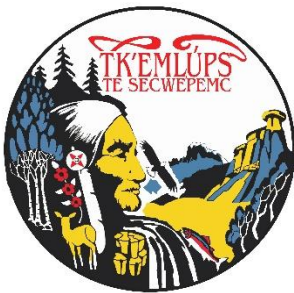




Re Stsq'ey's es Qellqéllt.s
(Community Health Plan)

2024-2034

Approved March 8, 2024



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April 3, 2024

We are proud to present *Re Stsq'ey's es Qellqéllt.s*, our updated community health and wellness plan. This document will guide Q'wemtsín Health Society services and community-provided wellness programs from 2024 to 2034.

This updated plan incorporates the results and recommendations from our Five-Year Evaluation, completed in October 2023. The evaluation process featured strong involvement by community members, from Elders to youth. Their wisdom and lived experience help make this plan strong. Our excellent staff team rolled up their sleeves and provided input throughout the process.

We are committed to working together to carry out this plan, putting the good thinking of our people into action. It will take many hands to continue to grow our healthcare services and wellness programs – developing the partnerships, securing additional resources, and meeting community needs.

Our people are strong, despite a history of genocide and persisting colonial patterns. Designing and delivering holistic health and wellness services is part of reclaiming our inherent Secwépemc right to self governance. We are grateful to the First Nations Health Authority and all our partners for stepping up to help us toward a shared vision of healthy Secwépemc individuals, families, and communities.

Kukwstsétsemc,

Darrel Draney, Board Member

Dave Manuel, Board Member

Leah Briault, Board Member

Mathew Lewis, Board Member

Morning-Star Peters, Board President

Tracy Hewitt, Board Member

Executive Summary

Introduction

This Community Health Plan, *Re Stsq'ey's es Qellqéllt.s*, provides direction for delivery of healthcare services and wellness programs and from 2024 to 2034. The scope includes Q'wemtsín Health Society (QHS) and the three participating communities: Skeetchestn; Tk'emlúps te Secwépemc; and Whispering Pines / Clinton. The planning process included strong involvement by QHS Board and staff members as well as community staff and elected leaders. Members of the three communities provided input through the 2023 Five-Year Evaluation process.



QHS Overview

Q'wemtsin works toward a vision of “healthy Secwépemc individuals, families, and communities”. We advance holistic health by providing programs, services, and education. Our core values are traditions and culture; respect; and professionalism.

Funded primarily by First Nations Health Authority, Q'wemtsin offers services through four departments: Primary Health, Dental, Home and Community Care, and Public Health.

- **Primary Health** services include general practitioner (Nurse Practitioner and Medical Doctor); naturopathic medicine; massage therapy; nutrition and diabetes education services.
- **Dental** services include COHI (Children's Oral Health Initiative) and basic dental services.
- **Home and Community Care** services include acute and chronic disease management; personal care support (including tub program); foot care; and wellness visits.

- **Public Health** services include maternal and child health (Circle of Life); communicable disease control; injury surveillance and prevention; school health; harm reduction; and events and training.

Engagement Activities

This plan reflects community, leadership, staff, and partner input provided through the 2023 Five-Year Evaluation process. Engagement activities included:

- ✓ 3 community feast events, including 7 focus groups with a total of 76 participants
- ✓ 187 surveys by community members
- ✓ An Elders focus group, with 4 participants
- ✓ 18 interviews with Q'wemtsin staff
- ✓ 11 interviews with partner organization representatives
- ✓ Full-day Board and staff workshops, to discuss future directions and draft recommendations.



The process to incorporate evaluation findings into this updated Plan, and to engage the three communities in planning for their next ten years of wellness services, included the following activities:

- ✓ Preliminary drafting of this Community Health Plan, updating content from the past plan and weaving in the Evaluation recommendations.
- ✓ Engagement with community staff and QHS Board representatives to review and update the sections on community-delivered wellness programming.
- ✓ Engagement with QHS Board and staff members through video conferences and email.
- ✓ Working meetings with the Health Director and HR Manager throughout the process.



Future Directions

To achieve our mission, to advance holistic health by providing programs, services, and education, Q'wemtsin works to achieve the following **five updated goals and sets of objectives**.

Goal 1. Build partnerships and collaborate. QHS plans to:

- 1.1 Continue to strengthen connections among member communities, families, and individuals.
- 1.2 Continue to work with the three bands to enhance programs and services.
- 1.3 Continue to actively engage in health tables, collaborate with partner organizations, and strongly advocate with health authorities.
- 1.4 Challenge funders so that QHS can extend services to off-reserve band members and other community members who are immediate family of band members.
- 1.5 Ensure funding transfers reach the community level.

Goal 2. Deliver programs and services addressing community needs. QHS plans to:

- 2.1 Deliver and evolve our existing services.
- 2.2 Expand primary healthcare, prioritizing general practitioner and nurse practitioner services.
- 2.3 Expand elders' services and other health services in the three communities.
- 2.4 Continue to explore possibilities for expansion of services, building on our past plans.
- 2.5 Continue to stay abreast of technology change in healthcare.

- 2.6 Explore development of an integrated mental wellness program, using multiple modalities.
- 2.7 Further explore opportunities to support community-driven traditional healing.
- 2.8 Further explore formation of crisis intervention teams.

Goal 3. Provide a trusting, open professional environment. QHS plans to:

- 3.1 Build relationships that ensure trust – at all levels.
- 3.2 Provide welcoming community environments.
- 3.3 Provide strong governance and administration.
- 3.4 Provide opportunities for professional growth of staff.
- 3.5 Continue to integrate departments and programs for provision of holistic care.
- 3.6 Explore QHS future facilities tenure, location, and expansion.



Goal 4. Create opportunities for learning. QHS plans to:

- 4.1 Organize educational health activities that bring people together.
- 4.2 Collaborate with other organizations to deliver health learning opportunities.
- 4.3 Support the three communities as they (re)connect with our language, Secwépemctsin, and traditional wellness.
- 4.4 Provide educational sessions, resources, and materials on current, relevant health and wellness topics.
- 4.5 Further strengthen communication and engagement with community members, continuing to raise awareness of what services QHS offers.
- 4.6 Encourage and support community members interested in becoming health professionals and provide a welcoming supportive environment for healthcare students.

Goal 5. Evaluate effectiveness. QHS plans to:

- 5.1 Use feedback and input from community members.
- 5.2 Monitor healthcare service statistics and data.
- 5.3: Do five-year evaluations of services and programs.

Wellness Programs Provided by Communities

Band-delivered wellness programs complement the more clinical services provided by Q'wemtsin. Communities address the broad determinants of health through diverse programs and services.

One of the areas that the Bands lead in is traditional wellness and cultural reconnection activities. Q'wemtsin plays a supporting role.

The following shows 2024-2034 priorities for Q'wemtsin flow-through funding in each community.



Skeetchestn

1. Increase frequency of community sweats, pit cooks, traditional games, and traditional on-the-land activities with Elders.
2. Normalize traditional teachings regarding medicines and on-the-land healing – so people can do it themselves.
3. Provide cultural orientation to staff coming from outside the community.
4. Provide respite for caregivers, ensuring children are cared for in a healthy, kind, responsible way outside of the home / within the community.
5. Provide respite training, so that young people can be taken care of in the community.
6. Ensure the safe house is properly staffed, trauma informed, and connected with mental health / wellbeing programs in the community.

7. Expand access to mental health counselling, providing dedicated space and times for virtual counselling / primary healthcare.
8. Further explore clustering Elders in adjacent, suitable homes to receive better support.
9. Increase Elder involvement in program development, organically coming and participating when decisions are being made.

Tk'emlúps te Secwépemc

1. Develop services to be delivered through new facilities: House of Healing; Elders gathering lodge; and Culture and language heritage building / museum.
2. Continue to develop healing spaces on reserve for traditional health practices, such as sweat lodge facilities and a revitalized, unified, fire pit area – in consultation with Elders.
3. Build programs to fulfil the TteS Healing and Wellness Plan.
4. Create a client centred care approach, working with Q'wemtsin, especially for people with complex needs and/or concurrent disorders.
5. Create a mobile crisis response team, with availability evenings and weekends - including clinical response and advocacy / referral to services.



6. Continue planning for a new youth recreation centre.
7. Continue to provide and develop food sovereignty programming.
8. Continue to assist membership to navigate and maximize their health benefits (such as First Nations health benefits, MSP, and others).
9. Work with funding partners to increase Community Health and NNADAP (Alcohol and Drug Abuse Program) funds, to better assist with needs of members on reserve and away from home.
10. Develop a homelessness action plan, partnering with the City of Kamloops.

Whispering Pines/Clinton Indian Band

1. Drive wellness programming through broader planning processes such as the Comprehensive Community Plan, including a health section, and combining with Aging Friendly services planning, strongly including the voices of Elders and focusing on ever-changing needs.
2. Plan for, resource, and build appropriate facilities for healthcare services and wellness / health promotion programming.

3. Continue to combine health flow-through resources with other resources to do planning and referrals to healthcare services.
4. Continue to expand and deliver health promotion and prevention programs.
5. Continue to expand and deliver food sovereignty programming.
6. Continue to support and raise awareness of traditional wellness and cultural activities.
7. Continue to offer mental health support for members seeking rehab and/or treatment.
8. Establish a youth and Elder worker, building on what is already happening.
9. Provide access to mental health and first aid awareness and support for staff and members, maintain awareness of services, and support development and implementation of safety plans with members who are at risk.
10. Partner with provincial / external agencies to respond to mental health crises, including after hours, and work with RCMP and other partners to increase presence in the community.



Conclusion

This updated Community Health Plan reflects the results and recommendations of our 2023 Evaluation report, building on our 2018-2023 Plan and feedback from members of Skeetchestn, Tk'emlúps te Secwépemc, and Whispering Pines / Clinton communities. It is designed as a guide for Q'wemtsin and the three Bands in continuing to develop and offer excellent healthcare and wellness services, from 2024 to 2034.

Key challenges for the coming ten years are to:

- Develop land-based community healing, mental health supports, and crisis intervention - including mainstream approaches while also developing traditional / cultural approaches.
- Redouble efforts to recruit and train our youth and community members to become healthcare professionals.
- Continue building our food sovereignty initiatives and working on our partnerships with FHNA and IH.

Acknowledgements

The Q'wemtsín Health Society (QHS) Board and Health Director are grateful to participating Elders, other community members, and staff for their roles in creating *Re Stsq'ey's es Qellqéllt.s*, our new Community Health Plan. *Kukwstsétsemc* (thank you) to everyone who engaged in the 2023 Five-Year Evaluation journey, and/or in the 2024 plan updating process.

Special thanks to Elders Christine Simon and the late Tony LaRue for the original translation of Community Health Plan as *Re Stsq'ey's es Qellqéllt.s*.



TRC and UNDRIP

QHS recognizes and endorses the **Truth and Reconciliation Commission of Canada (TRC) Calls to Action**, especially those that are specific to health (numbered [18-24](#)):

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends....

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools....

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to: i. Increase the number of Aboriginal professionals working in the health-care field. ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities. iii. Provide cultural competency training for all health-care professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

QHS recognizes that community-driven health planning is consistent with the **United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)**, especially [Articles 23 and 24](#):

Article 23: Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be involved in actively developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24: 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals, and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services. 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health...

Part 1: Introduction

Intention

This Community Health Plan, *Re Stsq'ey's es Qellqéllt.s*, provides direction for delivery of healthcare services and wellness programs from 2024 to 2034. It includes Q'wemtsín Health Society (QHS) and the three participating communities: Skeetchestn; Tk'emlúps te Secwépemc; and Whispering Pines / Clinton.

We built this plan to:

- Better serve the always-evolving needs of community members.
- Think ahead, building on our strengths.
- Expand and optimize services, making wise use of resources.
- Bring in culture and tradition.



How We Built This Plan

The planning process included strong involvement by QHS staff and Board members as well as community staff. Members of the three communities provided input through the 2023 Five-Year Evaluation process.

The 2023 evaluation process featured:

- ✓ 3 community feast events, including 7 focus groups with a total of 76 participants.
- ✓ 187 surveys by community members.
- ✓ An Elders focus group, with 4 participants.
- ✓ 18 interviews with QHS staff.

- ✓ 11 interviews with partner organization representatives.
- ✓ Full day Board and staff workshops, to reflect on the evaluation and discuss future directions.

The 2024 community health planning process incorporated the recommended future directions for Q'wemtsin and involved the three communities in updating their respective sections of *Re Stsq'ey's es Qellqéllt.s*.

Steps in 2024 included:

- ✓ Collaboration of the Health Director and Human Resources Manager with the planning consultant.
- ✓ Facilitated planning sessions with staff and leaders of Skeetchestn, Tk'emlúps te Secwépemc, and Whispering Pines / Clinton.
- ✓ Facilitated planning sessions with Q'wemtsin Board and staff members.

To build capacity and skills, the planning consultant mentored a community member and worked in close collaboration with the Health Director and Human Resources Manager throughout the process.

Determinants of Health

Aside from healthcare and wellness programs, there are many factors that determine people's health. These determinants include:

- Land, water, air, and environment.
- Climate change and natural disasters.
- Housing and community spaces.
- Social support networks.
- Personal health practices and coping skills.
- Biology and gender.
- Early childhood development.
- Lifelong learning.
- Income and employment.

All these factors impact the health of individuals, families, and communities. Healthcare services, such as those provided by Q'wemtsin, are crucial resources. Wellness programs and cultural reconnection opportunities, such as those provided by the three communities, are vital for prevention and health promotion.



Context: Naming the “Elephants”

This Plan exists in a time when there is great healing from the past, as well as innovation in developing First Nations healthcare. Organizations such as QHS provide services in an environment where leaders, staff, and community members are having to work with the existing systems, while also reconnecting with tradition and inventing new ways to deliver services.

Three of the “elephants in the room” that we identified in 2018 remain:

1. The damage caused by residential schools and other genocidal programs continues to be felt and colonial patterns persist.
2. Secwépemc people are reclaiming culture, in the face of continuing colonization.
3. Our desire to offer traditional wellness services faces many barriers.

We now face three additional challenges:

1. Annual wildfires / floods and damage to our sovereign food and medicine sources.
2. Healthcare provider / staff shortages.
3. The ongoing opioid / overdose crisis.

Effects of Residential Schools and Colonization

The Truth and Reconciliation Commission documented the cultural damage of residential schools and other genocidal programs. The effects on First Nations communities, families and individuals have rippled forward in time. Many have spoken of how “lateral violence” within communities continues to take a toll.

The generations in this post-residential school era face the challenges of re-learning family roles, relationships, and cultural practices/language.

Colonial patterns have continued in many shapes and forms. Recent examples in our communities include public agencies collecting personal information that focuses on negatives, generating data that could be used against the interests of participating individuals, their families, and communities.

Secwépemc People Reclaiming Culture

In the face of continuing colonization, Secwépemc people are stepping up to reconnect with the land and with each other. On one hand, mainstream media and consumer culture are powerful forces threatening cultural revival. On the other hand, Secwépemc families and communities are increasingly strong: remembering who we are, and how to live in a good way.

The Secwépemc Nation has three broad health priorities:

- Primary healthcare
- Mental wellness
- Traditional wellness

Barriers to Traditional Healing and Wellness Services

The idea of providing traditional First Nations healing and wellness services has been widely discussed. It is a health priority for the Secwépemc Nation, Q’wemtsin, and member communities.

However, there are many barriers and challenges, such as:

- How to identify qualified traditional healers?
- How to pay them?
- How to avoid cultural appropriation of traditional wellness knowledge by outside interests?
- How to protect plants used in traditional healing from overharvesting?



Annual Wildfires / Floods

The dramatic increase in wildfires and floods in our Traditional Territories in recent years is damaging to sovereign Secwépmc food and medicine sources. On one hand, our communities, families, and individuals are actively embracing reconnection with the land, rebuilding food sovereignty and reconnecting with traditional medicines. On the other hand, climate change is causing troubling setbacks in this cultural reclamation of our birthrights. One specific example is a Skeetchestn community garden being devastated by a flooding-induced landslide in 2023.

Wildfires are burning up our medicines and harming / displacing wildlife. This disproportionately affects people who rely on wild meat, salmon, and wildcrafted medicines. For example, some people who remember always having moose meat in the freezer have recently faced having none.

In addition, when our people are dislocated from their homes due to natural disasters, many experience re-activation of historical and more recent trauma associated with forced relocation of communities and the removal of children to attend residential schools. The mental health impacts of such displacement can be especially significant for survivors / Elders.

Healthcare Provider / Staff Shortages

The shortage of doctors, nurses, and other healthcare providers is an issue throughout Canada. For a small First Nations health agency such as Q'wemtsin, recruitment and retention have become especially challenging.

Because of health sector staffing shortages, Interior Health is now competing with providers such as Q'wemtsin. It is difficult to compete with pay rates they can offer. For example, if mental health counsellors are paid \$150/hour, it becomes nearly impossible for Q'wemtsin to find suitable, qualified counsellors to work for approximately \$50/hour. With the high inter-generational trauma levels of the communities we are serving, we need seasoned practitioners with strong, trauma-informed approaches.

The Opioid / Overdose Crisis

The toxic drug crisis is taking a grim toll in our communities. Given the inter-generational trauma our people are recovering from, and associated needs for self-medication, we have more than our share of addiction issues, overdoses, and deaths.

Harm reduction services, community awareness around opioid and overdose issues, and inclusive community building are even more important in this context.

Along with other challenges, the opioid / overdose crisis points to the need for development of more crisis intervention capacity and ability to address mental health issues.

Implications of these Challenges for Next 10 Years

Our next big challenge, to be addressed over the coming ten years, is to develop land-based community healing, mental health supports, and crisis intervention. We need a dual approach: to include mainstream approaches while also developing traditional / cultural approaches.

Meanwhile, we need to redouble efforts to recruit and train our youth and community members to become healthcare professionals.

We also need to continue building our food sovereignty initiatives and continue to work on our partnerships with FHNA and IH.

Part 2: Healthcare Provided by QHS

This part of the Plan profiles Q'wemtsin and summarizes healthcare currently being provided.

Overview of Q'wemtsín Health Society

“Q'wemtsín” is the Secwépemctsin word for “shore”. The head office of QHS is located near the North Thompson River.

The QHS logo features a bear paw. This symbolizes strength and protection.



Vision

Healthy Secwépemc individuals, families, and communities.

Mission

QHS advances holistic health by providing programs, services, and education.

Values

Traditions and culture

Holistic approach

Individual, family, and community

Sense of belonging

Connection

Respect

Empathy, acceptance, caring and support

Inclusion and connection

Fairness and equity

Honesty

Professionalism

Collaboration

Standards and ethics

Confidentiality and trust

Transparency and accountability

Goals

To achieve its mission, QHS works toward the following five broad goals:

1. Build partnerships and collaborate.
2. Deliver programs and services addressing community needs.
3. Provide a trusting, open and professional environment.
4. Create opportunities for learning.
5. Evaluate effectiveness.

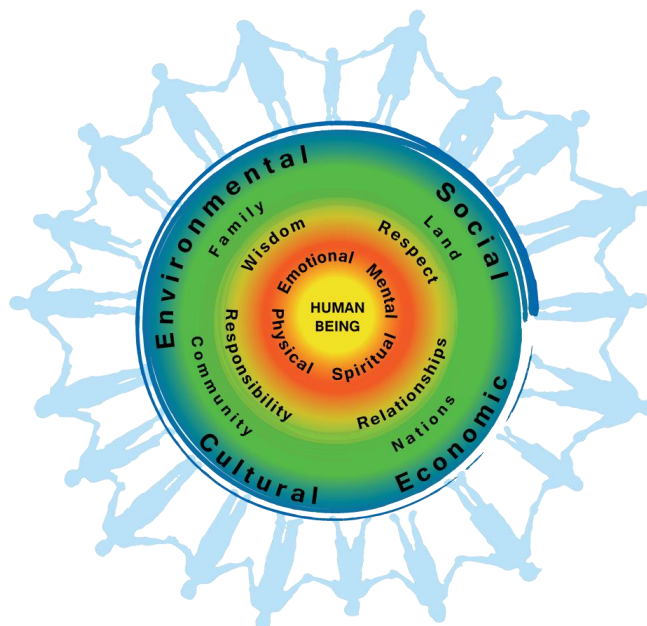
These five goals serve as a foundation for sets of specific objectives and action items, as spelled out in this plan.

Service Principles

QHS staff provide services in ways that uphold the following principles:

1. Welcoming environment and friendly service
2. Professional, confidential, culturally safe, and competent care
3. Person-centred, individualized approach
4. Holistic approach to health and wellness

The meaning of “holistic health” includes balance of physical, mental, emotional, and spiritual wellbeing, as illustrated in the First Nations Health Authority graphic below.



Services Currently Provided

The following tables describe the healthcare QHS provides - what is offered, who by, for whom, where, how, and why. These tables cover Primary Health, Dental, Home and Community Care, and Public Health. QHS provides these services by appointment or as scheduled, typically during weekday hours.

Primary Health

Q'wemtsin Primary Health services include:

- ✓ General practitioner (Nurse Practitioner and Medical Doctor)
- ✓ Naturopathic medicine
- ✓ Massage therapy
- ✓ Nutrition and diabetes education services



General Practitioner

What:	Primary health care: assessments, testing, referrals to specialists, treatment; education, advocacy, and support.
Who by:	General Practitioners and Nurse Practitioner, supported by Medical Office Assistants and a Medical Office Administrator.
Who for:	Members of the three Bands who do not have a General Practitioner (GP).
Where:	QHS clinic, Skeetchestn clinic.
How:	Build a professional relationship with clients to develop a treatment plan for health concern; Long term follow up for chronic health conditions.
Why:	To support client health goals.



Respiratory Therapy

What:	Respiratory testing using spirometry.
Who by:	Registered Respiratory Therapist.
Who for:	Band members permanently residing in one of the three communities.
Where:	QHS clinic, Skeetchestn clinic.
How:	Reports get forwarded directly to a Registered Respirology Specialist for interpretation and sent back to QHS, allowing clients to follow up with their regular provider for results.
Why:	To support respiratory health.

Naturopathic Medicine

What:	Nutritional support; vitamin injections; primary health care testing (allergy, blood, saliva, urine); acupuncture; scar therapy.
Who by:	Naturopathic Doctor (ND).
Who for:	Band members permanently residing in one of the three communities with a desire to include natural remedies for their health and healing.
Where:	QHS clinic, Skeetchestn clinic, Whispering Pines.
How:	Individually tailored treatment plans.
Why:	To support client health goals – for example: pain management, healthy weights, and personal control in managing diabetes / other conditions.

Craniosacral Therapy

What:	Manipulation of muscles, tendons, ligaments, joints, bones, nerves, and internal organs.
Who by:	Registered Massage Therapist (RMT).
Who for:	Band members who have been referred by a GP or Naturopath for therapeutic massage.
Where:	QHS Clinic, Skeetchestn Clinic, Whispering Pines (in home).
How:	An initial assessment on the first visit, and a treatment plan based on clients' desired physical health goals.
Why:	To support clients' physical health goals; decrease pain; increase mobility.

Nutrition Services

What:	Nutrition counselling and education.
Who by:	Registered Dietitian - and Naturopathic Doctor.
Who for:	Members of the three Bands.

Where:	QHS clinic, Skeetchestn clinic, in community.
How:	One-to-one client appointments; family appointments.
Why:	Food security; healthy eating and nutrition.



Dental

Q'wemtsin dental services include COHI (Children's Oral Health Initiative) and basic dental services.

Dental Services

What:	Basic dental services: silver and white fillings; exams; digital x-rays; hygiene services; extractions; dentures; night guards; oral cancer screening.
Who by:	Dentists, Certified Dental Assistant, and Registered Dental Hygienist. (Dentistry 2-3 days / month. Hygiene 2-3 days / month.)
Who for:	Members of the three Bands, on and off reserve (with status number).
Where:	QHS clinic.
How:	Convenient, friendly, caring, comforting – and professional (top quality, great service).
Why:	Improved oral health, and overall health. Getting out of pain, reducing infections and spread of disease - prevention.



COHI – Children’s Oral Health Initiative

What:	Screening; fluoride varnishes; sealants; educational visits (brush-ins); and hygiene; provides toothbrushes, toothpaste and floss to children and their families.
Who by:	COHI Aide and Dental Hygienist.
Who for:	Prenatal to 7 years old - living on or receiving services on reserve.
Where:	In communities – at the school, daycare, nursery, or clinic. (Screening yearly; fluoride 2- 4 times per year) - 3 QHS communities plus Adams Lake, Little Shuswap, and Simpcw.
How:	Close working relationships with community members - and daycare and Head Start providers, school principals, teachers, staff, and parents/guardians.

Why:	Reduced decay, fillings, and dental surgeries. Better care of teeth; more consistent dentist visits. Reduced fear of dentistry. Future parents connect oral health with overall health.
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Home and Community Care

Q'wemtsin Home and Community Care services include:

- ✓ Acute and chronic disease management – including Acute and Palliative Care
- ✓ Personal care support - including century tub program
- ✓ Diabetes program
- ✓ Foot care
- ✓ Wellness visits

Chronic Disease Management – Including Acute and Palliative Care

What:	Assessments; care plan development; wound management; support; education; advocacy (assisting clients to navigate services).
Who by:	Home Care Nurses.
Who for:	Members who require support.
Where:	QHS clinic, Skeetchestn clinic, and in homes.
How:	Collaborate with individual, family, and health care team; Based on client wants and needs - working with where they are at.
Why:	Support client goal of wellness and quality of life.



Personal Care Support

What:	Assistance with personal care needs.
Who by:	Health Care Assistant.
Who for:	People who require assistance with personal care needs.
Where:	In homes; QHS clinic.
How:	Care plans based on clients' personal needs and goals; assistance with activities of daily living in homes in accordance with care plans while promoting maximum independence. Tub program provided to those with unsafe bathing system in home.
Why:	Safely aging in place; Maintaining independence; Maintaining self care and hygiene.

Diabetes Program

What:	Diabetic screening, counselling, education, treatment, meal counselling.
Who by:	Certified Diabetes Educator (CDE) / Dietitian, working with Community Health Nurse, General Practitioner, Naturopathic Doctor.
Who for:	People with prediabetes and diabetes.
Where:	QHS clinic, Skeetchestn clinic, in community, in homes.
How:	In collaboration with the individual and the healthcare team; 1-1 client appointment; diabetic screening events; assessments through General Practitioner.
Why:	Reduced negative effects of diabetes; healthier life for people with diabetes.

Foot Care

What:	Basic foot care such a nail trimming, callous removal, and ingrown nails and corns; education on basic foot health; advice / recommendations on self care; walking and proper footwear assessments.
Who by:	Certified Foot Care Nurse.
Who for:	Members with diabetes, physical limitations and/or high-risk medical conditions – based on program capacity.
Where:	QHS clinic, Skeetchestn clinic, Whispering Pines, in homes as needed – based on clients’ limitations.
How:	Assessment of foot health. Referrals to specialist if needed.
Why:	Maintain foot health; maintain / improve ambulation.

Wellness Visits

What:	Assess and support management of health.
Who by:	Home Care Nurses as needed, and Health Care Assistants as scheduled by the Home Care Nurse.
Who for:	QHS Home Care clients.
Where:	QHS clinic, in homes, in community.
How:	Build a trusting relationship. Collaborate with clients and their chosen health care teams.
Why:	Support client wellness and quality of life goals.

Public Health

Q’wemtsin Public Health services include:

- ✓ Maternal & child health (Circle of Life program)
- ✓ Communicable disease control

- ✓ Injury surveillance and prevention
- ✓ School health
- ✓ Harm reduction
- ✓ Events and training
- ✓ Food sovereignty

Maternal & Child Health (Circle of Life)

What:	Pre-natal care; post-natal care; family support; baby assessments; growth and development assessments; support and education; play groups; school readiness.
Who by:	Community Health Nurses.
Who for:	Families who are expecting or who have children under the age of seven who permanently reside on one of the three reserves.
Where:	QHS clinic, Skeetchestn clinic, in homes, in community.
How:	Through development of a professional relationship between Community Health Nurse and family; In-home or clinic visit during pregnancy and after birth to assess, advocate and support families. Referral to midwife and doula services as needed.
Why:	To promote optimal family health.

Communicable Disease Control

What:	Immunizations from birth to elders, preventative education, and support; communicable disease testing (includes sexually transmitted infections – STI), treatment, referral, support, and education.
Who by:	Community Health Nurses, Doctor, Nurse Practitioner.
Who for:	Members of the three bands.
Where:	QHS clinic, Skeetchestn clinic, in community.
How:	Education, prevention, testing, and treatment done according to individual needs.
Why:	To prevent and protect community from communicable disease transmission.

School Health

What:	Immunizations; health and development support; education.
Who by:	Community Health Nurses.
Who for:	Students, families, and school staff.
Where:	In schools, QHS clinic, Skeetchestn clinic.
How:	Provide support, education, and resources for students, families, and staff.
Why:	To promote optimal health during the school age years.

Harm Reduction

What:	Naloxone training and supplies; sexual health education and supplies; STI (sexually transmitted infection) preventative education and treatment, support, and advocacy.
Who by:	Community Health Nurses.
Who for:	Community members permanently residing in one of the three communities.
Where:	QHS clinic, Skeetchestn clinic; in community; in homes.
How:	Individual or group educational sessions. Support and advocacy based on client needs.
Why:	Promote mental and physical wellness.



Events and Training

What:	Annual health fairs; Baby Welcome celebrations; Kindergarten Day; screening days; training events (for members as well as staff); guest speakers.
Who by:	QHS and community staff - collaborating.
Who for:	Members of the three communities; QHS and community staff.
Where:	In community, QHS clinic, Skeetchestn clinic.

How:	Host these events and trainings as community gatherings, in a spirit of celebration and learning together.
Why:	Build community; promote connection; promote health and prevent disease.



Food Sovereignty Program

What:	Land-based learning, mentorship, supporting traditional foods, gardening, and harvesting practices.
Who by:	Dietitian and Food Sovereignty Lead; Land to School Coordinator; Permaculture Designer; Everyone Eats Coordinator.
Who for:	All community members.
Where:	In each of the 3 communities & at the QHS clinic.
How:	Partnership with community members, chief and council, band staff, TRU, others.
Why:	Fostering a regenerative and sovereign food system; developing a food economy.

Part 3: Future Directions for QHS Services

Q'wemtsin is committed to the following action items for each of our goals and objectives. Some of these actions are continuations of existing practices, and some are new or anticipated.

Goal 1: Build partnerships and collaborate.

Objective 1.1: Strengthen connections among member communities, families, and individuals.

1. Participate with Bands in hosting educational workshops and community events. [see Action 1.2.6]
2. Provide welcoming environments. [see Objective 3.2]
3. Connect with schools and daycares.
4. Collaborate with communities in their health and wellness programming.
5. Support communities in times of crisis.
6. Support and participate in wakes and funerals, when invited.
7. Participate and collaborate with communities as they reclaim and revitalize their on-the-land practices.
8. Provide educational support around care by families, especially care of Elders.



Objective 1.2: Work with the three bands to enhance programs and services.

1. Hold event planning meetings with the staff of the communities.
2. Have monthly Board meetings.
3. Seek feedback, and initiate changes as required.
4. Link Q'wemtsin and band newsletters.
5. Participate in community events and activities.
6. Bring members of the three communities together (example: men's nights).
7. Partner with organizations already involved with food security, food sovereignty, and skill building.

8. Develop community food mentorship, including train the trainer, and promote participation in ongoing food sovereignty training, working with the three communities.
9. Support communities as they develop mental health and wellness programs.

Objective 1.3: Actively engage in health tables, collaborate with partner organizations, and strongly advocate with health authorities.

1. Participate in the 2005 Partnership Accord with Interior Health (IH) and the six other Interior Nations, sharing resources and transforming relationships with the Province of BC.
2. Participate in transformation at all levels, ensuring input to program changes.
3. Share the Q'wemtsín newsletter with IH, First Nations Health Authority (FNHA) and other relevant organizations.
4. Invite FNHA, IH and other organizations to attend Q'wemtsín events, set up booths, and share information.
5. Stay current on organization charts for both health authorities and stay informed about opportunities for collaboration.
6. Provide space and hosting for IH and FNHA meetings at Q'wemtsín.
7. Participate as a member of the Health Directors Hub, meeting monthly.
8. Participate in implementing the Partnership Accord with IH and *Le7 te Melámen* (formerly SHC, Secwépemc Health Caucus).
9. Participate in *Le7 te Melámen* meetings and other events such as forums and planning sessions.
10. Support advocacy with First Nations Health Authority to lobby for transfer of federal funding for Home Care, and seek further resources to provide consistent, culturally competent Home and Community Care services.
11. Support advocacy for development of domestic violence programs that are culturally safe and competent, working with community and partnering with other organizations (for example, transition house, counselling, sharing circles, and workshops).
12. Support advocacy for programs such as Car 40 (a mental health nurse and police officer team) and Domestic Violence Unit to provide service on reserve.
13. Advocate with all levels of government to protect existing funding and to actively source additional funding to resource QHS plans.

Objective 1.4: Challenge funders so that QHS can extend services to off-reserve band members and other community members who are immediate family of band members.

1. Support advocacy with FNHA to include off-reserve band members.
2. Document the number of people that QHS turns away and/or are on wait lists with QHS.

Objective 1.5: Ensure funding transfers reach the community level.

1. Flow funds to member bands as set out in the FNHA contribution agreement.
2. Advocate that health and wellness monies that come to the Secwépemc Nation flow to communities.
3. Advocate that new funding for elder care comes to QHS and communities.

Goal 2: Deliver programs and services addressing community needs

2.1: Deliver and evolve our existing services.

1. Provide existing QHS primary health, home and community care, and public health care services.
2. Engage communities to identify changes in needs.
3. Evolve services in response to changing needs.
4. Embrace Secwépemc cultural competency and expertise - and integrate these in QHS programs and services as appropriate.

Objective 2.2: Expand primary *healthcare, prioritizing general practitioner and nurse practitioner services.*

1. Inform community members about how Family Nurse Practitioners and Doctors provide the same services – and about their levels of professional training.
2. Expand General Practitioner and dentist services as necessitated by community need.
3. Head-hunt new and future graduates – especially GPs who are First Nations people – including through medical doctor residency programs.

Objective 2.3: Expand elders' services and other health services in the three communities.

1. Offer individualized support for community members who are caring for members with challenging palliative care needs (caring for the caregivers).
2. Engage elders and their families regarding falls prevention and other age-related safety concerns.
3. Develop ways to support and educate caregivers to support aging gracefully at home; develop a book and other resources / programming to support people aging at home.
4. Work in collaboration with the province to secure funding for palliative care.
5. Seek funding to provide respite care (to support family while they keep elders at home longer).
6. Collaborate in advocating for transfer of home care funding from Interior Health to QHS so that we can provide Home and Community Care services 24/7.
7. Address elder abuse prevention and response, re-activating the ReAct Program.

Objective 2.4: Explore possibilities for expansion of services, *building on our past plans*.

1. Provide transportation to QHS appointments for eligible clients, as per our policies.
2. Develop and expand nutrition counselling and education.
3. Support the three Bands in building regenerative food systems, and food sovereignty programming based on best practices.

Objective 2.5: Stay abreast of technology change in healthcare.

1. Use technology to provide access to health information, especially for youth (for example, crisis apps).
2. Promote and assist with accessing online health information resources and other personal health technologies.
3. Assist clients to navigate the virtual healthcare system - including provision of computer access at Q'wemtsin for medical purposes only.
4. Explore other uses of information technology in better serving community.

Objective 2.6: Explore development of an integrated mental wellness program, using multiple modalities.

1. Work with Band social development departments to advocate for mental health programs and services that are available through FNHA and IH.
2. Work with everyone to improve access to current services, staying informed and ensuring information is shared.
3. Explore on-the-land healing options and traditional ways of addressing mental wellness.
4. Stay current about mental health programs and services, the criteria, and how to access.
5. Ensure Band social development departments have copies of our Mental Health Provider booklet.
6. Work in partnership with FNHA, IH, and Ministry of Health to improve crisis management in community.
7. Continue to advocate for closer to home programs and services from IH and FNHA.

Objective 2.7: Further explore opportunities to support community-driven traditional healing.

1. Support and encourage traditional wellness practices.
2. Work in partnership with Band cultural workers and Knowledge Keepers, recognizing each community's autonomy.
3. Nurture and expand the Q'wemtsin healing garden for community, inviting people to participate and share knowledge / practices.

4. Harvest and offer traditional medicines and foods that are available, such as sage, sxusem (aka “hooshum”), salmon, mullein, cedar, and sweet grass, with the guidance of Knowledge Keepers.
5. Participate in and support hunting/fishing camps, berry picking, root harvesting, canning, smoking, and other ways of harvesting and preparing food for storage.
6. Provide opportunities for knowledge to be transferred regarding traditional practices through workshops and/or other ways of teaching/learning.
7. Include traditional crafts, storytelling, and other traditional practices when offering events.
8. Offer opportunities for community members and families to gather and connect whenever budget is available.

Objective 2.8: Further explore formation of crisis intervention teams.

1. Collaborate with crisis intervention teams that FNHA, BC Emergency Services, and IH have in place.
2. Work in partnership with member bands to explore formation of crisis intervention teams.
3. Support and encourage bands to provide first aid training to members and to prepare for emergencies.

Goal 3: Provide a trusting, open professional environment.

Objective 3.1: Build relationships that ensure trust – at all levels.

1. Provide consistent, high-quality care and services.
2. Provide training to staff on the nature of confidentiality - and how to reach a high standard of it in day-to-day service provision.
3. Maintain transparency and accountability through open communication and information with communities, via the website, newsletter, and open house forums, with current information on Q’wemtsín staff, goals, and what has been accomplished.
4. Maintain a friendly approach in all interactions with clients.
5. Maintain a professional image in the workplace (example: clean desk policy) and as individuals providing services.
6. Follow job descriptions.
7. Follow approved policy and procedures.
8. Encourage staff to get to know community members as individuals.
9. Engage staff and Board in cultural learning with community members.
10. Ensure policy and procedures are aligned with current harassment and ethics norms.

Objective 3.2: Provide welcoming community environments.

1. Bring in Secwépemctsin language and tradition where possible.
2. Maintain a friendly front desk presence, greet clients when they come in – by name, when possible; treat people with kindness, genuine interest, and presence.
3. Maintain a clean and tidy environment throughout Q'wemtsín facilities, including waiting rooms.
4. Offer refreshments to all clients waiting – including healthy beverage options.
5. Introduce new staff to community members and provide them opportunities to experience community/cultural events.
6. Feature traditional / cultural items in decoration of office facilities.

Objective 3.3: Provide strong governance and administration.

1. Develop, update, and implement policy.
2. Have regular staff, administration, and Board meetings, documented as minutes.
3. Support staff with organized, professional administration.
4. Review all policies to keep them current, consistent, and aligned with FNHA funding partnership.
5. Update operational procedure manual for the administration department.
6. Provide sound financial management.
7. Further develop and use a board orientation package, including a checklist.
8. Provide ongoing governance training for Board members.
9. Use an unbiased personnel review process for the Health Director and implement annually.
10. Assess capital assets management and continue to meet ongoing needs (for example, vehicles).
11. Review and update no-show policy.
12. Renew Social Development Lead / Community Service Manager as non-voting guests at Board meetings.
13. Engage Elders through existing lunch gatherings.

Objective 3.4: Provide opportunities for professional growth of staff.

1. Provide opportunities for training for all staff to stay current in their professions.
2. Provide opportunities for ongoing upgrading and recertification for all necessary / mandated certifications.
3. Support staff who want to upgrade or further their education relevant to QHS, providing leaves of absence when possible.
4. Provide opportunities and support for personal growth to improve communication skills and individual competencies.

5. Provide workshops, lectures, and other avenues for continued learning.
6. Plan for ongoing training needs, in connection with annual staff performance reviews.
7. Develop individual learning and professional development plans.

Objective 3.5: Integrate departments and programs for provision of holistic care.

1. Facilitate an environment where team members can effectively communicate and collaborate.
2. Encourage staff to bring issues forward and ask questions.
3. Hold monthly staff meetings.
4. Promote a positive organizational culture.
5. Provide staff professional development and team building opportunities.
6. Have regular manager meetings.
7. Develop succession plans, as needed, preparing impact of promotions of existing staff.

Objective 3.6: Explore QHS future facilities tenure, location, and expansion.

1. Take this issue to each of the three Councils.
2. Bring back to the Q'wemtsin Board table for further discussion.
3. Explore extension of the 25-year land and building arrangement with TteS beyond 2031.
4. Explore expansion of existing facilities.
5. Lead strategic planning on the future of Q'wemtsin facilities and operations.

Goal 4: Create opportunities for learning.

Objective 4.1: Organize educational health activities that bring people together.

1. Collaborate with communities in creating participatory learning opportunities.
2. Collaborate with community staff.
3. Provide inspirational speakers.
4. Encourage participation in support groups.
5. Prepare and provide healthy food samples / snacks, with recipes.
6. Promote drug and alcohol-free community events – such as games nights and dances.
7. Collaborate in organizing and hosting men's, ladies', and youth events.
8. Provide a program of diabetes education sessions regularly, including nutrition discussions, working in partnership with the bands.
9. Provide healthy eating workshops, including food samples and snacks – working in partnership with the bands.

Objective 4.2: Collaborate with other organizations to deliver health learning opportunities.

1. *Collaborate with band Social Development departments to provide education and programming.*
2. Participate with post-secondary programs and engage with medical residents.
3. Provide site tours of Q'wemtsin for student groups and visiting Indigenous groups.
4. Develop *and sustain* partnerships around food security and healthy eating.

Objective 4.3: Assist and support the three communities as they (re)connect with Secwépemctsin (our language) and traditional wellness.

1. Participate in cultural activities and events.
2. Convene large-scale family conferences involving the three communities - with activities to engage whole families.
3. Work with *Le7 te Melámen (formerly Secwépemc Health Caucus)* to provide security and assurances on protection of traditional knowledge property, based on standards defined by the TRC and the UNDRIP.

Objective 4.4: Provide educational sessions, resources, and materials on current, relevant health and wellness topics.

1. Generate community interest in attendance and participation.
2. Work with bands to focus on children and the future; promote and support healthy values in kids (for example, intergenerational activities).
3. Work with bands where possible to increase awareness of alcohol and drug use affects and risks, including harm reduction and updates on current trends.
4. Work with bands to host a conference on youth at risk.
5. Provide community education on medical use of cannabis, how it differs from recreational use, and relevant science.
6. Provide sessions, workshops, *conferences, and gatherings* on health topics, focusing on areas requested by community.

Objective 4.5: *Further strengthen communication and engagement with community members, continuing to raise awareness of what services QHS offers.*

1. Use social media to share information on services and events – as well as information on resources.
2. *Use our website to communicate and engage with community members.*
3. *Explore and find funding to resource ways to improve community communication, such as apps.*

4. Publish and distribute a quarterly newsletter *and collaborate with community communication teams for distribution purposes.*
5. Prepare and distribute flyers and posters.

Objective 4.6: Encourage and support community members interested in becoming health professionals and provide a welcoming supportive environment for healthcare students.

1. Provide opportunities for summer student positions from community.
2. Participate in school health fairs and community career fairs - and promote health careers as opportunities arise.
3. Promote health careers with entry level employees.
4. Host field placements of health career students and provide letters of support to them, on request.
5. Participate in discussions at the Nation level about the need for better funding for students going into health careers, including funding for programs beyond four years (e.g. medical school).



Goal 5: Evaluate effectiveness.

Objective 5.1: Use feedback and input from community members.

1. Provide opportunities for client feedback, including evaluation forms and suggestion boxes.
2. Provide a complaints *process and respond accordingly*.
3. *Engage Elders and seek advice and guidance regarding our services - through informal consultation.*
4. Attend community meetings, as invited, to share information.

Objective 5.2: Monitor healthcare service statistics and data.

1. Keep client database up to date (individual client information, changed addresses, etc.).
2. Use MedAccess and Panorama to collect stats and data.
3. Prepare and submit timely, engaging year-end reports.
4. Establish consistent systems and procedures for collection of data on MedAccess.
5. Provide opportunities for staff to engage in mandatory training on use of EMR.

Objective 5.3: Do five-year evaluations of services and programs.

1. Engage an external consultant to lead the evaluation process.
2. Collaborate with the consultant to design and carry out the evaluation process – see Section 5 of on this Plan.
3. Review evaluation recommendations and implement as appropriate.

Part 5, “Putting This Plan to Work”, offers further details on the evaluation approach, report contents, service usage statistics, and measurable outcomes.

Part 4: Wellness Programs Provided by Communities

This plan provides a brief community overview, a summary of existing wellness programs, and future directions for Skeetchestn, Tk'emlúps te Secwépemc, and Whispering Pines / Clinton.

This section also provides an overview of community resources and reflections on possible community-driven traditional wellness programs.

Resources

Skeetchestn, Tk'emlúps te Secwépemc and Whispering Pines / Clinton deliver wellness programs, using First Nations Health Authority funds that flow through QHS.

These band-delivered programs complement the more clinical services provided by Q'wemtsin. Along with other services funded from numerous sources, flow-through funded programs address the broad determinants of health.



Traditional Wellness and Healing

One of the areas that the three Bands intend to lead in is traditional wellness and related cultural reconnection programming. Q'wemtsin can play a supporting role in this area. For example, we could partner in new traditional wellness facilities located near our clinics. These spaces, designed for gathering in circles, ceremony, and experiential learning, will accommodate community-driven programs and activities.

Some of the activities suited to these spaces would be:

1. Opportunities to participate in ceremony - sweat lodge, drumming, singing, smudging.
2. Opportunities to learn about, and participate in, traditional medicine harvesting, preparation, and use.
3. Elders offering consultation, storytelling, workshops, and gatherings.
4. Workshops, classes, and other group activities to learn about traditional wellness.

To reintroduce traditional medicine to community members, such facilities could be used to provide access to:

- Learning resources, such as a glass display of medicines.
- Literature, books, and videos on medicinal plants.
- Meeting space for Knowledge Keepers and mentorship participants.

Developing the protocols for provision of traditional medicines will require further consultation and research, to protect traditional knowledge from external exploitation and to find appropriate ways to balance traditional practices with modern realities.

Part of the research needed is to adapt approaches used by other First Nations to protect their culture, in keeping with UNDRIP; especially Article 24: *“indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants...”*

Skeetchestn

Overview of the Community

Skeetchestn is a community of approximately 250 people located 60 kilometres west of Kamloops. In addition, approximately 250 Skeetchestn Band members currently reside outside the community. For information on community history, culture, leadership, governance, departments, and activities, see the Skeetchestn Indian Band (SIB) website www.skeetchestn.ca and/or the SIB Facebook page www.facebook.com/skeetchestn.



Community vision: Skeetchestn is a strong, prosperous, and sustainable community of the Secwépemc Nation that respects all people, our culture, our land, water, and all living things.

Existing Wellness Programs and Services

SIB provides an array of health services and supports to community members. In partnership with Q'wemtsin, the Skeetchestn Health Clinic provides on-reserve access to health services including medical (conventional and naturopathic), dental, counselling and wellness services - in addition to home and community care. SIB also provides wellness related resources to members, including extended health and dental benefits, a wellness and recreation fund, and information sessions focussed on specific health issues.

SIB supports healthy lifestyles through health and wellness programming that currently includes early childhood education programming, youth programming (4 nights/week), evening classes on traditional crafting, mini-sessions on anxiety / mental health and engagement in community; Elders luncheons, mom's groups, women's and men's groups, Elder and youth activities / mentoring, monthly culture nights, food forest / community garden involvement, an annual 5km fun run, and other physical activity programs.

The following tables show details of services provided with flow-through funding: Mental Health; Physical Health; After School Program; Patient Transportation; Holistic Prevention and Referrals; Homemaking; Food Sovereignty; and Traditional Language and Culture.



Mental Health

What:	Retreats for Elders, adults, youth, families, and staff; workshops on wellness, resilience through art; cultural arts; sports; music. Connecting people with virtual counselling, as well as detox and rehab services.
Who by:	Social Worker, Cultural and Youth Coordinator.
Who for:	Skeetchestn community members.
Why:	Self-growth and development of desire to invest in well-being.

Physical Health

What:	Floor hockey; softball team; drop-in volleyball; kick boxing; drop-in gym use, walking on the roadside path; and other physical activities.
Who by:	Social Worker, Cultural and Youth Coordinator, others.
Who for:	Skeetchestn community members – with some classes for youth; adults; Elders.
Why:	Improved physical fitness; ability to make healthy lifestyle choices.

After School Program

What:	Traditional / cultural activities; inclusive sport activities; seasonal / outdoors activities; arts and crafts activities; guitar lessons; snacks / food preparation; movie nights exploration and field trips; attending conferences, workshops, and Gathering Our Voices.
Who by:	Cultural and Youth Coordinator.
Who for:	Skeetchestn school-aged community children and youth and Skeetchestn Community School students.
Why:	To promote an engaged lifestyle, through interest-based and inclusive learning opportunities.

Patient Transportation

What:	Rides to SIB health clinic as needed; rides to medical appointments in Kamloops (currently Tuesdays and Thursdays). Assistance with accessing travel & accommodations support to see specialists outside the Kamloops area.
Who by:	Patient Travel Coordinator.
Who for:	Skeetchestn community members.
Why:	Improved access to healthcare services.

Holistic Prevention and Referrals

What:	Individual meetings; group / family meetings; parenting workshops; healthy coping; cooking classes; autism awareness; wildlife passes; senses walks around the community; referrals to foundational / grassroots services – such as family addiction centres.
Who by:	Social Worker.
Who for:	Community members.
Why:	Ability to navigate through various services and programs, healthy lifestyle choices.

Food Sovereignty

What:	Food forest/community garden, tanning and smoking shack, root cellar, community food preserving/preparation, nutritious and traditional cooking programs, promoting healthy eating within our schools
Who by:	Social Development, school principal, agriculture coordinator, community members, outside support.
Who for:	Community members, students, and Elders
Why:	Knowledge of traditional foods, food preparation and storage is part of our identity and belonging. Healthy eating will help prevent ill health among our Secwépemc People.

Traditional Language and Culture

What:	Incorporating the language into everyday life at work, home, schools, and community events. Language classes with mentorships, providing traditional gathering camps.
Who by:	Elders Language Committee.
Who for:	Knowledge Keepers, Language Committee, students, Elders.
Why:	Identity and belonging are key for overall well being of Secwépemc People.

Future Directions

Preventative wellness programs are a priority for the coming years. This includes early childhood and parenting supports with more resources invested in supporting mental and physical health from before birth to school age. Effective outreach services to prevent addictions and mental health issues will include outreach staff supporting people to be close to the land and to Secwépemc traditions.

For 2024-2034, Skeetchestn priorities for QHS flow-through funding are to:

1. Increase frequency of community sweats, pit cooks, traditional games, and traditional on-the-land activities with Elders.

2. Normalize traditional teachings regarding medicines and on-the-land healing – so people can do it themselves.
3. Provide cultural orientation to staff coming from outside the community.
4. Provide respite for caregivers, ensuring children are cared for in a healthy, kind, responsible way outside of the home / within the community.
5. Provide respite training, so that young people can be taken care of in the community.
6. Ensure the safe house is properly staffed, trauma informed, and connected with mental health / wellbeing programs in the community.
7. Expand access to mental health counselling, providing dedicated space and times for virtual counselling / primary healthcare.
8. Further explore clustering Elders in adjacent, suitable homes to receive better support.
9. Increase Elder involvement in program development, organically coming and participating when decisions are being made.



Review, Updating, and Evaluation

Implementation of this plan includes annual review and updating of the above priorities by Skeetchestn, in consultation with Q'wemtsin.

In addition, the community-delivered wellness services will be included in five-year evaluations led by Q'wemtsin.

Tk'emlúps te Secwépemc

Overview of the Community

Tk'emlúps te Secwépemc (TteS), formerly known as the Kamloops Indian Band, is the largest of the Secwépemc Bands. Tk'emlúps, meaning “where the rivers meet”, is home to approximately 1,412 Tke'emlupsemc (people of confluence) living in or away from the community. TteS utilizes the land for various development and economic opportunities, constantly strengthening the community for the future. Highly in tune with the land and culture, TteS also hosts large events for all Secwépemc communities. For further information visit tkemlups.ca/ and / or facebook.com/TkemlupsteSecwepemc.



Community Mission: *To promote & ensure the physical, mental, emotional & spiritual well-being of our people and community.*

TteS is dedicated to holistically supporting community health and wellness. As stated on the website, the Band is “...committed to developing, managing and delivering health and well being programs and services which provide members with income support, skill development, and other opportunities, as well as many learning resources to help the community thrive economically and socially.”

TteS organizes a variety of annual events to keep the community active, such as the Moccasin Mile, Pow Wow, and many others. TteS has an extensive youth program, allowing youth to explore various activities including traditional and cultural education and experiences. TteS understands the importance of including and focusing on individuals of all ages, families, and the community.

TteS upholds the following principles in how it delivers programs and services to community members:

- Responsive to expressed needs.
- Trauma informed practice.
- Opportunities and services that reduce the effects of poverty.

The following tables show details of programs and services provided with flow-through funding: Brighter Futures; Community Health Representative (CHR); Wellness Counselling (NNDAP) and Solvent Abuse Prevention; and Mental Health. All of these are provided for Tk'emlúps Band members and their immediate family members.

Brighter Futures

What:	Retreats for men, women, and Elders; food and playground equipment and supplies for youth centre; after school tutoring and homework program; parenting workshops, youth workers (contracted services); youth day camps.
Who by:	Community Services staff and qualified facilitators.
Why:	Reduced effects of poverty, motivate and challenge youth to excel; help parents with coping skills and tools to improve family relationships and communication, improve school outcomes; increase physical, mental, and spiritual health – holistic wellness.

CHR (Community Health Representative)

What:	Supports for new parents; education around FAE (fetal alcohol effects); Moccasin Mile; nutrition and diabetes support; community kitchen programs; girls' and boys' groups, healthy education supplies; administration of patient travel, benefits, medical/dental program; wellness visits; community garden; annual wellness fair (with QHS).
Who by:	CHR and other Community Services staff.
Why:	Improve food security; reduce unwanted pregnancy; gestate healthier babies; decrease diabetes, decrease incidences of FAE; improve holistic wellness; improve physical literacy; improve healthcare access and navigation; increase access to funding for patient travel / eyewear / dentures etc.

Wellness Counselling and Solvent Abuse Prevention

What:	Wellbriety program; community feasts; community wellness dance; weekly men's and women's sweats; transportation to AA meetings, 1-1 counselling, enrollment in treatment facilities; wellness visits; post treatment care; adult and youth harm reduction training; education on wellness shortfalls in First Nations communities (with TRU Social Work program); substance abuse interventions on request; family counselling and crisis support; addiction prevention workshops, resources, and referrals.
Who by:	Drug and Alcohol / Wellness Counsellor, other Community Services staff, TRU practicum students and staff.
Why:	Prevent suicide; prevent overdosing; reduce addiction rates; increase family healing; improve community connectedness; closure after trauma; improve mental wellness.

Mental Health

What:	Referrals to individual, couple, and family counselling; first aid training; mental health first aid training and intervention; conflict resolution, communication, personality type, and various other mental wellness workshops; CHOICES program funding; referrals to 1-1 counselling and supports.
Who by:	Community Services staff and qualified facilitators.
Why:	Improve mental wellness, improve family communication, reduce effects of trauma, assist with grieving process, increase community awareness of mental wellness; improve quality of crisis response.

Future Directions

For 2024-2034, TteS priorities for Q'wemtsin flow-through funding, in combination with other resources, are to:

1. Develop services to be delivered through new facilities:
 - 1.1 House of Healing.
 - 1.2 Elders gathering lodge.
 - 1.3 Culture and language heritage building / museum.
2. Continue to develop healing spaces on reserve for traditional health practices, such as sweat lodge facilities and a revitalized, unified, fire pit area – in consultation with Elders.
3. Build programs to fulfil the TteS Healing and Wellness Plan.
4. Create a client centred care approach, working with Q'wemtsin, especially for people with complex needs and/or concurrent disorders.
 - 4.1 Explore and address access to clinical services for people with complex needs.
 - 4.2 Further explore and develop land-based healing, building on cultural strengths.
 - 4.3 Build in a trauma informed lens and best practices.
5. Create a mobile crisis response team, with availability evenings and weekends - including clinical response and advocacy / referral to services.
 - 5.1 Develop programming resources for new safe house for women and children experiencing violence and abuse in relationships.
 - 5.2 Create relationships with services in town to enhance access in the community.
 - 5.3 Train community members to create crisis response capacity within the community.
6. Continue planning for a new youth recreation centre.
7. Continue to provide and develop food sovereignty programming.
 - 7.1 Make efficient use of the Kwseltkten mobile kitchen initiative, in partnership with Central Interior Community Futures.
 - 7.2 Create a food bank, including distribution of food we grow.
 - 7.3 Explore economic development and employment creation opportunities.
8. Continue to assist membership to navigate and maximize their health benefits (such as First Nations health benefits, MSP, and others).
9. Work with funding partners to increase Community Health and NNADAP (Alcohol and Drug Abuse Program) funds, to better assist with needs of members on reserve and away from home.
 - 9.1 Work with IH and other partners.
 - 9.2 Coordinate planning and event hosting with a reactivated Community Indigenous Champion Team.

10. Develop a homelessness action plan, partnering with the City of Kamloops.
 - 10.1 Continue to assist community members who are unhoused.
 - 10.2 Include client-centred approaches in assessments.
 - 10.3 Build capacity for providing mental health / addictions wellness checks.
 - 10.4 Collaborate with Housing Department to explore transitional / supportive housing for TteS members.
 - 10.5 Explore prioritization of access to shelters / transitional & supportive housing / resources.
 - 10.6 Identify ways to support people who do not want to go to shelters / services.

Review, Updating, and Evaluation

Implementation of this plan includes annual review and updating of the above priorities by TteS, in consultation with Q'wemtsin.

In addition, the community will participate five-year evaluation processes led by Q'wemtsin.



Whispering Pines / Clinton

Overview of the Community

The Whispering Pines/Clinton Indian Band is one of the 17 bands within Secwépemc Territory. Traditionally from the Clinton area, WPCIB membership includes ancestral lineage from both the *Pellt'iq't te Pésllkwes* (People of the White Earth/Kelly Lake) and *Steke'7ús* (People of the Little Hanging Bridge/Big Bar).



In 1972 the Province of British Columbia displaced the Band from Clinton to build a hydro station on their traditional lands. The Band was forced into a land exchange that involved moving members to Whispering Pines, 35 km north of Kamloops. As a result, Band members have had to travel approximately two hours to gather berries, fish, and hunt on their traditional lands there are approximately 222 Band members living on reserve or away from home.

Known as the *Pellt'iq't* people - people of the white earth, there are approximately 222 Band members living on reserve or away from home. This is an increase from approximately 100 in 2016 – more than doubling, due to the healthcare bill. This population increase has significant implications for health and wellness service needs. In addition, with more housing being built, the community anticipates rapid further growth in the coming years.

Chief and Council, along with staff, now include away-from-home members in all programming, activities, and funding applications, to the best of their ability and where resources allow.

The Whispering Pines / Clinton Band has various recreational activities and special events, including on-the-land programming with Elders and youth connecting with culture. For further information visit www.wpcib.com.

Existing Wellness Programs and Services

The following tables show details of services provided with flow-through funding: *mental health*, elders care; health promotion and prevention; food sovereignty and cultural activities; and preparedness / essential services. All of these are provided for Whispering Pines / Clinton community members.

Mental Health

What:	Mental health checkups, especially with Elders and youth. Wraparound services for life skills and support, access to opportunities within and outside the community, and building with personal autonomy. Opiate day activities, including acknowledging lost ones and community awareness around overdose response. Response to mental health crises, ranging from minor situations to RCMP involvement. Support for individuals to go into treatment and on-the-land camps. Provide FNHA directory of mental health counselling services.
Who by:	Band staff / Mental Health Outreach Worker.

Why:	Improve access mental health and wellness services and traditional wellness opportunities - and remove stigma.
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Elders Care

What:	Transportation for Elders to appointments; work in partnership with QHS to provide home care and other services to support. The community has acquired a new all-wheel drive vehicle for recreation, appointments, and going to conventions. Working with QHS to confirm set days for baths, massage, and Nurse Practitioner appointments.
Who by:	Band employees, contracted staff, and QHS healthcare providers / staff.
Why:	Improve access to healthcare; improve health and wellness of elders.

Health Promotion and Prevention

What:	Distributing diabetes books for individuals on the cusp of diet issue; providing first aid kits; providing hearing clinics, COVID booster clinics. Bannock bake-offs with Elders and youth; sewing with youth; medicine packets and pine needle baskets with youth; Overdose Awareness Day events – including releasing eagle kites for members who have passed. Health and wellness checks with Elders. Naloxone training and other workshops; annual flu clinics and mini-health fair; annual family fun day with health promotion activities (with QHS); Occupational Therapist assessments for safety of homes.
Who by:	Band / social development staff and contracted staff.
Why:	Improve community connectedness; improve mental wellness; reduce addiction rates; prevent overdosing.

Food Sovereignty and Cultural Activities

What:	Greenhouse; community garden with herbs, squash, etc.; beekeeping; making healing salves; looking at cold storage greenhouse to run through the winter. Allocated a van for food / canning deliveries. Canning salmon. Harvesting hooshum berries with youth and Elders. Making healing teas. Drum making with youth and Elders mentoring. Doll making with families to honour the inner child. Taking stones from the river, painting them, orange, and posting healing messages to let lost souls know we are thinking of them. Bringing back the practice of having smudge and welcome songs and prayer at every event. Bringing women together for monthly Women’s Warrior Nights – for wellness, healing, and connection. Resumed monthly men’s nights as a healthy sharing and connection space. Monthly cultural nights with beaded lanyards, rattles, leather pouches, medicine tea – responding to what community members are asking for. Coffee / walking / campfires with a cop – First Nations RCMP. All events are alcohol and drug free.
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Who by:	Cultural Coordinator, Events Coordinator, and Social Development staff; Chief and Council members, Elders, and Stsmemelt (children).
Why:	Connecting with the land, restoring our ties to the land, healing through food, and knowledge sharing.



Preparedness and Essential Services

What:	Coordinate provision of First Aid training up to level 3. Checks of fires extinguishers, chimneys, first aid kits, water coolers, air purifiers, smoke alarms, CO2 alarms, furnace filters, and air filters. Preparedness plans for when office is closed. Deliver bottled water and wood; food for elders and other community members in need.
Who by:	Healthcare workers with Emergency Response, Social Development, Housing, and Maintenance staff.
Why:	Safety and wellness of elders; meet basic needs – especially for families with young children and Elders. This is especially important due to geographic isolation (for example, typically over 1-hour wait for ambulances to arrive).

Future Directions

For 2024-2034, Whispering Pines/Clinton priorities for Q'wemtsin flow-through funding are to:

1. Drive wellness programming through broader planning processes such as the Comprehensive Community Plan, including a health section, and combining with Aging Friendly services planning, strongly including the voices of Elders and focusing on ever-changing needs.
2. Plan for, resource, and build appropriate facilities for healthcare services and wellness / health promotion programming.
3. Continue to combine health flow-through resources with other resources to do planning and referrals to healthcare services.
4. Continue to expand and deliver health promotion and prevention programs.
5. Continue to expand and deliver food sovereignty programming.
6. Continue to support and raise awareness of traditional wellness and cultural activities.
7. Continue to offer mental health support for members seeking rehab and/or treatment.
8. Establish a youth and elder worker, building on what is already happening.
9. Provide access to mental health and first aid awareness and support for staff and members, maintain awareness of services, and support development and implementation of safety plans with members who are at risk.
10. Partner with provincial / external agencies to respond to mental health crises, including after hours, and work with RCMP and other partners to increase presence in the community.

Review, Updating and Evaluation

Implementation of this plan includes annual review and updating of the above priorities by Whispering Pines/Clinton Indian Band, in consultation with QHS.

In addition, the community will participate five-year evaluation processes led by QHS.

Part 5: Putting this Plan to Work

Plan Implementation

Q'wemtsin will implement this Community Health Plan by using multiple tools and processes:

- Creating and annually updating an ACTION Plan that shows who leads, who else is involved, and timing for each action item.
- Continuously tracking progress and reporting to the Board on what has been achieved (Health Director).
- Providing annual to will inform community members and funding partners about how implementation is going.

Another way of putting this plan to work is linking it to budgeting and financial management. For example, the ACTION Plan will be used to:

1. Identify priorities for funds that become available in the event of an operating surplus.
2. Plan for capital and operating costs associated with changes in services and facilities.

Q'wemtsin will adjust this Community Health Plan annually and as needed in response to opportunities and changing needs. Band social development managers will collaborate in updating their respective sections of the Plan.

The Health Director and Board may identify ways to expand services, develop new programs, and/or adjust existing services. Such changes could be in response to emerging needs identified by community members. It could also be in response to new and changed healthcare funding.

Evaluation

In addition to annual reporting, Q'wemtsin will continue to do five-year evaluations that document how well services and programs are working. The idea is to assess progress and support reflective learning.

As with past five-year evaluations, these will aim to:

1. Learn how effective programs and services have been, and opportunities to improve.
2. Refine and develop services to better meet needs.
3. Demonstrate results to community members and funding partners.
4. Maintain accountability and transparency.

Five-year evaluations will be collaborative, building evaluation knowledge and skills. They will be designed to empower, so that clients benefit from sharing their feedback and information. They will likely involve surveys of service users, key interviews, focus groups, and facilitated dialogues of Board and staff teams.

The evaluation team will work with Band social development staff and QHS Board members to appropriately include assessment of Band-delivered programs.

Report Contents

Five-year evaluations will include the following kinds of information:

- **Resources / inputs:** leadership, staffing, funds, facilities, and equipment.
- **Services:** what is offered, by whom, for whom, how, and why.
- **Outputs:** quantities of service provided (statistics).
- **Outcomes:** changes in individuals or systems that are associated with a program or service. Outcomes may be initial, intermediate, or longer term.

Service Usage (output statistics)

The QHS evaluation will document service usage for each category of services by tracking output measures as shown in the tables below.

For each output measure involving appointments / 1-1 service, staff will also track numbers of no-shows.

Primary Care

<i>Key output measures</i>	<i>Who tracks</i>
# of general practitioner 1-1 services	MOA/Office Manager
# of nurse practitioner 1-1 services	
# of respiratory therapy 1-1 services	
# of craniosacral therapy 1-1 services	
# of naturopath 1-1 services	
# of CDE 1-1 services (Certified Diabetes Educator)	

Dental

<i>Key output measures</i>	<i>Other output measures</i>	<i>Who tracks</i>
# of clinic visits (1-1 services)	# of hygiene sessions; dental exams; fillings; extractions; referrals for treatment	Dental Programs Manager
# of COHI screenings / examinations (1-1 services)	# of referrals for treatment	
# of COHI fluoride varnish applications (1-1 services)	# of sealant treatments	

Home and Community Care

<i>Key output measures</i>	<i>Who tracks</i>
# of health care aide in-home visits	HCC Manager
# of century tub 1-1 services	
# of medic aid devices provided	
# of home care nursing 1-1 services	
# of foot care 1-1 services	

Maternal and Child Health

<i>Key output measures</i>	<i>Who tracks</i>
# of new families / clients served	PH
Total # of families / clients served	Manager

Communicable Disease Control

<i>Key output measures</i>	<i>Who tracks</i>
# of babies immunized	PH
# of children / youth immunized	Manager
# of other vaccinations provided (all diseases)	

Events

<i>Key output measures</i>	<i>Who tracks</i>
# of annual health fair participants	Community
# of Kindergarten Day event participants	Champion
# of other event participants	

Outcomes

Five-year evaluations will measure outcomes such as:

1. Increased access to healthcare services.
2. Improved ability to make healthy choices.
3. Improved ability to meet physical and mental / emotional health goals.
4. Strengthened cultural reconnection.

These evaluations will provide evidence on five aspects of increased service access:

- Receiving competent, capable care.
- Being treated with respect.
- Experiencing cultural safety (non-judgmental, racism-free healthcare).
- Feeling safe to be yourself and say what you need to.
- Feeling heard and included in decision making about care.

The evaluations will measure four aspects of improved ability to make healthy choices: 1) to eat well and have a balanced diet; 2) to access local, healthy foods; 3) to engage in physical exercise and active living; and 4) to achieve healthy community connections.

Evaluations will measure two aspects of improved ability to meet health goals: physical and mental / emotional.

To assess strengthened cultural reconnection, evaluations will measure factors such as:

- Healthy connection within families.
- Healthy connection to the land.
- Learning Secwépemctsin (the language).
- Re-established cultural ways of knowing and being.

Part 6: Conclusion

Re Stsq'ey's es Qellqéllt.s is a guide for Q'wemtsin and the three Bands as we continue to develop and offer healthcare services and wellness programs, from 2024 to 2034. This Community Health Plan reflects input from members of Skeetchestn, Tk'emlúps te Secwépemc, and Whispering Pines / Clinton, as well as their elected leaders and staff.

We secure and use the necessary resources to offer professional, racism-free, non-judgemental healthcare and wellness services to all members of our communities. This is part of decolonization. The strengths of Chief and Council members, Elders, and staff are vital in the work to support our people in reclaiming their health.

Reconnection with the land, Secwépemc culture, community, and family are at the heart of this healing journey. It is happening in many ways. One way is working together to create suitable facilities and locally driven traditional wellness programs and healing services.

Our big challenge for the coming ten years is to develop land-based community healing, mental health supports, and crisis intervention. We need a dual approach: to include mainstream approaches while also developing traditional / cultural approaches. Meanwhile, we need to redouble efforts to recruit and train our youth and community members to become healthcare professionals. We also need to continue building our food sovereignty initiatives and continue to work on our partnerships with FHNA and IH.

Continuing to develop holistic approaches to healthcare and wellness programming will further the Q'wemtsin vision of *healthy Secwépemc individuals, families, and communities*. This Plan will guide our steps on the path toward this vision.



Appendix 1: Attached Documents

The following documents will be attached to the *Re Stsq'ey's es Qellqéllt.s* to meet the requirements of FNHA regarding administrative information related to community health plans.

1. Summary of Additional Information Required in Community Health Plans
2. QHS Corporate Documents: Constitution and Bylaws; Certificate of Good Standing
3. QHS Organizational Structure
4. Job Descriptions
5. Human Resource Manual
6. Privacy Policies
7. Financial Policies
8. Operating Policies
9. Occupational Health & Safety Manual (vehicle policy is embedded)
10. Pandemic Plans
 - i. Skeetchestn
 - ii. Tk'emlúps te Secwépemc
 - iii. Whispering Pines/Clinton
11. Liability and Malpractice Insurance
12. Primary Health Care Agreement with Interior Health for Nurse Practitioner Services
13. Complaints Process
14. Business Resumption Plan
15. Proposed Budget: 2018-19
16. The Circle of Life Algorithm
17. Hub/Secwépemc Health Caucus Terms of Reference
18. Nation Shared Resources and Joint Project Board
19. Injury Surveillance Form