There was an enormous system of organizations that provided health and social services. Trying to get a large public service system and structure to change or adapt the way it provided services to Aboriginal peoples was like trying to change the direction of a really big ship. We knew we needed to establish new mechanisms for collaboration, new ways of thinking, and new ways of doing.

– Edith Cloutier, Executive Director, Val-d’Or Native Friendship Centre

Clinique Minowé, in Val-d’Or, Quebec, is an innovative model for the provision of integrated health and social services for Aboriginal people living in urban centres. The Clinique Minowé project was developed through a partnership between the Val-d’Or Native Friendship Centre (the main service organization in contact with Aboriginal people in the region), the Centre de santé et de services sociaux de la Vallée-de-l’Or (CSSSVO, the regional office of provincial health and social services), and the Centre jeunesse de l’Abitibi-Temiscamingue (CJAT, the regional youth protection services centre). The organizations came together to address concerns shared by many communities across Canada. The first is the existence of significant and disadvantageous disparities between the health status and health service usage of Aboriginal peoples and those of the rest of the population. The second is that Aboriginal families in the region are reported to social services far more frequently than non-Aboriginal families.

In December 2008, with support from Health Canada’s Aboriginal Health Transition Fund, the partners began work on a project to develop a new urban-based health and social services model. Their goal was to establish a model that would introduce new mechanisms for collaboration and partnership, would be based on knowledge and understanding of Aboriginal people’s health and social service needs, and would support the planning and provision of health and social services in ways that increased accessibility for Aboriginal people. The model they developed offers integrated and culturally appropriate health and social services for Aboriginal people at a community-based Aboriginal organization.

Clinique Minowé opened in February 2011 with a licensed practical nurse, a social worker, and a coordinator on staff. Health services available at the clinic include prenatal, natal, and postnatal care for children and families, and activities that promote a healthy lifestyle for all community members. The nurse has also been authorized to prescribe and inject the contraceptive Depo-Provera, with follow-up care provided by a clinic-affiliated doctor. The social worker provides support to children, youth, parents, and extended families at different phases of the youth protection process.

Clinique Minowé’s culturally relevant services address the real-life needs of the Aboriginal people and communities it serves. Its location at the Friendship Centre provides a culturally safe environment. The clinic and its practitioners approach health and wellness holistically, and are committed to community development. The nurse and social worker connect community members with a broad range of services and programs, including many available on-site at the Friendship Centre. The clinic staff members are a visible, active presence in the community, and have built considerable trust with community members. Both the nurse and the social worker make home visits and will travel together (sometimes a four- or five-hour drive) to visit encampments of families who spend their summers on the land.

Over the less than two years that Clinique Minowé has been in operation, it has grown rapidly. Service demands and the caseloads for the nurse and social worker have increased significantly. Families who are referred to social services and seek those services through Clinique Minowé are more likely to follow through on their appointments than families were before the clinic was available. Testimonials from the clinic’s clients describe how the clinic’s services have affected their health and well-being by relating compelling narratives. For example, one is about a pregnant woman who had struggled with addiction. As her due date approached, she considered giving up her child. After connecting with Clinique Minowé’s nurse and social worker, she was able to enter—and complete—a long-term residential treatment program. She has maintained her sobriety, and today has full custody of her young child.

The value and importance of the Clinique Minowé model has been acknowledged regionally, nationally, and internationally. The partners are currently working with representatives of other Friendship Centres on a plan to implement the Clinique model in other Quebec communities. The ODENA community-university research network has held the clinic up as an example of how community action coupled with research can provide a strong evidence base for the development of public policy.
Several factors have made important contributions to the clinic's success. The Friendship Centre provided strong leadership, and team members’ commitment ensured that the project kept moving forward, from development through implementation. The money provided through the Aboriginal Health Transition Fund (AHTF) gave the partners the time and resources they needed for effective planning and start-up. The partners sought and gained the trust of decision-makers, including regional department heads and ministers in provincial government departments. The partners have also leveraged their own resources to support the clinic project: CSSSVO has taken responsibility for the salary of the clinic’s nurse, and CJAT pays the salary of the social worker. The Friendship Centre has drawn on its relationship with a university-affiliated researcher to support research activities for the project. The partners have also been able to secure funding from a private foundation to support the clinic coordinator’s position.

The most significant challenges for the Clinique have related to the need for adequate sustainable funding, and to the clinic’s rapid growth. To manage current and future growth, the Friendship Centre is reorganizing its own internal structure to make it more integrated. Coordinating services will help leverage internal resources and support the clinic’s holistic approach to service delivery. As demand for services continues to grow, the Friendship Centre recognizes that the Clinique will need additional physical space for its activities, and is planning a construction project to expand the building it currently occupies. The clinic keeps careful statistics of its activities and gathers qualitative data on the impacts of its services. These data will provide invaluable support for future requests for funding.

CONTACT INFORMATION:

Inquiries about Clinique Minowé should be directed to Edith Cloutier, Executive Director, Val-d’Or Native Friendship Centre (edith.cloutier@caavd.ca). Additional information on Clinique Minowé is available online at http://caavd.ca/admin/editor/asset/CliniqueMinowe_ANGw_2fev.pdf
WRHA Framework for Action: Cultural Proficiency & Diversity

All the services at the Winnipeg Regional Health Authority that were developed to support Aboriginal people are now within the context of a larger framework for cultural proficiency and diversity. The framework came from the recognition that in a system of this size, it’s easy to silo. We wanted to retain the strength of all activities, but also recognized the need for a framework that supported the cultural proficiency of the organization, so that we wouldn’t further marginalize already marginalized populations.

– Dr. Catherine Cook, Vice President, Population and Aboriginal Health, WRHA

The Winnipeg Regional Health Authority (WRHA) has demonstrated its commitment to enhance cultural safety for First Nations, Inuit, and Métis people, and to improve health outcomes for the Aboriginal population. WRHA’s Aboriginal Health Programs (AHP) have focused on building WRHA’s capacity to respond to the Aboriginal community’s needs. The reach and impacts of AHP’s activities are being strengthened by the recent introduction of a system-wide Framework for Action: Cultural Proficiency & Diversity, a comprehensive plan designed to enable WRHA to deliver the best possible health care to all people, regardless of cultural identity or language proficiency.

WRHA serves residents of Winnipeg and surrounding rural areas, northwestern Ontario, and Nunavut. First Nations, Inuit, and Métis people constitute a significant and growing proportion of the population in each of these regions, and the city of Winnipeg is home to the largest community of urban Aboriginal people in Canada. As is true across the country, significant inequities exist between the health status of First Nations, Inuit, and Métis people and other residents. Working collaboratively with other WRHA programs and departments and with community and government organizations, AHP brings a coordinated approach to the needs of First Nations, Inuit, and Métis people and communities, and provides a wide range of services. To enhance the health care experiences and cultural safety of First Nations, Inuit, and Métis patients, AHP facilitates patients’ access to spiritual and cultural care, traditional healing, and interpreters in local Indigenous languages. In addition, it connects patients with community resources, offers advocacy services, and supports effective and comprehensive discharge planning and coordination. AHP also leads and participates in activities that enhance the cultural competency and cultural proficiency of health care providers, WRHA staff members, and the organization as a whole, including workforce development activities and education that builds staff members’ awareness and understanding of First Nations, Inuit, and Métis people’s cultures, historical experiences, and culturally distinct approaches to health and wellness.

The AHP, Human Resources, Community Development, and Research and Applied Learning departments are executive sponsors, leading the development and implementation plan for WRHA’s Framework for Action: Cultural Proficiency & Diversity. The region served by WRHA includes a large Aboriginal population (as noted above), and is home to a significant and growing number of newcomers to Manitoba. In response to the complex needs of the increasingly diverse population it serves, WRHA identified the development of cultural proficiency as a key strategic priority. The Framework for Action was completed and approved in 2011. WRHA is now in the process of implementing the framework.

The Framework for Action is ambitious, comprehensive, and innovative, and it emphasizes the importance of including the interests and experiences of a diverse population and authentically engaging and collaborating with community. It calls for system-wide organizational, structural, and clinical interventions, with the goal of transforming WRHA from a “one size fits all” health care system to one that responds to the needs of a diverse population.

- Organizational interventions focus on developing a representative workforce and leadership for WRHA. WRHA’s actions in this area have included a preferred Aboriginal hiring philosophy, outreach, recruitment, and retention activities for Aboriginal staff, and a respectful workplace policy and campaign.
- Structural initiatives focus on making the health care system more client-friendly and culturally appropriate for all clients. WRHA’s actions in this area have included forming a multi-year partnership with a local tribal council to identify and develop an action plan to address gaps and challenges to health system access for Aboriginal people; establishing

healthcouncilcanada.ca/innovativepractices
Community Health Advisory Councils (which report directly to the WRHA Board) and other processes to support public engagement and input; providing access to Aboriginal traditional healing services and health and wellness supports; putting in place Aboriginal patient advocacy and discharge coordination supports; providing interpreter services for all language constituencies; establishing community-based ACCESS centres (“one stop shops” for health and social service delivery) throughout the region; and establishing the BridgeCare Clinic for recently arrived, government-sponsored newcomers to Manitoba.

- Clinical interventions focus on helping health care providers gain the knowledge, skills, and tools they need to effectively manage the impacts of culture on clinical practice. WRHA’s actions in this area have included Aboriginal awareness training and other cultural proficiency and diversity workshops for staff members, and partnership in the Dignity in Care initiative, which provides practitioners with practical ideas and tools to support the development of a culture of compassion and respect in WRHA.

One of the lessons learned at AHP has been that, in spite of the fact that the board and senior management at WRHA have consistently supported, championed, and resourced the program’s activities, AHP is still, to some extent, marginalized as a “special” program. As Dr. Cook, WRHA’s Vice-President, Population and Aboriginal Health, commented, “It’s important that all of the programs think about the Aboriginal population, think about the diversity of the population when they’re planning their work…. They still think that somebody will tell them if they need to do it. That’s been a challenge.” Lasting change will require changes in knowledge, attitudes, values, policies, and practices at all levels of the organization. The framework is designed to support that kind of transformation, by building on the organization’s strengths and successes, bringing a commitment to cultural proficiency to all staff, and integrating and embedding cultural proficiency as an essential characteristic of WRHA’s system.

WRHA has accumulated considerable evidence to demonstrate the impacts of framework-related activities undertaken by AHP and other departments. It has documented and published anecdotal information that demonstrates support for the activities described above, and strengthened and extended its community partnerships. Aspects of AHP and other WRHA programming (including workforce development, service delivery, program development, partnerships and collaboration, and accountability) have been adopted and used by organizations in Manitoba, Saskatchewan, Australia, and New Zealand.

CONTACT INFORMATION:

Additional information on WRHA’s Aboriginal Health Programs is available at http://wrha.mb.ca/aboriginalhealth/index.php. WRHA’s Framework for Action: Cultural Proficiency & Diversity can be found at http://www.wrha.mb.ca/community/commdev/files/WRHA_cpd_framework_final.pdf.
St. John’s Friendship Centre

The Aboriginal Patient Navigators have opened the eyes of many practitioners. I’ve gotten support notes that say, “I never knew this. This is great! What did we ever do before these people were here?” It’s been very well received by medical staff.

– David Penner

Executive Director, St. John’s Native Friendship Centre, NL

The St. John’s Friendship Centre in Newfoundland and Labrador has developed innovative ways to bring much needed supports for First Nations, Inuit, and Métis people who travel to St. John’s for medical care. The Centre operates the Shanawdithit hostel and shelter, and administers an Aboriginal Patient Navigator program, provided in partnership with Eastern Health (EH). These supports are particularly valuable for people who have come to the city from remote and isolated communities.

The Aboriginal Patient Navigators (APNs) are employees of the Friendship Centre, but work out of EH’s Health Science Centre. The two APNs serve as many as 500 First Nations, Inuit, and Métis clients and their families each year, and have taken broad responsibility for supporting clients’ cultural safety throughout their experiences in the acute care system. The APNs are embedded in a multidisciplinary team, participating in medical rounds each morning and supporting the hospital’s capacity to provide health care services to Aboriginal people in culturally specific and sensitive ways. The APNs help clients and their family members navigate the health care system, accompanying them to medical appointments, ensuring that they understand their medical conditions and needs, arranging on-site ceremonies, and attending to other culturally distinct needs. The APNs are skilful communicators, and are often fluent in one or more of the local Indigenous languages. They have helped medical staff learn how to incorporate respect for culture into their practice, and how to communicate and interact more effectively with Aboriginal clients.

The APNs try to minimize the length of time their clients must spend in care by making sure that appointments are scheduled as closely together as possible and assisting with the development and implementation of discharge plans. In a few instances, when the hospital has not been able to release a patient because the patient cannot find a way to purchase or access a specific piece of medical equipment they will need at home, the APNs have ordered and temporarily covered the cost for the equipment. This has allowed patients to return home without having to wait for the issue of which jurisdiction is financially responsible to be resolved. The APNs also ensure that clients’ family members understand their medical conditions and needs.

Shanawdithit hostel and shelter, which began operating in 2004, offers temporary accommodations to Innu and Inuit residents of Labrador who are visiting St. John’s to access medical services (a group that now constitutes approximately two-thirds of the facility’s occupants), new Canadians, and people who are homeless. In its early years, Shanawdithit often struggled to fill its rooms. Today, demand for accommodations typically exceeds capacity. Shanawdithit is the only hostel/shelter in St. John’s that has a cultural focus or that is equipped to take in families. To support residents’ comfort and safety, management has implemented zero tolerance policies with respect to alcohol or drug use and aggressive behaviour. In addition to accommodations, Shanawdithit’s health clients can access the shelter’s transportation services to move between the airport, hostel, and health care sites, and they have on-site meals laundry and computer access. If needed, the hostel also arranges counselling for clients (a service used most often by women who have experienced violence) and assists them to find employment or more long-term housing.

Shanawdithit and the APN program work well together. The APNs often come to meet and visit with clients or family members in the culturally respectful environment provided by the shelter. For patients and clients, the combination of supports available through Shanawdithit and the APN program enables them to manage their time in St. John’s productively and return to their home communities as quickly as possible. In the environment of Shanawdithit and with the support of the APNs, clients generally feel less socially and culturally isolated, and more comfortable and more confident through the care experience.
The APN program and Shanawdithit have succeeded, in large part, because they meet the real-life needs of the people and communities they serve. As David Penner, the Friendship Centre’s executive director acknowledges, consultation is a “must-have” for success: “You need to get everyone’s opinion, so that you can provide not what you want or even what the people might think they want, but what the people need.” Research and documentation are also crucial components of success. Evaluations of the APN program have indicated that the services provided by the APN have minimized clients’ stress and anxiety, enhanced coordination of after-hours care, and raised awareness of cultural differences, practices, and traditions within the health care system. Medical staff have confirmed that the combination of Western and traditional medical approaches and practices has improved outcomes for their patients, and that the APNs, by demonstrating and supporting culturally sensitive care, have helped them become more effective practitioners.

The APN program started in 2009 as a pilot project, initiated by the Ethics Department at Eastern Health and supported by the federal Aboriginal Health Transition Fund (AHTF). Eastern Health’s leadership and its recognition of the need to work in partnership with an urban Aboriginal organization (which led to the Friendship Centre’s participation in the project) have been invaluable. In the development phase of the project, the partners completed consultation activities in St. John’s and Labrador, and established a steering committee and advisory committee to guide the project’s development. These bodies evolved into standing committees that continue to monitor the program and ensure that activities are informed by and attend to community members’ needs.

The most significant challenges for the APN program and Shanawdithit have related to the need for adequate sustainable funding. When the AHTF ended, Eastern Health and the Friendship Centre had to find alternate funding sources for the APN program; to date, it has not yet been able to secure sustainable funding. The Friendship Centre received some funding from the Homelessness Partnering Strategy (to cover Shanawdithit’s capital expenditures and start-up) and other provincial and federal sources, but it relies primarily on per diem funding to support day-to-day operations. This has affected Shanawdithit’s ability to recruit and retain staff because it cannot offer wages that compete with those provided by other local shelters, which receive block funding from the province. The centre has established tighter financial management for Shanawdithit, and now applies a social enterprise approach to this and all other programs at the centre. As David Penner has observed, “You need to do things that are going to sustain themselves, work towards the future, beyond your current activities, and bring a business approach to your work. Just because you are a not-for-profit doesn’t mean you can’t use a profit approach to your operations.”

**CONTACT INFORMATION:**

Additional information on St. John’s Friendship Centre is available at [http://www.sjinfc.com](http://www.sjinfc.com).
In British Columbia, the Provincial Health Services Authority's (PHSA) Aboriginal Health Program delivers a unique facilitated, online training program that acts as an educational bridge to transform attitudes, behaviours, and—most importantly—practice in health care. The PHSA Indigenous Cultural Competency (ICC) training program was developed in response to the 2006 Transformative Change Accord (more information on the Accord can be found here) signed by the Province of British Columbia and the First Nations Leadership Council. The Transformative Change Accord and ICC training both seek to reduce disparities between the health status of First Nations people and that of other BC residents. The accord includes a commitment from the partners to develop a curriculum for cultural competency and establish mandatory training for staff of the Ministry of Health and regional health authorities in BC. The ICC program provides that training. By placing the ICC training online, PHSA has the capacity to provide foundational cultural competency training to all 100,000 health care workers in the province.

The objectives of the ICC training are to increase knowledge, enhance awareness, and promote the development of cultural competency skills in learners, and to develop culturally safe health care environments. Participants proceed through online courses in cohort groups with the support of a facilitator. The curriculum is interactive and based on transformative learning models. The training gives participants an opportunity to learn about the present-day experiences of Indigenous people and historical experiences that continue to affect psycho-social determinants of health for this population; to self-reflect, and recognize and undo unconscious biases and stereotypes; and to draw on leading evidence-based cultural safety practices to develop new approaches for health service delivery that can be implemented in the real-world context of their work environment.

The combination of a custom-designed online training platform (incorporating a wide range of materials and activities that engage people with a variety of learning styles) and guidance from highly skilled and knowledgeable facilitators enhances safety and responsibility for learners, and offers an ideal environment for both learning and unlearning. This has been a critical component of the program’s success. Participants have described feeling shock, horror, disbelief, and anger as they learned about the history of Indigenous Peoples in Canada. Some wonder how they could have performed their jobs without knowing and understanding the ongoing effects that this history has on the health status and health experiences of Indigenous people. In the safe learning environment of ICC training, participants are able to recognize their own connections to that history and its implications for practice, take the time and space they need to reflect on and process what they are learning, and deepen their understanding through interactions with other students in their cohort and the facilitator. PHSA has also recognized that while its core training programs have been very successful in meeting the learning needs of non-Indigenous people, Indigenous learners have distinct needs, particularly with respect to cultural safety during the learning process. To support these needs, PHSA has established a protocol through which Indigenous learners can complete the training in cohorts in which all participants are Indigenous people, and have access to both facilitators and an Elder throughout the training.

PHSA understands that cultural competency is developed through a lifelong learning process, and the ICC foundational courses as only the first leg of that journey. PHSA is launching a post-training website where graduates will be able access supporting resources for each module, connect with Elders, and continue their relationships with the facilitation team. The ICC training
addresses some of the more challenging and fundamental issues (such as the residential school system, Indian hospitals, and the historical legacy of inequality and inequity) that affect all First Nations in British Columbia. It lays a strong foundation that regional health authorities and health organizations can build on by providing additional training that reflects more local needs, including teachings from First Nations people in the region they serve. As Cheryl Ward observed, “We’ve heard about people going in to do training and asking inappropriate, disrespectful, and hurtful questions. We want to give them the information they need to not ask those questions, so that when they learn from First Nations or other Aboriginal people, they can do so in a respectful way.”

The ICC training has been extremely successful. Completion rates for trainees are very high, demand for the training is growing, and internal and external evaluations have indicated that the curriculum, content, and facilitation meet learners’ needs. PHSA has also gathered considerable anecdotal evidence of the positive impacts of the training. Participants who have completed the training have reported that it has helped transform both their own practice and practice within their units. In addition to the core ICC health training course for health professionals and the core ICC for allied professionals, PHSA offers a core ICC mental health training module, and is currently developing new modules. These include modules on decolonizing anti-racism (which will equip learners with tools for anti-racist action) and narratives and counter-narratives (which will tackle pervasive harmful narratives about Indigenous Peoples that are circulated through, for example, the media, education system, criminal justice system, and everyday interactions among Canadians). PHSA is also consulting with colleagues in two other provinces who are interested in establishing similar activities.

The success of the ICC training program is related to several key factors, including (as already noted) the 2006 Transformative Change Accord: First Nations Health Plan, and the unique structure of the training. The process through which the training was developed has also played a critical role in its success. The provincial lead for ICC training assembled a skilled team to develop and implement the program. Early in the development process, Indigenous scholars, academics, front-line people, community members, and thought leaders came together to form a provincial think tank that explored what the training should be and how it should be developed. PHSA drew on that guidance as they laid out the syllabus. Other Indigenous and non-Indigenous leaders in health have supported the program from its inception, stepping up to contribute at various points throughout development and implementation. Strong leadership from PHSA’s senior management team (including Leslie Arnold, PHSA VP and President of BC Mental Health & Addiction Services, the project’s executive sponsor, and Leslie Varley, Director, PHSA Aboriginal Health, under whose direction the training program was developed) has also been invaluable to the program’s success.

Once the training package took shape, a year was devoted to piloting, evaluating, and refining the training before it was finally rolled out. Since the ICC program began formally delivering training, the facilitation model and facilitation team members have proven to be “must haves” for program success. The facilitation model used in the training is one of its unique features. The model includes protocols to guide, assess, and respond to the online interaction of students, and tools to support collaboration among facilitation team members and enable them to work effectively with the large volume of learners. The facilitators consistently demonstrate their commitment to participants’ learning, to the goals and objectives of the ICC training program, and to the social justice ends that the training will help achieve.

Additional information about the PHSA Indigenous Cultural Competency Training Program is available online at www.culturalcompetency.ca, or from Cheryl Ward, Provincial Lead for Indigenous Cultural Competency Training (cward-02@phsa.ca).
The Interior Health Authority (IHA) in British Columbia has made significant changes to the way it plans, delivers, and governs health services, following through on a long-standing commitment to make health care services and programs more accessible and appropriate for Aboriginal people and, ultimately, to improve the health status of that population.

Aboriginal people constitute nearly 7% of the population in IHA’s service region, home to 55 First Nations and 13 Métis Chartered Communities. IHA recognizes that the gap between the health status of Aboriginal people and other residents cannot be closed without also addressing inequities in health determinants, collaboration with Aboriginal people to identify and develop health care solutions that will meet their needs, and change across IHA’s care and service continuum. The organization, working in partnership with First Nations, Urban Aboriginal, and Métis people, has developed and implemented the Aboriginal Health & Wellness Strategy 2010–2014. The strategy set goals in five strategic areas:

- Develop a sustainable Aboriginal Health Program. Action in this area includes ensuring that services are aligned between a new province-wide First Nations Health Authority (to be fully operational in July 2013) and Interior Health, contracting with Aboriginal communities to provide programs and services identified by the communities, and standardizing Aboriginal Patient Navigators positions.
- Ensure Aboriginal people’s access to integrated services. Action in this area includes advocating for services that meet community-identified needs, considering the implications to and for Aboriginal people and communities in strategy development and implementation, and recruiting and retaining Aboriginal employees.
- Deliver culturally safe services across the care and service continuum. Actions in this area include providing Aboriginal Patient Navigators, providing space for sacred or ceremonial activities, integrating cultural practices in the provision of care, and having staff participate in the provincial Indigenous Cultural Competency Training program. IHA brings a cultural safety lens to its activities, emphasizing its responsibility to provide inclusiveness, accessibility, adaptability, acceptability, and accountability to all people in the region.
- Develop an information, monitoring, and evaluation approach for Aboriginal health. Action in this area includes implementing a voluntary Aboriginal self-identification initiative for both clients and employees, monitoring key performance indicators, and evaluating selected initiatives.
- Ensure ongoing and meaningful Aboriginal participation in health care planning. Action in this area includes establishing formal relationship documents with local First Nations, and engaging the community through the Aboriginal Health & Wellness Advisory Committee (a subcommittee of IHA’s board of governors that has 14 members from First Nations, Métis, and urban Aboriginal communities).

Interior Health’s ability to make system-wide changes was enhanced significantly when, in 2007, the Aboriginal Health Transition Fund (AHTF) provided support to a three-year project that enabled IHA to bring Aboriginal Patient Navigators on staff, add staff positions to its Aboriginal Health program, begin the self-identification initiative, and develop Aboriginal human resources policy. These activities generated momentum for change, and when AHTF support ended, IHA allocated funding in its own budget to sustain positions and activities developed through the project.
IHA’s transformation is inseparable from the context in which it is taking place—the 2007 Tripartite First Nations Health Plan (TFNHP), signed by the First Nations Leadership Council of BC, the Province of BC, and the Government of Canada. The plan recognizes Aboriginal rights and title, and formalizes a commitment to implement a First Nations health governance model in the province (with a new First Nation Health Authority operational in July 2013). The plan also includes 35 action items for which the parties share responsibility (more information on the TFNHP can be found at http://www.healthcouncilcanada.ca/tree/Aboriginal_Report_EN_web_final.pdf#page=30).

IHA has taken action in several areas to comply with TFNHP and with its own strategy. Aboriginal Health has been established as a core program of IHA’s Community Integration program, expanding its influence on activities. IHA has moved more employees through the Indigenous Cultural Competency training program than any other health authority in the province, and the baseline data that IHA collects through the Aboriginal self-identification initiative for employees have improved its ability to recruit and retain Aboriginal employees.

The client Aboriginal self-identification initiative will provide an evidence base for further change. When fully implemented, the initiative will enable IHA to track individual clients through their service experience. Data describing the experience of Indigenous clients will be anonymized and shared with local First Nations to support planning processes. Over the long term, the data will help First Nations evaluate the impacts of their own health investments on, for example, community members’ use of hospital services.

IHA is well prepared for the introduction of the First Nations Health Authority. IHA has already signed Letters of Understanding (LOUs) with two of the seven First Nations in the region, and is in the process of establishing similar relationship documents with the other five. The LOUs acknowledge inherent Indigenous rights, and empower the First Nations to work directly and as equal partners with IHA. The seven First Nations and the Métis Nation of British Columbia are forming a regional executive table, with which IHA will also work collaboratively.

One of IHA’s most significant strengths—and challenges—in the transformation process has been its relationships. IHA has established strong relationships with its Aboriginal partners, but recognizes that there is still work to be done. IHA rightly acknowledges that sustainable change to health outcomes cannot happen without change to determinants of health, a process that will require IHA to develop new relationships with municipalities and organizations that are mandated to address determinants. As one manager stated, “Relationship management is crucial and understanding what that means in an Indigenous context is vital…. It’s really understanding what ‘All My Relations’ means in an Indigenous sense.”

**CONTACT INFORMATION**

Additional information on IHA’s Aboriginal Health Program and the Aboriginal Health & Wellness Strategy, 2010–2014 can be found at www.interiorhealth.ca/YourHealth/AboriginalHealth/Pages/default.aspx.
All Nations’ Healing Hospital (ANHH)

The All Nations’ Healing Hospital (ANHH) in Saskatchewan offers a new model for collaboration in health service delivery, straddling cultural and jurisdictional boundaries to offer a full range of services. ANHH serves all community members in Fort Qu’Appelle and the surrounding region, which lies within the traditional territories of the 35 Treaty 4 First Nations. ANHH’s model, which has drawn national and international attention, is unique in its approach to service delivery, governance, and funding.

ANHH brings a holistic and integrated approach to health care delivery to address the health needs of the whole person. ANHH’s clients can access on-site both traditional health and wellness services and supports (including access to ceremonies, Elders, and helpers) and conventional Western treatment and care. ANHH provides services to clients across the continuum of care, including on-site acute and palliative care, diagnostic and emergency services, physicians’ and visiting specialists’ services, a Women’s Health Centre, maternal child health services, CRI clinics, and telehealth services. The hospital is also home to the First Nations Health Service department (which provides community health programs ranging from home and community care through child development, nutrition, and health education to water quality testing for 11 First Nations), and to the White Raven Healing Centre (which provides clinical counselling and other integrated services to address mental health and addiction-related needs, and cultural services within both the hospital and the community). Both of these organizations are overseen by the File Hills Qu’Appelle Tribal Council.

The physical environment at ANHH reflects the hospital’s commitment to a holistic and integrated approach. The facility is designed in a culturally sensitive way, with the First Nations Health Service and White Raven enclosed in a circular wing of the building. Acute care, emergency, and operations are each housed in one of three wings that radiate from the centre of the circular structure. The structure of the building represents the integration of traditional health and wellness and Western medical practices. Interior design elements evoke the earth, water, and fire, and the connection between mind, spirit, body, community, and land. Areas of the facility and grounds have been reserved for traditional health and wellness activities, including a Ceremony Room (where smudge and other ceremonies can take place), a Winter Lodge (where sweat lodge ceremonies are held several times a week), a Medicine Room (where traditional medicines can be processed and shared), and an Elders’ Suite (where Elders may hold ceremonies, or simply rest while they are on site).

ANHH is one of the first hospital or health care facilities in Canada owned and operated by First Nations’ governments. It opened in 2004 on tribal land in the town of Fort Qu’Appelle. Fifteen First Nations, represented by the File Hills Qu’Appelle Tribal Council and Touchwood Agency Tribal Council, own the hospital. The Board of Governors overseeing the hospital includes representation from the First Nations’ leadership and the local municipality. The process of establishing tribal control of the hospital began in the early 1990s, a time when the federal government was actively exploring options for increased First Nations control of health service delivery. When it became clear that the 70-year-old Fort Qu’Appelle Indian Hospital needed replacement, the Chiefs of the First Nations and Tribal Council were ready to take leadership in the development of the new facility.

ANHH is an affiliate of the Regina Qu’Appelle Health Region (ROHR), and under this arrangement ROHR (and, indirectly, the Government of Saskatchewan) is responsible for funding all acute care costs. Since 2006, a unique agreement between the two Tribal Councils and the Government of Canada has also been in place, providing federal funding to support ANHH’s traditional and cultural services. The federal government also provides funding to support the First Nations Health Services department and the White Raven Healing Centre.

ANHH’s unique governance structure and, in particular, its ability to bring the federal and provincial governments together as partners gives the hospital an unusual capacity to engage in innovative, creative activities, including the provision of holistic, integrated services. ANHH has considerable flexibility in service delivery and the hospital can monitor and respond quickly to the needs of the people and communities it serves. For example, after a 2007 needs assessment on maternal child health revealed that women in the region were not fully accessing available services, ANHH secured funding from Health Canada and other partners to enhance access by establishing a Women’s Health Centre. A full range of services, including midwifery, are available at the centre. ANHH has developed a horizontal, multi-disciplinary approach to care. Doctors, nurses, midwives,
practitioners, mental health therapists, diabetes educators, nutritionists, and other service providers work as a team to provide patient-centred wrap-around care. From a patient perspective, this approach has succeeded. Community members have let staff know that they are more comfortable coming to ANHH than to other facilities, and client and patient feedback gathered through activities such as a quality improvement survey indicate high levels of satisfaction.

ANHH counts among its successes its ability to recruit and retain professional, paraprofessional, and nonprofessional staff. As one staff member commented, “We don’t have to go out looking. They come to us.” This may be, in part, because ANHH is a teaching facility, hosting practicums and mentorships for students in health-related programs. ANHH, in partnership with health-related programs at Saskatchewan universities and colleges, RQHR, on- and off-reserve schools, and other organizations, has established a Pre-Health Professions Club, offering career development experiences to students at secondary schools in the region.

ANHH has grown rapidly since its start in 2004. In the last five years, the number of people accessing emergency services has doubled. The midwife at the Women’s Health Centre has a caseload of 80 to 90 women, far more than any other midwife in the province. Even while ANHH is growing, two other hospitals in ANHH’s broader catchment area have lost physicians and reduced services. This rapid growth presents new challenges to ANHH. It has outgrown its space, which limits its ability to develop new programs. With no federal or provincial money available for capital improvements, ANHH must now explore options for delivering programs and activities off site.

ANHH recognizes that its current success—and its ability to manage its current and future growth—is very much about people and relationships. Excellent staff, strong leadership, and willing partners have been “must-haves” for ANHH. Communication plays a crucial role in preserving, strengthening, and building on the trusting and collaborative relationships it has developed with its partners. ANHH’s senior management meets regularly with the Board, and with Health Directors of the First Nations and Tribal Council. The organization works hard to attain the objectives and goals it has set for itself and consistently strives for quality improvement, assessing its activities and looking for ways to make them better for clients and staff. In 2011/12, ANHH received accreditation with “exemplary standing” from Accreditation Canada.

CONTACT INFORMATION

Additional information about ANHH is available online (http://www.fortquappelle.com/anhh.html) or from Gail Boehme, Director of ANHH & Health Services, File Hills Qu’Appelle Tribal Council (gboehme@fhqtc.com).
Most often, service providers are considered “experts” on what’s best for the people they serve. When a problem arises, they develop a program. This can be a recipe for apathy and non-compliance, as well as a poor use of resources. It is critical that the people receiving services have an active voice in clarifying issues, determining solutions, and developing and evaluating programs. Taking the time and flexibility needed to build trust and relationships—particularly with a population that has come to distrust the system—pays huge dividends. Recognizing that individuals have their own priorities and using a holistic approach helps make practitioners more sensitive to where clients are in their lives and their ability to absorb, comprehend, and take action to effectively address health issues.

– Dorothy Lloyd, Eagle Moon Health Office, Regina Qu’Appelle Health Region

The Regina Qu’Appelle Health Region’s (RQHR) Aboriginal Home Care program has demonstrated the value of a holistic, patient-centred approach to service provision for urban Aboriginal people.

The Aboriginal Home Care program began after RQHR’s Home Care Services recognized that while First Nations and Métis people constituted a significant proportion of the population they served, very few Aboriginal people were accessing Home Care Services. In partnership with RQHR’s Eagle Moon Health Office, Home Care Services brought together RQHR managers, First Nations and Métis Elders, knowledge keepers, and health workers to form a working group tasked with identifying why the service gap existed and how it might best be addressed. Based on the working group’s findings and with financial support from the Aboriginal Health Transition Fund, Home Care Services developed and implemented the Aboriginal Home Care program.

The program’s aim is to improve access to home care services by developing and implementing comprehensive, culturally sensitive, and holistic services, and by improving screening, early detection, and management of chronic disease (in particular, type 2 diabetes and foot care complications) for Aboriginal people. The program has transformed service delivery to First Nations, Inuit, and Métis people, introducing changes that have included:

- strategic relocation of the home care team to offices in the North Central neighbourhood in Regina (where a significant proportion of residents are Aboriginal) along with decentralization of files and referral intake;
- introduction of a position for a community liaison worker. This position is currently filled by an Aboriginal woman who skilfully navigates both traditional and Western ways, builds and strengthens relationships in the community (including relationships between health care workers and their clients), and has helped build community members’ trust and confidence in home care services;
- access to traditional healers, as well as increased understanding of and sensitivity to Aboriginal cultural knowledge and practices;
- enhanced case management services, enabling more timely and effective assessments of and responses to clients’ needs and returning clients to a more active role in caring for their own wellness;
- flexibility in scheduling, to support client-centred care;
- development and introduction of a holistic assessment tool, used alongside a standard comprehensive assessment tool. Holistic assessment enables practitioners and clients to consider all aspects of well-being (physical, mental, spiritual, and emotional) and clients’ self-identified needs, which has increased communication, trust, and compliance. Attention to clients’ emotional and spiritual needs enables clients to draw on their own internal resources and find the strength and motivation to move forward on their path to wellness;
- increased focus on client education that, where possible, engages family and other people who are significant to clients. In this way, clients and their significant others become more deeply involved in the care process;
enhanced foot screening, care, and referral services;
• enhanced resources to support referrals and links between urban and rural/on-reserve services, thus improving
follow-up and continuation of care and treatment;
• establishment of a steering committee (which evolved out of the original working group) that monitors and provides
guidance to program activities and consistently seeks input and feedback from community Elders and Healers
throughout the program; and
• training for staff members to enhance their cultural awareness and cultural competency, along with weekly talking circles
at which the on-site team can debrief and share knowledge.

The care experience for clients accessing services through the Aboriginal Home Care program has changed profoundly. Clients
now access holistic, patient-driven care. When they identify and voice their needs, service providers are ready to listen.
Clients have a more active role in the “what” and “how” of the care they receive. For practitioners, the program enables them
to bring services to a sector of the population that had previously been underserved. Training activities and resources
developed for the program have enhanced practitioners’ skills and capacity, and the emphasis on consistency in team
members has enhanced cohesiveness, communication, and relationships, improving the scope and quality of care the team
members provide.

The impacts of the Aboriginal Home Care program are assessed quantitatively and qualitatively. An increasing proportion of
individuals in the region who qualify for home care are accessing the services they need. As a group, clients who access
services through the program are demonstrating more positive attitudes, increased participation, and increased compliance
compared with what typically occurred before the program was introduced.

To a considerable extent, the success of the Aboriginal Home Care program has come from its many internal and external
partnerships and working relationships. RQHR’s Eagle Moon Health Office (which works with departments in the health region
to make service delivery more effective in meeting the needs of First Nations and Métis people) partnered with Home Care
Services in the earliest stages of needs assessment and planning, and has provided knowledge, guidance, and support through
development and implementation. The program also collaborates with RQHR’s Native Health Services, urban and rural home
care managers, and RQHR’s research department. The executive director of Home Care Services has consistently
championed the program, and having someone in a senior management position committed to the program and empowered to
make change has been invaluable. External partners supported the creation of an online directory of services, which has greatly
enhanced practitioners’ ability to make timely and appropriate service referrals for their clients. Aboriginal community members
have also played a key role. By sharing their perspectives and insights on how they experience care, clients have contributed
significantly to Home Care Services’ ability to adapt services to meet the real-life needs of Aboriginal people and communities.

CONTACT INFORMATION:

Additional information about this program is available online at

External Source: http://www.healthcouncilcanada.ca/rpt_det.php?id=437
Aboriginal Support Workers, Southern Regional Health Authority

In Manitoba, the Southern Regional Health Authority’s (Southern RHA’s) Aboriginal Health Services has demonstrated that patient navigators can be central to the process of transforming relationships between health care practitioners, the health care system, and the First Nations, Métis, and Inuit people and communities they serve.

The Southern RHA was formed in 2012 through the merger of two existing health authorities, the Regional Health Authority—Central (RHA Central) and the South Eastman Health Authority. In the region Southern RHA serves, approximately one of every 10 residents is an Aboriginal person. In 2008, after community health assessments confirmed significant disparities between the health status of Aboriginal people and other residents of the region, RHA Central collaborated with local First Nations, Métis, and urban Aboriginal organizations on an initiative to adapt their system to make it more culturally appropriate for, navigable by, and capable of meeting the self-identified needs of Aboriginal people. Supported by the Aboriginal Health Transition Fund, the project enabled RHA Central to create two positions for Aboriginal Support Workers (ASW) within Aboriginal Health Services (AHS). The first ASWs began working out of the Portage District General Hospital (PDGH) in January 2009.

The ASWs are highly accessible and visible at PDGH and in the community, and available seven days a week. They circulate throughout the hospital, join the medical team for rounds, stop in at patients’ rooms for a check-in, assist clients as they arrive at the Portage Hospital and guide them through the admissions and triage process in the emergency department, and visit with residents at personal care homes. Their presence has greatly enhanced Southern RHA’s capacity to provide culturally appropriate health services. Clients can now request ceremonies or other traditional healing practices and, for example, within minutes of a request, the ASWs can arrange a smudge ceremony for a patient at PDGH. When the ASWs visit personal care homes, they are often joined by local Elders who facilitate monthly sharing circles and other cultural activities for residents. As Doretta Harris, Regional Director of AHS and a former ASW observed, “The residents yearn for their culture and traditions—and since they can’t get back to their community, we try to bring the community to them.”

The ASWs and AHS work closely with health practitioners and other staff in the RHA to ensure that Aboriginal clients can access the health care services they need. They have collected and developed culturally specific and culturally appropriate resources (available in local languages, including English, French, Ojibwe, and Dakota), offering information to support Aboriginal clients’ ability to access existing services. For example, AHS is collaborating with Aboriginal partners and Southern RHA staff to provide translation for signage about the triage process that will be posted in emergency departments. Content in the patient handbook given to all clients who use hospital facilities has been translated into Aboriginal languages. This information will help dispel the frequent assumption that the order in which clients receive treatment in emergency departments is influenced by cultural identity or race.

The emergency department’s triage process is only one of many sites within health systems where cultural conflicts can arise. The ASWs and AHS have played a major role in decreasing these conflicts. The ASWs often act as interpreters for clients and health practitioners, facilitating conversations between English, French, Ojibwe, or Dakota speakers. However, their communication skills extend well beyond language interpretation. They have also taken responsibility for interpreting meaning. One example of these valuable interventions involved surgical staff at PDGH who had contacted AHS because they were concerned about a client who had missed several appointments for a surgical procedure. The ASW participated in a meeting with the client and surgical staff, and as they talked, it became clear that the client did not understand what the procedure involved, but had imagined the worst. The client had been too afraid to show up for the surgical appointment, and delaying the surgery was having a negative effect on his well-being and daily life. When the ASW was able to interpret and explain the procedure, the client’s fears were alleviated. The next day, the client asked the ASW to accompany him to the appointment, and the surgery took place.

In this story, the client could not understand the surgical staff. The ASW was able to take the information the surgical staff had tried to share and communicate it in a way that made sense to the client. Physicians and other care providers have come to rely

healthcouncilcanada.ca/innovativepractices
on the ASWs, because they recognize that the ASWs have the trust of Aboriginal clients. In turn, the ASWs demonstrate to clients through their interactions with staff that they, too, are trustworthy, and this can help patients and physicians develop more confident, trusting relationships.

The ASWs are connectors. They have built strong, reciprocal working relationships with practitioners that enable collaboration in service delivery, and are valuable to all parties. Emergency medical services workers are able to contact the ASWs directly to request that they meet an Aboriginal client being brought into emergency. The ASWs are able to participate in clients’ planning meetings, and they connect with providers in clients’ home communities to make sure that clients will be linked to whatever services they might need when they return. Medical personnel recognize and appreciate that through these relationships they have increased their own cultural knowledge and cultural competency. The ASWs appreciate the extra efforts that are made to support their clients, improving the quality and continuity of care for their clients. Together, these relationships support patient-centred, patient-driven care and help create a culturally safe health care experience for Aboriginal clients.

An external evaluation completed in 2010 affirmed the important contributions the ASWs have made to the cultural competency of staff and to the care experience and cultural safety of Aboriginal patients. Communication, relationships, and collaboration have been key to the success of the ASWs and Aboriginal Health Services. The ASWs first appeared as part of a project undertaken in partnership with Aboriginal organizations, and the ASWs and AHS have maintained, strengthened, and built upon those relationships. They look to community leaders and community members for feedback, guidance, and direction, and find new ways to engage the participation of Aboriginal people. They recognize that the diverse perspectives that broad and deep engagement provides can only enhance and strengthen their own capacity.

The most significant challenges the program has faced have related to funding—in particular, whether funding can match the growth in demand for the ASWs’ services. AHTF funding supported the ASW positions for their first three years; since then, the RHA has allocated permanent funding to support the positions. The RHA’s commitment to support Aboriginal people, and the unwavering support (through initial planning and development stages to the program’s implementation and delivery) from the organization’s CEO, senior management, and board of directors have been “must haves” for success.

The commitment to a shared responsibility to improve health experiences and health outcomes for Aboriginal people has filtered throughout Southern RHA. As Doretta Harris acknowledged, “We all have a responsibility for the health of our patients. Patients share that responsibility too. We help them understand their own role in the healing journey, and discover their own ability to help themselves.”

CONTACT INFORMATION

For additional information on the Aboriginal Support Workers and Aboriginal Health Services at Southern Regional Health Authority, please feel free to connect with the office of Southern RHA’s Regional Director of Aboriginal Health at (204) 239 2304 or dharris@rha-central.mb.ca.