Operationalizing an Indigenous Health Model at the Southwest Ontario Aboriginal Health Access Centre

By

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We accept this Final Report as conforming to the required standard

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Executive Summary

The Southwest Ontario Aboriginal Health Access Centre (SOAHAC) is an Aboriginal community-governed, primary health care agency that blends western and Indigenous healing approaches. SOAHAC has 70 staff serving 35,000 people in 13 communities, is status blind¹ and operates four clinic sites: London, Chippewas of the Thames First Nation, Owen Sound and Windsor, and outreach clinics to four First Nation communities.

SOAHAC operates within the Aboriginal Access Centre (AHAC) Model of Care as western-based health models have limited effectiveness in addressing the significant health disparities and inequities between the general Canadian and Indigenous populations (Health Council of Canada, 2012, pp. 8–10). Indigenous-informed, culture-based, community-led services that include traditional healers are more effective (Ontario’s Aboriginal Health Access Centres, 2011).

Since 2012, SOAHAC has increased staff from 20 to 70; many of the new staff lack proper orientation or training required to operationalize a wholistic model of care. Many of the health-professional staff are non-Indigenous with limited experience and understanding of Aboriginal health and community priorities (D. George, personal communication, January 11, 2013). Cross-cultural and inter-professional conflicts have had negative impacts on service delivery, evidenced by feedback from clients (B. Dokis, personal communication, November 1, 2013). Improving Aboriginal health outcomes is fundamental to the organization’s ability to implement an Indigenous wholistic health model. Failure brings the risk of losing clients and reducing SOAHAC’s effectiveness as a unique Aboriginal service (B. Dokis, personal communication, January 11, 2014). This inquiry assisted the organization in developing strategies to increase common organizational and cultural knowledge and standards of practice and in turn provided the necessary skills to reconcile the multilevel diversity conflicts.

An initial analysis of the situation had revealed confusion amongst staff, a lack of common understanding of an AHAC model of wholistic health and wellbeing, vague agreement on how to implement it, and limited methods for inter-professional collaboration. This negatively impacted on client experience. Thus, the change goal of this inquiry was to create a common operational environment throughout SOAHAC to ensure clients have culturally safe experiences at all SOAHAC sites. The inquiry focused on staff, consulting professionals, board members, and Healers at all sites, posing the question: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? The inquiry also answered the following subquestions:

1. What innovative approaches to the AHAC model exist at SOAHAC and how can they be leveraged in the system?
2. What strategies can be developed to increase common organizational and cultural knowledge and standards of practice related to the AHAC model?

¹ Means the organization is inclusive and serves all self-identified, First Nation, Inuit, and Métis (FNIM) people, both status and nonstatus, living on and off reserve.
3. What are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

The literature review explored scholarly and grey literature that could assist the sponsor organization in implementing a culture-based wholistic health care model and improve Aboriginal client and staff experience across the organization. The academic topics included in this review were selected for their relevance in understanding the current state of Aboriginal health, leading Aboriginal-based health models, and addressing cultural safety within an Aboriginal health care setting. The first topic explores Aboriginal health status, Aboriginal concepts of healing and wellness, and existing models and approaches utilized to improve health outcomes. The second topic examines cultural safety as it relates to improved patient experience and its implementation within an Indigenous health care setting.

Action research is widely used within Indian Country as an anti-oppressive, decolonizing, and community development activator. Action research is a cyclic process whereby participants, in relation to the issues of the day, “look, think, [and] act” (Stringer, 2014, p. 9) through the various stages of planning, implementing, and evaluating solutions. In my practice utilizing the medicine wheel, as taught by the Ontario Federation of Indigenous Friendship Centres, I have included the domain of Vision—the cycle is then to envision, think, look, and act. This method ensures community ownership of the project by “empowering people to construct and use their own knowledge” (Lykes & Mallona; Rahman, as cited in Coglan & Brannick, 2010, p. 45). From the start, my inquiry design followed participatory action research principles and practices, which are widely supported in Indigenous and academic communities when conducting research involving Indigenous populations (Denizen, Lincoln, & Smith, 2008). Following Friere (1970), I utilized participatory action research for its social transformative impact on people who have been otherwise marginalized and disenfranchised (Glesne, 2011, p. 23). I also built cultural safety and appreciative inquiry into my inquiry to positively frame all questions as a protective factor and to mitigate potential stress impacting people throughout this process.

To ensure an adequate level of input from across the agency and that the people could have access to the research, a main participant selection criteria was that whoever was involved in the inquiry had to have either direct accountability to and/or responsibility for SOAHAC’s success or success of AHACs generally. Given that, all SOAHAC staff from the four sites, board members, and contracted visiting healers were invited to participate in the anonymous online survey. Additionally, a learning circle was conducted with members of the Indigenous Health Information and Knowledge Exchange group, an Indigenous research group of scholars and AHAC leaders currently partnered to conduct the urban Aboriginal population health survey, “Our Health Counts,” in London and Kenora, Ontario. The anonymous online survey and learning circle were the two main research methods for the inquiry.

The selection criteria excluded clients. Time constraints limited the feasibility of directly involving clients. As the inquiry did involve SOAHAC’s client experience of cultural safety, I reviewed SOAHAC client satisfaction survey results from all four sites for the 2014–2015 fiscal year. The client satisfaction survey asked in-depth questions about how SOAHAC clients experience services.

The Tri-Council Policy Statement’s (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research
Council of Canada, 2014) ethical guidelines describe three core principles: respect for persons, concern for welfare, and justice (p. 6). These principles align with Indigenous worldviews and value systems. In this organizational leadership project, I have included everyone equitably as participants, thus respecting their persons and consideration of justice. I leaned heavily on my sponsor, the formal representative for the SOAHAC board, who are the authorized community representatives of the people the organization serves. He reviewed my research proposal and the ethics review from Royal Roads University and approved my project to go forward within the organization. SOAHAC, as an Aboriginal Health Care Agency, had the final say on whether I would conduct this research at SOAHAC. “The main principles for research policy and practice must be that Indigenous people should control their own knowledge” (Battiste, 2008, p. 501). As a Mi’kmaq woman, with additional ethical responsibilities to the communities, I ensured this occurred. In my interactions with SOAHAC staff, the issues of privacy and confidentiality are discussed frequently. There is significant energy around these topics. As such, I strove in this project to protect individual and community privacy and confidentiality, while at the same time surfacing issues of colonization dealing with privacy and confidentiality that impact First Nation people’s ability to have open, free communications and dialogue with one another. As I have an employment reporting relationship with a number of participants, it was critical that I ensured free and informed consent within this organizational leadership project. I presented information that the benefits of my involvement outweighed risks. I continuously reminded people throughout the process of this aspect of the research and encouraged those who were not comfortable participating to step away from the process, while advocating for all people who have ideas to share to participate, for the good of the work SOAHAC undertakes.

The data analysis process involved categorizing and coding to derive meaning (Stringer, 2014, p. 139). Charmaz (2006) provided explicit examples of how to effectively code transcribed raw data so as to develop categories and to generate more robust information. “Qualitative quoting, the process of defining what the data are about is [the] first analytic step” (Charmaz, 2006, p. 43). The categories described by Charmaz (2006) and Stringer (2014) helped to generate the key concepts that shaped the findings for this inquiry. As Stringer (2014) wrote, action research requires reflection that “allows participants to better understand problematic features of the situation” (p. 136). In order to more effectively achieve this level of reflection, the categories and concepts generated in the analysis were used to produce memos, which became the initial findings for the inquiry.

Given that I am a member of the Indigenous community and the Associate Director at SOAHAC, I strove throughout the inquiry to reduce research bias and increase trustworthiness. Glesne (2011) provided a number of procedures to reduce qualitative researcher bias (p. 49). I utilized triangulation, peer review, and reflection to enable confidence in the validity of my findings. I chose methods that could generate transcribed, word-for-word data in order to more effectively utilize the verbatim principle. I developed questions with the assistance of my inquiry research team and promoted participants to provide recommendations. After conducting coding and memo writing exercises, I also reflected on my reactions to the information and referred back to the inquiry questions and prepared notes. I also then triangulated the data from the online survey and the learning circle with the literature. Finally, once the key findings were extrapolated, I shared those with the inquiry research team to generate recommendations to increase trustworthiness and reliability.
Participants in the inquiry were asked to reflect on the AHAC Wholistic Model of Health and Wellbeing and innovative practices inherent in the model, cultural safety within an Indigenous health care setting, and the impacts of diversity on cultural safety. Participants were also asked to discuss the challenges to Indigenous culturally safe care provision and health care systems change. The study findings revealed that the organization experiences high levels of engagement between staff and staff and clients. There was also interest to formalize cultural education and ways that Indigenous traditional knowledge holders interface with the organization, and how that knowledge translates within all levels of SOAHAC operations including leadership. The findings also proposed utilizing the existing capacity at SOAHAC and within the AHAC sector to consider priorities for broader system leadership towards the advancement of Indigenous health in Ontario. The intent of the recommendations is to create a framework that can assist SOAHAC to identify the next set of priorities in the development of its new leadership structure and integrated care model. The recommendations are as follows:

1. Develop a comprehensive cultural education framework for SOAHAC staff and community members.
2. Engage broadly with Indigenous traditional communities within the multiple communities and Nations served by SOAHAC and build a comprehensive strategy for SOAHAC’s advancement as an Indigenous-informed health organization.
3. Mandate cultural safety and lateral violence education at SOAHAC as part of performance management and assurance of culturally safe experiences for clients, staff, and board.
4. Further develop the framework for improved interprofessional collaboration.
5. Explore the techniques utilized to Indigenize SOAHAC’s healthy lifestyles program and its potential for spread across other programs and services at SOAHAC.
6. Consider the capacity of SOAHAC and the AHAC sector to be further involved in identifying priorities for leadership in broader systems change.

SOAHAC is at a critical juncture in its growth and maturity as an Indigenous-informed health agency. It has moved far beyond a time when everything could be overseen and managed effectively, solely by the Executive Director and when cultural knowledge held by a few staff and visiting healers could assure cultural safe client experiences across the organization. With increasing pressure from funding agents, accreditors, and the growing AHAC sector to codify performance measurement, the organization, now more than ever, has to assure authenticity as an Indigenous-informed organization operating within an Indigenous informed model of care (Normore & Issa Lahera, 2012). As a medium-sized, regional, accredited health service agency, the inquiry highlighted the need for the development of more sophisticated organizational frameworks focused on the functioning of Indigenous cultural knowledge, cultural safety, and inter-professional collaboration across the organization. To ensure consistent high levels of management, the organization has restructured its leadership team and in effect has moved to a shared leadership model. This is better aligned with traditional Indigenous governance structures, and the AHAC model of wholistic health and wellbeing, what Archuleta (2012) described as “the principle of interconnectivity” (p. 173). Basically, no one individual can exercise authority nor stand alone.
The recommendations also supported SOAHAC strengthen the AHAC model of wholistic health and wellbeing, apply SOAHAC’s new integrated care model for inter-professional collaboration, and consider the AHAC sector capacity towards broader systems change. An implementation plan for each recommendation was provided with support from the sponsor and SOAHAC’s senior leadership team.

Leading this change initiative will take the continued support of all SOAHAC management and staff, but the benefits to SOAHAC clients and the communities we serve will be worth our collective, coordinated efforts. I look forward to continuing this journey with SOAHAC and the AHAC sector across Ontario.
References


Dedication

For all the tireless, titled and untitled Indigenous Leaders, who make personal sacrifices for the survival of the people and the betterment of our lives. And for my great nieces and nephews that we provide a world whereby they can live in peace and honour the good life that we have been given.
Acknowledgements

I want to express my deep gratitude to everyone who has contributed to the success of this inquiry. Wellaylin, Miigwetch, Na:wen to the brave leadership shown by my sponsor, Brian Dokis, the Executive Director at SOAHAC and the staff, board, and healers at SOAHAC, who have participated and encouraged me to explore critical topics that are sensitive and not always easy to explore inside Indigenous communities and health organizations. I want to thank the members of the I-HIKE group. They participated in the inquiry and also made a space for me around their sacred fire and nourished me and this project at a time when it had become difficult.

I began this master’s program after nearly 20 years away from academic life, so I extend my humble gratitude to all the faculty members and support staff at Royal Roads who helped me to navigate through Royal Roads University academic corridors. A special thank you to faculty members, Kathy Bishop, Maureen Clarke, and Marie Graf.

My academic supervisor, Magdalena Smolewski, was instrumental in keeping me on track, ensuring I coloured inside the academic lines and really ‘got’ the challenges I faced as an Indigenous researcher. My editor, Shanaya Nelson from Amaya Editing Inc., kept this report clear, concise, and coherent. Wellaylin to you both. Thank you also to my cohort who were continually helpful and supportive. A special acknowledgement to Rick Bergen and Ian Blankenberg for their honesty and deep caring.

I would not have embarked on this path or completed this project without my partner, James Butler. He believed in my ability to peruse a master’s level education and was with me every step of the way. Finally, I want to acknowledge and thank my neglected family and friends who continuously cheered me on and waited patiently for me to finish this report.
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Chapter One: Focus and Framing

The Southwest Ontario Aboriginal Health Access Centre (SOAHAC) is an Aboriginal community-governed, primary health care agency that blending western and Indigenous healing approaches. SOAHAC has 70 staff serving 35,000 people in 13 communities, is *status blind*² and operates four clinic sites: London, Chippewas of the Thames First Nation, Owen Sound and Windsor, and outreach clinics to four First Nation communities.

Western-based health models have limited effectiveness in addressing the significant health disparities and inequities between the general Canadian and Indigenous populations (Health Council of Canada, 2012, pp. 8–10). Indigenous-informed, culture-based, community-led services that include traditional healers are more effective (Ontario’s Aboriginal Health Access Centres [AHAC], 2011). Ontario’s Aboriginal Health Access Centres (AHAC) leaders are currently formalizing its Indigenous *wholistic*³ model and renaming it the AHAC model of wholistic health and wellbeing. The Indigenous model (see Appendix A) is foundational to AHACs and is expected to be adopted in the 2015–2016 fiscal year (A. Fisher, personal communication, November 20, 2014).⁴

Since 2012, SOAHAC has increased staff from 20 to 70; many of the new staff lack proper orientation or training required to operationalize a wholistic model of care. Many of the health-professional staff are non-Indigenous with limited experience and understanding of Aboriginal health and community priorities (D. George, personal communication, January 11, 2014).

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² Means the organization is inclusive and serves all self-identified FNIM people, both status and nonstatus, living on and off reserve.
³ The word wholistic, rather than holistic, is often used in Aboriginal communities to keep the focus on the whole person and wholeness of things as understood within many Indigenous cultures.
⁴ All personal communications in this report are used with permission.
2013). Cross-cultural and inter-professional conflicts have had negative impacts on service delivery, evidenced by feedback from clients (B. Dokis, personal communication, November 1, 2013). Improving Aboriginal health outcomes is fundamental to the organization’s ability to implement an Indigenous wholistic health model. Failure brings the risk of losing clients and reducing SOAHAC’s effectiveness as a unique Aboriginal service (B. Dokis, personal communication, January 11, 2014).

Currently, I am the Associate Director at SOAHAC. As I moved forward with this inquiry, I complied with the highest ethical limits and standards at Royal Roads University and SOAHAC. Having worked in Aboriginal health planning and services design for over 20 years, I understand the complexity of Indigenous and cross-cultural diversity that interplay within this sector. An initial analysis of the situation had revealed confusion amongst staff, a lack of common understanding of an AHAC model of wholistic health and wellbeing, vague agreement on how to implement it, and limited methods for inter-professional collaboration. This negatively impacted on client experience. Thus, the change goal of this inquiry was to create a common operational environment throughout SOAHAC to ensure clients have culturally safe experiences at all SOAHAC sites. The inquiry focused on staff, consulting professionals, board members, and Healers at all sites, posing the question: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? The inquiry also answered the following subquestions:

1. What innovative approaches to the AHAC model exist at SOAHAC and how can they be leveraged in the system?
2. What strategies can be developed to increase common organizational and cultural knowledge and standards of practice related to the AHAC model?
3. What are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

**Significance of the Inquiry**

Rapid growth, organizational restructuring, management turnover, limited management and administrative support, as well as insufficient training and orientation of new staff are significant factors impacting SOAHAC (B. Dokis, personal communication, January 15, 2013). SOAHAC clients and staff have expressed concern relating to trust issues and increased cross-cultural and inter-professional conflicts developing within the organization (J. Morrissey, personal communications, September 1, 2014). Fukuyaman (as cited in Atkinson & Butcher, 2003) and Creed and Milles (as cited in Atkinson & Butcher, 2003) described trust in managerial relationships as the social glue that holds diverse organizational forms together; lack of trust can cause those forms to fail.

This inquiry assisted the organization in developing strategies to increase common organizational and cultural knowledge and standards of practice and in turn provided the necessary skills to reconcile the multilevel diversity conflicts. The risks of not implementing the recommendations from the inquiry include the potential for increasing mistrust and differentiated cultural groups leading to staff turnover, losing the quality of health care providers currently at SOAHAC, limiting the organization’s ability to provide comprehensive care, and leading to a decrease in clients and funding.

The board, senior leadership, management, front-line staff, consulting professionals at all SOAHAC sites, and clients were key stakeholders in this inquiry. All stakeholders had an interest in acquiring standard, predictable, and comprehensive knowledge about the AHAC

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5 Community members were also stakeholders but were not expected to directly participate in the project.
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Model of Care and how to successfully apply Indigenous worldview and cultural diversity within SOAHAC’s programs and services (B. Dokis, personal communications, November 15, 2014). Ultimately, SOAHAC’s clients and community members’ benefit from this inquiry, as the outcomes of the study will help SOAHAC in strengthening a culturally safe health services environment at all sites.

**Organizational Context**

SOAHAC’s (2014b) stated vision is “a healthy balanced life through mental, physical, spiritual and emotional wellbeing” (para. 3), and its mission “to empower Aboriginal families and individuals to live a balanced state of well-being by sharing and promoting wholistic health practices” (para. 5). SOAHAC’s (2014b) values include “respect for all, compassion, quality in health promotion and care, [and] honouring all traditional values” (para. 8). The Indigenous wholistic health framework and AHAC Model of Care are essential for achieving health and balance and for promoting the interrelationship between individuals and families and western and Indigenous health practices. The inquiry—focused on respect for all staff, professions, Indigenous health practices, and traditions of the people across the communities SOAHAC serves in order to improve collaboration and the quality of care—included all of SOAHAC’s (2014b) core values.

SOAHAC (2014b) has five main strategic goals: organizational infrastructure, functional work environments, traditional healing, quality, and expansion of needs-based services (Strategic Plan section, para. 2–10). This Indigenous-informed inquiry refocused SOAHAC on the AHAC wholistic care model, including traditional healers and focusing on client needs, and has provided the organization with a detailed plan to improve service delivery infrastructures and enhance the functioning of the work environment. This inquiry has enabled me to identify
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processes to improve the operationalization of the AHAC model of care, which, when implemented, will enhance cultural competency, inter-professional collaboration, and the high quality of care.

To stabilize the organization, in response to rapid change, the senior leadership restructured in January 2015. Integrated care managers were hired to assist in the development of high-functioning inter-professional care teams, including traditional healers. This was a fundamental shift for front-line staff accustomed to working in program-focused teams and across two or more sites, instead of in stabilized, consistent, client-centred, inter-professional, and integrated care teams. This is demonstrated in the new organizational chart (SOAHAC, 2015b; see Appendix B). Current core business components include primary care, maternal, family and child care, mental health and addictions services, diabetes and chronic disease prevention and management, traditional healing, and traditional lifestyles health promotion (Southwest Ontario Aboriginal Health Access Centre [SOAHAC], 2014b, p. 1). With multiple core service providers at each site, some programs and services are mobile, operating at multiple SOAHAC and community health sites as shown on the map of SOAHAC service locations (SOAHAC, 2015a; see Appendix C).

SOAHAC serves multiple Indigenous Nations within Southwestern Ontario, including the Oneidas, Chippewas, Delaware, Lenape, and Métis within First Nation on-reserve, urban Aboriginal, and rural communities. In the urban Aboriginal communities of London, Windsor, and Owen Sound, there is additional diversity with visiting Haudenosaunee, Mi’Kmaq, Cree, Oji-Cree, Inuit, and other Nations from across the Canadian and American borders. SOAHAC’s work is informed by each of these Nations, and, although there is often consensus on health priorities, which Nation’s cultural knowledge, healers, and Elders should be accessed and for
what purposes are continually negotiated. The non-Indigenous professionals who come to SOAHAC for employment, offering valuable clinical and medical services, often do not understand the Indigenous community context in which they will practice medicine and often lack skills to navigate its complex cultural milieu. Although high levels of collaboration between non-Indigenous and Indigenous professional staff and the Indigenous staff working from traditional models of care are expected, this is not always the case at SOAHAC (J. Morrissey, personal communication, September 1, 2014). At the start of this inquiry my intent was to inform improvements to inter-professional collaboration, integration of care, and support staff and staff groups to embrace diversity and resolve cross-cultural conflict. The change from this inquiry will improve alignment between SOAHAC operations and its vision, mission, and foundational values.

**Systems Analysis of the Inquiry**

Community Elder Dan Smoke always reminds the Aboriginal community that they are part of an “interrelated, interdependent, life support system” (D. Smoke, personal communication, September 18, 2014). In Mi’kmaq territory the phrase “Ms i t No'kmaq” is used, which means “All my relations.” These utterances reference a foundational cultural belief imbedded in an Indigenous whole-systems thinking worldview, commonly depicted as a medicine wheel (Dapice, 2006, p. 251). As Healer Adam Luccier taught the people, “Everything you need to address the needs of the people is within the circle” (A. Luccier, personal

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6 Dan Smoke is a member of the Seneca Nation of the Iroquois Confederacy. He is originally from the Six Nations Reserve, Grand River Territory. He is of the Killdeer Clan and a lifetime member of the Onondaga Longhouse.
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communication, January 11, 1996). Going around the circle enables the inquirer to think through the various systems factors impacting the inquiry and key interrelationships (S. Maracle, personal communication January 11, 2014). Utilizing the four basic quadrants of the medicine wheel, physical, mental, emotional and spiritual, one can examine the internal and external factors impacting the inquiry, as depicted in Figure 1. Many different forms of medicine wheels are utilized within Aboriginal health care settings and community service organizations. I have adapted this one, as taught to me by the Ontario Federation of Indigenous Friendship Centres and my family members who are Mi’Kmaq Elders and traditional knowledge holders within the community.

This inquiry involved three key stakeholder groups internal to the organization: senior leadership team, health professional staff, and Indigenous traditional healers. All three groups must adapt to the growth-driven change within the organization while responding to external pressures to meet new, more complex performance standards, and health quality outcomes. External stakeholders critical to this inquiry included the community members or clients, especially that the Ontario government, which is focused on improving the quality of care while envisioning that every Ontarian be attached to a primary care provider (Ontario Government, 2012, p. 9).

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7 Adam Luccier is a renowned Anishnawbe Healer from Red Lake Minnesota. He spent many years at Anishnawbe Health Toronto and was one of my traditional teachers. He has now journeyed back to the spirit world.

8 Sylvia Maracle is the long-standing Executive Director of the Ontario Federation of Indigenous Friendship Centres and respected Mohawk Auntie.

9 This is a wheel that I have adapted from teachings received at the Ontario Federation of Indigenous Friendship Centres and Mi’Kmaq Elders. I have been using these in teachings since 2005.
AHACs are a specific primary care delivery model, providing significant value to the system, but not everyone in Ontario knows about AHACs or their contribution. As part of a joint process to raise AHAC profile within the Ontario primary care sector, the AHAC Executive Director’s Circle gathered information and renewed the wholistic, Indigenous-informed health and wellness model of care. The approved new model is shown in Appendix A (AHAC, 2015). The inquiry included and considered the impacts that the new AHACs model of care may have on local AHAC operations.

Due to Ontario’s fiscal restraints and health transformation agenda, SOAHAC is experiencing greater demand to formalize and codify how health care providers blend western and traditional Indigenous models of care and how this increases quality of care, value for the system and patient experience. The knowledge is within the organization but is not easily
transferred to funding agencies and external stakeholders. Broadly, the inquiry supported the development of new organizational strategies to increase consistent organizational culture across all sites and intended to assist SOAHAC to define and communicate its uniqueness.

As the Associate Director of the organization responsible for the daily operations and delivery of culturally safe, high quality services, I had to reconcile my multiple roles as the inquirer and as a Mi’Kmaq woman who has responsibilities to myself, family, community, Nation, and the environment. The multiple roles inevitably influenced my understanding and analysis situated at the centre of this system and the Medicine Wheel (see Figure 1). Table 1 provides a detailed description of how the Medicine Wheel guided this inquiry.

Table 1

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<th>Internal Factors Impacting Inquiry</th>
<th>External Factors Impacting Inquiry</th>
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<td>East</td>
<td>• Long-term senior staff accustomed to managing small agency</td>
<td>• Primary Care sector in Ontario not familiar with value of AHAC sector</td>
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<tr>
<td>• Mental</td>
<td>• Long-term health provider staff not accustomed to formal process of interprofessional service delivery</td>
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<tr>
<td>• Vision</td>
<td>• Traditional healers outside the integrated systems of care</td>
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<td>• Request</td>
<td>• Improve referral processes</td>
<td>• Clearly demonstrate and message cultural safety</td>
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<td>South</td>
<td>• Improve interprofessional collaboration and integration</td>
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<tr>
<td>• Emotional</td>
<td>• Open lines of communications</td>
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<td>• Nurturing</td>
<td>• Improve sense of belonging</td>
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<td>• Knowledge</td>
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<td>• Grandmothers</td>
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<td>Medicine Wheel Direction, Aspect and Attributes</td>
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<td>• Need to formalize and codify how the organization blends western and traditional Indigenous models of care</td>
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<td>• Action</td>
<td>• Organization to reconnect with its centre (AHAC Model) which is “culture”</td>
<td>• Improve communications with new systems managers (LHINs)</td>
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*Note. AHAC = Aboriginal Health Access Centres; LHINs = Local Health Integration Networks; SOAHAC = Southwest Ontario Aboriginal Health Access Centre.*

**Chapter Summary**

Exploring the inquiry background in relation to its significance and context within an Indigenous systems framework was important to the integrity of the inquiry and to SOAHAC, as an evolving, grassroots, Indigenous health care model. The next chapter explores academic literature about effective models of care in addressing Aboriginal health disparities and the role of cultural safety.
Chapter Two: Literature Review

The literature review explores scholarly and grey literature that can assist the sponsor organization in implementing a culture-based wholistic health care model and improve Aboriginal client and staff experience across the organization. The inquiry question posed for the action research project was: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? The inquiry also included the following subquestions:

1. What innovative approaches to the AHAC model exist at SOAHAC and how can they be leveraged in the system?
2. What strategies can be developed to increase common organizational and cultural knowledge and standards of practice related to the AHAC model?
3. What are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

The academic topics included in this review were selected for their relevance in understanding the current state of Aboriginal health, leading Aboriginal-based health models, and addressing cultural safety within an Aboriginal health care setting. The first topic explores Aboriginal health status, Aboriginal concepts of healing and wellness, and existing models and approaches utilized to improve health outcomes. The second topic examines cultural safety as it relates to improved patient experience and its implementation within an Indigenous health care setting.

Aboriginal Healing and Wellness

SOAHAC provides a broad spectrum of health services to status and nonstatus First Nations, Inuit, and Métis (FNIM) people living on and off-reserve in urban and rural areas across
Southwestern Ontario. Understanding the current health priorities, emerging trends, and effective approaches within Aboriginal health provided context for the inquiry. Knowledge about the diverse approaches, methods, models, and strategies currently utilized within the system, focused on integrating Indigenous healing knowledge and approaches with the western biomedical model, is important to understanding the options available to SOAHAC when implementing the new AHAC model.

Within the main topic of Aboriginal healing and wellness the following five subtopics are explored: (a) defining the Aboriginal concept of healing and wellness; (b) current Aboriginal health priorities; (c) effective service delivery models, methods, approaches, and emerging trends within Aboriginal health; (d) traditional Aboriginal healing systems; and (e) approaches for integrating traditional Aboriginal healing with the biomedical model.

**Defining Aboriginal healing and wellness.** Prior to developing a process for embedding the AHAC model of care across SOAHAC, I found it helpful to examine whether or not the values, principles, and approaches informing the AHAC model are supported by the literature. It was also helpful for me to determine if the literature established a clear and broadly accepted definition of Aboriginal healing and wellness, and whether these definitions inform how Indigenous communities and health service providers plan and deliver services. Thus, this section contemplates the topic of Aboriginal healing and wellness by defining what healing and wellness means from Indigenous perspectives and worldviews. I then explore the subtopic of effective service delivery models, methods, and approaches currently operating within Aboriginal communities. The section concludes by considering the relevance of Aboriginal health models to improving health outcomes.
Indigenous perspectives and worldview of Aboriginal healing. “Simply put, Aboriginal Peoples rate significantly lower on virtually every measure of health and well-being when compared to the general Canadian population” (Lemchuk-Favel & Jock, 2004, p. 31). Over the last number of decades, Aboriginal people in Canada have been involved in what is colloquially referred to in Indian Country as the “healing movement” (Lemchuk-Favel & Jock, 2004; Antone, 2013). The concept of healing is often elusive and subjective; however, a common symbol within Aboriginal communities, the medicine wheel, provides Indigenous people a modern context, a way to make traditional healing and wellness concepts tangible. Most of the literature I reviewed referred to this basic symbol, demonstrating the diverse and varying uses across multiple health and social sectors and defining most of its concepts (Gone, 2011; National Collaborating Centre for Aboriginal Health, 2013; Ramsden, 2007; Riecken, Scott, & Tanaka, 2007; Royal Commission on Aboriginal Peoples, 1996; Slade, 2014). The one concept not highlighted in the literature I reviewed, that is intrinsic within the medicine wheel philosophy, is the focus on relationship. The medicine wheel and Indigenous thinking around it is all about having relationship to self, each other, different Nations, and, most importantly, the environment and the spirit world. This is taught by our Elders (J. Hester, personal communication, April 8, 2013) and is imbedded in the AHAC model.

“Indigenous peoples define wellbeing far more broadly than merely physical health or the absence of disease” (King, Smith, & Gracey, 2009, p. 76). The Anishnawbe have the concept of “the good life” (King et al., 2009, p. 76) and the Haudenosaunee have the concept of “the good mind” (Antone, 2013, p. 165). Inherent in these concepts are of balance, integration, critical thinking, creativity, learning, and completeness (Antone, 2013, p. 165). Adelson and Lipinski (2008) defined healing from the perspectives of Mi’Kmaq youth and Elders as “an active
process—and central to the process is finding balance” (p. 27). The concept of balance is often depicted within the medicine wheel with the four basic quadrants called physical, mental, emotional, and spiritual. This understanding about healing and wellness is widespread within Aboriginal communities and often built upon and implemented as a model within health and social service organizations. Indigenous wholistic frameworks are informed by Indigenous values systems and healing approaches. These involve the integrating or balancing of the mind, body, spirit, and emotions with the inclusion of self, the physical environment, and the spirit realm (Gone, 2011; King et al., 2009; Waldrum, Innis, Kaweski, & Redman, 2008; Walker, Cromarty, et al., 2010). The interpretations and use of the medicine wheel concept vary and are diverse, used in multiple sectors across Indigenous societies. Indigenous community health planners believe that utilizing the medicine wheel symbol in the depiction of an Aboriginal health philosophy grounds a cultural understanding of health and wellness into health service delivery. This provides inherent protective cultural factors, which increases resiliency for those considered most marginalized and vulnerable within the Aboriginal population, such as urban Aboriginal youth (Riecken et al., 2006, pp. 9–10).

Another concept interwoven within Aboriginal-specific health models, frameworks, and definitions of wellness is community wellness. Self-determination, determination in health, and community capacity development are all critical aspects of decolonizing responses and strategies within the wholistic health philosophy and approach. Efforts towards Nation rebuilding or community renewal within health care service delivery are current strategies being utilized (Gone, 2011, p. 196). However, limited progress has been made and, “despite a modest improvement in the socio-economic status of Aboriginal peoples in Canada over recent decades,
many of the underlying social determinants of poor health remain” (National Collaborating Centre for Aboriginal Health, 2013, p. 4).

**Effective service delivery models, methods, approaches, and emerging trends within Aboriginal Health.** One of the challenges of improving Aboriginal health status is the lack of understanding by health service providers, the health system, and society as a whole regarding the underlying causes of poorer health within the Aboriginal population. The widespread Aboriginal health disparities and inequities are a direct result of historical and current aggressive colonization and the pervasive daily pressures on Aboriginal people and communities to assimilate into a dominant western society (Gracey & King, 2009, p. 65). This has been well acknowledged and accepted within the literature (Gone, 2011; King et al., 2009; National Collaborating Centre for Aboriginal Health, 2013; Waldram et al., 2008; Walker, St. Pierre-Hansen, et al., 2010). The exception is Lemchuk-Favel and King (2004). They instead pathologized Canadian Aboriginal people and communities without a meaningful discussion of the obvious underlying causes.

Complicating factors in addressing the impact of social determinants is the jurisdictional wrangling that occurs between provincial and federal funders and the inequities in access and funding that it creates. This is a direct outcome of the colonial model that continues to divide responsibly for Aboriginal health across multiple jurisdictions. One of the starkest examples of this is Jordan’s Principle, which came out of the death of a young First Nations boy who was unable to access community supports and care because of a dispute between the Province of Manitoba and the federal government (Sinha & Blumenthal, 2014). The principle stipulates a child-first approach; care is provided first and financial disputes are dealt with later (Sinha & Blumenthal, 2014). However, violations of this principle continue in spite of federal court rulings
and it remains to be seen if action will continue to address these disparities (Sinha & Blumenthal, 2014, p. 87). Under these circumstances, Aboriginal-controlled models of health service delivery are essential. “They are succeeding in overcoming jurisdictional, cultural and other barriers” (Lemchuk-Favel & Jock, 2004, p. 28).

The biomedical model and euro-centric, western approaches alone do little to increase health status and close the gaps because they do not acknowledge colonization and its impacts and the subsequent cross-cultural incongruences. What is working are community-governed, culture-based, Indigenous-informed models and approaches that blend western modalities with traditional Indigenous knowledge and healing practices (Adelson & Lipinski, 2008; Gone, 2011; Health Council of Canada, 2012; Lemchuk-Favel & Jock, 2004; National Collaborating Centre for Aboriginal Health, 2013; Waldram et al., 2008; Walker, Cromarty, et al., 2010). According to Gone (2011), in the “higher-order, self-consciously promoted Aboriginal therapeutic discourse. . . [an] implicit non-Aboriginal therapeutic discourse was advanced as well” (p. 165).

**Aboriginal health models as a means to improving health outcomes.** Communities are employing Indigenous methods and approaches and engaging Elders, healers, medicine people, helpers, and other people from the traditional communities such as aunties, uncles, grandmothers, and grandfathers, who are recognized knowledge holders, to get involved in creating lasting change and transformation within the area of health and community wellness. The AHAC model does reflect the definitions, concepts, methods, models, and techniques represented in the literature.

However, AHAC’s were created in part in response to widespread systemic racism within the health care system, which causes significant harm to Aboriginal people (Allan & Smylie, 2015; Browne, 2007; Fiske, 2008; Morrison, Morrison, & Borsa, 2014). SOAHAC works with a
number of distinctive Indigenous Nations and cultures. This factor along with other complex
cultural diversity amongst the Indigenous and non-Indigenous staff and professional groups,
requires a comprehensive strategy to achieve cultural safety for all SOAHAC clients and staff.
The next topic explored in the literature is cultural safety as this is key to SOAHAC’s
effectiveness in improving access to health services to the Aboriginal population and reducing
barriers.

**Cultural Safety**

As previously noted, AHACs are mandated in part to redress systemic racism in the
health care system because of the high risks for harm to Indigenous people (Allan & Smylie,
2015; Browne, 2007; Fiske, 2008; Morrison et al., 2014). Providing culturally safe client
experiences is key to SOAHAC’s effectiveness in improving access to health services to the
Aboriginal population and reducing barriers to health care.

SOAHAC works with a number of distinctive Indigenous Nations and cultures, which
can lead to unsafe working environments due to the widespread lateral violence within
Aboriginal communities, another deep-rooted impact of the residential school era (Bombay,
Matheson, & Anisman, 2014). This factor along with the risks of prejudice and racism associated
with health professional discourse of egalitarianism in the treatment of Aboriginal people,
whereby health professional cultures inherently view themselves as providing equal services to
all people, in effect denies Aboriginal experience of being treated differently by them (Tang &
Browne, 2008). Within an Indigenous health organization with high levels of diversity, this can
become a double jeopardy for vulnerable community members accessing care and requires a
comprehensive strategy to achieve cultural safety for all SOAHAC Indigenous clients and staff.
For the purpose of this inquiry, cultural safety was explored with a lens to examining definitions specific to Indigenous cultural safety, the Aboriginal patient and health care provider experience of cultural safety within an Indigenous governed health care setting, and the impacts of diversity on cultural safety within Indigenous health care settings. The reason it is important to examine Indigenous-specific cultural safety in Canada stems from not only unique colonial history, but also because of the subsequent high levels of racism experienced by Indigenous people specifically in health care settings. Research has shown that, of all the racialized groups in Canada, Indigenous people are the most discriminated against and impacted by prejudice and racism (Allan & Smylie, 2015; Browne, 2007; Fiske, 2008; Morrison et al., 2014). The challenges with Indigenous cultural safety training interventions and aspects of the Canadian culture narrative that create barriers to cultural safety are also highlighted.

**Defining cultural safety.** Researchers widely agreed that when examining cultural safety within health care settings that it is best perceived on a continuum from cultural awareness to cultural safety, or what Cross, Bazron, Dennis, and Isaacs (1989) defined as ranging from “cultural destructiveness to cultural proficiency” (p. v). Walker, Cromarty, Kelly, and St Pierre-Hansen (2009) described the Indigenous-specific cross-cultural client safety zone as a continuum scale that moves from a “them” (p. 14), “them and us” (p. 14), to an “us” (p. 14) understanding, which is in itself a decolonizing process. This continuum is represented by a grid, moving from discrimination, cultural sensitivity, and cultural competence, to the final goal of Indigenous cultural congruence and integration (Walker et al., 2009 p. 14). Today, people who actively support Indigenous health care have an understanding that Indigenous cultural safety is a journey and process through these continuums. Ultimately, however, cultural safety is defined by the client’s experience of safety, and this demands health care providers practice self-reflection and
IMPLEMENTING AN INDIGENOUS HEALTH MODEL

develop an awareness of culture and power differentials within health care settings. Finally, Indigenous cultural safety must be linked to improving Indigenous health outcomes and systems change (Health Council of Canada, 2012). The need for Indigenous-specific strategies are becoming more apparent in Canada as Indigenous scholars conduct further research into Indigenous-specific racism within the health care system, which continues to cause inequitable access to health care, often leading to premature death and dying (Allan & Smylie, 2015; Guilfoyle, Kelly, & St Pierre-Hansen, 2008; Walker et al., 2009).

In Ontario, for decades, the predominant cultural training interventions focused on cultural awareness. Indigenous cultural safety, as it is now understood, is a relatively new concept and an emerging field of research. A few studies have been conducted to explore Indigenous people’s experience of cultural safety, but there is still a need for better-designed studies and the development of evidence-based methods (Brascoupe & Waters, 2009, p. 9). This need is especially evident as it relates to evaluation of existing training and education interventions. The thinking behind cultural-awareness-style training interventions is to address the expectation from Indigenous communities that if the “other” just knew enough about our customs, ways, political and social structures and treaties, then people interfacing with the communities or providing health care would simply treat us better (C. Ward, personal communications, September 1, 2013). In retrospect, it may be a naïve but understandable expectation from Indigenous cultures, which often do not have concepts for racism. As such, in effect, there is no way to know whether or not, or to what degree, the incredible effort over the past number of decades by well-meaning Indigenous scholars, traditional people, community leaders, trainers, and advocates has had any positive impact on improving Indigenous health outcomes. Although it does demonstrate resilience (Allan & Smylie, 2015, p. 48), there is no
proof that any of the ongoing efforts actually achieved improved health outcomes for Indigenous people. In fact, on most indicators Indigenous health in Canada is worsening (National Collaborating Centre for Aboriginal Health, 2013). This is why there is an increased call to apply more rigorous measurement of cultural competency and safety to health outcomes (Brascoupé & Waters, 2009; Health Council of Canada, 2012; Walker, Cromarty, et al., 2010). Cultural awareness training throughout the 1960s–1990s was not the magic bullet Indigenous scholars, traditional people, community leaders, and advocates hoped it would be. What continues to be missing from cultural-awareness-style training, in large part, are Indigenous perspectives on colonization in Canada and its impact on Indigenous people. More importantly, there is a need for a fuller discussion about the specific racism targeting Indigenous people, which has grown out of Canada’s particular colonial structures such as the Indian Act (1985) and are impacting on how Indigenous people in Ontario experience the health care system. Today, in part due to the research conducted by the Royal Commission on Aboriginal Peoples (1996), the national Aboriginal Healing Foundation (2006) summary research on residential schools, and more recently the Truth and Reconciliation Commission of Canada (2015) Calls to Action report, along with the recent winning of the human rights case of Assembly of First Nations and Cindy Blackstock against Canada (Canada Human Rights Tribunal, 2016), there is clear evidence of the degree to which systemic racism and discrimination impact Indigenous health and wellbeing and First Nation’s access to health care services.

There are hopeful developments in Ontario coming out of an online Indigenous Cultural Safety training program is currently underway by SOAHAC in partnership with the South West Local Health Integration Network Aboriginal Committee and the Provincial Health Services Authority in British Columbia (SOAHAC, 2014a). This training, funded by the Ontario Ministry
of Health and Long-Term Care and the South West Local Health Integration Network, is antiracist, anti-oppressive, and decolonizing and as such has moved far beyond a simple “cultural-exchange” experience to include history from a race perspective and discussions about systems of privilege (SOAHAC, 2014a).

Given all of the factors described above, Indigenous scholars, traditional people, community leaders, and advocates are now beginning to understand that cultural safety is about self-reflection and needs to move away from simple notions of euro-centric settlers learning about “us” to include white people learning about themselves. Rather, cultural safety is about a heightened self-awareness of health professionals, about their inherent professional cultural bias. This understanding of cultural safety also requires an awareness about how earlier definitions of cultural safety are western constructs and require a broader definition, one that includes Indigenous perspectives and indicators (Walker, St. Pierre-Hansen et al., 2010). There also continue to be barriers and resistance to workplace cultural safety training, organizational change, and systems change that require specific strategies (Johnstone & Kanitsaki, 2008).

Trouble with diversity, multiculturalism and colour blindness in Canadian culture. Generally, Canadians take pride in Canada’s global reputation as a diverse and multicultural society. This lends itself to notions of what is referred to as “colour blindness” (Henry & Tator, 2010, p. 12). This results an erroneous understanding that because Canada is both a diverse and multicultural country, citizens are somehow inherently protected from racism, and, worse, that as a society Canadians do not tolerate racism. This leads to a dangerous, faulty Canadian perception of citizens themselves, which is in effect “cultural blindness” (Cross, 2008, p. 2). Cultural and colour blindness are a denial that racism or discrimination based on race exists. This, in essence, collectively denies the experience of racism experienced by racialized groups in Canada (Henry
& Tator, 2010, p. 12). This false perception has significant implications for Indigenous people. By denying racism it becomes inevitable that Indigenous people’s experiences of disparity and inequities within the health care system are often denied. Worse, Indigenous health interventions are framed erroneously, together with other minority groups, or other priorities related to various determinants of health, which have very different causes within Indigenous populations than other minority groups in the Canadian multicultural mosaic (Guilfoyle et al., 2008, pp. 1–2; National Aboriginal Health Organization, 2008, p. 14).

Canadians also value citizens’ equal rights, guaranteed by the Canadian Constitution Act (1987). What is not always understood is that equality is not the same as equity. Indigenous people suffer from long-standing health disparities and inequities (Health Council of Canada 2012). Furthermore, Indigenous people also have treaty rights to health determination and constitutional rights, through Section 15 of the Charter of Rights and Freedoms (1982), to take measures for our collective survival as peoples. When non-Indigenous, health care professionals come into Indigenous community health organizations, notions of diversity, race, and equity become interestingly complex. If, as Indigenous health leaders, we want to benefit from the power of cultural and professional diversity to meet the complex and unique needs of Indigenous communities, we need to become sophisticated in navigating cross-cultural relationships within health care provision. Indigenous health leaders cannot simply gloss over these differences through a multicultural lens; we must find ways to recognize and harness this diversity as to contribute to better Indigenous health outcomes in a manner that ensures culturally safe experiences within Indigenous health care settings.
Chapter Summary

“Cultural consideration improves health outcomes” (Brascoupé & Waters, 2009, p. 7) for Indigenous people (see also National Aboriginal Health Organization, 2008). Aboriginal or Indigenous health models, worldviews, and clients accessing services must inform cultural safety experiences inside Aboriginal health care settings. To do this, wholistic health care providers have to examine race, inequity, and power imbalances within the organization, communities SOAHAC serves, and the society that health care staff and patients live in. Health leaders must build appropriate strategies and interventions across the organization (Brascoupé & Waters, 2009; Guilfoyle et al., 2008; National Aboriginal Health Organization, 2008; Walker et al., 2009). Doing this work inside an Indigenous-governed health care setting, in which there are uniquely high levels of Indigenous nationhood as well as Canadian cultural and professional diversity requires more rigorous research. In a health care system like Canada’s in which Indigenous people continue to suffer second-class treatment and health inequities, Indigenous-governed health service settings are an essential part of the transformation and change process.

This chapter reviewed the literature that could assist the sponsor organization in implementing a culture-based wholistic health care model and improve Aboriginal client and staff experience across the organization. The next chapter will discuss the inquiry project approach.
Chapter Three: Inquiry Project Approach

The change goal for this project was to create a common operational environment throughout SOAHAC to ensure clients have culturally safe experiences at all sites. The inquiry focused on staff, board members, and healers at all four SOAHAC sites in London, Chippewas of the Thames First Nation, Windsor, and Owen Sound, along with Indigenous health and cultural safety scholars partnered with SOAHAC. The inquiry explored the question: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? The inquiry also answered the following subquestions:

1. What innovative approaches to the AHAC model exist at SOAHAC and how can they be leveraged in the system?
2. What strategies can be developed to increase common organizational and cultural knowledge and standards of practice related to the AHAC model?
3. What are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

Inquiry Project Methodology

Action research is widely used within Indian Country as an antioppressive, decolonizing, and community development activator. Action research is a cyclic process whereby participants, in relation to the issues of the day, “look, think, [and] act” (Stringer, 2014, p. 9) through the various stages of planning, implementing, and evaluating solutions. In my practice utilizing the medicine wheel, as taught by the Ontario Federation of Indigenous Friendship Centres, I have included the domain of Vision—the cycle is then to envision, think, look, and act. Action research is a democratic, equitable, liberating, and life-enhancing methodology (Stringer, 2014, pp. 14–15). This method ensures community ownership of the project by “empowering people to
construct and use their own knowledge” (Lykes & Mallona; Rahman, as cited in Coghlan & Brannick, 2010, p. 45). From the start, my inquiry design followed participatory action research principles and practices, which are widely supported in Indigenous and academic communities when conducting research involving Indigenous populations (Denizen, Lincoln, & Smith, 2008). Following Friere (1970), I utilized participatory action research for its social transformative impact on people who have been otherwise marginalized and disenfranchised (Glesne, 2011, p. 23). I also built cultural safety and appreciative inquiry into my inquiry to positively frame all questions as a protective factor and to mitigate potential stress impacting people throughout this process. Additionally, my organizational leadership project (OLP) considered four of the research principled ethics from the USAI Research Framework of the Ontario Federation of Indigenous Friendship Centres (2012): utility, self-voicing, access, and interrelationally (pp. 910).

**Project Participants**

SOAHAC has a diverse staff comprising both Indigenous and non-Indigenous people. It also serves a diverse set of communities including First Nations living on and off reserve, and an urban population comprising non-Status Aboriginal, Métis, and Inuit clients. SOAHAC board members are formal representatives from each of the communities served and are directly accountable to those communities and to SOAHAC. Within the organization, I directly supervise nine staff including four site managers, three expert leads for clinical, traditional healing, and mental health and addictions services, as well as three staff responsible for data management, research, and Indigenous Cultural Safety (ICS) training. As my management scope includes all but five of SOAHAC’s 70 staff members, I needed to address power-over and concerns and potential conflicts of interest, which I mitigated throughout the OLP through the use of a
research assistant, an inquiry team member, and employing an anonymous research tool—an online survey.

To ensure an adequate level of input from across the agency and that the people could have access to the research, a main participant selection criteria was that whoever was involved in the inquiry had to have either direct accountability to and/or responsibility for SOAHAC’s success or success of AHACs generally. Given that, all SOAHAC staff from the four sites, board members, and contracted visiting healers were invited to participate in the anonymous online survey. After considering the high level of engagement that was happening within the organization and the impact this was having on all staff and board members, I changed the other proposed methods from a world café and interviews with staff, board, and healers, to a learning circle and invited members of the Indigenous Health Information and Knowledge Exchange (IHIKE) group to participate. IHIKE is an Indigenous research group of scholars and AHAC leaders currently partnered to conduct the urban Aboriginal population health survey, “Our Health Counts,” in London and Kenora, Ontario. SOAHAC is the sponsoring host organization for the survey in London. I further discuss these choices in the “Inquiry Project Methods” section of this chapter.

The selection criteria excluded clients. Time constraints limited the feasibility of directly involving clients. As the inquiry did involve SOAHAC’s client experience of cultural safety, I reviewed SOAHAC client satisfaction survey results from all four sites for the 2014–2015 fiscal year. The client satisfaction survey asked in-depth questions about how SOAHAC clients experience services and yielded rich data.

I had two members on my inquiry team. The first was my sponsor, who is the Executive Director at SOAHAC with over 30 years’ experience in Indigenous health service management;
my sponsor has the authority to implement recommended changes from this inquiry. The second member is a respected and trusted member of the community with extensive research, with facilitation skills and expertise in cultural studies. He assisted with sending out the online survey to SOAHAC staff, board, and Healers and pilot tested my survey and learning circle questions and processes. Prior to assisting with the research both inquiry team members signed a letter of agreement (see Appendix D). I could not secure additional members for my inquiry team, as the Indigenous master’s students from the local university I had originally sought came to work at SOAHAC during the life of the project. However, at mid-point, I did receive support from the IHIKE group in coordinating a learning circle with them. I also engaged a transcriptionist to transcribe the learning circle dialogue.

**Inquiry Project Methods**

This section outlines the data collection methods utilized and the reasons for changes in methods as the inquiry progressed. I also discuss the study conduct and the data analysis tools, technique, and methods utilized in the inquiry.

**Data collection methods.** Originally thinking to generate cross-cultural and cross-professional dialogue, I intended to consider four potential methods in this order: (a) a world café with as many staff, board, and healers as possible; (b) a talking circle with a smaller staff group at a satellite site; (c) an anonymous online survey to allow further staff participation; and, had I discovered significant Indigenous cultural knowledge gaps, (d) up to three individual interviews with visiting healers or community Elders. According to Coghlan and Brannick (2010), in action research, data come “through engagement with others. . . it is more appropriate to speak of data generation than data gathering” (pp. 73–74). This was the approach I envisioned the project to take. Once I studied further how to conduct a world café, however, I realized that it would limit
the success of my research because as a method it had too many power-over issues to resolve in SOAHAC’s context. In consultation with my sponsor and academic supervisor, I then considered other methods, new potential participants, changed the order of the methods, and decided to begin with the anonymous online survey.

**Anonymous online survey.** With the intent to engage as many SOAHAC staff, board members, and contracted visiting healers as possible, on October 13, 2015, my research assistant sent out a seven-question, anonymous, online survey to all potential participants via email; the survey had been approved by Royal Roads University (RRU) and remained open until October 30, 2015. A total of 16 participants responded and provided substantive data within that timeframe. Online surveys are generally considered to “have limited utility within the first stages of action research process” (Stringer, 2014, p. 118). It is considered risky to do the research in this manner. However, I had to consider the context at SOAHAC in late fall and be true to our story as an Indigenous-governed health organization and myself as an Indigenous health worker and researcher (Smith, 1999, p. 39). Staff calendars were full, SOAHAC had just gone through a grueling 9-month primary care accreditation process, which generally takes a full year, and the organization had accredited children and youth mental health services for the first time. In addition, at the time, SOAHAC had seven women in key roles across the organization going on maternity leave, so leadership were recruiting replacements, as well as managing a major capital project, and opening two new satellite sites and outreach clinics within an extended geographic area. Time was marching on, so in consultation with my sponsor and academic supervisor, although the survey was considered a little risky, it was the best way to begin considering the organizational and community context. In the end, substantive data was gleaned from the online survey perhaps because the questions and topics explored are ongoing challenges staff face
inside Indigenous health care and discussed widely across the agency over the last 2 years while the organization grew and restructured to improve client services. However, SOAHAC’s appetite to collaborate on interpreting the findings or to have further dialogue at that time was low. My sponsor and I had to respect this reality in the end.

**Learning circle.** On initial analysis of the online surveys, two gaps emerged in the data. The first gap related to strategies for increasing cultural safety within diverse, inter-professional, Indigenous community health care settings (i.e., AHACs) and extending cultural safety when clients are referred to non-Indigenous service providers. The second gap related to strategies for ensuring SOAHAC is grounded in local traditional Indigenous knowledge and that all staff have access to cultural teachings, education, and knowledge as part of their employment at SOAHAC.

In November 2015, during a regularly scheduled IHIKE meeting, I shared my research challenges. The group agreed they would assist me. Further, that they considered their participation as part of the collective research mandate. To assist in the OLP, the lead coordinator for IHIKE obtained information about the inquiry project, suggested questions for the learning circle, delivered consent forms to the members, and identified the best next date to host it. After receiving approval from RRU, my academic supervisor, and my sponsor for the set of eight questions relating to three overall themes, and with no ethical issues related to power over, I facilitated a learning circle on January 6, 2016. I worked with four of the six other IHIKE members via teleconference for 1.5 hours utilizing a virtual talking stick. The group included three Indigenous health research scientists from Well Living House in Toronto, an Indigenous action research team at St. Michaels Hospital including a physician, and a visiting scholar from Australia. An AHAC Executive Director from Northern Ontario also joined the circle. Learning circles, as a research method, are aligned well with Indigenous cultures (Riel, 2014). The IHIKE
group was comfortable with the method, despite the group going 30 minutes over time. McClure (n.d.) stated, “The circle of committed participants creates a spirit of safety, peacefulness, attentiveness, trust, respect, cooperation and creativity” (p. 1). This is how I experienced the learning circle and the others spoke very positively also. This method generated a substantive data set for analysis and blended Indigenous-specific knowledge from clinicians, researchers, and health leaders.

**Study conduct.** This section outlines the steps taken to undergo an anonymous online survey and learning circle via teleconference in the context of an extremely busy Indigenous health organization and taking into account that I, as the researcher, had power-over issues with the SOAHAC staff. I also describe the thought processes I worked through when it became necessary to change methods and approaches in the life of the inquiry. Furthermore, I outline how, in the later stages of the inquiry, it became increasingly more relevant to apply Indigenous methodologies. Of Smith’s (1999) 24 Indigenous methodologies, this project relied on celebrating survival, Indigenizing, connecting, envisioning, restoring, networking, protecting, creating, and sharing (pp. 140–161).

**Anonymous online survey.** After recognizing that a world café research method was not a good choice for the inquiry, I created an anonymous online survey tool using Google (n.d.) forms. Due to the general fatigue of SOAHAC staff and board members, I aimed to keep the survey completion time to 15 minutes. Each question was crafted linked to the overarching inquiry question and subquestions. I settled on seven open-ended questions (see Appendix E). Before submitting to RRU for final approval, I tested the questions with my inquiry team not only for relevance and clarity but also to mitigate risk and limit sharing of identifying information in order to maintain the survey tool’s anonymity. This was an essential component
to address the extensive power-over issues I had as a researcher. Once approved I created an invitation to complete the survey, which clearly stipulated the anonymity of the survey tool, how information was going to be collected, stored, and used, the risks and benefits to participation, and directions on how to withdraw. The invite provided my research assistant’s contact information (phone and email) with directions to contact him or my sponsor with questions, for more information, or to discuss the research project (see Appendices F and G for Letter of Information and Invitation Letters). My research assistant then sent out the link to the survey, attaching the research project Letter of Information (see Appendix F). Participants were told that consent was considered implicit once they began to answer the survey questions. Participants were given almost 3 weeks to complete the survey. Midway my research assistant sent out a reminder email and my sponsor also crafted an email encouraging staff and board participation (see Appendix H). I received 16 completed surveys in the timeframe. Responses were very thoughtful and complete. I could have written a report with the quality of information provided from those surveys alone. I found only two areas that could benefit from an additional data, as outlined in the “Data Collection Methods” section of this chapter. This is why at first I wondered if I should conduct two interviews to drill a little further down on those two gap areas. I proposed conducting interviews with my sponsor, a board member who has a dual role of community Elder, and Dr. Janet Smylie who is a leading Indigenous research scientist currently conducting research into cultural safety and is a practicing physician within Indigenous communities. My sponsor was open to this method and approach. My supervisor also approved. I drafted two sets of interview questions and tested them with my inquiry team members and supervisor. When I consulted with the RRU for approval of the method and questions, however, they expressed concerns about interviewing my sponsor and cautioned it may not get the results required for my
final report. Meanwhile, it became clear by late November 2015 that I would have to request an extension. I received approval by RRU for an extension to April 12, 2016. A number of complicating factors then emerged. A major event occurred at SOAHAC relating to the traditional healing services and traditional healers that would prevent a cross-organization dialogue on key aspects of my inquiry. Then I was seconded for a year to Toronto to work on provincial AHAC sector advancement. This is when, after consultation with my sponsor and supervisor, it was agreed that working with IHIKE was a good way to continue to generate additional data for SOAHAC through the learning circle method. I was able to utilize the questions I had originally drafted for interviews in formulating the facilitation plan for the learning circle (see Appendix I). These questions were tested with the inquiry team, my supervisor, and a member of the IHIKE group.

**Learning circle.** Prior to the learning circle event, information about the inquiry, a status report, and consent forms were circulated to those IHIKE members who agreed to join the circle (see Appendices F, J, and K). One member had indicated she was interested but could not attend on that date. The questions related to each of the methods are captured in Appendix I. I arranged to have the teleconference recorded with qualitative transcription services through Babbletype® (n.d.) an online service that is reasonably priced and protects confidentiality and has secured storage through its services agreement.

Only one participant provided a signed consent form well in advance of the event. Four total joined. Therefore, before getting started I reread the consent form, reiterated the meaning, and had each participant state their consent for the audio recording of the circle, on the recording itself. I also ensured participants understood how I was going to use the data generated from the circle, as described in the letter of information (see Appendix F), and I restated the status of my
inquiry. I then discussed the level of confidentiality expected by participants. I had also completed a smudging ceremony prior to the event and let the participants know that I had done that.

Once I had the data transcribed, I invited the participants to review the transcription for accuracy, validation, trustworthiness, and clarification. None of the participants had time to review the transcription, but they kept the door open for me if I had further questions of them.

**Data analysis.** The data analysis process involved categorizing and coding to derive meaning (Stringer, 2014, p. 139). Charmaz (2006) provided explicit examples of how to effectively code transcribed raw data so as to develop categories and to generate more robust information. “Qualitative quoting, the process of defining what the data are about is [the] first analytic step” (Charmaz, 2006, p. 43). The categories described by Charmaz (2006) and Stringer (2014) helped to generate the key concepts that shaped the findings for this inquiry. As Stringer (2014) wrote, action research requires reflection that “allows participants to better understand problematic features of the situation” (p. 136). In order to more effectively achieve this level of reflection, the categories and concepts generated in the analysis were used to produce memos, which became the initial findings for the inquiry.

Given that I am a member of the Indigenous community and the Associate Director at SOAHAC, I strove throughout the inquiry to reduce research bias and increase trustworthiness. Glesne (2011) provided a number of procedures to reduce qualitative researcher bias (p. 49). I utilized triangulation, peer review, and reflection to enable confidence in the validity of my findings. I chose methods that could generate transcribed, word-for-word data in order to more effectively utilize the verbatim principle. I developed questions with the assistance of my inquiry research team and promoted participants to provide recommendations. After conducting coding
and memo writing exercises, I also reflected on my reactions to the information and referred back to the inquiry questions and prepared notes. Understanding the complexity and challenges with use of verbatim and transcription itself in qualitative research relating to trustworthiness, I listened to the audio recording of the learning circle twice, once for context and the other to examine the gaps in the transcription itself (Davidson, 2009, p. 45). I also utilized an online word cloud tool to generate visual representations of both the survey and learning circle data and reflected on this. I then triangulated the data from the online survey and the learning circle with the literature. Finally, once the key findings were extrapolated, I shared those with the inquiry research team to generate recommendations to increase trustworthiness and reliability.

**Ethical Issues**

The *Tri-Council Policy Statement’s* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014) ethical guidelines describe three core principles: respect for persons, concern for welfare, and justice (p. 6). These principles align with Indigenous worldviews and value systems. In this OLP, I have included everyone equitably as participants, thus respecting their persons and consideration of justice. Clients are often dealing with trauma and stress, and this is why I purposely excluded them from direct participation within this project, as not to cause undue stress, over engagement, and/or set up false expectations. As the OLP deals with the interpretation and practice of local cultures and traditional healing, I had to ensure community support and apply the highest ethical standards from participating Nations in addition to adhering to RRU ethical guidelines. Therefore, balancing the research approach and methods was critical to the OLP’s success. As researchers have a “duty of care” (Canadian
Institutes of Health Research et al., 2014, p. 152) in relation to all the people they engage in processes of investigation.

I leaned heavily on my sponsor, the formal representative for the SOAHAC board, who are the authorized community representatives of the people the organization serves. He reviewed my research proposal and the ethics review from RRU and approved my project to go forward within the organization. SOAHAC, as an Aboriginal Health Care Agency, had the final say on whether I would conduct this research at SOAHAC. “The main principles for research policy and practice must be that Indigenous people should control their own knowledge” (Battiste, 2008, p. 501). As a Mi’kmaq woman, with additional ethical responsibilities to the communities, I ensured this occurred.

**Respect for privacy and confidentiality.** People in Indian Country often state that they do not have privacy. This is not only because Indigenous people are often close knit and living in small communities, in which everyone knows everyone’s business, but also because there is an inherent sense of being under pressure, that “big brother,” the Government of Canada, is constantly scrutinizing and running surveillance within First Nation communities. In my interactions with SOAHAC staff, the issues of privacy and confidentiality are discussed frequently. There is significant energy around these topics. As such, I strove in this project to protect individual and community privacy and confidentiality, while at the same time surfacing issues of colonization dealing with privacy and confidentiality that impact First Nation people’s ability to have open, free communications and dialogue with one another. I included questions relating to the complexity of privacy and confidentiality within Indigenous communities, explored this topic, and encouraged discussion.
**Requirement for free and informed consent.** As I have an employment reporting relationship with a number of participants, it was critical that I ensured free and informed consent within this OLP. I presented information that the benefits of my involvement outweighed risks. I continuously reminded people throughout the process of this aspect of the research and encouraged those who were not comfortable participating to step away from the process, while advocating for all people who have ideas to share to participate, for the good of the work SOAHAC undertakes.

For those conducting research, ethics should not be a difficult concept to grasp. As Coghlan and Brannick (2010) noted, “The ethical issues of action research are not different from the ethical issues of a good life” (p. 132).

**Chapter Summary**

This chapter outlined the inquiry approach, methodology, methods, and tools and explained why they were chosen and how they were applied. I described the participants involved in the project and the selection process. Ethical issues specific to an Indigenous inquiry and ways in which they were addressed were also outlined. I also explained how the data were generated and analysed. In Chapter 4, I constructed the research findings and documented my conclusions.
Chapter Four: Action Research Inquiry Project Findings and Conclusions

In this chapter I explore the relevant findings and conclusions as well as the scope and limitations of the inquiry. The change goal of the inquiry was to create a common operational environment throughout SOAHAC to ensure clients have culturally safe experiences at all sites. The inquiry posed the following question: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? The inquiry also answered the following subquestions:

1. What innovative approaches to the AHAC model exist at SOAHAC and how can they be leveraged in the system?
2. What strategies can be developed to increase common organizational and cultural knowledge and standards of practice related to the AHAC model?
3. What are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

Study Findings

Participants in the inquiry were asked to reflect on the AHAC Wholistic Model of Health and Wellbeing and innovative practices inherent in the model, cultural safety within an Indigenous health care setting, and the impacts of diversity on cultural safety. Participants were also asked to discuss the challenges to Indigenous culturally safe care provision and health care systems change. The five findings presented in this section acknowledge the complexity and success of the AHAC model of wholistic health and wellbeing while discussing next steps in the evolution and development of culturally safe care provision at SOAHAC and within the health care system generally. The five findings are as follows:
1. The AHAC Wholistic Model of Health and Wellbeing is an effective model of integrated care for Indigenous communities, which inherently provides a high degree of integrated services, innovation, and culturally safe care provision.

2. Successful implementation of the AHAC Wholistic Model of Health and Wellbeing requires comprehensive processes to ensure traditional and local Indigenous knowledge consistently informs leadership, services planning, development, and delivery of care.

3. Physical space and relationships are integral in implementing the AHAC model and achieving cultural safety for Indigenous clients.

4. Cultural safety has to include the development of indicators and methods to measure cultural safety across the organization.

5. AHAC’s could utilize its capacity to provide culturally safe care for the Indigenous population outside their walls into other parts of the health care system through an extended services scope and work on “Indigenizing” health professions.

These findings are explored and described below using excerpts from the online survey and learning circle. I utilized participant codes when direct quotes are presented to protect anonymity, in particular for the learning circle participants. I reference the data collection tools as OS to indicate the online survey and LC to indicate the learning circle, and unique codes have been assigned to each participant in both methods: OS1 through to OS16 for online survey participants and LC1 through to LC4 for learning circle participants.

**Finding 1: The AHAC Wholistic Model of Health and Wellbeing is an effective model of integrated care for Indigenous communities, which inherently provides a high degree of integrated services, innovation, and culturally safe care provision.** Participants
were asked to discuss their understanding of the AHAC model of care and their place at SOAHAC in relation to the model. Responses identified the integration of services to address physical, mental, emotional, and spiritual health and integrating Indigenous and western approaches to health care. Participant OS15 replied,

We can provide a level of care that is holistic from the beginning. . . not later and not as an afterthought. We are not a western care model that has Indigenous build in—we are an Indigenous care model with western systems built in.

Participants identified the model as client centred and asserted clients’ life stages are considered from a cultural perspective, across the lifecycle stages (OS3, OS8–OS10, OS16). Participants recognized that clients are seen at SOAHAC not only as individuals but also as part of family and community and as kin networks and systems (OS3, OS8). However, only one participant connected this to a decolonizing process, which is also one of the aims of the model (OS6). Instead participants discussed self-determination and holding multiple spaces within the agency. OS12 articulated,

As a First Nations person, I am able to use my life experience, knowledge in my work at SOAHAC. Personally I feel an obligation to continue to work towards self-determination in health. Other models have not worked and this model is a definite move in the right direction.

Participants highlighted sharing and celebrating traditional Indigenous teachings, knowledge, ways of knowing, ways of being, as well as western practices as it relates to the work at SOAHAC within the communities. Participant OS10 expressed,

I understand that my cultural identity is important to my colleagues and community members, and I feel that it is respected by the organization. I feel that I am more
confident in the work that I do for SOAHAC because I am able to celebrate and share my cultural identity with others.

The importance of relationships was strongly noted, not only between clients and providers but also within and across the organization. Participants saw themselves as part of a circle of care and as living the seven grandfather teachings as a method to inform relationship management (OS3, OS6). Participant OS1 noted, “SOAHAC embodies what it offers. ... a rare chance to be accepted and honoured for difference.” Referring to the iceberg model within the online ICS training, OS1 explained, “We connect at the deepest level, not on the superficial. We connect at spirit level and work collaboratively.” The potential for interconnectedness, which is a hallmark of the model, was also noted by participant OS8, who wrote,

Looking at the individual as a whole and understanding that that person’s health is impacted by all aspects. ... can cross many cultures. ... even if my belief system is different, fundamentally this notion that people are impacted by all aspects of self and culture, crosses mine.

When asked about what innovative practices are evident at SOAHAC, participants viewed the wholistic model itself as an innovation in Indigenous health care (OS1, OS7, OS8, OS10, OS14–OS16), citing the availability of Indigenous traditional healers and ceremony (OS1, OS2, OS5, OS6, OS8, OS9, OS11, OS13–OS16) and “incorporating Aboriginal teachings in theories and practice” (OS8). Participants also noted the client’s choice between western and Indigenous services and the quality of access (OS1, OS5, OS7, OS11, OS14). “It is easy to access primary care, mental health, traditional, dieticians often the same day. ... [SOAHAC is] able to quickly connect clients to services while they are in the building” (OS11). Other innovations participants identified relate to breaking down access barriers by “offering blood
drawing and small procedures in house [and] providing transportation, bus tickets, home visits, phone call follow up” (OS5). In particular, participants identified SOAHAC’s integrated care model and culture-based health promotion as innovative (OS1, OS2, OS7, OS10, OS15). The integrated care model, “which incorporates Integrated Care Managers at each site is a big improvement for the client’s experience with the health care system” (OS10). The “culturally specific health promotion practices. . . [ensure SOAHAC’s] health promotion activities honour and respect Aboriginal culture and spiritual practice” (OS2).

**Finding 2: Successful implementation of the AHAC Wholistic Model of Health and Wellbeing requires comprehensive processes to ensure traditional and local Indigenous knowledge consistently informs leadership, services planning, development, and delivery of care.** There was substantive data validating that SOAHAC is already engaged in a significant level of activity to improve the cultural knowledge of staff, board, and community. This is essential to cultural safety and the implementation of the AHAC Model. When asked what additional resources SOAHAC could develop to improve cultural knowledge and safety, one participant responded in all capital letters, “I have had an amazing experience at SOAHAC of being made aware of history, generational trauma, cultural safety. . . the best education I have had. My needs are more than met” (OS1). The online ICS Training is seen as an asset to the organization, and one participant recommended that SOAHAC management make mandatory “the ICS. . . and at least 2 of the post-trainings available” (OS6). The data indicated opportunities to enhance ICS education with “collected resources about the Nations and lands each of our sites is situated on and the history of those Nations” (OS14) and also about their “languages, foods and cultural practices” (OS2). Furthermore, these types of resources could be used for orientation of new staff, particularly students who may not have time to fully complete
the online ICS program but require a basic level of cultural safety training to work at SOAHAC (OS5). Participants also expressed interest in studying other Nations from further away, such as the Innu and Inuit (OS13) and learning from each other on a regular basis to share traditional knowledge held by SOAHAC staff (OS12). Other ideas brought forward were increasing staff and community access to ceremony (OS8) and having guest speakers conduct workshops to extend and enhance cultural education to clients (OS11). As one participant stated,

Educational programs/workshops should be provided for community members, clients. . . about colonization, residential schools and the impacts [these] should be accessible to the people not just workers and organizations. People need to know how the past has impacted their life choices today. (OS4)

Participants suggested the need for traditional and cultural knowledge to be accessible at all levels of the organization (OS15, LC1, LC2). One participant noted the need for SOAHAC to “provide culturally appropriate input into leadership, planning, training and implementation of health care services to all Aboriginal people and service sectors” (OS6). The data show that the critical enabling factor to achieving cultural safety and implementing the AHAC model is access to, engagement with, and involvement of the traditional Indigenous community (OS, LC). OS16 summed it up well: “It is vital to establish and maintain relationships with those who hold the knowledge and history within the local area. . . SOAHAC needs to involve local traditional peoples at its [decision making] tables at all levels.” Two LC participants also agreed with this statement (LC2, LC3), and this finding was supported by the literature reviewed (Adelson & Lipinski, 2008; Antone, 2013).

Participants provided a number of concrete approaches to address the issues raised in this section. They suggested a number of formal structures, including a cultural safety committee
Participants viewed creating formal Indigenous knowledge structures as a way to address the imposition of the hierarchy inherent in the western medical system and as “useful in trying to bridge, in some ways cross over, between that western perspective and as well as the Indigenous perspective” (LC3). Participants also identified the need to “support feeling strong and revitalizing our expressions of indigeneity in a way that we provide services and integrate [traditional knowledge] into our day-to-day activities” (LC2). They offered some suggestions that the Indigenizing process has to start at the governance level, with the board (LC1). Additional descriptors for such a group identified in the data included that the group should not be too large and have directive authority (LC2). Furthermore, the group should have the ability of skill to be self-reflective, be transparent and share learnings, have understanding about how to run and develop Indigenous organizations, respect the diversity within Indigenous communities, know how to identify gaps, and work in a manner that is grounded in the things that are important to the community (LC1–LC3). Groups of knowledge keepers with lived experience should inform community organizations about how to incorporate Indigenous values into day-to-day activities across the organization (LC1–LC3). For example, given that kin systems are very important, as is reciprocity within Indigenous cultures, how do we “build on or use them in contemporary Indigenous organizations, what are the specifics of that?” (LC2). “These are [Indigenous] organizational development management issues” (LC2). The scholars involved in the LC called for the articulation and sharing of our ideas and to speak about them and write them down so that we can refine and share them, even though in the past we did not have to write things down (LC1–LC3).

**Finding 3: Physical space and relationships are integral in implementing the AHAC model and achieving cultural safety for Indigenous clients.** Participants in the LC and OS
discussed the importance of relationship building, with clients and also between providers inside the centre (LC1; OS3). Within the current health care environment, Indigenous people continue to face systemic racism. Given this, whether or not Indigenous people access and receive quality and safe care outside of Indigenous health centres, strong relationships with clinicians and networks of clinicians are also crucial (LC2, LC3). In particular, participants placed specific emphasis on the need for good relationships between western-trained health care professionals and traditional Indigenous healers and medicine people (LC1–LC3). Building those relationships requires dedicated time. “If time is not taken to learn about one another and value the differences, whether it is a co-worker or client relationship, developing the relationship will be hindered from the get go” (OS3); LC participants also agreed with this statement (LC1, LC2). In the provision of wholistic and integrated care, service providers “need to understand what each other does so they can learn to accept it and figure out how they can work with it, not to do each other’s roles, but they have to see how they intersect and compliment” (LC1).

I found substantive discussion in the data, in particular in the LC, about how to Indigenize the agency’s governance and operations (LC1–LC3). Participants also shared questions about what exactly indigenous service agencies do and what such agencies would look like (LC1, LC2). Learning circle participants generally agreed that this is the critical work and key challenge of our time, “given the processes of ongoing reclamation, revitalization, uncovering, recovering of Indigenous knowledge, values, skills, beliefs and transformation that are happening” (LC2). The process for Indigenous service agencies and other health care facilities in creating safe spaces for Indigenous people and communities also must consider physical space (LC, OS). This physical space has to reflect Indigenous cultures. One participant expressed that SOAHAC could have, “more visual tools, pictures, furniture and other items [at
the clinics] that [demonstrates clearly] that this is a native services agency” (OS15). Even mainstream health service agencies, such as hospitals, need to be physically safe spaces designed with Indigenous people in mind (LC3). Another key element found in the data about the importance of Indigenous spaces in primary care settings was articulated best through a story shared by one of the participants in the LC. One of her Indigenous board members was driving through town with one of her children, and he pointed to the building that the centre had just purchased and asked what it was and what was going on there. The mother told the child, “That’s ours, we own that” (LC1). “It’s important for community to feel that sense of ownership . . . [and] to ensure its actually meeting their perceptions of what a safe place looks like, feels like and functions like” (LC1). One participant noted that when Indigenous people were asked in one study to discuss their health care interactions, “there was an important overlap between the actual physical space and the relationship space” (LC2).

**Finding 4: Cultural safety has to include the development of indicators and methods to measure cultural safety across the organization.** When asked about the strengths of diversity (cultural, generational, gender) at SOAHAC and the impact of high levels of diversity on relationships between staff and staff and clients, participants had some positive comments to share. People widely acknowledged the benefits of diversity in organizations. However, from the data it appears that when it comes to cultural safety within a health care environment, high levels of diversity can also inherently create levels of new risk for Indigenous people. This is consistent with the literature about systemic racism in the health care system specific to Indigenous people (Allan & Smylie, 2015; Bombay et al., 2014; Browne & Fiske, 2001; Morrison et al., 2014; Tang & Browne, 2008). Participants identified a number of areas relating to cultural safety that require attention:
Tensions between Indigenous and non-Indigenous staff about the perceived favouring of Indigenous hires, while not equally celebrating committed, non-Indigenous staff contributions (OS12).

Tensions between SOAHAC and the community members who would like to see more Indigenous staff at the centres when accessing services (OS7, OS12).

The lack of clear understanding of the definition of “status blind” by providers within the organization sometimes leads to non-Indigenous people getting care at SOAHAC and inadvertently exposes Indigenous clients to culturally unsafe experiences at SOAHAC (OS3).

One participant noted, “Primary health care [staff at SOAHAC] still need to make some effort in its work to integrate its practices with traditional approaches to health and wellness” (OS2).

Participants also expressed concerns that Indigenous clients do not always understand what cultural safety is or value high-quality health service provision. One participant stated, “They [clients] sometimes think that because this model is for the Aboriginal population that the service providers can do ‘short-cut’ in their care” (OS14). It was seen as important to raise awareness of cultural safety, as “many [Indigenous] people do not know what it means and that they have a right to experience a culturally safe environment when accessing health care services anywhere” (OS15); this statement was also supported by LC participants.

One participant shared the insight that some of SOAHAC’s external organizational partners do not always understand why Indigenous people require specific and dedicated health and wellness services (OS14). Clients are at risk in the referral processes, which needs attention to reduce cultural unsafe health care experience and the harm from those experiences on
Indigenous health outcomes (LC2). At SOAHAC, diversity is viewed as necessary and is welcomed and celebrated. However, staff are also keenly aware of the dangers of unsafe cultural experiences. As one participant articulated, “It is important that all staff feel safe and comfortable at SOAHAC despite cultural differences. That being said whoever works at SOAHAC needs to be the right fit and supportive of our culture and model of care” (OS13).

Participants in the LC discussed the necessity of cultural safety measurement within the health system. Similarly, OS9 questioned, “If there are checks and balances in place for non-Indigenous workers or highly colonized Aboriginal workers in how well they are providing services to people, [and] are ongoing, modern colonial practices allowed within the organization structure at SOAHAC?” To address this, participants supported and called for Elders and traditional Indigenous knowledge keepers to be engaged to ensure policies, practices, and guidelines are created and followed (LC, OS) and to “foster cultural safety within the SOAHAC family” (OS15).

**Finding 5: AHACs could utilize its capacity to provide culturally safe care for the Indigenous population outside their walls into other parts of the health care system though an extended services scope and work on “Indigenizing” health professions.** The participants in the LC had rich discussions about how to Indigenize community health centres in a way that is authentic and meaningful, reflecting Indigenous values, beliefs, and worldviews, grounded in local context and interests of the communities, blending the best of western and Indigenous approaches. In such a model, it is essential to have measurable impact in improving health outcomes while also building health capacity within Indigenous communities. Participants expressed concerns about how to address systemic racism while working on systems change, once clients are interfacing with other service providers and parts of the system, which may not
be culturally safe spaces (LC1, LC2). Participants acknowledged the strength of AHAC’s “whole range of services” and how communities find it useful to have services at one location as much as possible (LC3). This could potentially limit the exposure and lower the risk of experiencing racism, since AHACs are already doing integrated primary care, and by doing so are creating Indigenous safe spaces for community members to receive care (LC3).

The LC participants discussed extending both acuity of care and scope of practice to include shared care models with health agencies in other sectors. Within that “interface” they see an opportunity for AHACs to Indigenize other areas of the health care system where the people go to receive care (LC1–LC3). This suggestion was not aimed at forcing external providers to interface, but rather engaging with those providers who are already skilled at interfacing. In addition, efforts at interfacing should explore models of practice with already high levels of integration and build on those (LC2). Aboriginal midwifery and Aboriginal nursing were identified by participants as examples of how western models actually can become more Indigenous earlier on and can continue to create those Indigenous environments and cultural safe environments within the health care system. The thinking was best reflected by LC2, who stated, “The more Indigenized the whole AHAC is then that becomes an ongoing experience within an Indigenous context.” Specific strategies identified in the data include increasing levels of acuity seen by health care professionals within the centre, systems navigation, advocacy, and building culturally safe networks of referrals (LC).

**Study Conclusions**

The change goal of this project was to support SOAHAC to create a common operational environment throughout the agency to ensure clients have culturally safe experiences at all service sites. The inquiry explored the ways in which SOAHAC as an organization could more
effectively implement the newly refined AHAC model of wholistic health and wellbeing within a
diverse organizational environment. The OLP examined existing innovations and considered
strategies for creating common knowledge and practice.

A substantive amount of data were generated from the qualitative methods used in this
inquiry. The conclusions are based on analysis of this data, its themes, and are supported by the
literature and emerging trends in Indigenous health care. My conclusions are as follows:

1. There is appetite at SOAHAC to formalize organizational structures and practice
   relating to Indigenous knowledge and cultural safety.

2. The AHAC model of wholistic health and wellbeing must be situated as a
decolonizing and reconciliation process for clients, staff, and communities.

3. Diversity at SOAHAC is a strength that can be better managed and utilized.

4. SOAHAC can contribute to broader health systems advocacy efforts to improve
   Indigenous determination in health and health outcomes.

**Conclusion 1: There is appetite at SOAHAC to formalize organizational structures
and practice relating to Indigenous knowledge and cultural safety.** As Indigenous
communities heal and become empowered there is increasing demand for Indigenous-informed,
culturally congruent processes throughout the community. Figuring out how to do this generally
involves engaging with local traditional knowledge holders or keepers such as Elders, traditional
teachers, healers, medicine people, ceremony carriers, clan mothers and other traditional leaders,
and respected people within extended kin networks like aunts, uncles, and grandparents
(Waldram, 2008). Indigenous participants within the inquiry signaled a need at SOAHAC to
more meaningfully engage with Indigenous knowledge keepers and to set up formal structures
and processes for how Indigenous knowledge arrives and appears into the organization, is
translated, and informs SOAHAC at all levels of the organization. This reflects the traditional ways of decision making when considering means and methods of helping within Indigenous communities to have support and information brought directly to the group from the traditional knowledge holders (Waldram, 2008).

The benefits of the development of SOAHAC’s online ICS training over the past number of years were evident in the findings. Participants signalled a desire to continue building on this to ensure cultural safety is meaningfully implemented across the organization and that SOAHAC create measurement that can validate high-quality cultural safety. Participants offered suggestions on ways to do this, and these will be included in Chapter 5. The risks to Indigenous people associated with systemic racism within health care is well documented (Allan & Smylie, 2015; Browne, 2007; Fiske, 2008; Morrison et al., 2014), and I believe it is a good indicator that SOAHAC’s staff, board, and healers are signalling interest that SOAHAC more formally demonstrate that service sites are culturally safe for Indigenous clients, staff, and the communities the organization serves.

Another suggestion that emerged was to generate feedback from a broader range of community members and not only SOAHAC clients about cultural safety. Participants recommended gathering feedback from Indigenous people living in rural areas, two-spirited people, Elders and youth (OS, LC).

This conclusion helped to answer the main research question: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? Subquestions 2 and 3 have also been addressed in part by this conclusion: What strategies can be developed to increase common organizational and cultural knowledge and standards of practice related to the
AHAC model, and what are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

**Conclusion 2:** The AHAC model of wholistic health and wellbeing must be situated as a decolonizing and reconciliation process for clients, staff, and communities. At its inception in the mid 1990s, the AHAC model was created in part as a decolonizing model and intended to support Indigenous determination in health and the rebuilding of Indigenous communities. When the AHAC model of wholistic health and wellbeing was refined in 2015 the matter of reconciliation was added; a distinct subheading reads “A Time for Reconciliation” (AHAC Leadership Circle, 2015, p. 1), and also in the north direction of the medicine wheel the word “reclamation” (p. 1) is written (see Appendix A). This addition signals the willingness of the AHAC leadership to play a role in Canada’s reconciliation with Indigenous communities and continued commitment to be part of the reclamation of culture, knowledge, land, and resources. It was evident in the inquiry that there are high levels of decolonizing and even reconciliation activities happening throughout SOAHAC. However, this observation was not discussed in those contexts that are critical to the new AHAC model of wholistic health and wellbeing and full recovery of Indigenous communities in which AHACs have a key role. For colonized populations, the process of healing is intrinsically tied to a process of decolonizing individuals, communities, and Nations (Antone, 2013; Friere, 1970; Waldram, 2008).

Since the Residential School Apology (Indigenous and Northern Affairs Canada, 2008) and the Truth and Reconciliation Commission of Canada (2015) report with its 92 calls to action, reconciliation has become mainstream. As an active Indigenous health organization it is important that SOAHAC contemplate what decolonization and reconciliation means for the organization and the communities it serves. Non-Indigenous staff must be cognizant of the place
of decolonization within SOAHAC, and Indigenous staff must be actively engaged in decolonizing and reconciliation practices. Communities also have a role. Without engagement in decolonization and reconciliation across the organization and within community, outcomes on these fronts will be limited. Further, decolonization requires a consistent collaborative effort.

This conclusion helped answer the main research question: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? Subquestions 2 and 3 have also been addressed in part by this conclusion: What strategies can be developed to increase common organizational and cultural knowledge and standards of practice related to the AHAC model, and what are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

**Conclusion 3: Diversity at SOAHAC is a strength that can be better managed and utilized.** In a highly functioning AHAC and within a healthy community, differences are expected, welcomed, shared, and celebrated. The value of diversity on innovation, organizational performance, and the bottom line is well documented in the leadership literature (Jackson & Parry, 2011). However, Indigenous people are still actively healing; many hurt people struggle daily against the real pressures to assimilate into the dominant culture and may see non-Indigenous diversity as a threat. The residential school era has caused significant damage to Indigenous people, and widespread lateral violence continues within Indigenous communities, so even between Indigenous cultures there is potential for conflict. These realities complicate how an Indigenous health care centre inside an Indigenous community manages and utilizes diversity. The situation is wrought with politics, hurt feelings, misunderstandings, pain, and suffering. This was evident in the OS and LC data. Within SOAHAC, staff are highly committed and dedicated.
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However, if SOAHAC fails to act in this area there is risk of losing key professionals and corporate knowledge.

This conclusion helped answer the main research question: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? Subquestion 3 has also been answered in part by this conclusion: What are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

**Conclusion 4: SOAHAC can contribute to broader health systems advocacy efforts to improve Indigenous determination in health and health outcomes.** Participants in the inquiry saw SOAHAC and AHACs generally as key Indigenous health resources that could be doing more to advance the Indigenous health agenda within the broader health system. Leadership within health services can play a critical role in creating positive responses and interventions to reduce harm of systemic racism on the state of health and wellness (Allan & Smylie, 2015, p. 31). SOAHAC is an accredited health organization with now over 70 highly educated staff members. This final conclusion is about making the most effective use of this well-developed Indigenous health resource and providing leadership to the system. That is by selectively interfacing with both mainstream and Indigenous communities where SOAHAC and the AHACs can achieve the greatest results based on efforts. SOAHAC must recognize areas in which change is possible and those in which conditions are not ripe. Additionally, participants in the inquiry identified innovative approaches at SOAHAC that are good for Indigenous communities but may also be shared with other cultures and cultural paradigms.

This conclusion helped answer the main research question: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? Subquestion 1 was
also addressed by this conclusion: What innovative approaches to the AHAC model exist at SOAHAC and how can they be leveraged in the system?

Scope and Limitations of the Inquiry

My vision for the OLP was to create opportunities for learning by getting everyone in the same room from across the “whole system” (Weisbord, 2012, p. 337). I envisioned everyone talking and sharing ideas and information to inform the inquiry through large-group methods like a world café and focus group. In retrospect, this was highly naïve on my part considering that gathering all staff together is a luxury rarely afforded within Indigenous health care front-line service agencies. The summer and fall of 2015 at SOAHAC was hyper busy and turned out to be prohibitive to getting everyone together. As a result of various organizational factors related to rapid growth and a rigorous accreditation process, late in the fall 2015, I recognized that I would need to change my methods and approach to the direct opposite of what action research is all about and instead ask as little as possible of staff, board, and healers because they are all experiencing high levels of engagement fatigue. In spite of this, 16 people from the organization participated in the anonymous online survey that resulted in dense, rich data for the inquiry. My second method involved a learning circle with four Indigenous scholars whose area of focus is Indigenous health. These same scholars are currently engaged on a number of projects with SOAHAC involving extensive population-based surveys, primary care, and palliative care planning. While the learning circle had a more narrow focus than the survey questions, the data that emerged were very dense and added significantly to the findings for the inquiry.

Although I did review client satisfaction survey reports for the project, direct client and community engagement were not part of this project. Board members, who are formal
representatives of the communities SOAHAC serves, did have access to the project through the approval of the project and invitation to participate in the online survey.

**Chapter Summary**

This chapter outlined the study findings, conclusions, scope and limitations to the inquiry and addressed the project’s change goals while answering the main research question and subquestions. I identified the critical expectations of SOAHAC staff, board, and healers in response to the questions posed. Participants of the OS clearly articulated the need for formal structures, success indicator development, and formalizing and evolving SOAHAC and the AHAC model of care. Additionally the learning circle with Indigenous scholars focused on Indigenous health, recommending that SOAHAC leverage its capacity to extend its influence outside the normal boundaries of its local and regional operations to have an impact provincially and beyond. The critical intent here was to extend cultural safety as much as possible across multiple health sectors.

The conclusions are intended to support these findings and identify what needs to be operationalized to meet the goals of the inquiry. In the next chapter the findings and conclusions will be utilized to develop a set of recommendations that can help SOAHAC mobilize the collective intelligence from the inquiry participants and literature review.
Chapter Five: Inquiry Project Recommendations and Implications

This chapter outlines the recommendations proposed to the sponsor organization based on the findings and conclusions of the inquiry. I examine the organizational implications and opportunities for future inquiries. The research question posed in this inquiry was as follows: How can the AHAC model of care be put in full practice in SOAHAC’s culturally diverse environment? I also asked the following subquestions:

1. What innovative approaches to the AHAC model exist at SOAHAC and how can they be leveraged in the system?
2. What strategies can be developed to increase common organizational and cultural knowledge and standards of practice related to the AHAC model?
3. What are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

Study Recommendations

The inquiry focused on how to improve SOAHAC’s rapidly growing and changing operational environment to enhance the implementation of the AHAC model of care. It examined how SOAHAC honours, engages, and utilizes the organization’s inherent diversity to achieve high quality standards of care, integrated practice, cultural knowledge, cultural safety, and innovation. The study findings revealed that the organization experiences high levels of engagement between staff and staff and clients. Participants clearly expressed their desire to formalize cultural education and ways that Indigenous traditional knowledge holders interface with the organization. Another issue raised was how that knowledge translates within all levels of SOAHAC operations including leadership. The participants also proposed utilizing the existing capacity at SOAHAC and within the AHAC sector to consider priorities for broader
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system leadership towards the advancement of Indigenous health in Ontario. The intent of the recommendations is to create a framework that can assist SOAHAC to identify the next set of priorities in the development of its new leadership structure and integrated care model. This framework is also intended to facilitate growth into a regional Indigenous health care services provider. The recommendations are as follows:

1. Develop a comprehensive cultural education framework for SOAHAC staff and community members.
2. Engage broadly with Indigenous traditional communities within the multiple communities and Nations served by SOAHAC and build a comprehensive strategy for SOAHAC’s advancement as an Indigenous-informed health organization.
3. Mandate cultural safety and lateral violence education at SOAHAC as part of performance management and assurance of culturally safe experiences for clients, staff, and board.
4. Further develop the framework for improved inter-professional collaboration.
5. Explore the techniques utilized to Indigenize SOAHAC’s healthy lifestyles program and its potential for spread across other programs and services at SOAHAC.
6. Consider the capacity of SOAHAC and the AHAC sector to be further involved in identifying priorities for leadership in broader systems change.

**Recommendation 1: Develop a comprehensive cultural education framework for SOAHAC staff and community members.** This recommendation is about addressing knowledge gaps between staff, inconsistencies across the organization, and gaining agreement about how to incorporate traditional knowledge and healing services into the AHAC model generally and the SOAHAC new integrated care model specifically. SOAHAC is in the post-
launch stage of the introduction of the new integrated care model and its organization leadership restructuring. This recommendation is about creating the multiple levers required to address complex change initiatives within a growing organization (Burke, 2009, pp. 750–751). Up to now, all traditional knowledge and healing service provision was controlled and managed in a silo, effectively separate from other programs and services and staff groups. This recommendation will assist the organization to eliminate detached subcultures from continuing to thrive and grow at SOAHAC (Schein, 2010). A framework can be utilized to communicate message a new vision and path forward to staff, board, and visiting healers within the organization.

Currently, there are differing cultural education approaches, processes, and cultural events occurring at the different SOAHAC services sites. The people within SOAHAC are committed to determining what works best for the clients they serve and the organization as a whole. However, efforts are not always aligned. There is considerable confusion about what is intended for SOAHAC staff, what is intended for community, and when it is appropriate for clients, staff, and the broader community to be involved in sharing cultural knowledge, learning, experience, cultural events, and ceremony. The findings showed SOAHAC needs to not only raise the cultural education levels of staff but also that of clients and community members. By creating a framework, SOAHAC can consider organizational standards relating to the level of education expected within an Indigenous-informed health care organization and the AHAC model of care. SOAHAC can also utilize evidence-based methods for achieving those standards.

**Recommendation 2: Engage broadly with Indigenous traditional communities within the multiple communities and Nations served by SOAHAC and build a comprehensive strategy for SOAHAC’s advancement as an Indigenous-informed health**
organization. Indigenous culture is at the core of the AHAC model. Indigenous leadership is about the embodiment of Indigenous ways of knowing (Pigeon, 2012, p. 147). Taken together, these two facts mean that, as an Indigenous community service organization, it is necessary to situate SOAHAC within its Indigenous community context. The findings revealed stakeholders’ deep interest in expanding SOAHAC’s cultural engagement beyond the agency’s traditional healing staff and visiting healers and in documenting how SOAHAC is incorporating Indigenous ways of knowing and being throughout the organization. The participants also expressed interest in increasing cultural congruence and authenticity at SOAHAC from broader engagement with Indigenous traditional communities and knowledge keepers and formalizing structures at SOAHAC. Authenticity in purpose is also critical to leadership, organizational change, and transformation (Jackson & Parry, 2011). Within this restrained fiscal environment and growing expectations to actively contribute to reconciliation between Indigenous and non-Indigenous people, there are also continual pressures at SOAHAC to formalize and codify how the agency blends western and traditional Indigenous approaches to address inequities, disparities, and improve health outcomes. This recommendation supports a broader process for proliferating Indigenous worldviews and instilling Indigenous knowledge, methods, and approaches across the organization, in everyday organizational life. It will also support SOAHAC in stabilizing and evolving its traditional healing services to meet the growing demands for authenticity, consistency, documentation, and services integration.

**Recommendation 3: Mandate cultural safety and lateral violence education at SOAHAC as part of performance management and assurance of culturally safe experiences for clients, staff, and board.** The learning circle findings indicated that SOAHAC recruitment could include recruiting for not only demonstrated experience working within
Indigenous communities but also the ability for self-reflection when hiring for all roles. Participants saw this as a good starting point for hiring people who are, or who could become, culturally safe employees. Mandating training can ensure all board and staff have detailed and common knowledge of cultural safety and lateral violence. This would provide SOAHAC with a foundational platform to engage in meaningful discussions across the organization about cultural safety and to support a comprehensive understanding about why this is critical within an Indigenous primary health care setting. It would also assist senior management to uncover and mitigate risks amongst staff groups and within the organizational structure.

**Recommendation 4: Further develop the framework for improved interprofessional collaboration.** SOAHAC staff have considerably high levels of professional and cultural expertise. Despite this remarkable operational advantage, programs and services have operated in silos for over a decade and reported to managers who wielded all the power and authority for the group. Some staff groups that are still operating in silos and searching for the dominant manager without success are resisting broader team descriptions and functions. This recommendation is a continuation of building on the existing integrated care model, which is in affect a distributed leadership model that staff need to grow into (Lindstorm, 2012). At this time, staff are still adjusting to the additional professions and traditional healing groups that are now part of SOAHAC’s staff complement. At the same time, staff are learning the limits and potential inter-professional collaboration and integrated care approaches in their new environment. Staff require clearer information about the models, concepts, enablers, and limitations, which could be supported with the development of a framework.

Implementing the integrated care teams and focusing on increasing and improving inter-professional collaboration to be more aligned with the AHAC model is successful but requires
further development to support integrated care teams and their managers in excelling. In supporting integrated care teams, managers must understand the AHAC model of wholistic health and wellbeing, integrated care team composition and functioning, and the concept and enablers of inter-professional collaboration. Further, managers must be willing to explore additional innovation in blending western practice with Indigenous healers and approaches to health and wellness. The political climate is currently highly favourable for innovation in the delivery of health care, and this includes services to Indigenous people.

The health outcomes of Indigenous Peoples in Ontario — particularly those living in remote and isolated communities — are significantly poorer than those of the general population. Improving health care and health outcomes for First Nations, Métis and Inuit peoples is a ministry priority. (Government of Ontario, 2015, p. 10)

With the renewed focus at the Ministry of Health and Long-Term Care, SOAHAC could also utilize this framework to redirect teams to explore how to showcase SOAHAC’s ability to design services in collaboration with clients and to advance innovative practices throughout the organization.

**Recommendation 5: Explore the techniques utilized to Indigenize SOAHAC’s healthy lifestyles program and its potential for spread across other programs and services at SOAHAC.** Cultural safety is something that both is felt and experienced (Health Council of Canada, 2012). Within SOAHAC’s client satisfaction surveys and evaluations of cultural programs, clients consistently were satisfied with their experiences with SOAHAC’s healthy lifestyles program. Similarly, during the inquiry, when asked about existing innovations at SOAHAC, participants identified the culturally informed AHAC model and work within the healthy lifestyles program. Despite evidence that cultural safety through Indigenization is both
recognized and valued by staff and clients, the work of Indigenizing health care is incomplete. The success of Indigenous communities often rests with the ability to bring Indigenous ways of knowing and doing into the modern context in a meaningful manner (Antone, 2013; Battiste, 2008). As SOAHAC Indigenizes health care, staff have to become highly trained and skilled at the techniques and processes for doing this work.

**Recommendation 6: Consider the capacity of SOAHAC and the AHAC sector to be further involved in identifying priorities for leadership in broader systems change.** This recommendation is about finding the places in which SOAHAC and the AHAC sector have expertise and interest to affect change. There is considerable work still to do at all levels of the system. Many of the changes required to break down barriers to access to health care services, address racism, and close the gaps in health disparities are fundamentally structural and necessitate systemic changes across the broader health system. Although Indigenous communities do not control the health care system, as Indigenous people we must seek ways to better utilize our capacity to impact and lead change. SOAHAC could lead out a broader undertaking on behalf of AHACs to develop models and practices that act to more directly address the enormous health inequities Indigenous people face in Ontario. This should include, but not be limited to, engaging both political and professional stakeholders who have the capacity to shape health care policy and health structures in Ontario.

**Organizational Implications**

SOAHAC is at a critical juncture in its growth and maturity as an Indigenous-informed health agency. It has moved far beyond a time when everything could be overseen and managed effectively solely by the Executive Director and when cultural knowledge held by a few staff and visiting healers could assure cultural safe client experiences across the organization. With
increasing pressure from funding agents, accreditors, and the growing AHAC sector to codify performance measurement, the organization, now more than ever, has to assure authenticity as an Indigenous-informed organization operating within an Indigenous-informed model of care (Normore & Issa Lahera, 2012). As a medium-sized, regional, accredited health service agency, the inquiry highlighted the need for the development of more sophisticated organizational frameworks focused on the functioning of Indigenous cultural knowledge, cultural safety, and inter-professional collaboration across the organization. To ensure consistent high levels of management, the organization has restructured its leadership team and, in effect, has moved to a shared leadership model. This is better aligned with traditional Indigenous governance structures, and the AHAC model of wholistic health and wellbeing, which Archuleta (2012) described as “the principle of interconnectivity” (p. 173). Basically, no one individual can exercise authority nor stand alone. Staff and management can see the benefits of moving towards this model, but the organization requires further education and team coordination supports to actualize the full benefits. There is interest at the senior management level at present to tweak the leadership structure, but there is no consensus about how or when to do this. As the organization is change weary, no significant developments will be suggested at this time. However, staff may find strength in acknowledging that the move towards a participative and shared leadership model, unlike the dominant western culture, is not emergent within our communities but foundational to Indigenous leadership and communities (Antone, 2013). This kind of discussion within the organization presently could help reenergize staff. Given that staff are also generally at full capacity, in order to implement these changes, I recommend utilizing a phased approach reliant upon the expert knowledge of the leads team and the new Human Resources manager to develop the frameworks. It may also be important to utilize the community networks and expertise of the
board with perhaps an Indigenous cultural consulting firm to support the broader engagement of the Indigenous traditional community.

At each critical juncture in the data analysis and finding and conclusion development, I kept my sponsor and inquiry team informed and requested input and feedback. Due to the physical distance between my inquiry team members and I, most of our engagements and discussions were via telephone and email exchange. At a meeting with the sponsor and senior leadership team, specifically called to review the findings, conclusions, and recommendations of the inquiry, it was agreed that the next steps had to be to communicate these findings and recommendations to staff and board. I am currently on secondment for 1 year and have limited availability to SOAHAC to continue with staff and board engagement and implementation of recommendations. In order to ensure this work is advanced in my absence, the senior leadership team discussed delegating to teams and individuals with available capacity throughout the organization.

As a highly interconnected organization, a change in one part of the system affects other parts, and today’s problems are usually yesterday’s solutions (Senge, 2006, pp. 57-58). Health care is a complex, adaptive system (Lindstrom, 2012); therefore, as SOAHAC moves to bring about these proposed changes, it will be important to ensure continuous evaluation and improvement and make adjustments as required.

Failure to implement these recommendations over the next 1–2 years will impede SOAHAC’s maturation and limit its functioning and growth as a regional service delivery organization. SOAHAC must authentically have the look and feel of an Indigenous-informed organization, not only with staff and clients but also within the communities we serve as a whole, creating consistent, high levels of cultural safety. Failure on this front will encourage
communities to seek alternative ways to have their culturally safe health care provision needs met. Staff too have willingly engaged within this inquiry and have identified concerns that present opportunities for growth and change. As a result, staff have an inherent expectation that action will be taken based on these findings, and failure to address these could have negative impacts on staff moral and managerial relationships (Atkinson & Butcher, 2003).

It is important to note that SOAHAC is in the third phase of a major capital project and will begin its drawings in the current fiscal period. A finding of this inquiry is the importance of physical space to creating cultural safety. Over the past 2 years, SOAHAC has audited its physical space with cultural safety in mind and has completed a number of renovations at multiple locations to this end. Although not an official recommendation in this report, the Executive Director and SOAHAC will utilize that finding in its negotiations with Ontario’s Ministry of Health and Long-Term Care to secure appropriate and equitable levels of resourcing to create physical space conducive to the provision of Indigenous culturally safe services.

**Implications for Future Inquiry**

One limitation of this inquiry was the absence of direct engagement with the wider Indigenous communities served by SOAHAC. SOAHAC’s success relies on ensuring it reflects the diverse cultural perspectives and health care needs within the multiple Indigenous Nations and rural and urban Indigenous communities it serves. These include First Nations living on and off-reserve, in landless bands in urban settings, rural and urban Indigenous communities, and Métis settlements. As a community-governed and community-based agency, SOAHAC has dynamic and successful informal methods and approaches for engaging clients and community members. However, with the continuous rapid growth and change over the past number of years, community members have concerns that they do not always know what is happening at
SOAHAC and want to be assured that the core, or heart of the agency, is not lost. One future inquiry could be a more strategic and broad engagement plan to inform SOAHAC’s strategic development, through engagement with all the communities it serves, while taking opportunity to share information and confirm our interrelationship and understanding of our collective path forward.

As discussed in the “Organizational Context” section in Chapter 1, SOAHAC services highly diverse FNIM communities. Each of these communities has their own local concerns and differing needs that SOAHAC may not have full awareness of. Given the diversity within the communities, it is understandable that SOAHAC would have differing types and levels of engagement and relationship with the communities. Strengthening these relationships will involve increased formal engagement plans and processes. These circumstances present a unique opportunity to design future participatory action research projects each aimed at improving engagement with communities and providing critical input to SOAHAC’s strategic planning.

Currently, SOAHAC is partnered with Well Living House and Métis physician and research scientist, Dr. Janet Smylie and her team to generate urban Aboriginal population health data for the urban Aboriginal communities SOAHAC services in London, Windsor, and Owen Sound. The Our Health Counts project provides comprehensive, rich socioeconomic, health status and system utilization data. This will position SOAHAC to develop more rigorous population-needs-based planning, program development, stakeholder partnership development and cross-sector considerations. This will demand more sophisticated community and stakeholder engagement to confirm that the agency acts on the priorities that are most relevant to the communities it serves.
Another future inquiry that comes to mind is how to continue Indigenizing health services and the broader health system. Over the last number of decades, Indigenous communities have been involved extensively in Indigenizing health care. There are many methods identified as leading and wise practices, with many excellent international and national practices. However, within the models, local context is continually stressed and identified as pivotal to efficacy. Currently, SOAHAC has four main sites, each of which operates with a measure of independence that allows the centre to respond to unique local contexts and needs. Another future inquiry opportunity could be to identify leading practices that have emerged at the individual sites and determine the feasibility of standardizing these leading practices across the organization.

**Report Summary**

This OLP involved key organizational stakeholders input and a literature review. The inquiry findings and conclusions resulted in six recommendations to improve operational infrastructure, education and training, and engagement with Indigenous traditional knowledge keepers towards ensuring client and Indigenous staff have cultural safe experiences at all SOAHAC sites. The recommendations also supported SOAHAC strengthen the AHAC model of wholistic health and wellbeing, apply SOAHAC’s new integrated care model for inter-professional collaboration, and consider the AHAC sector capacity towards broader systems change. An implementation plan for each recommendation was provided with support from the sponsor and SOAHAC’s senior leadership team.

Once approved, the report Executive Summary will be circulated to all inquiry participants for fulsome discussion. While I am currently away on secondment for 1 year, the leadership team agreed that the sponsor, the Executive Director will lead out the work on
engaging the traditional communities with the support of the Traditional Healing Lead. It is intended that the cultural education framework could grow out of and be informed by that engagement. The Human Resources manager will lead the lateral violence training and ensure all current staff have completed SOAHAC’s online Indigenous Cultural Safety Training and schedule debriefing workshops available through the program. Although the client satisfaction surveys are available, not enough were completed to use with confidence for this inquiry. However, SOAHAC has initiated a new client engagement process that should yield better results and will also continue to inform SOAHAC’s services development going forward. The integrated care leads and management teams, with support from the integrated care teams at the various sites and the senior leadership team, are already working on a number of cross-organization operational supports to enable and strengthen integrated care processes. These are focused on integrated intake, referral, and case management processes across and between health professionals and service providers with SOAHAC’s clients and families. The further development of SOAHAC’s framework for improving inter-professional collaboration and integrated care will be added to the leads team work plan.

I recommended that a working group be struck of about three staff to work with the healthy lifestyles program staff to examine and write about the methods applied within the program to Indigenize health promotion. Once established, this group could develop options for knowledge exchange across the organization and within the broader AHAC sector.

SOAHAC recently hired a communications consultant on a contract for 1 year. Her responsibilities include the development of communications materials for broader community circulation. Given my 1-year secondment, some of the responsibilities I would have undertaken will have to be transferred to the communications consultant in my absence. However, while I
am away, I have agreed to work with her and the Executive Director remotely to synthesize key messages from the report for multiple audiences across staff groups and communities.

The Executive Director also agreed that he and I would bring this report and findings to a future AHAC Executive Director Circle meeting for circulation and discussion about the sector capacity and interest in impacting systems change. There is already work completed in Indigenizing community development workers and midwives education and training. There are also efforts underway in Ontario with Indigenizing the education of social workers and Aboriginal nurses. The Executive Director and I will raise questions as to whether the AHAC Executive Director Circle are interested in identifying future roles within indigenous health human resources that AHACS could support and develop strategies. Another idea could be working on systems barriers, such as jurisdictional discord, that AHACs could contribute towards changing. These are all areas for exploration and action.

Leading this change initiative will take the continued support of all SOAHAC management and staff, but the benefits to SOAHAC clients and the communities we serve will be worth our collective, coordinated efforts. I look forward to continuing this journey with SOAHAC and the AHAC sector across Ontario.
References


http://dx.doi.org/10.1016/j.socscimed.2007.02.006

http://dx.doi.org/10.1177/01939405902300203


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Appendix A: Ontario Aboriginal Health Access Centres Draft Model of Care

Note. From AHAC Model of wholistic health and wellbeing (p. 1), by Ontario’s Aboriginal Health Access Centres Leadership Circle, 2015, Toronto, Canada: Author. Copyright 2015 by Ontario’s Aboriginal Health Access Centres. Reprinted with permission.
Appendix B: Southwest Ontario Aboriginal Health Access Centre Organizational Chart

Note. CH = Chippewas Site; ICC = Indigenous Cultural Competency; IT = Information Technology; MD = Medical Doctor; NP = Nurse Practitioner; OS = Owen Sound; RPN = Registered Practical Nurse; RD = Registered Dietitian.

From Organizational Chart (p. 1), by G. M. Muise, 2015, Toronto, Canada: Southwest Ontario Aboriginal Health Access Centre. Copyright 2015 by the Southwest Ontario Aboriginal Health Access Centre. Reprinted with permission.
Appendix C: Map of SOAHAC Services including First Nation Health Centre and Friendship Centre Outreach Locations

SOAHAC Services Provided

Note. From Data Coordinator (personal communication, January 10, 2016).

Appendix D: Inquiry Team Letter of Agreement

In partial fulfillment of the requirement for a Master of Arts in Leadership Degree at Royal Roads University, Gertie Mai Muiise (the Student) will be conducting an inquiry research study at Southwest Ontario Aboriginal Health Access Centre (SOAHAC) to address the question: How can the AHAC model of care be put in full practice in SOAHAC’s culturally-diverse environment? The Student’s credentials with Royal Roads University can be established by calling Dr. Brigitte Harris, Director, School of Leadership, at [telephone number] or email [email address].

Inquiry Team Member Role Description

As a volunteer Inquiry Team Member assisting the Student with this project, your role may include one or more of the following: providing advice on the relevance and wording of questions and letters of invitation, supporting the logistics of the data-gathering methods, including observing, assisting, or facilitating an world café, talking circle or interview, taking
notes, transcribing, or reviewing analysis of data, to assist the Student and SOAHAC’s organizational change process. In the course of this activity, you may be privy to confidential inquiry data.

Confidentiality of Inquiry Data

In compliance with the Royal Roads University Research Ethics Policy, under which this inquiry project is being conducted, all personal identifiers and any other confidential information generated or accessed by the inquiry team advisor will only be used in the performance of the functions of this project, and must not be disclosed to anyone other than persons authorized to receive it, both during the inquiry period and beyond it. Recorded information in all formats is covered by this agreement. Personal identifiers include participant names, contact information, personally identifying turns of phrase or comments, and any other personally identifying information.

Bridging Student’s Potential or Actual Ethical Conflict

In situations where potential participants in a work setting report directly to the Student, you, as a neutral third party with no supervisory relationship with either the Student or potential participants, may be asked to work closely with the Student to bridge this potential or actual conflict of interest in this study. Such requests may include asking the Inquiry Team Advisor to: send out the letter of invitation to potential participants, receive letters/emails of interest in participation from potential participants, independently make a selection of received participant requests based on criteria you and the Student will have worked out previously, formalize the logistics for the data-gathering method, including contacting the participants about the time and location of the interview or talking circle, conduct the interviews (usually 3-5 maximum) or talking circle (usually no more than one) with the selected participants (without the Student’s presence or knowledge of which participants were chosen) using the protocol and questions worked out previously with the Student, and producing written transcripts of the interviews or talking circles with all personal identifiers removed before the transcripts are brought back to the Student for the data analysis phase of the study.

This strategy means that potential participants with a direct reporting relationship will be assured they can confidentially turn down the participation request from their supervisor (the Student), as this process conceals from the Student which potential participants chose not to participate or simply were not selected by you, the third party, because they were out of the selection criteria range (they might have been a participant request coming after the number of participants sought, for example, interview request number 6 when only 5 participants are sought, or talking circle request number 10 when up to 9 participants would be selected for a talking circle). Inquiry Team members asked to take on such 3rd party duties in this study will be under the direction of the Student and will be fully briefed by the Student as to how this process will work, including specific expectations, and the methods to be employed in conducting the elements of the inquiry with the Student’s direct reports, and will be given every support possible by the Student, except where such support would reveal the identities of the actual participants.

Personal information will be collected, recorded, corrected, accessed, altered, used, disclosed, retained, secured and destroyed as directed by the Student, under direction of the Royal Roads Academic Supervisor.
Inquiry Team Members who are uncertain whether any information they may wish to share about the project they are working on is personal or confidential will verify this with [Your name here], the Student.

Statement of Informed Consent:
I have read and understand this agreement.

________________________ __________________________ ___________
Name (Please Print)    Signature       Date

Appendix E: Questions for Online Survey

1. Have you been oriented to the AHAC model of care? Yes/No
2. Please briefly describe your understanding of the AHAC model as it relates to SOAHAC.
3. When you consider your cultural identity and you place at SOAHAC how do you see yourself contributing to AHAC Indigenous mode of care?
4. When you consider other health care agencies, what innovative practices do you see at SOAHAC? Please be specific.
5. When you think about diversity at SOAHAC (cultural, generational, gender etc.) what are some unique challenges you can identify?
6. When we consider cultural differences we include different First Nations, Urban Aboriginal, Inuit and Métis and diverse non-Indigenous cultural groups. In your experience at SOAHAC, how do cultural differences affect relationships between staff and with clients?
7. Knowing local history and the impact of that history upon Indigenous clients is key to developing cultural safety and is a critical part of the AHAC model. What additional resources do we need to develop at SOAHAC to improve cultural knowledge and safety?

Appendix F: Letter of Information

Implementing an Indigenous Health Model

My name is Gertie Mai Muise, and this research project is part of the requirement for a Masters of Arts in Leadership at Royal Roads University. My credentials with Royal Roads University
can be established by contacting Dr. Brigitte Harris, Director, School of Leadership Studies: [email address] or [telephone number].

**Purpose of the study and sponsoring organization**

The change goal of the inquiry is to create a common operational environment throughout SOAHAC that ensures clients have culturally safe experiences at all SOAHAC sites. SOAHAC is an Aboriginal community-governed, primary health care agency blending western and Indigenous healing approaches through the use of the AHAC model of care.

**Your participation and how information will be collected**

The research project participants include all SOAHAC staff, Board, visiting healers and Indigenous Research Collaboration Project Partners (IHIKE). The research will consist of:

- An anonymous online survey which will take 20 minutes to complete and all Board, Staff and visiting healers will be invited to participate

Following the initial analysis of the data the IHIKE will have an opportunity to participate in the research by adding active Indigenous health information and wise practice knowledge to validate findings and deepen the Indigenous scholarly inter-active input through a Learning Circle to be held via teleconference to include as many IHIKE members as possible. Questions relating to each of these methods will relate to the following overarching inquiry question. How can the AHAC model of care be put in full practice in SOAHAC’s culturally-diverse environment? It will also answer the following sub-questions:

1. What innovative approaches to the AHAC model exist at SOAHAC and how can they be leveraged in the system?

2. What strategies can be developed to increase common organizational and cultural knowledge and standards of practice as it relates to the AHAC model?

2. What are the challenges to fully operationalizing the AHAC model and how might they be mitigated?

**Benefits and risks to participation**

The intent of this Organizational Leadership Project (OLP) is to support SOAHAC’s Board, management and staff to examine how to fully operationalize the AHAC model across all SOAHAC service sites. It is about finding the right balance for SOAHAC in honouring and empowering its inherent diversity, achieving organizational goals and objectives while at the same time learning and developing talent while providing high quality, culturally relevant, Indigenous informed health care services. The project will benefit clients in ensuring consistent culturally safe experiences and benefit staff in identifying and honouring gifts, talents and diversity within the organization. While there is some risk that cross cultural conflict could arise, the risks to participation is considered low.

**Inquiry team**
The research inquiry team includes Brian Dokis, SOAHAC’s Executive Director as the sponsor for this project and James Butler PhD, who has many years’ experience within Indigenous communities and research. James will assist with piloting questions, facilitating the online survey and large group session and sending out invitations to SOAHAC staff and Board including staff who are my direct reports.

**Real or Perceived Conflict of Interest**

As the Associate Director at SOAHAC, I supervise nine middle management and information support staff who in turn supervise the majority of staff at SOAHAC who will be invited to fully participate in the research. Involvement in the research is strictly voluntary. Therefore, I disclose this information here so that you can make a fully informed decision on whether or not to participate in this study. All information will be held confidentially and an independent member of the Inquiry Team will manage correspondences and interactions in particular with direct report staff, on my behalf. I am also utilizing an anonymous survey method to protect confidentiality and allow for the maximum staff, board and visiting healer input as possible.

**Confidentiality, security of data, and retention period**

I will work to protect your privacy throughout this study. All information I collect will be maintained in confidence with hard copies (e.g., consent forms) stored in a locked filing cabinet in my home office. Electronic data (such as transcripts or audio files) will be stored on a password protected computer on my home computer. Information will be recorded in handwritten format, electronic format and in the case of the Learning Circle audio recorded and, where appropriate, summarized, in anonymous format, in the body of the final report. At no time will any specific comments be attributed to any individual unless specific agreement has been obtained beforehand. All documentation will be kept strictly confidential. Data will be kept confidential and safe for five years. Any participant can withdraw at any time. However, in the case of the group methods, it is not possible to keep the identities of the participants anonymous from the researcher, facilitator or other participants. Please respect the confidential nature of the research by not sharing names or identifying comments outside of the groups. Efforts will be made to keep the electronic surveys on a Canadian server. In the event that your survey response is processed and stored in the United States, you are advised that its governments, courts, or law enforcement and regulatory agencies may be able to obtain disclosure of the data through the laws of the United States.

**Sharing results**

In addition to submitting my final report to Royal Roads University in partial fulfillment for a Masters of Arts degree in Leadership Studies, I will also be sharing my research findings and disseminating the final report to SOAHAC’s Board, staff and visiting healers. The data may also be used to discuss AHAC success and Indigenous health models in journals, articles, books or conference presentations. The final report will be disseminated to all participants and potentially to other AHACs and Aboriginal health service organizations.

**Procedure for withdrawing from the study**

You can withdraw at any time from the study by contacting the principal researcher or any of the Inquiry Team members. All efforts will be made to withdraw participant data. However, please
be aware that it will not be possible to withdraw your data once you have engaged in the Learning Circle or submitted the anonymous online survey.

You are not required to participate in this research project. By replying directly to the e-mail request for participation, submitting an anonymous online survey, or signing the in-person consent form in the case of the Learning Circle, you indicate that you have read and understand the information above and give your free and informed consent to participate in this project.

Please keep a copy of this information letter for your records.

**Appendix G: Online Survey Email Invitations**

Greetings SOAHAC Board, Staff and Visiting Healers,

I would like to invite you to be part of a research project that I am facilitating on behalf of Gertie Mai Muise. The project is part of the requirements for her Master’s Degree in Leadership Studies at Royal Roads University.

The objective of her research project is to assist SOAHAC to create a common operational environment across the organization that ensures clients have culturally safe experiences at all SOAHAC sites. SOAHAC is an Aboriginal community-governed, primary health care agency blending western and Indigenous healing approaches through the use of the AHAC model of care. A Letter of Information is attached for your review.

Your name was chosen as a prospective participant because you are a Board member, Staff member or visiting healer involved at SOAHAC. By the nature of your voluntary or paid position, you are responsible and accountable for SOAHAC’s organizational success. This uniquely positions you to inform the inquiry.

This phase of Gertie Mai’s research project will consist of an online questionnaire that takes approximately 20 minutes to complete. No identifying information such as IP address or email address are tracked with submitted questionnaires. To further ensure anonymity, please do not include any personal identification information in comment sections of the questionnaire.

The questionnaire, with instructions can be accessed through the link below. By submitting the completed questionnaire you provide informed consent to Gertie Mai, to use the information from the survey. If you do choose to participate, you are free to withdraw without prejudice prior to submitting the questionnaire. Once responses become part of an anonymous data set, it is not possible to withdraw your information.

Due to her working relationship and involvement in the community, you may feel compelled to participate in this research project. Please be aware that though we would appreciate your participation very much, you are not required to participate and, should you choose to participate, your participation would be entirely voluntary. If you do not wish to participate, simply do not reply to this request. It is not possible to determine who has submitted a completed survey. Your choice will not affect your relationship or your employment status in any way.

The survey is due by October 23, 2015.
Please feel free to contact me at any time should you have additional questions regarding the project and its outcomes.

Name: James Butler, PhD
On behalf of Gertie Mai Muise
Email: [email address]
Telephone: [telephone number]

Appendix H: Email Reminder Messages for Survey Participants

I would like to invite you to be part of a research project that I am facilitating on behalf of Gertie Mai Muise. The project is part of the requirements for her Master’s Degree in Leadership Studies at Royal Roads University. You may have already received an e-mail inviting you to participate in this survey. If you have already completed and submitted the questionnaire, please accept our thanks and delete this e-mail as no further involvement is required. If you have not completed the questionnaire please take the time to consider helping us with this important Organizational Leadership Project (OLP).

The project objective is to assist SOAHAC to create a common operational environment across the organization that ensures clients have culturally safe experiences at all SOAHAC sites. SOAHAC is an Aboriginal community-governed, primary health care agency blending western and Indigenous healing approaches through the use of the AHAC model of care. Your name was chosen as a prospective participant because you are a Board member, Staff member or visiting healer involved at SOAHAC. By the nature of your voluntary or paid position, you are responsible and accountable for SOAHAC’s organizational success. This uniquely positions you to inform the inquiry. This phase of Gertie Mai’s research project will consist of an online questionnaire that takes approximately 20 minutes to complete. No identifying information such as IP address or email address are tracked with submitted questionnaires. To further ensure anonymity, please do not include any personal identification information in comment sections of the questionnaire.

The questionnaire, with instructions can be accessed here: [questionnaire link]

By submitting the completed questionnaire you provide informed consent to use the information from the survey. If you do choose to participate, you are free to withdraw without prejudice prior to submitting the questionnaire. Once responses become part of an anonymous data set, it is not possible to withdraw your information.

Due to her working relationship and involvement in the community, you may feel obligated to participate in this research project. Please be aware that you are not required to participate and, should you choose to participate, your participation would be entirely voluntary. If you do not wish to participate, simply do not reply to this request. It is not possible to determine who has submitted a completed survey. Your choice will not affect your relationship or your employment status at SOAHAC in any way.

Thank you very much for giving your time to help us with our research.
If you have any queries or comments about the questionnaire or the research study, please contact:

Name: James Butler, PhD

On behalf of Gertie Mai Muise

Email: [email address]

Telephone: [telephone number]

Appendix I: Questions for IHIKE Learning Circle – Via Teleconference

Related Theme: Primary Health Care and Cultural Safety in an Indigenous Holistic Wellness Model (AHAC Model)

There remains much perceived conflict between the western medical model and traditional Indigenous healing societies i.e. Between MDs and healers for instance. When Dr. Janet Smylie participated in the mental health training models for the online Indigenous Cultural Safety program, she discussed/encouraged MDs, NPs and other clinicians and Indigenous healers to think about the values of those professions as a way to reconcile those differences and work together inter-professionally.

1. Beyond taking the ICS training programs to increase cultural competency of health services providers and safety in the system, what other recommendations would you have for clinicians and healers?

2. What recommendations would you have for the leadership of Aboriginal health access centres like SOAHAC to more strategically address this critical matter?

In her most recent research with the Wellesley Institute on racism against Indigenous people in the health care system, Dr. Janet Smylie and her team discussed how First Peoples are treated as second class citizens. This reflects why at SOAHAC we are concerned about when we do referrals outside of the agency, knowing that much cultural harm occurs in hospitals, emergency rooms and other mainstream health institutions.

3. Considering this, when we refer clients outside of SOAHAC how would you advise medical staff and others to extend cultural safety practices to support the continued cultural safety of clients within Ontario’s health care system?

4. How can SOAHAC support cross sector relationship development and maintain relations which are grounded in cultural safety?

When you consider the complex needs of the Indigenous population and the ongoing impact of colonization and systemic racism within health care services structures and systems:
5. How would you describe an ideal culturally safe community, primary care service setting? How might the leadership at SOAHAC ensure that our strategies for creating a culturally safe setting are effective?

Related Themes:

☐ Thinking about cultural safety training and building cultural knowledge of staff, as professional development.

☐ Creating processes enabling traditional people to participate in SOAHAC’s organizational development, growth and health services delivery beyond the online Indigenous Cultural Safety Training and traditional healing services provision.

Cultural knowledge and safety is a core principle in the AHAC model as such we can link it to quality improvement and professional development of our staff. This includes access to traditional teachings from community elders, traditional knowledge holders and healers. It is also part of the integrated care model development efforts whereby we are dismantling programmic silos which impede inter-professional collaboration. In essence, we have undertaken to strengthen SOAHAC as an Indigenous-informed organization while honouring our diversity and differences.

1. Given these considerations how can we extend and support access to traditional teachings for staff by balancing cultural days and professional development days with front line service demands?

2. How can we ensure that the healing work at SOAHAC is grounded in the knowledge of community Elders, traditional knowledge keepers, healers and other members of Indigenous traditional communities?

3. What formal processes and/or structures do we need to put in place to ensure that both previous issues are appropriately addressed?

Appendix J: Learning Circle Email Invitations

Greetings IHIKE members,

I would like to invite you to be part of a research project that I am facilitating on behalf of SOAHAC. The project is part of the requirements for my Master’s Degree in Leadership Studies at Royal Roads University.

The objective of the research project is to assist SOAHAC to create a common operational environment across the organization that ensures clients have culturally safe experiences at all SOAHAC sites. SOAHAC is an Aboriginal community-governed, primary health care agency blending western and Indigenous healing approaches through the use of the AHAC model of care. A Letter of Information is attached for your review.
Your name was chosen as a prospective participant because you are considered an expert in the area of Indigenous health, actively informing the health care system. This uniquely positions you to inform the inquiry.

This phase of the research project will consist of an audio Learning Circle, which is similar to a focus group as it is interactive. The Learning Circle is scheduled for January 6, 2016 and will take approximately 60 minutes via teleconference to complete.

The Learning Circle questions along with a Research Consent Form is enclosed. Please read the consent form thoroughly, sign and submit prior to the Learning Circle.

Due to my working relationship and involvement in the community, you may feel compelled to participate in this research project. Please be aware that though we would appreciate your participation very much, you are not required to participate and, should you choose to participate, your participation would be entirely voluntary. If you do not wish to participate, simply do not reply to this request. Your choice will not affect your relationship or your employment status in any way.

Please feel free to contact me at any time should you have additional questions regarding the project and its outcomes.

Name: Gertie Mai Muise  
Email: [email address]  
Telephone: [telephone number]

### Appendix K: Learning Circle Research Consent Form

By signing this form, you agree that you are over the age of 19 and have read the information letter for this study. Your signature states that you are giving your voluntary and informed consent to participate in this project.

- I consent to the audio recording of the learning circle
- I commit to respect the confidential nature of the Learning Circle by not sharing people’s names or other identifying information about the other participants
- I consent to photos being captured for documentation purposes. I understand that these images will not be used for marketing purposes but may be used in the final report and or subsequent publication, conference presentations and dissemination processes described in the Letter of Information about the research study. I understand that I will be contacted again in the future should the Research Team wish to use any image of me for a secondary purpose beyond what is described here.
• I do NOT consent to photos of me being captured for documentation purposes only; however, I do consent to being audio recorded during my participation in the Learning Circle. I understand that due to the group nature of this study, the audio recording will be ongoing throughout learning circle and my voice or image cannot easily be removed.

Name: (Please Print): __________________________________________________________

Signed: __________________________________________________________________________

Date: ___________________________________________________________________________