



Ontario's Aboriginal
Health Access Centres
Centres autochtones d'accès
aux soins de santé de l'Ontario

Bringing Order to Indigenous Primary Health Care Planning and Delivery in Ontario

*AHACs and Aboriginal CHCs Response to Patients First: A
Proposal to Strengthen Patient-Centred Health Care in Ontario*

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I. Overview of Aboriginal Health Access Centres (AHAC)s:

Introduction

On behalf of the ten Aboriginal Health Access Centres (AHACs) and three Aboriginal Community Health Centres, we commend you on *Patients First: A proposal to strengthen patient-centred health care in Ontario*. Thank you, Miigwetch, Na:wen for the invitation to provide thoughtful input to your four proposals, structures and systems governance questions. We also appreciate your commitment to engage with Indigenous partners about how this process can complement the Ministry of Health and Long Term Care (MOHLTC) and the Government of Ontario's ongoing work to strengthen health outcomes in First Nations, Inuit and Métis (FNIM) communities on reserve and in rural and urban settings.

The AHAC and Aboriginal CHC ED Circle is determined to contribute to this pivotal engagement process and ongoing health system transformation. We collectively applaud your promise to put people at the center of your decisions, improve seamless linkages between primary care and other services, and the recognition that the needs of Ontarians are better served, through a health equity lens and inclusive of determinants of health. We also welcome the focus on more consistent and accessible home and community care and stronger links between population health, public health and other health services as these are all sectors which continue to experience challenges in delivering high quality, culturally appropriate and culturally safe services to FNIM communities on reserve and in rural and urban settings.

About AHACs and Aboriginal CHCs

AHACs grew out of one of the largest Indigenous consultations in Ontario's history in the early 1990s about how to improve Indigenous health. The Ontario Aboriginal Health Policy set out a holistic framework which includes three interrelated concepts: Indigenous knowledge of the life cycle, Indigenous concept of holistic health and the continuity of care from health promotion and prevention to rehabilitation. The framework identifies three strategic directions:

- Improving health status including health promotion and wellness, illness prevention, lowering rates of diabetes, complications from diabetes and mental illness, long-term care and disability;
- Access to services including care coordination, transportation, language translation, advocacy, health care facilities and traditional healing services; and
- Planning and representation including Indigenous driven and managed health planning processes, and improved accountability to Indigenous communities around Indigenous representation within government planning processes and public appointments.

The Ontario Aboriginal Health Policy remains relevant today as a framework and roadmap for Ontario and should be updated and complied with. We continue to show evidence that it is a successful framework to address the intergenerational impacts of colonization, the legacy of the residential schools, sixties scoop, millennium scoop and the community stress within

Indigenous communities. Additionally the framework maintains the integrity of Indigenous rights to determination in health and strengthening Indigenous informed health models of care.

In order to help guide providers, planners and funding agencies in their work with Indigenous peoples, in 2015 the provincial AHAC Executive Director Circle again adapted the *Ontario Aboriginal Health Policy* principles to create *The Guiding Principles for Decision Making for Aboriginal Health and Wellness Services*. These include:

1. Respecting Indigenous approaches to health and wellness
2. Controlling health planning and ensuring equitable resourcing
3. Self-Determination
4. Self-Governance
5. Ownership Control Access and Possession (OCAP) principles must be respected and guide all research with Indigenous people

Additionally, the AHACs have redesigned the *AHAC Model of Wholistic Health and Wellbeing: A Time for Reconciliation*, (see Appendix A), which was adapted from Ontario's *Aboriginal Healing and Wellness Strategy* (AHWS) wholistic framework.

The AHAC Model in the primary health care provision for the Indigenous population has provided some significant improvements both in delivery of and access to primary health care for Indigenous people across Ontario. These outcomes reflect local strategic planning and delivery of services and relationship building. The following sections outline some of reasons for these achievements.

AHAC Model is an Indigenous Solution that Gets Results

As primary health care agencies, during 2013 and 2014, AHACs had over 102,000 clinical encounters per year. There were over 50,000 unique clients accessing primary and traditional Indigenous health care and client's averaged 6.72 visits per year. AHACs serve some of the most socially and medically complex Indigenous clients with a range of SAMI scores from 1.17-1.61.¹

Approximately eighty percent of First Nation communities in Ontario have had First Nations member's access AHAC services. (Ontario AHAC, 2015, p.5) AHACs also deliver primary health care and work in collaboration with urban Indigenous communities throughout Ontario within Indigenous Friendship Centres and Métis communities to increase access to health services. New investments in AHACs would enable the sector to extend, culturally safe access to primary health care to the Indigenous population where there are current gaps.

AHACs are primary health care agencies with integrated, interprofessional care teams which blend western and Indigenous practices and places Indigenous cultures at the centre of

¹ The SAMI score measures health complexity and expected utilization rates. The average person in Ontario would have a SAMI score of 1.

everything they do. Early data indicates that AHACs also contribute substantively in helping Ontario lower emergency room visits, diverting people from emergency departments that are best served elsewhere, we follow up clients quickly after hospital discharge and help keep people well at home longer. AHACs also offer same day and next day appointments and are providing comprehensive cancer screening, chronic disease management and culturally safe health education and promotion. AHACs also recognize “culture as treatment” in addressing the underlying causes of poor health and rebuilding strong, healthy Indigenous communities. We should all focus on accelerating these Indigenous health gains across the province.

The AHAC Model is an Indigenous solution that gets results. Therefore, the Province must get serious about supporting AHACs to gain operational funding equity, and to thrive and grow to ensure all First Nations, Inuit and Métis (FNIM) people on reserve and in rural and urban settings are connected to culturally safe, primary health care provision.

Our Stories: Leading Practices and Innovations at AHACs/Aboriginal CHCs

N’Mninoeyaa AHAC: Example of AHAC Model fully optimized as a regional, full service provider

The N’Mninoeyaa AHAC is a great example of the *AHAC Model of Wholistic Health and Wellbeing*. The N’Mninoeyaa AHAC provides culturally safe primary health care, traditional health and healing, mental health and addictions and overall regional management of Community Support Services in the areas of care coordination, Occupational Therapy, Physiotherapy, Rehabilitation Assistants, Assisted Living for High Risk Seniors Program, systems navigation, hospital discharge planning, and other home and community care services on an outreach and collaborative basis with seven First Nations communities and one urban Indigenous community. A partnership with the local Indian Friendship Centre ensures that the urban Indigenous population is well-served in all areas of health care reference above, through locating and supporting health care services out of the Indian Friendship Centre facility. This Indigenous regional health management organization ensures recruitment and retention of quality health professionals who are continually supported in providing accessible, high quality, culturally safe care. This organization also follows best practice in accountability to Indigenous patients and communities and respects Indigenous treaty rights and rights to determination in health, as outlined in Ontario’s Aboriginal Health Policy.

Shkagamik-Kwe Health Centre: Woven Blanket concept - Example of Integrating western clinical best practice with traditional Indigenous healers and healing approaches

All AHACs and Aboriginal CHCs integrate western best practices with traditional healers and traditional Indigenous approaches. However, SKHC has designed a model incorporating a cultural symbol, the Blanket. Blankets are woven deep into Indigenous history and cultures. The Woven Blanket Model of Care at SKHC involves the mutual commitment by all team members to work towards the shared goal of improvement in the overall health of an SKHC client. The relationship that the SKHC team has with the client is to support the person to take a major

degree of responsibility for his or her care. As part of the “Woven Blanket Model of Care”, the partnership is a genuinely equal one with no helper being subservient nor superior.

The “Woven Blanket Model of Care” reinforces a client focused approach and recognizes that clients can determine who are their helpers in their care and can include professionals, SKHC team members and volunteers, other community services and friends and families. The SKHC community offers a unique opportunity for Indigenous people to connect with other families and community members in an urban context. The broader community offers endless benefits for individuals and families to support them in their development.

In this model of care, team members have flexible roles so they can “cross cover” and “back up” others when required so when a client’s principal provider or any other team member is away, another provider from the team fills in. This prevents a client from being “orphaned” should their principal provider cease practicing.

Similar to other primary health care models, clients have a principal primary health care provider (e.g. nurse practitioner, physician assistant or physician), but there are no “my clients” or “your clients,” only “our” team. The Centre’s Traditional and Four Directions Mental Wellness Programs are essential components of the team, ensuring that clients and families receive wholistic and comprehensive care.

Unique to the Woven Blanket model are the “Client Navigators”. In addition to coordinating an individual’s care, they are the “point people” for communication and advocacy. The “Principal Providers” and other team members are resources to be called on by the Navigators. Regular team meetings, involving the Traditional, Four Directions Mental Wellness and the Clinical Programs, are conducted in a case management fashion. Priority cases will be discussed in the circle of care thereby allowing team members to become aware of the issues and to offer their unique resources and suggestions.

Most significantly, the Woven Blanket model offers a culturally safe environment that respects traditional values and embraces an individual’s unique needs within the context of their family and community.

De dwa da dehs nye>s AHAC: Homeward Bound – Innovation in addressing determinants of health through collaboration

The new urban Indigenous population health data through the Our Health Counts project identified a 13% rate of homelessness amongst the urban Indigenous population in the City of Hamilton (Smylie & Firestone et al, 2011, pg. 36). Based on this information De dwa da dehs nye>s embarked on a collaborative homeless program and recently participated with the City of

Hamilton's 20,000 Homes Campaign Point in Time Count Survey, which found that 28% of Hamilton's homeless population are of Indigenous ancestry.²

The AHAC collaborated with multiple local, municipal, provincial and federal partners and adapted the Homeward Bound program to the Indigenous community within Hamilton. The goals of the program are to house chronically and episodically homeless individuals and to prevent homelessness. Program staff are a highly collaborative team with outreach, wellness and cultural workers and clients are treated as a member of the collaborative team working towards sustainable, long-term solutions for them and their families. Clients also have access to primary health care and mental health and addictions services at De dwa da dehs nye>s AHAC.

The innovative program began in April 2015 and will have already housed 40 people by April 1, 2016 and is currently supporting over 130 individuals in the community.

Waasegiizhig Nanaandawe'iyewigamig: Northern and remote oral health innovation and travelling primary healthcare provision

Waasegiizhig Nanaandawe'iyewigamig (WNHAC) provides comprehensive primary health care services to ten First Nations with twelve points of service in northwestern Ontario as well as the urban Anishinaabe and Métis population in Kenora. Uniquely, WNHAC provides a broad spectrum of children's oral health services to 9 of the 10 First Nations it serves.



Waasegiizhig Nanaandawe'iyewigamig AHAC Primary Health Care Providers

In order to facilitate access to primary healthcare services for the whole catchment population including remote communities, all of Waasegiizhig Nanaandawe'iyewigamig's health care providers travel regularly to each community. Each community has weekly Nurse Practitioner (NP) clinics, and at least monthly visits from other clinicians. In 2014-15 the clinicians (5 NPs, 4 diabetes clinicians, 2 RPNs, and 2 Community Health Nurses (CHNs) travelled a total of 169,940 KMs to carry out 1,124 community clinics. Eight health promoters, including the oral health care providers traveled 79,580 KMs to complete 210 events in communities.

The oral health program began in 1999 as a pilot project in response to communities' concerns about the many young First Nation children undergoing traumatic and expensive surgical extractions of baby teeth at the local hospital. Waasegiizhig Nanaandawe'iyewigamig's initiative

² The City of Hamilton's February 21-22, 2016 count can be viewed here: <https://www.hamilton.ca/social-services/housing/20000-homes-campaign>

informed Health Canada's Children's Oral Health Initiative (COHI). (Ontario's Aboriginal Health Access Centres, nd, p.30) Today Waasgegiizhig Nanaandawe'iyewigamig provides a broad spectrum of preventative oral health services to First Nations children including pit and fissure sealants (PFS) and interim stabilization therapy (IST) in addition to fluoride varnish, education, screening, and referral. When resources permit, oral health screening is also provided for diabetes clients and cancer screening is also carried out. As a wholistic primary care provider, WNHAC is proud to provide dental services as an integrated part of health care delivery.

Southwest Ontario Aboriginal Health Access Centre (SOAHAC) – Extending primary health care and traditional healing services across small, rural First Nations and with Indigenous Friendship Centres and Métis Communities

Fully accredited through the Canadian Centre for Accreditation (CCA), the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) is an Indigenous community-governed, primary health care agency that blends western and Indigenous healing approaches. SOAHAC has 70 staff serving 35,000 Indigenous people in 13 communities along the London-Windsor corridor and into the Grey Bruce, Owen Sound areas of the province. SOAHAC is *status blind*³ and operates four primary health care sites: London, Chippewas of the Thames First Nation, Owen Sound and Windsor, and outreach clinics to four rural, southern First Nation communities.

Part of SOAHACs integrated care model means that SOAHAC health providers work as a team, to ensure that clients have access to the right services when they need them. SOAHACs integrated care teams consists of Doctors and Nurse Practitioners, Traditional Healers and Elders, Dietitians, Child and Youth Workers, Mental Health and Addictions Counselors, Social Workers, Nurses, Support Staff and more. The service model promotes an Indigenous cultural worldview of interconnectedness and the balancing of the physical, mental, emotional and spiritual aspects of wellbeing. Everything SOAHAC offers is rooted in its wholistic, integrated approach to health and wellness. All services and aspects of service delivery relate to the life cycle, and relationship with everything within Creation – culture and empowerment, self, family/Clan, community, nation, and the universe.

A variety of outreach services are provided on location in the First Nation communities and within Friendship Centres.

These include:

- Onyota'a:ka (Oneida Nation of The Thames)
- Deshkan-Ziibiing (Chippewas of The Thames First Nation)
- Munsee-Delware First Nation
- Aamjiwnaang (Chippewas of Sarnia First Nation)
- Delaware Nation at Moraviantown
- Caldwell First Nation
- Bkejwanong (Walpole Island First Nation)

³ Means the organization is inclusive and serves all self-identified, First Nation, Inuit, and Metis (FNIM) people, both status and non-status, living on and off-reserve and in rural and urban settings.

- Can-Am Indian Friendship Centre, Windsor
- Zaagiing (Saugeen First Nation)
- Neyaashiinigamiing (Chippewas of Nawash First Nation)
- M'Wikwedong Native Cultural Resource Centre (Indigenous Friendship Centre), Owen Sound

Through extensive partnerships and collaboration SOAHAC connects Indigenous communities to culturally safe primary health care provision and the broader healthcare system.

Anishnawbe Health Toronto (AHT) – Development of a Traditional Healer Training Model – Innovative practice to advance Indigenous health human resources capacity

Anishnawbe Health Toronto (AHT) is a vision of the late Elder, Joe Sylvester who realized that a more comprehensive approach to health care was needed by the Indigenous community in Greater Toronto. In response, Anishnawbe Health Resources was incorporated in 1984. One of its objectives stated, “To recover, record and promote Traditional Aboriginal practices where possible and appropriate.” Today, AHT not only promotes Traditional Indigenous practices but has affirmed and placed them at its core. Its model of health care is based on Traditional Indigenous practices and approaches and are reflected in the design and delivery of its programs and services. As a fully accredited community health centre through the Canadian Centre for Accreditation, AHT offers access to health care practitioners from many disciplines including Traditional Healers, Elders and Medicine People. Ancient ceremonies and traditions are intrinsic to AHTs health care model are available at AHT daily and regularly.

Currently, there is no formalized training in place for Traditional Healers in the urban context. There is no clearly defined curriculum for such a training program. Developing and identifying a structure and curriculum is an essential first step in building capacity for the continuance and growth of traditional health care in the urban context. AHT’s efforts to address this gap for its own needs have been done on an ad hoc basis, without any dedicated resources to do so.

However, AHT is now conducting research into the development of a Traditional Healing Training Model through consultation and engagement with local and provincial traditional healers, elders and medicine people and other stakeholders. The consultation and engagement will inform curriculum themes, content, values, instruction/teaching ideologies, structural requirements and appropriate training venues.

Developing a comprehensive Indigenous Traditional Healers Training Model will ensure continuous Indigenous traditional healing knowledge exchange. It will contribute to Indigenous health human resources capacity development and sustaining traditional healing services provision within Indigenous primary health care settings.

Wabano Centre for Aboriginal Health – Innovation in urban Indigenous knowledge exchange and mobilization – *Cultural Symposium Series*

At the heart of the AHAC Model of Wholistic Health and Wellbeing is “culture” and the interpretation of Indigenous “ways of knowing and being”. Wabano Centre for Aboriginal Health in Ottawa is an example of the vibrant community health that can be achieved through celebrating Indigenous cultures and artfully living the AHAC Model of Wholistic Health and Wellbeing.



Wabano Centre for Aboriginal Health

In addition to the provision of comprehensive, culturally safe, inter-professional primary health care, Wabano is a unique place for Indigenous healing. The building itself is a major architectural landmark in the Nation’s capital. This magnificent structure, designed by renowned architect Douglas Cardinal, is a 25,000 square foot complex that is the heart, identity and expression of Indigenous people and cultures. The larger facilities enabled Wabano to respond to fastest growing population and increased services demands. Since the opening of the new building in May 2013, Wabano has expanded programs and services including a maternal and child wellness centre, social enterprise programming, enhanced mental health services and much more.

A very innovative program at Wabano is the *Culture as Treatment Symposium Series*. The annual symposiums bring Indigenous thinkers, thought leaders, traditional knowledge keepers, scholars, practitioners, Elders and medicine people to share knowledge with each other and the community. The talks focus on traditional medicines, child and youth mental health, journeys to wellness of youth and families and creating a place of belonging. To date, topics covered include:

- Historical Trauma and Impacts on Aboriginal Youth and Families
- The importance of Culture, Environment, and Language in the Wellbeing of Aboriginal Youth and Families
- Working with Aboriginal Youth and Families within Child Welfare
- Public Schools
- Health Care
- Criminal Justice Systems
- Aboriginal Dispute Resolution
- Cultural Safety and more.

Cultural safety and healing within Indigenous communities are always linked to physical space. In this regard, Wabano’s building has created a strong sense of belonging and pride for people of all cultures. The aesthetically stunning urban Indigenous space is, in itself, a real catalyst for healing, cultural reclamation and sharing of knowledge.

II. Recommendations for “Patients First”

Proposal #1: More Effective Integration of Services and Greater Equity

Despite the advances achieved by AHACs and Aboriginal CHCs there are still systemic impediments and barriers to AHACs/Aboriginal CHCs to further progress. Key issues are identified and AHAC and Aboriginal CHC leadership proposals for addressing these are outlined below.

Provincial Stakeholder Relationship Management and Jurisdictional Discord

The relations between Indigenous communities and organizations and between Indigenous people and government are diverse, complex and challenging due to colonialism and the impacts in particular from the residential school era. Indigenous people are responsible to heal our own relations with one another and address lateral violence and other traumatic impacts. We are all responsible however, to reconcile Ontario’s colonial relationship with Indigenous people. As we move in a more positive direction, it is imperative that the Minister of Health and Long-term Care support correcting stakeholder relations which have a direct impact on the health outcomes of the Indigenous population in Ontario.

Recommendation:

- 1. AHACs and Aboriginal CHCs be invited to participate in bi-lateral, tri-lateral and regional planning tables and participate on health working groups struck by the MOHLTC that have a direct impact on the health of Indigenous people, Indigenous primary health care services delivery and the AHAC sector.**

Rationale:

We all have to do more to address the real impacts of jurisdictional discord on the health of First Nations people living in Ontario and our society. Canada, Ontario and Indigenous communities have the means and intelligence to fully resolve jurisdictional discord in the provision of healthcare to the First Nations population in Ontario.

On February 24, 2016, the Grand Chief of Nishnawbe Aski Nation (NAN), Alvin Fiddler, declared a state of health and public health emergency in the semi-remote, remote and isolated First Nation communities in the NAN Treaty Area of northern Ontario. A local First Nation Health Authority, Health Director referred to the treatment of First Nations there as “atrocious” and those First Nations communities as being in a “jurisdictional black hole”.⁴

Jurisdictional discord has and can be resolved. However, it requires more robust strategies and interventions to break down these stubborn barriers and eliminate it from this province’s

⁴ Sol Mamakwa, Health Director for the Shibogama First Nation Health Authority, based in Sioux Lookout as quoted in CBC news article <http://www.cbc.ca/news/canada/thunder-bay/first-nations-health-emergency-1.3460198>

future. Providing quality health care to every Ontarian must come first. Real and lasting solutions can be found only through the collaborative efforts of all levels of government and Indigenous communities. AHACs and Aboriginal CHCs are part of the solution. We have to continually ask ourselves what more can we be doing together on this front? We can invite and ensure that representatives from the Federal government are engaged at every step in addressing Indigenous health disparities. If continuous engagement does not happen, real, sustainable change will not happen either.

Recommendation:

- 2. That the MOHLTC review the quality of its relationship with Health Canada as it relates to comprehensive strategies and interventions and remove provincial jurisdictional barriers to greater collaboration with Health Canada, First Nations and AHACs in all areas of shared responsibility.**

MOHLTC Stewardship, LHINs Roles and Indigenous Health Planning

Despite the efforts by the province and the LHINs, there remains no comprehensive, coherent and consistent planning across the province for Indigenous primary health care policy, priority setting, strategic direction and programs and services delivery. When LHINs were set up there was never a successful transfer of the Indigenous stakeholder and health knowledge held by the MOHLTC to the LHINs. The ad hoc nature of Indigenous health planning in Ontario over the last decade has created an environment whereby we are losing ground in key areas. The conceptual model of an integrated health care system while undertaken through LHSIA is incomplete. One result is the inconsistent and insufficient health care resources for Indigenous people in Ontario. The AHAC/Aboriginal CHC Leadership Circle is proposing changes to LHSIA and LHIN structures so as to bring order and stability to Indigenous primary health care planning and delivery across Ontario.

Proposed Changes to LHSIA

Ontario is one of only three provinces and territories in Canada with comprehensive Aboriginal health policies. Having such policies is considered a world class, Indigenous health intervention tool to close gaps in health disparities and inequities. (Lavoie, Boulton & Gervais, 2012) Yet, we do not fully utilize this capacity within Ontario. In 1994, Ontario adopted the Aboriginal Health Policy and by the late 1990s had created the Aboriginal Healing and Wellness Strategy (AHWS). Subsequently, the province created the Joint Management Committee (JMC) between Ontario government ministries and Indigenous provincial territorial and treaty organizations to oversee AHWS implementation. Despite the political breakdown and dismantling of the JMC by the early 2000s and chronic underfunding of AHACs and other programs funded under AHWS, the programs and services are exemplary in improving health outcomes (Government of Ontario, 2009).

Today, Ontario's health system all but ignores the Aboriginal Health Policy (AHP) 1994, as a successful intervention tool in closing the gaps in Indigenous health disparities. LHSIA is altogether silent on the Ontario AHP.

Recommendation:

- 3. That the MOHLTC embed the Aboriginal Health Policy (AHP) 1994 into LHSIA to include the AHP vision, definition of Aboriginal health and its core principles.**

Rationale:

Given this time of LHSIA review, the ten Aboriginal Health Access Centres (AHAC) and three Aboriginal Community Health Centres (CHC) in Ontario are calling for more meaningful participation in Ontario's health care system and increased accountability from Ontario's healthcare legislation including the Local Health System Integration Act (LHSIA).

It is time to align LHSIA and the longstanding Ontario Aboriginal Health Policy. The most effective path to such change is to embed the vision and definition of Aboriginal health, along with the core AHP principles within LHSIA while we concurrently consider options to update and renew AHP.

These include:

1. Aboriginal health is wholistic and includes the physical, mental, emotional spiritual and cultural aspects of life.
2. Aboriginal people are distinct and not part of a multicultural mosaic (this includes equity groups and provision of Francophone language services under LHSIA)
3. Accountability processes to include regular review of health program effectiveness, financial expenditures with annual reports to Aboriginal communities and the MOHLTC
4. Equitable access to provincial health services and culturally safe health care
5. Flexible policies, programs and services as required to respect and address Aboriginal diversity across Ontario including First Nations status and non-status, living both on and off-reserve, Métis, Inuit and urban Indigenous communities.
6. Respect for Indigenous healers and Indigenous informed approaches to health and wellness
7. Indigenous community control of health assessment, planning, design, development and delivery, resource management and ensuring equitable resourcing
8. Recognition and respect for Indigenous self-determination and individual choice of health services
9. Recognition and respect for Indigenous constitutional and treaty rights to self-governance and determination in health. This includes the assurance that

representation within Ontario's healthcare structures should fulfill the needs of the Aboriginal population in the community (see also Recommendation # 5)

Name AHACs as Health Service Providers (HSPs)

Recommendation:

4. That the MOHLTC specifically, name the Aboriginal Health Access Centres (AHACs) as *Health Service Providers* within the LHSIA

Rationale:

Although the Ontario and federal governments have made significant investments and efforts in health and socio-economic service sectors within Indigenous communities, current Indigenous population studies reveal significant gaps in Indigenous health outcomes as compared to non-Indigenous populations and high levels of systemic racism. (Allen & Smylie, 2015) Ontario's key investment in primary health care for the Indigenous population is largely within the AHAC and Aboriginal CHC sectors. Community Health Centres are named in LHSIA as *Health Service Providers*, however AHACs are not. This has seriously prevented knowledge exchange to inform LHINs on best and promising practices that are creating real solutions to close health gaps and inequities for the Indigenous population, address racism and break down systemic barriers. It has also prevented some AHACs from gaining access to funding for non-primary health care services.

Though we want to be named in LHSIA and have relationship with LHINs, this proposed change does not support the transfer of AHACs operational budget and agreements from the Ministry of Health and Long Term Care (MOHLTC) to the LHINs at this time. AHACs have widely varying levels of meaningful engagement, participation in decision making and access to health resources with its respective LHINs.

A number of LHINs continue to have token engagement with AHACs and the North West LHIN in particular is problematic with its rapid movement towards integrating community governed primary health care agencies, First Nations services, and other community-based service providers under hospital governance. This is happening with the integration underway in the North West LHIN called the Dryden and Area Local Health Hub.

Until these relational matters with all LHINs are effectively resolved, the AHAC Leadership Circle continues to work with the MOHLTC and LHINs to find appropriate solutions. These proposed changes to LHSIA may help to remedy these outstanding relational issues between AHACs and LHINs.

Designated Indigenous Director on the LHIN Board

Recommendation:

- 5. That the MOHLTC dedicate the minimum of one seat on each LHIN Board for Indigenous community members to provide *Indigenous health perspectives* directly to the LHIN Boards. Ensure that this dedicated Board position is an Indigenous person and also a formal member of the respective LHIN Indigenous Health Committees across the province.**

Rationale:

The model of linking dedicated Indigenous LHIN Board members to LHIN Indigenous Health Committees is already quasi-official within the North East LHIN and can be considered a leading practice. This proposed change improves, strengthens and spreads this leading practice. It grows out of the call for LHINs to improve accountability to the Indigenous population and improve Indigenous community's access to LHIN decision making, directly impacting AHACs, Aboriginal CHCs and the communities we serve.

Indigenous LHIN Board members would be required to demonstrate senior level Indigenous health expertise and experience working with status and non-status First Nations, Métis and Inuit communities, on and off-reserve and in urban settings. Neither First Nations nor the Government of Ontario should regard these as political appointments. Rather, the intent is to bring local Indigenous health expertise to the LHIN Board in service of the Indigenous population within the respective LHIN. This approach will positively impact on Indigenous health outcomes while meaningfully contributing to Ontario's health system transformation by reflecting the *Patients First* proposals.

Recommendations to Strengthen LHSIA and LHIN accountability to improving health outcomes for the Indigenous population in Ontario

Though we are not proposing further changes to LHSIA we do provide the following recommendations to strengthen LHSIA accountability and LHIN functioning towards improved health outcomes for the Indigenous population.

Recommendation

- 6. That the Minister of Health and Long Term Care immediately activate the LHSIA Indigenous/First Nation Provincial Advisory Council under LHSIA; and that the Council include people with lived experience, subject matter expertise and Indigenous health and wellness service delivery agencies involved in the LHIN Indigenous Health Committees.**

This Council, reporting directly to the Minister could support the creation of a provincial Indigenous primary health care action plan with a designated Associate Deputy Minister (ADM). This is discussed further below in under section entitled: *AHAC/Aboriginal CHC Leadership Proposed Conceptual Model*.

Rationale:

In LHSIA

Under Part III Planning and Engagement Section 14 Councils

(2) The Minister shall establish the following councils:

1. An Aboriginal and First Nations health council to advise the Minister about health and service delivery issues related to Aboriginal and First Nations peoples and priorities and strategies for the provincial strategic plan related to those peoples.

The Indigenous population is small and dispersed across Ontario. Jurisdictional barriers are common in spite of repeated efforts. The MOHLTC continues to manage multiple provincial Indigenous stakeholder relations and is a provincial Indigenous health knowledge holder that does not always easily inform LHINs or community health planning. Communities have been patiently waiting for over a decade for the formation of a provincial advisory council under LHSIA. We have in effect, lost ground provincially on a number of fronts to bringing rates of chronic disease and suicide down to manageable levels for examples. As we work locally to create real health solutions, we require a provincial primary health care action plan, a provincial body to advise the Minister directly, for information exchange and priority setting at provincial level strategy development and planning. It is time for a different approach and the AHAC and Aboriginal CHC Leadership Circle fully support the recommendation as a progressive way forward.

Recommendation:

7. Strengthen the purpose and mandate of the LHIN Indigenous Health Committees across the LHINs.

- Ensure Indigenous HSPs engaged with LHINs approve LHIN Indigenous committee membership
- Have the dedicated Indigenous LHIN Board member attend Committee meetings to establish strong links to LHIN Board
- Have representatives from each of the LHIN Indigenous Health Committees sit on the Provincial Aboriginal Advisory Council to the Minister.

Rationale:

In LHSIA

Under Part III Planning and Engagement Section 14 Methods of engagement

(3) The methods for carrying out community engagement under subsection (1) may include holding community meetings or focus group meetings or establishing advisory committees. 2006, c. 4, s. 16 (3).

Duties

(4) In carrying out community engagement under subsection (1), the local health integration network shall engage,

(a) The Aboriginal and First Nations health planning entity for the geographic area of the network that is prescribed; and

The variation between LHINs in quality of meaningful engagement, Indigenous health planning and the set up and management of the local Indigenous Health Committees is problematic and unacceptable. These local committees require strengthening with increased decision making authority. Additionally LHINs require direction and support from the Minister, embedded in LHSIA to improve the structure and functioning of the local Aboriginal Health Committees.

Recommendation:

8. That the Minister direct the LHINs to fundamentally change the role and functioning of LHIN Indigenous Health Leads positions.

- Dedicate a base funded position at each LHIN
- Increase the level of authority of the position to a Senior Director level (LHIN Senior Director of Indigenous Health)
- Person recruited to the role to have senior level expertise in Indigenous health planning and working within mainstream and Indigenous communities
- During recruitment, candidates are vetted through the local Indigenous Health Committees
- Reports regularly on Indigenous health outcomes and system performance

Rationale:

The LHIN CEOs have committed to identifying LHIN staff leads for Indigenous health within each LHIN. These positions are more often token positions and have to undergo fundamental change. The Minister of Health must take directive measures with the LHINs to ensure these roles within LHINs are high functioning, meaningful and contributing to real change in Indigenous health status. The AHAC/Aboriginal CHC Leadership considers changing the level of authority for people in these roles across the LHINs as the priority aspect of this recommendation.

Recommendation:

9. That the LHINs utilize its Local Health System Integration Act (LHSIA) mandate to convene inter-sectoral tables with AHACs and Indigenous communities to improve cross sector dialogue and collaboration to effectively address Indigenous health and determinants of health.

Rationale:

AHACs and Aboriginal CHCs focus is on strengthening the health and wellness of the whole community. In this way, AHACs are also community development agencies that could benefit from increased ministerial collaboration and cooperation in addressing the broader determinants of health like care for children and youth, housing and education. The LHIN with its legislative mandate can support the regular convening of inter-ministerial and cross sector

tables focused on addressing Indigenous inequities and health disparities, accountable to Indigenous people.

Recommendation:

10. That LHINs, public health agencies and any other new Ontario health system structure created through *Patients First*, be mandated to become educated on the complexity of Indigenous health issues, be accountable to the *Ontario Aboriginal Health Policy*, respect Indigenous rights to determination in health and be trained on Indigenous Cultural Safety.

Rationale:

While there have been considerable efforts put into addressing health inequities for Indigenous people across the province by various LHINs and other Ministries, these have largely been uncoordinated, inconsistent and lacking in comprehensive knowledge about Indigenous health and engagement with AHACs and Indigenous leadership. We do not have at LHIN levels multiple ministries involved in Indigenous health at the table, at the same time, collaborating and strategizing together in an effective manner. This recommendation is provided also to help address the challenges for multiple Indigenous communities and health service providers to effectively engage with their respective LHINs and other regional structures and the inconsistencies across LHINs as recently reported by the Auditor General.

Recommendation:

11. That the MOHLTC fund the establishment of an Indigenous Population Health Knowledge Directorate to support quality population health planning and evidence based decision making.

The AHACs and Aboriginal CHCs across Ontario are committed to working with the MOHLTC, LHINs and Indigenous communities to improve Indigenous health outcomes. We have worked diligently over the last decade to improve meaningful engagement and relationships with the LHINs and improve quality of primary health care provision.

We have recently heard that the MOHLTC may be considering the establishment of a fifteenth, Indigenous LHIN. At this time we do not support the establishment of such a LHIN as this will impede the progressive momentum already established on the ground throughout the province that has taken over ten years to build. We believe the legislation is in place and needs to be strengthened as reflected in the above proposed changes to LHSIA and recommendations to strengthen LHINs related to Indigenous health outcomes.

Instead, we recommend the establishment of an *Indigenous Population Health Knowledge Directorate* that can be overseen by the AHACs and Aboriginal CHCs and other Indigenous primary health care providers and stakeholders to advance the quality of population health based planning and evidence based decision making related to Indigenous primary health care services delivery. The Directorate will also include an Indigenous advisory group

comprised of people with lived experience interfacing with Ontario's healthcare system and support for cultural safety.

The Indigenous Population Health Knowledge Directorate mandate would include:

- Data Management, information synthesis and knowledge exchange
- Conducting population health surveys and research
- Reports on outcome measurement and evaluation support
- Ensuring Ownership, Control, Access, Possession (OCAP) research principles
- Stakeholder Relationship Management (MOHLTC Data Analytics, ICES, Public Health, PTOs, Research Centres etc.)
- Accept information and research requests and provide advice to the MOHLTC, LHINs, Indigenous community planners, PTO policy, Bi-Lateral/Tri-Lateral Tables
- Indigenous lived experience Advisory Group
- Cultural Safety program for healthcare professionals and HSPs

Rationale:

Indigenous health planning should be population and evidence based and requires a dedicated resource to support MOHLTC, LHINs, HSPs, AHACS, Aboriginal CHCs and Indigenous communities health planning. There are currently significant gaps in Indigenous population health information especially within the Métis and urban Indigenous communities. There are also significant amounts of Indigenous health data and information dispersed across multiple sites both provincially and nationally. The Directorate would be responsible to plan to address health information deficits while consolidating and integrating available data, health information and data sharing. The overall goals of the Directorate will be improving health outcomes, accelerating Indigenous health gains and closing the gaps.

AHAC/Aboriginal CHC Leadership Proposed Conceptual Model

To assist the reader with understanding the proposed changes to LHSIA and recommendations provided in this document, below is a conceptual framework model approved by the AHAC/Aboriginal CHC leadership for recommendation to the MOHLTC and LHINs.

Recommendations:

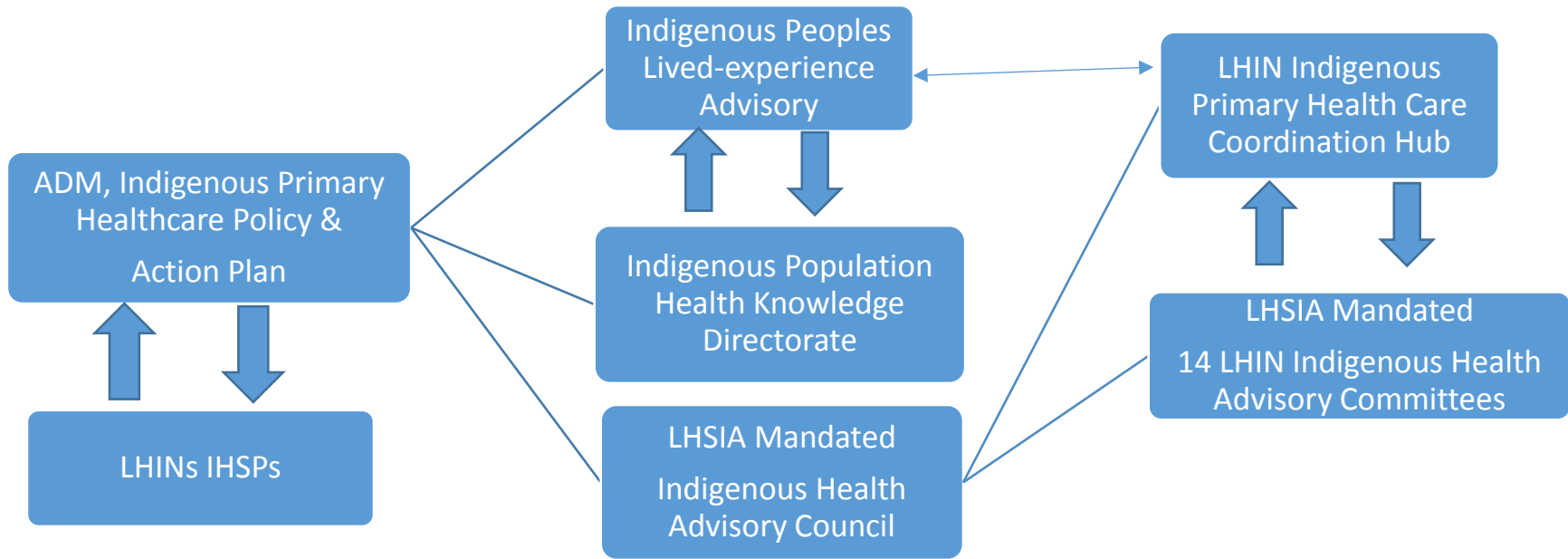
- 12. That the MOHLTC adopt the Conceptual Model below to assist Ontario, LHINs and Indigenous communities and health service providers plan, coordinate and deliver high quality primary health care focused on measurable health outcomes.**
- 13. That the Minister of Health and Long-Term Care direct the creation of an Ontario Indigenous Primary Health Care Policy and Action Plan.**
- 14. That the Minister of Health and Long Term Care dedicate an Associate Deputy Minister to oversee Plan implementation.**

Rationale:

Indigenous people rate far worse on every health and socio-economic indicator than non-Indigenous Canadians. (Gracey & King, 2009) Primary health care is viewed as the foundation of the Ontario healthcare system and the entry point to gaining access to the broader health care system. Indigenous communities have limited access to primary health care and significant gaps remain. Indigenous people, communities' health service providers continue to be marginalized within Ontario's health care system structures. For the past ten years of systems integration and transformation, Indigenous health planning, performance management, systems management and services delivery have been uncoordinated and confusing.

The conceptual model proposes improved organization, planning and delivery of primary health care with engagement and involvement of Indigenous people throughout. It ensures solid links between the Ministry of Health, LHINs, Indigenous communities and services providers, broader health system and Indigenous users of the health care system.

Conceptual Model: AHAC Proposed LHIN Indigenous Primary Health Care Advisory and Delivery Structure



About the Conceptual Model

This model calls for the updating, renewal and recommitment to Ontario's Aboriginal Health Policy and the creation of an Indigenous specific Primary Health Care Policy and Action Plan for Ontario. It also calls on the Minister to designate an Associate Deputy Minister (ADM) responsible to account for its implementation and success. The ADM will be responsible to ensure that LHINs Integrated Health Services Plans are in alignment with the provincial Indigenous Primary Health Care Policy and Action Plan.

The LHSIA mandated provincial, Indigenous Health Advisory Council once activated informs the Plan and directly advises the Minister on priorities for investment, stakeholder relations and emerging trends in Indigenous primary health care.

We propose that the Council be focused on Indigenous people with lived experience of Ontario's healthcare system; Indigenous health experts, primary health care service providers and selected members from each of the LHSIA mandated, LHIN based Indigenous Health Committees.

New elements introduced in this model are:

- the establishment of an Indigenous Population Health Knowledge Directorate,
- creation of an Indigenous People's Lived Experience Advisory and
- a delivery coordination arm referred to here, as LHIN Indigenous Primary Health Care Coordination Hubs.

The Directorate is intended as an independent, arm's length, government funded agency described further in Recommendation #11.

The People's Lived-experienced Advisory is proposed to ensure continual direct system user input and is also described further in Recommendation #11.

The LHIN Indigenous Primary Health Care Coordination Hubs are proposed as Indigenous led and managed entities. Hubs would have responsibility for ensuring Indigenous service providers are linked across the LHIN both to each other and the broader health care system. They would ensure each Indigenous person is rostered to a culturally safe primary health care provider and have a coordinated care plan that is comprehensive and utilizing existing resources.

Hubs would work closely with the LHSIA mandated LHIN Indigenous Health Advisory Committees to address challenges, gaps and areas for improvement. Hubs will also identify and communicate leading practices, innovations and emerging issues from the field.

Reconciliation and Healing Programs

The recent Truth and Reconciliation report identifies a number of recommendations or calls to action relating to Indigenous health. Two in particular of interest to AHACs and Aboriginal CHCs pertain to Indigenous community health care capacity building and valuing Indigenous healing

methods and healers. The AHAC/Aboriginal CHC leadership requests the consideration of a province wide, culture based healing services initiative towards reconciliation and an Indigenous focused health human resources development initiative towards continued Indigenous healthcare capacity development.

Recommendation:

15. That the MOHLTC fund healing programs in all AHACs and recognize and fund traditional healers within Indigenous governed primary health care organizations.

16. That the MOHLTC provide resources to the AHAC/Aboriginal CHC ED Circle to develop a health human resources strategy towards Indigenous primary health care capacity development.

Rationale:

A current leading healing program in the field is called *Beauty for Ashes*. It's a program based on the power of Indigenous storytelling to address unresolved intergenerational trauma and relational healing. This evidenced informed program originates from the Nuka Model in Alaska and is a successful model amongst the Indigenous people in Alaska. AHACs are seeing success in Ontario in First Nation and urban Indigenous communities. It is a successful program which could be easily spread within the system towards deeper healing and reconciliation.

Another priority identified is to focus on Indigenous community health capacity rebuilding initiatives. A number of AHACs and Aboriginal CHCs have ideas for initiatives including an accredited education program for Indigenous Healers and Medicine People for Ontario, health human resource strategy development for the AHAC sector and increasing access to healing programs like *Beauty for Ashes* and other reconciliation activities.

Proposal #2: Timely Access to Primary Care, and Seamless Links between Primary Care and Other Services

Expanding Indigenous Primary Health Care

In an effort to address the gaps in Federal health resources AHACs were originally established, in part, to bring primary health care into First Nations on those reserves which have limited to no healthcare infrastructure and to integrate federal and provincial programs and services towards improved access and health outcomes. We have collectively demonstrated how the AHAC model is effective in closing the gaps in access to primary health care for FNIM people both on and off-reserve and in urban and rural settings and providing comprehensive continuity of care.

Recommendation:

17. That the number of AHACs and AHAC satellites be increased across the province.

Rationale:

Despite AHAC and Aboriginal CHC significant successes, there are still FNIM communities throughout Ontario without primary health care access and people who travel long distances to access often culturally unsafe physician and nursing services. Services also do not have wrap around care for Indigenous clients. New investments must be made in funding clinical services, coordination and systems navigation for FNIM communities off and on reserve.

Priority areas include but are not limited to: North Bay, Dryden, Kitchener, Kingston, Windsor and surrounding First Nation communities and Métis settlements. Health leaders within these communities have signaled interest in working with the AHACs and Aboriginal CHCs to develop culturally safe primary health care services to those underserved Indigenous communities.

An urgent matter, on February 24, 2016, the Grand Chief of Nishnawbe Aski Nation (NAN), Alvin Fiddler, declared a state of health and public health emergency in the semi-remote, remote and isolated First Nation communities in the NAN Treaty Area of northern Ontario. A number of AHACs and the Aboriginal CHC operating in northern Ontario have experience and knowledge to help increase healthcare access and can be called on to share expertise and strategize solutions.

Proposal #3: More Consistent and Accessible Home and Community Care

Functional Home and Community Care Services Coordination and Provision

Home and Community Care continues to be an area of Ontario's health system where Indigenous people are at great risk and come into regular harm. There continues to be significant confusion amongst service providers, jurisdictional discord, systemic racism and inequities that are causing undue patient, family and community stress at best and premature death and dying at worse. AHACs and Aboriginal CHCs leadership have worked with LHINs and CCACs in a number of LHINs, to document patient journeys, expose gaps and risks along care pathways and consider solutions. Still, these inequities continue. A key success we are witnessing inside the system is AHAC leadership and management of home and community care coordination and services including palliative and end of life care.

Recommendation:

- 18. That the AHACS have extended mandate and service-provision scope, including care coordination, hospital discharge, home and community care services, and palliative/end-of-life care.**
- 19. That CCAC Care Coordinators working with Indigenous populations come under AHAC and Aboriginal CHC management where possible.**

Rationale:

These are sectors in the system where Indigenous people continue to come into most harm. We could immediately reduce these risks and accelerate Indigenous health gains by expanding AHACs and extending AHACs mandate and services scope to include care coordination, hospital discharge, home and community care services and palliative/end-of-life care. The Leadership Circle is looking to the successful models within Noojimawin Teg on Manitoulin Island and N'Mninoeyaa AHAC along the North Shore of Lake Huron as promising and best practices and best options forward. There, home and community care is integrated, under the management and/or coordination of the AHAC and delivered to communities in collaboration with First Nation community health centres, a Friendship Centre, CCACs and Hospitals focused on coordination of quality, culturally safe, seamless care.

Palliative and End of Life Care

We have been in a discovery and planning cycle for palliative and end of life care for over three years. The AHACs and Aboriginal CHCs are engaged with communities, the federal and provincial governments and LHINs on this front. However, while we plan, there are people falling through the cracks which require interim strategies. As the system creates lasting, sustainable change, we all have to be diligent about identifying those who require care today and reduce risks to the Indigenous population and communities.

Recommendation:

20. That the Minister direct the LHINs to ensure culturally safe, interim strategies are put in place in collaboration with Indigenous service providers to identify Indigenous people requiring palliative and end-of-life care and ensure they are linked to culturally safe service provision.

Proposal #4: Stronger Links between Public Health and Other Health Services

Building Stronger Public Health and Health Promotion Focused on Indigenous Population Health

The AHACs/Aboriginal CHCs agree that Public Health must be closer aligned with primary health care and other health services. The AHACs/Aboriginal CHCs support the Minister's proposal fully in this regard. AHACs/Aboriginal CHCs have varying levels of relationship and partnerships with Ontario's Public Health Units. Options for improvement could be further supported. There is a promising Indigenous governed public health pilot project currently proposed in the North East area of the province. The project is led by Weeneybayko Area Health Authority and involves a number of AHACs within the North East LHIN. The pilot project is highly collaborative and could benefit from the Minister's support as it could provide an improved public health model focused on the entire population within that region and enabling existing systems capacity. We also understand that the MOHLTC currently has a provincial Indigenous public health working group. It would be helpful that information relating to this working group be shared and made publically available for improved health planning.

Health Promotion

Recommendations:

- 21. That the MOHLTC revisit the work completed in 2013 by the AOHC and AHACs and fund the pilots proposed on the Indigenous health promotion framework which included planning and evaluation tools and indicator refinement.**
- 22. That the MOHLTC fund strategic Indigenous-informed Health Promotion Campaigns and Health Promoters positions within AHACs across the province.**

Rationale:

Health promotion is critical to changing negative health cycles within the population and requires attention, especially within Indigenous communities. There should be health promoters within each AHAC and Aboriginal CHCs. Health promotion seems like the poor cousin to Public Health within the system. Existing health promotion tools and approaches are more often euro-centric and miss the Indigenous population audience. In the fall of 2011, the Ministry of Health and Long Term Care (MOHLTC) funded the Association of Ontario Health Centres (AOHC) to work with the AHACs to identify the challenges and opportunities associated with the three health promotion program areas: the Diabetes Prevention (DP) strategy, the Smoke Free Ontario (SFO) strategy and the Healthy Eating Active Living (HEAL) strategy. A final report was submitted to the MOHLTC in March 2013 outlining recommendations for a health promotion framework and evaluation for AHACs including Indigenous health promotion indicator refinements. The recommendations from this report were never implemented.

Ontario has to invest upstream in health promotion in a culturally safe and congruent manner to support Indigenous communities in bringing widespread illness and disease rates down to manageable levels and build healthier communities. There is growing concern amongst AHAC/ACHC Leadership Circle that if we do not get upstream on a number of wide spread illness and disease within Indigenous communities, the population as a whole continues to be at risk.

Part III. Conclusion

AHACs and the Aboriginal CHCs are committed to the AHAC model of wholistic health and wellbeing as a community-driven, nationally recognized best practice. We are committed to building high levels of collaboration and relationships with health stakeholders focused on measurable, improved health and wellness outcomes for Indigenous people and communities we serve.

Summary of Recommendations

1. AHACs and Aboriginal CHCs be invited to participate in bi-lateral, tri-lateral and regional planning tables and participate on health Working Groups struck by the MOHLTC that have a direct impact on the health of Indigenous people, Indigenous primary health care services delivery and the AHAC sector.
2. That the MOHLTC review the quality of its relationship with Health Canada as it relates to comprehensive strategies and interventions and remove provincial jurisdictional barriers to greater collaboration with Health Canada, First Nations and AHACs in all areas of shared responsibility.
3. That the MOHLTC imbed the Aboriginal Health Policy (AHP) 1994 into LHSIA to include the AHP vision, definition of Aboriginal health and its core principles.
4. That the MOHLTC specifically, name the Aboriginal Health Access Centres (AHACs) as *Health Service Providers* within the LHSIA.
5. That the MOHLTC dedicate the minimum of one seat on each LHIN Board for Indigenous community members to provide *Indigenous health perspectives* directly to the LHIN Boards. Ensure that this dedicated Board position is also a formal member of the respective LHIN Indigenous Health Committees across the province.
6. That the Minister of Health and Long Term Care immediately activate the LHSIA Indigenous/First Nation Provincial Advisory Council under LHSIA; and that the council include people with lived experience, subject matter expertise and Indigenous health and wellness service delivery agencies involved in the LHIN Indigenous Health Committees.
7. Strengthen the purpose and mandate of the LHIN Indigenous Health Committees across the LHINs.
 - Ensure Indigenous HSPs engaged with LHINs approve LHIN Indigenous committee membership
 - Have the dedicated Indigenous LHIN Board member attend Committee meetings to establish strong links to LHIN Board
 - Have representatives from each of the LHIN Indigenous Health Committees sit on the Provincial Aboriginal Advisory Council to the Minister.
8. That the Minister direct the LHINS to fundamentally change the role and functioning of LHIN Indigenous Health Leads position.
 - Dedicate a base funded position at each LHIN
 - Increase the level of authority of the position to a Senior Director level (LHIN Senior Director of Indigenous Health)
 - Person recruited to the role to have senior level expertise in Indigenous health planning and working within mainstream and Indigenous communities

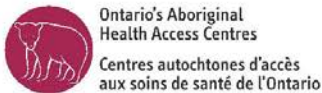
- During recruitment, candidates are vetted through the local Indigenous Health Committees
 - Reports regularly on Indigenous health outcomes and system performance
9. That the LHINs utilize its Local Health System Integration Act (LHSIA) mandate to convene inter-sectoral tables with AHACs and Indigenous communities to improve cross sector dialogue and collaboration to effectively address Indigenous health and determinants of health.
 10. That LHINs, public health agencies and any other new Ontario health system structure created through *Patients First*, be mandated to become educated on the complexity of Indigenous health issues, be accountable to the *Ontario Aboriginal Health Policy*, respect Indigenous rights to determination in health and be trained on Indigenous Cultural Safety.
 11. That the MOHLTC fund the establishment of an Indigenous Population Health Knowledge Directorate to support quality population health planning and evidence based decision making.
 12. That the MOHLTC adopt the Conceptual Model to assist Ontario, LHINs and Indigenous communities and health service providers plan, coordinate and deliver high quality primary health care focused on measurable health outcomes.
 13. That the Minister of Health and Long-Term Care direct the creation of an Ontario Indigenous Primary Health Care Policy and Action Plan.
 14. That the Minister of Health and Long Term Care dedicate an Associate Deputy Minister to oversee Plan implementation.
 15. That the MOHLTC fund healing programs in all AHACs and recognize and fund traditional healers within Indigenous governed primary health care organizations.
 16. That the MOHLTC provide resources to the AHAC/Aboriginal CHC Leadership to develop a health human resources strategy towards primary health care capacity development.
 17. That the number of AHACs and AHAC satellites be increased across the province.
 18. That the AHACS have extended mandate and service-provision scope, including care coordination, hospital discharge, home and community care services, and palliative/end-of-life care.
 19. That CCAC Care Coordinators working with Indigenous populations come under AHAC and Aboriginal CHC management where possible.
 20. That the Minister direct the LHINs to ensure culturally safe, interim strategies are put in place in collaboration with Indigenous service providers to identify Indigenous people requiring palliative and end-of-life care and ensure they are linked to culturally safe service provision.

21. That the MOHLTC revisit the work completed in 2013 by the AHACs and fund the pilots proposed on the Indigenous health promotion framework which included planning, evaluation and indicator refinement.
22. That the MOHLTC fund strategic Indigenous-informed Health Promotion Campaigns and Health Promoters positions throughout Ontario

Appendix A – Aboriginal Health Access Model of Wholistic Health and Wellbeing

AHAC MODEL OF *Wholistic Health and Wellbeing*

A TIME FOR RECONCILIATION



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

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