Well Living House

INDIGENOUS PRIMARY HEALTH CARE COUNCIL

OurCare Primary Care Gathering

for First Nations, Inuit, Métis, and Relatives living in Urban and Related Homelands:

New perspectives and possibilities for meeting FNIM primary care needs in Canada

June 2023

Community partners

INDIGENOUS PRIMARY HEALTH CARE COUNCIL

Well Living House

Visit the Well Living House website: **welllivinghouse.com**

Visit the IPHCC website: **iphcc.ca**

Acknowledgements

The OurCare project team gratefully acknowledges the co-leadership of the Indigenous Primary Health Care Council and the Well Living House in the development and hosting of the Ontario Priorities Panel on Primary Care from a First Nation, Inuit & Métis (FNIM) Perspective. This partnership was key to ensuring an Indigenous "by community, for community" approach to the gathering. The project team thanks those who volunteered their time to participate in the Roundtable and work towards improving care for their communities. The Roundtable was made possible by the contributions of:

Dr. Janet Smylie, Director of the Well Living House (www.welllivinghouse.com), Tier 1 Canada Research Chair in Advancing Generative Health Services for Indigenous Populations in Canada, and Professor at the Dalla Lana School of Public Health, University of Toronto

The Well Living House is an action research centre that is focused on Indigenous infant, child and family health and wellbeing. At its heart is an aspiration to be a place where Indigenous people can gather, understand, link and share knowledge about happy and healthy child, family, and community living.

Dr. Nicole Blackman, Director of Integrated Care and Clinical Services, Indigenous Primary Health Care Council (iphcc.ca)

The Indigenous Primary Health Care Council (IPHCC) is an Indigenous governed, culture-based, and Indigenous-informed organization. Its key mandate is to support the advancement and evolution of Indigenous primary health care services throughout Ontario. It works with 23 Indigenous primary health care organizations (IPHCOs) across Ontario including Aboriginal Health Access Centres (AHACs), Indigenous Interprofessional Primary Care Teams (IPCTs), Indigenous Community Health Centres (ICHCs) and Indigenous Family Health Teams (IFHTs) to address the physical, spiritual, emotional, and mental wellbeing of First Nations, Inuit, and Métis (FNIM) peoples and communities being served.

Roundtable Team

The Roundtable was supported by MASS LBP. Established by Peter MacLeod in 2007, MASS is Canada's recognized leader in the design of deliberative processes that bridge the distance between citizens, stakeholders, and government. For more than a decade, MASS has been designing and executing innovative deliberative processes that help governments develop more effective policies by working together with their partners and communities.

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OurCare Presenters

Dr. Janet Smylie is the Director of Well Living House (www.welllivinghouse.com) St. Michael's Hospital, Unity Health Toronto; Tier 1 Canada Research Chair in Advancing Generative Health Services for Indigenous Populations in Canada; and Professor, Dalla Lana School of Public Health and Department of Family and Community Medicine, Faculty of Medicine, University of Toronto. Her research is focused on addressing Indigenous health inequities in partnership with Indigenous communities. She has practiced and taught family medicine in diverse First Nations, Inuit, and Métis community contexts for 29 years. A Métis woman, Dr. Smylie acknowledges her family, traditional teachers, and ceremonial lodge.

Dr. Nicole Blackman is the Director of Integrated Care and Clinical Services, Indigenous Primary Health Care Council. Nicole is a member of Algonquins of Pikwakanagan First Nation but was born and raised in Durham Region. Academically, Nicole has been studying Indigenous health since 2006, completing her Doctor of Nursing Practice with her capstone project focusing on Indigenous programming from a public health perspective. Professionally, Nicole has had the privilege of serving as Director of Professional Practice for Weeneebayko Area Health Authority, working together with First Nation communities in the James and Hudson Bay region to address various health needs. Nicole has strived to use her education, experiences and knowledge to work towards building awareness of the history of the Indigenous population and how that history impacts the population's health today.

Dr. Tara Kiran is the Fidani Chair in Improvement and Innovation at the University of Toronto and Vice-Chair of Quality and Innovation at the Department of Family and Community Medicine. She practices family medicine at the St. Michael's Hospital Academic Family Health Team (SMHAFHT). Dr. Kiran completed her family medicine residency at McMaster University in 2004 and spent her first couple of years in practice as a locum in Indigenous communities in northern Ontario and in community health centres in urban Toronto. She practiced at the Regent Park Community Health Centre from 2006 to 2010 before joining St. Michael's in 2011.

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New perspectives and possibilities for meeting FNIM primary care needs in Canada

What Policy Makers Should Know

Our current reality in health care, particularly primary care, is ugly. The worldwide pandemic has wreaked havoc on our already strained health care system - especially along pre-existing fault lines such as access to timely, relevant, and upstream care; health human resources; and social determinants of health. The needs simply outweigh what is available, and when this happens it is the populations already experiencing social exclusion who suffer most. From an Indigenous perspective, First Nation, Inuit, and Métis (FNIM) living in urban and related homelands have consistently fought to have their voices heard about how the system is failing them, and what needs to be done to address it.

As mainstream entities work to implement strategies to improve primary care service delivery for Ontarians, it's not understood that broad stroke initiatives commonly fail to meet the needs of those impacted the most by COVID-19 or who have historically experienced health inequities. The OurCare Community Roundtables are bringing those often-unheard voices to the forefront so a better system can be designed based on the values, needs, and priorities of all Ontarians. To do so, it is essential for policy makers moving the change forward to know the following primary care considerations with regards to FNIM living in urban and related homelands:

- There is considerable socio-cultural, linguistic, political, historical, and geographic diversity among FNIM in Canada. As such, a pan-Indigenous or one-size-fits-all approach is not appropriate to primary care design and delivery;

- FNIM health needs are unique and require a different approach than mainstream models of care;
- Indigenous models of care focus on wholistic health and see a need for balance in all components (mental, emotional, spiritual), not just physical;
- Culture as healing is an important part of health for many FNIM;
- Mainstream focus on Indigenous health tends to be deficit-based, missing the opportunity to incorporate positive perspectives and protective factors into care models;
- Today's health care system continues to be an unsafe place for FNIM living in urban and related homelands, just as it was with the initial establishment of Indian hospitals in 1946 at Charles Camsell Indian Hospital in Edmonton;
- Approximately 85 percent of the Indigenous population in Ontario now live in urban settings where they are commonly discounted in enumeration, needs assessment, community engagement, and linkages to policies, programming and service agreements;
- FNIM across geographies (urban, rural, and remote) have the largest gaps in access to a regular primary care provider of any population group in Canada.

* Ontario Ministry of Health and Long-term Care, Population and Public Health Division. Relationship Indigenous Communities Guidelines, 2018. Toronto, ON. Available from: **https://health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Relationship_with_Indigenous_Communities_Guideline_en.pdf**

FNIM and Relatives in Urban and Related Homelands – Participation at a Glance

This process was led and co-facilitated by Indigenous people and Indigenous organizations in partnership with Indigenous allies. It was a partnership between Indigenous Primary Health Care Council, Well Living House and OurCare. The day was co-chaired by Dr. Janet Smylie, Director, Well Living House, and Dr. Nicole Blackman, Director of Integrated Care and Clinical Services Indigenous Primary Health Care Council.

Name	**Organization**
Co-Chairs	
Dr. Janet Smylie (Director)	Well Living House
Dr. Nicole Blackman (Director)	Indigenous Primary Health Care Council
WLH & IPHCC Supporting Team Members	
Caroline Lidstone-Jones	Indigenous Primary Health Care Council
Darryl Souliere-Lamb	Indigenous Primary Health Care Council
Alexandra Barlow	Indigenous Primary Health Care Council
Julia Creglia	Indigenous Primary Health Care Council
Sophie Roher	Well-Living House
Genevieve Blais	Well-Living House
Maggie Ykorennio Powless-Lynes	Well-Living House

Participants	
Sara Gleeson	Anishnawbe Mushkiki
Bev Dyer	De dwa da dehs nye s Aboriginal Health Centre (DAHAC)
Natalie Paavola	Dilico Anishinabek Family Care
Chantal Gaudreau	Mino M'shki-ki Indigenous Health Team
Tom McLeod	Mushkegowuk Council Area Primary Care Team
Erin Peltier	Noojmowin Teg Health Access Centre
Katie Wantoro	Sioux Lookout First Nations Health Authority
Maureen Tomasini	Algonquins of Pikwakanagan First Nations
Curtis Hildebrandt	Dilico Anishinabek Family Care
Shanna Weir	Gizhewaadiziwin Health Access Centre
Carol Eshkakogan	Maamwesying North Shore Community Health Services
Crystal Bell	Matawa Health Cooperative
Constance McKnight	Misiway Milopemahtesewin Community Health Centre
Nicole Sokoloski	Noojmowin Teg Health Access Centre
Samantha Bottigoni	North Bay Indigenous Hub
Tera Osborne	Tsi Kanonhkhwatsheriyo Indigenous Interprofessional Primary Care Team
Mary Watson	Durham Region Representative
Amy Shawanda	Peterborough Representative
Julia Candlish	Indigenous Health Learning Lodge, McMaster University
Paul Tylliros	Waasegiizhig Nanaandawe'iyewigamig
Special thank you to the participation of:	
Marie Gaudet	Elder
Jimmy Gaudet	Elder

Participant Values

- **Community**
- **Relationships**
- **Culture**
- **Wholistic Care**
- **Indigenous Models of Care**
- **Trust**
- **Partnerships**
- **Access**

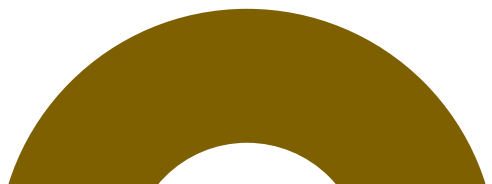
Primary Care Gathering

The Primary Care Gathering, consisting of 22 participants from across the province, met in-person on Friday, June 2, 2023. The day was chaired by Drs Nicole Blackman (Director of Integrated Care and Clinical Services IPHCC) and Janet Smylie (Director, Well Living House), and supported by the IPHCC and WLH staff along with the OurCare team. Those who were unable to attend in-person were welcome to participate online via Zoom. Participants were invited in such a way to ensure a broad representation of voices across the province, particularly those from urban and related homelands. During their time together, participants shared information about primary care (an aspect of the broader health system) and primary health care (focus on prevention and social determinants of health), as well as Indigenous-designed models of care. Participants also spent a significant amount of time in conversation with each other, as they engaged in a series of facilitated conversations sharing their experiences and identifying the needs of their communities.

We used the following prompts to help frame participant conversations:

- What is working well and positively contributing to our health?
- What barriers affect better health? What are barriers to more of the things that are working well?
- What do we need in Indigenous models? What are these models rooted in? How do you do your own primary care?
- What about mainstream models of primary care: what is working and what are key challenges and barriers?
- What do we need so that we can build on existing strengths and capacities? How do we achieve more of what's working and less of what is not working?

Participants' conversations have been organized by the Indigenous co-chairs, with support of the roundtable team, into themes that highlight the experiences and challenges they shared, and recommendations that detail potential solutions shared by participants during the roundtable discussions.



Government Representatives

Well Living House and the IPHCC invited representatives from the following governmental entities.

- Ministry of Indigenous Affairs
- Ministry of Health - Primary Care Branch
- Ministry of Health - Mental Health & Addictions Branch
- Ministry of Solicitor General
- Ontario Health - all regions
- Indigenous Services Canada

The intent was for governmental representatives to engage with gathering participants and hear directly from them regarding the challenges experienced with primary care, areas where things were going well, and recommendations on how to improve primary care to better meet the health needs of FNIM living in urban and related homelands. FNIM living in urban and related homelands are commonly excluded from the provincial and federal tables despite them comprising 85% of FNIM population in Ontario and more than 60% of the FNIM population nationally.

Invited guests joined the roundtable for lunch, which was followed by a discussion with the roundtable leads from Well Living House and the IPHCC. Discussions focused on how population health is defined at the respective governmental areas and tables. Through invited guests, emphasis was placed on the importance of culture as healing and the need to explore opportunities to harmonize cross-ministerial strategies for supporting Indigenous health. The harmful impacts of discounting and/or excluding First Nations, Inuit, and Metis relatives living in urban and related homelands from planning and policy tables and the importance of needs and population based resourcing and services was highlighted. It was also shared that population health should encompass social determinants of health, not purely just access to healthcare services. Discussions also focused on health system transformation and what that means from a governmental perspective as it relates to Indigenous health. It was acknowledged that the government needs to recognize and respond to the strengths and needs of constitutionally recognized FNIM across geographies, including in urban and related homelands.

Invited guests shared that it's helpful to understand from Indigenous Primary Health Care Organizations (IPHCOs) what's happening on the ground - where the gaps and challenges are. It was felt that hearing real examples of what is happening on the ground is key to ensuring true health system

transformation, as this needs to be based on ground level impacts. Another area of focus for discussions surrounded Indigenous models of care and the importance of collaborative efforts. Various areas throughout government are doing what they can to ensure they are working with Indigenous primary care partners to make sure that care is safe and equitable. Ensuring implementation of primary care models that effectively and sustainability meet Indigenous health needs is a priority area for the government.

Following the lunch roundtable, representatives were then invited to join the Sharing Circle at the end of the engagement, listening to the themes and recommendations generated by the roundtable discussions. Representatives independently responded to the recommendations shared by participants. The takeaways of their reflections include:

Collaboration, Partnership, and Information Sharing

Guest reflections highlighted the significance of working together with urban FNIM populations, Indigenous communities, and Indigenous service providers to support the populations they serve. They recognized the unique opportunity of the roundtable to identify areas of support and continue to foster partnerships. They indicated an openness to receiving more information about the unmet health needs of First Nations, Inuit, and Metis relatives living in urban and related homelands.

Strengthening Healthcare Delivery

The reflections included commitment to consider Indigenous perspectives and models for enhancing healthcare delivery. Guests acknowledged the need to improve their work within their ministries and expressed excitement about the potential for future collaborative efforts with Indigenous service providers.

Community Integration and Social Determinants of Health (SDOH)

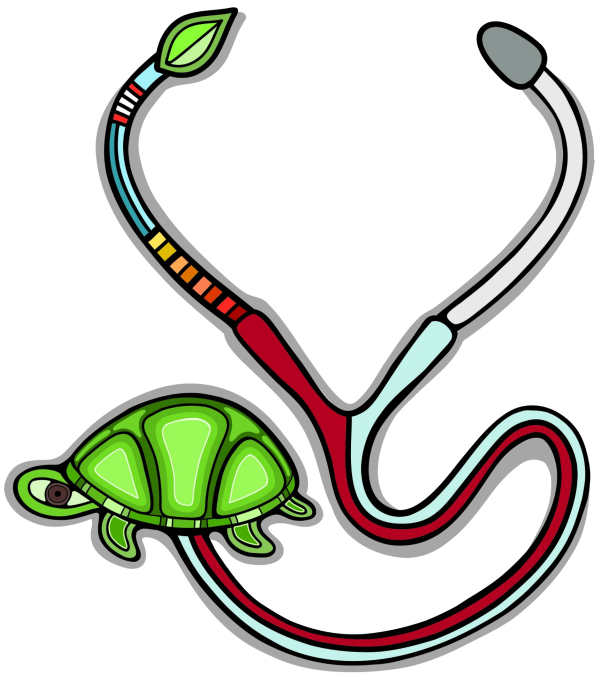
The importance of community, access to services, and social determinants of health was stressed throughout the Sharing Circle. The guests thought that early and ongoing engagement with Indigenous communities was needed to better understand the unique needs of First Nations, Inuit, and Metis relatives living in urban and related homelands.

Funding Flexibility and Bureaucratic Barriers

Guests acknowledged and recognized the challenges posed by bureaucratic systems that hinder the ability of Indigenous practitioners to shift models and adapt the funding to suit their context. There was a call for

reflection on what funding flexibility truly means and what can be done to mitigate these barriers until change can be enabled by political actors. Policy and funding opportunities must be responsive to and inclusive of FNIM across urban, rural and remote geographies.

Report on Shared Stories from FNIM Primary Care Gathering



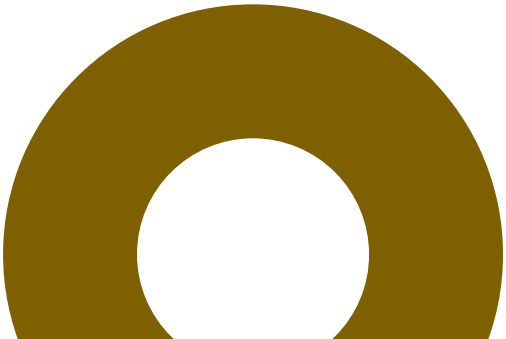
Who are we and why we participated

Following the dissemination of the OurCare national survey that reached more than 9,000 Canadians to gather perspectives, aspirations and priorities for primary care in Canada, priority panels were held in Ontario, British Columbia, Nova Scotia, Quebec, and Manitoba. The Ontario Priorities Panel consisted of 35 randomly selected volunteers who met five times over a four-month span, shared their stories and experiences with primary care, and identified priorities for change. The outcome of their work included 23 recommendations on how to improve primary care to better meet the health care needs of all Ontarians. And while many of the recommendations resonate with FNIM, specific priority areas were left unidentified.

FNIM community members from across the province appreciated the opportunity to come together at one of the ten OurCare community roundtables to help provide a closer understanding of the needs and priorities specific to FNIM clients and communities. Through this opportunity, FNIM service users and providers were given the space to have their voices heard, and now they look forward to seeing the actions that will come from it. The intent of this incredibly important gathering was to focus on FNIM living in urban and related homelands, as they represent 85 percent of the Indigenous population in Ontario, have very high rates of primary care unattachment, and are commonly discounted and/or excluded from planning and policy tables and rarely involved in program design at the local level. Through this opportunity, FNIM service users and providers were given the space to have their voices heard, and now they look forward to seeing the actions that will come from it.

What was shared

A strength-based approach was applied in learning what was working well in primary care for FNIM, while identifying areas where things are not working well. With this comprehensive picture in mind, participants highlighted strengths, raised issues, and proposed solutions.



The strengths we want built upon...

1. **Indigenous Models of Care** delivered through Indigenous primary health care organizations (IPHCOs), which are rooted in connections to community and culture through ceremonies, land, and language, have been shown to

- Support delivery of wholistic health that support all elements of health including mental, emotional, spiritual, and physical care;
- Provide effective care that cultivates trust, active listening, and relationship development with clients and communities;
- Bridge cultural gaps;
- Acknowledge the unique needs of FNIM clients and communities;
- Provide a space for participation of Elders, Knowledge Keepers, community advisory boards, and provision of care that is relevant to diverse Indigenous nations and their unique cultures.

2. **Client-led, community-based care** tthat understands and meets the unique needs of FNIM living in urban and related homelands through relationships and culture. This builds upon Indigenous principles of autonomy of decision-making and self-determination by:

- Listening to clients and community;
- Hearing and responding to self-expressed needs and priorities;
- Supporting client and community choice;
- Taking adequate time to engage and build relationship and trust;
- Assessing needs from a community context by asking communities what they need from their primary health care provider.

3. **Empowering clients and communities to be the experts** in their own health needs, while at the same time recognizing and responding to externally imposed limitations with respect to unmet basic material and health needs. This includes teaching youth about health and health services who are able to share this information with their families and community, who then also learn and benefit.

4. **Employing innovative outreach strategies** that mitigate challenges of accessibility. This includes supporting clients in accessing their care through:

- Transportation resources;
- Mobile health teams that meet clients where they are;
- Flexibility in appointment times/clinic hours to respond to local needs daily;
- Virtual care, when accessible, for improving access to care and respecting client's time;
- Outreach teams comprising interprofessional care providers, cultural teams, and Traditional Healers who travel to clients and communities to provide care while enabling them to stay in their homes.

5. **Providing care that respects Indigenous expertise and ways of knowing.** TThis includes offering traditional healing practices such as land-based care, access to ceremonies and teachings, one-on-one counselling with a Traditional Healer, and more.

6. **Providing welcoming, warm, safe, and cultural health care environments.** This includes creating a welcoming relational and physical space by ensuring there is clear Indigenous presence in staffing and leadership at all levels, that non-Indigenous staff are knowledgeable, skilled, and experienced in serving Indigenous populations. It also includes the display of artworks and the use of culturally appropriate resources in English as well as community appropriate Indigenous languages.

7. **Implementing a primary health care model vs. primary care model.** This involves extending far beyond just managing illness but to also include disease prevention (e.g. immunization) and health promotion (e.g. education) as well.

8. **Embedding Indigenous models within mainstream frameworks.** This provides culturally relevant care choices, respects client preferences, and improves collaboration Indigenous and mainstream models. For example, mainstream organizations that have created service navigation roles with the expectation that they work with local Indigenous organizations have seen better coordination and health outcomes for FNIM clients and communities.

9. **Establishing partnerships** between Indigenous and non-Indigenous specific providers to bring services such as dentistry and allied health to communities

10. **Recognizing and responding** to the unique strengths and needs of FNIM across rural, remote, and urban geographies.

The issues we want addressed...

1. **Existing funding models** for Indigenous health care continue to be a formidable barrier, encompassing restrictions that curtail Indigenous sovereignty and self-determination in health care decisions. For example, IPHCOs may find hiring two Nurse Practitioners more useful for their service delivery than one medical doctor but the funding model restricts how the funds can be allocated.

2. **Funding of 'appropriate' health services** is based on the Western definition of health care and suitability. This limits the potential breadth and depth of 'appropriate' health care, as Traditional Healers and Cultural Practitioners are not properly or equitably compensated, salaried, or recognized in comparison to Western practitioners.

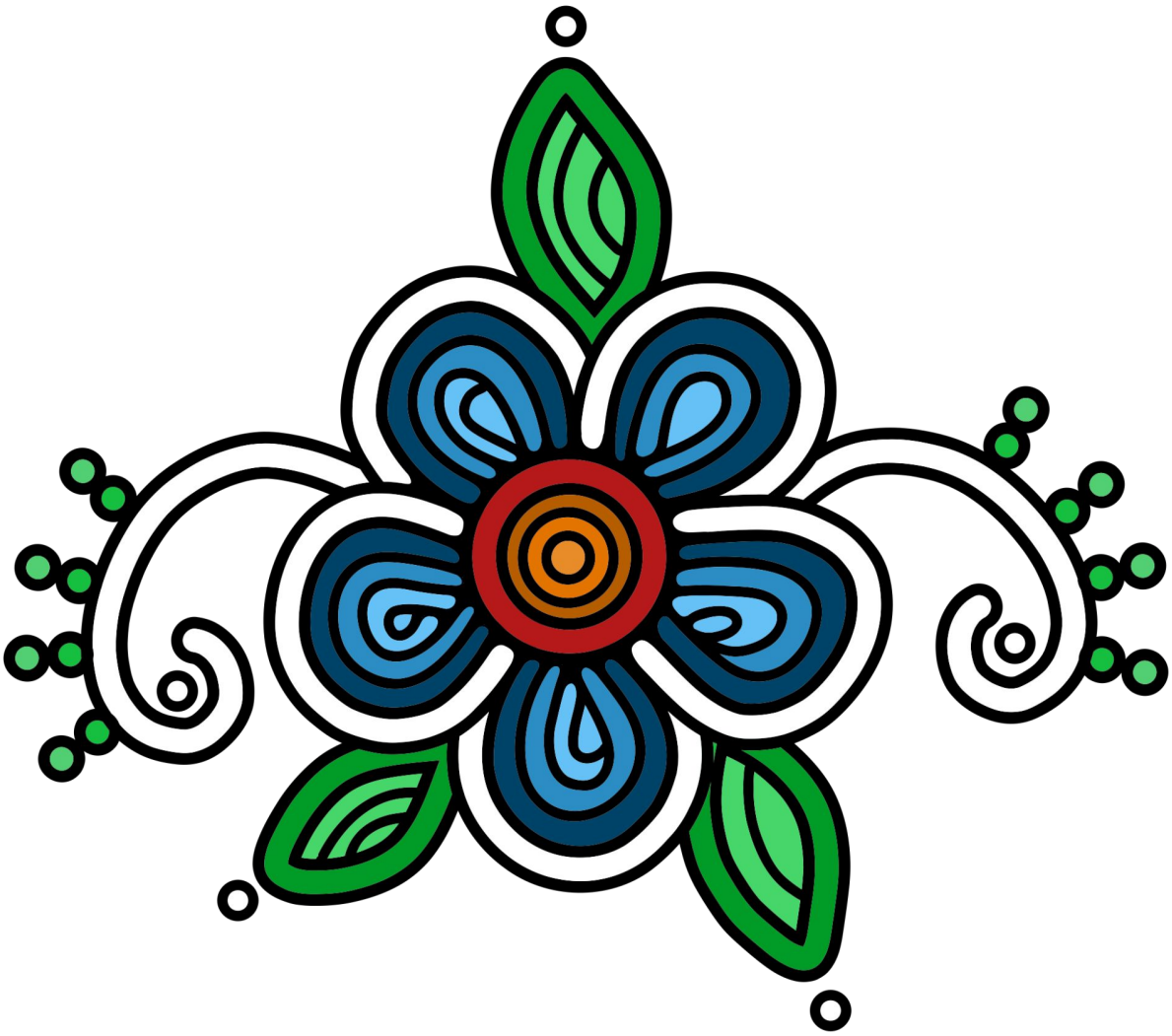
3. **Continued devaluation of Indigenous models of care by mainstream practitioners** is evident through the continual disregard of traditional healing practices such as medicines, ceremonies, land-base care, and the Cultural Practitioners providing the care. There are continued tensions and resistance from Western practitioners when FNIM clients request cultural care to be embedded within their care plan. For example, mainstream providers are hesitant to support use of traditional medicines due to uncertainties of interactions with other treatments or medications. This could be mitigated by working collaboratively with Traditional Medicine Practitioners.

4. **Recognize and respond** to strengths and population-based unmet health needs of FNIM relatives living in urban areas. FNIM relatives living in urban and related homelands are commonly excluded or under-represented in population counts, health needs assessments, decision-making tables, and funding streams. For example, during COVID-19 vaccine roll-out, despite public policy statements regarding prioritized access for FNIM populations in Ontario, elderly and homeless FNIM living in urban centres with high density of COVID-19 infection had delayed access compared to FN on-reserve communities. Policy and funding support for Indigenous health care organizations for FNIM living in cities is poorly matched to the actual population distribution and health service needs. The result is low rates of primary care attachment and high rates of emergency room use for FNIM living in cities, despite evidence of high rates of disease burden and social challenge. Strengths which could be built on include strong and resilient social networks and pre-existing urban Indigenous health and social services organizations.

5. **Geographical barriers impact access** tto comprehensive, safe, and culturally appropriate care for those living in remote areas as well as those living in urban settings. This is seen through challenges with recruitment and retention in remote communities, lack of internet connectivity to access virtual care or other resources, lack of transportation to access services, lack of eldercare and childcare, as well as continued discrimination from health practitioners in the mainstream system.

6. **FNIM experiences in primary care are marred by systemic racism and colonial legacies.** Participants shared numerous examples of clinical encounters, punitive actions, and dismissive attitudes of health care providers they believe stemmed from anti-Indigenous racism and discrimination. Within Western care settings, participants reported experiencing discrimination, detachment, and rushed care, which negatively impacted their

clinical experiences and undermined positive health outcomes. Participants highlighted how the rigidity in appointment times or lack of flexibility in service delivery poses a barrier due to possible penalization. Acts of discrimination and anti-Indigenous racism perpetuate FNIM mistrust of the health care system and those working within, which discourages Indigenous uptake of Western models of care.



Our Recommendations

A. Models of Care

To build upon the strengths shared of primary care delivery through Indigenous models of care, and to address the barriers identified of devaluing said models, we recommend that policy makers and mainstream organizations, including providers, work with FNIM leaders and service users to actively support the advancement of Indigenous models of care across urban, rural and remote geographies by:

I. Recognizing the value, diversity, and uniqueness of FNIM health, wellbeing, and healing practices, and supporting access to them in the care of FNIM clients and communities;

II. Implementing a model of client-led, community-based care that understands and meets the unique needs of FNIM clients through relationships and culture while empowering clients to take leadership in their own health and wellbeing;

III. Working in collaboration with Traditional Healers and Cultural Practitioners where requested by FNIM clients and communities;

IV. Advocating for and advancing Indigenous health policy that recognizes the need to increase the number and size of IPHCOs, so they match the size, distribution, and health needs of FNIM in Ontario across geographies; and

V. Developing, sharing, and implementing wise practice examples of Indigenous models of care.

B. Funding

To address the identified barriers associated with funding that include restrictions, Western approach to defining appropriate health services, and the continual devaluing of Traditional Healers and Cultural Practitioners, we recommend that the federal and provincial governments work with FNIM leaders to ensure that funding barriers currently undermining the advancement of FNIM health, wellbeing, and reconciliation are corrected by:

I. Ensuring that FNIM specific funding streams, at the provincial and local level, are matched to local and regional FNIM population size, distribution, and needs across urban, rural, and remote geographies;

II. Advancing sustainable (versus short-term/last-minute) funding for IPHCOs that will support mental, emotional, and spiritual health, in addition to physical health;

III. Ensuring there are FNIM funding streams specific for FNIM youth, as they represent a significant proportion of the FNIM population, have life stage specific service requirements, need to be able to self-determine their own health and health services, and are the future leaders of communities; and

IV. Ensuring funding mechanisms and structures support rather than undermine full-scope Indigenous models of care and the Traditional Healers and Cultural Practitioners working within them.

C. Culturally Safe Care

To build upon the strengths shared of Indigenous-led organizations providing welcoming, warm, safe, and cultural health care environments, and to address the systemic anti-Indigenous racism and colonial processes embedded in the Canadian health care system, we recommend that policy makers and mainstream organizations, including providers, work with FNIM leaders and service users in urban, rural, and remote homelands to acknowledge, recognize, and respond to anti-Indigenous racism at the individual, organizational, and systems level by:

I. Acknowledging personally and in statements of reconciliation that the current state of Indigenous health in Canada is a direct result of previous Canadian government policies, including residential schools and Indian hospitals;

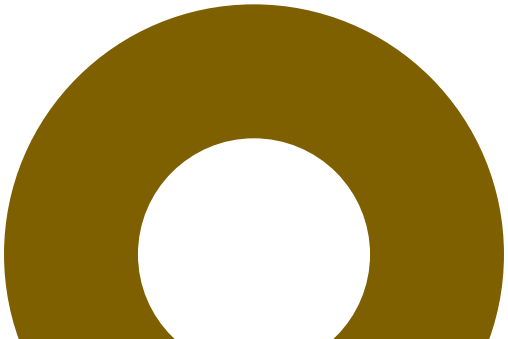
II. Recognizing that advancement of Indigenous models of care, Traditional Healers, and Cultural Practitioners is insufficient and that a two-pronged approach is required in which non-Indigenous specific models, services, and providers are also providing high quality, culturally safer care to FNIM;

III. Working in partnership with FNIM leaders and service users to develop and implement organizational and system level strategic plans with clear and measurable indicators of success that tangibly advance the health care rights of FNIM people as identified in international law, constitutional law, and under the Treaties;

IV. Ensuring all health care providers and health care trainees have completed baseline, evidence-based Indigenous cultural safety training and are participating in ongoing evidence-based practice evaluation and continuing medical education CME that is tailored to their learning needs and is advancing the knowledge, self-awareness, and skills required to provide high quality and culturally safer care to diverse FNIM clients and communities;

V. Working in partnership with FNIM experts and health leaders to develop and implement quality assurance systems that document and respond to incidents of anti-Indigenous racism and differential adherence to clinical practice guidelines; and

VI. Advancing Indigenous staffing and leadership presence at all levels by working in partnership with relevant FNIM organizations to co-develop and co-implement Indigenous specific health and human resource plans.



D. Partnership

To build upon the strengths of shared collaborative partnerships, and to address systemic racism and colonial activities such as mainstream organizations planning Indigenous services without Indigenous input, we recommend that policy makers and mainstream organizations, including practitioners, work with FNIM communities and organizations in urban, rural and remote homelands to advance Indigenous Health in Indigenous Hands by:

I. Ensuring adequate and inclusive FNIM representation (including representatives of FNIM living in urban and related homelands) at all decision-making tables where discussions take place and decisions are made that will impact FNIM health and wellbeing.

II. Supporting outreach to FNIM clients and communities who are experiencing barriers to accessing primary care and other health care sectors (e.g., acute care, home care, long-term care).

III. Advancing information flow, defined care pathways, and service navigation within and between primary and tertiary care.

IV. Supporting Indigenous specific care teams and/or visits by primary care providers for FNIM patients in other health sectors such as acute care, home care, and long-term care.

About OurCare

OurCare is a pan-Canadian conversation with everyday people about the future of primary care. The project is led by Dr. Tara Kiran, a family doctor and renowned primary care researcher based in Toronto. OurCare has three stages:

1. **National Research Survey**
   The survey was online from September 20 to October 25, 2022. More than 9,200 Canadians completed the survey, sharing their perspectives and experiences. Vox Pop Labs co-designed and executed the survey.

2. **Priorities Panels**
   Priorities Panels were held in five provinces: Nova Scotia, Quebec, Ontario, British Columbia, and Manitoba. MASS LBP co-designed and executed the panels with OurCare advisors and local delivery partners.

3. **Community Roundtables**
   Community roundtables were hosted in each of the five provinces, focusing on historically excluded groups that we did not hear enough from during stages 1 and 2. MASS LBP co-designed and executed the community roundtables with OurCare advisors and local community organizations.

OurCare Project Partners

OurCare is funded by:

Health Canada
Health Canada is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances. Production of this document has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Max Bell Foundation
Max Bell Foundation began making grants to Canadian charities in 1972. Today, the Foundation supports innovative projects that are designed to inform public policy change in four program areas: Education; Environment; Health & Wellness; and Civic Engagement & Democratic Institutions. The Foundation also delivers the Public Policy Training Institute, a professional development program designed to help participants more effectively engage in the public policy process, and PolicyForward, a future-oriented speaker series that brings thought leaders together to discuss the intersections of policy, technology, and innovation.

Staples Canada — Even the Odds Campaign
Staples and MAP have come together to create Even the Odds: an initiative to raise awareness of inequity in Canada and to help build vibrant, healthy communities. The partnership is based on the shared belief that everyone should have the opportunity to thrive. Even the Odds funds research and solutions to help make the future fair for everyone. Learn more at staples.ca/eventheodds.

OurCare Project Partners

OurCare is based at:

MAP Centre for Urban Health Solutions
The MAP Centre for Urban Solutions is a research centre dedicated to creating a healthier future for all. The centre has a focus on scientific excellence, rapid scale-up and long term community partnerships to improve health and lives in Canada. MAP is based at St. Michael's Hospital.

St. Michael's Hospital, Unity Health Toronto
St. Michael's Hospital is a Catholic research and teaching hospital in downtown Toronto. The hospital is part of the Unity Health Toronto network of hospitals that

OurCare is also supported by:

Department of Family & Community Medicine, University of Toronto
The University of Toronto's Department of Family & Community Medicine is the largest academic department in the world and home to the World Health Organization Collaborating Centre on Family Medicine and Primary Care.

St. Michael's Foundation
Established in 1992, St. Michael's Foundation mobilizes people, businesses and foundations to support St. Michael's Hospital's world-leading health teams in designing the best care – when, where and how patients need it. Funds support state-of-the-art facilities, equipment needs, and research and education initiatives. Because St. Michael's Foundation stops at nothing to deliver the care experience patients deserve.

To learn more about OurCare and the members of the advisory group, please visit our website at ourcare.ca.

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