Alberta Health Services

We Are One

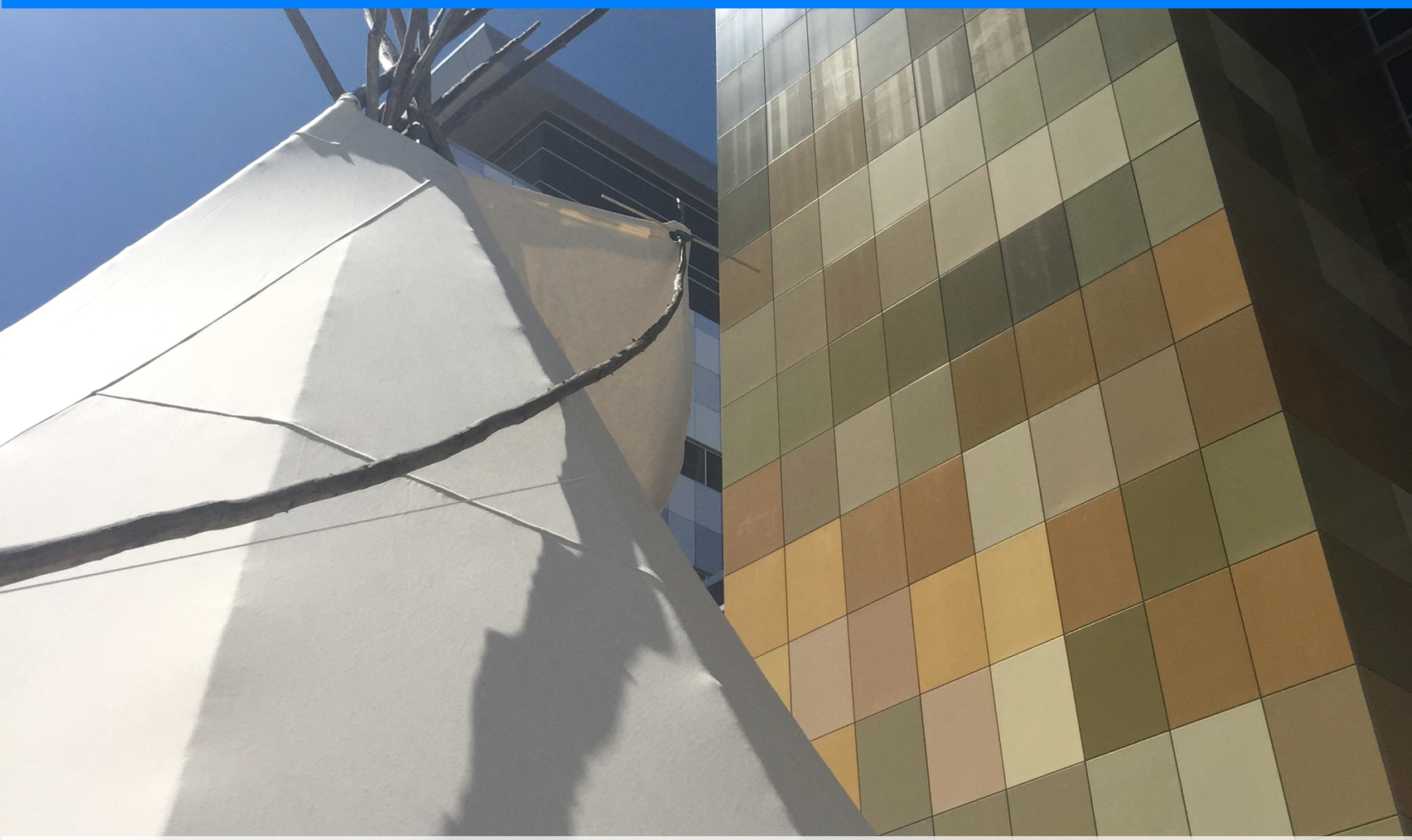
CALGARY ZONE INDIGENOUS HEALTH ACTION PLAN:

2020

Creating a New Path to Indigenous Health in the Calgary Zone

"Aistowaípiiyaóp" *"Barhe Inázebīche"*

"Átłīsīlāts'ādīłí" *"Walking Together"*



"We can certainly change the path of tomorrow because we have the resilience and motivation to do so. Together, WE can empower each other to work towards this common goal."
Wisdom Council

TABLE OF CONTENTS

Appendices

1. Letter from Sponsors: Our Commitment

"We have the opportunity for our vision to establish a strong foundational relationship built on trust and respect with all Indigenous people within Calgary Zone. Through engagement and collaboration with our First Nations, Métis and Inuit peoples, we will create lasting partnerships and work together on opportunities. Together we can address any barriers that exist and enhance the quality of care that is responsive, appropriate, and culturally safe for all Indigenous Peoples within the Calgary Zone."

– Harley Crowshoe, retired Provincial Director South, AHS Indigenous Health Program, and past Co-Chair of the Steering Committee, of Blackfoot ancestry, from Piikani Nation

Alberta is home to a large Indigenous population, with rich heritages and cultures. Calgary Zone is located in the traditional territory of the Blackfoot peoples, which is within the Treaty 7 area including Siksika, Stoney Nakoda and Tsuut'ina First Nations. The Zone is also home to Métis peoples, Inuit peoples, and a large urban Indigenous population. These people all come with strong traditional knowledge, medicines and ceremonies that have been passed down through generations.

This Indigenous Health Action Plan represents a commitment by Alberta Health Services (AHS) Calgary Zone to improve relationships, service delivery and health outcomes for all Indigenous people in the Zone. We have a unique opportunity in Calgary Zone, as this Action Plan is an adjunct of the Calgary Zone Health Care Plan which offers a 15-year long-range plan. This demonstrates commitment from the Zone for sustainable change.

All of us have the ability to make a difference by speaking the truth, building trust, and working together on common goals and actions. As the Co-Chair of the AHS Wisdom Council Casey Eaglespeaker says, "**Let's move to ReconciliACTION.**"

We will do this by focusing on:

- building trust
- creating strong respectful relationships
- collaborating
- listening
- identifying new ways of working together as equals
- maintaining flexibility.

AHS is committed to continue on this journey forward, together, and thanks all participants for sharing your wisdom and sacred stories, and for bringing new bold ideas to this work. It is through our conversations and action that we can create meaningful transformation.

Brenda Huband

AHS Vice President & Chief Health Operations Officer, Central & Southern Alberta,

Executive Lead, Population, Public & Indigenous Health; Correctional Health

Dr. Sid Viner

AHS Zone Medical Director, Calgary Zone

Message from one of our Partners: Stoney Nakoda Tsuut'ina Tribal Council

Âba wathtech, Danit'ada, Oki & Hello!

The Stoney Nakoda Tsuut'ina Tribal Council was established in 2017 as a mechanism for impactful Collaboration and Capacity Building for the Stoney and Tsuut'ina First Nations. The Tribal Council is governed by the Chiefs of the Bearspaw, Chiniki, Tsuut'ina and Wesley First Nations. The Tribal Council's Health Program serves as a positive advocate since its creation and has embarked on a journey towards boundary breaking dialogue for the positive health outcomes of its First Nations. By engaging at the Health Director level, the Health Program has created a process that links directly to the communities. Our main goal is to discuss, advocate, strategize and gain a collaborative understanding of what is needed to improve the health and wellness of our unique communities and to further implement a proactive process to meet the needs of our people.

An opportunity the Health Directors have welcomed openly was to begin dialogue and build a relationship with Alberta Health Services. This relationship has helped to break down stigma's, understand the challenges from both sides, and to positively strategize on new innovations that are culturally respectful and mindful of the challenges First Nations communities and their peoples face on a day to day basis such as racism and isolation. We have had the opportunity to meet with a number of team leads from Alberta Health Services and look forward to meeting more for the continuation of a strong relationship. We will continue this journey by strategizing together for the collective health of our people. The relationship built has been insightful, respectful, pro-active and together we have created an unbiased table that allows both First Nations and Alberta Health Services to potentially change, improve and most of all recognize the health of First Nations in Alberta. This is only the beginning of a long overdue road for change.

We look forward to continuing this journey, knowing that our work doesn't only impact the current generation but can pave the way for the health and well-being of future generations!

Pînamach, Siyasgaas, Thank you!

Margo Dodginghorse, Health Director, Stoney Nakoda Tsuut'ina Tribal Council/G4

"We are walking together equally in this journey to wellness."

(Elder)

2. Acknowledgments

We offer our sincere gratitude to:

The Calgary Zone Indigenous Health Action Plan Working Group and Steering Committee (see listing page 49), AHS Wisdom Council, Sharon Berry, Tessy Big Plume, Georgina Bird, Tom Briggs, Scott Callinglast, Soyun Chapman, Christine Cormier, Bernadette Crowchild, Paul Daniels, Margaret Dickson, Margo Dodginghorse, Tara Duhaney, Casey Eagle Speaker, Mary Eaglespeaker, Joe Eagle Tail Feathers, Carol Easton, Lloyd Ewenin, Paula Finnson, Karen Freimark, Shane Gauthier, Sharon Goulet, Naomi Gordon, Candy Gronwald, Marlene Hamilton, Ruth Holland Richardson, Vern Houle, Jennifer Houle-Famakinde, Brenda Huband, Tina Jacobs, James Jenka, Lene Jorgensen, Julie Kerr, Aaron Khan, Tapisa Kilabuk, Courtney Kozakewycz, Marty Landrie, Mike Lang, Mark Laycock, Amie Liddle, Morris Little Wolf, Betty Anne Little Wolf, Avani Maleshri, Jocelyn Maxwell, Lorraine Meneen, Duane Mistaken Chief, Darlene ONeill, Alice Peters, Joanne Pinnow, Tim Poitras, Brenda Rehaluk, Wally Sinclair, Sid Viner, Jackson Wesley, Brenda Wesley, Blue Cloud Williams, Calvin Williams, Kienan Williams, and Paul Wright.

3. Executive Summary

Our focus is to improve health outcomes of Indigenous individuals and communities. We are committed to delivering culturally safe health services for every Indigenous person in our community. This Action Plan summarizes what we have heard from from key stakeholders and outlines a path forward and foundation for working together in a good way. This document captures what we heard from you - your ideas on areas we can improve as a health service and partner in care. As one participant said, *"we are on a journey of wellness together as a community."*

Racism and culturally inappropriate healthcare services have been identified provincially, nationally and globally as key barriers to accessing health services. We know that healthcare access is improved when services are owned and managed by, or tailored to the needs of, the local Indigenous communities. Improving determinants of health is foundational to improved health outcomes. Indigenous peoples have told us their desire to have choice between traditional and/or westernized medicines. Integration of Indigenous holistic traditional health practices into AHS health service delivery will improve uptake of medical advice, openness, trust, and positive health outcomes. Access to traditional ceremonies (such as smudges and sweat lodges), traditional spaces and medicines (such as sweetgrass and sage), are critical to Indigenous cultures.

Our listening and engagement processes have identified five foundational and interconnected pillars for action, affecting all areas across the Zone. These are:

1. **System Requirements and Shared Accountability**
2. **Providing Culturally Safe & Responsive Care**
3. **A focus on Engagement & Relationships**
4. **Creating Integration & Continuity of Care**
5. **Supporting Traditional Wellness**

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Acknowledgments
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On the Cover
South Health Campus and
Prairie Mountain Tipi
Photo by Penny Morelyle

Photos by
Penny Morelyle
AHS Communications

4. Our Journey

4.1 The Beginning: Ways of Working and the Importance of Ceremony

We began by looking to address disparities and improve health outcomes for Indigenous peoples. In Fall 2017, Calgary Zone AHS leadership started a unique journey to create an Indigenous Health Action Plan. A group of committed passionate individuals and leaders representing various program areas came together to build this Action Plan, bringing forward honest discussion about gaps in knowledge with an ongoing willingness to learn, and respect the process.

The journey was premised on the need to ground the project in ceremony and traditional protocol, which began with a Pipe Ceremony. The process evolved with a Talking Circle to outline our goals, ambitions and ideas for the Action Plan, and to understand the diversity of people that this plan would need to involve. The individuals we invited to engage graciously accepted our invitation to meet and participate, grounding and advising us throughout on how best to work together respectfully.

Conversations were held with Elders, Traditional Knowledge Keepers, patients, Indigenous and non-Indigenous AHS staff, AHS leaders and operational managers, First Nations health centre directors, community members, Indigenous non-profit agencies, and the AHS Wisdom Council. The connections were meaningful and resulted in both laughter and tears as we heard stories of heartache, racism and confusion. From the gaps and challenges identified, opportunities and new ideas were developed. Our commitment to action throughout our journey helped to build trust and goodwill.

The conversations culminated at a gathering at Blackfoot Crossing in May 2019, on the sacred ground where Treaty 7 was signed. More than 70 AHS and Indigenous community partners came together to review what had been shared and to develop concrete ideas to shape our next steps.

"Involve us in the conversation, and we will create the steps together on this journey." (Elder)

4.2 Redefining Medicine in Indigenous Terms:

Indigenous Health & Wellness

What did we learn throughout this journey? We learned that we need to start with the definition of medicine.

From the Western clinical perspective, biomedicine is defined as "a science that includes different fields of knowledge and explains disease essentially based on the conceptualisation of biological facts" (Leguizamon 2005).

For Indigenous peoples, medicine represents a holistic and diverse wellness philosophy. Health components are intrinsically linked to connection to others, the land and ancestors.

Medicine can be found in ceremonies such as the sacred Sundance or in a Sweat Lodge. It is in the traditional medicines used in spiritual practices such as smudging. People receive medicine when communities gather together to pick sacred plants, share meals, and support each other through times of physical or emotional pain.

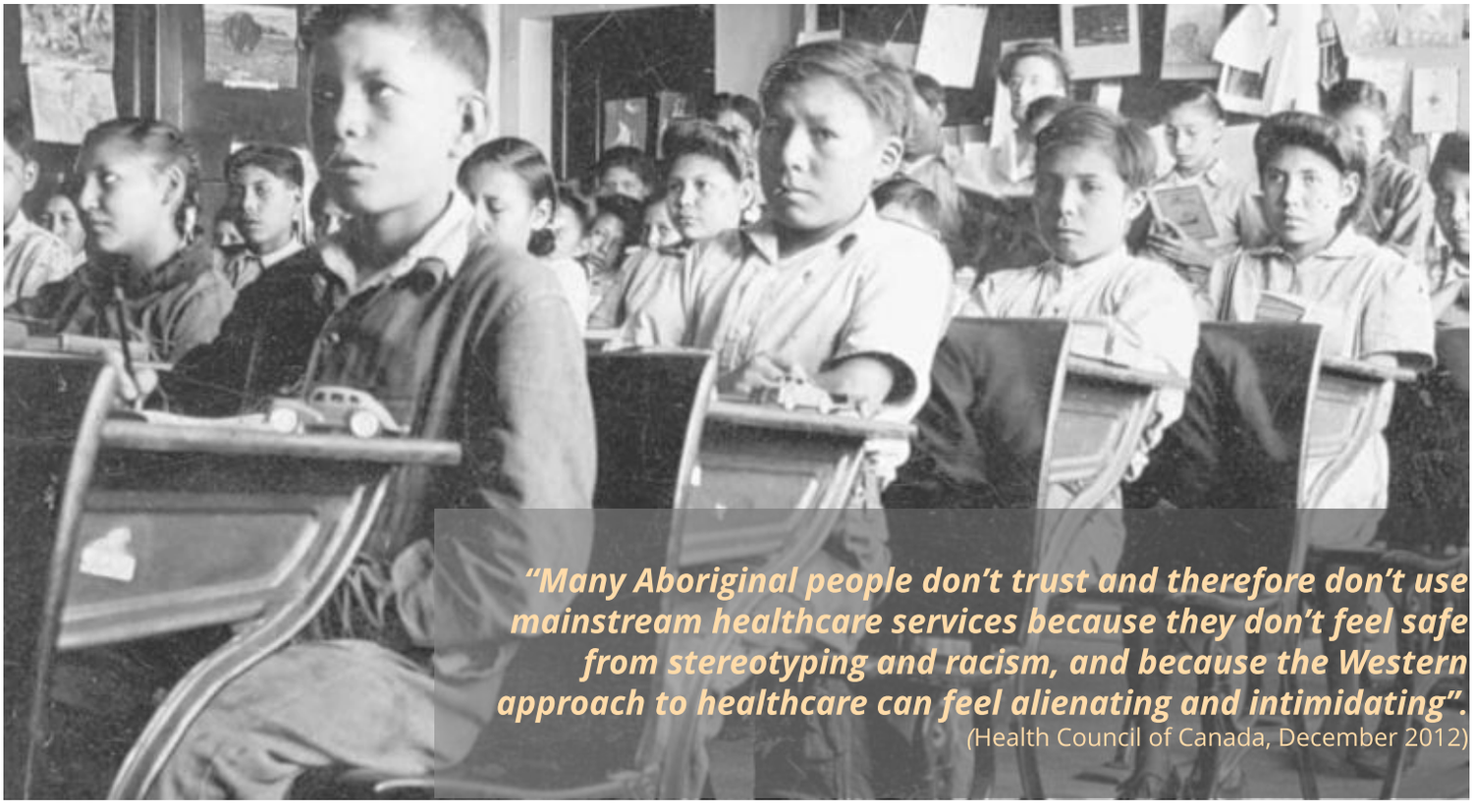
Appreciating, understanding, and embedding this broader definition of wellness will help guide AHS' collective response to support and improve Indigenous health and well-being while encouraging us to create a strong path forward that builds on our strengths, reciprocal sharing of gifts and respect of others' ways. This is how we can bring the strengths, power and benefits of the AHS system (staff, technology, policies) together with the strengths of the traditional Indigenous ways, practices, and medicines.

"Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises. Traditional medicine follows a holistic model health."

(Traditional Models of Wellness Environmental Scan Summary, First Nations Health Council)

"I don't need a pill. I just need to talk and to be with my community. That is the medicine I need."

(Community Member)



5. Why Do We Need a Plan? Commitment to Indigenous-Focused Health Planning

5.1 Setting the Context

Addressing Historical Legacies

Improving the health of Alberta's Indigenous peoples is a strategic priority for AHS, with a focus on reducing health disparities between Indigenous and non-Indigenous peoples. Our journey towards healing starts with acknowledging truths of historical treatment, racism and inequities. We heard many stories of how lack of trust impacts healthcare experiences for Indigenous patients and families. We understand that making space for, and hearing these truths, needs to happen before action can occur. AHS recognizes that healthcare services for Indigenous people are often fragmented and difficult to navigate for patients and providers and that large inequities and disparities in health exist.

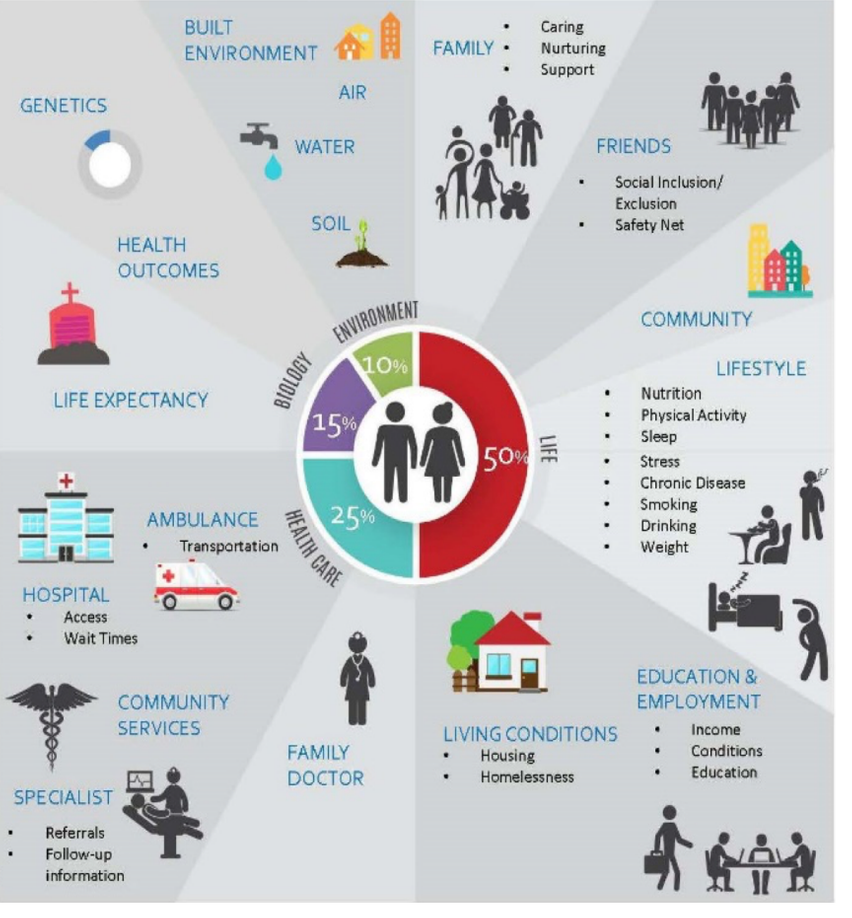
Understanding the context and history is essential to moving forward in a positive way. The health of Indigenous communities and peoples continue to be impacted by assimilation, colonization, historical and intergenerational trauma, residential schools, the 60's scoop, and racism. More systemically, the collective outcome of historical legacies have resulted in:

- **Intergenerational trauma**
- **Distrust of institutions by many Indigenous people**
- **Challenges due to inequity surrounding determinants of health (housing, income etc.)**
- **Issues regarding access to healthcare and services**
- **Jurisdictional barriers**
- **A systems-focused approach to Indigenous health instead of a person-centred or community-resiliency approach**
- **Disparities of health outcomes for Indigenous peoples in Alberta**

Understanding Indigenous Health Inequities

The Canadian Medical Association (CMA) believes that any actions to improve health and tackle health inequity must address the social determinants of health and the impact these have on daily life. The CMA break downs what makes Canadians sick as follows (2013):

Figure 1: What Makes Canadians Sick



The CMA acknowledges that addressing inequities caused by the social determinants of health will improve the health system in an economic sense, and will also create a more compassionate approach to healthcare.

AHS recognizes that the historical legacy of colonialism in Canada has resulted in considerable differences between Alberta's non-Indigenous and Indigenous populations. Indigenous populations in the province experience a greater burden of disease, death and disability than the general population. Primary needs and challenges include:

- Lower reported average **life expectancy** (82.4 for the general population vs. 70.4 for First Nations Albertans in 2018[1)])
- Higher reported **addictions** for First Nations Albertans with respect to alcohol use, illicit drug use and smoking (e.g., Emergency Department visits for opioids and narcotics are five times higher than for the general population)[1]
- Higher rates of **mental health** issues such as depression and suicide (e.g., suicide rates are triple)[1]
- **Chronic disease prevention and management** in areas of arthritis, cancer, cardiovascular diseases, diabetes, hypertension, and respiratory diseases (e.g., COPD prevalence is triple)[2]
- **Infectious and communicable diseases** such as chlamydia and HIV/AIDS[2]
- Higher **injuries** and death resulting from injuries (e.g., mortality due to unintended injury is 2.5 times higher)[1]
- **Maternal and child health** concerns specific to high birth weights and gestational diabetes (e.g., infant mortality rates are double)[1]
- **Lifestyle factors** that impact health, such as poor nutrition, low levels of physical activity and high stress levels[2]
- **Health care utilization** (e.g., Emergency Department visit rates are nearly double)[1]

[1] Alberta First Nations Information Governance Centre, 2015

[2] Alberta Health Analytics and Performance Reporting Branch, 2015

5.2 Goals

Our primary goal is to improve Indigenous health outcomes by partnering with Indigenous communities in the Calgary Zone to jointly identify priorities and co-design solutions.

Table 1: AHS Calgary Zone Indigenous Health Action Plan Goals

Short-term Goals	▸ An Indigenous focused, stakeholder led Indigenous Health Plan ▸ Identify and respond to existing health service gaps for Calgary Zone Indigenous populations
Medium-term Goals	▸ Ongoing, systematic, meaningful engagement with Indigenous communities across program areas ▸ Action plan embedded into Calgary Zone healthcare plan
Long-term Goals	▸ Improved Indigenous health outcomes by working in partnership with Indigenous communities to identify priorities and co-design solutions

5.3 Organizational Alignment and Drivers of Change

This work is based on foundational documents which inform and drive Indigenous health planning across the province. Key national and international documents include:

- Royal Commission on Aboriginal Peoples (RCAP);
- United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP);
- Truth And Reconciliation and Calls to Action (TRC);
- Elder's Declaration of Alberta;
- Jordan's Principle; and
- Murdered and Missing Indigenous Women and Girls report recommendations (2019).

This work is also grounded in Government of Alberta and AHS provincial priorities, as well as learnings from the past. Government and AHS priorities include:

- AHS Health and Business Plan;
- Executive Leadership Team (ELT) Commitment for Reconciliation;
- Wisdom Council priorities;
- Calgary Zone Health Care Plan;
- Provincial Indigenous Health Strategy (currently under development); and
- Population and Public, Indigenous Health Strategic Clinical Network.

"Make sure you have the right people at the table"

(Non-profit representative"

5.4 WHO DO WE SERVE?

Alberta Health Services serves all Indigenous people across the province including First Nations, Métis, non-Status individuals, and those in urban centres.

Indigenous Population within Calgary Zone

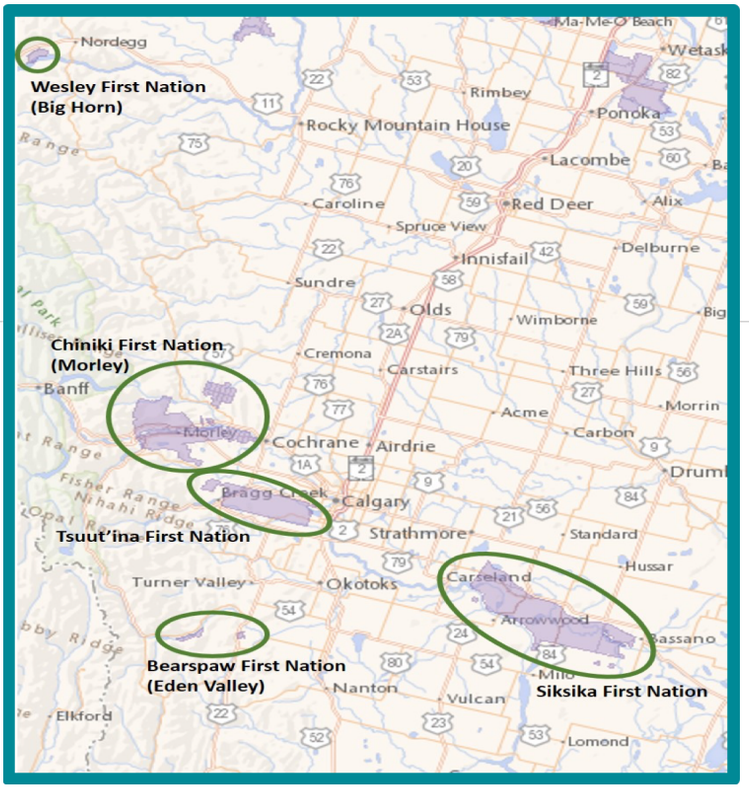
The Calgary Zone is home to the following people:

- Treaty 7 First Nations which include Stoney Nakoda Nations (Chiniki, Bearspaw, Wesley); Tsuut'ina Nation; and Siksika Nation
- The Métis people and Métis Region 3;
- Inuit people
- Many urban and non-status Indigenous peoples (e.g., Sioux, Cree, etc.)

This work builds on and aligns with:

- The South Zone Action Plan which acted as an important starting point.
- The *AHS Integrated Planning for Indigenous Health Planning Guide* is a document to help AHS navigate jurisdictional complexities including healthcare funding and to help bring awareness to common steps that we can all take forward.
- To support appropriate and traditional protocols, an *Indigenous Traditional Protocol Guide* was developed. It was endorsed by the Wisdom Council in fall of 2018, and approved by AHS Executive Leadership Team December 2018. The *Indigenous Traditional Protocol Guide* outlines and guides processes for:
  - Traditional protocols (and honoraria)
  - Ceremonial tobacco
  - Smudging
  - Land acknowledgments
  - Principles for respectful engagement
  - Gifting
  - Medicines.
- The *Calgary Zone Health Care Plan* approved in December 2018 by AHS Executive Leadership Team (ELT), AHS Board and Alberta Health. The plan is a visioning document that projects healthcare in the Calgary Zone over the next 15 years. The recommendations and actions will align with and shape our collective path forward across all program areas within the Calgary Zone.

Figure 2: Indigenous Communities in AHS Calgary Zone



COMMUNITIES AT A GLANCE

Calgary Zone and Alberta

In Alberta in 2016, the reported population of Indigenous people was 258,640, making up 6.5% of the total provincial population. (Statistics Canada 2017). Of that, 114,000 Métis people live in Alberta, and 17,040 live in the City of Calgary. In 2018, the First Nations population in Calgary Zone and Alberta was 30,369 and 165,156 respectively (Gov. of Alberta, 2019).

Treaty Status or Inuit

In 2016, First Nations with treaty status or Inuit as a per cent of total population in Calgary Zone Primary Care Networks (PCN) and Alberta PCN was 1.2% and 2.6% respectively (Gov. of Alberta, 2018).

On-Reserve Population

In 2015, the total on-reserve population in Treaty 7 was 19,497, making up the highest (73%) of the population of all three treaty areas (Voyageur et al, 2015).

First Nations Youth

49% of Indigenous people are under the age of 25, compared to 32% for the rest of the province. In 2016, the average overall age in Canada was 41 years, with 35.4% of the population being under the age of 30. In comparison, the average age of First Nations children, youth, and adults living on reserves and in Northern communities combined was 30.8 years, with 51.6% being under the age of 30 (First Nations Information Governance Centre, 2018).

Indigenous Languages

In Alberta, 45% of First Nations people living on a reserve reported the ability to conduct a conversation in an Indigenous language, a rate higher than off-reserve First Nations people (13%), Métis (4%) and Inuit (8%). The Indigenous languages most commonly spoken by First Nations people are Cree, Blackfoot, and Stoney. Métis spoke mostly Cree, Michif, and Dene. Inuktitut is the Indigenous language most commonly spoken by Inuit (Statistics Canada, 2016).

6. Approach to Health Planning

6.1 Collaboration and Relationship Building

As part of the **co-design process**, the Calgary Zone used stakeholder engagement to identify engagement methods and strategies to guide this process. We respected and applied the use of traditional protocols, engaged with Elders and urban Indigenous agencies, and clarified internal and external processes to improve timely communications.

The Calgary Zone will continue to work to create a culture of mutual trust to move forward together through:

- **Prioritizing meaningful ongoing engagement**
- **Establishing respectful relationships**
- **Listening to what is important to people and communities**
- **Co-designing and customizing healthcare**

"The product is the process"
(Elder)

6.2 Acting Holistically

A **holistic and comprehensive approach** was purposefully adopted in the health action planning process including the planning, design and decision-making process for Indigenous healthcare.

Within Indigenous culture, the Medicine Wheel is divided into four quadrants to represent the interconnectedness of all aspects of one's being. The Calgary Zone understands the value of integrating traditional wellness practices in a culturally safe manner. This includes honouring recommendations stemming from the Truth and Reconciliation Commission's Calls to Action, and supporting reconciliation and self-determination of health priorities with a focus on building relationships, and working collaboratively with Alberta's Indigenous people as key partners in health action planning, design and decision-making.

CO-DESIGN PROCESS

HOLISTIC APPROACH

STAKEHOLDER-LED PROCESS

STRENGTHS-BASED DATA

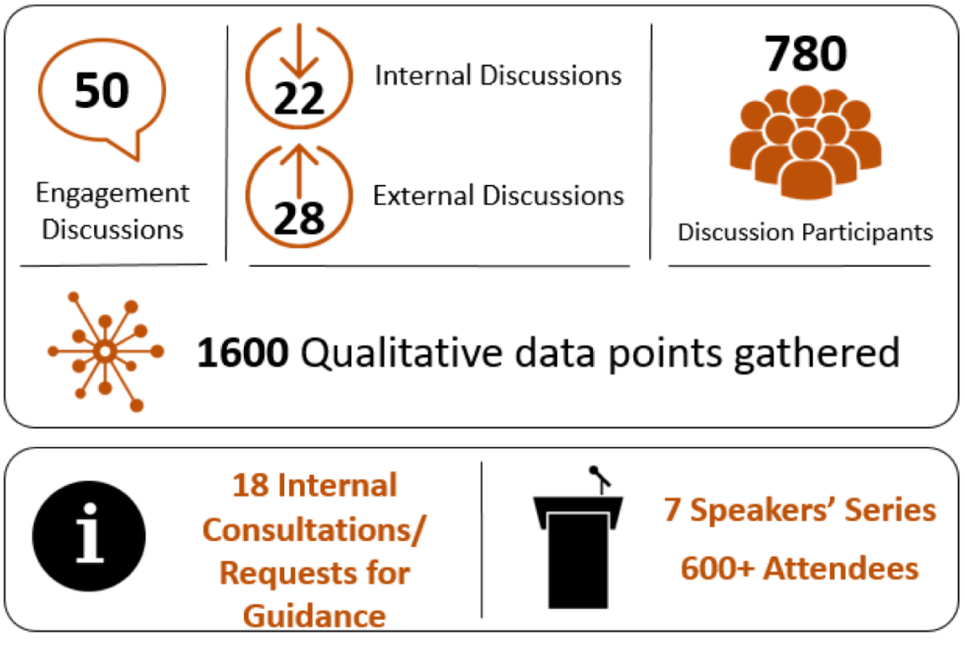
Using a co-design approach that embeds Indigenous holistic world views, including traditional practices, the Calgary Zone will continue to foster openness, transparency, flexibility, trust, respect and cultural safety into our health care delivery system, with the goal of transforming the way we work and practice as an organization.

The Action Plan used a **stakeholder-led process**, which included:

- ***Internal and community engagement sessions***: Throughout an 18-month period, more than 50 engagement sessions and discussions were held with 750 participants including First Nations Health Directors, urban Indigenous non-profit agencies, patients, Elders, Tribal Councils, AHS Wisdom Council, and community members as well as AHS staff, physicians and leaders.
- ***Staff Survey***: An online survey took place in March 2019 to allow additional opportunity for input to the Action Plan. More than 300 responses were received.
- ***Draft Plan Review Session***: A final gathering was hosted in May 2019 at Blackfoot Crossing on the sacred ground where Treaty 7 was signed. Over 70 AHS and Indigenous Community Partners came together to review what had been shared and to develop concrete ideas to shape our next steps.

This process ensured we were learning from our community and our people's wisdom to help shape our direction forward. While we acknowledge the importance of data and evidence to help ground actions, we honour the voices and guidance of the community and staff. Our plan is a careful accumulation of more than 1600 entry points of qualitative information capturing all of the ideas and stories that have been shared. We then themed the learnings into main categories.

Figure 3: Indigenous Health Action Plan Engagement Process



6.3 Guiding Principles and Values

The following guiding principles were essential for the partnership development during the planning process:

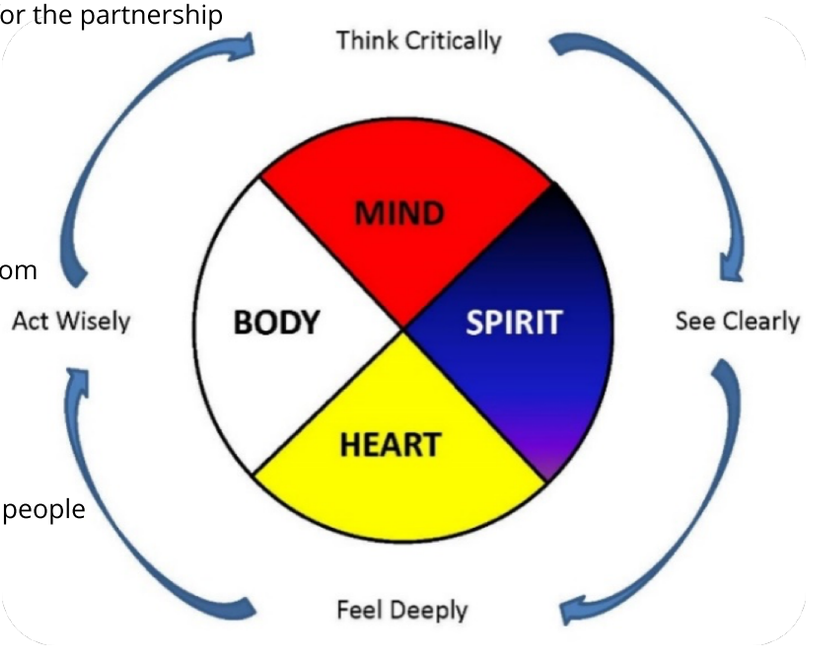


Figure 4: Holistic Health Model

- Indigenous values
- Holistic health model
- Strength-based resiliency focus
- Traditional knowledge and community wisdom
- Co-design and collaboration
- Learning culture
- Take action as we go
- Relationship focus
- Determinants of health
- Indigenous right to health. We are all treaty people
- Indigenous self-determination
- Coordination and integration
- Healing focused and trauma informed
- Trust takes time
- Sustainability
- ReconciliACTION. Acknowledging truth is an important first step in reconciliation.
- Ethical space and two-eyed seeing

Figure 5: Indigenous and AHS Values

AHS cares

Indigenous Values

To cherish knowledge is to know **WISDOM**;

To know **LOVE** is to know peace;

To honour all of the Creation is to have **RESPECT**;

BRAVERY is to face the foe with integrity;

HONESTY also means "righteousness", be honest first with yourself – in word and action;

HUMILITY is to know yourself as a sacred part of the Creation;

TRUTH is to know all of these things.

compassion

We show kindness and empathy for all in our care, and for each other.

accountability

We are honest, principled and transparent.

respect

We treat others with respect and dignity.

excellence

We strive to be our best and give our best.

safety

We place safety and quality improvement at the centre of all our decisions.

6.4 Celebrating Strengths; Acknowledging Limitations

Strengths-based Data

As part of our commitment to accountability, AHS reports on and uses data to identify health and wellness status and guide future planning. Current approaches to health monitoring and reporting typically focus on deficits or the negative aspects of health. AHS acknowledges the value of taking a strengths-based approach as a driver for investment. The Action Planning process validated this approach. We heard that deficit-based reporting on aspects of Indigenous health can continue to stigmatize at risk individuals or communities. While the identification of health trends and opportunities to create evidence-based change is essential for success, we must also value the qualitative nature, such as oral storytelling, that take more of a wellness and success perspective, and which is informed by community perspective and wisdom. Borrowing from the Medicine Wheel philosophy, the Action Plan committee champions the use of qualitative data as an equalizing measure to more traditional quantitative indicators that respect oral culture and deconstruct colonial Westernized approaches to data and health planning. It is acknowledged that this is also a shared responsibility, with the understanding that Indigenous strength-based data need to be developed, informed, tailored and monitored with, by and for Indigenous people and communities as co-owners in health.

Data Gaps and Limitations

The capture of local (community) health service utilization data and health trends to evaluate evidence based practice is challenging. AHS currently reports on one provincially mandated performance measure used for Indigenous health (i.e., perinatal mortality rates). This is partly due to the lack of systematic monitoring of patients' cultural identifiers within AHS, which includes Indigenous status. This information is needed if we are to gather, monitor, and respond to a more complete picture of trends, and to address Indigenous health challenges and disparities. In the absence of robust local or zonal data, provincial aggregated and national data is often referenced in part to follow Ownership Control Access and Possession (OCAP®) principles of First Nation ownership. OCAP® principles are foundational to support autonomous First Nation-owned data and strength based approaches to health monitoring.

To inform health service improvements, developing and reporting against quantifiable measurements allows AHS to identify poorly designed care processes and pathways, partly to measure successes or areas that require improvement. From a health system perspective, “You manage what you measure. What is measured gets done” (*Indigenous 101 Health Primer*, Nov. 2018, Indigenous Health Strategic Clinical Network). The risk of inaccurate data was highlighted in a Canadian study that found that the “Canadian census underestimated the size of the Indigenous population in Toronto, Ottawa and London by two to four times” (Janet Smylie 2011). Health service planning requires up-to-date and accurate data, as evidenced in the TRC Calls To Action Recommendation 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… and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services” (TRC Calls to Action 2015).*

The absence of data will not delay moving forward on the action steps outlined in this document. However challenges to create meaningful change will continue if accurate Indigenous health indicators and measurements are not systematically prioritized and measured. Specific recommendations are outlined in the Next Step Section to guide a focused action strategy that is provincial in scope and collaborative in nature.

The Action Plan committee has developed an addendum to this plan for more information on demographics and important key indicators (see *Demographic and Health Status Data for Calgary Zone Indigenous Populations: Addendum to the Calgary Zone Indigenous Health Action Plan www.ahs.ca)*.

7. AHS Commitments for Action

The following section summarizes the main themes we have heard from the engagement discussions and the resulting commitments and actions that AHS Calgary Zone will implement over the next number of years. The overarching Pillars summarize the universal themes and commitments that touch all areas of the Zone. In addition, AHS Calgary Zone's operational areas have summarized priority actions arising from the recommendations for their specific operational program or portfolios (i.e., Emergency Department, Maternal Health, etc.).

Grounding Concept

Ethical Space:
"Two worlds together in unity"

"'Ethical space' is formed when two societies, with disparate worldviews, are poised to engage with each other. The process of engagement between these diverse societies contribute to a framework for dialogue... The ethical space of engagement proposes a way of examining diversity while positioning Indigenous peoples and Western society in the pursuit of a relevant discussion on Indigenous (...) issues, ethical standards and the emergence of new rules of engagement. The new partnership model grounded in the co-creation of ethical space, will create new currents of thought that flow in different directions and overrun the archaic ways of interaction" *(Will Ermine, 2007).*

The Vision Moving Us Forward

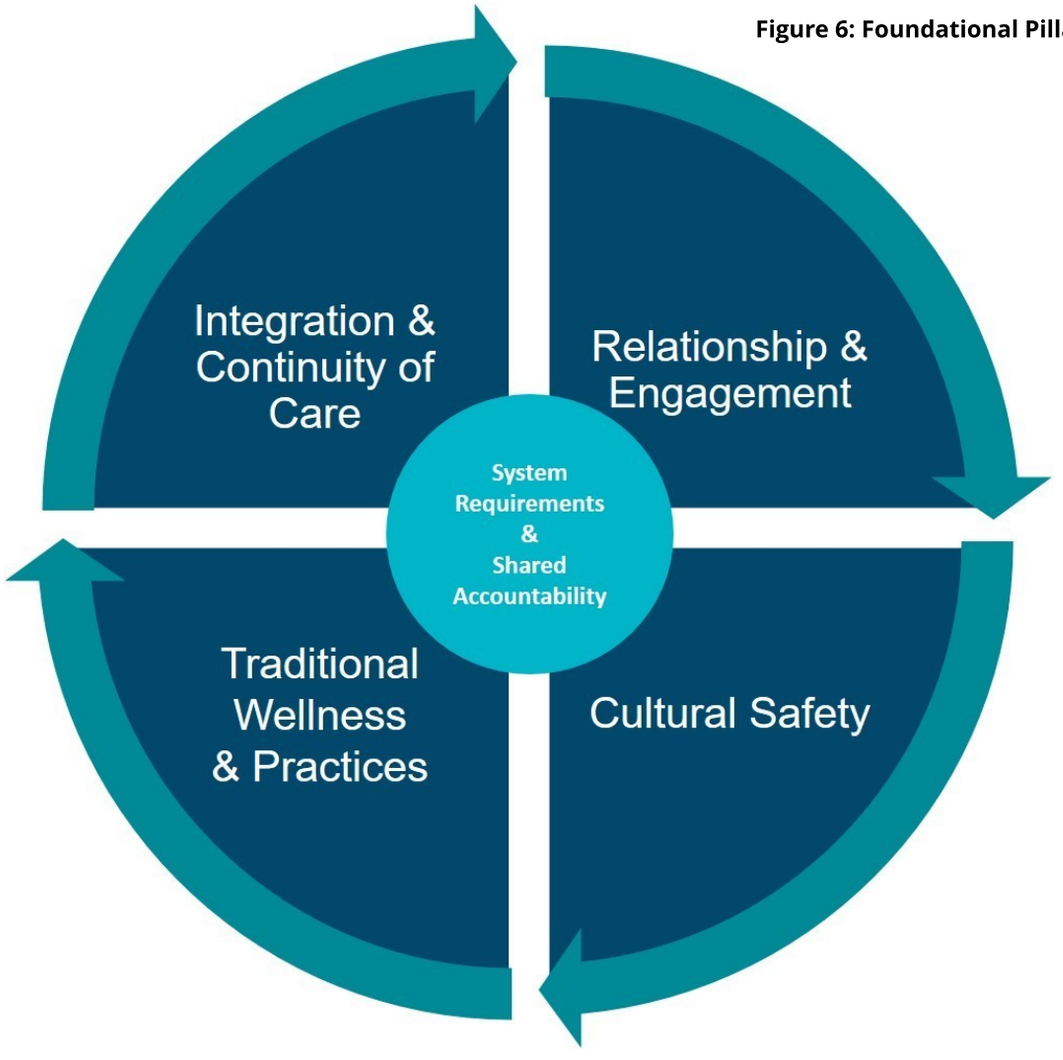
INDIVIDUAL FOCUSED	Indigenous individuals and communities in Calgary Zone are healthy and supported in their wellness journey.
COMMUNITY VISION	Indigenous individuals in Calgary Zone are supported through integrated culturally-based primary care that offers navigation, seamless transitions of care, is community-based, holistic, and culturally safe. AHS is a reliable, trusted, collaborator in the delivery of health services in partnership with Indigenous communities.
AHS ORGANIZATION VISION	Calgary Zone commits that Indigenous patients receive respectful patient-centered quality care that is culturally safe, holistic, and accessible in AHS services/facilities. Services will be delivered in respectful ways that are culturally appropriate and in partnership with Indigenous communities.

7.1 Our Commitments: Foundational Pillars for Action

The culmination of what we heard during the engagement process translated into the development of the following foundational pillars for action. All pillars are inter-connected and affect all areas across the Zone. (See Appendix I for diagram of *Overarching AHS Calgary Zone Indigenous Health Action Plan*).

1. **System Requirements & Shared Accountability**
2. **Providing Culturally Safe & Responsive Care**
3. **A focus on Engagement & Relationships**
4. **Creating Integration & Continuity of Care**
5. **Supporting Traditional Wellness & Practices**

Figure 6: Foundational Pillars for Action



"It will take 15 years to see the changes we start today"
(Wisdom Council Representative)

1 PILLAR FOR ACTION

7.1.1 SYSTEM REQUIREMENTS: SHARED ACCOUNTABILITY AND LEADERSHIP

To create a new path forward, develop improved strength-based health outcomes, and become a reconciliation-focused organization, AHS must create ethical space. This involves building on the strengths of AHS systems and structures, and on the strengths of Indigenous wisdom, values, and ways of working. Building ethical space will help us see new methods and practise new ways of working. New strengths and mutual respect will create a reciprocal system, one in which the strengths of the western medical model enrich the strengths, knowledge and history of Indigenous peoples.



PILLAR ONE

PILLAR FOR ACTION 1 – SYSTEM REQUIREMENTS and SHARED ACCOUNTABILITY AND LEADERSHIP

OUTCOME: Creation of ethical space through development of clear accountability, collaboration, and planning between Indigenous Health and Zone Operations.

What We Heard	We are responsible for
• Identification of Indigenous knowledge, ways of working and leadership structure. • Calls for creation of ethical space and shared transparent leadership between Operations and Indigenous Health Program. • Call for increase Indigenous representation and leadership. *"We need a lot of prayers and ceremonies to make sure we are on the right path. And we don't burn the bridges".*	• Developing Zone Indigenous Leadership models. • Formalizing connection and engagement expectations of AHS leaders. • Honouring ceremony and protocols in decision making tables. • Ensuring Indigenous lens is incorporated into relevant governance documents. • Clear commitments and directives from Executive leaders on Action Plan implementation and cultural competency training. • Ensuring Indigenous experiential learning opportunities are given the same credit/priority as professional development training. • Providing leadership/policy guidance for contracted Indigenous Health planning services. • Supporting leaders to become vocal champions to support sustainable change in AHS. Share successes and models with staff. • Developing leadership mentoring; support growth of young leaders. • Supporting staff access to traditional knowledge and cultural supports. • Creation of ethical space and fostering Indigenous ways of working.

AHS Commitment 1.1: Internal organization and alignment commitment to breakdown siloes and collaborate meaningfully. Development of clear shared accountability and planning between Indigenous Health and Zone Operations.

• More purposeful allocation of resources to support patients, practitioners, families, and communities closer to home. *"Honour the ways. Don't let bureaucracy get in the way."*	• Prepare and support for capacity building and self managed models for First Nations partnerships as opportunities arise. • Lead change through influence when not accountable. • Long term quality improvement focus. • Support First Nations Health Centers as a mechanism to address access issues, determinants of health and historical jurisdictional challenges. • Support alignment within Contracting Services.

AHS Commitment 1.2: Resourcing, accountability structures and operational business plans utilize a sustainable substantive equity framework: a) Sustainable resource investments are established in partnership with Indigenous communities; b) Closer to home rural and outreach models prioritized.

Pillar for Action 1 continued …

PILLAR FOR ACTION 1 – SYSTEM REQUIREMENTS and SHARED ACCOUNTABILITY AND LEADERSHIP

OUTCOME: Creation of ethical space through development of clear accountability, collaboration, and planning between Indigenous Health and Zone Operations.

What We Heard	We are responsible for
• Access to culturally specific and traditional wellness practices are key to reconciliation, healing, balance, healthy communities, and steps to decolonizing our health care system. *"Understand and respect the mastery of learning. It takes years and generations for the knowledge keepers to get where they are. It is the same as a degree. We should honour the wisdom in the same way".*	Budget for community medicines and traditional practices in similar way as Western medicine: • Tipi and poles, set up, staff training, maintenance • Traditional Indigenous Protocols (Honoraria) • Tobacco, gifts, cloth • Celebrations, sacred spaces within facilities • Sweat lodges • Medicines
AHS Commitment 1.3: Traditional practices are at the forefront of program delivery and services for Indigenous populations in partnership with community, Elders and Knowledge Keepers.	
• Development of Indigenous ways of working and work structures and partnerships. • Need for more Indigenous staff, traditional wellness staff, Indigenous Health Mental Health staff and Indigenous Hospital Liaisons. *Staff are dealing with highly emotionally charged traumatic situations while confronting the challenges of working within a large system. They consistently said that it would be helpful to have access to traditional practices, which is critical for retention and creation of ethical space.*	Development of HR strategy for Indigenous Health Program (IHP). • Commitment to increase Indigenous leadership and representation including on advisory committees, operational leadership, medical leads, Primary Care Boards, and volunteers. • Pro-active recruitment for Indigenous staff (identify prioritized program needs). • Revise hiring practices to support lived experience and traditional knowledge keepers. • Development of a long-term succession plan. • Develop community engagement plan to support Indigenous recruitment. • Increase partnership development with post-secondary institutions to support hiring of Indigenous workforce. • Commitment to professional development and two-eyed way of seeing.
AHS Commitment 1.4: The organization is committed to creating a culturally safe environment and workplace for our Indigenous workforce.	
• Support for staff internally to participate in traditional wellness. Integrate traditional wellness in professional work to help avoid burn out and support traditional ways, retention, ethical space, leadership style. *"When you can bring your best and whole self to work, we do our best work. Patient care improves".*	• Support AHS staff, clinicians and leaders to integrate traditional wellness in their own work by honouring traditional wisdom and practices (e.g., provide time for medicine picking, participation in sacred ceremonies and sweatlodges, access to Elders and other supports, etc.). • Development of recruitment strategy for Traditional Knowledge Keeper/Cultural Helpers/Elders. Work in partnership with communities. • Develop mechanisms to mitigate staff burn out and foster capacity to work within AHS system. • Acknowledging ethical space and creating new ways of working. • Building an internal Indigenous community for support (i.e., offer traditional cultural supports and mentoring for Indigenous staff). • Ensure adequate supports and resourcing are in place for employee self-identification project.
AHS Commitment 1.5: Indigenous staff are supported and encouraged to celebrate and practice traditional cultural ways.	

Pillar for Action 1 continued ...

PILLAR FOR ACTION 1 – SYSTEM REQUIREMENTS and SHARED ACCOUNTABILITY AND LEADERSHIP

OUTCOME: Creation of ethical space through development of clear accountability, collaboration, and planning between Indigenous Health and Zone Operations.

What We Heard	We are responsible for
• AHS staff, clinicians, and leaders need supports and knowledge of how and when to provide protocol and create more understanding of the importance of traditional practices and ways of working. *"Tobacco is the way. The protocol is the way. Follow the tobacco".*	Full implementation of the *Indigenous Traditional Protocol Guide* which serves as a framework to provide guidance for Indigenous protocols, including respectful processes for gifting, tobacco and honoraria when engaging with FN, Métis and Inuit Elders and Traditional Knowledge Keepers: • Increase cultural awareness *(underway).* • Simplify business processes with Finance and Accounts Payable (e.g. Indigenous Traditional Protocol processes). • Funds are available for traditional protocol. • Access to ceremonial tobacco. • Smudging processes are clear, and available at all sites including administrative buildings.

AHS Commitment 1.6: Implement the *AHS Indigenous Traditional Protocol Guide* across the Zone. Increase respectful processes and understanding that there are many diverse practices.

Shared accountability...

Leadership...

"Change happens at the speed of trust"

(Community member)

2 PILLAR FOR ACTION

7.1.2 CULTURALLY SAFE AND RESPONSIVE CARE

Indigenous community members are concerned about:

- Discrimination and access to culturally safe care
- Staff understanding about inter-generational trauma
- Capturing patients' concerns
- Staff understanding of the challenges in accessing health services and the daily consequences from the determinants of health.

Example Story:

"In our community we treat Elders with respect and reverence. One of our Elders went into the hospital and he was proud. When he came out five days later he was filled with shame. What happened in there that in only five days this proud man became filled with shame?"

PILLAR TWO

PILLAR FOR ACTION 2: CULTURALLY SAFE AND RESPONSIVE CARE

OUTCOME: Calgary Zone will create a more welcoming, culturally safe environment with culturally appropriate services for Indigenous community members.

What We Heard	We are responsible for

• Experiences of racism, discrimination and (un)conscious bias towards Indigenous patients. This manifests in different ways in healthcare, which can perpetuate negative health outcomes due to avoidance of preventative or early intervention health care services, minimal follow up with health care providers as recommended, lack of trust with health care providers, and reduced patient self-advocacy.
 	
"Experiential learning is essential for understanding"
	Providing and supporting cultural competency training for employees, physicians, and volunteers to enhance understanding of historical and intergenerational trauma, as well as Indigenous customs and beliefs as they relate to health and care provision.
	• Expanding and supporting experiential multi-level tiered education, secondments and training:
	  • leadership curriculum development and transition supports for site and program leads (including training with Traditional Knowledge Keepers)
	  • focused clinician training on (un)conscious biases through e-SIM clinician training *(underway)*
	  • targeted awareness and training for prioritized program areas
	  • report card of portfolio/program/site competencies to assess and promote sustainable change across the health continuum; local site and program leadership responsible for ongoing transfer of knowledge
	• Anti-racism strategy and accountability.
	• Academic partnerships to develop competencies in next generation of health care providers:
	  • curriculum, practicums, and partnerships for post-secondary training
	  • collaboration with the Indigenous Health SCN on curriculum development and practice integration
	• Develop messaging of AHS Calgary Zone as a learning organization that supports working in new ways and taking responsible risks.
	• Partner with First Nation (FN) Health Centers on education and curriculum development (e.g., share AHS clinical education modules with FN Health Center staff).
	• Expand awareness and celebration for staff and clinicians through ongoing dialogue, biannual opportunities, community based training, face to face gatherings.

AHS Commitment 2.1: Establish organizational patient- and family-centered cultural humility to combat discrimination, racism and conscious/unconscious biases which directly impact the delivery of health care (including the overall client experience and feelings of safety).

Pillar for Action 2 continued ...

PILLAR FOR ACTION 2: CULTURALLY SAFE AND RESPONSIVE CARE

OUTCOME: Calgary Zone will create a more welcoming, culturally safe environment with culturally appropriate services for Indigenous community members.

What We Heard	We are responsible for
• Patient concerns are not shared via formal Patient Relations channels due to lack of awareness, lack of trust, or perceptions of the process being overly formalized and impersonal. • Sharing stories informally with AHS Indigenous staff can result in a heavy burden for those staff, unresolved issues that are shared within the community, and little accountability due to informal reporting mechanisms utilized.	• Hiring of Indigenous Patient Concerns staff. • Developing communication and awareness strategy focused on patients & communities *(underway).* • Incorporating a culturally-focused reporting and resolution process in partnership with the Indigenous Health Program for Indigenous patients/families/communities and staff *(underway).* Consideration for an AHS Indigenous Ombudsman. • Building a mechanism to enhance trust and appreciation of and learning from Indigenous stories. • Patient Relations staff participate in cultural competency and humility training *(underway).* • Sharing the learnings from this Action Plan and work together with the other Zones and Tribal Councils across the province to help create a robust provincial system *(underway).* • Development and tracking of emotional or psychological harm within the AHS Reporting and Learning (RLS) system.
AHS Commitment 2.2: A patient concern submission process that is welcoming, responsive and reflects Indigenous cultural values, including resolution for the patients/families/communities.	
• Trauma described as an underlying reason for many health concerns (e.g., addictions and mental health, chronic pain etc.). • Experiences of trauma and misunderstandings of how it manifests psychologically and physically in individuals is a concern. raised by communities. • Prioritize community healing.	• Focus on managing and healing underlying trauma that may include intergenerational trauma from residential schools, 60's scoop, domestic violence, and PTSD. • Support clinicians and staff understanding of the effects of trauma across all domains of holistic health (e.g., emotional/spiritual health, psychosomatic symptoms, transmission of intergenerational trauma, addictions, alienation, shame, physical manifestations). • Support healing focused strategy including education, assessment, screening, relationships, clinical focus and approach.
AHS Commitment 2.3: Delivery of healing-focused and trauma informed care across the care continuum.	

• Social determinants of health (SDOH) impact the health and wellness of individuals, families and communities in a multitude of ways.
• Access to health services is impacted by SDOH, proximity, transportation, interpretation and language supports; hence, navigation of the health care system is of resulting higher importance.
• Misconceptions of access issues in rural settings.
• There might be times when financial barriers impede access to health services (e.g., childcare, transportation costs, etc.).
	• Increase staff understanding of the historical impacts and current environments that impact Indigenous patients with respect to SDOH.
	• Development of positive health indicators.
	• Respond to access issues (e.g., transportation, program flexibility, navigation supports, language barriers, trust).
	• Develop patient-centered approach to care transitions and care including:
	  • *What is important to the patient or family?*
	  • *Is transportation a barrier for keeping appointments or upon discharge?*
	  • *Are there other issues at home that may be contributing to their health?*
	  • *Do patients feel trust and open to ask questions?*
	  • *Do patients/families understand the medical directions or are there language barriers?*
	  • *Do patients have access to medical equipment?*
	  • *Do we have a plan in sync with their primary care physician?*
	• Partner with community initiatives such as community-based patient liaisons *(underway in partnership with Stoney Nakoda Tsuut'ina Tribal Council).*

AHS Commitment 2.4: Increase staff and clinicians understanding of the effects of determinants of health to support a patient-centered holistic approach to health services. Personalized patient- and family-centered care approaches.	

3 PILLAR FOR ACTION

7.1.3 ENGAGEMENT AND RELATIONSHIPS

A theme that emerged from the engagement process is the idea that this work must be grounded in building trusting and reciprocal relationships in order for us to move forward as partners. As a western institution, we acknowledge our default to operate within a western medical worldview. We are still learning and we are committed to creating 'ethical space' within our system. Collaboration means we are all willing to compromise, and build on each other's strengths. A key component of doing **"nothing for us, without us" is a true co-design approach.** We heard repeatedly throughout this process that there is a need to ask, listen, involve early, consult and validate our Indigenous partners. Our thorough and inclusive engagement process was appreciated by the Indigenous partners who generously provided their time and valuable input.

Example Story:

"Relationships matter. Spend time to introduce yourselves. Go pick berries. Eat a meal. You will get comfort, respect, trust. It takes time. No one is home. I don't know you in this big system."

PILLAR THREE

PILLAR FOR ACTION 3: ENGAGEMENT AND RELATIONSHIPS

Outcome: AHS will build trusting relationships that focus on the wisdom of the community, meaningful partnerships, and sustainable collaborations.

What We Heard	We are responsible for
• Trust, which is needed to collaborate effectively, takes time. • Communities would like to partner in a new way with AHS. There is a strong desire to come together and work in a new way together. • Current consultations, engagement and collaboration can be ad hoc, siloed, task-oriented or issue-specific. • Comprehensive and sustainable planning and funding is needed. *"Everything is clocked. We can't have an open heart and dialogue with a clock ticking".*	The following are underway: • Focus on respectful relationships and establishing trust between AHS and Indigenous communities who access services as a part of our reconciliation journey. AHS acknowledges that this process requires, time, patience, flexibility, trust and collaboration. • Meaningful co-design with a long-term commitment and sustainable focus using stakeholder feedback and community-led processes. Focus on the determinants of health, health equity, and health needs identified by Indigenous peoples and communities. • Establish local tables/task group/leadership structure in partnership with local FN Health Center, Primary Care, operational leader, and Indigenous Health Program to support responsible problem solving, proactive planning, alignment and collaboration. Other areas: • Resource allocation to support meaningful engagement processes. • Formalizing engagement expectation of leaders. • Development of local FN relationship agreements, service agreements, data sharing agreements, or Memorandum of Understandings (MOU) as community supports/requests.

AHS Commitment 3.1: Partnership, relationships, and meaningful co-design with a long-term commitment and sustainable focus is required. The most promising ways to promote wellness is focused on effective relationships and community led processes. Ensure that the local and community context provides the foundation for Calgary Zone planning. Foster long-term relationships with indigenous partners based on respectful practices, dialogue and protocol. AHS recognizes the significance and importance of elders and culture.

Pillar for Action 3 continued ...

PILLAR FOR ACTION 3: ENGAGEMENT AND RELATIONSHIPS

Outcome: AHS will build trusting relationships that focus on the wisdom of the community, meaningful partnerships, and sustainable collaborations.

What We Heard	We are responsible for
• Communication gaps and lack of sharing information between AHS, Primary Care, and Health Centers results in patient information not being shared, gaps between services, misunderstandings, siloed approaches for care, intervention vs prevention focus. • Stories of racism and discrimination possibly leading to misdiagnosis or ignoring of symptoms until care required is escalated.	• More proactive and timely patient health information upon discharge. Support and build on the Primary Care initiative on Admittance and Discharge Notifications Processes *(underway – expand on Primary Care and Rural Health Discharge pilot).* • Sharing of cultural competency materials with Primary Care. • Development and ongoing maintenance of communication pathways (internal and external). Community profiles available online (underway). Team-based approach to problem solving between AHS, Health Center, PCN, Primary Care and family. • Cross-jurisdictional table to problem-solve and plan proactively. • Elbow River Healing Lodge (ERHL) will continue to be grounded in Indigenous culture through leadership style, community partnerships, in collaboration with the IHP, Elders Advisory, and community. Support proper transfer protocols and sustainable support with Elders/ Knowledge Keepers.
AHS Commitment 3.2: Integrated communication pathways and systems.	
• Confusing of who to engage with, how to work best with Zone Operations and Indigenous Health Program, high turnover. • Indigenous representation could be expanded.	• Key responsibilities identified and shared between IHP and Zone Operations and Executive leaders. • Listen to and honour the diversity and perspectives of Indigenous peoples in planning and decision making (underway). • Develop an uban partnership table with Elbow River Healing Lodge, AHS Operations, non-profit stakeholders and Elders to support problem solving, proactive planning, alignment and collaboration.
AHS Commitment 3.3: Meaningful Indigenous lens and influence are incorprorated across levels of AHS Calgary Zone.	

Meaningful engagement...

Building trust...

"Nothing about us without us"

(First Nation Health Center Representative)

4 PILLAR FOR ACTION

7.1.4 INTEGRATION AND CONTINUITY OF CARE

Due to the jurisdictional complexity of accessing health care by Indigenous community members, a focus is supporting integration between organizations, program areas and community services. Discharge and transitions is highlighted as a major area of concern, as is transportation. Care closer to home was highlighted as a top idea for certain programs, especially important for Addictions & Mental Health, Dialysis, and Continuing Care. AHS can improve cross-jurisdictional pro-active problem solving and internal patient centered coordination.

Example Story:

One community was lacking a medical transportation team, so patients were asking family members to drive them to medical appointments, despite not having car insurance and registration, because they were worried their doctor might refuse to be their physician anymore if they did not show up for their appointment.

PILLAR FOUR

PILLAR FOR ACTION 4: INTEGRATION AND CONTINUITY OF CARE

Outcome: AHS will continue to work towards seamless provision of health services across jurisdictional and operational boundaries, with a commitment to find solutions together in partnership in the spirit of putting reconciliation into action (reconciliACTION).

What We Heard	We are responsible for
• Discharge processes to be improved. • Existing challenges: transportation, lack of coordination with primary care and HC, limited hours for pharmacy, and medical equipment. • Medical transportation from federal govn't is not under patient control, and many patients do not have transportation or resources for taxis. • Discharge summaries are not shared in a timely way with primary care, and patient information is sent to the physician clinic but not the FN Health Center.	• Discharge starts upon admission ("what plan needs to be in place upon patient discharge?"), including consideration to pharmacy access, medical equipment, and sharing information with home Health Centre. • Investigate update of *Discharge Protocol for Treaty 7.* • Community-led agreement on sharing patient info (e.g., formalized data sharing agreements, or local community Memorandum of Understanding [MOU]). • Communication pathways between AHS, First Nations Health Center and Primary Care. • Ensure connections for follow up care; enhance coordination of care. • FN Health Center notification for admit/discharge/decease notifications (expand on Primary Care and Rural Health pilot).

AHS Commitment 4.1: Proactive, timely and accurate discharge planning. Ensure that downstream communication to relevant health providers occurs.

• Information on how to access health services/resources would be helpful for individuals/families (incl. AHS services and federally-funded resources). • Language barriers exist. • What federal services are available to patients in the provincial system? • Patient info flow is disjointed and not fully accessible at the FN Health Center.	• Pathways for patients to and from AHS/FN Health Center. • Increase in availability of Indigenous Hospital Liaisons. • Navigation supports are available. Partner with FN Health Centers on community-based patient navigation. • Increase in language supports and translation services. • Staff are trained and clear about how to support FNIHB applications. • Partner with FN Health Centre patient liaisons/navigators (underway with Stoney Nakoda Tsuut'ina Tribal Council new patient liaison pilot).

AHS Commitment 4.2: Improved health service patient navigation and transition between care providers, programs and services. Timely appropriate sharing of patient health information between care teams.

Pillar for Action 4 continued ...

PILLAR FOR ACTION 4: INTEGRATION AND CONTINUITY OF CARE

Outcome: AHS will continue to work towards seamless provision of health services across jurisdictional and operational boundaries, with a commitment to find solutions together in partnership in the spirit of putting reconciliation into action (reconciliACTION).

What We Heard	We are responsible for
• System-centered delivery of health services has resulted in fragmentation of care and reduced focus on prevention. • Disjointed and short-term planning; ad hoc, targeted funding has prevented a proactive preventative approach for Indigenous centered health services on- and off-reserve. **Example:** special short-term grant funding to support gaps in service identified through Jordan's Principle).	• All portfolios will use the Action Plan as their point of reference for operational planning to support achieving the goals of the Action Plan. • Strengthen internal connections and collaboration between AHS portfolios (including Contracted Services standards and guidelines). • Shared responsibility, data collection and accountability framework to support internal collaboration. Highlighted areas of focus: 1) Indigenous Hospital Liaisons and Social Workers, Emergency Departments, Acute Care sites; 2) IHP/Zone Operations; and 3) IHP/AMH. • Development of local community cross-jurisdictional problem-solving tables including (as required): community/Health Centers/Primary Care/AH/Federal Government/ AFNIGC/ SCN/IHP/ Zone Operations.

AHS Commitment 4.3: Cross-jurisdictional problem-solving and communication from highest levels to front line leaders. Improved program alignment and coordination of services to increase effectiveness of health services (i.e., greater problem solving, communication, shared program development/partnership).

• More mobile outreach services are needed within Calgary and rural settings. • Service gaps on-reserve are often related to pediatric population (specialist assessments, social work, speech & occupational therapists). • Care closer to home prioritized for chronic diseases and urgent mental health and addictions supports.	Future investments using a substantive equity framework which acknowledges built-in barriers leading to health inequities. • Investigate partnering opportunities for co-service delivery with First Nations Health Centers and neighbouring communities. • Support outreach strategy and expanded support services via a hub and spoke model for Elbow River Healing Lodge. • Fill service gaps and development of mobile services.

AHS Commitment 4.4: Improved equitable access, quality and sustainability of health services for Indigenous populations will result in more effective service delivery and system integration. Provision of care closer to home for prioritized services. Examples of priority areas for care closer to home include: dialysis; continuing care; detox services; mobile services (e.g., lab, DI, crisis mental health, safe consumption); and mental health and addictions.

• Addictions and mental health affected by underlying trauma (central theme related to most health concerns). • Desire for integrated traditional practices/holistic ways of working (people felt that traditional wellness is poorly understood by providers). • Flexible model of Indigenous Mental Health (IMH) services is greatly appreciated, as transportation and reliable access is a challenge. • Drug prevention strategies to be more inclusive of substance abuse in the community (incl. meth, alcohol, prescription drugs, etc.). • An urban strategy is missing. • Community connections and relationships is foundational to building trust with community/ individuals, which takes time. • Healing is a community practice.	• Adequate and appropriate access to traditional supports as a part of treatment program and care pathways (such as ceremonies, practices, Elders, land based therapies, clinical holistic assessment tools). • Merging of mental health and addictions modalities. • Addictions and Mental Health (AMH) and Indigenous Mental Health (IMH) structures/leadership to incorporate Indigenous representation, create stronger alignment and collaboration with internal programs (awareness, streamline continuity of care, investigage possible cost sharing programs for prevention purposes. Consider grassroots management style where management active with staff to address issues that are brought forward. • Increase support for trauma counseling and addictions treatments (critical for promoting healing from of addictions, family violence, mental illness, Justice system, child and family services, etc.). • Community development and connections to be standard practice within AHS to be involved in community initiatives. • Cultural relationship brokers to support patient centered approaches to transitions and care planning.

AHS Commitment 4.5: Holistic, culturally-focused, and trauma-informed approaches for addiction and mental health (AMH) services across the continuum of care. A prevention focus to support patient access to health services earlier in the disease trajectory versus at the end stage, resulting in a reduction of ED visits and AMH acute care service utilization.

Pillar for Action 4 continued ...

PILLAR FOR ACTION 4: INTEGRATION AND CONTINUITY OF CARE

Outcome: AHS will continue to work towards seamless provision of health services across jurisdictional and operational boundaries, with a commitment to find solutions together in partnership in the spirit of putting reconciliation into action (reconciliACTION).

What We Heard	We are responsible for
• Lack of identified primary care supports and resources. • Communities utilize local Health Centers, which is seen as a trusted medical home for health services. • Some patients feel lack of trust when accessing AHS services. • Fragmentation between sharing patient info between care providers. • Lack of coordination between AHS, Primary Care and FN Health Centers. Primary MD receives and holds patient records, which isn't available to the local FN Health Centers.	• Development of a culturally specific Indigenous Medical Home model and primary health care strategy. • Support Primary Care Network relationships (underway). • Work with community partners for continuity of care with the goal of building local capacity.
AHS Commitment 4.6: Locally defined and built culturally safe local primary health services are integrated into community.	
• Challenges with accessing Non-Insured Health Benefits (NIHB) that FN patients are entitled to. • Community members concerned about the challenges of accessing NIHB benefits; this barrier is seen as violating the treaty right to health. • Need better inter-jurisdictional coordination around insured services. • Staff questions regarding role clarity and efficient processes for supporting NIHB benefits for patients.	• Examination of roles to ensure efficiencies and acceptability (e.g., confirm scope of practice with RNs, social workers, Indigenous Hospital Liaisons related to NIHB application requirements). • Advocate and support standardized processes across the system including proactive discharge planning and NIHB application and advocate processes. • Determine plan for priority areas where AHS has influence (transportation, scheduling etc.). • Focus on appropriate supports for staff and patients and help to influence and advocate for process changes. • Cross-jurisdictional problem-solving table with Alberta Health and Indigenous Services Canada to collaborate and advocate for changes. • Create escalation pathway to support Indigenous Health Liaisons and other staff. • Professional practice leads in Social Work support to increase awareness related to health care access issues, education, processes and policies.
AHS Commitment 4.7: Patients are supported in accessing available health care services and benefits.	
• Gaps related to sharing of patient info with FN Health Centers and large fragmentation between data systems. There are concerns about ensuring alignment and confirming access to future AHS Electronic Medical Record systems such as Connect Care. • Disjointed planning and collaboration, unclear accountabilities, little data available to measure success.	• Enhanced education on traditional wellness and integration of prompts in Connect Care system. • Alignment and integration between FN Health Centers EMR with Connect Care. • Follow OCAP principles of compliancy. First Nations guidance and direction. • Support the development of the provincial Indigenous Health Analytics Portal (Data Integration and Reporting).
AHS Commitment 4.8: Appropriate, timely and accurate communication and sharing information with relevant health providers.	

5 PILLAR FOR ACTION

7.1.5 TRADITIONAL WELLNESS AND PRACTICES

Indigenous healing and wellness practices are extremely important to many Indigenous people including health care providers. The cultural concept of medicine is a true holistic definition. Participants stated that they would utilize traditional services if available, and they desired for traditional medicines and approaches to be accepted into health care services.

Example Story:

An Elder had to undergo an amputation of his leg. He was filled with shame, staying in his room and reluctant to leave. The Traditional Wellness Counselor came to visit and did a ceremony and wrapped his leg with a blanket with a prayer and a smudge. The health care providers could see the pride growing in the elder after the ceremony. He started to leave his room to go to the ceremony room and other places. The next step was then to update the clinical policy to allow for a proper ceremony for the limb to follow proper protocol for his whole spirit to connect.

PILLAR FIVE

PILLAR FOR ACTION 5: TRADITIONAL WELLNESS AND PRACTICES

Outcome: Traditional wellness practices, spaces, languages and medicines will be integrated into AHS' delivery of care.

What We Heard	We are responsible for
• Access to culturally specific and traditional wellness practices are important for: reconciliation, healing, balance, healthy communities, and steps to decolonizing our health care system.	• Build awareness and understanding within AHS (e.g., Medicine Walk, Grand Rounds, and presentations on Traditional Wellness Medicines). • Multiple levels of learning opportunities are available to enhance education and awareness of traditional practices as related to clinical practice. • Supporting Indigenous-focused research and evaluation. • Better relationships and trust is foundational to integrated traditional wellness and practices.
AHS Commitment 5.1: Increased awareness of traditional wellness and holistic approaches throughout the Zone. Clinical staff and physicians have increased knowledge and understanding to support patients in their care journeys.	
• Need more traditional wellness practices throughout the health care journey • Lack of acknowledgment on the intricacy of skill set of Elders/Knowledge Keepers. • Increased access to female and male Traditional Wellness Counselors. • Flexibility is required for Indigenous Health Program (IHP) in hiring traditional knowledge keepers. (i.e., bureaucratic and lengthy hiring practices; compensation to align with Elder status and years of required training).	• Incorporate a community-led approach to respectful diverse partnerships with Elders/Traditional Knowledge Keepers (e.g., develop an Elders casual pool, advisory group, wellness counselors – identify strategy with proper compensation). • Utilization of holistic clinical assessments tools and traditional and land-based therapies. • Work with HR and talent acquisition (i.e., staff and resourcing for appropriate Elder/Traditional Knowledge Keeper compensation; flexible HR and recruitment policies to accommodate community practices). • Utilize Indigenous agreement methodologies in partnership with AHS contracted services/agreements/MOU's (pipe ceremony). • Support for participation and hosting sacred practices and ceremonies (sweat lodge, pipe ceremonies, sundance, pow wow's, medicines, practices).
AHS Commitment 5.2: Traditional medicines and wellness practices are available and a part of a patient's care journey. Traditional wellness strategy is based on the principles of: trust; community led processes; mutual respect; reciprocal relationships; support vs. paternalistic approaches; sacredness of knowledge; community holistic healing; and understanding vs. proprietary ownership.	

Pillar for Action 5 continued ...

PILLAR FOR ACTION 5: TRADITIONAL WELLNESS AND PRACTICES

Outcome: Traditional wellness practices, spaces, languages and medicines will be integrated into AHS' delivery of care.

What We Heard	We are responsible for
• Smudging is an important element of traditional wellness practices both for community engagement and also to support staff traditional healing and wellness. • Timely and standardized access could be improved both in administrative buildings and acute care settings.	• Work with site managers/zone leaders/staff to improve smudging processes and communication. • Develop plan with Capital Management on new capital projects, renovations, and existing facilities. Work towards accessibility of timely smudging available in all patient rooms. Ensure provincial guidelines are updated to reflect smudging capabilities (underway). • Develop inventory of 'smudge friendly' sites and ceremonial rooms (underway). • Work with facilities management to streamline smudge processes (underway). • Develop communication and awareness with site leaders.
AHS Commitment 5.3: Smudging is available in a timely basis in all health care facilities including administrative buildings and contracted services.	
• Need to share, act and celebrate together as an essential place for healing, reconciliation and community building.	• Celebrate Indigenous culture and support wellness (e.g., National Indigenous People's Day celebrations, drumming circles; community gatherings and meals; honour staff and volunteers; community and AHS hosted powwows; and storytelling). • Enhance focus on prevention and community healing.
AHS Commitment 5.4: Celebrations are seen as an important aspect of traditional wellness and healing and AHS journey of reconciliation. Celebrations can provide examples of us working together in partnership. They are also an important part of the personal healing journey, including recovery from trauma and re-claiming culture and land traditions.	

Traditional wellness...

Holistic healing...

"Tears heal. It is a celebration"

(Traditional Knowledge Keeper)

The following model is a recommended approach for guiding AHS in moving forward towards integration of traditional wellness in AHS Calgary Zone.

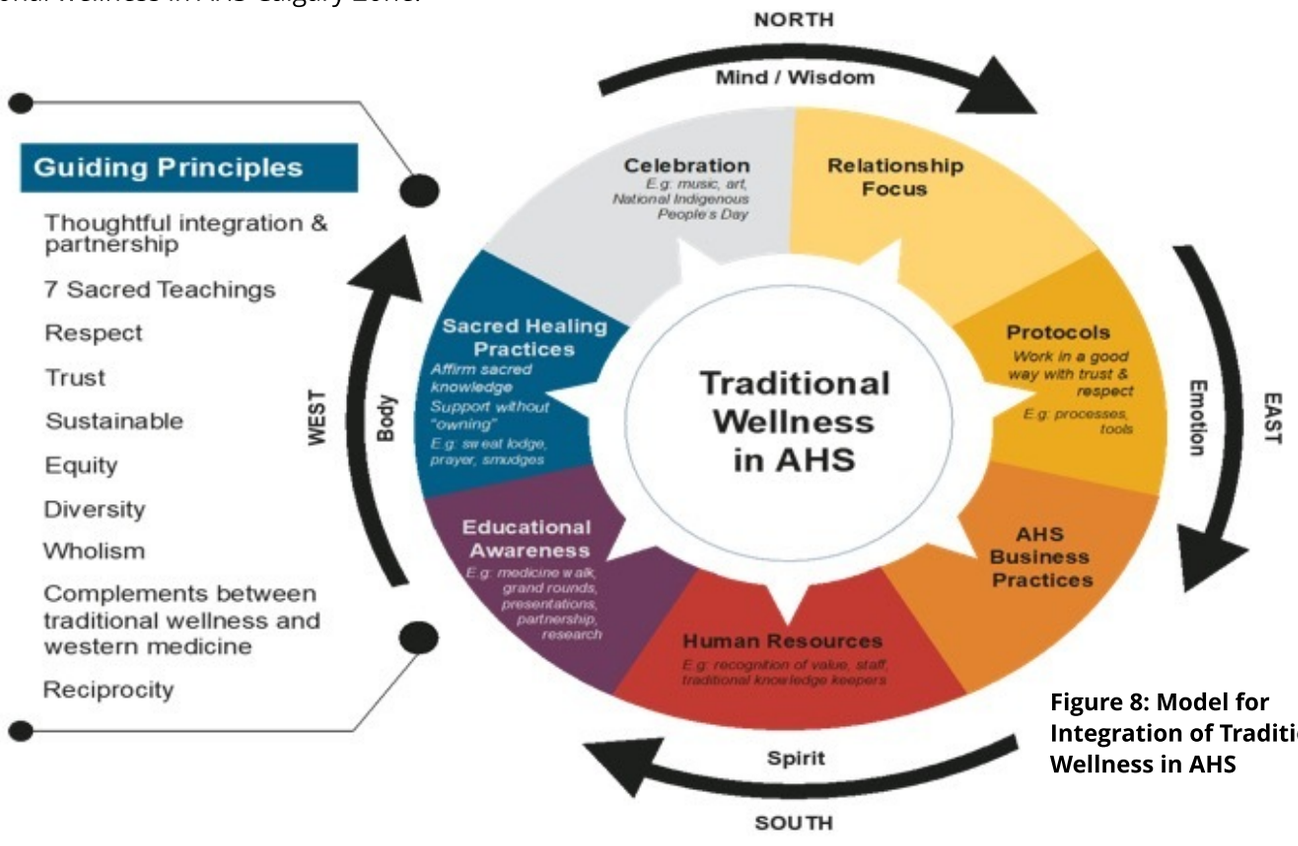


Figure 8: Model for Integration of Traditional Wellness in AHS

7.2 Recommendations and Actions from Prioritized Operational Areas

Several operational-specific themes and recommendations emerged from the engagement discussions, which will further support the commitments arising from the universal Pillars of Action. Operational program areas across AHS Calgary Zone will align their individual Operational Plans to support the Action Plan, whereby this Action Plan serves as a starting point. The recommendations will continue to be revised and modified for local areas as implementation commences. Prioritized operational areas have been highlighted below. Please see *Appendix B* for more detailed operational themes and recommendations.

Table 2: Operational Areas: Themes & Recommendations

OPERATIONAL AREAS: TOP THEMES & RECOMMENDATIONS		
	THEMES	RECOMMENDATIONS
ADDICTIONS & MENTAL HEALTH (AMH)	• Trauma-informed care • More AMH involvement in Indigenous urban community • Address access issues • Indigenous Mental Health Program	• Introduce use of Adverse Childhood Experiences • Shared Resources • Cultural Humility Training • Respond to drug misuse/abuse and identify appropriate services
EMERGENCY CARE	• Enhance culturally safe care • Access to Indigenous Health Liaisons and Social Work • Discharge planning	• Increase cultural awareness and supports of resources • Indigenous acknowledgement signage • Patient advisors • E-Sim development to enhance cultural competency

Operational Areas: Themes & Recommendations (continued) ...

OPERATIONAL AREAS: TOP THEMES & RECOMMENDATIONS		
	THEMES	RECOMMENDATIONS
INDIGENOUS HEALTH PROGRAM	• Increase access/supports for traditional wellness and resources for navigation • Wellness supports for staff • Experiential learning opportunities • Clarity of roles	• Resource allocation to support Indigenous health across Zone • Increase navigation and spiritual support for patients and families • Self-care support mechanisms to support Indigenous staff
KIDNEY CARE	• Co-design a dialysis and prevention model with First Nations Health Centres and communities • Collaborative partnerships • Care closer to home	• Health promotion and holistic approaches including traditional wellness practices. • Improve cultural understanding and support culturally sensitive care options. • Assess and manage transportation challenges and care needs geographically. Integrate services through partnership.
MATERNAL HEALTH	• Increase support for Maternal Health nursing • Implement harm reduction approach for new mothers • Expansion of midwifery	• Cultural competency training. • Newborn Post-Discharge Social Risk Assessment • Engagement with FN Health Centers • Health promotion and prevention strategies
PATIENT RELATIONS	• Patient concerns are not shared via formal Patient Relations channels • Informal sharing of patient stories results in unresolved issues • Patients report racism, and bias	• Establish relationships • Review and revise Patient Relations communication materials and processes • Track racial concerns in database • Establish diverse workforce
PEDIATRICS	• Cultural competency training • Gaps in rural services and specialized assessments • Strengthen referral process • Greater supports for grandmothers	• Cultural competency training and awareness on trauma-informed care • Support traditional wellness • Expand care closer to home and remove access barriers • Improve navigation and discharge practices
PRIMARY CARE	• Address communication gaps • Patient health info upon discharge • Case management • Data sharing • Improve culturally safe care	• Improved connections and relationships with FN Health Center teams and primary care leadership • Increase understanding of trauma informed care and context • Information translation • Enhanced health services closer to home
RURAL HEALTH	• Enhance culturally safe care • Reduce misdiagnosis • Improve language supports & discharge planning	• Increase cultural competencies • Expand Indigenous Hospital Liaisons program • Improve communication with FN HCs • Provide care closer to home
SENIORS, CONTINUING & PALLIATIVE	• Transitions support • Care closer to home • Traditional wellness options and services	• Increase staff cultural competency training • Build relationships with Indigenous communities to ensure Indigenous practices are embedded in services
SOCIAL WORK & ALLIED HEALTH	• Culturally safe care and referral processes • More social work support in ED and Maternal Health • Partnership building	• Transitions support • Care closer to home • Traditional wellness options and services

8. What's Next?

8.1 Governance

A ReconciliACTION Steering Committee will be created to support implementation, development of quality indicators, support sustainable improvements and monitoring.

- **Implementation:**
  - Support actions and implementation within program areas through identification of operational next steps and identification of accountabilities, priorities and timelines.
  - Shared networking, shared resources, information sharing, awareness and co-manage opportunities
  - Support alignment of engagement activities and communication pathways.
  - Maintenance of network of support to help move forward. Co-manage steps forward together.
- **Accountability and oversee evaluation:**
  - Strength based indicators to be developed.
  - Develop quality indicators for each sector/program area/set up recommendations.
- **Advocacy and influence:**
  - Lead/bring together cross-jurisdictional problem solving table.
  - Bridge to get the attention of influencers.
  - Maintain energy and momentum.
  - Maintain proactive focus.
  - Spread the wealth of knowledge and awareness.
- **Provincial Integration:**
  - Ensure alignment and integration with provincial Indigenous Health Strategy, internal operational planning and direction, and Quadruple Aim.
- **Ensure External representation**

8.2 Evaluating Our Progress

Under the direction of the ReconciliACTION Steering Committee, a Working Group will be established to oversee a developmental evaluation plan using a participatory research approach, which will include an engagement process and outcome measures that can then be shared with other areas. Meaningful co-design will both be evaluated and celebrated with a goal of improving the health system for Indigenous populations. We will use this opportunity to articulate and promote Indigenous co-design best practices with program areas across AHS and with external partners and to support knowledge translation. The evaluation approach will respect traditional knowledge, ways of working, and history oral storytelling. Budget to support participation will be required. Please see the Appendix I for recommended elements of action to support evaluation.

"I have the privilege, obligation, rights, and the responsibility to keep working."

AHS Staff Member

8.3 Improvements in Data Sharing and Data Management

Acknowledging data limitations identified in Section 6.4, we highlight the following recommendations for implementation as a means to improve data capturing and measurement in partnership with Indigenous patients and communities for the purpose of health service planning:

1. Follow OCAP principles or Indigenous ownership, governance and control.

2. Equal respect for qualitative measures as a mechanism to respect historical oral cultures, traditions and wisdom. Doing so creates ethical space and can help to push AHS as a health system to gain greater understanding of oral culture and strength based approaches.

3. Develop local relationships with communities and sign local or Tribal Council/Confederacy/Nation MOU data sharing agreements with First Nations and Métis Nation built on OCAP principles. Agreements can identify the most relevant data to the community, and also can outline the collaborative intentions for collecting and sharing the knowledge. Sharing agreed upon information will support more accurate, timely, patient care. One such model to consider ensure that the data is governed/approved by the Health Center Director, therefore locus of control maintains at the local nation/region level.

4. Support provincial initiative on self-reported Indigenous identification for patients and AHS workforce. This can allow individuals to self-select whether they want to self-identify for the purpose of gathering data on health utilization, program evaluation, and improving access to resources. The principle of individual choice is foundational to this initiative. This entails supporting efforts to understand the risk and benefits of self-identification.

5. Support roll out of Connect Care across First Nations Health Centres. Support the provincial Indigenous Health Analytics Portal development.

6. Support greater strategic alignment with First Nations Health Centres and primary care to bridge the information gap that has been identified.

7. Develop consistent provincial outcome measures. Align and partner with the Alberta Indigenous Information Governance Center (AFNIGC).

8. Actively support and guide AHS provincial efforts to better align and leverage research, measurement, evaluation, and data collection. This priority area requires a strategic, coordinated partnership to leverage resources.

9. Commitment to maintain community profiles in partnership between Indigenous Health Program and Zone Operations.

10. Cross-jurisdictional initiative with First Nations and provincial and federal governments on partnership opportunities.

9. Summary Remarks: Wisdom Council Co-Chairs

*"**We need to recognize our commonalities**. That will fill the gaps and help to co-create a healthy Alberta. Inclusion at all levels is very important for improving health for all of us. We need the voice of youth so we can do the best for our people. We need to stay strong, committed, and focused on what we need to do to achieve traditional wellness. We need to listen to the guidance of the Wisdom Council and the Knowledge Keepers.*

***Let us walk together** to make it happen. This is a movement forward. Positive flux happens in all of our relationships and we need to be okay with what that means. Let us embrace and acknowledge the past to help us move forward. We can certainly change the path of tomorrow because we have the resilience and motivation to do so. Together, WE can empower each other to work towards this common goal.*

***We have the shared collective responsibility** for the well-being of all people in Alberta and in Canada. Let us make the movement forward together.*

***There is hope for tomorrow and for the future for our children.** We will work together so that they will not have to struggle through the system, and that they will have smoother transitions to a place of well-being."*

Casey Eagle Speaker and Wally Sinclair

"We may need to help speak for those who can't."
(First Nation Health Center Representative)

APPENDICES

Appendix A: Glossary

Aboriginal: Defined by Section 35 of the Constitution Act (1982) to refer to the Indian, Inuit, and Métis peoples of Canada.

Cultural competency: A set of behaviours, attitudes, and policies that come together in a system, agency, or among professionals which enables that system, agency, or those professionals to work effectively in cross-cultural situations. Indigenous cultural competency within AHS will contribute to Indigenous patients, clients and families feeling respected and being treated with sensitivity.

Cultural humility: A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.

Elder: A person who is a spiritual leader/practitioner and plays a prominent, vital and respected role in their community. An Elder is held in high regard as a leader, teacher, role model, and mentor, and is recognized within his or her community as having knowledge of First Nations, Inuit or Métis history, languages, customs, traditions or ceremonies. An Elder may also have life experiences that have allowed them to gain knowledge that others can learn life lessons from. An Elder is an advisor, who is often consulted on various issues within the community and provides encouragement, direction and support in moving work forward. An Elder has gained respect for their guidance and knowledge from their depth of understanding within the culture. It is recommended to consult with the community as to who they identify as the Elder.

Ethical space: Formed when two societies, with disparate worldviews, are poised to engage with each other. It is the thought about diverse societies and the space in between them that contributes to the development of a framework for dialogue… The ethical space of engagement proposes a framework as a way of examining the diversity and positioning of Indigenous peoples and Western society in the pursuit of a relevant discussion on Indigenous (…) issues, ethical standards and the emergence of new rules of engagement. The new partnership model of the ethical space, in a cooperative spirit between Indigenous peoples and Western institutions, will create new currents of thought that flow in different directions and overrun the archaic ways of interaction" *(Will Ermine, 2007).*

First Nation: First Nations people are people of the diverse Nations who occupied these lands prior to the time of Europeans and others began settling in the country we now call Canada. A "First Nations person" is the contemporary term for "Indian". Indian is now mainly used in legal contexts – e.g. in the Constitution and the Indian Act. The term "First Nation" can refer to an individual, a community (or reserves), or its government (or band councils).

Indigenous: Indigenous people are the descendants of the original inhabitants of a land or territory. The Canadian Constitution recognizes the following three groups of Indigenous people: First Nations, Métis, and Inuit (FNMI). First Nations people include both Status (a person who is registered as a First Nation or Inuit under the Indian Act) and non-status (a person who self-identifies but is not registered as a First Nation or Inuit under the Indian Act). Indigenous is not defined in Canada's constitution.

Inuit: The Inuit are distinct from other Indigenous people and originate from Canada's Arctic. The Inuit and Inuvialuit came together as a political body with the creation of what is now called the Inuit Tapiriit Kanatami. Inuit means "the people" in the Inuktitut language, so saying "Inuit people" is redundant. The term Eskimo is generally regarded as inappropriate. The singular of Inuit is Inuk. Alberta has only a small Inuit population of about 1,985.

Métis: Métis means a person who self-identifies as Métis, is distinct from other Aboriginal peoples, is of historic Métis Nation Ancestry and who is accepted by the Métis Nation. One of the Indigenous peoples of Canada, the Métis are distinct from Inuit and First Nations people; they are descended from First Nations people who intermarried with European fur traders in the 18th century in the Canadian west. The word "Métis" comes from the Latin misère, meaning "to mix." Michif is a distinguished language of several Métis communities. Alberta is home to the only recognized Métis land base in Canada, with eight Métis Settlements located primarily in the east-central and northern areas of the province.

Appendix A: Glossary (continued)

Protocol: The process followed within a community or cultural group to request the participation or assistance of an Elder or Traditional Knowledge Keeper. The steps taken to ensure traditional practices are followed when inviting an Elder to participate or assist, when attending a ceremony or other traditional practices.

Status Indian: A First Nations person who is registered according to the Indian Act's requirements and therefore qualifies for treaty rights and benefits. The Indian Act is Canadian federal legislation, which first passed in 1876 and amended several times since.

Traditional Knowledge Keeper: A person who has been transferred sacred rights to uphold, maintain, and sustain oral culture and traditions through generations. Having these qualifications, individuals who accept transferred rights make a commitment to a life-long role and dedication to carrying out this 'way of life' to support the collective well-being in their communities. By passing their sacred knowledge and wisdom onto subsequent generations, Traditional Knowledge Keepers continue to preserve their way of life and belief systems (City of Calgary). It is very common for Elders or Traditional Knowledge holders to be called upon to help communities with decisions regarding everything from health issues, to community development, to government negotiations.

Traditional Indigenous Protocol (Honorarium): Honoraria remuneration is a common and accepted practice in order to gain access to Indigenous traditional knowledge which has been found to be an essential criterion to ensure credibility, sustainability, and trusting relationships. The purpose of Traditional Indigenous Protocols and gifts/offerings is to acknowledge and show appreciation for the sharing of knowledge and respect for personal time given. A Traditional Indigenous Protocols is a payment made to an individual for participation and contribution to a meeting or event in honour and acknowledgment of their unique and valuable experience and wisdom.

Treaty Indian: A status Indian who belongs to a First Nation that signed a treaty with the Crown.

Two Eyed Seeing: Learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing, and learning to use both these eyes together, for the benefit of all (Alberta Marshall, 2004).

The following may help:

- Aboriginal is an all-encompassing term that includes Inuit, First Nations (Indians), and Métis. The term is utilized in the Canadian Constitution.
- Indigenous is also an all-encompassing term that includes Inuit, First Nations (Indians) and Métis. The term is commonly used internationally.
- Aboriginal and Indigenous ARE interchangeable terms in some contexts, though Aboriginal is defined in the Constitution (1982) and thus a legal term, while Indigenous is not. Aboriginal is most often used in the context of Aboriginal rights.
- Aboriginal and First Nations are NOT interchangeable terms.
- First Nation is the contemporary term for "Indian" although Indian is in the Constitution and thus used in some legal contexts.
- Inuit are not referred to as First Nations (Indians) even though, in law, they are included under federal jurisdiction under section 91(24) of the constitution (which refers to Indians). The term Eskimo is generally regarded as inappropriate.
- AHS is Status Blind, which means "the organization is inclusive and serves all self-identified FNMI people, both status and non-status, living on and off reserve" (http://soahac.on.ca/wpcontent/uploads/2015/01/Operationalizing-an-Indigenous-Health-Model.pdf pg 15)

"Support from behind"

(Health Center Representative)

Appendix B: Operational Program Recommendations

OPERATIONAL AREA:

ADDICTIONS & MENTAL HEALTH

What We Heard: **Addictions & Mental Health**

- Trauma informed care required.
- Call for more AHS involvement in Indigenous community collaborations and initiatives.
- Access concerns.
- Greater integration of Addictions services with Mental Health.
- Apply Indigenous lens on mental health treatments and assessment. (Holistic Medicine Wheel clinical assessment tools and treatment).
- Need for better processes and planning for discharge when brought in for crisis support.
- Increased need for traditional wellness supports.
- Physical infrastructure is needed to grow any Addictions and Mental Health programming as First Nations Health Centres are beyond capacity.

Addictions & Mental Health Commitments for Action	
Recommendation #1: Introduce the use of Adverse Childhood Experiences (ACE) to Indigenous Mental Health (IMH).	**Short Term Action:** • Train IMH staff on the use of ACEs.
	Intermediate Action: • Implement tool for all new and existing clients in IMH.
Recommendation #2: Develop a shared understanding of the resources in Calgary Zone A&MH services and Indigenous communities.	**Short Term Actions:** • Identify and highlight the synergies of the teams and the gaps. • Set up a consistent communications process.
	Intermediate Action: • Clarify roles of AM&H Calgary Zone staff and individuals working in Indigenous communities.
Recommendation #3: All staff participate in Indigenous cultural humility training opportunities.	**Short Term Action:** • Complete online Indigenous Awareness and Sensitivity Certificate Program by October 2019.
	Intermediate Action: • Offer opportunities for staff to participate in experiential training (i.e. - Blanket exercise, medicine picking ceremony, sweat lodge, and cultural professional development opportunities.).
Recommendation #4: Identify ways to respond to drug misuse/abuse and identify relevant, timely and appropriate services and/or access to services.	**Short Term Action:** • Work with Indigenous communities to identify what services are already in place and what are required to respond to drug issues. Increase alignment and coordination of services.
	Intermediate Action: • Offer consultation to individuals responding to drug crises in Indigenous communities.

Appendix B: Operational Program Recommendations (continued)

OPERATIONAL AREA:

EMERGENCY CARE

What We Heard: **Emergency Department**

- Indigenous Patients & Families perceive they are not always welcome at triage.
- Enhance culturally safe care and eliminate racism and biases (conscious and unconscious)
- Increase access to IHP Liaisons and Social Work to support patient navigation (focus on after hours and sites without services
- Improve discharge planning.
- Support linking patients to primary care.
- Inclusive, welcoming signage.
- Improve support for urgent Mental Health cases (e.g. discharge and communications with home health care providers and supports).

Emergency Department Commitments for Action	
Recommendation #1: Increase cultural awareness and understanding of resources and supports available to Indigenous patients.	**Short Term Action:** • Create awareness and understanding of IHP Liaison roles and responsibilities in Calgary Zone.
	Intermediate Action: • Explore expanding IHP Liaison role to support greater access.
Recommendation #2: Increase staff cultural awareness and competency to support culturally appropriate care.	**Short Term Actions:** • Promote completion of the Indigenous Awareness modules throughout the department by October 2019.
	Intermediate Action: • Develop strategies to support Indigenous cultural awareness sessions for Zone ED staff, including Indigenous speakers and blanket exercises.
Recommendation #3: Indigenous acknowledgement signage as a step to creating welcoming and supportive environments for patients & families.	**Short Term Actions:** • Completion of the Indigenous Acknowledgment signage pilot (currently being piloted at PLC ED).
	Intermediate Action: • Finalized Indigenous Acknowledgment signage to be incorporated in all Zone EDs.
Recommendation #4: Explore Patient Advisor support to inform department decision making with patient perspectives and needs.	**Short Term Action:** • Explore inclusion of an Indigenous Patient Advisor on the Zone Department of Emergency Medicine Committee.
	Intermediate Action: (TBD)
Recommendation #5: E-Sim development to support greater awareness and responsiveness to relevant issues in the provision of culturally competent care.	**Short Term Action:** • Introduce themes related to culturally/structurally competent care into department simulation training.
	Intermediate Action: • With IHP, develop a bank of appropriate E-Sim cases that can be used across the educational spectrum.

Appendix B: Operational Program Recommendations (continued)

OPERATIONAL AREA:
INDIGENOUS HEALTH

What We Heard: **Indigenous Health**

- Resources and support for navigation.
- Increase access and supports for traditional wellness.
- Supports required for Indigenous staff (i.e., self-care, recruitment, and retention)
- Clarify roles with Social Work.
- Options for experiential learning.

Indigenous Health Program Commitments for Action	
Recommendation #1: Required budget lines/resource allocations from zone operational budgets to support Indigenous health across the continuum of care.	**Short Term Action:** • Meet with Senior Executive to explore and discuss the opportunity to have an integrated approach to Indigenous Health Planning and budgeting/resource allocation.
	Intermediate Action: • Budget line(s) with sustainable resource allocation for Indigenous health planning across operational programs.
Recommendation #2: Increase navigation and spiritual support access for patients and families.	**Short Term Action:** • Review workload statistics and understand the needs of each site in the Zone.
	Intermediate Action: • Hire Indigenous Liaisons and Traditional Wellness Counselors to support the needs of both acute and community care settings.
Recommendation #3: Self-care support mechanisms to be implemented and flexible to support the wellness of Indigenous staff. (Supports for recruitment and retention.	**Short Term Action** • Review current and potential self-care mechanisms with staff that will help them with their roles.
	Intermediate Action • Review opportunities with HR to support and develop Indigenous employees' self-care strategy through benefits, guidelines and policies.

Appendix B: Operational Program Recommendations (continued)

OPERATIONAL AREA:

KIDNEY CARE

What We Heard: **Kidney Care**

- Co-design a dialysis and prevention model with First Nations Health Centres and communities.
- Create a collaborative partnership in provision of dialysis care. Ultimate goal is to offer dialysis closer to home.
- Patients grouped together for ease of traveling. Provide a coordinated approach.

Indigenous Health Program Commitments for Action	
Recommendation #1: Aim to slow the progression of end stage kidney disease through promotion of holistic approaches to identify and manage risk factors.	**Short Term Action:** • To inform future service expansion, assess existing practices to identify care that aligns with themes of respect (December 2019).
	Intermediate Action: • Develop linkages with internal medicine clinics and referrals via the Chronic Kidney Disease pathway. Provide focused screening, treatment and monitoring clinics. • Leverage existing experience in delivering care in FN locations. Collaboratively plan an event to share existing best practices for all renal services in AKC-South. (June 2020) • Evaluate impact of Blood Tribe program as a potential model. (2020-2021)
Recommendation #2: Understand cultural perspectives on conservative kidney management and kidney transplantation to ensure culturally sensitive care options.	**Short Term Action:** • Assess existing practices to identify care that aligns with themes of respect to inform future service expansion (December 2019.) • Review workload stats; understand needs of each site in the Zone.
	Intermediate Action: • Leverage existing experience in delivering care in FN locations. Collaboratively plan an event to share existing best practices for all renal services in AKC-South. (June 2020) • Evaluate impact of Blood Tribe program as a potential model. (2020-2021)
Recommendation #3: Expand knowledge and skills in providing culturally safe and relevant renal care that incorporates traditional wellness practices to Indigenous people in all AKC South locations.	**Short Term Action** • In collaboration with Siksika and Levern Clinic health care providers, document best practices. (2019)Identify areas for collaborative practice (e.g. interpretors, translators) (2019) • Review current and potential self-care mechanisms with staff that will help them with their roles.
	Intermediate Action • Incorporate best identified practices in all future renal services planning. Review opportunities with HR to support and develop Indigenous employees' self-care strategy through benefits, guidelines and policies.

Appendix B: Operational Program Recommendations (continued)

OPERATIONAL AREA: KIDNEY CARE (CONTINUED)

Recommendation #4: Assess current First Nations clinic locations to determine if needs are adequately met and review options to manage transportation challenges.	**Short Term Actions:** • Conduct analysis of utilization patterns/service demand for FN dialysis patients, with the aim of adjusting schedule or treatment location. (2019) • Monitor referral rates and measure KPIs to identify scope of need and impact of service improvements. • Review planned expansion at PLC dialysis for feasibility of dedicating spaces to Indigenous patients (2020). • Identify KPIs to track current dialysis services provided to Indigenous patients via analysis of service demand areas and gaps. (2019) • Conduct a current-state Canada-wide environmental scan, identifying new or unique approaches to the delivery of renal replacement therapy for Indigenous, rural or currently underserved areas. (2020) • Collaborate with care providers, Zone leadership and AHS FN leaders to review findings, service priorities, potential synergies and funding sources. • Engage Chiefs and key stakeholder in understanding approaches to conservative kidney management and transplantation (2019).
	Intermediate Action: • Include assessment of transportation challenges in all future dialysis service planning anticipated to serve Indigenous populations. (Ongoing) • Environmental scan of FN locations to identify needs/service gaps (2019). • Liaise with other service providers to leverage existing activities and feasible service opportunities (2020). • Identify possible funding sources (2019). • Prepare program plan, draft briefing note to acquire funding and obtain approval to implement plan. (Timing plan dependent)
Recommendation #5: **I**n areas where First Nations Renal Clinic are not located, integrate services through partnerships to support navigation.	**Short Term Action:** • Promote increased awareness of CKD Pathway and e-Referral program among primary care providers south of Red Deer. (Ongoing) • Liaise with Calgary Zone Indigenous Health Action Plan stakeholders to identify further areas for potential service integration.
	Intermediate Actions: • Monitor referral rates and measure Key Performance Indicators (KPIs) to identify scope of need and impact of service improvements. (Ongoing) • Liaise with Calgary Zone Indigenous Health Action Plan stakeholders to identify further areas for potential service integration (2019). • Liaise with AHS partners to identify other initiatives with potential to leverage services (e.g., dialysis capacities at EMS stations, FN clinics) (Dec 2019)

Appendix B: Operational Program Recommendations (continued)

OPERATIONAL AREA:

MATERNAL HEALTH

What We Heard: **Maternal Health**

- Increase support for Maternal Health nurses who seek advice and follow-up care for new mothers to avoid escalating referral to Child and Family Services.
- Improve Maternal Health Program and First Nations Community Health Centres communication pathways.
- Implement a harm reduction approach for supporting new mothers.
- Provide education for nurses on the supports available to mothers in their home communities.
- Support expansion of midwifery.

Maternal Health Commitments for Action	
Recommendation #1: Develop plan for cultural competency educational opportunities for Maternal Health Program	**Short Term Action:** • Maternal Health Program providers to complete required Indigenous learning opportunities as per established AHS timelines. Include as ACE requirement for staff.
	Intermediate Actions: • Collaborate with IHP leaders to develop opportunities specific for Maternal Health Program providers.
Recommendation #2: Develop a Newborn Post-Discharge Social Risk Assessment Tool for use by nursing and social work staff.	**Short Term Action:** • Establish Working Group including stakeholders from Acute Care and Community Services and IHP.
	Intermediate Actions: • Complete assessment tool with decision tree to guide communication of critical information. • Outline cases in which consultation with Children's Services would be appropriate.
Recommendation #3: Collaborate with key stakeholders to create engagement for Maternal Health Program and First Nations Community Health Centres.	**Short Term Action** • Identify key stakeholders and establish Zonal contacts for Working Group members. • Identify appropriate linkages to accreditation principles/indicators.
	Intermediate Action • Establish working group to review consultations and themes to determine priorities and next steps. • Support development of culturally appropriate content such as Indigenous Best Beginning prenatal materials.
Recommendation #4: Health promotion and prevention strategies accessible to Indigenous populations. (e.g. - prenatal group care).	**Short Term Action** TBD
	Intermediate Action TBD

Appendix B: Operational Program Recommendations (continued)

OPERATIONAL AREA:

PATIENT RELATIONS

What We Heard: **Patient Relations**

- Indigenous patients have reported experiences of racism, discrimination, and conscious and unconscious biases.
- Patient concerns are not shared via formal Patient Relations channels due to lack of awareness, lack of trust, and perceptions that the process is overly formalized and impersonal.
- Informal sharing of patient stories with Indigenous AHS staff can result in a heavy burden for those staff, unresolved issues are shared within the community increasing distrust, and resulting in little accountability or learning for AHS.

Patient Relations Commitments for Action	
Recommendation #1: Establish relationships between Indigenous Health Program and Patient Relations to strengthen the concerns management process and improve services at the front lines.	**Short Term Actions:** • Provide IHP with contacts for all Provincial Patient Relations Consultants. • Establish Working Group with PCC and IHP to identify opportunities for improvements and engagement. • Facilitate connection between CQM and IHP to build IHP awareness of current concerns.
	Intermediate Actions: • PCC to connect with IHP Liaisons for support with Concerns Management. • Develop a Patient Relations Action Plan. • IHP to collaborate with CQM to arrange ongoing reporting.
Recommendation #2: Review and revise Patient Relations Communications materials and methods.	**Short Term Actions:** • Redevelop PR website to improve accessibility and ease of understanding of info • Establish a working group to revise brochures. • Explore alternate methods of communication, including social media.
	Intermediate Actions: • Patient Relations to ensure that website content is reviewed by AHS Communications. • Disseminate updated brochures and posters to all locations identified by IHP and develop a regular supply schedule. • Establish and implement a PR Communications Plan in partnership with IHP.
Recommendation #3: Examine opportunity to capture racial concerns in PCC database to improve data capture tracking and monitoring.	**Short Term Action:** • Patient Relations to provide information related to data capturing in FACT.
	Intermediate Action: • Collaborate with IHP to identify areas for data capture.
Recommendation #4: Establish a diverse workforce by exploring opportunity for Indigenous new hire for PCC role.	**Short Term Action:** • PR to provide current PCC job description
	Intermediate Action: • PR to inform IHP of any open vacancies.
Recommendation #5: Seek opportunities for PCC Education related to cultural diversity and sensitivity.	**Short Term Action:** • PR to evaluate current educational needs and gaps.
	Intermediate Action: • PR to engage with IHP to identify learning opportunities.

Appendix B: Operational Program Recommendations (continued)

OPERATIONAL AREA:

PRIMARY CARE

What We Heard: **Primary Care**

- Need for more proactive and timely patient health information upon discharge.
- AHS, Primary Care and First Nations Health Centres alignment and data sharing is required.
- Patients have experienced racism and discrimination, which have sometimes led to misdiagnosis or ignoring of symptoms until care required has escalated.
- Collaborate to develop an Indigenous culturally specific model for Primary Care. Develop Indigenous concept of expanded "medical home" in First Nations communities.
- Advised that the Alternative Reimbursement Program (ARP) model and case management approach to patients works best in this population.
- Ensure trauma-informed approaches are utilized, including importance of ACEs.

Primary Care Commitments for Action	
Recommendation #1: Develop improved connections with First Nations Health Centre operational management teams and primary care leadership in Calgary Zone.	**Short Term Actions:** • Invite Health Centres to Community Coalition meetings. • Investigate possibility of representative for all 4 FNs to Zonal Meetings.
	Intermediate Action: • First Nations representative on supportive transitions committee.
Recommendation #2: Increase Primary Care understanding of trauma-informed care and cultural Indigenous context through targeted learning.	**Short Term Actions:** • Work with AMA as they develop the Indigenous physician's module. • Consider adding education sessions on trauma-informed care within the current mental health working group activities within the MH PCN grant.
	Intermediate Action: • Identify Indigenous physician "Champions" through existing programs (ERHL, U of C).
Recommendation #3: Primary Care information translation to Indigenous partners to increase mutual understanding, collaboration and shared resource approaches to care in FN communities.	**Short Term Action:** • Targeted sessions to engage with Indigenous Health by AHS and PCN leaders to better define and communicate roles, mandate and structure.
	Intermediate Action: • TBD
Recommendation #4: Enhanced health services closer to home to improve access and health outcomes for Indigenous Albertans in the Calgary Zone.	**Short Term Action:** • Develop a list of prioritized service gaps that would benefit from on-reserve or at home approaches.
	Intermediate Action: • Implementation of services on sites/at home that improve access for Indigenous Albertans.

Appendix B: Operational Program Recommendations (continued)

OPERATIONAL AREA:

RURAL HEALTH

What We Heard: **Rural Health**

- Identified priority to enhance culturally safe care due to multiple stories of racism and biases. Some sites deemed more welcoming by Indigenous patients.
- Many stories of misdiagnosis or ignoring of symptoms. Patients have expressed concerns as to whether this is due to discrimination or racism, and have perceptions that health care providers assume patients are looking for pills.
- Need for Indigenous Health Liaisons at all hospital sites, including after hours and weekend care. Language supports are required.
- Improvements needed for discharge planning.

Rural Health Commitments for Action	
Recommendation #1: Increase cultural competency and humility among all AHS staff and Physicians.	**Short Term Actions:** • Staff and physicians (80%) to complete the mandatory Indigenous cultural competency training. • Identify 3 sites for future expansion of traditional wellness/healing facilities. • Complete the Indigenous land acknowledgment pilot project in Strathmore.
	Intermediate Actions: • All Rural sites to host an experiential learning exercise within one year of competency training completion. • 80% of staff and physicians participate in experiential learning by 2021.
Recommendation #2: Expand the Indigenous Liaison Program across Calgary Zone Rural sites.	**Short Term Action:** • Initially target the communities of Strathmore and Black Diamond for new positions. Expand to other rural sites as required.
	Intermediate Actions: • After hours and remote site access to Indigenous Liaison expertise for all Rural Sites. • SharePoint site for forms, key contacts, resource access pathways.
Recommendation #3: Improve communication between AHS staff and First Nations Health Services staff to more easily facilitate problem solving and issue escalation.	**Short Term Actions:** • Rural Directors to set up monthly meetings with IH Services Directors.
	Intermediate Actions: • Expand connections with Patient Family Advisors, IHP Liaisons and other expertise as required. • Rural Health to continue exploring alternative access options (i.e. 1-800 calls)
Recommendation #4 Provide care close to home.	**Short Term Action:** • Explore feasibility of renal replacement therapy options in partnership with Alberta Kidney Care and Indigenous Health Services.
	Intermediate Action: • Starting with home therapies (peritoneal and home hemodialysis), examine implementation options with Siksika Health Services as a pilot site to provide renal replacement therapy in the community.

Appendix B: Operational Program Recommendations (continued)

OPERATIONAL AREA:

SENIORS, PALLIATIVE & CONTINUING CARE

What We Heard: **Seniors, Palliative and Continuing Care**

- Continuing care closer to home - capital infrastructure is needed and identified as a major issue on all First Nations.
- Opportunity for the Community Palliative Care Grant to more fully recognize the local community and cultural lens.
- Support is needed to facilitate smoother transitions home with more proactive and timely discharge.
- Increase Traditional Wellness options and services.
- Ensure Contracted Services are offering Traditional Wellness practices (e.g., smudges, etc.)

Seniors, Palliative and Continuing Care Commitments for Action	
Recommendation #1: Increase staff educational opportunities to generate awareness of Indigenous cultural competency and initiate on creating a more culturally sensitive workforce.	**Short Term Actions:** • Develop plan to support staff completion of Module 1 by October 2019. • All portfolio leaders to have completed 7 online courses by October 2019.
	Intermediate Actions: • Track portfolio-wide attendance monthly. • Address barriers to module completion. • Utilize team meetings to discuss learnings and identify ways to support Indigenous needs and practices in the clinical setting.
Recommendation #2: Build relationships with Indigenous communities to ensure that Indigenous practices are embedded in clinical services.	**Short Term Action:** • Identify key Indigenous Health Leaders that SPCC leaders can meet with over the next year (end 2021).
	Intermediate Actions: • Leadership from SPCC to engage with identified Indigenous leaders to learn about needs and identify issues with clinical services. • Work with AHS IHP identify community needs to increase knowledge on creating culturally safe spaces in practice.

Appendix C: Committees

Calgary Zone Indigenous Health Planning Working Group		
Name	**Representing**	**Title**
Chelsea Crowshoe (Co-Chair)	PPIH	Provincial Director South, Indigenous Health
Penny Morelyle (Co-Chair)	Planning & Performance	Senior Planner, System & Service Planning
David Turner	PPIH	Community Engagement Advisor, Disaster Management, Indigenous Health
Shelley Goforth	PPIH	Senior Advisor, Calgary Zone, Indigenous Health
Catherine Morrison	ACH	Patient Care Manager, Patient Family Centered Care
Vacant	PPIH	Elbow River Healing Lodge Supervisor, Indigenous Health
Simon Ross	PPIH	Senior Advisor, Cultural Competency
Michael Beech	Calgary Zone	Exec Assoc, Office of Senior Operating Officer, Community & Rural Health
Kari Simonson	Calgary Zone	Program Specialist, Rural Health
Colleen Karran	Calgary Zone, AMH	Director, Adult and Geriatric, Addiction and Mental Health
Tracy Sutton	Calgary Zone, Seniors	Consultant, Palliative & End of Life Care
Janice (Gale) Blondeau-Getz **Tina Nash (alternate)**	Indigenous Addiction & Mental Health	Family Counsellor, Indigenous Mental Health
Colleen Blackwell	Indigenous Health	Administrative Coordinator
Carolyn Paradis	Prov Communications	Advisor, Community Engagement
Folake Arinde (ad hoc)	Research & Innovation	Specialist / Research Associate
Calgary Zone Steering Committee		
Name	**Representing**	**Title**
Nick Thain(Co-Chair)	Calgary Zone	Senior Operating Officer, Community, Rural Health
Chelsea Crowshoe (Co-Chair)	PPIH	Director, Calgary & South Zones, Indigenous Health
Nadine McRee	PPIH	Executive Director, Indigenous Health
Dr. David Strong	Quality & Chief Medical Officer	Lead Medical Officer of Health, Communicable Disease Control
Scott Holland	Calgary Zone	Executive Director, Rural Health
Dr Colin Del Castilho	Calgary Zone	Associate Zone Med Dir Community, Rural and Cont Care, Facility Medical Director South Health Campus
Lori Anderson	Calgary Zone	Senior Operating Officer, South Health Campus
TBD	Quality & Chief Medical Officer	Lead Medical Officer of Health, Indigenous Health
Bev Berg	Palliative Care, Seniors Health	Director, Palliative & End of Life Care
Debra Renz	Planning & Performance	Executive Director, System & Service Planning,
Penny Morelyle	Planning & Performance	Senior Planner, System & Service Planning

"We have a voice"

(Elder)

Appendix D: Engaged Stakeholders

Stakeholder	• How will they be impacted?
Indigenous community members including: First Nations Communities (Siksika, Stoney Nakoda, Tsuut'ina); Metis; Urban community members	• Focused engagement sessions on health priorities and effective processes to develop the Indigenous Health Action Plan. Improved long term health outcomes and inclusion in the planning process.
AHS Wisdom Council	• Included in Ad Hoc consultation. Focused engagement sessions on their health priorities and effective processes. Consultation on Indigenous Health Action Plan.
Elders and Traditional Knowledge Keepers	• Focused engagement discussions to receive guidance on process and protocols.
Community non-profit groups including Aboriginal Friendship Center of Calgary, Metis Calgary Family Services, INN from the Cold, United Way, City of Calgary and others.	• Focused engagement sessions on Indigenous health priorities and effective processes. Consultation on Indigenous Health Action Plan. Partnership opportunities to be developed for implementation and strategy development.
Internal AHS Departments and Program Areas including: Indigenous Health Program, Research and Evaluation/ DIMR, Operations, Communications and Community Engagement, Provincial Planning Advisory Committee	• Focused engagement sessions on Indigenous health priorities and effective processes. Consultation on Indigenous Health Action Plan. • Partnership opportunities to be developed for implementation and strategy development. Collaboration and support for specific action strategies. • Alignment and integration of engagement practices and Indigenous health priorities within operational planning.
Alberta Health	• Consultation and collaboration on Indigenous health priorities and effective processes. • Partnership opportunities to be developed for implementation and strategy development.
Federal Ministries	• Consultation and collaboration on Indigenous health priorities and effective processes. • Partnership opportunities to be developed for implementation and strategy development.

"The Elders are so important. They have so much value. They have sacred knowledge. We need to listen and not ignore them. To ignore them is so much disrespect"

(Health Center Director)

Appendix E: Truth and Reconciliation Commission (TRC) Health-Related Calls to Action

The TRC report states that redressing the legacy of residential schools and achieving reconciliation will have a direct impact on improving Indigenous health outcomes. It is important to note the specific health related Calls to Actions.

Recommendation 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.

Recommendation 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. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

Recommendation 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.

Recommendation 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, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

Recommendation 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.

Recommendation 23:

We call upon all levels of government to:

- *Increase the number of Aboriginal professionals working in the health care field.*
- *Ensure the retention of Aboriginal health-care providers in Aboriginal communities.*
- *Provide cultural competency training for all health-care professionals.*

Recommendation 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.

Recommendation 55:

We call upon all levels of government to provide annual reports or any current data requested by the National Centre for Reconciliation so that it can report on the progress towards reconciliation. The reports or data would include, but not be limited to: Progress on closing the gaps between Aboriginal and non-Aboriginal communities in a number of health indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

Recommendation 57:

We call upon federal, provincial, territorial, and municipal governments to provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, UNDRIP, Treaties and Aboriginal Rights, Indigenous Law, and Aborginal-Crown relations. This will require skills based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Appendix F: Treaty Rights to Health: Declaration of Treaty 6, 7 & 8 First Nations

Treaty Right to Health

Declaration of Treaty 6, 7 & 8 First Nations

Recalling and agreeing with the Chiefs in Canada 1981 Declaration which stated that…

"We the original peoples of this Land know the Creator put us here. The Creator gave us Laws that govern all our relationships to live in harmony with nature and mankind. The Laws of the Creator define our rights and responsibilities. The Creator gave us our spiritual beliefs, our languages, our culture, and a place on Mother Earth which provided us with all our needs. We have maintained our freedom, our languages, and our traditions from time immemorial. We continue to exercise the rights and fulfill the responsibilities and obligations given to us by the creator for the Land upon which we were placed. The Creator has given us the right to govern ourselves and the right to self-determination. The rights and responsibilities given to us by the Creator cannot be altered or taken away by any other Nation."

Noting that the Royal Proclamation of 1763 initiated and adopted by the British Government, recognizes nations or tribes of Indians. The proclamation recognizes our original title of all lands traditionally occupied and used by our ancestors. The status of our Indian nations was confirmed and entrenched by our entering into Treaties with the British Crown.

Recognizing that in 1982, at the peak of our Indian Nations' struggle to securely entrench our Treaty and Inherent Rights in the Constitution Act; Justice Lord Denning supported the solemnity, integrity and durability of our treaties with the British Crown. On January 28, 1982, Lord Denning in the High Court of the United Kingdom, proclaimed in his judgement, "There is nothing, so far as I can see, to warrant any distrust by the Indians of the Government of Canada. But, in case there should be, the discussion in this case will strengthen their hand so as to enable them to withstand any onslaught. They will be able to say that their rights and freedoms have been guaranteed to them by the Crown, originally by the Crown in respect of the United Kingdom, now by the Crown in respect of Canada, but, in any case, by the Crown. No Parliament shall do anything to lessen the worth of These guarantees. They should be honoured by the Crown in respect of Canada 'as long as the sun rises and the river flows'. The promise must never be broken."

Further on July 5, 1973 Her Royal Highness Queen Elizabeth II affirmed that Treaties in an address to the Chief in Alberta, stating "You may be assured that my Government of Canada recognizes the importance of full compliance with the spirit and intent of your treaties."

The Treaty which became known as Treaty No. 6 contains a medicine chest clause which was agreed to due to existing circumstnances at the time.

Emphasizing that Sections 25 and 35(1) of the 1982 Constitution Act of Canada recognizes and affirms treaty rights.

Also emphasizing that the Treaty 6, 7 & 8 Unity Agreement of 2003 recognizes that the Cree, Dene, Chipewyan, Blackfoot, Nakoda Sioux, Assiniboine, Saulteaux, Beaver, Ojibway, and Tsuu T'ina within their traditional territories have always considered ourselves integrally related, possessing from time immemorial, all the attributes of nationhood and all it entails under international law.

Acknowledging that International Law recognizes the nationhood of the Cree, Dene, Chipewyan, Blackfoot, Nakoda Sioux, Assiniboine, Saulteaux, Beaver, Ojibway and Tsuu T'ina in Treaty 6, 7 and 8, and the Geneva Declaration on the Health and Survival of Indigenous Peoples (23-26 November 1999) Part 1 includes "a call on governments where Treaties, agreements and other constructive arrangements exist, that the original spirit and intent of these international agreements be honoured, respected, and implemented."

We now further declare,

As Treaty Indians there is nothing more important than our Treaties, our land and the well being of our future generations.
All rights recognized in Treaties between the Crown and Nations or Tribes of Indians in Canada ensuring the wholistic and the spiritual concept of Treaties

That the medicine chest clause binds the federal government to provide medicines and all that is required to maintain proper health.

Treaty 6, 7 & 8 discussions were based on previous treaties and that all were equally inclusive and applicable.

So long as the sun shines, rivers flow and the grass grows, these words must never be broken.

Dated: March 16-17, 2005
Signed by
Chiefs in Treaty No. 6, No. 7 and No. 8

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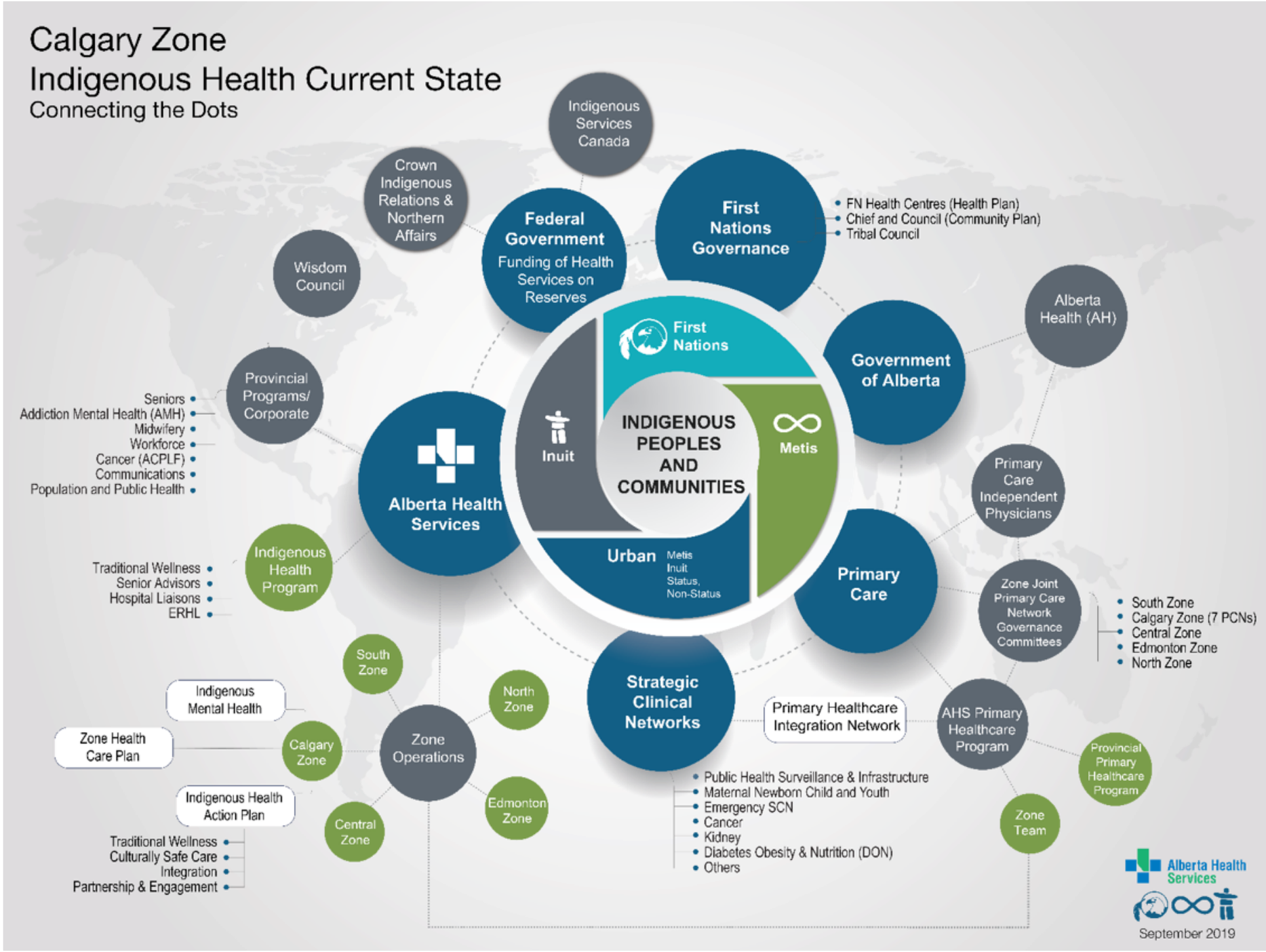
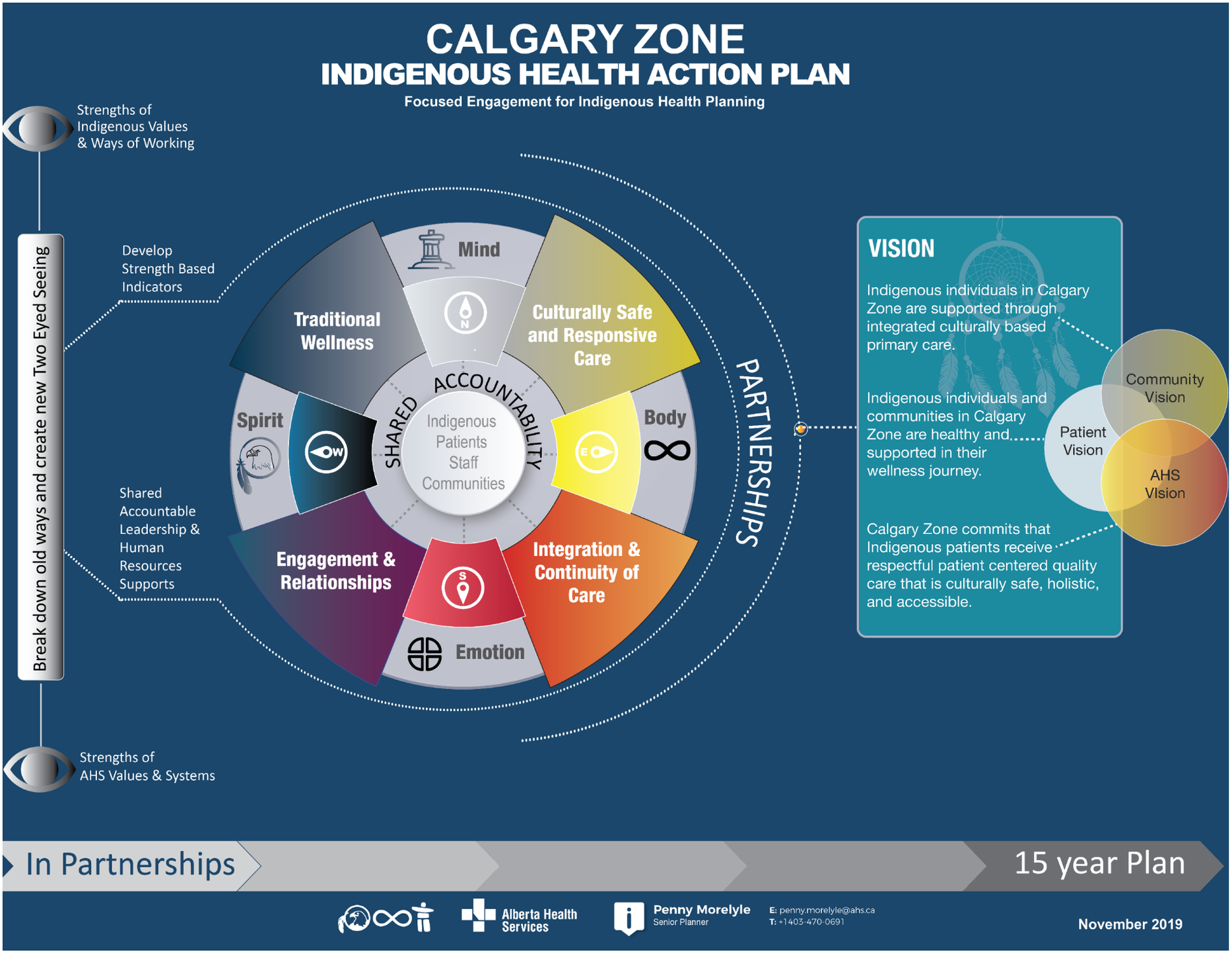
"New research is demonstrating that drumming can help reset the parasympathetic nervous system for patients with trauma. Can we use this traditional practice more effectively?"

(AHS Staff Member)

Appendix H: Calgary Zone Indigenous Health Action Plan Mind Map: Connecting the Dots



Appendix I: Overarching AHS Calgary Zone Indigenous Health Action Plan

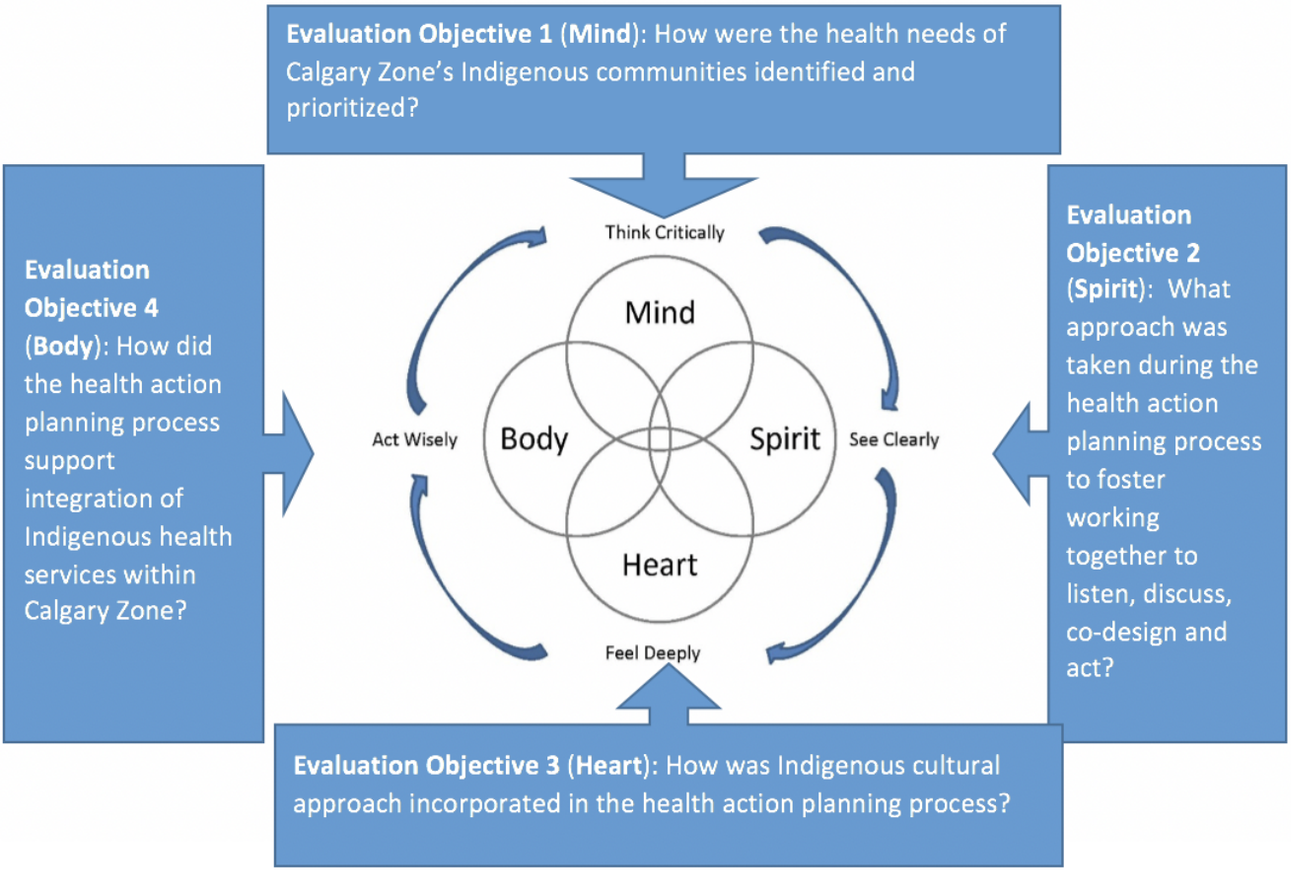


Appendix J: Evaluation

There are two elements of evaluation that are to be supported moving forward.

1. Process developmental evaluation report of the process for the Action Plan and knowledge translation of the key learnings and findings upon approval of the Action Plan. This includes:
    a. Documentation and description of the Calgary Zone Indigenous Health Action Planning process.
    b. Use of Traditional protocols.
    c. Understanding a different process for system and service level planning.
    d. Incorporation of Indigenous ways of knowing, seeing and learning into our system and service planning process.
2. Development of an evaluation framework including key indicators for the approved plan (align with strength based community health indicators of well being and provincial initiatives).
    a. Align with provincial Indigenous Health Strategy and Indigenous Health Strategic Clinical Network.
    b. Identify key indicators for each prioritized action item.
    c. Respond to Alberta Health accountability measures such as perinatal mortality rate.
    d. Support efforts within operations across the Calgary Zone to have unified evaluation indicators and strategy (including process and outcome indicators).
    e. Commitment to support work from Data Integration Measurement and Reporting unit (DIMR)
    f. Develop relationship agreements with communities.

The evaluation will document the steps involved in developing the action plan, as well as the successes, challenges and key learnings observed during the process. It will also identify tools and resources utilized in the overall process.



"It is not integrating. It is inter-connecting but not merging" *(Wisdom Council Representative)*

Appendix K: Calgary Zone Indigenous Health Action Planning Logic Model 2018

Calgary Zone Indigenous Health Planning Logic Model 2018 (Draft 5.0 August 27, 2018)

Vision and Goal: *Health equity for Calgary Zone Indigenous community members (to be determined once Health Plan is drafted).*

Inputs

Human Resources (Steering Committee and Working Group)
- Indigenous Health Program
- Rural and Community Health
- Population and Public Health
- Acute Care
- Planning & Performance
- Addictions & Mental Health
- Community Engagement
- Seniors Health
- Research & Evaluation, SCN

Partnerships & Stakeholders
- Indigenous community members, including First Nations, Metis and Inuit
- Community Non-Profit Organizations
- Government of Alberta
- Federal Government
- University of Calgary
- City of Calgary
- Other internal partners

Technology
- Telehealth
- Skype

Supporting Reference Materials
- Professional Resources
- Academic Studies (Literature Reviews)
- Provincial Integrated Approach to Planning Guide

Provincial Initiatives
- SCN, TRC Group, Prov IHP
- Workforce Planning

Financial Resources
- TBD

Activities

Current State and Information Gathering

1. Document review
   - *Patient experience*
   - *Health and population data*
   - *Literature and research*
   - *Provincial priorities*
   - *Urgent health priorities*
2. Engagement

Formal and informal engagement with communities, patients & families, staff, AHS departments, & other external providers, both rural and urban, to help inform the Indigenous Health Action Plan.

Integration

Align with existing initiatives, both internal and external to AHS, to enhance consistent Indigenous health planning.

1. Organizational Integration
   - *Partner with Indigenous Health Program (provincial and Zone) to enhance Zone initiatives as it aligns with planning work, such as cultural competency, awareness building and traditional cultural wellness and spaces planning.*
   - *Align, support and share wise practices with provincial programs and initiatives that are underway or initiating.*
2. Stakeholder Integration
   - Partner with Alberta Health, Government of Alberta, Federal Government.

Development of the Calgary Zone Indigenous Health Action plan

Develop an Indigenous Health Action Plan, which may be built on the four pillars (of cultural competency, traditional wellness, engagement and integration) and include recommendations on priority action areas

Evaluation

Investigate how to support evaluation efforts of the Indigenous Health Action Plan, including integrating evaluation in the health action planning and evaluating the current planning process

Sustainability

Explore sustainability strategy for the Calgary Zone Indigenous Health Action Planning and Implementation.

Outputs

- Current state reports
- Engagement Plan (including Guide & Tools)
- Communication Plan
- Summary report of engagement sessions

- Identified opportunities for Indigenous health program and initiative integration, including provincial initiatives to be implemented locally
- Communications mechanisms identified
- Enhanced training opportunities

- Approved Indigenous Health Action Plan
- Integration into annual operational and business plans

- Evaluation plan
- Identification of effective Indigenous Health Planning process elements
- Data sharing
- Evaluation report
- Documentation of lessons learned

- Sustainability plan/strategy

Outcomes (Short, Med & Long)

SHORT TERM: Links to Calgary Zone Operational Plans clearly identified to build sustainable changes to the health system.

MED TERM: Action Plan embedded into Calgary Zone Healthcare Plan.

MED TERM: Engagement is ongoing, systemic, & meaningful across program areas.

MED TERM: Enhanced relationships with Indigenous partners

LONG TERM: Indigenous focused considerations embedded and integrated within operational planning.

LONG TERM: Improved access to culturally safe care for Indigenous community members

LONG TERM: Improved Indigenous health outcomes.

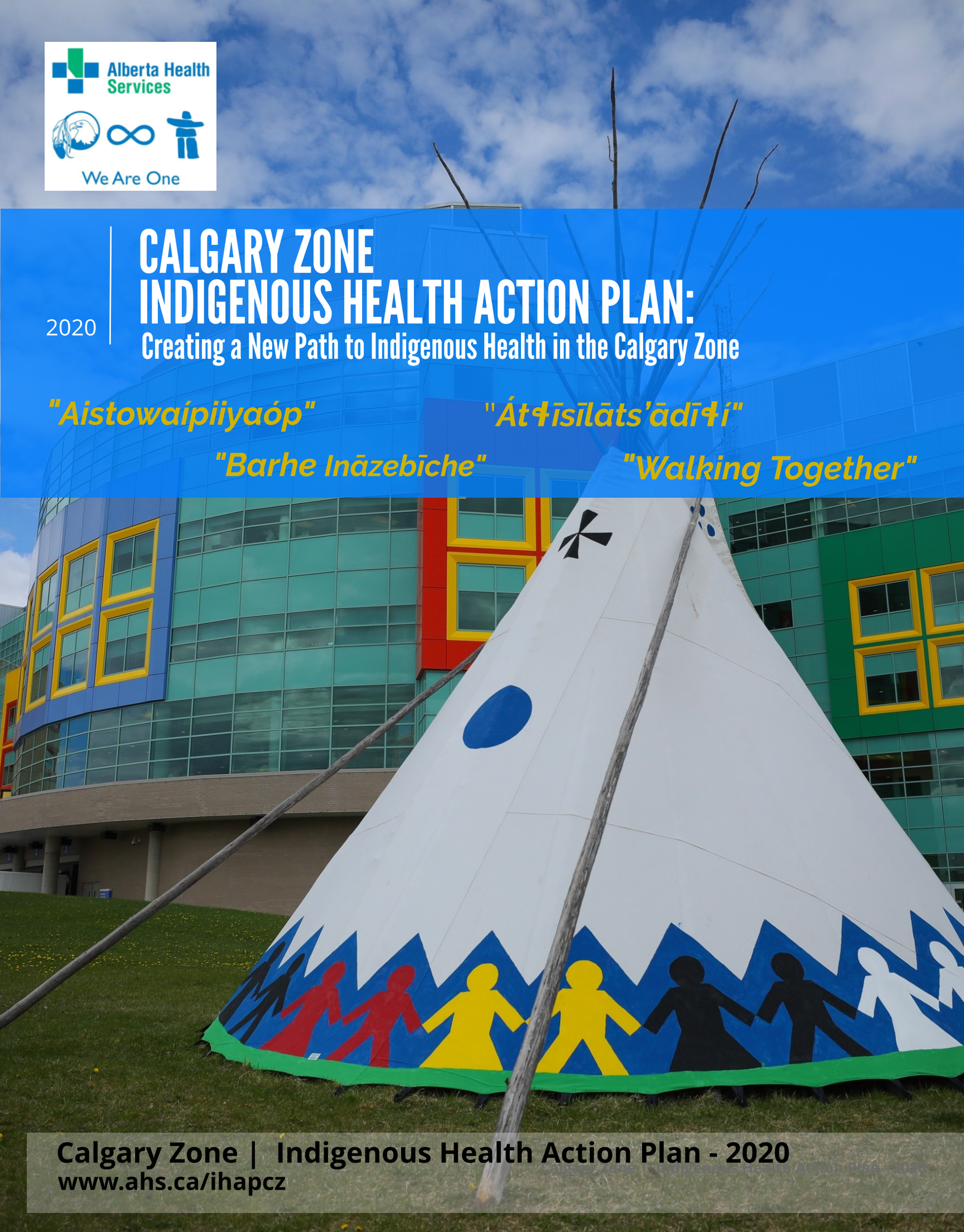
LONG TERM: Ongoing partnerships with Indigenous communities to achieve their health goals.

Guiding Principles

- Engagement & Partnerships leading to Co-Design
- Strength Based Approach
- Cultural Safety and Provision of Culturally Safe Care
- Sustainability
- Trust
- Diversity of Indigenous Peoples
- Traditional Indigenous Knowledge & Practices
- Indigenous Right to Health
- Seven Sacred Teachings
- Transparent & Timely Communication
- Coordination and Integration
- Indigenous Self-Determination

"We need to take care of the Elders. We need to take care of these roles and this sacred knowledge" *(Wisdom Council)*

In gratitude for the stories shared, the lessons learned, and walking the path forward together.



Alberta Health Services

We Are One

2020

CALGARY ZONE INDIGENOUS HEALTH ACTION PLAN:

Creating a New Path to Indigenous Health in the Calgary Zone

"Aistowaipiiyaóp"

"Átɬīsīlāts'ādīɬí"

"Barhe Ināzebīche"

"Walking Together"