Creating Harmony in Care

With Indigenous Communities in Alberta

Alberta Health Services Inspiring solutions. Together.
Diabetes, Obesity & Nutrition Strategic Clinical Network™

April 2023

Executive Summary

The Alberta Health Services Diabetes, Obesity and Nutrition Strategical Clinical Network is committed to improving the health outcomes and health care experiences for Indigenous Peoples in Alberta, and to co-create solutions with Indigenous Communities.

Creating Harmony in Care is an approach to integrate western care with culturally relevant practices that has been co-created in collaboration and consultation with Indigenous communities, stakeholders, champions and Elders in Alberta.

Creating Harmony in Care considers the following four key aspects:

1. **The person** living with, or at risk of, a chronic condition,
2. **The community** where the person lives, or that the person belongs to,
3. **The care** required to prevent, treat, and manage chronic conditions, and
4. **The system** that prevents or enables optimal health, such as the health care system and the environment.

Creating Harmony in Care has been used to enhance several point-of-care-testing initiatives in Alberta, including the Kidney Health Check Screening. As a result:

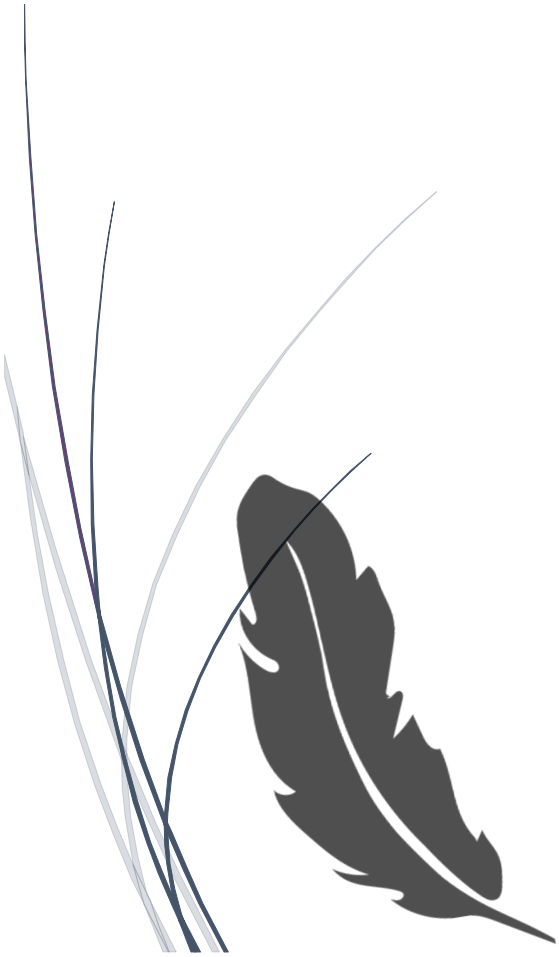
- ✓ **The person** is screened for diabetes, hypertension, kidney disease, obesity, retinopathy, and diabetic foot ulcers in the community and by local health care providers and champions. The person receives in-the-moment results, referrals to primary and specialty care if required, and wellness coaching.
- ✓ **The community** is able to offer a comprehensive Wellness Model that ensures people screened have access to:
    - Medical programs and services, such as education (diabetes, kidney, hypertension) and medication management.
    - Lifestyle programs and services, such as physical activity, nutrition, weight management, stress management, and appropriate tobacco use.
    - Cultural programs and services, such as smudges, ceremonies, land-based education, and traditional medicines and practices.
- ✓ **The care** includes Western and Traditional evidence-based practices, approaches, and recommendations.
- ✓ **The system** considerations ensure people screened are appropriately referred and seamlessly flow to and from primary and specialty care.

In developing Creating Harmony in Care, the following ten Reconciliation measures have been adhered to, and ultimately form recommendations for policy changes:

1. Work together across jurisdictions to ensure appropriate and timely care is available in the most appropriate setting and as close to where the person lives, works, and plays.
2. Provide sustainable support for local and community champions to successfully build capacity and expertise.

3. Acknowledge that the communities have wisdom and answers to address local health challenges.
4. Build local capacity to ensure that local efforts can continue as effortlessly as possible.
5. Allocate resources to do it right.
6. Commit to the time it takes to engage, build trust, and collaborate.
7. Support the people doing the reconciliation work.
8. Listen to and include the Elders.
9. Enable continuous and reciprocal learning.
10. Commit to doing the work differently and use stories, graphics, and beliefs.

Creating Harmony in Care will continue to inform current efforts and future priorities, as identified in collaboration with stakeholders. This will enable continuous improvements in the health outcomes and health care experiences for Indigenous peoples in Alberta.



Acknowledgement

Trust leads to partnerships, collaboration, relationships, and change. Trust has been the key ingredient throughout the journey to co-Create Harmony in Care. This work would not have been successful without people trusting each other, people trusting their own and others' value, and people trusting that wisdom comes in many forms.

This project was created in the spirit of collaboration and co-creation with Indigenous communities, stakeholders and Elders, and in a manner that resonates with those stakeholders while in alignment with the Alberta Health Services vision to create: Healthy Albertans. Healthy communities. Together.

Numerous meaningful graphics, that have been produced during the project, are featured throughout this document. These graphics tell the stories that stakeholders have graciously shared. The images are the central focus of the engagement that has taken place and are represented in a manner that resonates with, and matters to, these attendees, stakeholders, and individuals.

All images are a result of being rendered by the artist's hand and as such, logos, symbols, and icons are shown with the distinct characteristics of the artist's style.

This has resulted in a unique process, approach, and product. Please honor the spirit in which this was created, when referencing the content.

Project Team

Harley Crowshoe
Piikani and Blackfoot Elder

Aaron Russell
Alberta Health Services Graphic Recorder

Nicki Kirlin
Alberta Health Services Project Planner

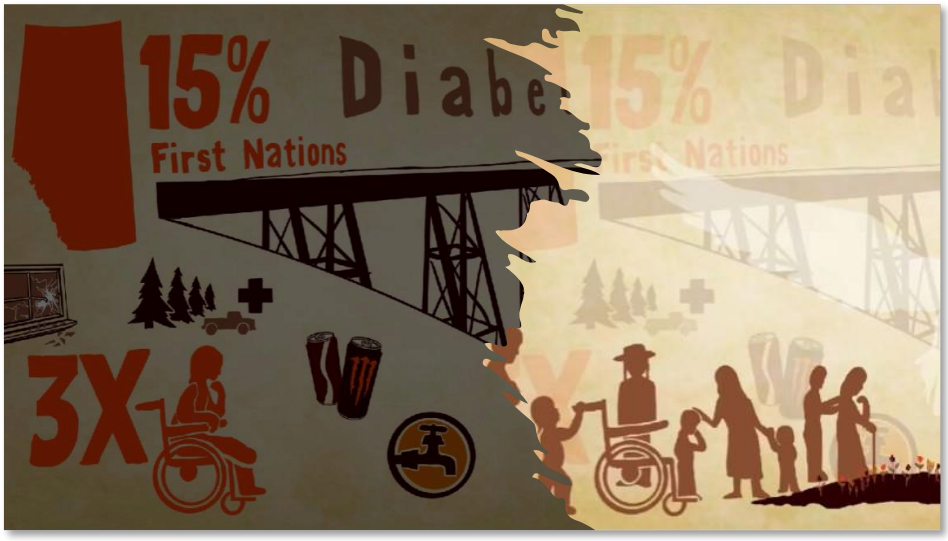
Lene Jorgensen
Alberta Health Services Project Lead

Contents

Bundles represent a continuous journey through life, starting in the East with discovery, extending to the South with building responsibility and family, then moving to the West and establishing connection with the Creator, and culminating in the North with a journey home to the Creator.

Elder

Improving Health Outcomes and Health Care Experiences for Indigenous Peoples in Alberta



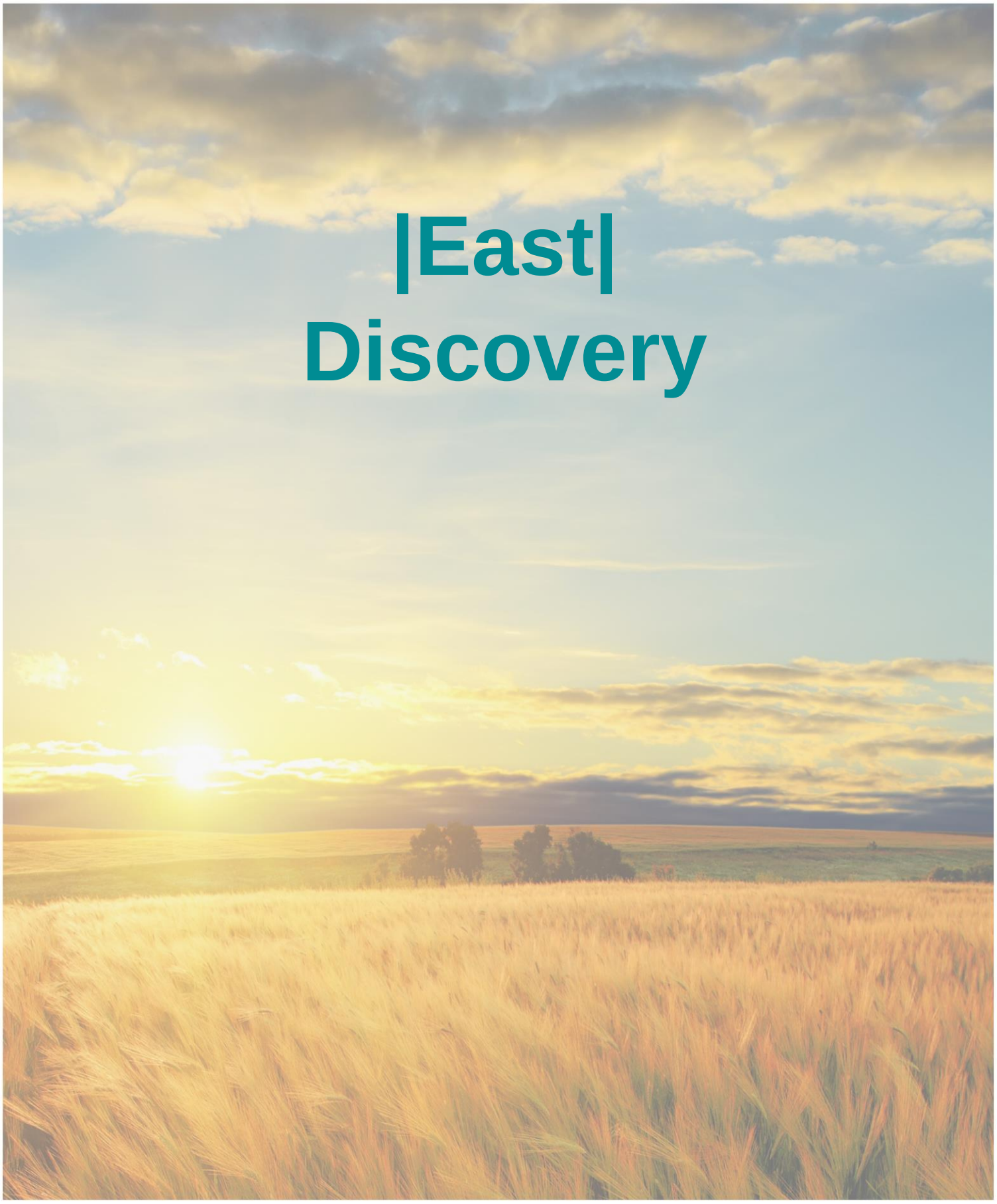
The Alberta Health Services (AHS) Diabetes, Obesity and Nutrition Strategic Clinical Network™ (DON SCN) is a network of a diverse group of patients, healthcare providers, healthcare organizations and researchers.

In 2020, efforts began to customize existing DON SCN initiatives to better suit the needs of Indigenous peoples in Alberta. The initial focus of this work has been on diabetes and diabetes related complications such as diabetes eye disease, foot complications, and kidney disease.

Specific to diabetic foot ulcers and amputations, Indigenous peoples:

- are at higher risk of peripheral neuropathy
- have worse outcomes with lower limb revascularization
- have higher rates of lower extremity amputations
- experience quicker progression to major amputations
- are affected at a younger age
- are at an increased likelihood of amputations associated with old age
- are more likely to experience complications if they are male
- lower extremity amputation rates for First Nations people in Canada are 30 times higher than non-First Nations

(Schoen et al.,2014 and Martens et al., 2011)


|East|
Discovery

The DON SCN Indigenous Health Commitments

The DON SCN is committed to reconciliation and recognizes the importance of acknowledging past and current experiences of Indigenous peoples that impact health, particularly in the areas of diabetes, obesity and malnutrition. Specifically, the Truth and Reconciliation Commission (TRC) of Canada has stated, that "the federal government knowingly chose not to provide residential schools with enough money to ensure that kitchens were properly equipped, that cooks were properly trained, and that food was purchased in sufficient quantity and quality for growing children." (p. E1044, Mosby & Galloway, 2017). Further, "We can be fairly certain that the elevated risk of obesity, early-onset insulin resistance and diabetes observed among Indigenous peoples in Canada arises in part from the prolonged malnutrition experienced by many residential school survivors." (p. E1045, Mosby & Galloway, 2017).

The DON SCN is committed to honoring the Seven Sacred Teachings of traditional values when collaborating with Indigenous communities in Alberta. These are respect, humility, love, truth, honesty, wisdom, and courage (Bouchard, 2016). The DON SCN's commitment to Indigenous Health aligns with the AHS Indigenous Health Roadmap to Wellness, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and the TRC Calls to Action. These commitments include trust, collaboration, acknowledging Indigenous rights to self-determination, access to traditional health practices, and special considerations related to historical trauma (see appendix 1 for further information).

The Evidence and Literature

A literature search of provincial and national research pertaining to diabetes care, obesity and other chronic diseases in Indigenous populations was completed in 2020. There were no limitations for year of publication and the goal was to inform considerations for tailoring western health initiatives to best suit the needs of Indigenous peoples in Alberta.

The collected literature was analyzed according to:

- Data: prevalence, incidence, rates, health outcomes, risk factors, complications, and determinants of health (DOH).
- Specific programming, interventions, and initiatives: awareness, promotion, prevention, screening, treatment, capacity, partnerships, guiding principles, best practices, and guidelines.
- Provider specific information: frameworks, principles, cultural competency, and cultural practices.
- Patient experiences: trauma, colonization, structural barriers, health care experiences, partnerships, and relationships.

This information was organized by the following themes, providing the guidepost of conversations and the frame of the project (see more detail in Table 1):

- SYSTEM: The role of healthcare as a "system" and of the broader environment on health.
- CARE: Evidence and promising practices.
- DETERMINANTS OF HEALTH: Societal and historical impacts, such as colonialism and other barriers faced by Indigenous peoples.
- BELIEFS: Traditional and cultural beliefs and approaches to care.

Table 1: Themes and sub-themes from the 2020 review of evidence and literature

System	Care	Determinants of Health	Beliefs
Providers -access to generalists and specialists: cultural competencies and cultural humility -use allied health and community workers -follow-up after discharge -use frameworks such as E4E **Patients** -self-management, shared decision making, co-creating care plans, social networking, literacy -focus on increasing the knowledge of diabetes management and facilitate effective communication with providers **Delivery Mechanism** -primary care, referral, mobile, walk-in, community-based -policies and guidelines being supportive of culture **Information System** -database, registries, tools & resources, and supports -electronic support tools & virtual care -establish indicators, evaluation, monitoring -public & community information **Partnerships** -local Indigenous organizations, FNIHB, MNA/Métis Settlements -data sharing and funding issues -optimize service sharing	**Screening** -care guidelines -timely referrals -medical advice -include screening for resource limitations and adverse life experiences -screening results review and recommendations, along with care plans **Prevention** -education, exercise, healthy eating and cooking -screening for precursors -provision of risk score -identify people at risk -include youth and schools **Patient-centered Care** -multidisciplinary team -transparent communication -equality in provider & patient relationship -consider: trauma-informed care, social, culture, Indigenous health workers and advocates	**Enablers** -culture -Elders -community -family -social networking, youth groups, community participation, Elder Talking Circles **Barriers** -lack of access to primary and specialty care -low income, employment, and lack of housing & infrastructure -geographic location and remoteness -intergenerational trauma and loss of culture -colonization -loss of traditional foods and activities	**Local Languages and Knowledge** **Food Sovereignty** **Traditional Medicines** **Cultural Practices & Ceremonies** **Indigenous Worldviews**

The Data

A review of available data and statistics was also undertaken in 2020. There are several limitations and precautions associated with the Indigenous population and health care data that were taken into consideration. These include challenges related to how Indigenous population numbers are recorded and published, and the lack of patient identifiers related to Indigenous identity. Following the Seven Sacred Teachings of respect includes adhering to Ownership, Control, Access and Possession (OCAP®) principles to ensure First Nations have control of data collection processes in their communities, including how the information is used.

The use of data was cautiously approached; Dr. Evan Adams from the British Columbia First Nations Health Authority (FNHA) appropriately speaks to the nature of possessiveness in research resulting in Canada's first peoples receiving second class treatment, and Indigenous bodies being viewed as the "new frontier" for which people are staking their claim (Adams, 2018). Bearing this in mind and to ensure an ethical approach to data collection, the initial intent was to identify 3-5 First Nation (FN) communities in Alberta that would be interested in collaborating. Although this was not completed, a description of the intended approach is outlined in Appendix 2. This approach has the potential to inform ways of utilizing data when working on Indigenous health initiatives, without infringing on Indigenous rights to self-determination.

The Call to Action: Listen to the Stories and Make Voices Heard

The Stories

In addition to literature, evidence, and data, stories framed this project. Stories from people living with diabetes and people whose communities are greatly impacted by diabetes and diabetes related complications. Three distinct stories are highlighted:

My Heart is Broken

The geographic landscape for Indigenous communities is complex in Alberta. The province covers three Treaties (Treaty 6, 7 and 8) and six Métis Regions (Métis Nation Regions 1-6). Within the Treaties and Métis Regions, there are 45 FN Communities and eight Métis Settlements. In addition, there are numerous Urban Indigenous Organizations throughout the province.

During the summer of 2020, the DON SCN participated in a national virtual roundtable discussion on the Indigenous Health Policy Framework (IHPF). This is a collaborative between Boehringer Ingelheim Canada Ltd., Bimaadzwin and Indigenous health care leaders, intended to improve health outcomes for Indigenous Peoples in Canada. This initial roundtable discussion was focused on addressing the gaps in health care disparities for Indigenous peoples related to the high rates of chronic diseases, such as diabetes. A story that emerged from this event was from an individual who had grown up in a small and isolated Indigenous community in Alberta, who said:

"It is one thing to have one's heart broken. It is another to have it broken wide open as in when I see the people in my community die from diabetes complications."

I Lost my Spirit

A devastating complication of diabetes is the risk of lower limb amputations. According to the literature, FN people living with diabetes in Alberta experience lower limb amputations sooner in life compared to non-FN people. In addition, FN people with diabetes in Alberta progress more quickly to severe complications compared to non-FN Albertans. Beliefs associated with limb amputations for FN patients can include the belief that their spirit must be whole, and their bodies must leave this world the way they came into it. An Elder, who was hospitalized following the amputation of one of his lower limbs because of diabetes-related complications, shared these words:

"When I lost my limb to diabetes complications, I lost my spirit as well."

Tell the Truth

The path to reconciliation is a challenging journey of discovering and uncovering truths. According to Chief Robert Joseph, a Hereditary Chief of the Gwawaenuk People: "Reconciliation is a journey, always beginning with the first step and when the first step is completed, you take the next. The journey unfolds bit by bit, block by block. When that rhythm kicks in, you know that the process of reconciliation is underway" (Joseph, 2022).

According to the Public Health Agency of Canada, Indigenous peoples are impacted by a higher burden of disease for diseases such as diabetes and being Indigenous is considered a risk factor for developing Type 2 diabetes (Public Health Agency of Canada, 2019).

"We must tell the truth!"

Indigenous peoples experience poorer health outcomes compared to non-Indigenous Canadians including:

- Diagnosis of diabetes is increasing in younger Indigenous individuals
- Indigenous individuals with diabetes have higher rates of complications
- Indigenous individuals with diabetes experience poorer treatment outcomes
- End-stage renal disease and death rates are higher in Indigenous individuals
- Microvascular disease rates, cardiovascular disease, and metabolic risk factors are higher in Indigenous individuals
- Retinopathy is more severe in Indigenous individuals, and
- Foot abnormality rates are higher in Indigenous individuals

(Crowshoe et al., 2018)

The Focus

As a result of hearing and considering these stories, this project has specifically focused on:

- Almost 15% of FN peoples in Alberta have diabetes compared to only 7% of non-FN Albertans.
- Lower limb amputations and kidney dialysis rates are 3 times higher in FN peoples compared to non-FNN Albertans.
- Determinants of health (DOH), such as poverty, barriers to access healthcare, inferior food supply, and lack of clean running water often result in earlier onset of diabetes and a quicker progression to severe health outcomes.

The Team

In preparation for engagement with Indigenous communities and in discussions about how to best involve key partners and Elders in Indigenous communities, it was decided to capture feedback graphically. An initial meeting, that included a Blackfoot Elder and a graphic recorder, set the stage to form the backbone structure of the planning team. This team was formed in the spring of 2020 and remains instrumental in shaping the project. This team consists of:

- Piikani Blackfoot Elder Harley Crowshoe
- AHS Graphic Recorder Aaron Russell
- AHS Senior Planner Nicki Kirlin
- AHS Senior Planner Lene Jorgensen
- AHS Lead Lene Jorgensen

The Bundles Concept

As the evidence, literature, data, statistics, and stories were reviewed, early discussions focused on themes as steppingstones on a pathway leading to considerations related to the person, the community, partnerships, and care.

Discussions covered Traditional and Sacred Bundles and the beliefs of how these can help and guide a person to live a good life; bundles can provide support and strength to a person; bundles come with expectations from the Creator about how to live responsibly; and bundles can be utilized to help create harmony in life.

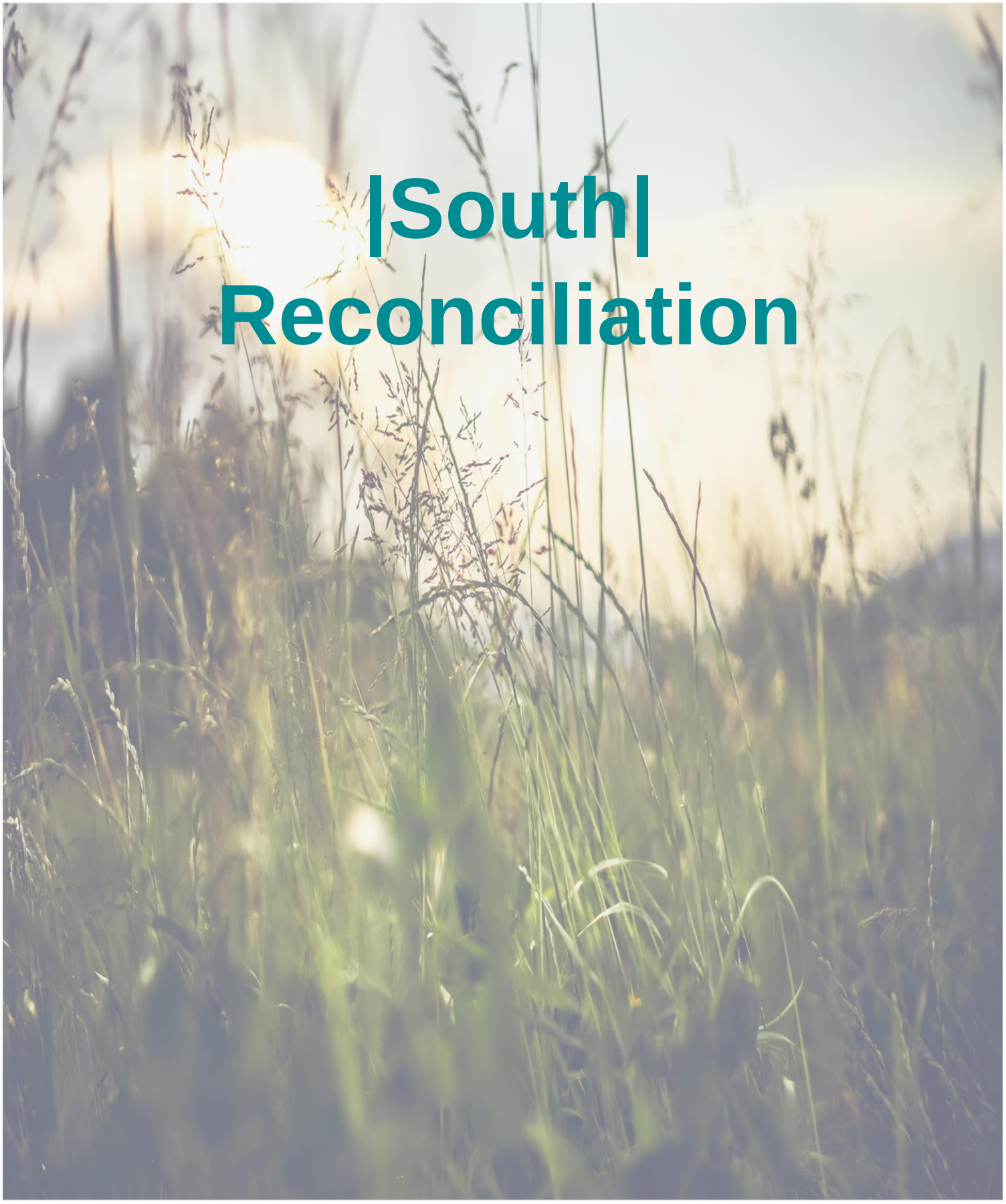
The concept of bundles and their meaning were explored to understand what is contained within a bundle, both from an Indigenous and non-Indigenous perspective, and with relevance to addressing the needs of a person or community.

Explained by Elder Crowshoe, bundles are sacred and can represent healing, protection and serve as a guide to live a healthy life. From an Indigenous understanding, the origin of bundles is based on an individual's communication with the Creator or Creator's messages received through a vision.

> Bundles represent a continuous journey through life, starting in the East with discovery, extending to the South with building responsibility and family, then moving to the West and establishing connection with the Creator, and culminating in the North with a journey home to the Creator.
> *Elder*

Bundles can be focused on the community, the bands, extended families and individuals. Bundles contain the elements related to the instructions of the original message from the Creator, and contain physical, as well as abstract, components. Physical content may include feathers, pipes, medicines, and herbs. Abstract elements can be songs and prayers. Animals are represented in bundles, such as feathers representing the Eagle and quills representing the Porcupine. A 'custodian' will commit themselves to be the keeper and caretaker of bundles that extend to a broader community, and an individual will play the same role for a personal bundle (Crowshoe & Manneschmidt, 2002).

For this project, the bundles were chosen to represent the elements needed to create harmony in care for the person, the community, the chronic care, and the broader system.


|South|
Reconciliation

Laying the Foundation: Co-Creating Harmony in Care

There were several events, projects, and funding opportunities that enhanced the Creating Harmony in Care concept:

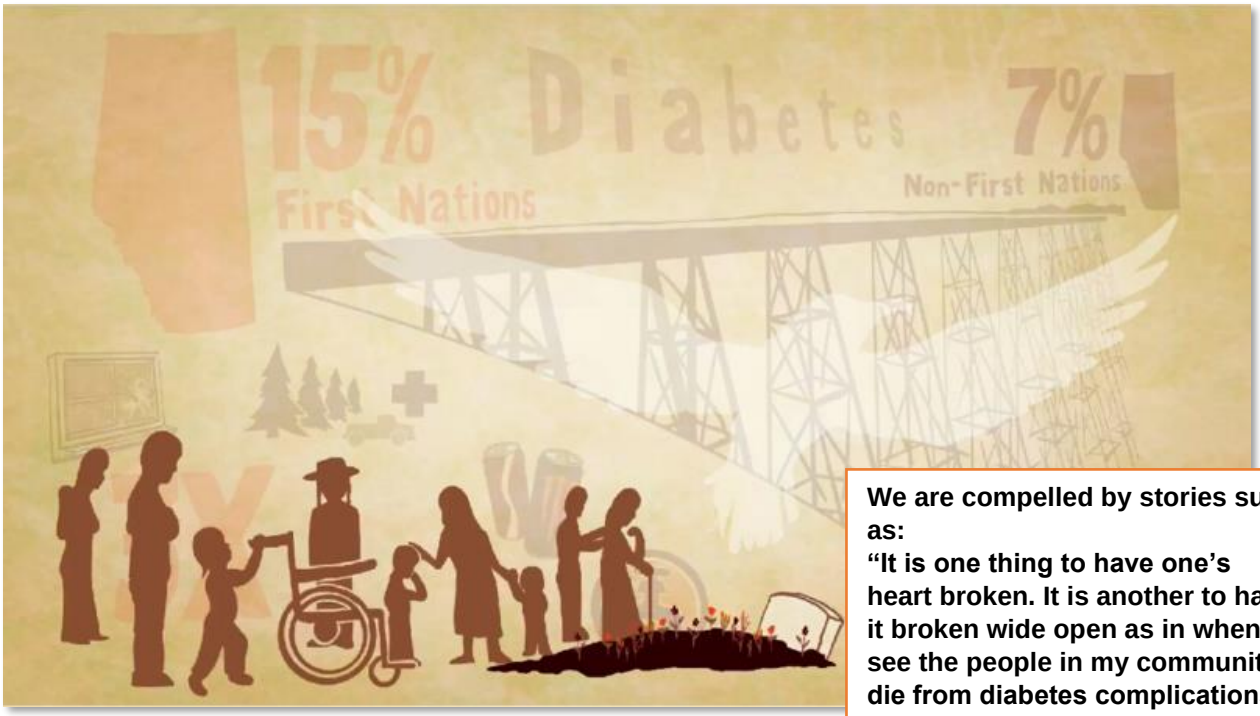
- The AHS i4 Launchpad,
- The Kidney Check Screening Project,
- The DON SCN adaptation of the Alberta Kidney Health Check Screening Protocol, and
- The Indigenous Primary Health Care Policy Research Network.

i4 Launchpad

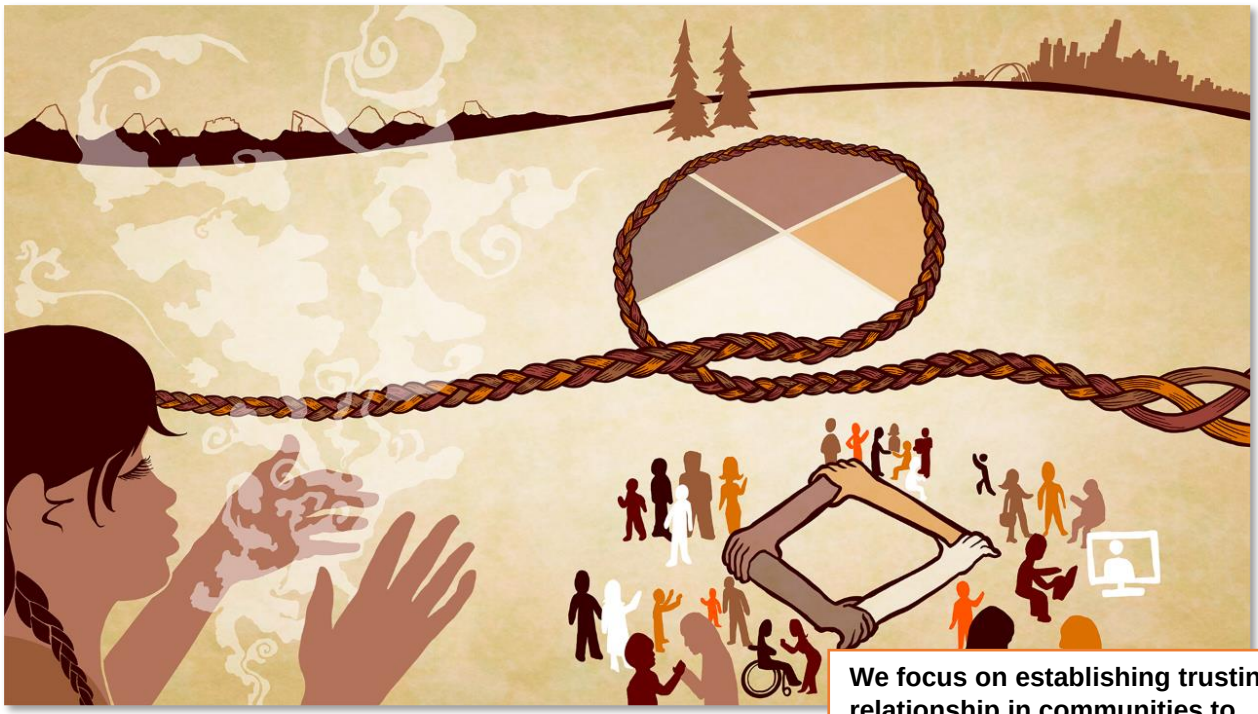
The AHS i4 Launchpad is a platform to showcase health and care ideas. The Indigenous Diabetes Project: Harmony in Diabetes Care proposal was submitted in 2020 with the intent to improve health equity, health outcomes, patient – provider interactions, and co-create wholistic patient-centered supports with Indigenous communities. While the proposal was not successful in receiving funding, pitching the approach provided an opportunity to tell the story graphically. As a result, a video was developed, which has since been used to showcase the project and received nearly 1,000 views:
[Creating Harmony in Diabetes Care with Indigenous Communities. - YouTube]

Image 1 – 5: i4 Launchpad Pitch Slides and Speaker Notes

We have a long way before we eliminate disparities in health outcomes between Indigenous peoples and mainstream Albertans:
15 % of First Nation peoples in Alberta have diabetes, compared to 7% of non-FN Albertans.
Lower limb amputations and kidney dialysis rates are 3 time higher. DOH like poverty, access to health care, inferior food supply and lack of clean running water, further exacerbate the disparity.



We are compelled by stories such as:
"It is one thing to have one's heart broken. It is another to have it broken wide open as in when I see the people in my community die from diabetes complications."
From an Elder: "When I lost my limb to diabetes complications, I lost my spirit as well."



We focus on establishing trusting relationship in communities to enable co-design.

We are focused on braiding together evidence-based diabetes care with culturally relevant practices, that are both traditional and non-traditional, and address the role of determinants of health. We want to ensure solutions include healing factors that already exist within the community and in the person living with diabetes.

Kidney Check Project and The Alberta Kidney Health Check Protocol

In the fall of 2020, the DON SCN was approached by the AHS Medicine SCN to support the implementation and ultimately lead, the Kidney Check Project, as the former Kidney SCN was undergoing structural changes. The Kidney Check Project is a screening, triage, and treatment protocol for chronic kidney disease, high blood pressure and diabetes in Indigenous communities in Alberta. The aim is to improve health outcomes of Indigenous peoples through early identification of disease. Funded and coordinated nationally by canSOLVE, this project is based on the First Nation Community Based Screening to Improve Kidney Health and Prevent Dialysis (FINISHED) program in Manitoba. The project was designed to rollout to Indigenous communities nationally, including three communities in Alberta (Curtis et al., 2021).

As a result, the Alberta Kidney Health Check Protocol was developed in 2017, with a goal of working with local communities to sustain the initiative after initial implementation. The study aims to demonstrate that in high-risk populations, such as Alberta's Indigenous Peoples, active community-based screening programs conducted by screening teams using modern and efficient risk assessment tools are feasible, affordable, and lead to prevention, early detection and improved management of existing chronic conditions. The focus of the protocol is to identify chronic kidney disease (CKD), diabetes, hypertension, and risk factors for chronic diseases. In addition, the project is designed to evaluate the feasibility and effectiveness of an overall chronic disease management (CDM) screening strategy and its impact on health outcomes. The project is led by Dr. Aminu Bello, with the University of Alberta (U of A), as the Principal Investigator. He is an Assistant Professor/Consultant Nephrologist at the Division of Nephrology & Immunology. The Alberta protocol, once adapted, became a collaborative effort between the team under Dr. Bello at the U of A, as well as key leaders within AHS, including the SCNs. Since transitioning the project to the DON SCN, it remains a collaborative effort between the U of A, AHS, and the canSOLVE network nationally.

DON SCN Adaptation of Kidney Health Check in AB: Creating Harmony in Kidney and Diabetes Care with Indigenous Communities

While the screening protocol, equipment, and training of providers is led by Dr. Bello's research team, the DON SCN's role is to ensure a productive and interactive relationship between the provider carrying out the screening and the person receiving the screening. This includes a focus on appropriate referral to primary and specialty care and addressing modifiable risk factors to prevent disease or progression of disease.

In alignment with Creating Harmony in Care, the DON SCN focus is to:

- Support self-determination in Indigenous communities by combining relevant screening initiatives and supporting the health care providers in carrying out those that are relevant to the community. Relevant screening initiatives, to date, include screening for kidney disease, diabetes, hypertension, obesity, and diabetes foot and eye care.
- Build capacity within the community, health care providers and leaders by supporting champions and leaders, facilitating gifting of the necessary screening equipment and supplies, training and supporting providers, supporting the planning for transitioning of the cost, and working with other organizations to identify opportunities for support to cover ongoing costs.

- Work across health care jurisdictions to ensure that people screened have access to follow-up and wrap-around programs and services. This includes AHS operations and primary care to ensure local involvement, partnership, and co-design. The goal is to create access to full continuum of care options (virtual and in-person) that are in alignment with the community, culture, language, beliefs and geography.
- Address determinants of health and mitigate the role these play in creating barriers to access care as early as possible to prevent progression of disease and/or increasing severity of poor health outcomes.

In addition, the focus is on ensuring that:

- Screening takes place in the community, provided by community health care providers,
- Wrap-around services are available across the continuum of care and as close to home as possible,
- Evidence-based care aligns with the uniqueness and reality of each Indigenous community,
- Tools and knowledge are available to empower individuals to live a healthy life,
- A local precision medicine approach is co-created to ensure optimal outcomes for each person, and
- Graphic recordings are continuously utilized to capture community conversations.

Indigenous Primary Health Care Policy Research Network – Seed Grant

The Indigenous Primary Health Care and Policy Research (IPHCPR) Network brings together Indigenous communities, researchers, health system leaders, and health service providers with the focus to improve primary health care with Indigenous peoples to achieve Indigenous health equity.

In 2021, the DON SCN, with support from Dr. Aminu Bello (U of A), was successful in receiving the IPHCPR Annual Seed Grant to explore the readiness within the primary health care to create systemic changes based on traditional Indigenous concepts and approaches, especially related to oral traditions.

The focus of this seed grant includes:

- Building capacity and sustainability in three Indigenous communities in Alberta.
- Supporting the most vulnerable people.
- Incorporating voices of local Elders, cultural advisors, and champions.
- Utilizing graphic recording.
- Enhancing screening services in Indigenous communities in Alberta by:
  - Co-designing the Bundles,
  - Offering a broad menu of screening initiatives,
  - Creating a virtual bridge between an Urban Metro community and a Rural Remote community, and
  - Graphically recording the collaboration process to help inform policy changes in primary health care.

Creating Harmony in Care

Describing Creating Harmony in Care

Creating Harmony in Care with Indigenous communities blends traditional ways (bundles) with innovation (precision medicine). Collaborating with Indigenous communities in Alberta, this approach has been co-created to address healing factors that exist within the person, the community, and across health care jurisdictions. This approach considers the broader system so that each person can live a healthy life. Collectively, this ensures that care initiatives build resiliency, community connections, and overall wellness in alignment with the environment surrounding each individual.

Creating Harmony in Care considers four key aspects:

1. **The person** living with, or at risk of, a chronic condition,
2. **The community** where the person lives, or that the person belongs to,
3. **The care** required to prevent, treat, and manage chronic conditions, and
4. **The system** that prevents or enables optimal health, such as the health care system and the environment.

This logo illustrates how Creating Harmony in Care was developed with equal attention to both Indigenous and western ways of thinking and doing. The feather represents how closely Elders have guided the work, and each of the icons show the consideration needed towards the person, the care, the community, and the system to create harmony in care.

In collaboration and consultation with local Indigenous Elders, bundles were chosen to represent these four areas, because bundles are seen as sacred and can represent healing, protection and serve as a guide to live a healthy life. While bundles may not resonate with all Indigenous communities or peoples in Alberta, utilizing the concept of bundles may provide a way to bridge Indigenous and western ways.

The goal of Creating Harmony in Care is to co-create local solutions to integrating western care with culturally relevant practices (Care and Community). Positioning each person at the center and considering system factors that impact health and wellbeing ensures specific, targeted, and relevant solutions for each individual (Person and System). This is a version of precision medicine, and ultimately the definition of Creating Harmony in Care, meeting the person where they are at in their health journey.

I feel like Creating Harmony in Care is about two worlds that are trying to come together. *Elder*

The Four Components of Creating Harmony in Care

The Person

- Support each person with a chronic condition to live a good life and prevent progression to complications.
- Identify and support at-risk individuals in preventing or delaying chronic diseases.
- Use a personal care plan to help the person navigate and access services, care, information, and education, as well as self-care and advocacy.

The Care

- Utilize western and traditional evidence-based care.
- Provide access to traditional and cultural practices that are community specific.

The Community

- Access beliefs, traditions, knowledge, tools, programs, services, and resources that are already available in the community.
- Include culture, language, beliefs that enable healing and wellness.

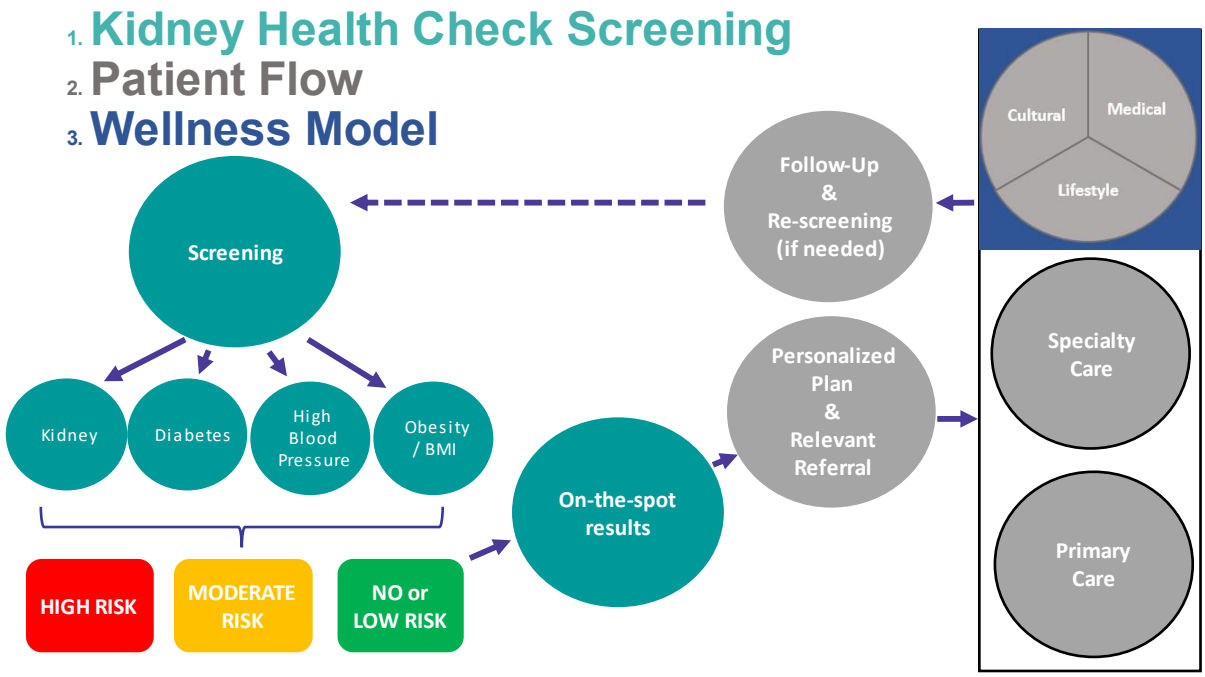
The System

- Address system impacts on health, such as colonization, while building on healing factors in the environment.
- Create smooth transitions between jurisdictions to ensure continuity of care.

Creating Harmony in Care: Screening

The kidney health check screening includes point-of-care-testing (POCT), the Kidney Failure Risk Equation for risk stratification (see Appendix 3), the CKD Care Pathway for appropriate referral and eConsult for communication between physicians and specialists. The POCT includes screening for kidney disease, diabetes, hypertension and obesity with on-the-spot results in the high risk, moderate risk and no/low risk ranges.

The image below depicts the flow of the screening process in the teal color.



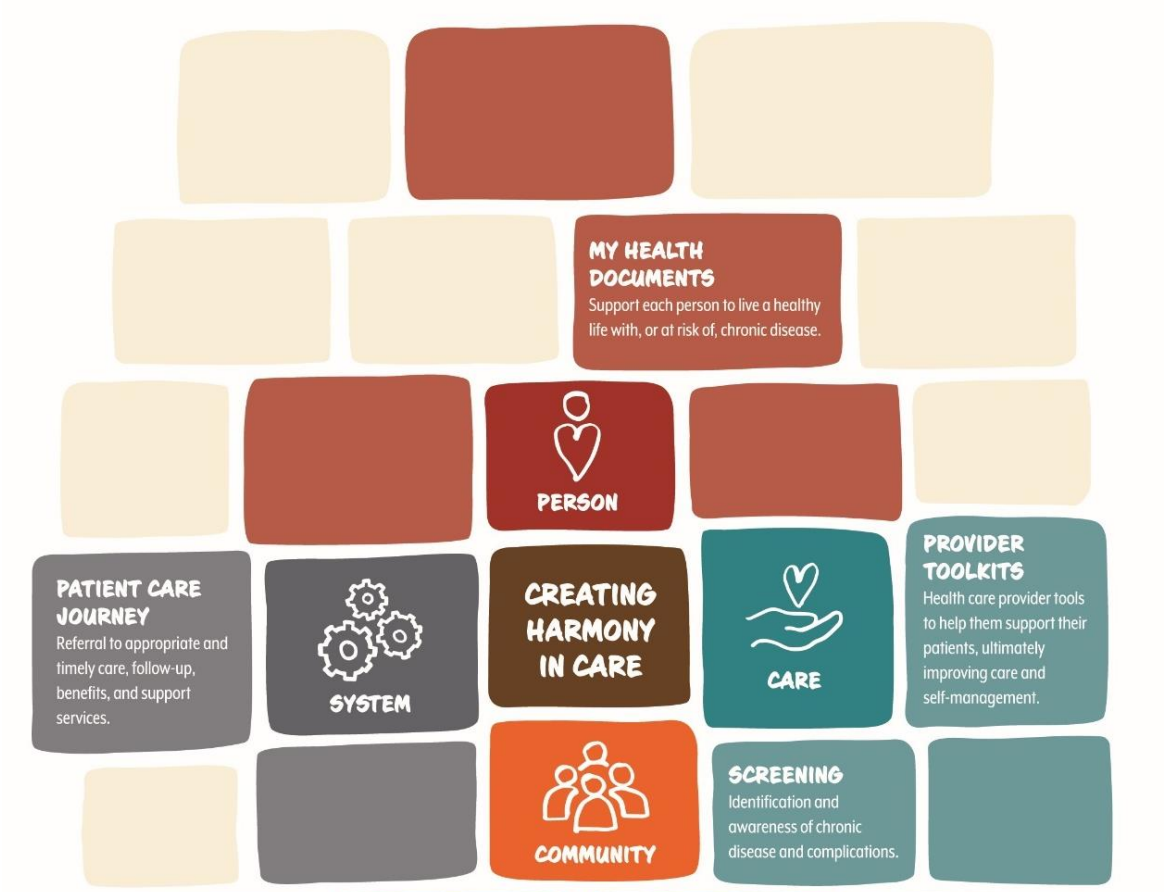
Creating Harmony in Care supports the provider carrying out the screening to appropriately refer the patient to primary or specialty care. This is facilitated by a provider resource, an "At-A-Glance Provider: Health Report", where the provider logs the results, and the associated color scheme guides the provider to take appropriate follow up actions (see Appendix 4). The provider is supported to address the targeted outcomes of the Kidney Health Check (KHC) protocol:

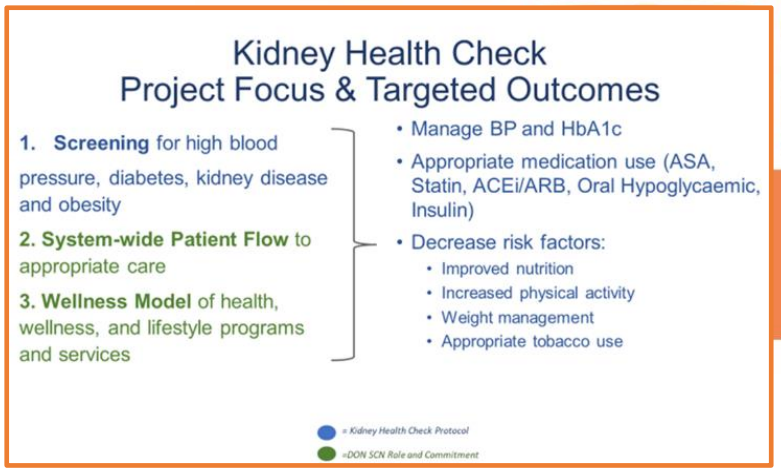
- managing blood pressure and hemoglobin A1C (HbA1C)
- ensuring appropriate medication use (ASA, Statin, ACEi/ARB, oral hypoglycemic, insulin, etc.)
- reviewing factors such as nutrition, physical activity, weight and tobacco use, and the use of lifestyle programs

Another tool, "My Health Report", enables the provider to have a coaching conversation with the person screened, to co-create a personalized plan and discuss available health and wellness programs and services. These are outlined in a community Wellness Model (see more information in next section), that contains available and relevant medical, lifestyle, and cultural programs and services that an individual can access regardless of risk results. This part of the

process, as well as recommendations related to re-screening, are outlined in gray and dark blue in the image above.

The image below illustrates these tools and resources that have been co-created with communities for the KHC and in alignment with the Creating Harmony in Care approach. The image also illustrates that additional tools, resources, and processes might be continuously co-created with Indigenous communities, as Creating Harmony in Care: Screening is implemented.





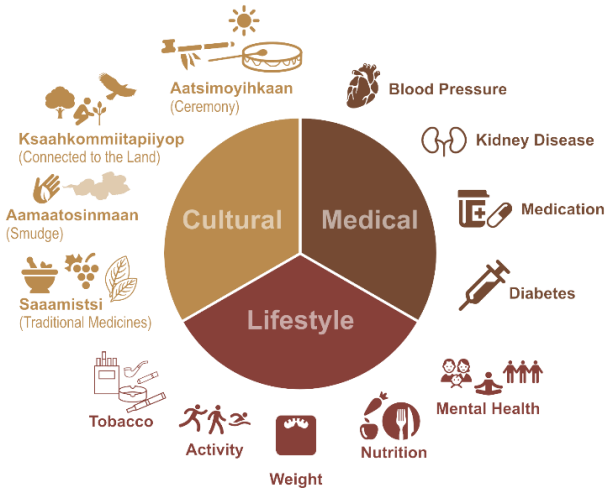
Creating Harmony in Care: The Wellness Model

As mentioned, Creating Harmony in Care: Screening is focused on:

1. Screening people at risk of diabetes, hypertension, kidney disease, obesity, and diabetes related eye and foot complications
2. Ensuring appropriate referral and patient flow, following screening, to primary and specialty care. Patient flow includes seamless transition from primary and specialty care back to the community health team(s), and
3. Providing access to programs and services that address the targeted outcomes and risk factors, such as:
    - Medical management
    - Appropriate medication use
    - Healthy lifestyle

While only some individuals screened will need referral to primary and specialty care, as identified in the KHC protocol, all individuals screened should be coached to access information to help prevent disease, or progression of disease. To address this need, the Wellness Model was co-created in collaboration with the project team and champions from Piikani's Aakom-Kiyii Health Services team.

The Wellness Model provides a structure to create a 'menu' of programs and services, and ensures that people screened have access to:

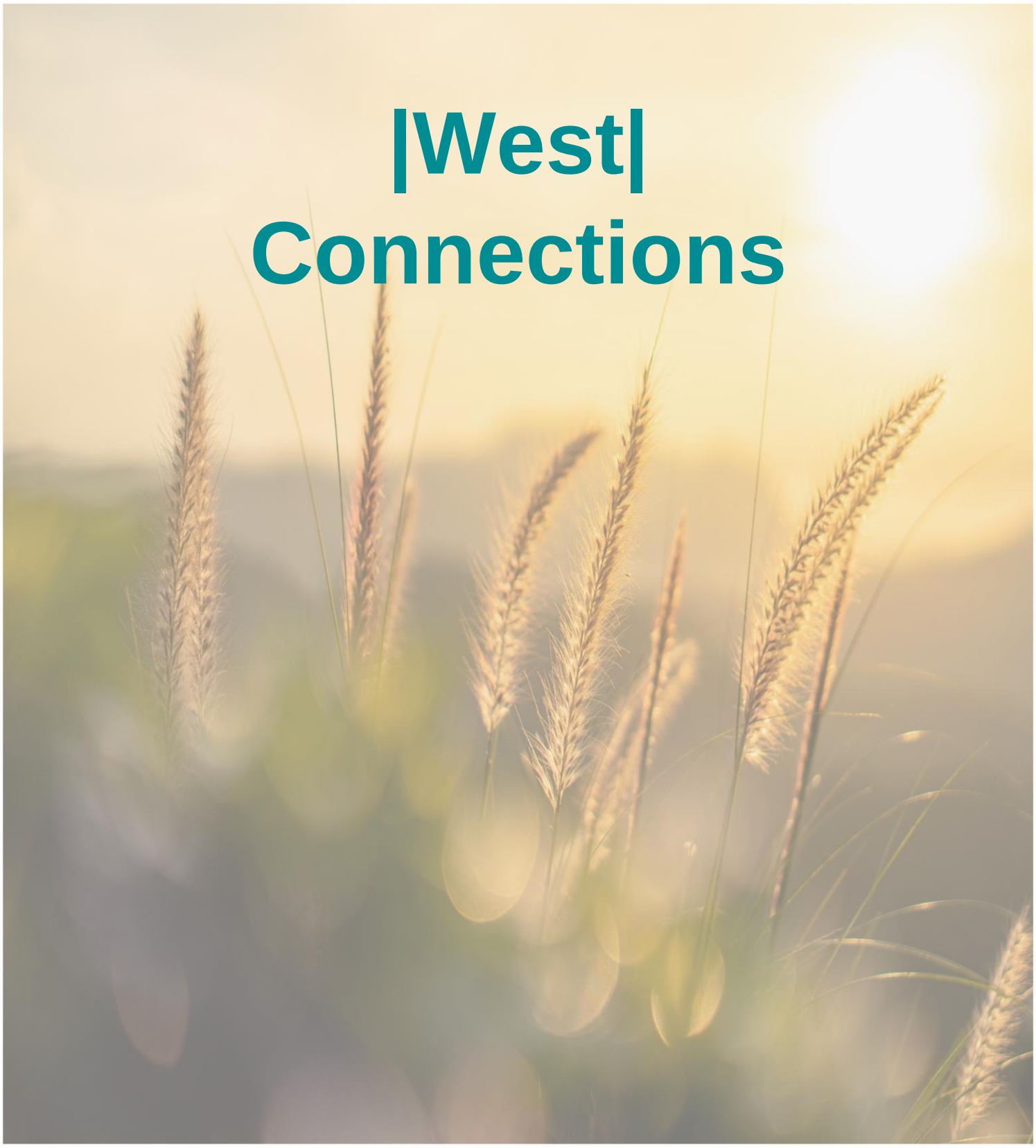


Medical programs and services, such as education (diabetes, kidney, hypertension) and medication management.

Lifestyle programs and services, such as physical activity, exercise, sports, nutrition, cooking, weight management, emotional and stress management, and appropriate tobacco use.

Cultural programs and services, such as smudges, ceremonies, land-based education, and traditional medicines and practices.

The creation of the wellness model also included collaboration with health and wellness services off-reserve, as well as groups such as the AHS Alberta Healthy Living Program, the Chinook Primary Care Network (PCN), and My Kidneys My Health (see Appendix 4). While this model was developed with the champions from Piikani FN, the Blood Tribe Department of Health (BTDH) and the Kainai Diabetes Team have also adopted this approach.


|West|
Connections

Collaboration

Creating Harmony in Care is ultimately about establishing trusting relationships with Indigenous communities and collaborating to develop sustainable and relevant community approaches. The following communities and groups have been integral in the co-creation process.

Blood Tribe First Nation

The Kainai or Blood Tribe First Nation is located in Southern Alberta and within the AHS South Zone geography. Prior to the DON SCN taking the lead on the Kidney Health Check project, collaboration with the Blood Tribe First Nation and the BTDH was underway, staff had been trained to carry out the screening and agreements had been signed by early 2020. Screening was put on hold with the COVID-19 pandemic until the fall of 2021, when collaboration resumed with the Kainai Diabetes Team.

Since the fall of 2021 the key activities include:

- Supporting staffing challenges: Due to staff-turnover, initial discussions centered around identifying appropriate providers to complete the training and subsequently offer the screening. The Kainai Diabetes team was identified as responsible for this screening.
- KHC and POCT Training: The Kainai Diabetes team completed the training over the summer of 2022. Upon request, the team received additional training in 2023.
- Screening Events: The initial screening event took place in the Fall of 2022, with regular screening taking place beginning March 2023.
- Coordinating Screening Equipment and Reagents: Equipment, such as the iSTAT and the DCA Vantage machines, have been gifted by the KHC, canSOLVE and Dr. Bello to the community. The Kainai Diabetes team is being supported by the DON SCN to appropriately store, maintain and use the equipment, and to order and receive the necessary reagents and supplies.

Piikani First Nation

Piikani Nation is located in Southern Alberta and within the AHS South Zone geography. Piikani Nation and the Aakom-Kiyii Health Services also emerged from the initial waves of the COVID-19 pandemic with a priority to address health care challenges in the communities, such as diabetes and kidney disease. Initial discussions and ongoing collaboration with the health department and teams commenced in the fall of 2021.

Since the fall of 2021 the key activities include:

- Focusing on Patient Flow: conversations have focused on the patient flow following the screening, with an understanding of the importance of a holistic wellness perspective for all patients and clients accessing Aakom-Kiyii Health Services. This was of special interest to this community, because of the challenge with primary care physician attachment in the geography.
- Community Wellness: the focus has remained on supporting the community and the health services from a broad perspective and across the continuum of care. These conversations have formed the foundation for a Community Wellness Model.
- KHC and POCT Training: an initial training session was hosted with health care staff in December 2021. Due to subsequent COVID 19 pandemic waves, the hands-on training

was delayed until the Nurse lead for the Come Care and Community Health Programs identified readiness for the team to receive the full training. This was completed in January 2023.

- Screening Events: to be initiated in April 2023.
- Coordinating Screening Equipment and Reagents: Equipment, such as the iSTAT and the DCA Vantage machines, have been gifted by the KHC, canSOLVE and Dr. Bello to the community. The Aakom-Kiyii Health Services will be supported by the DON SCN to appropriately store, maintain and use the equipment, and to order and receive the necessary reagents once regular screening is initiated in April 2023.

Urban Indigenous - Lethbridge

The City of Lethbridge is home to many Indigenous peoples. In addition, many people living in Lethbridge struggle with lack of attachment to primary care and primary care services. Several successful initiatives have been implemented over the years to mitigate this challenge. One of these is IMPACT (Innovative Models Promoting Access-to-Care Transformation), which focuses on improving access to health & community services, especially for the most marginalized and vulnerable people who experience a lot of barriers to accessing care.

During the summer of 2022, the AHS South Zone organized an urban Indigenous primary care pop-up event in Lethbridge for September 23, 2022. The event was to coincide with the city's Reconciliation Week celebrations and the DON SCN was contacted to gauge interest in supporting the event and providing screening at the event. The contributions from DON SCN team included:

- Participating in regular planning meetings with the local organizations during the summer.
- Training two DON SCN staff who are nurses, and one nurse from the Chinook PCN, to support the screening.
- Attending the event and offering screening for kidney disease, diabetes, hypertension, obesity, and diabetes foot care.
- Working with the AHS South Zone primary care lead, to ensure follow up care for any unattached patients.

The event included approximately 30 different services such as local non-profit organizations (Boys and Girls Club, Lethbridge Legal Aid, etc.), as well as several AHS teams (Cancer screening, Alberta Healthy Living Program, Home Care, etc.). The IMPACT research team supported the Lethbridge Urban Indigenous Pop-up Event in September to help identify whether the event was successful in enhancing access to services. Providers and attendees indicated that the event was generally positively received and that important connections were established (Scott & Halma, 2022).

In addition, the DON SCN identified that while not many individuals took part in the screening offered by this team, offering this service along with the multiple other programs and services can be an example of a successful partnership and response to unique zone operations requests. The DON SCN's key learnings from the event were:

- Having a clear outline of the original request and accountability was beneficial.
- Attending the planning meetings was valuable.

- Training providers from AHS and primary care help build local capacity.
- Streamlining and shortening the screening at events like this would be beneficial.
- Having access to Netcare at the event would ensure screeners have access to valuable patient information and the ability to enter results in the moment.
- Collaborating with providers from other programs and services was a great networking opportunity.
- Being able to offer follow-up care, such as with a diabetes or CDM educator, would greatly benefit the patients.

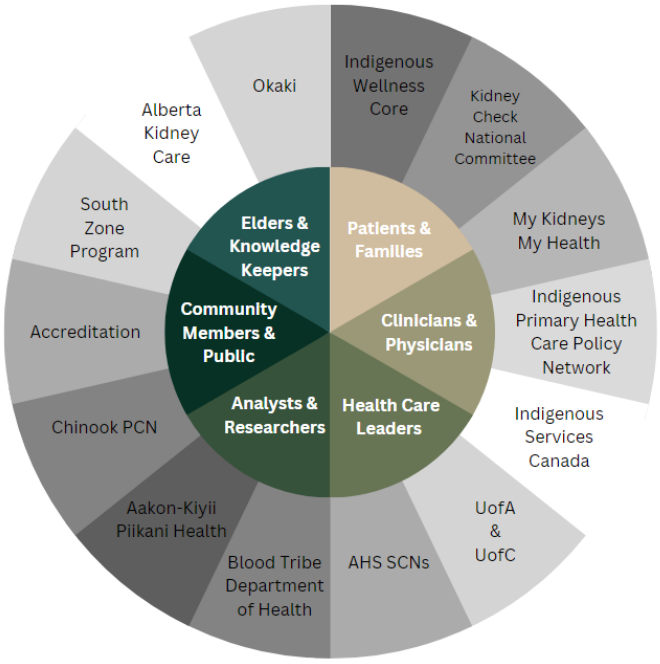
Elders

Many Elders were involved, engaged, and consulted throughout the project creation process. Many Elders were Blackfoot and from the Blood Tribe and Piikani First Nations. Some Elders live in the community and others live in urban centres, such as Cardston and Lethbridge. Connections were also made with Elders of Métis and Inuit background. Elders were involved both on a one-on-one basis and in group sessions; rich feedback and meaningful stories were graciously shared and the themes from these Elder consultations include:

- The importance of having knowledge and awareness of diseases such as diabetes and kidney disease,
- The importance of food, nutrition, cleansing, and feasting in preventing and managing diseases,
- The value of community, wellness, bundles and creating harmony in ensuring attention to the whole being: body, mind, and spirit,
- Acknowledging the impacts of colonization on health, and
- The value of including Elders in community-based solutions.

Other

Many groups and individuals were involved and engaged throughout the development of this work. This image shows the breadth, depth and variety of partnerships established throughout the journey of this project. Partnerships and collaboration have taken place mainly virtually, due to the COVID-19 pandemic. However, several in-person sessions were carried out, especially with the health care teams in the two communities and with Indigenous Elders.



|North|
Delivering on our Commitment

Recommendations for Reconciliation and Policy Changes

Written

As a result of this project, the DON SCN's commitment to Reconciliation and to Creating Harmony in Care with Indigenous Communities consists of the following ten recommendations for reconciliation and creating policy changes, especially in primary health care settings. These recommendations are a result of the learnings throughout the project creation, and each recommendation is described in western report-writing style in the first section, followed by a section with a graphic recording that describes each recommendation in images.

1. **Work together across jurisdictions to ensure appropriate and timely care is available in the most appropriate setting and as close to where the person lives, works, and plays.**

   The delivery of health care services for Indigenous peoples in Alberta is provided by several levels of government and often results in complexity, confusion, and fragmentation of care. Yet, the rights of Indigenous communities to self-determination and in providing the best care should ensure local solutions that center around the community and its people. The goal is to ensure that these various jurisdictions operate efficiently, in a coordinated manner, and in alignment with local preferences.

   Recommendations include considering:

   - Coordination across the continuum of care and care settings, such as community-based, primary care, ambulatory care, acute care, and specialty care.
   - Equal efforts across the disease trajectory, from screening and identification to treatment, care, and management. It is important that these efforts focus on chronic conditions and complications from chronic conditions.
   - Collaboration among health care administrators and care providers, focusing on the best and consistent care for the person/patient.
   - Seamless, consistent, patient flow and patient communication across care encounters.
   - Working together to share funding, resources, programming, services, and staff.
   - Availability of a broad range of programs and services (medical, lifestyle, cultural), offered on- and off-reserve, and using a variety of modalities (virtual, in-person).

2. **Provide sustainable support for local and community champions to successfully build capacity and expertise.**

   Most care happens in the community by local providers and champions. Dedicated time and resources are required to work with and support these individuals and teams. On-going and sustainable support can and should include:

   - Being available, willing, and able to do tasks such as planning, coordination and information finding to ensure that champions feel supported.
   - Providing information that may not be available in or accessible to the community, to optimize the use of programs and services.
   - Building long-term relationships and connecting champions with local and relevant partners in the specific geography.

3. **Acknowledge that the communities have wisdom and answers to address local health challenges.**
   Quality and culturally relevant care already exist in Indigenous communities in Alberta. Some communities may benefit from support to enhance this care; therefore, on-going collaboration with the communities should ensure that efforts continuously support and build on existing knowledge and expertise.

4. **Build local capacity to ensure that local efforts can continue as effortlessly as possible.**
   Supporting the creation of tools and processes that are relevant for the community and that can be sustained long-term. The Wellness Model that was developed in partnership with the local champions includes supportive tools for providers and patients that will be used in the communities long-term.

> Make sure to have tobacco for the Elders, because the tobacco gives you the answers. You give tobacco to their Spirit. The Elders don't speak, it is their Spirit.
> *Elder*

5. **Allocate resources to do it right.**
   This includes honoring Elders and their time with providing them gifts and honoraria. It also includes staging conversations as respectfully as possible, which may include a ceremony and a smudge, or a shared meal. Allocating resources also include providing tools and resources to support the work in the community, long-term.

6. **Commit the time it takes to engage, build trust, and collaborate.**
   A linear path, from plan to action, is rarely achievable. Working with Indigenous communities takes time to respectfully establish relationships, engage, build trust, and collaborate. In addition, unpredictable factors, such as a pandemic, often impact timelines. Regardless of the factors that impact this process, it is important to be flexible in terms of timelines, plans, and deliverables.

7. **Support the people doing the reconciliation work.**
   Doing reconciliation work is challenging and hearing the truths along the way is difficult. The project team involved in this project worked tirelessly to navigate and manage people, relationships, barriers, events, deliverables, and unforeseen circumstances. The team continuously adapted despite the numerous changes and delays, while ensuring that the needs of the communities and the champions were at the center of decisions. In addition, the team, like so many other teams, managed other projects and priorities -- many of these urgent and pandemic-related. While the weariness from this balancing act was palpable at times, the team came together and capitalized on individual team member's strengths to support one other. At times, this included relying on the graphic recordings to help find the path forward. Other times, the guidance was provided by the Elder and his prayers.

> Give people Berry Soup or a Gift for their help.
> *Elder*

8. **Listen to and include the Elders.**
   Elders have been included in the co-creation of this project since the beginning and their involvement, expertise and wisdom have been invaluable. The Elders that have been consulted have been present with open minds and have demonstrated respect for all people. They have graciously offered us their stories, wisdom, and prayers.

   To truly create harmony in care, Elders need to be involved. An Elder's Spirit listens, and that Spirit then guides the advice, on behalf of the Creator. Elders should be fully engaged and involved in the process from planning, to teaching, and advocacy. Formal Elder roles within health services should include a focus on connecting with youth, being available to provide guidance towards people's wellness journey, and to help people learn/relearn traditional ways of living a good life.

> Being in Spirit is listening to your inner spirit and the messages it receives from the Creator. This helps you understand when something is wrong. When you are in spirit, that is your conscience and your inner spirit telling something is wrong. You can remove yourself, like sweat lodge. Believe in the Creator who carries the message to all of us. Understand, have compassion, respect people. Even when you don't know them. Have an open mind.
> *Elder*

9. **Enable continuous and reciprocal learning:**
   - Between team members,
   - From and with Elders,
   - From and with communities and the local champions,
   - From and with other key stakeholders,
   - From the project as it evolves, and
   - From every meeting and encounter during the project creation.

10. **Commit to doing the work differently and use stories, graphics, and beliefs.**
    Ethical space is the space between people, cultures, and knowledge systems. Creating equality in the ethical space can happen when we enter the space using stories. As we gain trust, we create connections and develop respect through understanding. Utilizing stories, ceremonies and symbols are essential to people and cultures, and convey rich meaning beyond the meaning of words. While the ethical space can separate people and cultures due to lack of understanding, it also holds the potential to create cross-cultural literacy and equity between people. Utilizing graphic recordings of conversations between diverse people and groups can help join people in this ethical space to create equality, common understanding and help jointly move forward toward co-designed solutions.

    This project imbedded the use of graphics throughout the process, which has been a powerful tool in bringing people together and co-creating solutions. The next section illustrates graphic recordings associated with each of the 10 recommendations.

Recommendations for Reconciliation and Policy Changes
Graphics

1. Cross-jurisdictional Collaboration

Date of event	Individuals attending	Purpose of Session
June 3, 2021	Lene Aaron Anita Melanie Sasha Kathy	Graphically record expert evidence-based care information. Specific focus on diabetes related kidney complications.

2. Sustainable Local Support

Date of event	Individuals attending	Purpose of Session: Scoping the "Big Picture" with Piikani
November 17, 2021	Harley Lene Aaron Austin Rachel Nicki	Present, connect and discuss the Kidney Check project. Exploratory conversation to understand, scope and define what is needed specifically for Piikani. Co-creation of a wellness model: Link the Kidney Check screening project to a model that addresses the needs of the clients/patients within community. Co-creation of coordinated Indigenous chronic disease health screening program.

3. Community Wisdom

Date of event	Individuals attending	Purpose of Session: Building the Wellness Model with Piikani
November 24, 2021	Harley Lene Aaron Austin Rachel Nicki	Discuss and define content and topics for in-person training session on December 14th. Further exploration of co-creating Piikani wellness model.

4. Local Capacity

Individuals involved

Austin
Rachel
Jenny
Harley
Lene
Aaron
Nicki

Purpose:
Co-create a Piikani Wellness Model

There have been numerous conversations to co-create the tools to support individuals screened, long-term.

5. Resource Allocation

Date of event	Individuals attending	Purpose of Session: Building the "Bundles" with Piikani
December 14, 2021	Harley Lene Aaron Austin Rachel Nicki	Brainstorming and visioning the resources to be created for staff and patients within the wellness journey. Discuss the look, feel and use of resources to support the staff in guiding patients in their kidney check screening journey. Understand how to best meet the needs of the community, based on patient-first perspective.

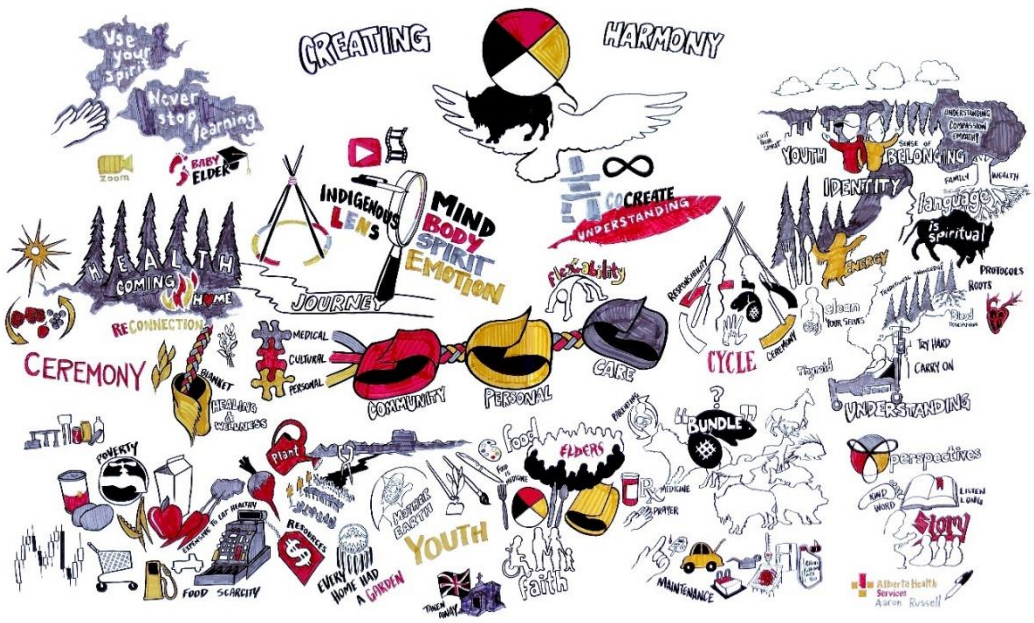
6. Time Commitment

Date of event	Individuals attending	Purpose of Session: Making Connections with our Concepts
March 17, 2022	Harley Lene Aaron Nicki	Prepare and discuss the concept of the “bundles” and how it might resonate for members of the community. Incorporate and integrate the concept of Creating Harmony within the larger project and understand the connection to the bundles.

7. People Support

Date of event	Individuals attending	Purpose of Session: Addressing Barriers
March 31, 2022	Harley Lene Aaron Nicki	Upon facing a major barrier in the work and needing an opportunity to course correct the progression of the project, this meeting focused on understanding how the barriers are created. In order to better understand how to move forward in a successful way with both AHS as an organization and the community, this requires understanding from two different perspectives.

8. Elder Role



Dates of events	Individuals attending	Purpose of Sessions:
June 15, 2022	Harley Lene	Learn about creating harmony, wellness, and bundles from local Elders.
June 22, 2022	Aaron Nicki	
November 1, 2022	**Elders:** Maurice Winston Shirley Les Alice Rebecca Joyce	

9. Continuous and Reciprocal Learning

Date of event	Individuals attending	Purpose of Session: Looking & moving forward with the Bundles and Creating Harmony
May 4, 2022	Harley Lene Aaron Nicki	To prepare, outline and determine the conversation to collect, listen and receive the guidance, wisdom and perspectives of the Elders on the Creating Harmony and Bundles concept.

10. Doing it Differently

Date of event	Individuals attending	Purpose of Session: Looking & moving forward with the Bundles and Creating Harmony
October 21, 2022	Harley Lene Aaron Nicki	Preparing for session with Piikani Health, Accreditation Canada and Piikani Elders

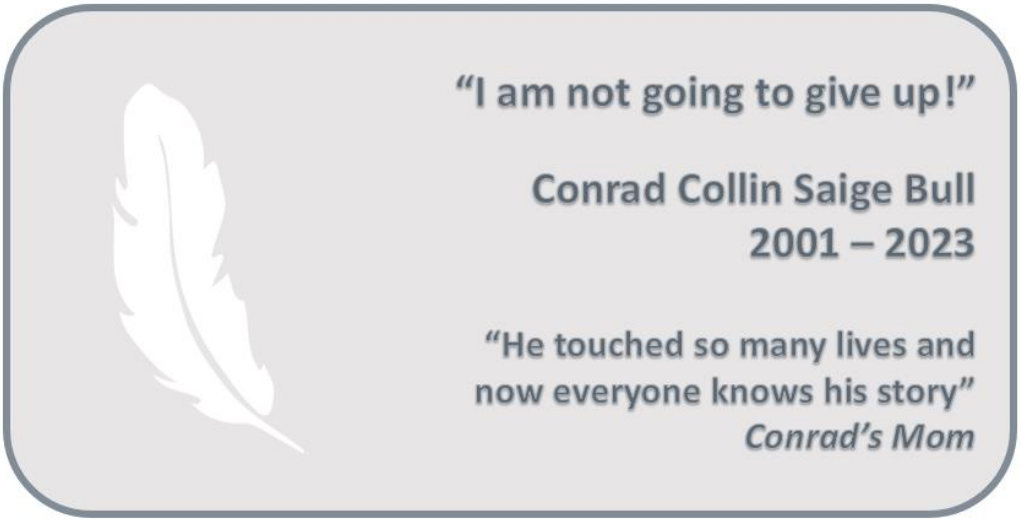
Our Learnings

Below are the themes that form four key learnings from the creation of the Creating Harmony in Care approach. These include a header and a graphic recording.

1. Focus on one Community at a Time

2. Address Needs of One Person at a Time

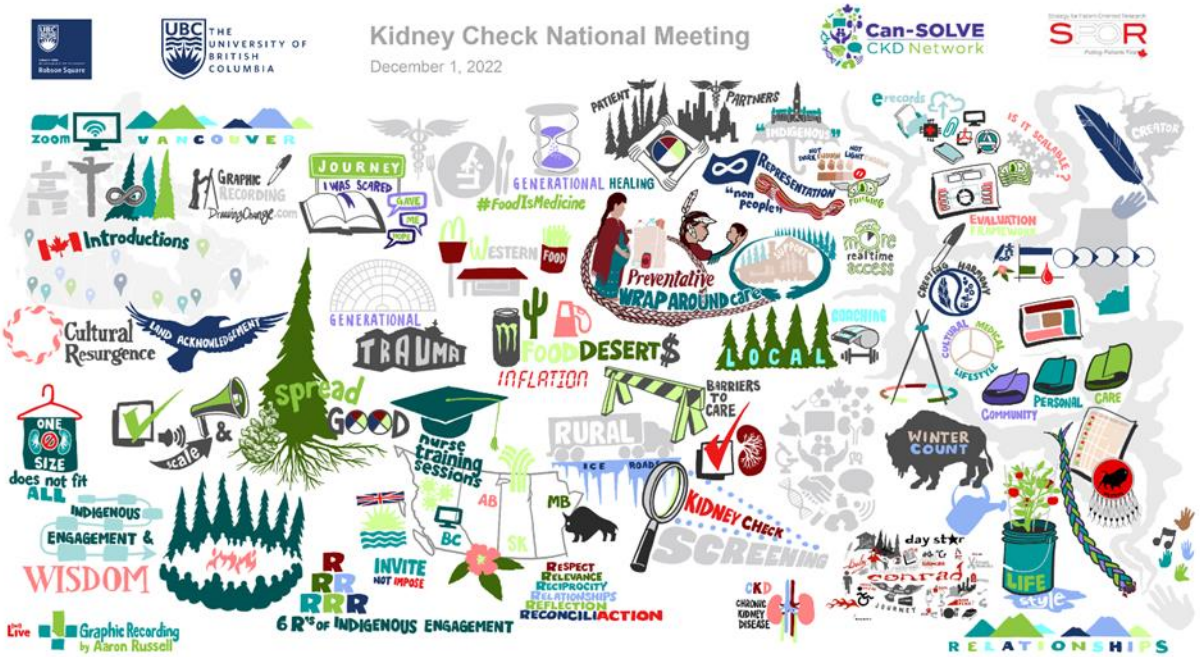
CONRAD COLLIN SAIGE BULL, KISIKAWCAHK (Day Star)



Note from the project team: Towards the end of life, Conrad graciously shared his story of living with obesity, diabetes and severe diabetes related complications. He touched our hearts and souls and will forever be remembered. We are committed to use the lessons he taught us to prevent other Indigenous Youth from facing similar experiences.

3. The Process is the Product, and the Relationships are the Deliverables

4. The Power of the Project Team



Next Steps

The DON SCN is exploring initiatives that will continuously improve the health care outcomes and experiences for Indigenous peoples in Alberta. As potential initiatives are explored, the prioritization process will include alignment with Creating Harmony in Care. Similar to how Creating Harmony in Care was used to implement Kidney Health Check, new projects will be undertaken with the understanding that this structure will be applied to them.

Potential projects currently being scoped are related to:

- Expanding **Creating Harmony in Care: Screening** to a broader 'menu' of screening initiatives, to ensure more screening and in-the-moment results can take place in the community.
- Engage with Indigenous individuals and communities to address **Malnutrition in Indigenous Youth and Elders.**
- In collaboration with the AHS Indigenous Wellness Core and the Maternal, Infant, Newborn & Youth SCN, identify care aspects to ensure that Indigenous women can have a **Healthy Pregnancy with Diabetes and Gestational Diabetes.**

Appendices

Appendix 1. DON IH Commitments

- AHS Indigenous Health Commitments:
  - Goals 3: Support Indigenous health through reciprocal relationships and engagement with Indigenous communities and organizations.
  - Goal 4: Strengthen partnerships with Indigenous communities to co-design, develop, plan and prioritize Indigenous health.
  - Goal 7: Collaborate with Indigenous patients, families and communities to identify and fill programming and service gaps.

- UNDRIP Articles
  - Article 3
    Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

  - Article 21
    Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, **health** and social security.

    States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. **Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.**

  - Article 24
    Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. **Indigenous individuals also have the right to access, without any discrimination, to all social and health services.**

    Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

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

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

- 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.**

Appendix 2. Intended approach for the collection of data

In brief, we had intended to use data in the following way:

Create a Local Geographic Area (LGA) Map

There are 132 total LGA maps, or profiles, in Alberta which summarize and theme health trends and patterns within that area, allowing for customizable and tailored health service planning. Create a map of the LGAs in Alberta with information for each LGA on:

- percent Indigenous population
- diabetes prevalence
- percent increase in diabetes prevalence over 10 years
- number and severity of diabetes related complications, such as lower limb amputations

List FN Communities, Métis Settlements, and major Urban Indigenous Organizations

Adding information to the LGA map with the specific FN Communities, Métis Settlements, and Urban Indigenous Organizations that are located within each LGA.

Shortlist Potential Indigenous Communities

Using the expertise of groups such as the AHS Indigenous Wellness Core (IWC), other SCNs and zone operational teams, to analyze a list of 8-10 LGAs with:

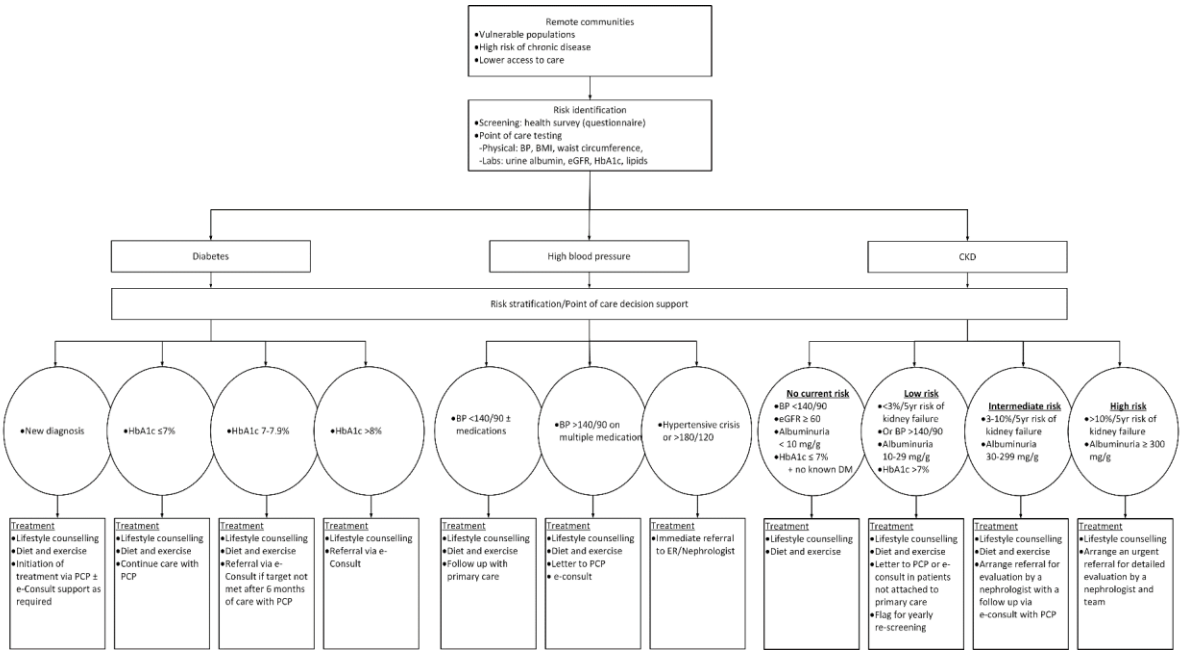
- high need, such as high Indigenous population numbers and communities and high disease prevalence
- high potential: existing champions and relationships
- other: remoteness and existing community diabetes assets

Track Disease Trajectory

Using a ‘cohort’ of individuals, sourced from AHS Tableau, who were diabetes prevalent and had experienced a lower limb amputation between January 2, 2017 and January 1, 2018, we would review the data to help identify system touch-point opportunities where a person’s trajectory towards amputation might be changed. This information included:

- numbers by zone, age, gender
- percent with history of chronic ulcers
- number of primary care visits
- number of emergency department visits
- number of inpatient admissions and length of stay
- insulin use and HbA1c in year prior
- hypertension and chronic kidney disease prevalence

Appendix 3. KHC Risk Identification, Stratification and Treatment

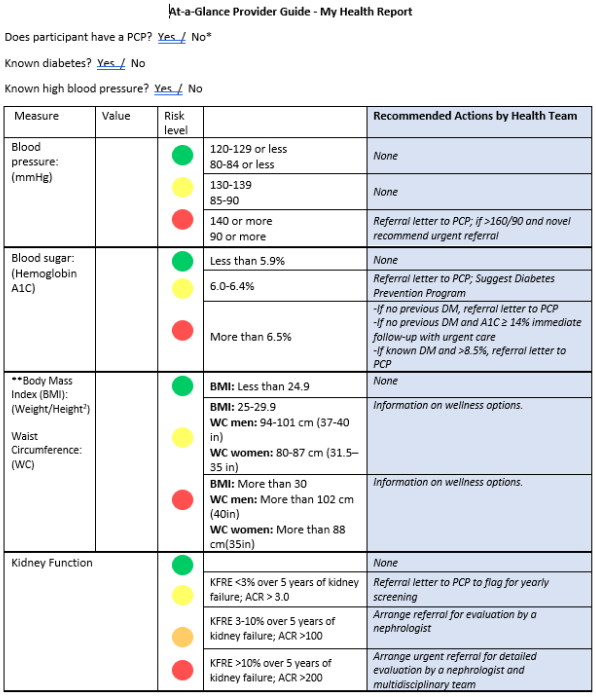


Appendix 4. Resources co-designed and co-developed with community

In an effort to streamline the patient flow part of the screening process, we recognized the importance of developing and considering resources that could facilitate the conversation between provider and patient regarding the screening results.

We also saw this as an opportunity to capitalize on a larger wellness conversation for the patient – understanding that the results from the screening could open the door to conversations regarding various aspects of the patient's current health status, and centering the discussion around the patient's desires, wishes and goals for health.

The two resources capture from the provider perspective (on the left), specific actions that could be taken based on the results of the screening. On the right, the patient version of this same report is a chance for the patient to walk away from the encounter with the health care provider (HCP) with their own capture of their results, and importantly, understand what those results mean. Ideally, these tools support and enhance the discussion between the HCP and the patient.



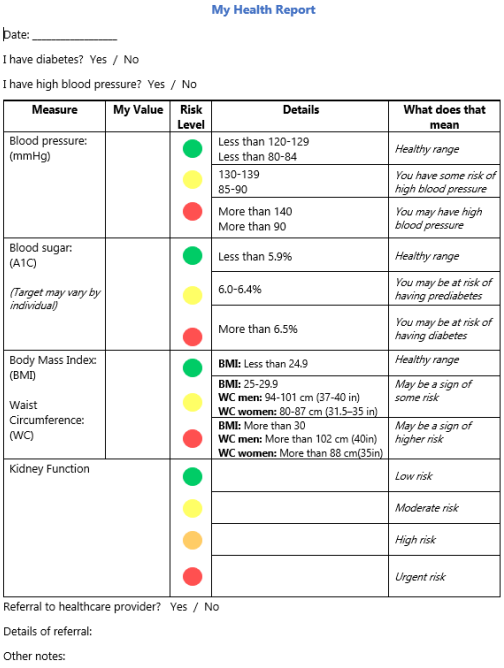
At-a-Glance Provider Guide - My Health Report

Does participant have a PCP? Yes / No*

Known diabetes? Yes / No

Known high blood pressure? Yes / No

Measure	Value	Risk level		Recommended Actions by Health Team
Blood pressure: (mmHg)		🟢	120-129 or less 80-84 or less	*None*
		🟡	130-139 85-90	*None*
		🔴	140 or more 90 or more	*Referral letter to PCP; if >160/90 and novel recommend urgent referral*
Blood sugar: (Hemoglobin A1C)		🟢	Less than 5.9%	*None*
		🟡	6.0-6.4%	*Referral letter to PCP; Suggest Diabetes Prevention Program*
		🔴	More than 6.5%	*-If no previous DM, referral letter to PCP* *-If no previous DM and A1C ≥ 14% immediate follow-up with urgent care* *-If known DM and >8.5%, referral letter to PCP*
**Body Mass Index (BMI): (Weight/Height²) Waist Circumference: (WC)		🟢	**BMI:** Less than 24.9	*None*
		🟡	**BMI:** 25-29.9 **WC men:** 94-101 cm (37-40 in) **WC women:** 80-87 cm (31.5–35 in)	*Information on wellness options.*
		🔴	**BMI:** More than 30 **WC men:** More than 102 cm (40in) **WC women:** More than 88 cm(35in)	*Information on wellness options.*
Kidney Function		🟢		*None*
		🟡	KFRE <3% over 5 years of kidney failure; ACR > 3.0	*Referral letter to PCP to flag for yearly screening*
		🟠	KFRE 3-10% over 5 years of kidney failure; ACR >100	*Arrange referral for evaluation by a nephrologist*
		🔴	KFRE >10% over 5 years of kidney failure; ACR >200	*Arrange urgent referral for detailed evaluation by a nephrologist and multidisciplinary team*



My Health Report

Date: _____

I have diabetes? Yes / No

I have high blood pressure? Yes / No

Measure	My Value	Risk Level	Details	What does that mean
Blood pressure: (mmHg)		🟢	Less than 120-129 Less than 80-84	*Healthy range*
		🟡	130-139 85-90	*You have some risk of high blood pressure*
		🔴	More than 140 More than 90	*You may have high blood pressure*
Blood sugar: (A1C) *(Target may vary by individual)*		🟢	Less than 5.9%	*Healthy range*
		🟡	6.0-6.4%	*You may be at risk of having prediabetes*
		🔴	More than 6.5%	*You may be at risk of having diabetes*
Body Mass Index: (BMI) Waist Circumference: (WC)		🟢	**BMI:** Less than 24.9	*Healthy range*
		🟡	**BMI:** 25-29.9 **WC men:** 94-101 cm (37-40 in) **WC women:** 80-87 cm (31.5–35 in)	*May be a sign of some risk*
		🔴	**BMI:** More than 30 **WC men:** More than 102 cm (40in) **WC women:** More than 88 cm(35in)	*May be a sign of higher risk*
Kidney Function		🟢		*Low risk*
		🟡		*Moderate risk*
		🟠		*High risk*
		🔴		*Urgent risk*

Referral to healthcare provider? Yes / No

Details of referral:

Other notes:

Inspired by early conversations with Austin and Harley, we discussed creating a folder or, a toolkit, of resources a patient could have that would contain opportunities for them to learn more and plan out their health journey. It was important that the tools be person-centered and allow the patient to identify what/when they would like to focus on certain elements of their health and wellness.

Resources co-designed with Piikani

The “health report”, includes the results of the screening, along with recommendations for how the results could be interpreted, with an associated risk categorization.

Second is a capture of the wellness model, and a table that has community programming specific information, so that a patient might pick and choose those pieces they want to participate in most fitting.
Third is a goal setting tool, designed to support a conversation regarding what the client would like to focus on in their journey to wellness.

Finally, the last resource is a tool to organize various appointments, contact information and other important connections in the community.

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With gratitude:
We acknowledge and thank the many Elders for their wisdom, guidance, and support in this journey. We are grateful for their shared sacred knowledge.

Elders: Jim Swag, Maurice Little Wolf, Linda Yellow Face, Roberta Yellow Horn, Winston Wadsworth, Alice Zwart, Joyce Mountain Horse, Rebecca Many Grey Horses, Les Bonkman, Shirley Crowshoe and Jordan No Chief

A heartfelt thank you:
We sincerely thank Elder Harley Crowshoe for his continued support and wisdom, which has guided the team's reconciliation journey in ways that are beyond words to describe.

Elder Harley Crowshoe, kiááyo'pooka (Bearchild)