Memorial Hospital Centre by seeking innovative ways to integrate Kanien'kehá:ka culture and language across all health priorities of the Community Health Plan.

8. We recommend increasing the frequency and accessibility of communications about the Community Health Plan and related programs, services, and activities to the community.

9. We recommend maintaining the seven health priorities identified through community consultation prior to 2012, while working to obtain and gather the data needed to assess the accuracy of the health priorities and update them accordingly in 2022.

10. We recommend continuing to engage Kahnawa'kehró:non in dialogue, on a sustained basis, about Community Health Plan implementation and priorities, programs, and services.

11. We recommend developing a strategy to better support programs in reaching the most vulnerable, with the objective of increasing participation in programs and use of services by high-risk segments of the Kahnawá:ke population.

12. We recommend that Onkwata'karitáhtshera produce a regular report on the Community Health Plan, including summaries of activities related to the health priorities and integrating data from all organizations involved in delivering programs and activities under the Community Health Plan.

List of Acronyms

ADI	Aboriginal Diabetes Initiative
AHSOR	Aboriginal Head Start On Reserve
ALS	Assisted Living Services
ARS	Addiction Response Services
CBRT	Community-Based Reporting Template
CFCC	Client- and Family-Centred Care
CHP	Community Health Plan
e-SDRT	electronic-Service Delivery Reporting Template
FASD	Fetal Alcohol Spectrum Disorder
KMHC	Kateri Memorial Hospital Centre
KSCS	Kahnawá:ke Shakotiia'takehnas Community Services
KSDPP	Kahnawá:ke Schools Diabetes Prevention Project
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer/Questioning and others
MCK	Mohawk Council of Kahnawá:ke
OCAP	Ownership, Control, Access, Possession

1. Introduction

Onkwata'karitáhtshera serves as the advisory and coordinating body for health and social services in the community of Kahnawá:ke. It is mandated by the Mohawk Council of Kahnawá:ke. Two of the member organizations within Onkwata'karitáhtshera, Kahnawá:ke Shakotiia'takehnas Community Services (KSCS) and Kateri Memorial Hospital Centre (KMHC), operate under the 2012-2022 Health Funding Consolidated Contribution Agreement. Contribution Agreements between Health Canada and First Nations and Inuit communities have taken various forms in the past few decades. Indeed, the Mohawks of Kahnawá:ke have over 15 years of experience working with Health Canada to negotiate several Health Transfer Agreements.

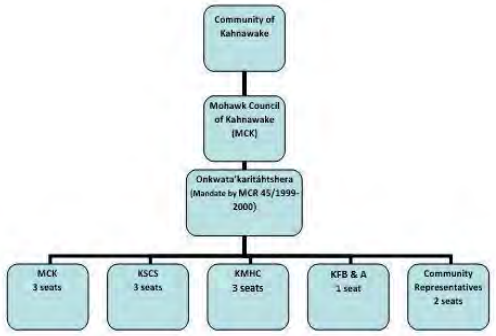

Figure 1 Organizational Structure

The 2012-2022 Health Funding Consolidated Contribution Agreement includes funding for a number of programs in various community health topic areas.

These Agreements have supported the Mohawks of Kahnawá:ke in developing and renewing their Community Health Plan (CHP), which identifies the needs and priorities of the community. Currently, the seven identified health priorities in Kahnawá:ke are:

1. Substance Abuse/Addictions
2. Mental Health Issues
3. Learning/Development Disabilities
4. Cardiovascular Disease (hypertension)
5. Cancer
6. Diabetes
7. Obesity

These seven priorities are being implemented under four subcommittees within Onkwata'karitáhtshera: Mental Wellness and Addictions, Early Childhood and Family Wellness, Chronic Disease, and Cancer. In addition, there are four supporting areas:

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

The Community Health Plan outlines how various programs and services offered by KMHC and KSCS address one or more of each of the health priorities, discusses organizational capacity and structure, and includes a training plan, an emergency preparedness plan, and an evaluation plan. See figure 2 for an overview of the programs and services under each health priority, and their subcommittees.

Community health programs and services have evolved in Kahnawá:ke over the past 25 years. At the stakeholder workshop held near the end of the data collection and analysis phase of this evaluation, Community Health Plan stakeholders were invited to identify key milestones related to the CHP that have occurred since 1990. The resulting timeline presents a collectively crafted overview of the CHP's evolution and of the milestone events that define it. For a copy of the timeline, please refer to Appendix 6.1.

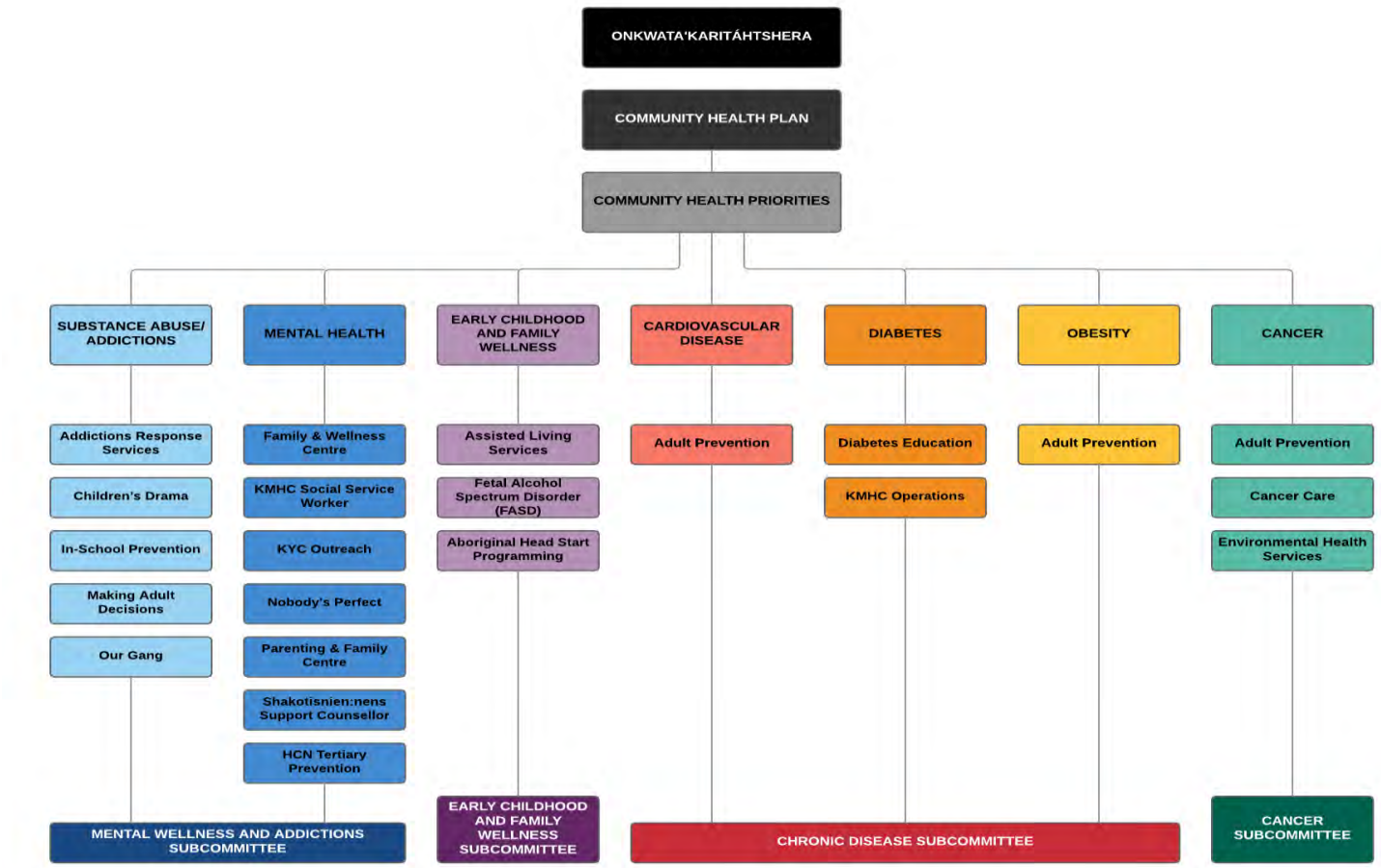

Figure 2 Overview of programs and services under the CHP Health Priorities

2. Methods

The purpose of this evaluation is to assess to what extent Onkwata'karitáhtshera is making progress on achieving the goals of the Community Health Plan (CHP). This is a five-year mid-point evaluation of the ten-year Consolidated Contribution Agreement. It includes both formative and summative components, as described in the evaluation design section. The findings from this evaluation will be used to update the CHP and inform its delivery over the next five years.

2.1 Evaluation Design

The evaluation design outlines the approach that we used to demonstrate cause-effect relationships. In the case of the CHP, it included both formative and summative evaluation questions, and used primarily a historical/retrospective approach by reviewing monitoring data and collecting primary data from key stakeholders and partners. This approach involved asking partners[1], stakeholders[2], and users[3] to contribute information and opinions based on their experiences. In all cases, we asked respondents to comment on the changes observed since 2012. To do so, we conducted a series of interviews and focus groups with staff, stakeholders, and service users. The data gleaned from this approach is primarily qualitative in nature, and we identified emerging trends throughout the process.

Where possible, we employed a quasi-experimental approach. The quasi-experimental approach is generally used to demonstrate the effectiveness of a project, by attempting to prove that an intervention produced a desired result. This approach involves planning for the evaluation prior to the implementation of the project. Best practice in this regard involves mixed methods with quantitative measurements being enriched by qualitative observations. Basic elements of this approach include:

- Collecting baseline data on project beneficiaries prior to their involvement in the project;
- Collecting information from the same beneficiary group after the project has been in place for some time;
- Assessing the change in beneficiaries and trying to attribute the change or some portion of the change to the project.

[1] Partners refer to staff at organizations directly involved in the planning and delivery of CHP programming and services (e.g. KSCS staff, KMHC staff).

[2] Stakeholders refer to individuals and organization representatives with an interest or indirect involvement in the planning and delivery of CHP programming and services (e.g. Tewatohnhi'saktha staff).

[3] Users refer to individuals in the community who use the programs and services offered under the CHP (i.e. clients).

Our approach was a mixed methods approach, including multiple data sources, and both quantitative and qualitative data. This approach was used to allow for triangulation of results. Triangulation is a process in which we use multiple data sources and tools to answer each question. It aims to reduce the inherent biases that exist in any one source of data, and creates a more complete answer to each evaluation question.

The development and implementation of the evaluation plan was done with ongoing input from the Onkwata'karitáhtshera executive and secretariat. Throughout this evaluation, we employed participatory action research methods for facilitating collective meetings (focus groups and a stakeholder workshop). This means that the CHP stakeholders were involved not only in data collection, but also in data analysis. Making sense collectively of evaluation findings is a major way through which we endeavour to integrate capacity building and learning about monitoring and evaluation methods into the evaluation process.

2.2 Data Collection Methods

This evaluation addressed the summative evaluation question that assesses the impact of the CHP on the health priorities (Evaluation Question 4), identified in the previous evaluation. It also addressed the formative evaluation questions (Evaluation Questions 1, 2, 3, and 5), identified by Onkwata'karitáhtshera, which assess the efficiency and relevance of the CHP.

Our evaluation consisted of four main methods of data collection: a document review, key informant interviews, focus groups and a CHP stakeholders workshop. All personal identifiers collected throughout the data collection process were removed when we reported the data. Participants were assured of the confidentiality of their responses.

Document Review

Document review consisted of two main stages. We completed an initial document review to deepen our understanding of Kahnawá:ke, Onkwata'karitáhtshera, the relevant organizations, programs and services, and what data exists. This first stage informed the drafting of the complete evaluation plan. The second stage included a deeper analysis of the available documents that contribute to answering the evaluation questions. Documents reviewed included:

- Kahnawá:ke Community Health Plan
- Annual Reports (2011-2012, 2012-2013, 2013-2014, 2014-2015, 2015-2016)
    - Community-Based Reporting Form
    - KSCS Annual Report
    - KMHC Annual Report
    - KMHC Community Health Unit Annual Report
- Onkwata'karitáhtshera Steering Committee reports (2015 and 2016)

- 2010 Report on the Kahnawá:ke Community Health Plan for Health Transfer Programs
- Kahnawá:ke's current Health Funding Consolidated Contribution Agreement (2012-2022)
- Health Canada's Health Plan Evaluation Guide
- Regional Health Survey 2015 - Youth Questionnaire, Child Questionnaire, Adult Questionnaire
- Additional internal documents from KMHC, KSCS, and other relevant organizations.

We used internal documents to address the following evaluation questions:

1. To what extent have the organizational needs (global needs, health service needs, infrastructure needs) been addressed as outlined in the CHP?
2. To what extent have the activities listed in each logic model been completed, per priority area?
3. What activities took place that are not included in the CHP?
4. To what extent were the target groups involved in the programs and services for each health priority area?
5. To what extent do the priority health needs and problems reflect the current data?
6. What trends are seen in the data on the health indicators relevant to the CHP?
7. To what extent have the impacts from the priority area logic models been achieved?
8. How many of the indicators in the logic models have had data collected, per priority area?

Interviews

We conducted 23 key informant interviews with staff of main partner organizations and stakeholders, including KSCS and KMHC, Onkwata'karitáhtshera, and other organizations and programs (e.g. Mohawk Council of Kahnawá:ke, Step by Step). Staff interviewed included frontline staff, managers, and directors. Each interview lasted from one to two hours. Interviewees were randomly selected from a list generated by Onkwata'karitáhtshera. Each interviewee was contacted by Onkwata'karitáhtshera, then by the consultants. Most of the interviews were done in person over the course of one week.

We used the interviews to address the following evaluation questions:

1. To what extent have the organizational needs (global needs, health service needs, infrastructure needs) been addressed as outlined in the CHP?
2. To what extent have the activities listed in each logic model been completed, per priority area?
3. What factors have affected the extent to which the activities listed in the CHP took place?
4. What activities took place that are not included in the CHP?

5. To what extent were the target groups involved in the programs and services for each health priority area?
6. To what extent did program and service staff observe benefits for the different target groups for each priority area?
7. What are seen as the major impacts of the CHP to the health priorities by program staff, participants, and stakeholders?
8. What are the information system and data gathering needs identified by program staff?

Focus Groups

Figure 3 Group Discussion During a Focus Group

In addition to the key informant interviews, we conducted four focus group sessions with CHP subcommittee members, and one with health and social services users from the community. We held one focus group for each of the four health priority subcommittees; each was attended by staff from the CHP partner and stakeholder organizations and in some cases, by community members who sit on the subcommittee. In total, 31 subcommittee members participated in the four focus groups. One user (client) focus group was held, attended by seven community members who are users of programs and services that fall under the CHP. Focus group logistics were coordinated by Onkwata'karitáhtshera staff, and were designed and facilitated by Niska. Onkwata'karitáhtshera staff were present at the beginning of each focus group, to answer any questions that participants had about CHP implementation and progress to date, and about the present evaluation. Onkwata'karitáhtshera staff were not present for the remainder of the focus groups, during which the evaluation questions were addressed.

We used the focus groups to address the following evaluation questions:

1. To what extent did the participants feel that they benefitted from the programs and services for each priority area?
2. What are seen as the major impacts of the CHP to the health priorities by program staff, participants, and stakeholders?

Stakeholder Workshop

Following a first round of analysis of the interview and focus group data by our team, we returned to Kahnawá:ke for a CHP stakeholder workshop. The intention of the workshop was for professionals and

stakeholders who are directly involved in the CHP to collectively make sense of the preliminary evaluation findings and formulate recommendations for the next five years. In total, 35 CHP stakeholders participated in the workshop. This 'whole system in the room' approach enables a large amount of energy and organizational learning to ensue, and it contributed to Onkwata'karitáhtshera's wish to pursue higher levels of collaboration among departments. During the workshop, we shared our preliminary findings and gathered stakeholders' comments and questions. Then, we followed with several participatory activities that engaged stakeholders in addressing the evaluation by asking themselves 'so what?' (impacts and changes) and 'now what?' (recommendations), which allowed the whole system to reflect on the CHP's unfolding over the last five years, and into the next five years. The stakeholder workshop was an important opportunity for the evaluation team to triangulate and refine evaluation findings from the document review, interviews, and focus groups.

Recommendations Prioritization Exercise with Onkwata'karitáhtshera

The consultants drafted the evaluation report and shared it with Onkwata'karitáhtshera. Following a chance to review, the evaluation team met with the Onkwata'karitáhtshera executive and secretariat to receive feedback on the draft report, and to lead the committee in a prioritization exercise for the recommendations. This exercise gave committee members the chance to rate the feasibility of each recommendation (i.e. how likely is it that Onkwata'karitáhtshera would implement this recommendation, given real-world constraints and priorities) and its contribution (i.e. what level of impact would the implementation of this recommendation have). They also rated the implementation strategies suggested for each recommendation, and proposed new strategies as needed.

The recommendations in this report have been prioritized to reflect the input of Onkwata'karitáhtshera along with the analysis carried out by the evaluation team.

Please refer to the appendices to review the data collection tools used in this evaluation.

2.3 Limitations

At this stage, there was limited quantitative data available to assess the impact of the CHP on the health priorities, as well as the ongoing relevance of the health priorities to the community.

As noted in the findings for Evaluation Question 5, over the past five years Onkwata'karitáhtshera has made improvements to how data is collected, organized, and stored. However, there continue to be challenges in identifying what data to collect, and how to analyze it beyond what reporting is required by funders. There was limited quantitative data available that measured the indicators in the logic models, particularly for any outcome indicators. Therefore, we were unable to support the findings with statistical data.

Kahnawá:ke has for the first time participated in the First Nations Regional Health Survey, coordinated by the First Nations of Quebec and Labrador Health and Social Services Commission. It was anticipated that

this data would be available for this evaluation, however external delays meant that the data was not available. We do anticipate that the Regional Health Survey will be a useful tool for the final impact evaluation that will occur in 2022, if combined with quantitative outcome data collected specifically for the CHP.

There is a risk of bias with the selection of those to be interviewed.

Onkwata'karitáhtshera staff were responsible for drafting the list of potential individuals to be interviewed. The consultants worked to prevent bias by requesting individuals from a variety of backgrounds, and for a list with twice as many people as needed. The consultants randomly selected a subsection of individuals from the list provided by Onkwata'karitáhtshera. However, there remains a risk that Onkwata'karitáhtshera staff unintentionally omitted certain key individuals (e.g. individuals with unique perspectives) from their interview list. Triangulation of data sources may limit this risk.

There was limited access to users (clients) of the programs and services under the CHP.

Due to restricted time and resources, we had limited access to service users. Onkwata'karitáhtshera invited users for one focus group session, which was attended by seven community members. Given that focus group participants were not randomly selected (i.e. they volunteered to come), there is a high risk of self-selection bias. It is likely that those who chose to attend the focus group had particular issues they wished to raise (either positive or negative), and they may not represent the average community member. In addition, it is likely that the most vulnerable groups in the community were not represented at the user focus group.

We have included the findings from the user focus group, however the reader should be aware that the themes that emerged from the user focus group may not represent the overall views of Kahnawa'kehró:non.

3. Findings

3.1 Evaluation Question 1

Did the activities listed in the Community Health Plan take place?

a. To what extent have the organizational needs (global needs, health service needs, infrastructure needs) been addressed as outlined in the CHP?

b. To what extent have the activities listed in each logic model been completed, per priority?

c. What have been the factors that have affected the extent to which the activities listed in the CHP took place?

d. What activities took place that are not included in the CHP?

In order to address this question, staff[4] were asked to comment on the extent to which the activities listed in the CHP for the health priority or priorities that concern them had taken place. They were also asked to identify the factors that have affected the extent to which those activities took place, and to list any unanticipated activities that took place.

The Community Health Plan logic models have been treated as living documents and have been updated over time. This is a common practice, and reflects the need for program managers to adjust their programs' activities based on reality (e.g. emerging needs, changes to available resources). Therefore, the findings included in this evaluation are based on an assessment of the activities reported, rather than an assessment of how many of the original logic model activities have occurred. Annual reports were also reviewed to identify any data collected on the logic model indicators for each health priority area[5]. As there is no centralized annual report on the CHP, this review was limited, and most of the findings from this section came from the interviews with relevant staff.

This section does not include a comprehensive list of all of the activities listed in the CHP. It is intended to provide a general overview of the extent to which the activities listed in the CHP have occurred. Finally, this section also includes an update on progress made on the organizational needs identified in the CHP. Senior

[4] We use the term *staff* to refer to employees of the organizations under the CHP (e.g. KSCS, KMHC, etc.), including frontline workers, managers, and directors, who participated in this evaluation.

[5] Note that the data presented in the tables in this section come from the KSCS and KMHC annual reports, as well as the annual CBRTs.

staff involved in each of the organizational needs were contacted and asked to provide details on the extent to which each need had been met, and any comments on factors that affected this.

SUMMARY OF FINDINGS

3.1.1. Progress has been made in completing the health priority activities of the CHP

Overall, there is a shared sense among staff that progress is being made to complete the activities listed in the CHP. It is difficult to know the extent to which the health priority-specific activities have been completed, as the logic models have been continuously updated since the CHP was drafted.

3.1.2. Most of the organizational needs have been at least somewhat addressed

Approximately half of the organizational needs identified in the CHP have been fully met, and over 80% have been fully met or partially met.

MENTAL WELLNESS AND ADDICTIONS

The Mental Wellness and Addictions subcommittee integrates the Mental Health priority and the Substance Abuse/Addictions priority. This area includes a wide range of programming, and coordination within the subcommittee has been a challenge. The subcommittee recently completed an assessment of the gaps and overlaps Mental Wellness and Addictions programs and services, and it is now working to address the findings.

Programming that targets youth (e.g. Our Gang) appears to be running fairly consistently, and is well received by youth. Since 2012, program staff have increased the amount of education not only on mental wellness and addictions, but all the health priorities. The Children's Drama program stopped running in 2013-2014, but has started again on a smaller scale.

There has been an increase in the availability of culturally based programming, such as Where the Creek Runs Clearer. Where the Creek Runs Clearer was established as a youth program, however, it was expanded into a family program in response to community demand. The program includes cultural teachings, a space for group discussions, and cultural events.

In table 1 we see the participation rates for some of the programs and services under this area. Participation in the Teen Social Club and the Young Adult's Program has been fairly consistent over the last five years. There has been a drop in participation in Our Gang. However, the annual reports from KSCS do not indicate a reason. In 2012-2013, the full-time clinical psychologists were not available (one retired while the other was on maternity leave), and the number of clients accessing psychological services dropped. As noted in the annual reports, it took several years to secure a full-time replacement. In 2015-2016, a full-time replacement

joined the psychological services team, and it is anticipated that the number of clients accessing these services will rise in the coming year.

Table 1 Number of participants in select programming over the last five years

Activity	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Teen Social Club	14	-	12	16	18
Young Adult's Program	15	-	13	23	16
Our Gang	141	-	136	91	67
Psychological Services	406	-	223	85	84

Chronic Disease

This area has seen significant consolidation of organizational oversight structure over the past five years. The three health priorities, Diabetes, Cardiovascular, and Obesity, are overseen by one subcommittee: Chronic Disease or Asahtahkaritake, which means "to be well". In addition, in the spring of 2016, the Physical Activity Initiative subcommittee was amalgamated into the Asahtahkaritake subcommittee, as membership for both subcommittees was very similar, and there was overlap in their activities.

Staff noted that activities under this area have been fairly stable over the past five years, with some changes. Adult prevention services continue to offer educational sessions on risk factors for chronic disease throughout the community, a new chair fitness class has begun targeting adults unable to participate in the Vitality class, and the diabetes nurse and nutritionist now work more closely together to provide services to clients diagnosed with diabetes. As seen in table 2, the average number of participants in the Vitality adult fitness class has been slowly increasing over time.

Table 2 Participation at select chronic disease activities over the last five years

	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Average # participants in each Vitality Class	12-16	14-18	16-20	15-20	18-22

It is also worth noting that in the 2012 logic model, the goal of the obesity health priority was to determine whether obesity should be identified as a true health priority. No decision was made on this, and the subcommittee members continue to question whether obesity should remain as a health priority.

Early Childhood and Family Wellness

In general, staff felt that the programs and services under Early Childhood and Family Wellness were consistently available, and that the key activities in the logic models were complete or in progress. There have been some notable changes in Aboriginal Head Start and Assisted Living Services. In Aboriginal Head Start on Reserve (AHSOR), there was a shift in how funding is distributed. Now, organizations apply for annual project-based funding, and organizations are required to submit annual reports to the AHSOR committee. While some organizations have limited resources or capacity to meet the reporting requirements and the annual funding application requirements, staff shared an overall sense that AHSOR programming has been working well.

There were mixed views on the activities of Assisted Living Services (ALS) over the past five years. Some staff noted that ALS has increased the integration of its services, and has also succeeded at increasing the integration of those with developmental disabilities into the community. However, others reported that minimal changes to programming had occurred.

It was noted by staff that while Fetal Alcohol Spectrum Disorder (FASD) programming has been consistently available in the community, this area has limited resources, and therefore has reduced reach in the community. In the years when there was reporting on the number of individuals reached by FASD programming, the numbers varied from 466 to 990 community members.

As seen in table 3, the number of Well Baby visits and immunizations have been fairly consistent over the past five years. There was a drop in the number of children accessing Aboriginal Head Start on Reserve (AHSOR) in 2012-2013. This drop is not accounted for in the Community Based Reporting Template. However, it rises to similar levels in the 2013-2014 and 2015-2016 years.

Table 3 Number of people reached for select programming over the last five years

Program	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Well Baby visits	991	852	861	860	865
# of immunizations	1102	936	1107	1092	1076
Fetal Alcohol Spectrum Disorder (FASD)	990	-	466	-	-
Aboriginal Head Start on Reserve (AHSOR)	312	196	360	-	321

CANCER

Overall, it appears that the activities for this priority area are progressing consistently. While cancer education activities have shifted over the past five years, there have been no major reported changes to the proportion of the community being reached.

An unexpected change was identified in Cancer Care, which is the shift from having a cancer survivor support worker to a cancer nurse. As seen in table 4, in 2012-13 - the year when the support worker left the position and there was a gap of over four months in services - the number of clients seen and meetings held was significantly lower. However, since hiring the cancer nurse there has been an increase in cancer support meetings, and in the number of cancer clients reached annually. Staff noted that overall, this was a positive change, and that they are looking to expand the nurse's role in the coming year, from two to five days a week.

Table 4 Statistics on select cancer programming over the last five years

	2011-12	2012-13	2013-14	2014-15	2015-16
Number of cancer clients reached through individual consultation	19	3	23	23	17
Number of Cancer Support Meetings	8	1	10	9	6
Environmental Health: Air Quality Investigations	24	12	12	22	18

ORGANIZATIONAL NEEDS

The Organizational Needs were identified in the Community Health Plan as a series of programs, services, or resources needed to "enhance the level of service currently being offered by community health organizations."[6] As part of the evaluation, relevant managers and directors were asked about the extent to which those needs had been addressed over the past five years. For a description of each of the needs, refer to the CHP, pages 25-40.

Of the 23 organizational needs identified in the CHP, 11 have been addressed, seven have been partially addressed, and four have not been addressed. For those that haven't been addressed or have been partially addressed, reasons given included that funding could not be acquired, that progress was taking time but there have been developments, or that the need was not prioritized.

[6] Community Health Plan 2012-2022, pg. 24.

See table 5 for a summary of the organizational needs, and the status (fully complete, in progress, or not started). A full table that includes the responses of relevant senior staff is included in the Appendices.

Table 5 Summary of Status of Organizational Needs

NEED	COMPLETE? (YES, NO, SOMEWHAT)
Global Need (To Support All Other Health Needs)	
Staffing & Human Resources	Yes
Operations	Yes
Health Service Needs (Enhancements to Existing Services)	
Integration of mental health programs/services	Somewhat
Nutritionist dedicated to community initiatives	Yes
Clinical Psychologist	Yes
Addictions Clinical Supervisor	Yes
Mental Health Nurse	No
Volunteer Coordinator	?
Physician Recruitment and Retention Strategy	Somewhat
Strategic Community Health Careers Program	Somewhat
Preconception Health Program	Yes
Prenatal Clinic Nurse	Yes
Well Baby Clinic Enhancement	Yes
Diabetic Foot Clinic	Yes

NEED	COMPLETE? (YES, NO, SOMEWHAT)
French Language training	No
Infrastructure Needs (Information Systems & Technology)	
Electronic health records (Logibec for health systems)	Somewhat
Database system with resources (developmental & maintenance)	Somewhat
Software licences for computer programs	Somewhat
Smart board with videoconferencing	Yes
Infrastructure Needs – Facilities & Resources (New)	
Mental health facility/resources for acute care	No
Foster-care facility for adults with limited mental capacity (Alzheimer's, dementia)	No
Facilities and resource personnel for severely disabled/ handicapped	Somewhat
Adult Wellness Clinic	Yes

3.2 Evaluation Question 2

Did participants benefit from the programs and services provided?

a. To what extent were the target groups involved in the programs and services for each health priority area?

b. To what extent did the participants feel that they benefitted from the programs and services for each priority area?

c. To what extent did program and service staff observe benefits for the different target groups for each priority area?

Summary of Findings

Overall, individuals accessing and participating in the programs and services covered by the CHP appear to be benefitting from them. However, more could be done to reach out to target groups in the community, meet new and shifting needs, and ensure that Kahnawá:ke's most vulnerable populations are served.

3.2.1. Programs and services benefit those using them

Staff share a sense that program and service users of all ages draw benefit from their participation. The popularity of some programs and an increased awareness of health issues in the community are signs that target groups are benefitting.

3.2.2. More community outreach is needed

Education, promotion, and outreach are needed to increase community buy-in and awareness of programming. Social media should be harnessed as a communication tool.

3.2.3. The most vulnerable are not being reached

Many programs and services are accessed by community members who are already engaged and interested, or by the children of engaged parents. The most marginalized and high-risk populations are less likely to participate in programming.

3.2.4. Access to services within the community is important

Kahnawa'kehró:non draw an important benefit from having access to services within the community, in the English language. Efforts are required to fill in the gaps between service demand and availability.

3.2.5. Some users feel that improvements are needed so as to enhance the benefits of services

Some service users feel that they would benefit more were there less bureaucracy, better coordination of services, and if services were more family- and community-centred.

Mental Wellness and Addictions

Accessible, diverse programming and dedicated staff are factors that lead to greater benefit for target groups in the community.

Overall, target groups within the community appear to be benefiting from existing Mental Wellness and Addictions programming. Such benefits include building relationships with others in the community and developing a support system, accessing information and new knowledge, learning new skills, and access to detox and medical care.

Staff attribute the presence of these benefits to the diversity of programming available (enabling a larger client base to be reached), to a committed, dedicated, and compassionate workforce, and to the accessibility of services within the community and in the English language. The fact that Kahnawá:ke is providing services

and care to its own people within the community is considered an important factor that leads to high levels of staff commitment and dedication.

Although staff state with confidence that clients benefit from programs and services when they access them, it is less clear whether these benefits remain once a client stops participating in the program or using the service. For example, the rate of relapse by former addictions program and service users would be required to determine whether benefits are persistent.

Children and youth are important target groups for Mental Wellness and Addictions programs. There is a lot of beneficial programming for youth, but there could be more.

Children and youth are targeted by a number Mental Wellness and Addictions programs, many of which are perceived to be quite successful. In-School Prevention targets children and youth from Grade One through high school, reaching approximately 80% of the school-age population, while teachers receive training to address mental health issues such as bullying. After-school and evening programs such as Our Gang and Children's Drama are very popular, as is their summer camp programming, for which parents line up early in the morning to access limited spots. The traditionally-focused Where the Creek Runs Clearer youth group received interest within its first year from youth both older and younger than its target age group (12-17 years); this led the program to shift its approach to a family-oriented group open to all ages, including parents.

Despite the diversity of programming available for children and youth, there is a shared sense among staff that more is required to meet the growing needs of the community. Addictions issues are still prevalent among youth in Kahnawá:ke and as new substances come into the community (e.g. opioids), programming needs to adapt and expand to meet the real needs of youth.

Examples of areas for improvement cited by staff include:

- Adding an extra addictions prevention counsellor and ensuring that these workers reach out to youth when and where they are most at risk (at night, on the streets and in the places around the community where youth engage in substance abuse);
- Adding more sessions to the very popular Our Gang summer program;
- Adding a drama program for teens. Children's Drama is cited as one of the few activities available to youth in the community that is not sports-centred, and it is not presently available to teens;
- Adapting the Youth Centre hours, currently open only during the school/working day, to young people's real needs (services in the evenings, on the weekends);
- The community should have a youth drop-in centre;
- The Family and Wellness Centre is not accessible by public transport. More networking and outreach is needed by the Centre to render its services more widely used;
- KSCS should be on social media to reach youth. The majority do not attend programs.

Some of the most vulnerable populations are not being reached.

Reaching the most vulnerable populations within the community is a major challenge. Many staff share the observation that more work is needed to reach out to and engage the most disadvantaged and high-risk members of the community. Staff recognize that program participants tend to be "keeners", and the parents of participating children and youth are often already engaged and enroll them repeatedly in the programs. Children of parents who are not involved in programs themselves, who are grappling with their own issues, and those in youth protection are not being reached. There is now work being done to make sure that the popular summer camp spots are made available to low-income families and not only taken up by working parents looking for summertime activities for their kids. Services for LGBTQ+ youth are needed; many LGBTQ+ youth are accessing counselling and teen programming. Akwesasne's LGBTQ+ programs could serve as a good model for developing such services in Kahnawá:ke.

Although the need to better reach the most vulnerable is a clear concern, some staff and users also mentioned that services are less available for community members who are not considered high-risk or who present a less severe case. Denial of services, such as counselling, to those who are not in a crisis situation can lead to frustration as community members have few alternatives to access affordable and English-language services outside the community.

More education and outreach within the community are needed, as is greater engagement with clients and frontline workers for decision-making processes.

Education and outreach are both seen as the keys to community buy-in with regards to mental health and addictions programming. More education and promotion are needed both to educate the wider community about risk behaviours (prevention) and to increase awareness among community members about the services and programs that are available. Communication through social media is necessary in order to reach a large segment of the community and should be embraced by KSCS and KMHC.

Engagement with the community should not be unidirectional. Staff and users feel that there should be more involvement and input in decision-making by the community. Many staff would like to gain a better understanding of whether clients are satisfied and to hear their opinions. Communication in both directions should be continuous and take the form of a dialogue; a community liaison position was suggested as one option for achieving this. Frontline workers could likewise be more included in decision-making processes. Some users reported feeling disconnected from the organizations and not informed or consulted. They likewise called for more consistent and continuous communication and information sharing.

Chronic Disease

Programming and outreach activities take place across the community and diverse populations are benefitting. However, some target groups are not being reached.

Chronic disease prevention activities and programs are reaching children, adults, and the elderly. Children are targeted through KSDPP programming and benefit from such activities as cooking classes, education for parents on how to pack healthy lunches, traditional cooking at the longhouses, and gardening workshops for

Step by Step participants. Adults can choose from many inexpensive activities available across the community to engage in healthy living. Although working adults are harder to reach, as they are busy and work long hours, efforts are made to engage them through prevention outreach. Prevention activities are adapted to different target groups and reach out to people at the workplace and at community events to provide health education, blood pressure and glucose tests, and sun safety tips. Elders are benefitting from specialized fitness programs at KMHC, including chair fitness which was added as a result of the demand for exercise options by an aging population. It appears that overall, there has been an increase in healthy eating and exercise in the community.

Some improvement is needed to maximize benefits for these users, however. KSDPP programming is very well-established, but for this same reason, some updates and innovation could help renew interest and better benefit students. There is concern that those who most need the services are not accessing them, such as already obese youth and adults, and people who are not interested in physical activity. Child and youth active lifestyle programming tends to be attended largely by young people who are already active. Accessible infrastructure and more programming for special needs clients are required to make activities more inclusive. Better coordination and pooling of resources across the community would help maximize use of existing infrastructure and spaces ("work with what we have"), reducing overlap and improving access to services.

Better outreach to the community is needed.

Promotion and awareness are important, but even more so is that people *adopt* healthy lifestyles using the information and knowledge gained through prevention programming. Staff feel that this crucial step could be better encouraged through outreach solutions such as seeking increased buy-in from influential people in the community (e.g. employers), using social media, better engaging and supporting parents to create healthy environments for their children, and promoting culturally relevant, sustainable, and appropriate options to the community.

Early Childhood and Family Wellness

There is a growing need for early developmental disability screening and diagnostic services for young children in the community.

Early screening and detection services are an important component of service delivery for those with developmental disabilities. It is well documented that earlier identification of developmental disabilities can positively impact the wellbeing of individuals with developmental disabilities, as they are more rapidly paired with programs and services to support them. In Kahnawá:ke, there are limited early screening and diagnostic services.

In addition, in recent years there has been an increase in the number of young children who could benefit from screening and diagnostic services. Service providers must be aware of this shift, and ensure that screening and diagnostic services are offered at appropriate ages to identify needs as early as possible.

There are not enough on-reserve programs and services for people with disabilities and their families.

Staff identified a need for increased support as individuals transition between services destined for different age groups. Specifically, there is a need to better ensure a full continuum of care so that these individuals and their families have continued access to services during periods of transition, such as when an individual with a developmental disability is leaving high school and is no longer able to access programs through school. Such circumstances currently lead some individuals to become "lost" in the transition from one set of programs and services to another.

There is also a lack of on-reserve support and respite services for the families of individuals with disabilities. Individuals with developmental disabilities and their families can become isolated from the rest of the community.

Those who access the services are benefitting from them.

There is a clear need in the community for the programs and services offered by Assisted Living Services and Aboriginal Head Start. Staff have observed benefits among those who use these services.

For example, the Young Adults Day Program teaches life skills, social skills, cooking skills, and keeps adults with disabilities connected and integrated with the world around them. While the program typically runs Monday through Friday, it also offers occasional respite services, and evening and weekend activities. Staff noted that programs like this are needed in the community.

CANCER

Participants are benefitting, however the reach of cancer support services is limited given the few resources available.

Cancer support services offer support to individuals at various stages of diagnosis and treatment for cancer. However, the limited resources available for cancer support services limit the impact these services may have. Those interviewed noted that the target group was benefitting, but not as much as it could be should there be access to more resources.

There is insufficient outreach and coordination to ensure that all cancer patients are being reached.

It is not known whether cancer patients remain engaged in the support system as they navigate through the various stages of their condition. This is in part because there is insufficient coordination and communication between the various divisions involved in cancer diagnosis, treatment, and support. For example, physicians whose patients are diagnosed with a form of cancer should always refer their patients to cancer support services, however this does not always happen.

Moreover, there is limited outreach and promotion of services, which means that some may suffer in isolation while unaware of existing services, or may not have the support to access those services.

SUPPORTING AREAS

The intake and case management system improves the accessibility of primary care services to the community.

The intake and case management system used at KMHC supports the coordination of services and ensures that community members are put in contact with the services relevant to their needs. While it was noted that there are always ways to improve this system (e.g. identify how to better reach vulnerable families), overall it is seen as an effective way of reaching the community.

Overall, the programs and services under the supporting areas are reaching and benefitting their target groups.

In general, there was agreement among staff that the programs and services under the supporting areas are benefitting their target groups. For example, it was noted that all newborns are seen by the Well Baby Clinic at least twice, and immunization rates are good.

In Home and Community Care, staff help community members identify their needs, and can support clients to stay in their home as long as possible. Moreover, Home and Community Care offers flexible services such as a short-term care service, which provides an introduction to home and community care services, allowing clients to transition into them as needed. Providing services that enable clients to stay at home for longer not only reduces the resources required by health-care services, but also contributes to improved health outcomes for clients.

In fact, a rising challenge is the increasing number of non-community members who are trying to access programs and services meant for community members only. Some physicians who see non-community members at KMHC referring the latter to programs and services that are meant for First Nation clients in the community.

There are some specific target groups that may not be reached by the programs and services that fall under the supporting areas.

In some cases, the most vulnerable groups are not reached. For example, while the Well Baby Clinic does an excellent job of seeing all babies at least twice after they are born, the mothers who access the services offered by the clinic tend to be those who have support and resources. New mothers who have fewer supports and are most in need of the services, are less likely to access them.

Other examples of specific target groups that may not be reached include:

- Home and Community Care services may be missing socially isolated elders for day programming;
- Children under youth protection;
- Target groups for HIV prevention programming;
- Adults at risk of acquiring a sexually transmitted infection;

- Target groups for tertiary prevention are not always reached, as there is an insufficient number of beds at KMHC and at the Elders Lodge.

User Perspectives on Program and Service Delivery

Some service users (clients) shared their experiences accessing and participating in CHP-funded services and programs. These perspectives were gathered during the users focus group held as part of this evaluation. It is important to note that given the timeline, scope, and resources available for this evaluation, we had limited access to service users, and those who participated in the focus group were not randomly selected (see section 2.3 Limitations). We believe that it is important to value and consider the perspectives shared by those users with whom we spoke. We cannot infer, however, that these opinions are representative of the user experience throughout Kahnawá:ke.

Bureaucracy can make it difficult for Kahnawa'kehró:non to access services.

Some service users find there to be too much red tape, leading to unacceptably long waits to access services or for follow-up with KSCS or KMHC frontline staff. Users understand the need for the organizations to follow federal and provincial laws, however some suggest that "more could be done with less" - that existing resources could be used more creatively to enhance access to services. Inconsistent services were likewise flagged as issues to be resolved (e.g. too few visits by a social worker, changes in quality and consistency of care due to staff turnover). It is worth noting that some staff likewise felt that bureaucracy could be reduced in the interest of enhancing inter-organizational coordination and better meeting clients' needs. However, they recognize that some bureaucracy is necessary in order to provide structure and guidelines for service delivery.

Services could be better coordinated.

Users would like to see greater coordination between the different services and organizations. Some feel that more could be accomplished with limited resources if overlapping services were eliminated and program and service providers enhanced the way they work together. The most vulnerable families, who are accessing multiple services, would experience less stress "managing our lives" if services were better coordinated. For example, a service user cited the complexity of managing meetings with multiple social workers alongside medical appointments and the care of a family member with a developmental disability.

The family and the community should be at the centre of health care.

Some users emphasized the importance of the family at the centre of Kanien'keha:ka society and that it is in the family where issues are addressed and resolved. For this reason, health care confidentiality rules can be detrimental to the family dynamic. Several users mentioned having been denied information about family members who were accessing services or in care, which they felt limited the family's ability to cope with

issues and maintain harmony. These users would like to see consideration for the “whole family” in health and social service delivery.

These users generally favoured a community-centred approach that integrates traditional values and holistic ways of understanding health. They suggested incorporating the Community Vision Statement as the guiding framework for the CHP, so as to formally align the CHP with the initiatives and shared values of the wider community. They would likewise appreciate seeing greater integration of community members in decision-making processes, in accordance with Kanien'keha:ka ways.

Service users have many opinions and ideas to share, but do not know where or how to voice them.

Users would like to be able to share their experiences with service and program delivery, voice their concerns and unmet needs, and suggest ideas for improvement. However, some expressed that they do not feel like they have easy access to KSCS and KMHC management and do not know where to turn to express their opinions.

3.3 Evaluation Question 3

Are the priority health needs and problems the same or have they changed?

a. To what extent do the priority health needs and problems reflect the current data?

b. What are the top priority health needs and problems currently facing Kahnawá:ke identified by program participants, program staff, and stakeholders?

c. How have the top priority health needs and problems changed in the past five years?

SUMMARY OF FINDINGS

3.3.1. Better data would help determine the accuracy of the health priorities, but they do appear to ***reflect major issues faced by Kahnawa'kehró:non***

Without access to data that provide a current portrait of health in Kahnawá:ke, it is difficult to determine with confidence whether the CHP health priorities accurately reflect community health needs, and whether these needs have changed since 2012. Nevertheless, many staff feel that because the seven health priorities were developed through community consultation, they represent the major and recurrent issues faced by community members.

3.3.2. Some changes to the health priorities may be needed

Many staff share a sense that *violence* should be considered a health priority as in the past. *Obesity* as its own health priority remains a point of discussion in the Chronic Disease subcommittee, while adding *culture and language* as a health priority might help ensure that concrete actions are taken to better integrate Kanien'kehá:ka culture into CHP planning and implementation.

ACCURACY OF PRIORITY HEALTH NEEDS

It is difficult to determine accuracy without access to the relevant data.

Lack of access to statistical data that provide a current portrait of health indicators in Kahnawá:ke limits our ability to determine whether the seven health priorities of the CHP reflect the real needs of the community, and whether priority health needs have changed over the past five years. Notably, we were unable to obtain the First Nations Regional Health Survey data within the timeframe of this evaluation (see Section 2.3 Limitations).

In interview, some staff voiced a concern that the current priorities may not be accurate reflections of the key issues in the community, because they were developed based on anecdotal and not statistical data. As a result, some fear that priority health needs may be missing from the CHP.

The current health priorities reflect the lived experience and day-to-day concerns of community members.

When asked what changes they would make to the content of the CHP, many staff felt that no changes were necessary because the CHP health priorities were identified in consultation with the community. More specifically, they consider that the CHP community consultation process led to an accurate picture of the major recurring issues that Kahnawa'kehró:non are grappling with in their daily lives. Some mentioned the importance of learning to trust the accuracy of "anecdotal" evidence that is based on real, lived experience.

Possible Changes to Priority Health Needs

Many question why *violence* is no longer included as a health priority.

In previous Community Health Plans, Violence is listed as a health priority. Many staff wonder whether it should have been maintained as a priority health issue for 2012-2022. Some fear that violence remains a major issue in the community and that by removing it from the CHP, resources and efforts will no longer be directed toward addressing violence and violence prevention.

Whether *obesity* should be its own health priority is still being debated.

Members of the Chronic Disease subcommittee reported that they are still considering whether Obesity should be a stand-alone health priority. They report that obesity is rarely addressed through programming of its own but rather through other Chronic Disease programs.

Should *culture and language* be added as a health priority?

The evaluation brought out much discussion about the importance of incorporating Kanien'kehá:ka culture and language across the priority areas of the CHP. Some were concerned that strategies be developed to ensure that culture and language are integrated in concrete ways. During the stakeholders workshop, the idea emerged that Culture and Language could become a health priority of its own, thus ensuring that a group of people is responsible for developing concrete actions to enhance the incorporation of Kanien'kehá:ka values and practices into the CHP. Others felt that culture and language should be integrated as a strategy across all existing health priorities.

3.4 Evaluation Question 4

What was the impact of the CHP to the health priorities identified in the last evaluation?

a. What trends/changes are seen in the data on the health indicators relevant to the CHP?
b. To what extent have the impacts from the priority area logic models been achieved?
c. What are seen as the major impacts of the CHP to the health priorities by program staff, participants, and stakeholders?

SUMMARY OF FINDINGS

Available data does not provide enough information to measure the impact of CHP implementation on the health priority indicators. However, many staff observe that progress has been made toward achieving the goals associated with each health priority. Increased inter-organizational collaboration, greater community engagement, and the integration of culture and language into program and service planning and delivery are some of the factors that could enhance the effectiveness of the CHP in addressing community needs.

3.4.1. Insufficient quantitative data makes it difficult to measure impact

Although overall, staff feel that progress has been made toward achieving the goals and strategies identified for each health priority, a lack of quantitative data that measure changes in the relevant health indicators poses a limitation to determining the impact of the CHP on the health priorities.

3.4.2. Collaboration and coordination are important for ensuring effective implementation of the CHP

The CHP has played an important role in breaking down silos and enabling collaboration across organizations and programs, notably through the creation of the subcommittees. However, this is a work in progress and effective collaboration remains a challenge that is being addressed by all subcommittees.

3.4.3. Awareness and engagement by staff and the community are essential for a successful CHP

Community members and some staff (notably, frontline workers) are not sufficiently informed of the CHP and its content, and strategies should be developed to better consult with and engage the wider community. More communication about the CHP, in accessible language, could help build awareness and increase community buy-in and sense of ownership of the Plan.

3.4.4. The CHP would benefit from the integration of culture and a holistic approach to wellness

Integrating Kanien'kehá:ka culture and values into CHP program and service planning and delivery is a widely shared priority. While some initiatives have successfully integrated traditional knowledge and

practices, many would like to see a more widespread integration of culture and language across the CHP program areas.

MENTAL WELLNESS AND ADDICTIONS

Overall, there has been progress made toward meeting the two priority area goals. However, a lack of data and other factors make it difficult to identify real impact on the community.

- The goal of the Addictions health priority is *to reduce alcohol/drug abuse in Kahnawá:ke.*
- The goal of the Mental Health priority is *to ensure the continued growth of services in the prevention of mental health; to improve mental wellness of community members and support them while facing mental health challenges.*

Overall, staff feel that the health priority goals are being met or that progress has been made toward achieving them. However, there is also a sense that cases of substance abuse and mental health issues remain prevalent in the community. This is based on staff's own experience and observations, rather than data on the health indicators. Many staff feel that access to more and better data is required in order to determine whether CHP programs and services have had positive impacts on health priority goals.

Some pointed out that mental health and addictions issues have become less stigmatized in the community over the years. As a result, more individuals and their families are willing to admit the existence of these issues. In turn, if more people are seeking help and accessing services and programs, this could lead to a perceived increase in the frequency of mental health and addictions cases in Kahnawá:ke. This may not, however, indicate an actual increase in the prevalence of these issues in the community.

The health priority strategies should be addressed through increased collaboration and integration of services.

- The Addictions health priority strategy is *to provide comprehensive prevention, intervention, aftercare addictions services and to mobilize the community to change perceptions regarding addictions.*
- The Mental Health priority strategy is *to provide comprehensive and accessible prevention and intervention services.*

Coordination of services is a key factor suggested by staff for successful implementation of these strategies. Some feel that the strategies are being met, due to the increasing number of programs and services available to the community and to increased collaboration among services. Some examples cited include an increased offer of traditionally focused programs and services (e.g. the growth of Where the Creek Runs Clearer group), the steady development and enhanced coordination of mental health services (e.g. better integration of services for clients with severe and persistent mental health issues by KMHC and KSCS), and more frequent and diverse messaging on mental health and addictions leading to greater awareness of these issues among community members and staff.

Others feel that greater coordination of services remains necessary and that a tendency to work in isolation from one another persists. Suggestions include greater emphasis on the importance of coordination (e.g. "coordination of services" should be included in the strategies themselves) and integrating services in a more holistic manner, taking into account the client as a whole person without segmenting their needs based on funding categories.

The subcommittee has increased collaboration by bringing KSCS and KMHC staff together, but the two institutions need to clarify and optimize how they work together.

Despite the persistence of "silos" in program and service development, management, and delivery, staff from both institutions are dedicated to finding the best ways to increase collaboration and work toward a common goal. By bringing together staff from different services and both institutions, the Mental Wellness and Addictions subcommittee has been a very positive force for breaking down silos in how programs and services are offered to the community. However, staff feel that there is much work yet to be done.

An important challenge is the difference in approaches taken by KMHC and KSCS to manage services and follow clients. The Mental Wellness and Addictions subcommittee is composed of professionals from nursing and medical fields, and from social services fields, each accustomed to different methods and approaches. The *case management* model used by KMHC and the *case manager* model used by KSCS were frequently cited as a difference that has been challenging to reconcile. Some suggest that KSCS should adopt the case management approach used by KMHC, while others hope that the two institutions will look for a way to combine the strengths of both models and develop a new way of working that meets both organizations' needs. There is an overwhelming desire by subcommittee members to develop a team approach and find collaborative solutions to enhance the impact of services and programs.

CHRONIC DISEASE

Although staff share a general sense that goals are being reached, it is difficult to determine impact without statistical data.

The Chronic Disease subcommittee works toward three health priority goals, namely:

- *To reduce the incidence of diabetes and support people who have health impacts associated with diabetes;*
- *To reduce the incidence of cardiovascular disease in Kahnawá:ke;*
- *To determine whether obesity should be identified as a true health priority. If so, to identify action steps to reduce obesity in the community.*

Overall, staff feel that these goals are being achieved, however they are unable to state with confidence to what extent this is the case and how these impacts can be measured. Access to quality data on the prevalence of the three chronic diseases in Kahnawá:ke is needed in order to determine impact.

Discussion is ongoing with regards to whether Obesity should be maintained as a stand-alone health priority. Some feel that obesity has not been sufficiently addressed by the subcommittee and that obesity

programming has been slow to develop. Others emphasize that obesity is addressed through other chronic disease programs, such as KSDPP and fitness activities.

Increased collaboration and coordination have had positive effects on the implementation of health priority strategies. Many advocate for a holistic approach to chronic disease.

The Chronic Disease health priority strategies are:

- *To educate community members on the impact of diabetes, identify diabetes in early stages and create programs to ensure access to programs efficiently;*
- *To create a comprehensive prevention, intervention and support spectrum of services for cardiovascular disease;*
- *Through evidence-based research, review the obesity picture in the community and collaborate with organizations to take action.*

Examples of success in implementing the subcommittee strategies cited by staff include the growth of adult prevention fitness activities (Vitality and chair fitness), an increase in information made available to the community to promote awareness of nutrition and exercise, and perceived increases in client satisfaction and turnout at events.

Increased collaboration and cooperation through the creation of the subcommittee is seen as an important factor that has enhanced the client experience and eliminated some service overlap. The coordination of services between the diabetes nurse and nutritionist is a commonly cited example, along with the integration of the Physical Activity Initiative working group into the Chronic Disease subcommittee. While KSDPP programming is regarded as a well-established program that has led to an important increase in diabetes awareness within the community, many feel that changes to the program's approach would help maintain its relevance and popularity. Increased collaboration with the subcommittee and a holistic vision that considers diabetes as part of overall wellness were cited as examples of positive steps that KSDPP has begun to take. Overall and despite these advances, fragmentation of services due to programs' and organizations' differing funding sources and priorities remains a challenge.

Many feel that the subcommittee cannot look at the three health priorities in isolation of one another and of the other health priorities. They emphasize the need for a holistic approach that tackles the overall wellness of individuals and the community (healthy mind/healthy body, community wellness, spiritual wellness, identity). Increased integration of traditional medicine and healing practices was recommended by some.

Early Childhood and Family Wellness

Overall, there has been progress toward meeting the priority area goal. However, a lack of data and other factors make it difficult identify real impact on the community.

- The goal of Early Childhood and Family Wellness is *to assess, identify and plan for the needs of families experiencing developmental disabilities.*

Overall, staff feel that there has been progress in working toward meeting the goal, however there are mixed feelings regarding the extent of this progress over the past five years. As one staff member noted, "We are just on the threshold. We can't quite pat ourselves on the back yet." Moreover, several staff members noted that it is difficult to assess the extent to which the goal has been reached, given that no clear measurable indicators were assigned to it. They recommended identifying some key ways to measure progress toward the goal.

In general, the strategy is being implemented and there is an increase in community collaboration.

- The subcommittee's strategy is *to collaborate with community stakeholders to assess the needs of special needs community members and to strategize service delivery and future needs.*

Staff noted that there has been an increase in collaboration with the various community stakeholders. An example of this is the Connecting Horizons group, which includes service providers, individuals with disabilities, KSCS, Step by Step, parents' advocacy representatives, MCK, family members, and others. This group allows various stakeholders to work together to strategize service delivery and future needs for community members with special needs.

As one staff member noted:

"We absolutely have done that. Now we have to be brave, stop asking the same questions, and get moving. We have a really good picture and content for what the needs are…now we need to roll up our sleeves and do the hard work. Doesn't mean we don't continue to talk along the way."

CANCER

There has been some achievement of the goal.

- The goal of the Cancer subcommittee is *to provide education that promotes the decreased incidence of cancer.*

There is a shared sense that awareness of cancer has increased in the community, along with an increased awareness among community members of the cancer services available within the community. It was perceived by staff and subcommittee members that Kahnawa'kehró:non are more willing to share their experiences with cancer with one another and to seek out cancer-related services.

However, it was noted that the current goal is only focused on decreasing the incidence of cancer, and didn't include increasing awareness. It was noted that it would be challenging to measure whether the incidence of cancer is decreasing, as there is no clear picture of the current incidence of cancer in Kahnawá:ke.

In addition, it was noted that cancer prevention and early detection services could be improved in the upcoming five years. While services are available, there was sense that the community would benefit from an expansion of those services.

In general, the strategy is being implemented.

- The strategy of the Cancer subcommittee is *to provide a comprehensive prevention, intervention, and support spectrum of services related to cancer*.

Staff and subcommittee members noted that the strategy is being implemented, as there is a broad range of prevention, intervention, and support services available. However, at this point they do not have the data to identify community needs with precision. It was noted that better data would indicate the cancer profile of Kahnawá:ke, and allow for increased evidence-based decision-making in a context of limited resources.

Supporting Areas

This evaluation focused primarily on the health priorities, and the impacts of the supporting areas were not assessed. However, it was noted that the goal of each of the supporting areas followed the same format: *to identify objectives and activities which contribute to [specific supporting area] in the achievement of the health plan*. The strategy of each of the supporting areas also followed the same format: *to review all community activities and services and ensure they describe their contribution to the health plan*. It was recommended by several staff members that the goal and strategy for each of the supporting areas be reviewed and updated to increase clarity and relevance.

Overall Impact of the Community Health Plan

The following subsection addresses impacts of the Community Health Plan's implementation that were identified as affecting all or many of the health priorities, and that are not associated with any particular subcommittee.

The CHP provides a structure that helps channel program and service planning to address the health priorities.

The CHP and its logic models are seen by many as a guideline that focuses efforts and resources on addressing the health priorities and as a result, keeps programs and services aligned with community needs. Staff cited the CHP as being a "working tool" and a "relevant" and "living" document that contains information they can use for planning, preparing funding proposals, and selecting topics to cover with program participants. The CHP is also cited by some staff as having increased their awareness of community health needs and the steps that can be taken to work toward resolving them.

However, some staff flagged that the CHP was created based on existing programs and services, and worked to fit these into a structure, rather than developing or modifying programming in response to the health priorities. Because of this "bottom-up" approach, the existence of some programs not because of their proven impact on the health priorities but simply because they already exist, remains an issue.

The subcommittees have played an important role in increasing collaboration and breaking down organizational silos. However, this is a work in progress and the complexities of collaboration have yet to be overcome.

By bringing together programs and services into the four subcommittee areas, the CHP has helped managers coordinate their efforts and think strategically about how to share resources. Staff reported benefits such as improved communication, more consensus building, less duplication of services, bringing managers and frontline workers together to address the health priorities, and reducing instances of programs existing because the funding is there, without addressing the real needs of the community. Perceived positive impacts on the health priorities include increased effectiveness, increased creativity, better aligned and more comprehensive services, more services for the community, and better use of resources.

However, most staff take care to emphasize that many of these efforts remain works-in-progress and that improvement has been significant but slow. Organizational and program "silos" were often cited as a persistent problem and staff share the priority of working together to break down these silos. Some of the frequently mentioned challenges to enhanced collaboration include the over-representation of KSCS and KMHC on the subcommittees (not enough involvement by MCK, Peacekeepers and ideally, other organizations across the community), the perception that these other organizations do not feel the same sense of connection to and ownership of the CHP, a need for better internal communication, and the complexities of bringing together two large organizations (KMHC and KSCS), each with its own approach (medical approach and social services approach), strategic plan, and decision-making structure.

Impact may be limited by insufficient community awareness, consultation, and involvement.

That the CHP is grounded in and shaped by the health priorities identified through community consultation is regarded as an important strength by many staff (see also Evaluation Question 3). However, both CHP staff and service users identified low community awareness of the CHP and insufficient community consultation and involvement in CHP implementation as a weakness that should be addressed.

Many pointed out that the CHP is not widely known and understood in the community. Overall, staff felt that more community input and feedback would help them better understand to what degree programs and services are meeting users' needs. Suggestions ranged from including more service users on the subcommittees and filling the Elders' seats at Onkwata'karitáhtshera, holding focus groups and other forms of consultation more frequently, seeking the input of community members facing the toughest issues, enhancing the visibility of the CHP across the community, and keeping community members informed about the health priorities, CHP implementation, and the current evaluation process and results. Some service users expressed feeling disconnected from KSCS and KMHC, and called on the organizations' managers to "open their doors" and consult, follow up, and inform community members. These users felt that consultation should take place with the grassroots of the community, and not exclusively with frontline workers and service providers; they expressed a hope to see more spaces created for dialogue and discussion about CHP services and programs, referring to the service users' focus group held for this evaluation as an example of the type of forum that could become more common.

Improved communications would help grow community and staff engagement with the CHP.

Staff and users alike felt that the content of the CHP could be better communicated to the community, so as to increase awareness, understanding and ultimately, ownership of the Plan. Many felt that the CHP is a

complex document that should be communicated in a clearer and more accessible way to the community. Examples of suggestions offered by staff and service users include:

- Inform people about how the CHP was developed and why it is important;
- Communicate continuously and target all ages;
- Communicate the essential content of the CHP in accessible language and with the help of visuals such as a chart showing the health priorities and subcommittees; make the CHP more easily accessible on the KSCS website;
- Reach out to the community through social media;
- Engage MCK in promoting the CHP to increase awareness and buy-in across the community;
- Provide the community with a statistical portrait of community wellness as related to the health priorities;
- Onkwata'karitáhtshera could put out a community newsletter annually or at regular intervals.

Internal communication within KMHC and KSCS and in particular, to frontline workers, was likewise flagged as an area for improvement. Some mentioned that frontline workers are less likely to be informed about and understand the CHP, and that staff are often only aware of the health priority or program that they are directly involved in implementing, without having a big-picture understanding of the CHP. However, it seems that staff are more aware of and engaged with the current CHP than with past community health plans.

Kanien'kehá:ka values, culture and language are an important part of wellness, and they should be well integrated into the CHP.

The importance of integrating Kanien'kehá:ka culture, identity, values, and practices into all areas of the CHP emerged as a strong theme among staff and service users. Many cited a resurgence of interest in returning to "our ways" within the community, which has led to a hunger for traditional knowledge, cultural values and practices, traditional medicine, and language. The Tekanonhkwatsheraneken Traditional Medicine Unit project at KMHC was frequently cited as an example of the successful integration of traditional healing knowledge and practices into health service delivery, as was the Family and Wellness Centre. Both provide culturally focused healing and healthy living options to community members. Many staff and service users would like to see a more widespread integration of culture and language across the CHP program and service areas. Suggestions include integrating language and culture in CHP goals and service delivery strategies, providing more programming that integrates cultural teaching and values, ensuring culturally safe environments, and incorporating basic Kanien'kehá:ka values into the CHP. On this last point, several service users felt that the CHP itself is structured in accordance with a "western" model (e.g. hierarchical decision-making, compartmentalization of issues based on the western medical model), which presents a challenge to integrating Kanien'kehá:ka ways (e.g. inclusive decision-making) and a holistic understanding of wellness.

3.5 Evaluation Question 5

Is the current information system and data gathering methods sufficient to meet the data needs to inform the summative evaluation and annual review process?

a. How many of the indicators in the logic models have had data collected, per priority area?

b. What are the information system and data gathering needs identified by program staff?

It is worth noting that, as the logic models have been updated over the past five years, we were unable to calculate the total proportion of indicators which had data collected (Evaluation Question 5a). While a number of indicators have had data collected, this data has not been reported together. In other words, there is no regular report that monitors the progress of the activities and outcomes identified in the logic models. Rather, any data collected has been reported in various annual reports as relevant. Without a centralized reporting system for CHP monitoring data, it is difficult to assess the extent to which the indicators have had data collected.

These findings should be considered preliminary, as the the consultants will continue reviewing the information system and data gathering methods in the upcoming months.

SUMMARY OF FINDINGS

Collecting more relevant data and determining strategies to analyze and interpret data meaningfully are goals shared by staff from across the CHP priority areas. Some important challenges faced by staff include the non-standardization of data gathering tools and methods across programs and organizations, and the need for improvements to the logic models and training on how to use them effectively. Significant advances have been made through efforts such as data mining and the centralization of data management and analysis at KSCS.

3.5.1. For data to be useful, it must be relevant and interpreted for meaning

Currently, data is not being collected strategically. Programs under the CHP should be collecting data with relevance to key indicators that will allow for measuring outcomes and trends.

3.5.2. Data collection has not been coordinated among programs and organizations

Data gathering methods, priorities, and tools vary across programs. As a result, it can be difficult to share and compare data meaningfully. The CHP has led to some improvement in data sharing by bringing together staff from different programs and organizations under Onkwata'karitáhtshera and the subcommittees.

3.5.3. The logic models can be good tools for tracking data, but could be made more effective

The logic models help staff focus on measuring specific indicators and tracking progress. Staff feel they could be more effective as monitoring tools if they were simpler, more practical, and if staff were better trained in how to use them. More follow-up may be needed to ensure indicators are monitored regularly and that data collected is analyzed for meaning.

3.5.4. Reporting on the health priorities is incorporated into organization-specific annual reports

There is no centralized annual reporting on all CHP-related activities. Rather, data on specific programming under the CHP are reported in their respective organization's annual report. This makes it a challenge to maintain a clear sense of the overall progress toward addressing the health priorities.

DATA GATHERING NEEDS AND CHALLENGES

A lot of data is collected, but it is not clear whether the most relevant data is being collected. Much data remains in raw form and is not interpreted or analyzed.

Staff overwhelmingly share the opinion that collecting and analyzing relevant data remains a challenge. Many would like to have a clearer, more complete portrait of health issues in the community, so that they could plan service and program delivery in accordance with statistical evidence of community needs and of the outcomes of their interventions. For example, Early Childhood and Family Wellness staff would like comprehensive data on the special needs population of Kahnawá:ke (e.g. by age group), while Cancer subcommittee staff and Cancer Support Group members would like to have a clear statistical picture of how cancer affects the community (e.g. who is affected, what types of cancer are present). Many share the perspective that program and service design should be based more on the analysis of indicators and less on anecdotal evidence.

Staff do acknowledge that data is being collected, and that progress has been made in gathering data for specific indicators, for example to meet CHP reporting requirements. However, most data are collected to meet the reporting requirements of funders (mainly Health Canada); as a result, data collection responds to funders' needs and is not necessarily providing the most relevant information for measuring indicators that are important for the programs and for the CHP as a whole. An example cited by KMHC staff is Health Canada's eSDRT data recording system, which allows staff to input only the primary reason why a client is accessing a service. The system does not allow for recording secondary health issues that a client presents and that may be directly connected to the primary issue. In this way, recorded data does not provide a holistic picture of the client and does not allow services and programs to make the links needed to interpret the data meaningfully.

It is unclear whether staff are using the data collected for more than generating required reports, that is, whether data is being applied to measure progress and adapt programming accordingly. Some staff cite the "overwhelming" nature of data as a barrier that makes it difficult for staff to use and interpret the numbers. As

a result, much data collected by service and program staff has remained in its raw form, without being interpreted or analyzed to provide the "big picture" that many would like to see. Some staff suggest that data is currently being collected "for the sake of collecting it" and not with the goal of gaining the insights needed to monitor outcomes and improve service and program design.

The logic models are good tools for collecting and tracking data, but they could be improved.

Some staff reported using the logic models as guides for collecting data and tracking progress for reporting purposes. Those who refer to them regularly consider the logic models to be good tools for focusing attention on what needs to be achieved by their team or program, and whether progress is being made. However, others reported that often the logic models "sit on a shelf" and are not used by staff, either because they do not know how to use them, do not understand how their work fits into the logic model, or because it is difficult for many programs to keep up with the work needed to properly use the logic models for tracking progress. Some might be overwhelmed by the complexity or number of logic models that they must refer to for their programming.

Some cited the need to better inform staff about how to use the logic models. Examples of such needs include training on how to develop a logic model that is simple and user-friendly, how to develop good indicators, and fostering a greater understanding of the active, "living" nature of logic models (i.e. that they can be adapted to changing realities). The latter need responds to the perception that some staff see logic models as useful only to meet funding and reporting requirements.

Some staff consider that the logic models should be updated more regularly and could be reworked to be more realistic. There could be better follow-up on the logic models through more consistent reporting and the use of report content to analyze and make sense of data at regular intervals (e.g. annually). Some expressed interest in seeing indicators developed not only for specific programs but for the subcommittees and for the CHP overall, which would in turn allow for a bigger-picture analysis of trends and progress.

It is worth noting that while some of the indicators in the logic models are collected and included in annual reports (e.g. KSCS annual report, KMHC annual report, Health Canada CBRTs), it is not clear that all the indicators are monitored, and there is no one central report where all indicators are reported. The logic models do not specify the frequency of data collection, nor how the data should be analyzed.

Data sharing between organizations has been a challenge. Data collection methods have not been standardized across programs and organizations.

A commonly cited obstacle to generating meaningful and useful data on CHP programs and services is the lack of standardization in data collection and storage methods. Staff reported that most programs keep statistics using internally developed tools (e.g. spreadsheets) that are developed to respond to reporting requirements (e.g. CBRT), other indicators of interest, and to keep track of target group use of services. Many noted that KSCS and KMHC collect, report, and store data differently, as do the other organizations and departments throughout the community. Many staff feel that a coordinated effort should be made to collect data strategically, for example by having a common set of indicators for all programs within a health priority.

This lack of standardization can make it difficult to share information effectively between organizations. Staff cited examples such as having difficulty accessing certain data from other organizations in the community (e.g. MCK), and receiving requested data in formats that cannot be used (e.g. no baseline). Many staff suggest that much could be gained from gathering data in a more coordinated, collaborative manner, including a clearer picture of the trends for each health priority.

The CHP has led to improvements in how data is shared, according to staff. The subcommittees have made it easier for staff to share information across programs and organizations. Onkwata'karitáhtshera has brought staff together in meetings to share information on their respective projects, which has provided face-to-face opportunities for data sharing. Suggestions made by staff include building in time at the subcommittee or health priority level for staff to share and review data specific to their area (e.g. annually), and that annual reports could present information by health priority or by subcommittee.

Time constraints and insufficient training pose challenges to effective data collection and interpretation.

Some staff cited the reality of day-to-day service delivery as taking priority over data collection and reporting. Faced with heavy workloads, many staff prefer to focus on their core tasks rather than on proving progress through data collection and interpretation. Time constraints mean that not all programs meet Onkwata'karitáhtshera's reporting requirements in a timely manner, while reports that are submitted are not always read. When they are, they are done so in isolation of one another and not for the purpose of interpreting and monitoring larger trends.

Insufficient training for staff in how to evaluate programs, use logic models, and develop indicators was flagged by some as an additional challenge. There have been some training sessions held by Onkwata'karitáhtshera on these topics, which were well attended.

The centralization of data is an important step in the right direction.

At KSCS, data is now stored and managed centrally. The hiring of a data manager, who is responsible for analyzing and making sense of data received from the different programs and services, is seen by many as an important step. The data manager also standardized the reporting forms used by all the program areas, allowing for easier roll-up into the KSCS annual report.

Moving forward, many staff would like to see the centralization of data not only within their organization, but from different sources across the community. A centralized data hub or "data warehouse", where all data linked to the CHP could be stored and accessed, was cited as one solution.

Access to data remains a problem, but Onkwata'karitáhtshera's data mining initiative is expected to help resolve this issue.

Accessing relevant data that is held both inside and outside of the community has been a challenge. This gap is being addressed by Onkwata'karitáhtshera's Data Mining working group. The project's intention is to obtain specific data from Health Canada, the Régie de l'assurance maladie du Québec, and other sources

such as the cancer registry. Data held within the community is also targeted by the project, particularly from KMHC and the Peacekeepers.

Some of the cited challenges associated with accessing data, especially when held outside of the community, include high cost, the lengthy process of accessing government data, and difficulties agreeing internally on what data should be collected.

Some staff are confident that the data mining project will help generate a more accurate picture of health in Kahnawá:ke. However, it was noted that continuity and consistency will be needed so that the relevant data be collected again in the future, at determined intervals, and that developing a good system for gathering data from within the community regularly should not be neglected.

4. Discussion & Analysis

There has been good progress made with the current Community Health Plan over the past five years. Staff noted that while previous iterations of the CHP did not significantly impact the planning or delivery of programs and services, the 2012-2022 CHP is widely seen as a living, working document. Staff identified ways in which they use the CHP on a regular basis to inform the planning and delivery of their programs and services, making an effort to integrate the health priorities into programming and services as much as possible. In addition, staff have noted that there is an increase in collaboration between the organizations. This has been attributed in large part to the formation of the four health priority subcommittees. These successes should be acknowledged and celebrated as the next steps for continual improvement are discussed.

The following subsections discuss the major themes that arose from the findings. They include strengths, challenges, and recommendations identified by CHP stakeholders and service users. Section 5 summarizes the recommendations that emerged from this discussion.

4.1 Collaboration

As noted in the findings, there has been an increase in collaboration over the past five years. The development of the health priority subcommittees has improved collaboration between organizations. Many staff spoke to how, over the past few years, they have been making efforts to work together and break down the silos. More work is required, but progress has been made.

Figure 4 Stakeholders engaging in discussion and activities during the Stakeholder Workshop

A strong finding from the evaluation is that most staff continue to report that program and services areas are working in silos. As one senior staff member noted, "silos are a legacy of our history of having always received funding as First Nations from different sources, e.g. Indian Affairs, Health Canada … individual organizations were developed around these specific funding sources." Increasing collaboration between organizations will continue to be a challenge and priority for Onkwata'karitáhtshera and the CHP organizations over the next five years.

Finally, in addition to increasing collaboration between the organizations significantly involved in the CHP, stakeholders also identified a need for increased collaboration with other organizations across the community, such as the schools, MCK and the Peacekeepers. Involving other community organizations will support the promotion and adoption of the CHP throughout the community, and increase the sense of ownership among all stakeholders.

4.2 Community Engagement

Community awareness of the CHP, engagement with it, and sense of ownership of it are clear priorities for CHP stakeholders. Concern that Kahnawa'kehró:non are uninformed or partially informed about CHP content and the health priority areas emerged strongly throughout the evaluation. Both staff and service users themselves would like to see increased consultation of community members regarding how the CHP is being implemented and greater involvement of people from across the community in CHP implementation. Meaningful community engagement, including in decision-making processes, was frequently cited as representing the Kanien'kehá:ka way.

Informing the community effectively about the CHP would be an important first step. An informed community will be more likely to engage actively in CHP-related activities. Many feel that more frequent and more effective communications about the CHP would help build awareness and buy-in among Kahnawa'kehró:non. Key ideas for accomplishing this emerged during the evaluation, and emphasize making communication more dynamic. This includes communicating the essential information about the CHP in accessible, plain language, and reaching out to community members regularly and through diverse media. Social media is not currently being harnessed by Onkwata'karitáhtshera nor by KSCS and KMHC and it seems clear that a social media strategy will be needed in order to successfully reach out to most age groups in the community. A number of staff commented that they had not seen a visual representation of the structure of the CHP prior to this evaluation, and that such a simple, visually engaging tool could help enhance understanding of the CHP in the community (and among less informed staff, such as frontline workers). See page 10 for a proposed visual tool.

Beyond awareness, CHP stakeholders feel that community engagement and involvement are important for enhancing participation and building a community-wide sense of ownership of the CHP. Many would like to extend community consultation beyond the establishment of health priorities and develop mechanisms to consult community members more regularly about the effectiveness of CHP programs and services. This would allow staff to better understand whether and how programs and services are meeting clients' needs, and where improvements are needed. Some staff and service users would like to see greater involvement of community members within the CHP decision-making structure. Notable ideas that emerged during the evaluation include increasing participation of service users on the subcommittees and of Elders in advisory roles at Onkwata'karitáhtshera, and holding focus groups or other forms of community consultation more regularly (e.g. at defined intervals). Strategies for engaging community members to participate in these processes will be needed.

4.3 Holistic Care

The CHP is the result of a community caring for its own members. This fact clearly contributes to the high levels of commitment shown by staff to enhancing the client experience, and to their demonstrated sense of pride in and collective ownership of the CHP. Staff share the goal of seeing the needs of all Kahnawa'kehró:non met by and within the community, which can be seen as a way of asserting self-governance over health care in Kahnawá:ke. Other factors driving this shared goal include the difficulty of accessing English-language services outside of the community and the wish to see the most vulnerable be well integrated into the community (e.g. individuals with special needs).

Meeting the full spectrum of needs of all Kahnawa'kehró:non means working toward a tightly coordinated service offer that leaves no gaps between the needs present in the community and the programs and services offered. This is a concern and priority shared by many staff (see also section 4.1 Collaboration). The distinct case management systems used by KMHC and KSCS are a point of concern. While each organization has developed a system for client follow-up that works well internally, these different systems do not facilitate integrated and comprehensive client follow-up by both organizations and as a result, gaps in the spectrum of needs may remain unidentified or unaddressed. Moreover, a holistic approach to health care would take into account not only the coordination of client follow-up between KSCS and KMHC, but also with organizations across the community, to address other issues that affect a client's health, such as housing, environmental factors, or spirituality.

Indeed, implementing a holistic (or wholistic) concept of health care would require working in coordination with diverse community organizations to address the interrelated aspects of the whole self of each individual - physical, emotional, spiritual, mental - which together influence wellness. Holistic care emphasizes the person who is living with a health issue, rather than focusing on the issue that the person has. This approach encourages healthcare providers to consider the whole person rather than isolating the part of the person affected by an illness. Care providers can in this way, together with the client, address a client's symptoms by considering and acting on her or his overall state of physical, emotional, spiritual, and mental wellness. A holistic approach to healthcare is congruent with Kanien'kehá:ka culture and conceptual framework for understanding wellness. We discuss this in depth in section 4.5 Integrating Culture & Language.

4.4 Client- and Family-Centred Care

To optimize the implementation of the CHP and its programs and services, and to move toward a more holistic form of healthcare, many staff at KMHC and KSCS prefer a client- and family-centred approach. Accreditation Canada defines client- and family-centred care in this way:

Client- and family-centred care (CFCC) is an approach that fosters respectful, compassionate, culturally appropriate, and competent care that responds to the needs, values, beliefs, and preferences of clients and their family members. (...) Instead of health care providers doing something to or for the client—where the

provider's perspective is dominant—CFCC means doing something with the client—so the health care provider and the client have a true partnership.[7]

Implementing client- and family-centred care at KMHC and KSCS would imply shifting from an approach to "providing for" a client, with responsibility centred on the service provider, to "working with" the client, and her or his family, to collaboratively address the client's health. Some CHP programs and services have begun making this shift, to encourage building clients' autonomy and capacity to take responsibility for their health. Like holistic care, client- and family-centred care emphasizes individualized solutions that take into account the unique context of each client (needs, values, beliefs, and preferences). To put into practice this individualized approach, service providers must work in partnership with the client to plan her or his care. Some other elements of client- and family-centred care cited by Accreditation Canada include respecting client choice, involving clients in monitoring and evaluating the services they receive, and including clients and their families on advisory and planning committees.[8]

Importantly, a client- and family-centred approach takes into account the role of family as a client's support system, and requires working closely with a client's family throughout the care process. In this sense, it can be seen as an approach that is well-adapted to Kanien'kehá:ka culture, in which the family is seen as a central sphere of society, where issues are resolved so that harmony can be maintained. The "family-oriented" nature of Kanien'kehá:ka culture was a subject of much discussion during the users focus group. Confidentiality rules were flagged by some as a barrier to family-centred care, insofar as confidentiality does not allow families to be fully informed of the issues faced by a family member and therefore, leaves them unable to properly address these issues within the family sphere.

To successfully and thoroughly implement a client- and family-centred approach across the CHP programs and services, it will be important for KMHC and KSCS to agree on a shared definition of the approach, whether this mean adopting the Accreditation Canada definition or adapting it to the Kanien'kehá:ka context.

4.5 Integrating Culture & Language

During the evaluation, the integration of Kanien'kehá:ka culture, identity, values, and practices into the services and programs implemented under the CHP emerged as a goal shared by many staff and service users.

Important work is being done by several CHP programs to integrate cultural values and practices into health care provision, notably by the Family and Wellness Centre, Step by Step, and the Tekanonhkwatsheraneken Traditional Medicine Unit Project at KMHC. Both the Family and Wellness Centre and Tekanonhkwatsheraneken are efforts by KSCS and KMHC to offer clients the option of traditional healing and healthy living (prevention) services within Kahnawá:ke's health and social services system. These

[7] https://accreditation.ca/client-and-family-centred-care
[8] https://accreditation.ca/client-and-family-centred-care

programs were frequently cited as successful (e.g. Where the Creek Runs Clearer) and as exciting moves to address the observed resurgence of interest in "our ways", by integrating Kanien'kehá:ka culture, teachings, traditional practices, and Kanien'keha into health services and programming.

Given that the primary focus of the above-mentioned initiatives is to offer clients a traditional alternative as a complement to the "mainstream" health services offered by KMHC and KSCS, efforts to integrate culture are centred on these specific programs and reach is limited to clients who express interest or actively seek out such services. Staff from both organizations and some service users would like to see culture and language integrated more consistently and coherently across all programs and services that fall under the CHP. This objective could be best addressed if Kanien'kehá:ka culture and values are incorporated as a guiding principle of the CHP and integrated into goals and strategies across the CHP priority areas. Alternatively, culture and language could become an additional health priority under the CHP, which might help bring about desired outcomes by ensuring that a group of people is responsible for studying, developing, and monitoring the implementation of concrete actions to enhance culture and language integration. Both of these options were evoked during the stakeholder workshop; we do not see them as mutually exclusive.

Integrating culture and language into the CHP in a comprehensive yet concrete manner will require innovative thinking. Some service users felt that the CHP is currently structured in accordance with a western framework for understanding health, notably by structuring services based on western biomedical categories, and a hierarchical (or top-down) decision-making model. Reconciling these with a Kanien'kehá:ka set of values and wellness framework should not be seen as impossible, but as a challenge that will require creative thinking. The CHP is bound to a certain degree by requirements made by its funder, Health Canada. However, the community's many years of experience managing Health Transfer Agreements, the existence of Onkwata'karitáhtshera as a coordinating body, and especially, the shift toward a 10-year agreement for health funding allow for enhanced self-governance of health and social service delivery and provide an enabling context for innovation.

To feed into this process, we offer a brief overview of some of the literature on the connections between culture, language, and health. Although our intent is to share some perspectives and good practices that have emerged from different First Nations, we have tried, where possible, to address Haudenosaunee practices and contexts. With more time, further research could be conducted to draw out good practices specific to the Haudenosaunee Confederacy.

Brief Review of Literature on Culture, Language, and Health

Any discussion of health services for Aboriginal peoples in Canada should be prefaced by recognition that prior to European contact, Aboriginal communities in what is now Canada already had regionally specific, locally controlled, culturally appropriate systems of health care in place, many of them quite sophisticated.[9]

[9] Smylie, J. (2001). A guide for health professionals working with Aboriginal peoples: Aboriginal health resources. Policy Statement of the Society of Obstetricians and Gynaecologists of Canada. Journal of SOCG, March, Report No. 100. Cited: http://firstnationshealing.com/intro.html

The Indigenous frameworks of health (or wellness/wellbeing) that formed the basis for the pre-colonial health care systems referred to above tend to emphasize finding balance within the individual, family, and community. For many First Nations, this balance is represented by the Medicine Wheel teachings: wellness means maintaining a balance between the four aspects of life, Physical, Spiritual, Emotional, and Mental. Wellness can only be achieved if all four aspects are addressed; health care means caring for the *whole person*. From a Kanien'kehá:ka perspective, this corresponds to the concept of being Onkwehon:we, or a true being who lives in spirit. Health and wellbeing are connected to one's spiritual and emotional state, and the sense of empowerment that arises from recognizing the presence of the Great Spirit within oneself.[10] In English, Indigenous concepts of wellness are often categorized as *holistic* approaches to health and health care; some choose to further emphasize the importance of wholeness by adding a *w* to the word *w*holistic.

It is now widely understood that the effects of colonization have had, and continue to have, very negative consequences on the wellbeing of Indigenous Peoples across this continent. Psychologist Eduardo Duran refers to the interconnected historical traumas such as loss of self-determination, the erosion of culture, and the intergenerational trauma caused, most strikingly, by the residential school system as a *soul wounding*. To restore health in this context requires *soul healing*.[11] Relationships, between the individual, family, and community, and with the land and non-human beings are central to what it means to be Indigenous. From a Haudenosaunee perspective, the importance of these relationships is evoked in the words of the O:henton Kariwatehkwen, or thanksgiving address. Many such relationships were ruptured by the process of colonization, which has led to negative health impacts for multiple generations.[12] Culture is widely accepted as a determinant of health and its erosion to negatively affect mental wellness, causing stress and loss of sense of identity and as a result, symptoms such as depression, anxiety, substance abuse, and suicide.[13] In turn, chronic diseases may be physical manifestations of mental health imbalances[14] as well as being symptoms of socio-economic marginalization caused by colonization.

Demonstrated Links Between Culture and Whole Health

The role of culture and identity in maintaining whole health and healing soul wounds has been demonstrated by a number of studies. Chandler and Lalonde (1998) found that cultural continuity - measured by factors such as self-government, control over services, efforts to control traditional lands, and presence of cultural facilities - has a direct impact on the prevalence of youth suicide. First Nations youth suicide rates were lower in communities where measures of cultural continuity were present. Suicide rates in communities with no

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[10] Hovey, R.B., Delormier, T. and McComber, A. (2014). Social-Relational Understandings of Health and Well-Being from an Indigenous Perspective. International Journal of Indigenous Health, 10(1): 35-54.

[11] Eduardo Duran, E., Firehammer, J. and Gonzalez, J. (2008). Liberation Psychology as the Path Toward Healing Cultural Soul Wounds. Journal of Counseling & Development, 86(3): 288-295.

[12] Hovey, R.B., Delormier, T. and McComber, A. (2014).

[13] National Collaborating Centre for Aboriginal Health (2016). Culture and Language as Social Determinants of First Nations, Inuit and Métis Health. Prince George, BC: National Collaborating Centre for Aboriginal Health. Available: http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/15/NCCAH-FS-CultureLanguage-SDOH-FNMI-EN.pdf

[14] Cadet-James, Y., Whiteside, M.,& Tsey, K.– Humanities, Social Sciences and Law. (2014). *Promoting aboriginal health the family well-being empowerment approach* (1;2014; ed.). Dordrecht: Springer International Publishing.

cultural continuity were almost 140 times greater than in communities where all factors of cultural continuity were present.[15] In a later study, the authors applied the single factor of Indigenous language knowledge as an indicator of cultural continuity. They found that youth suicide rates were very low in those communities where over half the population had conversational knowledge of their Indigenous language.[16]

Language is a vehicle for transmitting cultural knowledge and values. Language loss has a negative impact on self-identity, self-esteem, empowerment, and well-being, all of which are directly linked to healthy and resilient individuals and communities. The 2008-2010 First Nations Regional Health Survey found that adults who used their language daily reported greater spiritual balance than those who did not, as did adults who took part in traditional land-based activities. Those who took part in traditional cultural activities also reported feeling more control over their lives, less depression, less substance abuse, and more physical, spiritual, emotional, and mental balance.[17] A study with Indigenous adults at risk for type 2 diabetes found that a six-month program of culture and language teachings was more effective at reducing diabetes risk factors than conventional diet and exercise teachings.[18] A study from Australia found that people reporting knowledge of Indigenous language, connection to culture, and/or living on traditional lands also reported higher levels of happiness - correlated with mental wellness - irrespective of social factors such as education, income, and employment.[19]

Integrating Culture and Health Care

In the health and social services fields, cultural competence and cultural safety are common approaches for acknowledging and integrating culture into service provision and care. Cultural competence and safety go beyond ensuring cultural awareness and cultural sensitivity among health professionals. The latter are essential starting points, but they are not enough to ensure a culturally safe environment. *Culturally competent* health care implies that service providers have the knowledge, skills, behaviours, and attitudes necessary to work in cross-cultural settings and the ability to communicate between and among cultures. *Cultural safety* requires cultural competence, but goes a step further by recognizing the unequal power relations in health service delivery and addressing these by educating service providers. Culturally safe practice implies that service providers, both Indigenous and non-Indigenous, are able to communicate with a client from a place within that client's social, political, linguistic, economic, and spiritual world. In turn,

[15] Chandler, M. J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. Transcultural Psychiatry, 35(2), 191-219.

[16] Hallett, D., Chandler, M.J. and Lalonde, C.E. (2007). Aboriginal language knowledge and youth suicide. Cognitive Development, 22: 392-399.

[17] National Collaborating Centre for Aboriginal Health (2016).

[18] McGavok, J. The link between culture and health is vital for First Nations. Toronto Star, 27 May 2016. Available: https://www.thestar.com/opinion/commentary/2016/05/27/the-link-between-culture-and-health-is-vital-for-first-nations.html

[19] Biddle, N., & Swee, H. (2012). The relationship between well-being and Indigenous land, language and culture in Australia. *Australian Geographer, 43*(3), 215.

culturally unsafe practice ensues when actions are carried out that may diminish or disempower a client's cultural identity.[20,21]

The concept of cultural safety was developed by Māori in Aotearoa (New Zealand) in the 1980's as a response to dissatisfaction with nursing care provided to Māori patients. The Tikanga Best Practice Guidelines were developed in 2004 as guiding principles for a culturally safe practice that is directly linked to Māori cultural knowledge. The Tikanga Guidelines are in turn the basis for the National Aboriginal Health Organization's guidelines for culturally safe health care for First Nations, which include elements such as ceremony, sacred items, family support, and protocols related to food, the body, and death.[22]

Overall, there is a shared sense in the literature that integrating Indigenous wellness concepts and practices with western biomedical practices is an important step toward reestablishing the balance of individual, family, and community wellness among First Nations. Culturally safe health care can lead to improved use of services and better health outcomes. Some paths to creating culturally safe and culturally appropriate health care within the existing "mainstream" health system include: combining Indigenous healing knowledge and practices with western medicine; integrating culture and language into mental health interventions; ensuring that health professionals can use the local Indigenous language; and control of health care by the community.[23] An *enmeshing training process* was proposed by three psychologists to help mental health professionals provide culturally safe care. This is characterized by an intensive cultural immersion experience that involves engaging in daily activities with Elders and other cultural experts in the community. The goal is for all service providers to have the capacity to enter into the cultural life world of the individuals and communities that they are serving.[24]

Initiatives that recognize the complementarity of Indigenous and western healing practices and that place culture at the centre of practice enable First Nations health and social services to be (w)holistic. Below, we share just a few interesting examples from First Nations across Canada. Some elements that these examples have in common are the inclusion of traditional and biomedical health practices in a shared space, the provision of an array of health and social services under one roof, and the integration of health services with other aspects of community life.

- Aboriginal Health Access Centres are found on and off reserve in Ontario. They are community-led primary health care organizations, providing a combination of primary care, traditional healing, cultural programming, health promotion, community development, and social support services.[25]

[20] National Aboriginal Health Organization (NAHO) (2008). Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators.

[21] Aboriginal Nurses Association of Canada (2009). Cultural Competence & Cultural Safety in First Nations, Inuit and Métis Nursing Education.

[22] NAHO (2008).

[23] National Collaborating Centre for Aboriginal Health (2016).

[24] Eduardo Duran, E., Firehammer, J. and Gonzalez, J. (2008).

[25] Hopkins, C. (2016). Principles of effective service delivery systems for Indigenous mental health and well-being. Presentation to Canadian Foundation for Health Care Improvement: Northern and Remote Roundtable.

- Wabano Centre for Aboriginal Health in Ottawa offers clinical healthcare and specialized programming including mental health, fitness, housing, diabetes, and maternal and infant health. Traditional teachings with Elders, drumming, singing, art, language, and ceremonies are integrated through a weekly cultural program.[26]
- In British Columbia, health services are coordinated through regional health authorities; recently, a First Nations Health Authority (FNHA) was established to oversee health services for all First Nations in the province. The FNHA has developed a framework for Indigenous health, including four wellness streams: Being Active, Eating Healthy, Nurturing Spirit, Respecting Tobacco.[27]

To these, we can add some examples specific to communities that are members of the Haudenosaunee Confederacy:

- Tsi Non:we Ionnakeratstha Ona:grahsta' is a Maternal and Child Centre of the Six Nations of the Grand River Territory. It is the result of a community decision to return the birthing process to the realm of the family by promoting Onkwehon:we midwifery care. At the Centre, full-time midwives provide care options for pregnant women and their families, including traditional and contemporary midwifery services. The Centre has a training program for Aboriginal midwives and is guided by a group of Elders who provide spiritual, cultural, and ethical direction.[28]
- The Mohawk Council of Akwesasne's Department of Health runs a Wholistic Health & Wellness service, which community members can contact if they are facing medical, physical, or mental health issues and are unsure of the options available to them. This service is meant to help connect community members with the right people and programs so that they can attain the highest level of wholistic health, while privileging a place for traditional Onkwehon:we medicine within mainstream and alternative healing methods.[29]

4.6 Health Priorities

Community Health Plan stakeholders share a preoccupation for determining whether the seven health priorities remain an accurate reflection of community needs. Indeed, this concern formed the basis of one of the questions addressed by this evaluation. The health priorities are the backbone of the CHP; they are meant to provide a structure and a guideline for designing and implementing health and social service interventions that address the real needs of the community.

In order to determine with confidence whether the health priorities accurately reflect the health needs of Kahnawa'kehró:non, we require data that provide a complete portrait of health in Kahnawá:ke. In order to

[26] National Collaborating Centre for Aboriginal Health (2016).

[27] http://www.fnha.ca

[28] http://www.snhs.ca/bcBackground.htm

[29] http://www.akwesasne.ca/content/wholistic-health-wellness

determine whether the community's health needs have changed over time (i.e. over the five years since the health priorities were identified), we require both data that paint a current picture, and data that provide a portrait of community health five years ago (a baseline). These sets of data are currently unavailable. However, it is feasible to address this question with more confidence in 2022 by making adjustments and improvements to the data gathering and analysis strategies and techniques employed by all programs and services under the CHP. It is worth noting that the First Nations Regional Health Survey, soon to be obtained by Onkwata'karitáhtshera, should serve as a good baseline for addressing changes in health priorities between the mid-term (2016) and completion (2022) phases of the current CHP.

In the meantime, many feel that because the seven health priorities were identified through a process of community consultation, they provide a true picture of the main health issues that Kahnawa'kehró:non experience in their daily lives. When looking at the health priorities identified for Community Health Plans since 1998, we mostly see continuity in the priority areas, with incremental rather than major shifts in the issues that Kahnawa'kehró:non identify as most significant. It therefore seems reasonable to maintain the current priorities as the guiding structure of the CHP, while working toward enhanced data collection and management. Coupling solid data with an in-depth community consultation should allow Onkwata'karitáhtshera to reassess the health priorities with confidence in 2022.

One exception for more immediate consideration is the absence of violence as a priority area in the current CHP. Many staff questioned the loss of this former health priority. While we do not have the data as "hard" evidence of the shared feeling that violence remains an important problem in the community, it is worth referring to the recently published *Chief Public Health Officer's Report on the State of Public Health in Canada 2016: A Focus on Family Violence in Canada*. Using statistics from 2014, this report addresses some of the trends in violence relevant to First Nations across Canada. Notably, 40% of Indigenous people reported experiencing abuse before the age of 15 years (as compared to 29% of non-Indigenous people), and 9% of Indigenous people reported experiencing unhealthy conflict, abuse, or violence committed by a spouse or common-law partner in the previous five years (as compared to 4% of non-Indigenous people). First Nations women were more likely to report experiencing severe spousal violence and more severe impacts on health than non-Indigenous women. Unlike for non-Indigenous women, spousal violence for First Nations women has not decreased over time.[30] While this report is not specific to Kahnawá:ke, it does support the argument made by staff that violence should be considered (and perhaps prioritized) when looking at the overall health and wellbeing of the community.

[30] Available online: http://www.healthycanadians.gc.ca/publications/department-ministere/state-public-health-family-violence-2016-etat-sante-publique-violence-familiale/index-eng.php?_ga=1.268342926.1290276798.1469461892#s2

4.7 Serving the Vulnerable

Reaching the most vulnerable and high-risk populations of Kahnawá:ke is a challenge faced by programs and services across the CHP priority areas. Staff note that it is often not the most disadvantaged who participate in programs and activities, and who seek out services. This dynamic was commonly reported in relation to prevention and healthy living programming for families. Parents who participate in these programs and who enroll their children in youth programming tend to belong to a segment of the community that is at lower risk and already engaged in other community activities. As a result, some programs see the same individuals participating repeatedly.

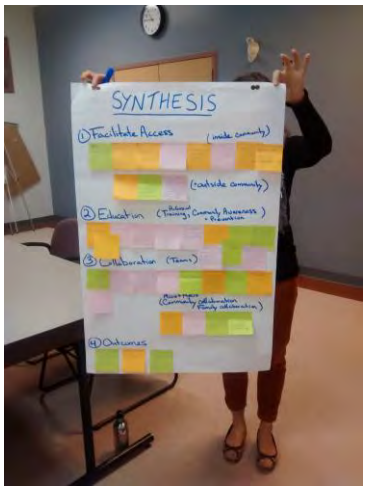

Figure 5 Key themes identified in a focus group

Reaching the most vulnerable population is a common challenge in health and social services interventions. Barriers range from unawareness of existing services and the inaccessibility of services (e.g. for those without a car), to feelings of alienation and discomfort with the established health system (e.g. fear of being judged, negative past experiences). Good practices emerging from experiences in other Indigenous contexts could help point the way to innovative approaches for resolving this issue in Kahnawá:ke.

For example, a team studying diabetes prevention among urban Māori in Aotearoa (New Zealand) suggests that providing health education and services using "conventional" approaches is often insufficient, and that greater concern should be paid to the settings in which such interventions take place. Specifically, they observed that the settings most conducive for engaging with Māori for diabetes awareness and support activities were those where they felt most relaxed and open to learning and participating, that is, in established community meeting places where they are surrounded by familiar social networks. For the Māori, this means basing interventions in the *marae*, or meeting house that is the cultural, ceremonial, and social centre of the community. Examples include health promotion days, serving healthy food, running active lifestyle activities, and declaring the *marae* a smoke-free zone.[31]

A similar study in Oklahoma (USA) emphasizes the importance of appropriate communication channels for reaching the most vulnerable. Specifically, individuals are more receptive to information when it comes through interpersonal channels among those who share similar beliefs, education, and socio-economic status. Again looking at diabetes awareness and prevention, the authors suggest that in the case of the Native population in Oklahoma, health information is best received (most trusted and best implemented) when it comes from a source within the community, in particular through community-operated media and online communication (when internet is readily available among high-risk populations).[32]

[31] Simmons, D. and Voyle, J.A. (2003). Reaching hard-to-reach, high-risk populations: piloting a health promotion and diabetes disease prevention programme on an urban marae in New Zealand. Health Promotion International, 18(1): 41-50.

[32] Veil, S.R. and Rodgers, J.E. (2010). Reaching at-risk populations: The inconsistency of communication channels among American Indian tribes and nations in Oklahoma. Public Relations Review, 36: 302-305.

4.8 Data & Information System

The need for timely, relevant, and accessible data was highlighted by almost all staff who participated in this evaluation. Staff expressed concerns over what data is collected, how it is analyzed, how it is shared, and how it can be used to inform programming and services. Indeed, many staff felt that there was insufficient data to assess the impacts of the CHP on the health priorities. While there have been improvements over the past five years, such as Kahnawá:ke's participation in the Regional Health Survey, the hiring of a Research and Systems Administrator at KSCS and an epidemiologist at KMHC, and the re-establishment of the Data Mining Working Group, there remain significant challenges with the current data management and information system.

Purpose of Data Collection

Data is currently collected in large part to fulfill reporting requirements set by Health Canada and other funders. Staff noted that much of this data is not used for more than fulfilling reporting requirements, and it is not clear that this data is useful to staff and managers. It will be key for Onkwata'karitáhtshera and the subcommittees to review the objectives for which they are collecting data. In other words, is data collected to promote CHP programs and services to the public, to inform frontline staff, to influence the decisions of managers and directors, or to fulfill funding requirements? By identifying the objective or objectives of data collection, Onkwata'karitáhtshera can better identify what data should be collected.

What Data is Collected

Once the purpose of data collection is clarified, the types of data that need to be collected must be identified. Staff noted that while a lot of data is collected for reporting requirements, much of it is not useful for informing program and service planning or delivery.

The logic model can be a useful tool for identifying what data should be collected, the frequency of data collection, and who is responsible for collection and analysis. Typically, a logic model will include inputs, activities, outputs, and immediate, intermediate, and long-term outcomes, as shown in Figure 2. Each of these elements can have indicators attached to them, which would then include a data source for that indicator, the frequency of data collection, and who is responsible for collection and analysis.

While the CHP logic models generally follow this format, it is not clear that all the data is collected as intended for each logic model. In addition, the logic models do not all include outcome or impact level indicators.

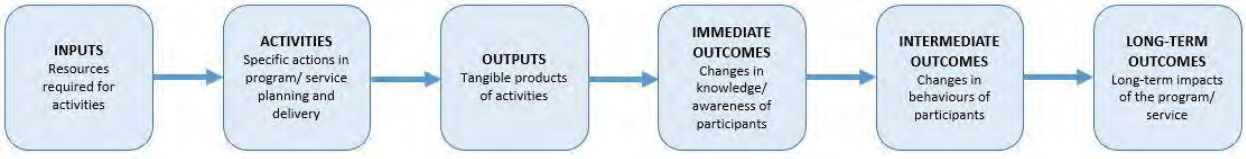

Figure 6 Simplified logic model

Data Collection and Analysis Responsibilities

Many staff noted that they did not have the resources to analyze the data themselves, and did not use the data other than for their funder-required reporting. It will be important to ensure that resources are in place to collect, store, and analyze CHP-specific data.

Data Sharing and Reporting Protocols

Finally, there is a need for continued discussion on how the different program and service areas can best share data with one another, particularly between organizations. The different *case management* and *case manager* systems for data collection used by KMHC and KSCS is an example of one of the data-sharing challenges. As the health priority programs and services are implemented by many organizations, it would be beneficial to provide some method for organizations to share information on programming and services.

Currently, there is no centralized reporting on the Community Health Plan. Rather, each organization reports on their own programming and services. While the key organizations do report on their CHP-related programs and services, they have taken different approaches to reporting on the CHP. For example, KMHC began including a CHP section in its annual report, while KSCS integrates CHP reporting into the division-specific sections of its annual report. Introducing some standardization to reporting on the CHP could improve awareness of all the activities of the CHP among staff and the community, and could facilitate the impact evaluation of the CHP in 2022.

4.9 Approach to Updating Programs and Services

Over the past five years, Onkwata'karitáhtshera has focused on addressing internal processes and structure (e.g. creating the subcommittees to improve collaboration, improving the information system). Considerable effort has been made to improve collaboration between the organizations involved in implementing the CHP, and to ensure that the CHP is a living, working document used by staff. Consequently, promoting significant changes or innovation to existing programming and services has not been a priority.

Staff noted that in some cases, programming could benefit from a more thorough review and update to the activities offered. In addition, it is apparent that while the health priorities have influenced program-specific priorities (e.g. Our Gang plans lessons to address the health priorities), the whole of programming and services has not changed significantly to respond to the health priorities. Instead of the health priorities driving decisions of what programs and services to offer, the existing programs and services have been categorized into whichever health priority was seen as a best fit. Moving forward, the subcommittees can continue to identify gaps and overlaps in their specific programs and services, and alter or develop new programming and services to address those gaps and overlaps.

In reviewing the recommendations in the following section, Onkwata'karitáhtshera could consider how to use innovative and community-specific approaches to address the recommendations and continue to build on the strengths of the Kanien'kehá:ka.

5. Recommendations

The recommendations presented in this section are part of a three-phased process. The first phase represents the core evaluation activities, which culminated with the stakeholders workshop held on October 14th, 2016. At the final stage of this workshop, the participating stakeholders together formulated a series of recommendations that we present below. We built on these stakeholder recommendations by applying our analysis to propose a set of preliminary recommendations. These recommendations were in turn discussed with Onkwata'karitáhtshera and evaluated for feasibility and benefit prior to production of the final evaluation report. See Section 2 (Methodology) for some additional details on this process. Recommendations have been prioritized based on the analysis done by the evaluation team and the results from these discussions with Onkwata'karitáhtshera.

Figure 7 Recommendations prioritization exercise with Onkwata'karitáhtshera

The second and third phases of the evaluation will provide the consultants the opportunity to deepen our understanding of the key issues that emerged during the evaluation, and to refine the recommendations accordingly. To do so, we will develop a work plan to help Onkwata'karitáhtshera and program areas address recommendations in a practical, meaningful way in their daily work (Phase 2), and will develop more in-depth recommendations for increasing CHP effectiveness over its remaining five years (Phase 3). In particular, the recommendations surrounding the information system and data gathering methods will be refined over Phase 2 and Phase 3, and at this stage, should be considered preliminary.

By building a set of practicable recommendations in close collaboration with Onkwata'karitáhtshera and relevant CHP stakeholders, we aim to maximize the effectiveness and feasibility of our recommendations while building evaluation capacity within Onkwata'karitáhtshera and the CHP program areas.

5.1 Stakeholder Recommendations

The following list of recommendations was formulated collectively by the CHP stakeholders who participated in the stakeholder workshop held by Niska on October 14th, 2016. The list represents keywords that identify the main areas for which recommendations are needed. They are based on more in-depth recommendations developed by workshop participants, the content of which we integrated into our emerging recommendations (Section 5.2).

1. Data
2. Community Engagement
3. Our Ways: Language & Culture (Tsiniionkwaritho:ten)
4. Client- and Family-Centred Care (Full Spectrum)
5. Collaboration Challenges
6. Focus on High Risk & Most Vulnerable
7. Collaborative Planning
8. Community Wellness Plan (CWP)
9. CHP as Tool & Resource
10. Communications

5.2 Evaluator Recommendations

The recommendations were drafted and shared with the executive committee and secretariat of Onkwata'karitáhtshera. They categorized each recommendation according to the level of contribution (impact) that its implementation would have on CHP activities and outcomes (high-medium-low), and the feasibility of implementing that recommendation (high-medium-low). They also rated each recommendation strategy on scale of one to five (5 = excellent strategy, 1 = poor strategy).

The recommendations are presented based on this ranking exercise. Note that no recommendations were identified as having a low contribution.

HIGHEST PRIORITY RECOMMENDATIONS

The following recommendations were identified as having both a high contribution (implementing the recommendation would have a significant impact on the activities and outcomes of the CHP) and a high feasibility (it would be feasible to implement within the next five years). These recommendations should be considered as a top priority for Onkwata'karitáhtshera over the next five years.

Data

1. We recommend that Onkwata'karitáhtshera identify the data needs for the CHP in the upcoming years. This includes identifying what data is required by funders, as well as what outcome-type data is needed to contribute to the impact evaluation in 2022. *(Findings 3.3.1., 3.4.1., 3.5.1., 3.5.2., 3.5.3.)*

Key strategies for implementing this recommendation could include:

a. Completing a gaps and overlaps assessment on all CHP-related data sources (i.e. identify what data isn't being collected that should be, and what data is being collected by multiple sources);
b. Standardize data collection procedures for CHP-related activities to ensure that all areas are collecting data on CHP activities and outcomes in a similar way;
c. Develop a centralized database that identifies all indicators and their data source.

2. We recommend that Onkwata'karitáhtshera develop a data-sharing protocol to identify what data can be shared, how it can be shared, and any other logistical considerations. The purpose of this protocol would be to better facilitate data-sharing between organizations while respecting client confidentiality. *(Findings 3.4.2., 3.5.2., 3.5.4.)*

Key strategies to implement this recommendation could include:

a. Establish a working group with representatives from the key partner organizations;
b. Identify what data should be shared, based on the data needs identified in the logic models;
c. Identify barriers to sharing data and strategies for addressing these barriers, while promoting and adhering to OCAP principles.

Collaboration

3. We recommend that KSCS and KMHC continue working to enhance the client experience and to **ensure that a full continuum of care is available and accessible for all Kahnawa'kehró:non, by making** incremental improvements to inter-organizational coordination and collaboration. *(Findings 3.2.3., 3.2.4., 3.2.5., 3.4.2.)*

Such a process might include:

a. Promoting the use of a client- and family-centered approach across all programming and services, with an initial focus on working together to reach a shared definition of Client- and Family-Centred Care and core strategies to ensure its implementation;
b. Identifying new opportunities for collaboration between organizations offering CHP activities and services;
c. Ensuring that all subcommittees have identified gaps and overlaps in their programs and services, and are applying this analysis to inform decision-making.

Communication and Engagement

4. We recommend that Onkwata'karitáhtshera continue to promote the CHP as a practical tool and resource for staff. Building on its success at making the current CHP a living document, **Onkwata'karitáhtshera should continue to promote the CHP as a guide for programs and services.** *(Findings 3.4.3., 3.5.3.)*

Key strategies that can be used to implement this recommendation over the next five years include:

a. Develop strategies to promote the CHP among frontline staff, who are currently less aware of the CHP than managers;
b. Establish guidelines for how managers and directors can use the CHP to inform their programming and services, with a special emphasis on planning and adjusting the program and service offer in accordance with the CHP health priority goals and strategies;
c. Promote the use of innovation among staff to better address the health priorities, for example, by adding innovation as a criterion for evaluating future requests for program funding.

HIGH PRIORITY RECOMMENDATIONS

Recommendations 5 through 7 were identified as having a high contribution (implementing the recommendation would have a significant impact on the activities and outcomes of the CHP) and a medium feasibility (it would be somewhat feasible to implement within the next five years), while Recommendation 8 was identified as having a medium contribution (implementing the recommendation would have an impact on the activities and outcomes of the CHP) and a high feasibility (it would be feasible to implement within the next five years). These recommendations should be considered a priority for Onkwata'karitáhtshera over the next five years.

Data

5. We recommend that the four subcommittees update their logic models to include process and impact indicators and their associated data sources. Subcommittees should identify key outcome indicators that can be measured over the next five years. *(Findings 3.3.1., 3.4.1., 3.5.1., 3.5.3.)*

Key strategies for implementing this recommendation could include:

a. Offering training to staff on how to develop and maintain logic models for evaluation purposes;
b. Identifying the individuals responsible for coordinating the regular reporting of CHP indicators;
c. Incorporating logic model reviews into meeting agendas on a regular basis (e.g. once per quarter).

Collaboration

6. We recommend that Onkwata'karitáhtshera consider implementing regular community-wide collaborative planning sessions with KSCS, KMHC, and other key stakeholders (e.g. Peacekeepers, Mohawk Council of Kahnawá:ke, Kahnawá:ke Fire Brigade, schools) to encourage collective decision-making and prioritization. *(Findings 3.2.5., 3.4.2.)*

Onkwata'karitáhtshera might take the following steps:

a. Identify partner organizations and stakeholders to be included in collaborative planning;
b. Develop a strategy for collaborative planning (e.g. developing a CHP strategic plan, annual planning meetings);

c. Introduce opportunities for team-building and collaborative work within the subcommittees (e.g. team-building exercises, team-based subcommittee projects) and with all CHP stakeholders (e.g. an annual workshop to inform and monitor progress, similar to this evaluation's stakeholder workshop).

Culture and Language

7. We recommend that Onkwata'karitáhtshera build on successful culturally-based health initiatives at KMHC and KSCS by seeking innovative ways to integrate Kanien'kehá:ka culture and language across all health priorities of the CHP. *(Findings 3.2.5., 3.3.2., 3.4.4.)*

To do so, Onkwata'karitáhtshera could consider one or both of these options:

a. Incorporate Kanien'kehá:ka culture and values as a guiding principle of the CHP, shared by all health priority areas and integrated into each of their goals and strategies, and aligned with the Kahnawá:ke Shared Vision Statement;
b. Create a Culture & Language health priority area for the remaining five years of the current CHP, comprised of CHP stakeholders engaged in culturally-based programming and community Elders and cultural experts. The Culture & Language health priority committee would be responsible for studying, developing, and monitoring the implementation of strategies and actions to integrate Kanien'kehá:ka culture and Kanien'keha across all programs and services under the CHP.

As part of the process recommended above, Onkwata'karitáhtshera might explore:

c. Working with community cultural organizations to develop a Cultural Safety Guideline for health and social services in Kahnawá:ke, to be adopted by KSCS and KMHC. The National Aboriginal Health Organization's Guidelines for Practicing Cultural Safety could provide a good base, which could be adapted to the Kanien'kehá:ka context;
d. Considering changing the name of the CHP to "Community Wellness Plan" to better reflect a Kanien'kehá:ka understanding of holistic wellness;
e. Conducting further research on Haudenosaunee culture and how Haudenosaunee ways could be best integrated into programs and services while respecting the diverse needs of community members.

Communication and Engagement

8. We recommend increasing the frequency and accessibility of communications about the CHP and CHP-**related programs, services, and activities to the community. Onkwata'karitáhtsher**a could consider developing a simple communication strategy to guide communication efforts over the coming five years. *(Findings 3.2.2., 3.2.3., 3.4.3.)*

Key elements of this strategy might include:

a. Creating a social media strategy for continuous and regular communication with Kahnawa'kehró:non;
b. Harnessing multiple platforms across the community (e.g. community radio and television) and techniques for targeting all age groups;

c. Developing a simple, plain language summary of the CHP, its importance to the community, and its health priority areas, including a visual representation (simple diagram), for dissemination online (KSCS, KMHC, and other community websites), in print, and on social media.
d. Ensuring that regular reporting on the CHP is shared with key stakeholders, for example, through annual meetings.

Medium Priority Recommendations

The following recommendations were identified as having a medium contribution (implementing the recommendation would have an impact on the activities and outcomes of the CHP) and a medium feasibility (it would be somewhat feasible to implement them in the next five years). These recommendations should be addressed to the extent possible over the next five years.

Health Priorities

9. We recommend maintaining the seven health priorities identified through community consultation prior to 2012, while working to obtain and gather the data needed to assess the accuracy of the health priorities and update them accordingly in 2022. However, special consideration should be given to studying the possibility of reinstating Violence as a health priority. *(Findings 3.3.1, 3.3.2., 3.4.1.)*

During the period from 2017-2022, Onkwata'karitáhtshera could:

a. Focus data mining efforts on obtaining data specific to the prevalence of violence in Kahnawá:ke, as well as other health priority areas under question (e.g. Obesity);
b. Develop a violence working group or other mechanism within the Mental Wellness and Addictions subcommittee, to assess whether and how to ensure that concrete actions are taken to address the issue of violence within the community;
c. Develop a strategy to consult Kahnawa'kehró:non on their perceptions of the presence of forms of violence in their lives and in the community, with a strong focus on strategies to engage high-risk segments of the population in the consultation.

Communication and Engagement

10. We recommend continuing to engage Kahnawa'kehró:non in dialogue, on a sustained basis, about CHP implementation and priorities, programs, and services. As much as possible, community members should be involved in assessing the progress of the CHP priority areas and providing input for decision-making. *(Findings 3.2.2., 3.2.3., 3.2.5., 3.4.3., 3.4.4.)*

This could be accomplished by:

a. Increasing the number of service users who sit on the subcommittees, and bringing back the presence of Elders who serve in an advisory role to Onkwata'karitáhtshera;
b. Holding periodic focus groups or discussion circles to consult with and seek guidance from community members on CHP-related issues and progress;

c. Identifying methods for integrating ongoing user feedback (e.g. feedback forms) for CHP activities and services;
d. Developing a strategy for engaging community members to participate in the above-mentioned processes, including a strategy for reaching out to the most vulnerable sectors of the community.

11. We recommend developing a strategy to better support programs in reaching the most vulnerable, with the objective of increasing participation in programs and use of services by high-risk segments of the Kahnawá:ke population. Further research into good practices for reaching vulnerable populations would be helpful, in particular those practices that are best adapted to a First Nations context. *(Findings 3.2.3., 3.2.4., 3.2.5., 3.4.1.)*

Elements of an innovative approach might include:

a. Supporting programs to bring outreach and prevention activities to the spaces within the community used by vulnerable populations and to gathering spaces where high-risk individuals feel comfortable and surrounded by like-minded individuals;
b. Promoting healthy lifestyles and awareness of programs and services on media regularly used by high-risk populations (e.g. community radio and television, Facebook);
c. Conducting research to identify public health strategies for reaching vulnerable populations that Onkwata'karitáhtshera and CHP stakeholders could incorporate into their policies and procedures.

Low Priority Recommendations

The following recommendation was identified as having a high contribution (implementing the recommendation would have a significant impact on the activities and outcomes of the CHP) but a low feasibility (it would not be particularly feasible to implement within the next five years). This recommendation should not be given high priority over the next five years, but should still be considered.

12. We recommend that Onkwata'karitáhtshera produce a regular report on the Community Health Plan, including summaries of activities related to the health priorities and integrating data from all organizations involved in delivering programs and activities under the CHP. This document could be used to promote the CHP and raise awareness among staff, partner organizations, and the wider community. *(Findings 3.2.2., 3.4.3., 3.5.1., 3.5.2, 3.5.4.)*

Key strategies to implement this recommendation include:

a. Identify the individuals responsible for coordinating the preparation and the distribution of the report;
b. Select the frequency and format of the report (e.g. quarterly newsletter, annual report).

6. Appendices

6.1 Timeline

At the stakeholder workshop held near the end of the data collection and analysis phase of this evaluation, Community Health Plan stakeholders were invited to identify key milestones related to the CHP that have occurred since 1990. The resulting timeline presents a collectively crafted overview of the CHP's evolution and of the milestone events that define it. While it is not comprehensive, it provides a snapshot on the perceived major milestones related to the CHP over the past 26 years.

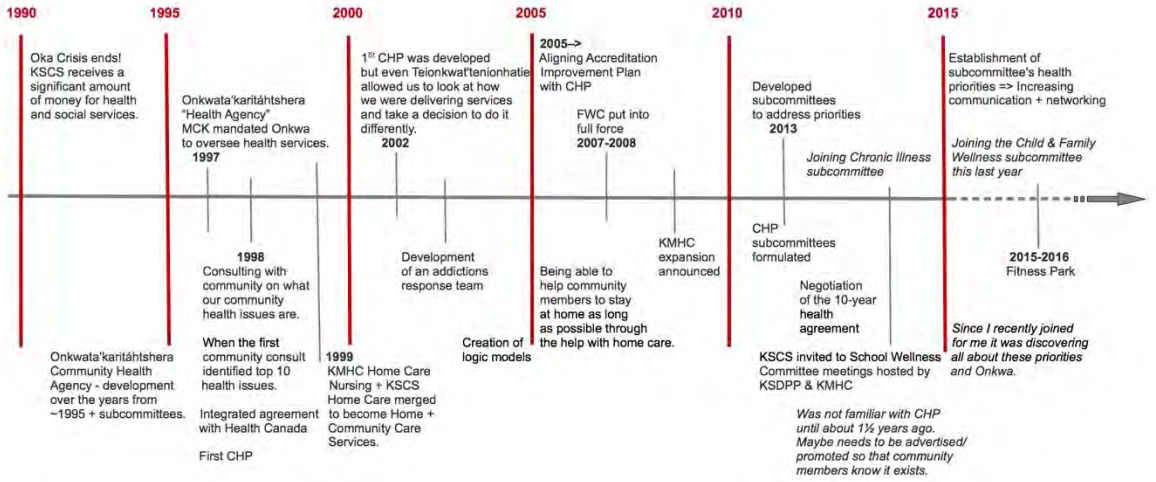

Figure 8 CHP timeline exercise results

6.2 Evaluation Matrix

The evaluation matrix summarizes the evaluation questions and sub questions indicators of success, and appropriate data sources and data collection methods. The evaluation matrix has the following headings:

Evaluation Question: The five evaluation questions that have been outlined in the 2012 evaluation plan.

Evaluation Sub Question: specific questions that fall under the theme of each evaluation question.

Indicator: The indicator seeks the measure results and to provide evidence to answer the evaluation sub question. For all indicators, we are seeking to measure the change between 2012 and 2016.

Data Source: The data source identifies the individuals, organizations, documents, or reports from which the data will be obtained.

Collection Method: This lists the methods and/or techniques that will be used to gather the data used to address the indicator.

Analysis: This column explains how the data will be analyzed.

Responsibility & Timing: This column explains who is responsible for the data collection, and the timeframe in which they are expected to do it.

Table 6 Evaluation Matrix

Evaluation Question	Evaluation Sub Question	Indicator	Data Source	Collection Method	Analysis	Responsibility and Timing
1. Did the activities listed in the Community Health Plan take place?	1.a to what extent have the organizational needs (global needs, health service needs, infrastructure needs) been addressed as outlined in the CHP?	1.a % of identified organizational needs that have been addressed	1.a internal records and interviews	1.a records to be provided by Onkwata'karitáhtshera, interviews to be conducted with relevant Onkwata'karitáhtshera staff	1.a quantitative and qualitative analysis to identify the extent to which the activities in each priority were completed	1.a Onkwata'karitáhtshera will provide the internal records on an ongoing basis. The consultants will conduct these interviews in September 2016
	1.b to what extent have the activities listed in each logic model been completed, per priority	1.b % of activities in each logic model completed	1.b internal records and interviews with project managers	1.b records to be provided by Onkwata'karitáhtshera, interviews to be conducted with at least one project manager per CHP priority area	1.b quantitative and qualitative analysis to identify the extent to which the activities in each priority were completed	1.b Onkwata'karitáhtshera will provide the internal records on an ongoing basis. The consultants will conduct these interviews in September 2016
	1.c. what have been the factors that have affected the extent to which the activities listed in the CHP took place?	1.c reported factors that have effected the extent to which the activities listed in the CHP took place, by CHP priority area	1.c interviews with project managers	1.c interviews with at least one project manager per CHP priority area	1.c qualitative analysis to provide context to the quantitative data	1.c the consultants will conduct these interviews in September 2016

Evaluation Question	Evaluation Sub Question	Indicator	Data Source	Collection Method	Analysis	Responsibility and Timing
	1.d what activities took place that are not included in the CHP?	1.d reported activities that occurred that are not in the CHP	1.d internal records and interviews with project managers	1.d records to be provided by Onkwata'karitáhtshera, interviews to be conducted with at least one project manager per CHP priority area	1.d quantitative and qualitative analysis to identify the extent to which other activities took place	1.d Onkwata'karitáhtshera will provide the internal records on an ongoing basis. The consultants will conduct these interviews in September 2016
2. Did participants benefit from the programs & services provided?	2.a To what extent were the target groups involved in the programs & services for each health priority area?	2.a # of participants from each target group per program & service for each health priority area, per year.	2.a internal records	2.a records to be provided by Onawa	2.a quantitative analysis of records	2.a Onkwata'karitáhtshera will provide the internal records on an ongoing basis.
		2.a reported access of target groups to the programs & services for each health priority area	2.a project managers	2.a interviews with at least one project manager per CHP priority area	2.a qualitative analysis to assess the extent to which each target group was accessing the programs & services	2.a the consultants will conduct these interviews in September 2016
	2.b To what extent did the participants feel that they benefitted from the programs & services	2.b reported benefits of each target group from the programs & services by priority area	2.b participants, per priority area	2.b focus groups with participants per priority area	2.b qualitative analysis of findings from focus groups	2.b the consultants with lead these focus groups in September 2016

Evaluation Question	Evaluation Sub Question	Indicator	Data Source	Collection Method	Analysis	Responsibility and Timing
	for each priority area?					
	2.c To what extent did program & service staff observe benefits for the different target groups for each priority area?	2.c reported benefits experienced by the participants of each target group by priority area	2.c project managers	2.c interviews with at least one project manager per CHP priority area	2.c qualitative analysis to assess the identified benefits experienced by participants	2.c the consultants will conduct the interviews in September 2016
3. Are the priority health needs and problems the same or have they changed?	3.a. to what extent to the priority health needs and problems reflect the current data?	3.a % of priority health needs and problems that are also identified as high need in the most recent data	3.a Regional Health Survey, other internal records	3.a Onkwata'karitáhtshera will provide all relevant records and data (e.g. data from regional health survey)	3.a quantitative analysis of the data, with some qualitative analysis as necessary. Where possible, we will compare findings from the Regional Health survey with health data from 2012	3.a Onkwata'karitáhtshera will provide these records as they become available.

Evaluation Question	Evaluation Sub Question	Indicator	Data Source	Collection Method	Analysis	Responsibility and Timing
	3.b What are the top priority health needs and problems currently facing Kahnawá:ke identified by program participants, program staff and stakeholders?	3.b % of priority health needs and problems in the CHP that are identified by program participants and stakeholders as current top priority health needs and problems	3.b program participants and stakeholders	3.b prioritization exercise during a CHP stakeholders workshop	3.b participatory analysis of the top priorities during the workshop	3.b The consultants will conduct the workshop in October 2016
	3.c How have the top priority health needs and problems changed in the past five years?	3.c % of health priorities that have remained the same, ways in which the top priority health needs and problems have changed	3.c program participants and stakeholders, 2010 Evaluation Report	3.c prioritization exercise during community workshop	3.c compare the findings from this evaluation with the 2010 Evaluation Report	3.c The consultants will conduct the workshop in October 2016
4. What was the impact of the CHP to the health priorities identified	4.a. What trends/changes are seen in the data on the health indicators relevant to the CHP?	4.a % change in health indicators	4.a. internal records – Regional Health Survey, Annual reports, Community-Based	4.a Onkwata'karitáhtshera to provide internal records	4.a quantitative analysis of data trends among each health indicator, per priority area	4.a Onkwata'karitáhtshera to provide records as they are available

Evaluation Question	Evaluation Sub Question	Indicator	Data Source	Collection Method	Analysis	Responsibility and Timing
in the last evaluation?			Reporting Templates			
	4.b To what extent have the impacts from the priority area logic models been achieved?	4.b % of health impacts identified the logic model that have seen change	4.b internal records– Annual reports, Community-Based Reporting Templates	4.b Onkwata'karitáhtshera to provide internal records	4.b quantitative and qualitative analysis of reported health impacts per priority area	4.b Onkwata'karitáhtshera to provide records as they are available
	4.c What are seen as the major impacts of the CHP to the health priorities by program staff, participants and stakeholders?	4.c # and type of impacts of the CHP to the health priorities, by priority	4.c staff, participants and stakeholders	4.c interviews with staff and focus groups with with participants per priority area	4.c qualitative analysis of major themes around the impacts seen	4.c the external consultants will conduct the interviews and focus groups in September 2016
5. Is the current information system and data gathering methods sufficient	5.a How many of the indicators in the logic model have had data collected, per priority area	5.a % of indicators that have had data collected, per priority area	5.a internal records	5.a Onkwata'karitáhtshera will provide internal records	5.b quantitative analysis to identify the % of indicators that have data available, per priority area	5.b Onkwata'karitáhtshera will provide the internal records on an ongoing basis

Evaluation Question	Evaluation Sub Question	Indicator	Data Source	Collection Method	Analysis	Responsibility and Timing
to meet the data needs to inform the summative evaluation and annual review process?	5.b What are the information system and data gathering needs identified by program staff?	5.b # and type of information system and data gathering needs identified by program staff, per priority area	5.b staff	5.b interviews with relevant program staff (e.g. data management staff)	5.b quantitative analysis of the frequency of which information system and data gathering needs are identified. Qualitative analysis to identify emerging themes.	5.b the external consultants will conduct interviews with relevant staff in September 2016

6.3 Organizational Needs

The following table provides a summary on the progress made in addressing the organizational needs identified in the CHP. It includes a summary of the extent to which the needs have been met, along with any relevant comments. This table was updated by senior staff involved in addressing the organizational needs.

Table 7 Update on organizational needs

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
GLOBAL NEED (TO SUPPORT ALL OTHER HEALTH NEEDS)					

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
Staffing & Human Resources	3 to 4 staff positions to support the overall administrative and coordination support to Onkwata'karitáhtshera through the operation of a Secretariat. Onkwata'karitáhtshera Secretariat would be responsible to ensure health priorities are achieved. Some initial responsibilities identified for these positions include but are not limited to: -Developing strategic frameworks for each of the health priorities (major goals) by bringing stakeholders together (including federal and provincial representatives) -Assist Onkwata'karitáhtshera table with planning (conducting action research). -Research both internally and externally to assist Onkwata'karitáhtshera with decision making, and to create briefs on the research conducted. -Oversee files for the various subcommittees and assist with decision making.	$275,000 annually	Yes	Achieved except that Onkwata'karitáhtshera is responsible for addressing the priorities, not the secretariat;	Assisted in developing frameworks for each health priority; assisted in Onkwata'karitáhtshera with planning; assisted in brief preparation; oversaw files. Will need to look at what other staff is recommended (e.g. data)

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
Operations	Includes space rental, utilities, equipment and supplies.	$25,000 annually	Yes	Achieved	
HEALTH SERVICE NEEDS (ENHANCEMENTS TO EXISTING SERVICES)					
Integration of mental health programs/services	Mental health programs and services are offered through both KSCS and KMHC. An integration of the two would improve collaboration/quality of service by utilizing the successful Home and Community Care integration approach e.g. case management and personnel in one locale.	To be determined	Somewhat	This is being address in the Mental Wellness and Addiction sub-committee We are at the buy in phase.	This is ongoing and making progress. The challenge is the integration of services.
Nutritionist dedicated to community initiatives	In light of Obesity identified as a new health priority, the workload and demand for community nutrition services will increase creating the need for an additional nutritionist at KMHC on a part time (4 day) basis. A nutritionist was hired in 1988, with the specific objective of introducing nutrition education to the schools. Since 2000, the community has benefited from the services of an additional nutritionist who has been funded on a yearly basis through ADI (Aboriginal Diabetes Initiative). The objectives in community nutrition are to create	$78,326 annually	Yes	This program was done; it was funded by ADI funding.	We need to find the funding to ensure this can become an operational program.

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	healthy eating environments for children at school, at home and in the community; and to serve as a nutrition resource and support community efforts to promote a healthy lifestyle and reduce the top health problems in the community. Nutrition education is promoted in the community through health and nutrition events, presentations to community groups, and nutrition classes and activities in the schools. The community nutritionist is also a resource for schoolteachers and community organizations, and develops and implements nutrition projects and programs.				
Clinical Psychologist	The addition of 1 full-time Psychologist at KSCS is needed to address the health priority need of mental health issues. Currently there is no psychologist in place to facilitate or manage overall psychological cases i.e. to ensure there is a comprehensive strategy in place to	$70,470 annually	Yes	Achieved in year 5 of the health plan; we did contract a psychologist in the interim.	Need to maintain staffing support for the position so we do not result in a similar situation.

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	efficiently coordinate services. In 2010-2011 there was a 27% increase (165→210) from the previous year (2009-2010) in psychological services. The top problem issues consistently identified were behavioural, depression, parental capacity and anxiety.				
Addictions Clinical Supervisor	The addition of 1 full-time Addictions Clinical Supervisor at KSCS is needed to solidify the existing Addictions Response team and deal with increasing mental health issues which, in most cases, identifying dual diagnosis. Addictions has been identified as the number one health related problem in our community for many years, and more recently highlighted as the number one health related problem in the last 2 Community Health Plans. When analyzing the ARS team's combined workload, we must take into account both on-going cases they have been providing service to, as well as new cases within the current fiscal year. The following data is	$88,349 annually	Yes	Achieved	Going well, but the position's role could also be expanded to include supervision of other areas (e.g. elder's caseworker, ALS caseworker)

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	reflective of 11 months of service (does not reflect any new cases for the month of March 2011). -a total of 130 different requests for addictions response service within fiscal year 2010-2011, with 74 clients being newly assigned in that year, this works out to an average of 32.5 cases per worker -age range of clients varied between 13 years old to 67 years old. -of these 130 clients, 84 clients (65%) had alcohol as their primary drug of choice and 55 clients (42%) had cocaine as either their primary or secondary drug of choice. This indicates that many clients do not present with a single substance addiction, which can complicate detoxification, treatment and/or follow-up. -of the 130 clients, 61 (47%) have a known or suspected concurrent mental health disorder. With almost half the clients in the past year with a known or suspected mental health disorder, this definitely complicates the detoxification, treatment or follow-up process, but also demands an increase in time and resources to effectively create change. KSCS' approach to address addictions problems within the community is multitiered, multi-disciplined				

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	and involves both prevention activities and intervention activities. The current team that provides direct intervention services to clients requesting support for addictions recovery is comprised of 4 Addictions Response Services (ARS) Workers. A consultant was contracted in the past to work with this team and had been instrumental in the following areas; developing the capacity of the individual ARS staff members, raising awareness of addictions recovery techniques and issues for all of KSCS and providing quality direct clinical supervision. However, it has been identified that there is the need to have a full time Addictions Supervisor in place. Given how far the services have advanced and its successes along with the steady number of requests for services, an Addictions Supervisor in place to continue the work that the consultant had started would be the best option.				
Mental Health Nurse	The addition of 1 full-time mental health nurse is needed considering the rapid increase in the number of intakes by mental health nursing since 2006. This position would be full time, including replacement costs. There has been an overwhelming 240%	$102,803 annually	No	This was not met, no funding.	Still a need. The challenge is funding for this positon.

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	increase in intakes from 2006 to 2011 for clients that require a mental health nurse in their care. The numbers of referrals are as follows: 2006: 1 2007: 3 2008: 3 2009: 14 2010: 18 2011: 24 in a 6 month period.				
Volunteer Coordinator	There is an increasing need for volunteers to assist community health programs such as providing support/escort services to community members (for example, home care clientele) to medical appointments in/outside of the community. The cost involved would be the increase from a part time to a full time position. Presently working part time (2 days per week) does not give enough time to effectively organize volunteers. Volunteers also need support and supervision with the volunteer coordinator present. From 2005-2006 (558.25 hours) to the present 2011 (2210.1 hours), there has been a 34% increase in volunteer hours (1,652 hours).	$39,307 annually	?		

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
Physician Recruitment and Retention Strategy	The physician incentive fund needs an increase of 38% or $64,600 annually. This strategy/fund was established in 2005-2006 as KMHC was experiencing great difficulty in recruiting and retaining physicians; this problem was attributed to the overall shortage of physicians allowed to work in the Province and the inferior billing rates a physician receives in a hospital out patient clinic such as KMHC versus private practice. As far back as 2005, KMHC has had to decrease the number of evening clinics and day clinics were also understaffed with at least one morning per week without a physician which continues today. This situation plays havoc with access to and continuity of care for community members, especially those with chronic illness. To turn things around, the community implemented the physician incentive fund of $170,000 annually and provided physicians financial incentives based on each physician's commitment to work in the community. The fund amount has remained the same since 2005. KMHC is proposing increased funding based on inflation and the fact that the strategy has been successful. Looking back, KMHC has experienced retention of 5 of the 11 physicians	$64,600 annually	Somewhat	We were not successful in accessing increased dollars for this purpose in the 10-year health agreement. We were, however, able to implement an annual increase to the $170K fund which is equal to the annual cost of living salary increases that are attributed to other hospital centre employees. Of course, this is dependent on receiving annual increases via the health agreement.	

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	present in 2005 and were able to retain 5 of the 8 physicians recruited since then. The full benefits of this strategy were somewhat mitigated by the fact that we had six overlapping maternity leaves, 4 out of 6 of these physicians were back as of September 2011.				
Strategic Community Health Careers Program	With the upcoming expansion of KMHC, there will be a significant increase in the demand for nurses and other health-care workers in Kahnawá:ke. There is a nationwide shortage of nurses and other health professionals and Kahnawá:ke is not immune. To meet this challenge, the Kahnawá:ke Education Center, Tewatohnhi'saktha Employment & Training Division and KMHC formed a partnership with the goal of strengthening our health care workforce. Strategic Community Health Careers (SCHC) was initiated in September 2010 to maximize the opportunities presented by existing and expanding health careers in the community. Through this collaboration, SCHC is being pro-active in promoting health career awareness to students at both the high school and elementary levels, and in providing academic and financial support to post-secondary	$40,000 annually	Somewhat	We were not successful in accessing increased dollars for this initiative in the 10-year health agreement. We did, however, continue the SCHC strategy with the dollars on hand. This continued until funding ran out and the other partner organizations could no longer contribute financially. Despite this development,	

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	students in health career programs. To recruit students and provide support in their academic endeavours, SCHC has been working closely with Champlain College, St-Lambert, which has a new Nursing Program starting this Fall, and preparatory courses were offered at Kahnawá:ke Survival School (KSS), through John Abbott College, to give prospective students an opportunity to upgrade academically and ensure they have the credits needed to enter Nursing or other health programs. Tutoring was provided as needed. Eight of these students have been accepted into Champlain's Nursing Program. Other program events included setting up an information booth on the project at the 2011 KSS Career Fair and upcoming presentations are planned for high school students at the Kahnawá:ke Library and KSS, as well as an interactive display for younger students at the Kahnawá:ke Youth Center. SCHC will continue to provide important information to the community, encourage students, and support their efforts as they venture into their studies and training that will prepare them to be part of a vital health care force. Plans are also underway to offer scholarships to			networking between organizations to promote health careers continues.	

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	students enrolled in health career programs. Given the above, we want to continue with this valuable partnership; to also involve KSCS and to include the promotion of the social work profession. As well, provide financial support for the program for at least the next five years; i.e. $40,000 annually.				
Preconception Health Program	Enhancement is needed to the KMHC Preconception Health Program with a parttime 1 day/week community health nurse and overhead costs. The missing aspect of care is individual counselling. With the promotion of preconception health, messages would include a contact at KMHC for any questions or concerns. Physicians would be encouraged to refer anyone needing counselling.	$20,044 annually	Yes	We were able to move forward on preconception health program, prenatal clinic nurse and well baby clinic enhancement. We obtain funding for an additional nurse within our Community Health unit to move this programs forward.	We are very pleased to move this programs forward.
Prenatal Clinic Nurse	An increase from 1 day/week to 2 days/week is needed for the prenatal clinic nurse. KMHC presently has a physician that delivers at Centre Hospitalier Anna-Laberge (CHAL) which is the nearest hospital to Kahnawá:ke that delivers babies. Previously, KMHC clients would see physicians in Chateauguay that delivered at CHAL. Last year, a KMHC physician did 254 (65.8% of all prenatal visits done at KMHC) prenatal visits. So far this year, in 7 months, she has	$20,044 annually	Yes		

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	done 230 prenatal visits. KMHC also has two other physicians who see prenatal clients. To improve health outcomes for all moms and babies who come for prenatal appointments, KMHC wants all prenatal clients to be able to see a specialized prenatal nurse.				
Well Baby Clinic Enhancement	Increased accessibility to the Well Baby Clinic by 1 day/week is needed; this clinic is presently offered 3 days/week. KMHC is experiencing a notable increase in the number of babies that are being delivered by physicians who also work at KMHC. This has resulted in an increased number of families bringing their newborns for follow-up care at the KMHC Well Baby Clinic (WBC). For example, in 2004-2005 there were 798 WBC visits and in 2009-2010 there were 938 visits, it is becoming increasingly difficult to provide timely appointments with the present level of service. This is especially important for the 1 month visits that would have been followed up with the physician that delivered the baby (previously in Chateauguay).	$20,044 annually	Yes		
Diabetic Foot Clinic	There is a need to institute a permanent Diabetic Foot Clinic that would operate 2 days per week. The costs would include salary & overhead. This clinic	$40,088 annually	Yes	This year we were able to secure funding to make	We are very pleased that we were able to made Diabetic Foot Clinic permanent.

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	started as a project with Aboriginal Diabetes Initiative Funding due to non-insured health benefits cutbacks in podiatry. From 2009-2010 to 2010-2011, there has been a 38% increase (39 to 54) in the number of clinics held, a 32% increase (124 to 164) in the number of patients receiving care and a 40% increase (316 to 444) in the total number of visits.			Diabetic Foot Clinic operational.	
French Language training	Intensive French Language Training is critical and necessary for Kahnawá:ke organizations under Onkwata'karitáhtshera. The primary languages used in Kahnawá:ke are historically Kanien'keha (Mohawk language) and English, while the community is surrounded primarily by the French language. Kahnawá:ke as an English speaking First Nations community in Quebec is faced with a major challenge to participate as a full partner with the provincial health and social services system. Senior management is expected to interface with their provincial counterparts and stay abreast with health issues within the province. As the majority of the existing health forums are presented primarily in French, Kahnawá:ke managers have been marginalized in the past. The same holds true for any	$46,380 (for 6 people). Replacement salary costs to be determined	No	Not achieved nor worked on yet.	

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	legislation impacting health and social services. The law is presented bilingually; however, all supporting and resource documents are in French only. This creates service delivery limitations as was demonstrated in the Pandemic Response and Planning. The Kahnawá:ke Aboriginal Health Transition Fund Evaluation Report 2011 reinforced this finding and recommended increasing Manager/Director fluency in the French language through access to French language training as a means to combat this issue. It is our understanding that an employee of the provincial and federal government could be mandated to attend an intensive language course for which they would be required to take a leave of absence from their full time position. The French Language training would be best suited for staff positions under the umbrella of Onkwata'karitáhtshera and its member organizations, targeting upper management. In addition to compensating a staff member while attending full time training there would be the supplementary financial cost of backfilling these positions.				

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	Any language training should be staggered over several years by sending one senior manager to attend training at a time and then waiting a year before sending another to training. McGill University School of Continuing Studies offers a full time Intensive French Language program comprised of five levels which upon completion a successful student will receive a Certificate of Proficiency in French. The cost of the program for all five levels and application fee is $ 7,730.00 per person x 6 people for a total of $46,380.00.				
INFRASTRUCTURE NEEDS (INFORMATION SYSTEMS & TECHNOLOGY)					
Electronic health records (Logibec for health systems)	The introduction of an electronic health record (EHR) system within KMHC, as well as the teaching of the use of such technology, is a huge and complex project, albeit an inevitable one, as an EHR will be the standard in health-care delivery in the near future. At this point, KMHC does not have an updated dollar figure to implement such a system. It is believed there will be a province-wide deployment. In the past, KMHC has been quoted $700,000 to pursue the system on its own.	$700,000	Somewhat	We have begun the initial steps necessary to implement an electronic health record. We have purchased, trained and deployed, November 15th, 2015, software addressing inpatient	Outstanding is the actual electronic health record software. KMHC continues to research this file as there are a number of variables to consider within the Quebec health network.

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
				admission, registration, patient identification, therapeutic nursing plan, patient profile, appointment scheduling, as well as electronic document management.	
Database system with resources (developmental & maintenance)	It is often challenging to strategize and plan prevention/intervention services effectively when critical information (trends, incidence, prevalence, population profiles) is limited or not available. Many community organizations are data rich but information poor; meaning the data is there but no one dedicated to its compilation, analysis and interpretation. Sifting through files (computer and hard copy) and collating the data takes a lot of time because it has to be done manually. The majority of human resources are targeted to frontline services and their support there is little or no time left for the compilation of data generated. There is also an ever	$1,000,000+	Somewhat	Achieved in part, need a lot more work	There is a dedicated resource at KSCS to assist in managing data, however it may be good to expand the role or hire additional resources at an Onkwata'karitáhtshera level. Continued work on data mining and creating a community portrait is required. Continued investment in the RHS is encouraged. Continued investment with partnerships (like the McGill Center for Research on Children and Families or the FNQLHSSC) is encouraged.

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	increasing demand to collect and analyze statistical information to justify funding. Without the available human and technical resources to manage the data systems, the existing data serves no one. When services can successfully and consistently identify ways to improve a program by determining what works, what doesn't work and why, they can actually reduce costs and reallocate resources to prevention efforts or other identified areas of need. KSCS and KMHC are two different facilities with different needs, however both need to improve, synchronize and coordinate the management information system(s)currently in place so planning efforts are provided with compiled, analyzed and interpreted data. Doing so will result in the following long term outcomes: -Increased use of meaningful data analysis in decision-making re: policies, programs and services. -Planning and reporting practices well integrated and consistent throughout the organizations. -Improved prevention and support services that will ultimately lead to addressing the priorities identified in the CHP. -Statistics to support the above.				

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	It is anticipated that a project this size will require a number of human resources over a long term but more specifically one full time statistician/evaluator/ researcher and database consultant(s) to work with internal subject matter experts. Depending on the research (needs assessment) a pre-packaged or tailored database system can be purchased; however, this will also require an upgrade of the current system in place and possibly a new server. The costs could easily fall within the range of 1 million dollars.				
Software licenses for computer programs	There is a need for licensing upgrades for word processing & e-mail, presentation software, and an upgrade to the server. For KSCS, every employee should have a license for software; presently this is not available for all staff. An upgrade to the basic Microsoft Office 2010 (word, excel, power point, outlook one note and publisher) would need licences at approximately $498 per computer. For KMHC staff under transfer, the cost would be $6,972. Communications would also need special programs by Adobe called Design Standard and Master Collection totaling $9,097.	$38,977 approximately Needs at KMHC are $3000 per year for message system licences and approximately $3000 every five years for	Somewhat	KSCS: Achieved. KMHC has been able to purchase approximately 10 Microsoft Office licences per year; at present, 28% of licences is outstanding. KMHC Communications has acquired the special software programs	KSCS: We do need to upgrade or replace the KSCS case manager program still.

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	There are 60 (46 KSCS and 14 KMHC) employees who are salaried under Health Transfer (the CHP)	software license updates.		that were required.	
Smart board with videoconferencing	KSCS currently does not have a Smart Board or Videoconferencing capabilities. KSCS has to access the use of these resources through the few other organizations in the community, some of which have service charges. The advantages of having a Smart Board are numerous. Lessons and presentations can be prepared well in advance and reused and updated as needed. The ability to combine sound, video, interaction and Internet gets and keeps the attention of participants more than traditional media. The interactive whiteboard works with any program loaded or available on the host computer. Some applications commonly used with the Smart Board are Microsoft PowerPoint, Excel, Word, and AutoCAD. Uses include teaching, training, conducting meetings, and delivering presentations. Video conferencing is a communications technology that integrates video and voice to connect remote users with each other as if they were in the same room. Each user needs a computer, webcam,	Smart board (approximate cost $15,000) Video-conferencing (approximate cost $30,000 plus annual fees)	Yes	Achieved for both smart boards and video conferencing.	Achieved in year 2, 3, 4; cost was through IT proposal

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	microphone, and broadband internet connection for participation in video conferencing. Users see and hear each other in real time, allowing natural conversations not possible with voice-only communications technology. Video conferencing helps save time and money on travelling and housing costs by bringing people face-to-face virtually. Many prominent universities have adopted video conferencing as an educational tool to be used in conjunction with online courses. KSCS does a lot of work with, and for the community, and both the smart board and video conferencing tools will definitely provide staff the capabilities to do their work more efficiently and effectively. Furthermore, KSCS will also be able to offer these resources to the many community members, organizations/agencies that already use our facilities. For example, from 2005 to 2008, there were on average 163 room bookings with more than 5,000 people a year coming into the organization (numbers do not include internal staff room bookings). There has been a decrease in room usage externally over the years due to other organizations within the community incorporating				

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	space for meetings and trainings; however, KSCS still has been averaging well over 100 room bookings per year with over 3700 people using our facilities. Both tools would enable the following: -provide staff up to date resources when offering training to community members or other remote communities -staff to participate in online training sessions themselves without the added time for off-site training and additional expenses -offer other organizations/agencies and community members access to these resources -be used in day-to-day operations, as well as in any emergency response situations that may arise within the community i.e. pandemic				
INFRASTRUCTURE NEEDS – FACILITIES & RESOURCES (NEW)					
Mental health facility/resources for acute care	The shortages faced in all acute care hospitals at this time also affect Kahnawá:ke's mental health clients. The two main hospitals that KMHC sends patients to are Centre Hospitalier Anna-Laberge (CHAL) and the	To be determined	No	There has been some discussion on this topic; no action has been taken in this direction.	

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	Montreal General Hospital (MGH). Both these hospitals have a limited amount of acute care mental health beds which are usually full. When this occurs, community members have to be assessed quickly in an emergency room and are usually discharged prematurely. As a result, these persons often end up back in the emergency room after discharge, at their physician's office at KMHC or in trouble with the law. If KMHC had a facility in the community to receive the client back after an ER visit or admission to CHAL or MGH hospitals, these patients would receive a treatment plan for after care in their own community.				
Foster-care facility for adults with limited mental capacity (Alzheimer's, dementia)	A foster care facility would meet the needs of people with early dementia or Alzheimer's that are staying long term at KMHC but do not require hospitalization. Their families have no other option open to them to deal with this type of illness. These patients require a closed facility because they may wander. It is estimated that approximately 39 individuals may fit into this category currently. This number includes people who may already be in existing facilities but would do better in foster care. Considering that such	To be determined	No	No action has been taken in this direction.	

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	a facility usually houses approximately 10 people, the number of 39 potential residents proves that there is definitely a need. At present there is no facility to meet the needs of this population so they are put on the list for Long Term Care at KMHC when they do not necessarily have to be in a hospital. Statistics show that 20% (2,096) of the population are 60 years of age and older and represents the group likely to require this type of specialized care.				
Facilities and resource personnel for severely disabled/ handicapped	KSCS provides support services to individuals and their families living with developmental delays and special needs through Assisted Living Services (ALS). Through a team of case workers, needs are assessed, a service plan is developed and clients are linked to services appropriate to their needs and abilities. Resources utilized within ALS include the Young Adults Program (YAP), the Teen Social Club (TSC), Inclusion Support Workers (ISW), and ALS Case Workers. In the 1990's the province closed most of the residential care facilities that were taking care of individuals with special needs. At that time many of Kahnawá:ke's community members were relocated	To be determined	Somewhat	Achieved only in part	Staffing resources have been stabilized; renovation and expansion of the building has not occurred except for an emergency stair; on reserve residential is still a long term goal but operational funding needs to be secured and a new building to house the EHS program need to be addressed.

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	back on reserve with their families and the support of KSCS. Some of those same individuals are now living with aged parents who are voicing growing concern and anxiety over who will care for their children when they are no longer able. The responsibility and concern is shared by KSCS/ALS. Although these clients are presently receiving the maximum amount of available services, this is inadequate to address their growing need for care. Specifically, these individuals have significant developmental delays; all are non-verbal and about half have physical disabilities that make them dependent for meals and general personal care. At this time Kahnawá:ke lacks a residential type facility to care for this special needs population. Outside resources are extremely limited and KSCS lacks the financial resources to pursue outside placements on an individual, case by case basis. ALS Client Statistics: - On-Reserve Clients: 44 - Respite Services: Weekends: 5 Summer Camp Respite: 4 - Off- Reserve Placements: 4				

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	- Receiving Inclusion Support Service: 17 - YAP Participants: 17 - TSC Participants: 8 - Families Requesting Residential Placement: 8 Kahnawá:ke has always maintained responsibility for its people. This is historically and culturally supported through our commitment to the seven generations ahead. Current community resources and funding agreements however do not make it possible for the placement on reserve of our most vulnerable population. In fact, our current funding agreements also make it cost prohibitive to place these high need clients off-reserve as well. Although it is reasonable and logical to expect that this clientele had the right to receive services on-reserve comparable to those living off-reserve, the present reality is much different.				
Adult Wellness Clinic	A feasibility study for an Adult Wellness Clinic will be completed by March 31, 2012. It is anticipated that this new program would require a full-time chronic disease management nurse, administrative support and overhead. It is anticipated that the Clinic would	Full time nurse: $89,813 annually Full time	Yes	This study was done. We have incorporated some of the outcomes with our Diabetes Nurse	To run the program to it's full potential we will need another nurse.

Need	Description	Cost	Complete? (yes, no, somewhat)	To what extent has this need been met over the last 5 years?	Comments? (e.g. challenges with addressing it, timing of when it was addressed, updates to cost, etc.)
	offer clients the opportunity to meet with a Community Health Nurse after each doctor's visit where teaching, promotion and prevention activities would occur, based on the client's individualized needs. This approach would not only support the needs of well adults but would enhance the continuity of care of clients suffering from chronic diseases. Out patient clinics presently average 35 to 50 clients per day.	administrative support: $46,737 annually		Educator, which we now call Wellness Nurse.	

6.4 Key Informant Interview Guide

Thank you for participating in our interview. The information you give us will be used as we evaluate the implementation and impact of the Community Health Program over the last five years. Your name or any personal identifiers (like your job title) will not be attached to the information you give us, so you will remain anonymous.
You are welcome to skip any question that you do not feel comfortable answering, or that does not apply to your work.

Role in the Community Health Plan

1. Can you tell me how you have been involved in the Community Health Plan?

    a. Who is your employer – KMHC, KSCS, Onkwata'karitáhtshera, other?

    b. Are you involved in program or service delivery? Which one(s)?

2. Looking at the list of priorities and programs/services (see pages 4-6 of the interview guide), please identify which ones you feel you can speak to for this interview. If you think a program/service is missing, please let us know.

Implementation of the Community Health Plan

3. For each program or service that you wish to speak to, can you comment on the extent to which this program/service have been running and available in the community over the last five years, and what factors contribute to its implementation? Please only speak to the programs and services that you are involved in to some capacity.

Impacts of the Community Health Plan

4. For each priority area that you are involved in, overall, do you feel that the current programs and services are meeting community needs in Kahnawá:ke?
    a. Are the target groups being reached? To what extent?

    b. Are some target groups or groups of the population not being reached by the current programs and services for each priority area? Why not?

    c. Are some unexpected groups using the programs and services of each priority area?

d. Are the target groups benefitting from the programs and services of each priority area? In what ways?

5. In the last five years, what changes have you seen in the priority area(s)?
   a. How have the programs and services changed?

   b. What impacts have you seen on staff, clients, stakeholders, etc.?

6. Please review the goal(s) of the priority area(s) you are involved in. (See the last page of the interview guide).
   a. To what extent to you feel this goal is being achieved?

7. Please review the strategy/strategies of the priority area(s) you are involved in. (See the last page of the interview guide).
   a. To what extent do you feel this strategy is being fully implemented?

Data Collection and Reporting

8. What tools do you currently use to collect data, share information, and monitor trends/activities?

9. Do you experience any challenges in collecting data or accessing data?
   a. What could be done to improve the current information system and data gathering tools?

Final Questions – Overall CHP

10. What do you see as the strengths of the Community Health Plan?

11. What do you see as the weaknesses of the Community Health Plan?

12. What changes would you make to what is in the Community Health Plan?

13. What can be done to improve the implementation of the Community Health Plan?

14. Do you have any final thoughts you would like to share?

Thank you for your time!

A. HEALTH PRIORITIES

ADDICTIONS

Goal: To reduce alcohol / drug abuse in Kahnawá:ke

Strategy: To provide comprehensive prevention, intervention, aftercare addictions services and to mobilize the community to change perceptions regarding addictions

Programs/Services:

- Addictions Working Group (Onkwata'karitáhtshera)
- Addictions Response Services
- Children's Drama
- In school Prevention Program
- Making Adult Decisions
- Our Gang

MENTAL HEALTH

Goal: To ensure the continued growth of services in the prevention of mental health. To improve the mental wellness of community members and support them while facing mental health challenges

Strategy: To provide comprehensive and accessible prevention and intervention services.

Programs/Services:

- Mental Health Working Group (Onkwata'karitáhtshera)
- Nobody's Perfect
- Parenting & Family Center

- Healing and Wellness Lodge
- KMHC Social Service Worker
- KYC Outreach
- Shakotisnien:nens Support Counsellor
- HCN Tertiary Prevention

CARDIOVASCULAR

Goal: To reduce the incidence of cardiovascular disease in Kahnawá:ke

Strategy: To create a comprehensive prevention, intervention and support spectrum of services for cardiovascular disease

Programs/Services:
- Cardio vascular Working Group (Onkwata'karitáhtshera)
- Adult Prevention

DIABETES

Goal: To reduce the incidence of diabetes and support people who have health impacts associated with diabetes

Strategy: To educate community members on the impact of diabetes, identify diabetes in the early stages and create programs to ensure access to services efficiently

Programs/Services:
- Diabetes Working Group (Onkwata'karitáhtshera)
- KMHC Operations
- Diabetes Education

OBESITY

Goal: To determine whether obesity should be identified as a true health priority. If so, to identify action steps to reduce obesity in the community

Strategy: Through evidence-based research, review the obesity picture in the community and collaborate with organizations to take action

Programs/Services:	· Obesity Working Group (Onkwata'karitáhtshera)	· Adult Prevention

CANCER

Goal:	To reduce incidence of cancer, provide for early detection of cancer, and support community members affected by cancer
Strategy:	To provide a comprehensive prevention, intervention, and support spectrum of services related to cancer

Programs/Services:	· Cancer Working Group (Onkwata'karitáhtshera) · Adult Prevention · Cancer Care	· Environmental Health Services

EARLY CHILDHOOD AND FAMILY WELLNESS

Goal:	To assess, identify and plan for the needs of families experiencing developmental disabilities
Strategy:	To collaborate with community stake holders to assess the needs of special needs community members and to strategize service delivery and future needs

Programs/Services:	· Developmental Disabilities Working Group (Onkwata'karitáhtshera) · Assisted Living Services	· Fetal Alcohol Spectrum Disorder (FASD) · Aboriginal Head Start Programming

B. SUPPORT PRIORITIES

MULTIPLE SUPPORT PRIORITY

Goal: To identify objectives and activities which contribute to multiple priorities in the achievement of the health plan.

Strategy: To review all community activities and services and ensure they describe their contribution to the health plan.

Programs/Services:

- Multiple Support Priority Working Group (Onkwata'karitáhtshera)
- Brighter Futures
- Communications
- KMHC Operations
- KSCS Administration & Operations

PRIMARY CARE

Goal: To identify objectives and activities which contribute to primary health in the achievement of the health plan.

Strategy: To review all community activities and services and ensure they describe their contribution to the health plan.

Programs/Services:

- Primary Health
- Child Injury Prevention
- CHU - Breastfeeding Support
- CHU - Newborn Home Visits
- CHU - Prenatal Clinic
- CHU - Prenatal to Toddler Data & Statistics
- CHU - Well Baby Clinic
- HIV
- Preconceptual Health
- Reportable Diseases
- School Health - Elementary Schools
- School Health - Survival School
- Staff Health
- Volunteer Program

HOME AND COMMUNITY CARE

Goal: To identify objectives and activities which contribute to home and community care services in the achievement of the health plan.

Strategy: To review all community activities and services and ensure they describe their contribution to the health plan.

Programs/Services:

- Home and Community Care Services
- Home Care Nursing - End of Life Care
- Home Care Nursing - Home Hospital
- Home Care Nursing - Tertiary Prevention
- Home Care Program

HEALTH MANAGEMENT

Goal: To identify objectives and activities which contribute to health management in the achievement of the health plan.

Strategy: To review all community activities and services and ensure they describe their contribution to the health plan.

Programs/Services:

- Health Management
- Home Care Nursing - Data & Stats
- Home Care Nursing - Skills Development
- Human Resources
- Recruitment & Retention of Health Care Professionals
- Risk & Quality Management

6.5 Subcommittee Focus Group Design

Intention: Give each sub-committee a chance to pose a reflective look at where it's been with the CHP, focusing on the health priorities

Objectives:

- Construct a common understanding of the CHP broadly and relate that to our work
- Rate how much we feel our target groups benefited from programs & services under the priority areas, and why
- Name and rate the major impacts of the CHP in contributing to our health priority

An Onkwata'karitáhtshera Executive Committee member will accompany Niska for the beginning of each focus group, and will leave after the Q&A on the CHP

Participants: sub-committee members (7-12 people/group)

Time	Activities
15 min	Welcome, opening, thanks and introducing Niska (Onkwata'karitáhtshera representative) Check-in (Niska), How people are feeling re: CHP? - Introduce themselves and what they do on a day-to-day basis that touches on the priority area? Sign consent forms
25 min	Review of the broader context of the CHP (Niska) Objective: Construct a common understanding of the CHP and relate that to our work *Participatory PowerPoint:*

	• Small groups (3-4) • Participants are given slides with information on the CHP • They have 15 minutes to circle the elements that you connect with most, and write their questions • A Q&A with the Onkwata'karitáhtshera representative ensues
55 min	Feedback session (benefits and impacts) (Niska) *Objective: Get participants' feedback on the benefits they observed for participants, areas for improvement for the holistic health intervention on each priority action as well as impacts they would like to see* Individually - write benefits, areas for improvement and desired impacts in 5 years on 3 colours of post-its In small group - Put them together; see if some are similar - A group secretary takes notes on canvas Get back together as a large group; discussion and highlights
5 min	Check-out (Niska) One takeaway/learning from the focus group Focus group evaluation

6.6 Users Focus Group Design

Intention: Gather input from CHP service users on what their priorities are for next steps

Objectives:

- Construct a common understanding of the CHP
- Get the CHP service users' input on the health priorities they were in contact with

An Onkwata'karitáhtshera Executive Committee will accompany Niska for the focus group, and will leave after the Q&A on the CHP.

Participants: CHP service users

Time	Activity
6:30-6:45 (15 min)	Welcome, opening, thanks and introducing Niska (Onkwata'karitáhtshera representative) Check-in (Niska) – *names and our connection with the CHP (what priority),*
6:45-7:05 (20 min)	Review of the broader context of the CHP-(Niska) *Objective: Construct a common understanding of the CHP* *Participatory PowerPoint:* - Participants are given slides with information on the CHP - In small groups (4), participants have 20 minutes to circle what strikes them, and write their questions - Groups present their work - A Q&A with the Onkwata'karitáhtshera representative ensues
7:05-7:25 (20 min)	Feedback session: keep/drop/change *Intention: get the participants' perspective on what is working and not working in programming*

	Individually, participants are asked to brainstorm what they would keep, drop and change in terms of programming and services for the health priorities they'd like to work on. 1 idea/post-it Message: you don't need to write something for each priority Participants are invited to put their post-it on the flip chart on the wall (Art Gallery)
7:25-7:55 (35 min)	Feedback session: synthesis and discussion We ask for volunteers to read the material and produce a synthesis for each priority Each synthesis is presented and discussed
7:55-8:20 (25 min)	General feedback session on CHP The following questions are asked and discussed in group (free discussion form): ● Based on what you heard, what would you like the CHP stakeholders to know? ● What would you like them to do? Someone writes on the flip chart paper
8:20-8:30 (10 min)	Closing Next steps, Evaluation Check-out: one thing I learned from my evening

6.7 Stakeholder Workshop Design

Intention: Gather input from people in charge of CHP service delivery on where we've been, where we are at, and where we want to go with the CHP

Objectives:

- Construct a common understanding of the CHP and what has been achieved in the last five years
- Understand what the evaluation findings mean for our work
- Discuss recommended next steps that make sense for us

The Onkwata'karitáhtshera Executive Committee is present at the workshop for its entire duration.

Participants: front-line staff and managers who are people in charge of CHP service delivery - 29 people plus Onkwata'karitáhtshera - 34 people)

Time	Activity
8:45	People arrive Niska can we set up the morning of around 7:15-7:30, just tell Hotel what time -
9:00-9:15 15 min	Official welcome, opening and thanks (Onkwata'karitáhtshera representative) Check-in (Niska), - Find someone you don't work with on the day to day basis, and share your expectations AND/OR intention - 2-3 rounds if possible - Take a few comments Program for the day: objectives and agenda

9:15-9:35 20 min	Review of where we come from (Niska, co-facilitated with Onkwata'karitáhtshera), Objective: Construct a common understanding of the CHP's past *Timeline methodology* ● Participants are invited to write the most significant milestones of the CHP on a piece of post-it notes (one per person) ● Each participant explains their milestone and puts it on the wall ● Collective review
9:35-10:20 45 min	What? Review of evaluation findings (co-facilitated) *Objective: Understanding and validating the evaluation findings* *Participatory PowerPoint* - Participants are given slides with preliminary findings from the evaluation - In small groups (4 - 8X4), they have 20 minutes to circle the most important findings of the evaluation, and write their clarification questions and comments (for nuancing) - A Q&A with the Niska and Onkwata'karitáhtshera representative ensues (25 min)
10:20-10:40 20 min	Break
10:40-12:00 80 min	So what? Based on the most important findings from the evaluation, what do we need to do in order to better serve the purpose of the CHP? *Camembert technique* 4 groups of 6 + 2 groups of 5 In small groups (6), the following questions are answered: 1. What is the impact of the CHP? 2. What changes have we seen in the last five years?

	3. What does that mean for our priorities? *About 20min* Shuffle groups Each group takes the responsibility of making a synthesis of Question 1, 2 and 3 *About 20min* Results are shared with the whole group and discussed *About 20min* Add in something to do with priorities, like a process to prioritize? *20 min*
12:00-13:30 90 min	Lunch
13:30-14:30 60 min	Now what? Recommendations Carrousel *Given what we know about the programs and services and their impacts, what should we do moving forward?* 4 groups of 6 + 2 groups of 5 - Groups work on 3 recommendations for the CHP implementation in the next five years, and they write them down - A representative from each group travels to the next group to present their recommendations and get feedback (twice) - Groups rework their recommendations based on feedback and write them on the canvas as well as on Post-It
14:30-15:15 45min	Going further with recommendations

	Intention: go further with our recommendations - Write recommendations on Post-its - Group similar recommendations (already written) together - Have an open discussion; facilitator asking questions and moderating using Rationalization of Conflict method
15:15-16:00	Next steps and closing remarks (Onkwata'karitáhtshera) Check-out (Niska), one thing you learned or one thing you will do in your department Evaluation

6.9 Contribution-Feasibility Rating Exercise

The following is a summary of the results from the contribution-feasibility exercise. The columns are divided into low-feasibility, medium-feasibility, and high-feasibility ranked recommendations, and the rows are divided into low-contribution, medium-contribution, and high-contribution ranked recommendations.

Table 8 Contribution-Feasibility exercise results

		Feasibility →		
		Low	Medium	High
↑ Contribution	High	12. Onkwata'karitáhtshera produce a regular report on the Community Health Plan.	5. The four subcommittees update their logic models. 6. Onkwata'karitáhtshera consider implementing regular collaborative planning sessions partners and stakeholders. 7. Onkwata'karitáhtshera build on successful culturally-based health initiatives at KMHC and KSCS.	1. Onkwata'karitáhtshera identify the data needs for the CHP. 2. Onkwata'karitáhtshera develop a data sharing protocol. 3. KSCS and KMHC explore ways to continue enhancing inter-organizational collaboration. 4. Onkwata'karitáhtshera continue to promote the CHP as a practical tool and resource for staff.
	Medium		9. Working to obtain and gather the data needed to assess the accuracy of the health priorities in 2022. 10. Continuing to engage Kahnawa'kehró:non in dialogue about the CHP. 11. Developing a strategy to reach out to the most vulnerable in the community.	8. Increasing the frequency and accessibility of communications about the CHP to the community.
	Low			