INDIGENOUS HEALTH SYSTEMS TRANSFORMATION

Foundations for IPHCC's OHT Provincial Framework

INDIGENOUS PRIMARY HEALTH CARE COUNCIL

Artwork by Lisa Boivin.

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ACKNOWLEDGEMENTS

INTRODUCTION

The government of Ontario has committed to undertake structural and systems health reform as specified in Bill 74: The People's Health Care Act, 2019 and as directed in the Ontario Health Teams: Guidance for Health Care Providers and Organizations which require Ontario Health Teams (OHTs) to:

- Reduce current health disparities experienced by Indigenous peoples in Ontario;[1]

- Redesign care in a way that will improve care for and meet the diverse needs of the Indigenous population[2] (OHT Guidance Document);

- Demonstrate that they respect the role of Indigenous peoples in the planning, design, delivery, and evaluation of services for their community;[3] and

- Demonstrate that they can provide culturally safe care for Indigenous people.[4]

OHTs are expected to achieve this through partnerships with Indigenous-governed organizations. When an OHT application has been submitted for a region that includes one or more First Nation communities, endorsement from those communities is necessary and is supposed to be part of the selection criteria for approval.

PURPOSE

This document details foundational components for Indigenous Health Systems Transformation and its underlying concepts and terms which in turn help inform the development of the IPHCC OHT Provincial Framework. The purpose for defining these terms is to:

- Define terms from an Indigenous lens and relevance to the work of IPHCC and its members;

- Support the application of equity perspectives as referenced in the Model of Wholistic Health and Wellbeing; and

- Bring clarity and a consistent understanding of the terms defined by government and non-Indigenous providers as they apply to Indigenous settings.

These definitions reference the Truth and Reconciliation Commission (TRC) of Canada Report and Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG), both of which help guide the work of IPHCC and its members. Priority has been given to using available IPHCC and member information and documents where available (e.g., cultural safety training, Indigenous engagement, jurisdictional scans). There was also consideration given to incorporating Government of Ontario information to emphasize their role and responsibility in improving the health and well-being outcomes of Indigenous peoples in Ontario and advancing Indigenous Health in Indigenous Hands.

The information provided in this document may evolve over time as the IPHCC continues on its learning journey.

Federal Health Transformation

At the same time, Indigenous Services Canada is working with First Nations across Canada on health transformation through a separate process.

"*First Nations health transformation is a collaborative process between First Nations partners, the federal government, and provinces and territories. The intent is to create a more coordinated health system in which First Nations-led health organizations assume greater control of the design, administration, management and delivery of health services and programs that support community wellness and address their health needs and priorities*".[5]

To support this process in Ontario, Indigenous Services Canada, the Nishnawbe Aski Nation (NAN), and Ontario Ministry of Health agreed to work together. "*The parties agreed to continue with an on-going relationship to develop and oversee transformative change in First Nations health with a focus on NAN communities.*" This led to the execution of a trilateral commitment document: The Charter of Relationship Principles Governing Health System Transformation in NAN Territory (the Charter) which was mandated by NAN Resolution 17/21. The Charter was signed by the Parties (Grand Chief Alvin Fiddler, Minister Jane Philpott, and Minister Eric Hoskins) on July 24, 2017.[6]

To help guide this relationship the parties define health transformation as "*restoring and enhancing accountability, responsibility, and resource allocation [to] First Nation members and moving from a crisis-response system to one that is centred on wellness and the needs and priorities of its communities.*"[7]

Ontario Health System Transformation

The introduction of OHTs provides an opportunity for Indigenous health systems transformation to occur not only from a First Nation, on territory perspective, but to a process that is inclusive of urban First Nation, Métis, and Inuit populations.

The IPHCC, its members, partners, and government can collaboratively work together to transform health systems so that Indigenous health outcomes are improved. To achieve this, transformation should be rooted in mutual respect, understanding, equitable funding, shared accountability, and reciprocity so that equity is achieved.

It is important to note, the IPHCC recognizes and respects that federal health transformation processes are ongoing throughout the province of Ontario and are occurring in a number of its members' communities. In support of this, the IPHCC will strive to respect autonomy and align its efforts where possible to help maximize benefits.

Terms for Indigenous Health Systems Transformation

Health systems transformation often introduces new terms which become part of everyday vernacular with the assumption that they mean the same thing for everyone who is involved.[8] However, these terms have a fundamentally different meaning for Indigenous peoples as their worldviews and approaches to health and wellbeing differ from Western views and approaches.

The following sections provide a glossary of terms and describes their definitions, and relevance to the Indigenous health systems transformation.

Figure 1 below identifies these key terms and places them within the foundational elements of the Indigenous health systems transformation model that builds system capacity to:

- Practice Indigenous Health in Indigenous Hands so that Indigenous people are in control of their health decisions and resources;

- Deliver culturally safe care and health services that are free from racism and barriers to participation;

- Build collaborative and reciprocal relationships based on trust and respect; and

- Collect and analyze data to promote better health outcomes.
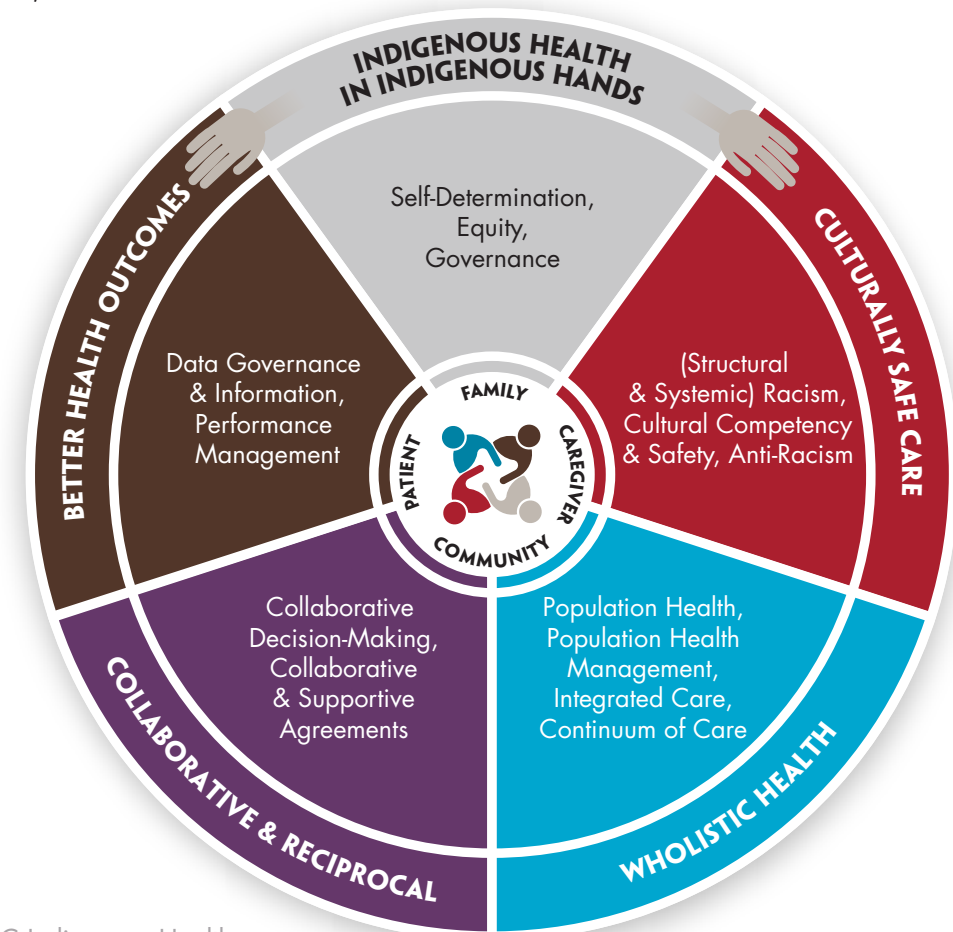
Figure 1: IPHCC Indigenous Health Systems Transformation Model

INDIGENOUS HEALTH SYSTEMS TRANSFORMATION

Indigenous health systems transformation is a process whereby IPHCC and its members, along with Indigenous and non-Indigenous partners and alliances:

1. Analyze, adapt, strengthen, and grow Indigenous health programs and services;

2. Integrate the IPHCC's Model of Wholistic Health and Wellbeing within the Ontario health care system; and

3. Promote and ensure that Indigenous resources are being delivered by Indigenous providers throughout health systems.

The ultimate aim is to provide equitable health and wellness services for First Nations, Inuit, and Métis peoples in Ontario, and to address and eliminate gaps in Indigenous health outcomes.

Relationship Agreements

Through the development of government and provider relationship agreements, the IPHCC and its members will support Ontario's health systems transformation process to implement wholistic integrated health systems of care. The goals of these relationships include:

Indigenous Health in Indigenous Hands

- The right relationship(s) premised on Indigenous self-determination, equity, governance, and reciprocity;

- Implementing an attribution model that embeds Indigenous organizations and providers within the health systems network to ensure Indigenous Health in Indigenous Hands is promoted across the system; and Ensuring equitable and sustainable funding throughout the system.

Culturally Safe Care

- A culturally safe care experience throughout an integrated care continuum with IPHCC and members working with governments and providers to actively dismantle structural and systemic barriers through IPHCC training and change management;

- Managing complexities and comorbidities due to intersecting marginalization through integrated, wholistic care to enhance health and wellbeing in order to prevent more serious illness, and prevent more costly services;

Model of Wholistic Health and Wellbeing

- Continuing a patient-centred approach that reflects the patient, family, caregiver, and community (PFCC) in the co-design, delivery, and evaluation of services as it pertains to the Model of Wholistic Health and Wellbeing;

- A wholistic, population health approach across an integrated system of care that explicitly includes Traditional healing services and medicines and Indigenous models of care while addressing improvements in the Indigenous and social determinants of health and wellbeing;

Representative Workforce

- Ensuring a robust health workforce that represents Indigenous leadership and frontline staff who can work to their respective full scope of practice with equitable pay and benefits;

Knowledge Keeping

- Equitable information technology and management systems using a Two-Eyed Seeing approach to performance measures that inform the collaborative decision-making arrangements and outcomes of care; and

- Innovations in Indigenous care and technology to provide culturally safe care closer to home.

INDIGENOUS HEALTH IN INDIGENOUS HANDS

Indigenous Primary Health Care (IPHC)

Indigenous Primary Health Care (IPHC) takes an Indigenous-led and community-centred wholistic approach to improve the mental, emotional, physical, and spiritual health and wellbeing of Indigenous peoples. Traditional knowledge, traditional healing practices, and self-determination underpin IPHC and are central to restoring balance at the individual, familial, community, and nation levels.

IPHC also encompasses distinct Indigenous models of care and existing Western knowledge and practices that are adapted to be inclusive of Two-Eyed Seeing and traditional healing and wellness approaches. Indigenous peoples may choose either approach or a blended model of care which best facilitates and enhances their wellness journey.

System partners play an important role in promoting Indigenous Health in Indigenous Hands by advocating for Indigenous health equity and justice, ensuring that primary health care is provided in a culturally safe manner and working to address the broader determinants of health.

Self-determination and traditional knowledges and practices are foundational; they empower individuals, families, and communities to self-heal and lead and manage their well-being.

The overall result leads to the improvement of health outcomes for Indigenous peoples.

Self-Determination

The foundation of the IPHCC is based on self-determination. Self-determination is generally accepted to mean that "*human beings, individually and as a group, are equally entitled to be in control of their own destinies.*"[10] The TRC and MMIWG's recommendations point to the UNDRIP and Aboriginal and Treaty rights that form self-determination.

For IPHCC, self-determination is the right to exercise Indigenous Health in Indigenous Hands through:

- The ability to "Design, deliver, manage and ultimately, control [Indigenous] health programs and services";[11]

- Ensuring Indigenous resources and services are delivered by Indigenous peoples;

- Ensuring the portability of rights for Indigenous people regardless of where they live;

- Empowering Indigenous peoples and communities to have a voice in and control over the forces and solutions that affect their health and wellbeing;

- Access to health services that are wholistic, culturally safe, and free from discrimination and systemic racism, culturally relevant, encompass Two-Eyed seeing, and reflect coordinated health and social services which address the determinants of health; and,

- Equitable and sustainable resources to deliver, measure and improve Indigenous health and wellbeing.

Indigenous peoples have consistently regarded the right to self-determination as a prerequisite to the protection and promotion, as well as the exercise and enjoyment, of all other human rights...And they have articulated self-determination as an inherent right, not a right that is "given" or "created" by others but pre-existing.

- Dalee Sambo Dorough, 2011[A]

Governance

Governance is how society or groups within it organize to make decisions.[12] It is fundamentally about "who has voice," "how decisions are made," and "who is accountable."[13] How the organization intentionally structures and implements strategies convey what is important.

Governance ties closely to self-determination in that Indigenous peoples and communities have a voice and ultimate control over decision making for their health programs and services. This principle of Indigenous Health in Indigenous Hands has shown to lead to better outcomes for Indigenous communities because it helps to ensure accountability rests with those who are most impacted.

Governance structures and social institutions should be designed to empower individuals and reinforce tradition in order to maintain the balance found in nature.[8]

Equity

Equality means each individual or group of people is given the same resources or opportunities to address an inequity. Equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.[14] Justice addresses why additional resources are needed to fill a gap, as in it looks at why an inequity exists to begin with.[15]

Figure 2 helps to distinguish the differences between equality, equity, and justice.
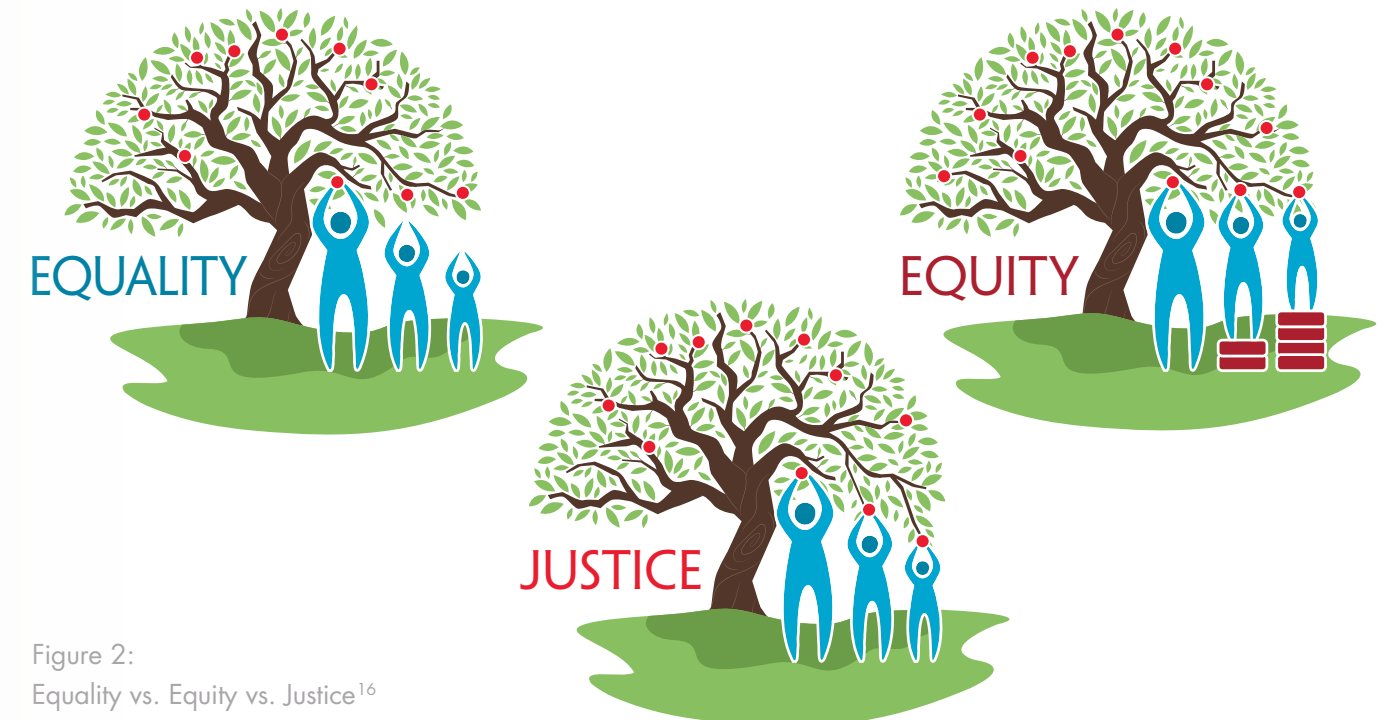
Figure 2:
Equality vs. Equity vs. Justice[16]

For IPHCC and its members, equity is a precursor towards the journey of obtaining justice. How does the IPHCC do this? This can be achieved by the following means:

- Working with the Ministry of Health to impact required change in order to remove systemic barriers;

- Establishing collaborative decision-making arrangements that are targeted towards addressing root causes of inequities and injustices;

- Ensuring that resources are directed towards strategies that promote and foster required

system changes like cultural safety and change management, on-going creation, and support for Indigenous models of care, the embedding of traditional healing, wellness and medicines approaches into primary health care; and

- Ensuring resources are directed and support required infrastructure needs so that services are accessible across the system, regardless of location and geography.

CULTURAL SAFETY

There are steps for creating cultural safety, as depicted in Figure 3. Providing cultural safety is a process and not a destination; it is dynamic and iterative. The crucial understanding is in leaders' and providers' ongoing actions to ensure culturally safe care.

STEP 1

CULTURAL AWARENESS

A beginning step towards understanding that there is a difference between cultures.

STEP 2

CULTURAL SENSITIVITY

An attitude that recognizes the differences between cultures and that these differences are important to acknowledge in health care.

STEP 3

CULTURAL COMPETENCY

An approach that focuses on people and practitioners in particular attaining skills, knowledge, and attitudes to work in more effective and respectful ways with Indigenous patients & people of different cultures.

STEP 4

CULTURAL HUMILITY

Cultural humility is only achieved through humbly acknowledging that every culture has value and should be respected and through the acknowledgement of oneself as a life-long learner when it comes to understanding a person's experience.

Figure 3: Steps to Creating Cultural Safety [17]

The IPHCC strives for cultural safety, which is an outcome based on respectful engagement that acknowledges power imbalances inherent in the health care system. Cultural safety considers how social and historical contexts, as well as structural and interpersonal power imbalances shape a person's health and health care experiences. Health-care providers and organizations that practice cultural safety are self-reflective and self-aware about their position of power and the impact this role has on Indigenous clients. The most important part about cultural safety is that it is defined by those who receive care, not by those who provide it. Cultural safety is a framework that integrates awareness, sensitivity, competency, and humility. It is a paradigm shift.

IPHCC's training, *Anishinaabe Mino'ayaawin: Foundations of Indigenous Cultural Safety*, provides everyone working in the health field with information and ways to take knowledge, lessons, and experiences about culture learned over time and apply them to their practice to improve health outcomes for the person receiving care. A key imperative is for the provincial government to support and fund cultural safety training and change management processes throughout the health system. This approach enables the cultural shift that has been elusive in all reform efforts so that all providers embrace seeing, thinking of, and providing care differently. Two-Eyed Seeing and cultural safety benefit everyone.

IPHCC Model of Wholistic Health & Wellbeing

Cultural teachings and traditional practices vary between nations and regions. All are recognized and respected. The value systems represented by this Model of Wholistic Health and Wellbeing are the common ones that frame the work of the Indigenous primary health care organizations toward healthy communities.

North
SPIRITUAL
RECLAMATION
GENEROSITY

West
PHYSICAL
TEACHING
INTERDEPENDENCE

CULTURE, OUR WAYS OF KNOWING AND BEING

East
EMOTIONAL
HEALING
BELONGING

South
LEARNING
LANGUAGE
MENTAL

INDIGENOUS HEALTH IN INDIGENOUS HANDS

BETTER HEALTH OUTCOMES

CULTURALLY SAFE CARE

COLLABORATIVE & RECIPROCAL
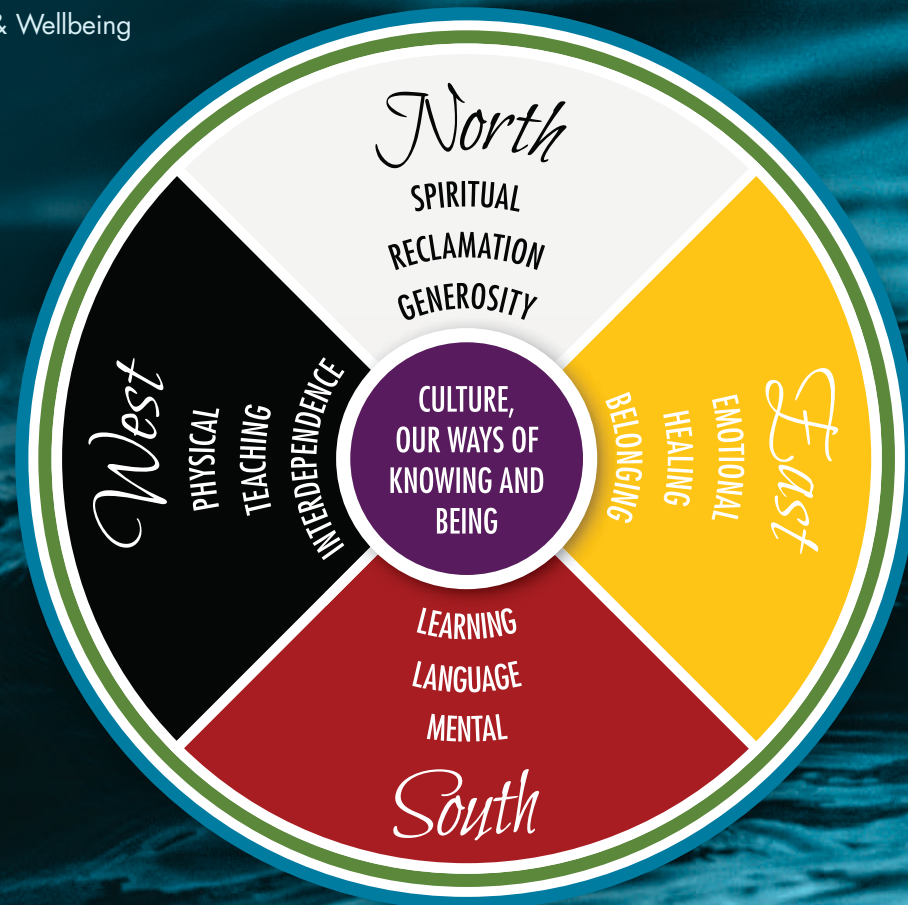
WHOLISTIC HEALTH

WHOLISTIC HEALTH

Model of Wholistic Health and Wellbeing

IPHCC promotes high quality care provision through the Model of Wholistic Health and Wellbeing. The model is rooted in a population needs based approach to health care planning and delivery for the Indigenous population. The model incorporates physical, mental, emotional, and spiritual elements of wellbeing and it is the belief that all elements must operate in harmony.

There is a belief that culture is treatment and culture is healing and this model of care solidly implants a strong self-identity so that self-determination is fostered, and positive health outcomes are advanced. This model of care promotes and celebrates the diversity in Indigenous peoples so that all voices are elevated and the power to control their destiny lies within communities.

Population Health

The Public Health Agency of Canada defines population health as *"an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health"*.[18]

For Indigenous peoples and IPHCC, population health is as follows:

- *"Both a collective and an individual inter-generational continuum that encompasses"* the Model of Wholistic Health and Wellbeing.

- The Model incorporates four cores, but distinct, dimensions of life: the spiritual, intellectual, physical, and emotional aspects of wellbeing.

- Is inclusive of the entire First Nations, Inuit, and Métis populations in Ontario regardless of where they live.[19]

- It is inclusive of personal and collective efforts so that balance and harmony are achieved and maintained within the population.

- Removing systemic barriers so that all Indigenous peoples, regardless of where they live are able to effectively participate in the health care system.

- It is linked to spiritual wellbeing and is directly connected to respective Indigenous places, land, language, and culture and this aspect of wellbeing is celebrated and promoted throughout Indigenous populations.

- Traditional knowledge and traditional healing practices support spiritual wellbeing and, therefore, the outward manifestation of health in the intellectual, physical, and emotional dimensions of being.

Indigenous personal and collective efforts do not exclude Western knowledge and practices. Instead, Western approaches are included via Two-Eyed Seeing to address emergent health episodes, disease, and other aspects of health and well-being. An example is when an Indigenous Elder received cancer treatment in the form of Western medicine that was provided at an Indigenous health care organization by Indigenous health care staff, where he was also able to receive cultural healing and medicines for wholistic care.

Social Determinants of Health

Social determinants" of health[20] are crucial elements within population health. These determinants are the "conditions in which people are born, grow, live and work,"[21] such as education, employment, housing, water, food security, geography, income security, and are key aspects to everyone's wellbeing. For Indigenous peoples, there are additional determinants beyond those specified by Western scholars and practitioners, which include:

- Language, culture, and place;[22]
- Geography and location;
- Strong Self-identity;
- Racism free environments;
- Colonization and systemic racism;
- Intergenerational trauma and legacy effects;
- Access to health services

These determinants reflect a wholistic approach that moves beyond the absence of disease to building individual and collective identity, hand health and wellbeing that is demonstrated through:

- Indigenous self-determination, inherent jurisdiction, place (geography, including the health of the land), worldview, laws, and the ability to self-govern;

- Languages, culture, traditions, ceremonies, kinship networks, shared communal responsibility, and intergenerational strength;

- Ensuring access to basic needs in order to enable individuals, families, and communities to thrive; and

- Dismantling colonial interference by eliminating systemic and interpersonal racism and removing structural and systemic barriers.

A population health approach uses evidence[23] to identify Indigenous population issues, priorities, and health inequities. Through co-design with Patient, Family, Caregiver, and Community (PFCC), Indigenous providers develop interventions and measures to monitor health outcomes and progress on the Indigenous determinants of health.

Population Health Management

Population health management applies "*population health concepts and measurements*"[24] to a specific patient population to shift the "*whole population curve from unhealthy to healthy … in a way that respects each person's autonomy.*"[25]

For IPHCC and its members, this means a wholistic and strategic approach to managing Indigenous health and wellbeing. This refers to a community-driven approach based on strong & trusting relationships.

This population health management approach proactively addresses the accessibility and availability of services that account for and address geography, jurisdictional issues, infrastructure, and communications. It also includes how health delivery systems and services embrace Two-Eyed Seeing, cultural safety, traditional healing services and medicines, and other promising practices for providing care within Indigenous populations. The approach to successful population health management must also incorporate and embed Indigenous measures and indicators within the health systems' performance framework for **all providers**. These measures are crucial for accountability and improving system performance and outcomes.

INDIGENOUS LED

DELIVERABLES TO ACTION

FNMI Population as a Segment	Data Governance and Performance Indicators for Informed Decisions	Equitably Resourced	Application of Culturally Appropriate Models & Interventions
Reciprocal and Trusted Relationships Across Sectors	Accountable to Health Outcomes & Future Generations		Community Engaged and Informed

PROGRAMMING

Prevention	Promotion	Culture is Healing	Health Protection	Diagnosis	Treatment and Care

FOUNDATIONAL PRINCIPALS

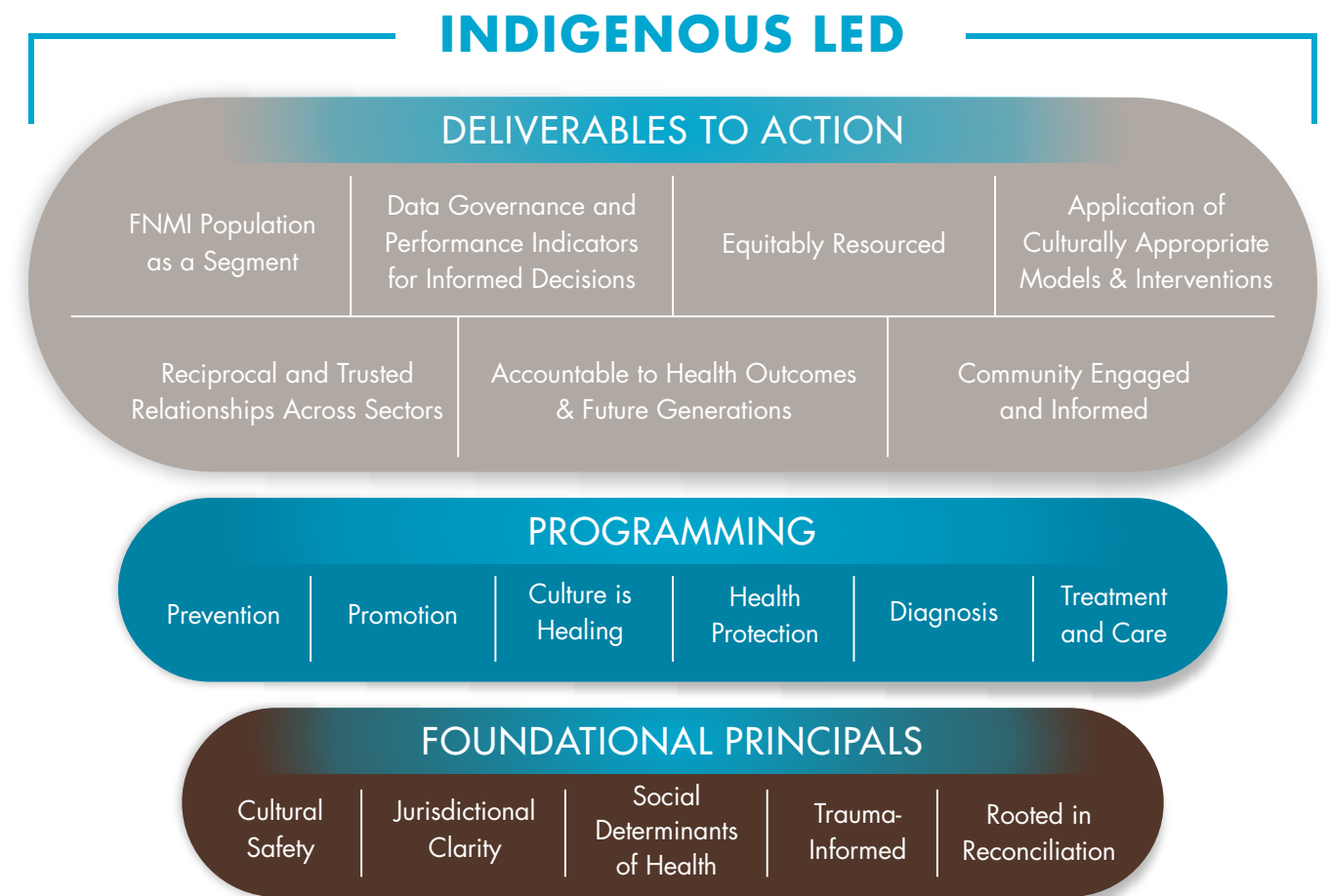| Cultural Safety	Jurisdictional Clarity	Social Determinants of Health	Trauma-Informed	Rooted in Reconciliation

Figure 4: IPHCC Population Health Management Implementation Model

Attributed Population

Each OHT is held clinically and fiscally accountable for an "*attributed*" population which "*is based primarily on where patients seek care and not on geography and where one lives, [hence] networks, teams, and OHTs do not have geographical boundaries.*"[26] The attributed population assumes that patients are linked to a network of services based on a methodology "*developed by IC/ES, uses administrative data (2015-2017) [which looks at] patient utilization patterns, referrals and other criteria to identify how patients access care.*"[27] The result is that patients are predominantly linked with their primary care physician, who are then linked to a hospital where specialists are also linked.

However, there is a significant exception that currently does not capture IPHCC members from this attribution methodology. First, the data that identifies the primary care provider does not include patients who receive services from Nurse Practitioner-Led Clinics (NPLCs), Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs), and Indigenous Interprofessional Primary Care Teams (IIPCTs) as data from these sites is not submitted through Ontario Health Insurance Plan.[28] These primary care models are community-based and structured around salary-based models of compensation. As a result, Indigenous patients who regularly access care at one of these organizations may be attributed to a different OHT if they access care at any other health care services, or not attributed to any OHT.

Elements that do not get factored into the attribution model include:

- Access to primary care physicians: some patients have no choice but to seek primary health care outside of the community due to availability of providers within their home communities;

- Those who do not have access to a regular and consistent primary care provider and seek care through walk-in clinics and emergency care when needed;

- Individuals who use and seek care from Traditional Healing Practitioners on a regular basis;

- The complexity of patient care for those who have multiple comorbidities and conditions that require more time to address and multiple providers to be engaged;

- Social determinants of health (dealing with issues of food security, housing security, water quality, etc.); and,

- Quality of care received and satisfaction of those accessing it (it does not factor in elements of systemic racism & discrimination).

This exception currently excludes IPHCC member organizations and providers from the assigned networks. Indigenous peoples are affected if their primary choice of provider is excluded, which has a corresponding impact on the provider. Ultimately, equitable and sustainable Indigenous Health in Indigenous Hands is compromised.

Indigenous peoples have continuously voiced their rights to control their health and ensure it remains in their hands. IPHCC and its members are designing patient segmentation models that embed Indigenous organizations and providers within Indigenous integrated health care teams. It is based on equity and inclusion principles as it is expressed in the Ontario Health Equity and Inclusion Framework.[29] Consequently, for IPHCC and its members, the "attributed population" is the segment of the Indigenous community in Ontario (all First Nations, Inuit, and Métis people regardless of where they live). IPHCC's 20 members, along with their satellite locations, and their respective client populations make up IPHCC's "attributed population": over 100,000 [30] Indigenous peoples served.

Population Segmentation

Population segmentation is a type of analysis that allows health care providers and organizations to separate populations into subgroups so that they can better assess each group's wants, needs, and health priorities. Sub-population segmentation targets subsets of the entire population and allows packages of care to be defined around needs.

IPHCC's segment of the population was determined by applying an equity lens that takes the entire provincial population of health care users and created the segment of the priority population of First Nations, Inuit, and Métis peoples in Ontario that access IPHCC members' services, as users with similar needs and health priorities.

As IPHCC members continue to care for their respective client bases, they are supporting OHTs across the province by providing an additional layer of care for Indigenous peoples in Ontario beyond the Western health care system. This model of care delivery is espoused in the IPHCC Model of Wholistic Care and Wellbeing.

Integrated Care

The World Health Organization (WHO) and IPHCC and our members define integrated health care as care that is planned, controlled, coordinated, and delivered by a network of providers who work together to best meet the service user's needs. IPHCC and our members further include Patient, Family, Caregiver, and Community (PFCC) voices in the co-design, delivery, and evaluation of services.

From the health system perspective, WHO defines integrated health as:

"An approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care. It should be effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continuously improve performance and to tackle upstream causes of ill health and to promote well-being through intersectoral and multisectoral actions."[31]

Four dimensions are identified for the integration of care in Figure 5[32] on the facing page. The challenge with identifying only these dimensions is that a wholistic approach to integrated health care could get lost.

The elements found in the IPHCC Health Systems Transformation model and Wholistic Model of Health and Wellbeing strengthen these dimensions for an **enhanced and effective integrated health systems** that improves Indigenous health. Collaboration between IPHCC and its members and the Ontario government can uplift and augment these dimensions in the change management process for health systems transformation that is inclusive of all First Nation, Métis, and Inuit people regardless of where they live.

DIMENSION	IPHCC NETWORK

1 ORGANIZATIONAL
 	
Integration of organizations are brought together formally by mergers or through 'collectives' and/or virtually through coordinated provider networks or via contacts between separate organizations brokered by purchaser
	Indigenous Primary Health Care Council
	■ Aboriginal Health Access Centres
	■ Indigenous Community Health Centres
	■ Indigenous Interprofessional Primary Health Care Teams
	■ Indigenous Family Health Teams
	■ First Nations Health Centres
	■ Relationships and Partnerships
	  □ Hospitals □ Non-Indigenous organizations
	  □ Allied Health □ Indigenous organizations

2 FUNCTIONAL Integration of non-clinical support and back-office functions, such as electronic patient records	■ Practice Solution Suite ■ Business Intelligence Reporting Tool ■ Culturally appropriate indicator design ■ Data governance framework

3 SERVICE
 	
Integration of different clinical services at an organizational level, such as through teams of multidisciplinary professionals
	■ Social Determinants Lens
	  □ Food security □ Family security
	  □ Temporary housing □ Cultural safety
	  □ Transportation
	■ Primary Care
	■ Traditional Healing and Wellness
	  □ Land-based healing □ Cultural retention (language, crafts, arts, singing, dancing etc.)
	  □ Ceremonies
	  □ Traditional food systems
	■ Mental Health and Addictions
	■ Rehabilitation therapy
	■ Home and Community Care
	■ Midwifery

4 CLINICAL Integration of care delivered by professional and providers to patients into a single or coherent process within and/or across professions, such as through use of shared guidelines and protocols	■ Model of Wholistic Health and Wellbeing ■ IPHCC Health Systems Transformation Model ■ Traditional Healing and Wellness Models ■ Traditional Medicines ■ Patient Pathway Mapping

Figure 5: WHO Dimensions of Integrated Care with IPHCC comparison

Continuum of Care

The continuum of care "is a concept involving an integrated system of care that guides and tracks patient [sic] over time through a comprehensive array of health services spanning all levels of intensity of care."[33] Figure 6 below offers one example of a continuum of care that spans birth through end-of-life health.
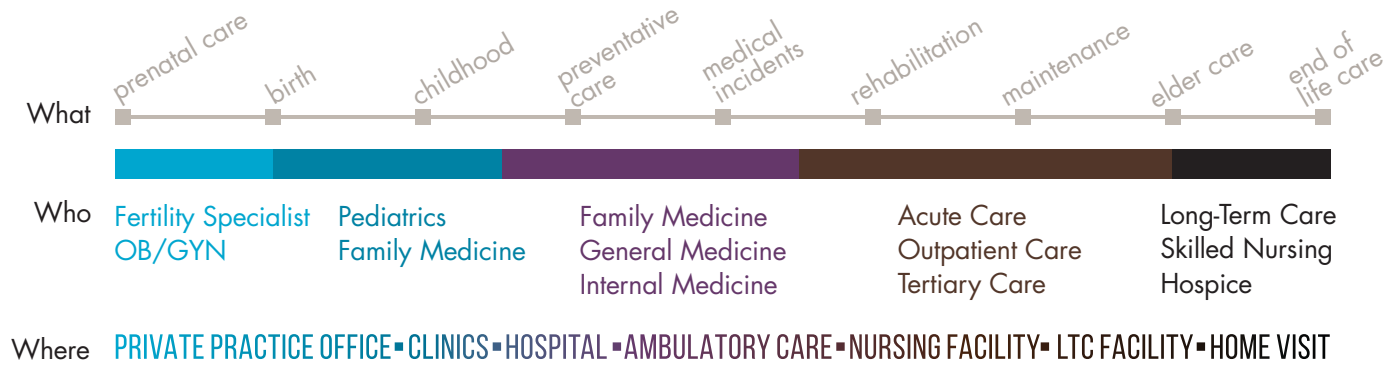

Figure 6: Continuum of Care

An Indigenous continuum of care requires additional attributes, including:

- Understanding where people live and grow and addressing the Indigenous determinants that impact health (self-determination, jurisdictional clarity, impacts of colonization, trauma-informed, cultural retention, language);

- Providing the cultural, social, spiritual, and emotional supports to maintain a healthy inner fire and balance;

- Integrating Traditional healing and wellness services and medicines throughout health systems; and

- Embracing a long view or Seven Generations approach.

  □ The Seventh Generation Principle is an Indigenous Concept, to think of the 7th generation coming after you in your words, work and actions, and to remember the seventh generation who came before you.

  "*It serves not only as a reminder of the wrongs of the past but also the hopes and aspirations of the future seven generations.*" - Tāwera Tahuri

  (Source: https://theseventhgeneration.org/blog-the-seventh-generation-principle/)

Figure 7 below depicts the Urban Indigenous Continuum of Care which ensures an Indigenous voice and participation in Indigenous health systems transformation. It is a fully integrated care delivery model from birth to end of life care that empowers First Nations, Inuit, and Métis clients, families, and communities. This model incorporates the Indigenous Life Cycle , which includes Eight Stages of Life and Seven Phases of Life.[34]
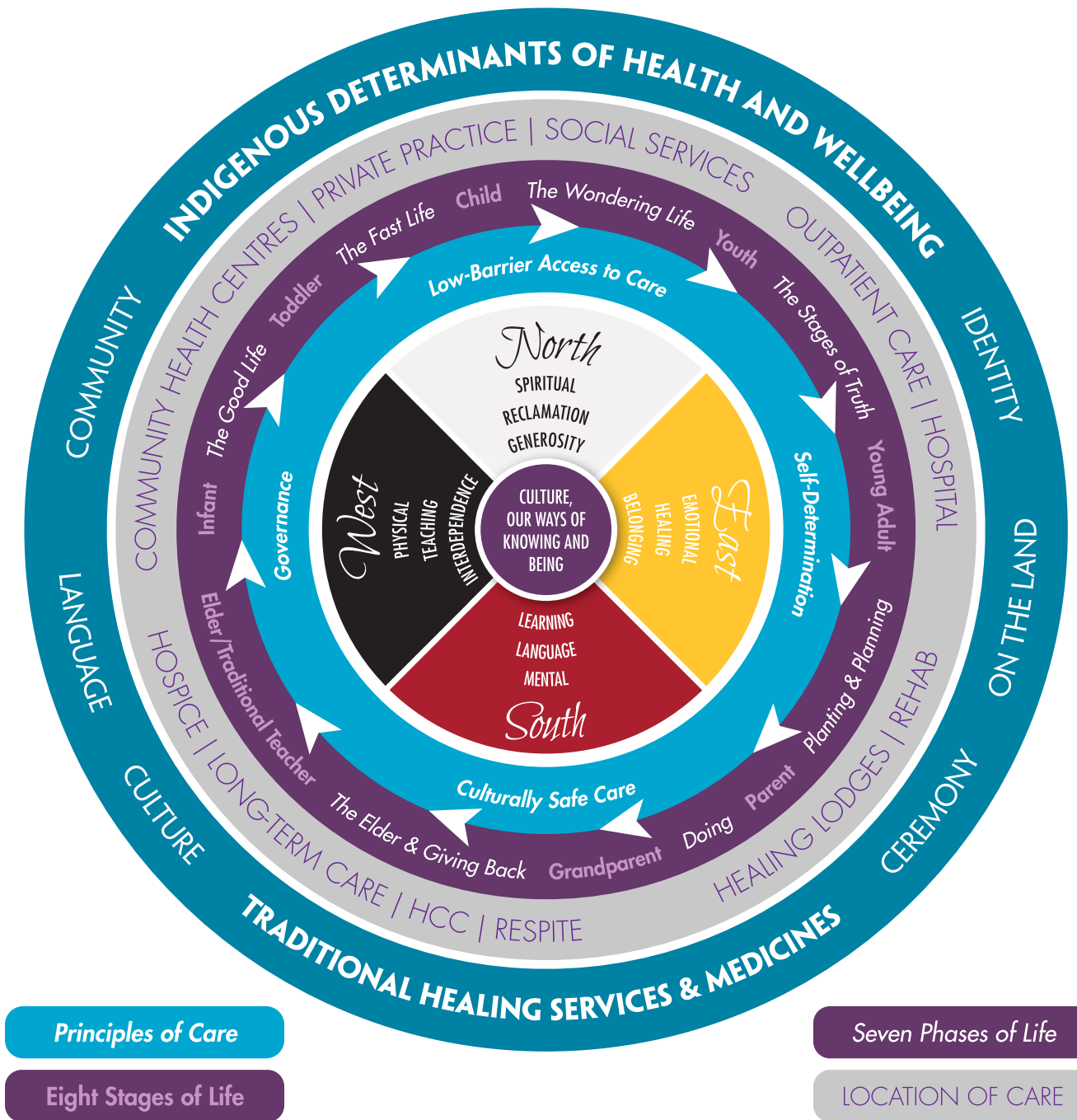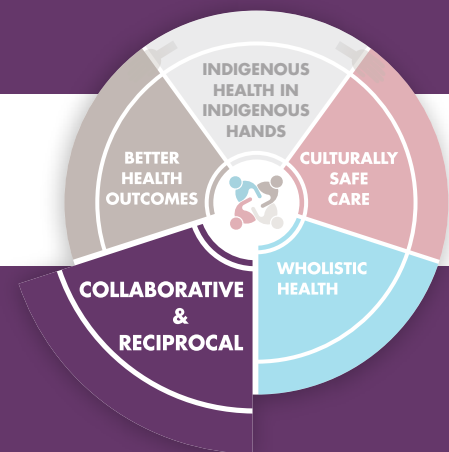

Figure 7 : IPHCC Urban Indigenous Continuum of Care

IPHCC and its members can work with the government and system providers through existing and new relationships, partnerships, and collaborative decision-making arrangements to map this broader vision of a continuum of integrated services so that it is embedded in health systems.

Artwork by Lisa Boivin.

COLLABORATIVE & RECIPROCAL

Collaboration

Collaboration is defined as different groups of people from diverse backgrounds working together to identify, consider, and determine solutions for implementation. Collaboration is fundamentally about relationships based in mutual respect, reciprocity, and accountability.

For IPHCC and its members, these principles are vital to reconciliation and health. How relationships are collectively engaged in is as important as the processes and methods for collaborative decision-making.

> Collaboration is more than a seat at the table; **it is about meaningful engagement & ensuring our voice counts.**

This definition has implications for the process of health systems transformation, including:

- How PFCC work with governments, providers, and related organizations to identify needs and co-design improvements that are embedded within community infrastructures;

- How the patient works with providers to have control over their care with culturally safe access and services;

- How governments, providers, and related organizations dismantle structural and systemic barriers and ensure equitable and sustainable resources and funding that is embedded across health systems;

- How legislation, regulations, and policies support Indigenous Health in Indigenous Hands, regardless of where Indigenous people live, thereby fostering health systems transformation;

- How performance is measured and monitored; and,

- How all participants work together to strengthen relationships and improve Indigenous outcomes.

The four principles for meaningful engagement and collaboration summarized in Figure 8 were developed by the North Simcoe Muskoka Indigenous Health Circle (IHC), a Ministry of Health (MOH) recognized Indigenous health planning table. Members of this planning table include Barrie Area Native Advisory Council, three First Nation communities (Rama, Beausoleil, and Moose Deer Point), urban Indigenous organizations and the broader Indigenous community situated within the region. The full Position Statement is in Appendix A.

Principal 1: **Appropriate and Meaningful Consultation**

- Initiated at the onset of a process to facilitate full and equitable partnership.
- Not precluded by pre-existing relationship(s) with Indigenous leadership.
- Respectful recognition of the legacy of colonization upon Indigenous peoples.
- Follows the consultation policies, guidelines, and protocols of the Indigenous communities they are working with.

Principle 2: **True and Equal Partners**

- Recognition of Indigenous peoples as the experts in their health care needs and the circumstances that have led to health inequities.
- Efforts made to repair and build relationships, ensuring Indigenous people are represented at all levels of positions.
- Recognize Indigenous rights in decision-making and agreement to diplomatic, multi-lateral relationships.

Principle 3: **Right to Self-governance**

- Indigenous right to self-governance must be respected and applied within the context of Ontario health systems transformation planning.
- Integration of formal structures through which Indigenous communities would oversee & lead the administration of their health care service provision, related programs, and policies.

Principle 4: **Indigenous Health in Indigenous Hands**

- Indigenous organizations and communities positioned to plan, manage, and deliver their own health care, including funding.
- Health care must be Indigenous governed, positioning Indigenous leaders as the central authority for decisions about Indigenous health and well-being.
- Indigenous-governed organizations are led entirely by Indigenous leaders and boards of directors – Indigenous representation on a board does not mean it is Indigenous-governed.

Figure 8: Principles of Collaboration

Collaborative Decision-Making Arrangements/ Relationship Agreements

The responsibility to adhere to these principles as well as a relational responsibility to each other must be embedded within the MOH designated Collaborative Decision-Making Arrangement (CDMA), or an alternative Relationship Agreement structure into which organizations enter. This at minimum includes:

- The obligations and duties of both parties;
- How parties come together and make decisions;
- How parties resolve disputes; and
- Performance measures that address mutual obligations and duties and skills that address the relationship and meaningful engagement.

The table[35] in Appendix B provides a CDMA Development tool that identifies some essential features for how participants convene, make decisions, and frame CDMAs. The government of Ontario provides OHTS with a guide[36] for establishing collaborative relationships, and their description addresses some of these features. The IPHCC approach builds on this guide and calls for reciprocal relationships with mutual accountability. It further develops and implements these vital features and guiding principles and reflects them in CDMAs to enable system transformation for better Indigenous health outcomes.

Artwork by Lisa Boivin.

DATA GOVERNANCE AND PERFORMANCE MANAGEMENT

Artwork by Lisa Boivin.

Indigenous Performance Indicators

Performance measurement is a tool for decision-makers and helps them understand how health systems and providers perform, enables them to collect reliable and credible data, monitor and assess results, make informed decisions, and publicly share information at a policy level. In a health care setting, the data collected track population health, quality of care, patient wait times, access to health care providers, and identify system efficiencies that can reduce healthcare expenditures.

IPHCC's Performance Measurement Committee is tasked with designing a performance measurement framework that incorporates an Indigenous wholistic view of health and wellbeing and reflects Indigenous values, principles, and indicators through an equity lens that is reflective of Indigenous realities.

Data Governance Framework

The IPHCC Data Governance Framework is structured to:

- Clarify how member data is treated by the IPHCC;

- Inform members of promising and wise practices;

- Hold partners with whom the IPHCC shares data accountable to actions that benefit the First Nations, Métis, and Inuit clients and IPHCC member sites;

- Respect and be inclusive of all Indigenous voices, including First Nations, Métis, and Inuit and member sites, regardless of where they are at in their own journey to develop data governance capacity; and

- Honour Indigenous culture and worldview, and respect and enable self-determination.

Data Governance Principles

IPHCC's approach to data governance is deeply rooted in our Touchstone Values, Data Governance Principles, and Data Governance Objectives.

These values, principles, and objectives ensure that the IPHCC's work:

- Honours the Indigenous data sovereignty of individuals, member sites, communities, and Nations;

- Builds and maintains respectful and reciprocal relationships with member sites and partners;

- Ensures that data, stories, and information are validated by those involved;

- Supports and improves the wholistic health and wellbeing of individuals, their families, and their communities;

- Helps the IPHCC to respectfully share Indigenous stories;

- Reflects a wholistic and accurate view of Indigenous realities and Indigenous primary health care in Ontario;

- Properly identifies actions that cultivate positive health outcomes for Indigenous people and communities in Ontario;

- Reliably advocates for change; and

- Meets legal and regulatory compliance.

Indigenous Health Outcomes

Indigenous health outcomes require the inclusion of Indigenous peoples, their concerns, provider experiences, and the desire to be self-determining. The objectives reflect a wholistic approach to health, the importance of culturally safe care, and that health systems consistently addresses health equity through embedding Indigenous services within health systems. There is shared accountability for both Indigenous and Western health providers to collect Indigenous health outcome-based data. PFCC experience health systems that consistently addresses the Indigenous determinants of health as part of care.

Appendix A | Excerpt from Position Statement:
Ontario Health Teams – Indigenous Engagement in Simcoe Muskoka

Principle 1: Appropriate and meaningful consultation

To ensure constructive, co-operative relations based on mutual respect, the province of Ontario has stressed the importance of an 'effective approach to consultation that will move Ontario and [Indigenous] peoples toward a new era of cooperation and partnership'.[37] With this in mind, consultations must respect the diversity of opinions, histories, and decision-making processes present 'at the table'. As well, consultation must be initiated at the onset of a process to facilitate full and equitable partnership, and not as an after-thought.

OHT applicants must understand that any form of pre-existing relationship with Indigenous leadership-such as Indigenous board or committee members and individual employees-does not preclude the need for undertaking focused consultation on potential OHT partnerships with First Nation communities and Indigenous governed organizations. Further, in order to comply with the Ministry of Health's expectation that OHT's address current health disparities experienced by Indigenous people of Ontario,

consultation must include a respectful recognition of the legacy of colonization upon the health and wellbeing of Indigenous Peoples. Lastly, it is important for organizations that wish to successfully consult with Indigenous leadership, to understand the Indigenous collectivism mindset. Leadership from an Indigenous perspective is approached as a unified whole; through meaningful consultation and input from their broader community. In this way consensus is reached.[38]

Consultation and engagement in the past have been inadequate and as a result, health disparities continue to worsen.[39] To remedy this situation, non-Indigenous health care leaders must follow the policies, guidelines and protocols related to consultation of the Indigenous communities with which they are working and ensure that consultation is based around mutual respect and fairness. Failure to follow processes for consultation with Indigenous stakeholders will inevitably prove to be counter-productive and endorsement will not be provided.

Principle 2: True and equal partners

Indigenous people are the experts regarding their health care needs and solutions and are experts in the circumstances that have historically created existing health inequities which continue today. It is essential that Indigenous leadership is engaged as true and equal partners in the redesign of health services to ensure improved care that will meet the diverse needs of the Indigenous population. It is incumbent upon

OHT applicants to recognize the nature and quality of existing relationships and how this may be impacting health outcomes of Indigenous peoples. It is essential that every effort be made to repair and build relationships, ensuring Indigenous health leaders and delegates have positions on governing boards, Indigenous community members are included as members of advisory committees, and clear mandates and

responsibilities are agreed upon by the parties involved. Delegates will not be provided if health care leaders do not take the appropriate steps to ensure an equitable partnership.

The Indigenous perspective of partnership within the context of *Bill-74, The People's Health Care*

Principle 3: Right to self-governance

By virtue of their sovereignty and under Canadian Law, Indigenous peoples have the right to self-governance.[40] The United Nations Declaration on the Rights of Indigenous Peoples, - which Canada has a commitment to - echoes a similar message: "Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions".[41] As stated in *Bill-74, The People's Health Care Act*, the ministry has stipulated that the Ontario Health Teams will be expected to "demonstrate that they respect the role of Indigenous peoples in the planning, design, delivery and evaluation of

Act would ensure that mainstream partners recognize Indigenous rights in decision-making and agree to diplomatic relations. Multi-lateral relationships engage one another diplomatically through respectful dialogue and cooperation. Decisions are not made unilaterally.

services for their community".[42] Our belief is that this is a firm statement of Indigenous rights in health care design and delivery.

The Indigenous right to self-governance must be respected and applied within the context of OHT planning. Mainstream partners will be required by Indigenous leadership to integrate formal structures through which Indigenous communities would oversee and lead the administration of their health care service provision, related programs, and policies. More Indigenous ownership regarding the design and control of health services will help to address Indigenous communities' health needs and challenges.[43]

Principle 4: Indigenous Health in Indigenous Hands - Indigenous Governed Health Care Services

An Indigenous governed health systems would see Indigenous organizations and communities positioned to plan, manage, and deliver their own health care; this includes receiving and managing their own health care funding. By ensuring Indigenous peoples are leaders in their health care, rather than passive beneficiaries, emphasis is placed on finding Indigenous solutions to Indigenous concerns.

While non-Indigenous health professionals often demonstrate compassion and empathy for their patients, it is not typical that they are able to comprehensively understand the full impact of Indigenous histories, worldview, and cultural paradigms; all necessary in order to provide-patient centred care. As such, health care must be Indigenous governed, positioning Indigenous leaders as the central authority for decisions about Indigenous health and well-being.

It is important to note here that Indigenous-governed organizations are led entirely by Indigenous leaders and boards of directors in which the members are Indigenous themselves, and where governance and operations are fully determined by Indigenous people. Indigenous representation on a board does not mean the board is Indigenous-governed.

Although Indigenous health services have historically been planned and delivered by the Western medical systems organizational leadership, the evidence clearly indicates that Indigenous health outcomes only improve at the rate in which self-determination and Indigenous control over Indigenous-informed health processes increase.[44] Given the emergence of Ontario Health Teams, the Alliance for Healthier Communities' resolution that Indigenous health should be in Indigenous hands is both time sensitive and urgent to act upon.[45]

Appendix B | CDMA Development Tool: Indigenous Engagement

COMMIT TO THE PRINCIPLES OF INDIGENOUS ENGAGEMENT AND COLLABORATION

Principle 1: Appropriate and meaningful consultation
Principle 2: True and equal partners
Principle 3: Right to self-governance
Principle 4: Indigenous Health in Indigenous Hands - Indigenous Governed Health Care Services

STRUCTURE

Assessment	Organization
What is the issue, problem or improvement being addressed?	How is the group structured & what processes are designed?
Who needs to be involved and how are they represented (i.e., decision-maker or information gatherer)?	How does the group reflect diversity, equity, and inclusion?
How is the process structured and how does it address equity and power imbalances?	How does the group define consensus and what processes are put in place to resolve conflicts? How is power shared among the group?

THE WORK

Education	Negotiation, Consensus and Resolutions
Does everyone have a common understanding for discussion and negotiation? What areas of education are necessary? ■ Historical and Treaty Rights ■ Métis rights ■ Inuit rights ■ Colonization and racism ■ Cultural safety and humility ■ Legislation, regulations, and policies ■ Relevant data	What criteria will the group use, and how will it be applied to achieve agreed-upon goals while ensuring equitable and active participation by stakeholders in the solution? What is required? ■ Decision-making process with responsibilities ■ Generating options for solutions ■ Methods for reconciling conflicting interests that is based on shared principles

IMPLEMENTATION AND PERFORMANCE MEASUREMENT

How does the group implement the agreed upon solutions? What is required? ■ Defined responsibilities and timeframes ■ Communication plan ■ Change management strategies	How does the group monitor implementation and performance? Are there validation methods in place to help confirm understanding of performance? What is required? ■ Early monitoring as plans always require adjustments ■ Identifying the performance measurements ■ How are results communicated to Indigenous partners? ■ How are results validated? ■ How are results linked to continuous improvements?

REFERENCES AND ENDNOTES

1   Government of Ontario. *(n.d.). Ontario Health Teams: Guidance for Health Care Providers and Organizations.* Accessed March 2022.
https://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf

2   Ibid.

3   Elliott. C. (2019). *Bill 74: The People's Health Care Act, 2019.* Legislative Assembly of Ontario.
https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-74

4   Government of Ontario. *(n.d.). Ontario Health Teams: Guidance for Health Care Providers and Organizations.* Accessed March 2022.
https://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf

5   Indigenous Services Canada. (2022). *Canada Continues Support for First Nations Health Transformation for Mi'kmaw Health and Wellness.* https://www.canada.ca/en/indigenous-services-canada/news/2022/01/canada-continues-support-for-first-nations-health-transformation-for-mikmaw-health-and-wellness.html

6   Nation Talk. (2019). *NAN: Health Transformation.* https://nationtalk.ca/story/nan-health-transformation#:~:text=This%20led%20to%20the%20execution%20of%20a%20trilateral,and%20Minister%20Eric%20Hoskins%29%20on%20July%2024%2C%202017

7   Indigenous Services Canada.(2021). *Nishnawbe Aski Nation, Federal and Provincial Governments Reaffirm Strategic Partnership in Support of First Nations Health Transformation.* https://www.canada.ca/en/indigenous-services-canada/news/2021/03/nishnawbe-aski-nation-federal-and-provincial-governments-reaffirm-strategic-partnership-in-support-of-first-nations-health-transformation.html

8   Wulff, H. R. (2004). *The Language of Medicine.* Journal of the Royal Society of Medicine.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1079361/

9   *"Two-Eyed Seeing is understood as a guiding principle and teaching that directs attention toward the importance of learning to see from one eye the strengths in Indigenous knowledge and ways of knowing, and from the other eye the strengths in Western approaches. Two-Eyed Seeing implies that we work from an Indigenous world view as the foundation of our knowing and then utilize that as our foundation for [applying] and accepting ideas from other world views based on our knowledge base."* IPHCC and our members incorporate the philosophy of Two-Eyed Seeing into our health care delivery models. This philosophy is employed in our Model of Wholistic Health and Wellbeing. The Model of Wholistic Health and Wellbeing promotes the use of traditional medicine and healing practices but also incorporates Western biomedicine models of care so that healing is maximized from an integrated care perspective.

10   Anaya, J. (2009). *The Right of Indigenous Peoples to Self-determination in the Post-declaration Era.* Making the Declaration Work: The United Nation Declaration on the Rights of Indigenous Peoples. Copenhagen: International Working Group for Indigenous Affairs. 187.

11   Halseth, R. & Murdock, L. (2020). *Supporting Indigenous Self-determination in Health: Lessons Learned from a Review of Best Practices in Health Governance in Canada and Internationally.* National Collaborating Centre for Indigenous Health.
https://www.nccih.ca/Publications/Lists/Publications/Attachments/317/Ind-Self-Determine-Halseth-Murdoch-EN-web-2020-12-02.pdf

12   Institute on Governance. (n.d.) *What is Governance.* Accessed March 2022. https://iog.ca/what-is-governance/

13   Ibid.

14   George Washington University - Milken School of Public Health. (2020). *Equity vs. Equality: What's the Difference?.* https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/

15   Greenlaw, E. (2021). *Health Equity vs. Health Equality: What's the Difference?.* Boston Medical Centre - Health City. *https://healthcity.bmc.org/policy-and-industry/health-equity-vs-health-equality-whats-difference*

16   Adaption of work by University of Florida: Counseling & Wellness Center. (n.d.). *Module 1.3 – Equality, Equity, And Social Justice.* Accessed April 2022. https://counseling.ufl.edu/resources/bam/module1-3/

17   Indigenous Primary Health Care Council. (2022). *Anishinaabe Mino'ayaawin: Foundations of Indigenous Cultural Safety.* https://www.iphcc.ca/ontario-ics-program/

18   Government of Canada. (2007). *What is Population Health?.* https://www.canada.ca/en/public-health/services/health-promotion/population-health/population-health-approach.html

19   Committee on Indigenous Health.(1999). *The Geneva Declaration on the Health and Survival of Indigenous Peoples.* Accessed at:
https://dialoguebetweennations.com/N2N/PFII/English/HealthAnnex1.htm

20   According to the Government of Canada. (2015). *What Makes Canadians Healthy or Unhealthy?* The determinants of health in Western systems currently include *"income and social status, social support networks, education, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, culture."*
https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/what-makes-canadians-healthy-unhealthy.html

21   Ontario Association of Children's Aid Societies. (2015). *Aboriginal Children in Care Report to Canada's Premiers.* https://www.oacas.org/2015/08/aboriginal-children-in-care-report-to-canadas-premiers/

22   While culture is included in the Western determinants of health, it does not convey the intersection between language, culture, and place.

23   According to the Public Health Agency of Canada: Canadian Best Practices Portal. *Key Element 3: Base Decisions On Evidence.* "Evidence-based decision-making refers to an approach in which a body of information is put through a broad critical review process. This means that every decision should be justified by reference to the best available evidence and reasoning. Evidence, when used with good reasoning and principles of appraisal, answers the question "Why did you decide that?" It is imperative that evidence be inclusive of the voices and experiences of the patients experiencing health inequities and the relevant providers working with them." https://cbpp-pcpe.phac-aspc.gc.ca/population-health-approach-organizing-framework/key-element-3-base-decisions-on-evidence/

24   Kindig, D. (2015). *What are We Talking About When We Talk About Population Health?.* Health Affairs Blog. *https://www.healthaffairs.org/do/10.1377/forefront.20150406.046151/full/*

25   Rapid Improvement and Support Exchange (RISE). (2019). *Population-health Management.* https://www.mcmasterforum.org/docs/default-source/rise-docs/rise-briefs/rb6_population-health-management.pdf?sfvrsn=327757d5_9

26   Ontario Health Teams Division. (2021). *Ontario Health Teams: Data Support Guidance Document.* 5. https://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/OHT_data_supports_guidance.pdf

27   Ontario Medical Association. (n.d.). *OMA's Attribution Model & Physician Assignment.* FAQs.

28   Ibid. p6.

29   Ontario Health. (2022). *Equity, Inclusion, Diversity and Anti-Racism.* https://www.ontariohealth.ca/our-work/programs/equity-inclusion-diversity-and-anti-racism

30   This number is an estimate. An environmental scan is underway to update this number.

31   WHO Regional Office for Europe. (2013). *Strengthening People-centred Health Systems in the WHO European Region.* https://www.euro.who.int/__data/assets/pdf_file/0005/231692/e96929-replacement-CIHSD-Roadmap-171014b.pdf

32   WHO Regional Office for Europe. (2016). *Integrated Health Models: An Overview.* https://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf

33   Evashwick, C. (1988). *Creating the Continuum of Care.* National Library of Medicine. https://pubmed.ncbi.nlm.nih.gov/10293297/

34   Centennial College. (n.d.). *Our Stories - First Peoples in Canada.* Accessed March 2022. https://ecampusontario.pressbooks.pub/indigstudies/chapter/stages-of-life/

35   Adapted from Hallmark, E. (2012). *Policy Consensus Initiative.* National Policy Consensus Center. https://policyconsensus.wordpress.com/2012/05/18/9-3-collaboration-assessment/

36   Ontario Health. (2020). *Guidance for Ontario Health Teams: Collaborative Decision-Making Arrangements for a Connected Health Care System.* https://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/OHT_CDMA_Guidance_Doc.pdf

37   Government of Ontario. (2021). *Draft Guidelines for Ministries on Consultation with Aboriginal Peoples Related to Aboriginal Rights and Treaty Rights.* https://www.ontario.ca/page/draft-guidelines-ministries-consultation-aboriginal-peoples-related-aboriginal-rights-and-treaty

38   Gambrell, K. (2017). ,*The Case for an Indigenous Collectivist Mindset.* Emerald Insight. https://www.emerald.com/insight/content/doi/10.1108/S2058-880120170000003001/full/html

39   Richmond, C. A. M. & Cook, C. (2016). *Creating Conditions for Canadian Aboriginal Health Equity: The Promise of Healthy Public Policy.* Public Health Reviews. https://publichealthreviews.biomedcentral.com/track/pdf/10.1186/s40985-016-0016-5.pdf

40   Department of Justice Canada. (2018). P*rinciples: Respecting the Government of Canada's Relationship with Indigenous Peoples.* https://www.justice.gc.ca/eng/csj-sjc/principles.pdf

41   United Nations.(2007). *United Nations Declaration on the Rights of Indigenous Peoples.* https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

42   Elliott, C. (2019). *Bill 74.* Legislative Assembly of Ontario. https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2019/2019-04/b074ra_e.pdf

43   HealthCareCan. (2018). *Bringing Reconciliation to Healthcare in Canada: Wise Practices for Healthcare Leaders.* https://www.healthcarecan.ca/wp-content/themes/camyno/assets/document/Reports/2018/HCC/EN/TRCC_EN.pdf

44   Alliance for Healthier Communities. (2019). *Resolutions.* Presented at 2019 Annual General Meeting. https://cdn.ymaws.com/aohc.site-ym.com/resource/resmgr/agm_docs/agm_may_30/Alliance_2019_AGM_Resolution.pdf

45   Ibid.

. . . .

A   United Nations. (2009). *State of the World's Indigenous Peoples.* New York: United Nations.

B   Maaka, R. CA. & Andersen, C. (2006). *The Indigenous Experience: Global Perspectives.* 328.

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