British Columbia Cultural Safety and Humility Standard

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British Columbia Cultural Safety and Humility Standard

HSO's Technical Committees include diverse representation from multiple groups, including people with lived experiences, care providers, clinicians, researchers, and policy makers, who lead the development of HSO's standards. Working with a HSO project team, Technical Committees oversee the standard development process, ensuring that all points of view are represented.

The development and publication of this standard would not have been possible without the contributions of the Technical Committee members listed below. The generous time commitment and insights each member provided are greatly appreciated.

Please note that the views of the Technical Committee members on HSO's TC034 Cultural Safety and Humility are representative of their expertise and not of their respective organizations.

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Preface

Health Standards Organization (HSO) develops evidence-based health and social services standards, assessment programs, and quality improvement solutions. Recognized as a Standards Development Organization by the Standards Council of Canada, we work with leading experts and people with lived experience from around the world, using a rigorous public engagement process, to co-design standards that are people-centred, integrated and promote safe and reliable care. For more information visit www.healthstandards.org

HSO's People-Centred Care Philosophy and Approach

People-centred care (PCC) is an integral component of HSO's philosophy and approach. PCC is defined by the World Health Organization as: "An approach to care that consciously adopts the perspectives of individuals, families, and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases" (World Health Organization, 2016). This definition is inclusive of all individuals – patients, residents, clients, families, caregivers, and diverse communities.

As such, PCC guides both what HSO does and how HSO does it. PCC calls for a renewed focus on the interaction and collaboration between people, leading to stronger teamwork, higher morale, and improved co-ordination of care (Frampton et al., 2017). This ensures people receive the appropriate type of care in the right care environment.

With a mission to inspire people, in Canada and around the world, to make positive change that improves the quality of health and social services for all, HSO has developed the following guiding PCC principles:

1. ***Integrity and relevance:*** *Upholding the expertise of people in their lived experiences of care; Planning and delivering care through processes that make space for mutual understanding of needs/perspectives and allow for outcomes that have been influenced by the expertise of all.*
2. ***Communication and trust:*** *Communicating and sharing complete and unbiased information in ways that are affirming and useful; Providing timely, complete, and accurate information to effectively participate in care and decision making.*
3. ***Inclusion and preparation:*** *Ensuring that people from diverse backgrounds and contexts have fair access to care and opportunities to plan and evaluate services; Encouraging and supporting people to participate in care and decision making to the extent that they wish.*
4. ***Humility and learning:*** *Encouraging people to share problems and concerns in order to promote continuous learning and quality improvement; Promoting a just culture and system improvement over blame and judgement.*

About Our Standards

HSO standards are the foundation on which leading-edge accreditation programs and great public policy are built. Standards create a strong health care structure that the public, providers, and policy makers can rely on, assuring high quality health services where it matters most.

HSO's standards are formatted using the following structure:

- **Section Title:** A section of the standard that relates to a specific topic.
- **Clause**: A thematic statement that introduces a set of criteria.
- **Criteria**: Requirements based on evidence that describe what is needed by people to achieve a particular activity. Each criterion outlines intent, action, and accountability.
- **Guidelines:** Provide additional information and evidence to support the implementation of each criterion.

About This Standard

This is the first edition of HSO 75000:2022(E) *British Columbia Cultural Safety and Humility* standard. The target audiences are governing bodies, organizational leaders, teams, and the workforce from health authorities and health and social services organizations in the province of British Columbia (BC), Canada. The standard helps governing body members and organizational leaders identify, measure, and achieve culturally safe systems and services that better respond to the health and wellness priorities of First Nations, Métis, and Inuit peoples and communities, regardless of where they are located. A number of foundational documents, including the following supporting documentation and legislative commitments, were used to inform the content of the standard.

a. **Supporting documentation** are significant reports pertaining to Indigenous-specific racism and/or discrimination as well as truth and reconciliation.

    a. In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Full and Summary Reports) (Turpel-Lafond, 2020a)
    b. Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
    c. Truth and Reconciliation Commission of Canada Calls to Action (Truth and Reconciliation Commission of Canada, 2015a)
    d. Report of the Royal Commission on Aboriginal Peoples (Canada et al.,1996)

b. **Legislative commitments** are based on Canadian and/or international legal commitments to which Canada has subscribed.

    a. United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007)
    b. Canadian Human Rights Act (1985)
    c. Constitution Act, Part II, Rights of the Aboriginal Peoples of Canada, Section 35 (1982)

The standard will be available to health and social services organizations as a resource document.

The standard will undergo periodic maintenance. HSO will review and re-publish the standard on a five-year schedule.

Acknowledgements

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The intended application of this standard is stated in the Scope section below. It is important to note that it remains the responsibility of the users of this standard to judge its suitability for their particular purpose.

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British Columbia Cultural Safety and Humility Standard

Introduction

Widespread and systemic racism, stereotyping, and discrimination against First Nations, Métis, and Inuit (FN/M/I) peoples and communities in British Columbia (BC) health systems have resulted in a range of negative impacts, including trauma; physical, psychological, and spiritual harm; and even death.

The HSO 75000:2022(E) *British Columbia Cultural Safety and Humility* standard addresses racism and discrimination against First Nations, Métis, and Inuit peoples in BC. The standard outlines the responsibilities of health systems and health and social service organizations in BC to establish a culture of anti-racism and cultural safety and humility in their services and programs, to better respond to the health and wellness priorities of First Nations, Métis, and Inuit peoples and communities served by those organizations. The standard has been developed to address long-standing issues of Indigenous-specific racism perpetuated by health systems and organizations. It focuses on designing, implementing, and evaluating culturally safe systems and services. In the standard, cultural safety is defined as an outcome of respectful engagement based on the recognition of, and the work needed to address, power imbalances inherent in the health care system. A culturally safe environment is free of racism and discrimination, and people feel safe when receiving health care (First Nations Health Authority [FNHA], 2016a; Turpel-Lafond, 2020a).

Significant Indigenous-specific racism exists at all levels of Canada's health care system (Health Council of Canada, 2012; Reading, 2013; Allan & Smylie, 2015; Harding, 2018; Turpel-Lafond, 2020a). "Indigenous-specific racism is ongoing, systemic and includes race-based discrimination experienced by First Nations, Métis, and Inuit peoples and communities. It maintains unequal treatment and is rooted in colonial practices and policies. More specifically, it is a form of racism against Indigenous peoples in which bias, stereotypes, and prejudice are rooted in colonialism (Turpel-Lafond, 2020a).

In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report) (Turpel-Lafond, 2020b) explores the experiences and impact of Indigenous-specific racism on health system performance and on the health and wellness of Indigenous peoples in BC. The report reflects over 9,000 voices and analyzes health system performance data from more than 185,000 Indigenous individuals. The findings show health care inequities, with up to 23 percent of Indigenous respondents feeling "not at all safe" when receiving services for assisted living, long-term care, and mental health services. This is three to four times higher than non-Indigenous respondents' experiences. The report outlines three common complaints with regard to health care: negative individual interactions with health providers (e.g., disrespect and discrimination based on stereotypes, including verbal abuse), restricted access to timely care (e.g., delays, lack of appropriate assessments or referrals, denial of treatment), and poor care (e.g., lack of application of practice standards resulting in misdiagnoses and treatment errors).

Other reports yield similar findings. The *National Report of The First Nations Regional Health Survey*, *Phase 3, Volume 2* (First Nations Information Governance Centre, 2018) reports on regional and provincial community-delivered findings for health and wellness indicators in BC. More than 5,700 individuals from 122 communities contributed to this report. It found that First Nations peoples experience inequity when accessing health services for themselves or family members. Barriers include lack of access to health care (59 percent), inadequate health care (33 percent), high cost of associated services such as childcare (32 percent), and transportation issues (21 percent).

The *First Peoples, Second Class Treatment* report (Allan & Smylie, 2015) found that 42 percent of respondents experienced racism in the previous three years. In addition, the majority of Indigenous people in Canada actively strategize on how to manage negative responses from health care providers prior to accessing care.

First Nations, Métis, and Inuit peoples and communities experience racism and discrimination in distinct ways that can be compounded by other forms of social exclusion associated with a person's race, religion, sex, gender identity, sexual

orientation, disability, or other protected characteristics, and this often causes further injustice and harm. In this standard, anti-racism and anti-discrimination principles include intersectionality (e.g., 2SLGBTQQIA people, people with disabilities).

First Nations, Métis, and Inuit peoples and communities experience racism and discrimination at many levels when seeking health-related care and services. Racism in the health system is a serious problem that poses a danger to those experiencing it. Indigenous-specific racism and discrimination in health care creates systemic barriers and causes harm in many ways, including:

- Unacceptable rates of illness and distress among Indigenous peoples in Canada, as outlined in the *Royal Commission on Aboriginal Peoples* (Canada et al., 1996)
- Physical and emotional harm caused by racism and stereotyping (Harding, 2018; Turpel-Lafond, 2020a)
- Reduced access to care and services due to racism, discrimination, stigma, sexism, and bias (Health Council of Canada, 2012; Harding, 2018)
- Acting as a barrier to obtaining health education (Waterworth et al., 2015)
- Avoidance of the health care system due to fear and mistrust (Harding, 2018; Teixeira et al., 2018; Waterworth et al., 2015)
- Ignorance of cultural practices resulting in non-adherence to treatment plans because of cultural incongruence (Turpel-Lafond, 2020a)
- Missed or delayed diagnoses (Harding, 2018)
- Lack of treatment (e.g., denied treatment, improper assessments, or referrals) (Harding, 2018; Turpel-Lafond, 2020a)
- Common and pervasive exposure to racism and discrimination that results in chronic stress and is made worse by unique psycho-social and contextual factors (American Psychological Association, 2020)
- Death, as in the case of Brian Sinclair or Joyce Echaquan (Browne et al., 2017; Canadian Broadcasting Corporation, 2017), among others

The First Nations, Métis, and Inuit workforce (e.g., staff, physicians, volunteers, students) is also harmed through workplace policies that do not respect family and community values, do not support those experiencing trauma, do not support advancement, or do not offer mentoring opportunities (Turpel-Lafond, 2020a). The First Nations, Métis, and Inuit workforce also experiences racism from colleagues, supervisors, and clients.

Cultural safety and humility is an approach to health care that addresses health inequities and seeks to improve First Nations, Métis, and Inuit health outcomes (Northern Health Indigenous Health, 2016). In 2017, a declaration of commitment to advance cultural safety and humility in health care organizations was signed by the registrars of all professional colleges in BC (British Columbia Health Regulators, 2017).

The concept of cultural safety was introduced by Irihapeti Ramsden, a Māori nurse in Aotearoa, New Zealand, in response to disparities in Māori health, and the need to acknowledge and understand the impact of historical, social, and political processes on Māori health care. Ramsden (2002) developed the concept of cultural safety as an educational framework to examine power relationships between health care providers and service recipients. Health care providers Melanie Tervalon and Jann Murray-García (1998) first coined the term cultural humility to educate other providers on how to best provide services to cultural minorities. This standard defines cultural humility as a process of self-reflection to understand personal and systemic biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience (FNHA, 2016a). Engaging in cultural humility during client/provider interactions positions Indigenous voices at the forefront and promotes mutual decision making that makes Indigenous clients partners in their health care treatment (Turpel-Lafond, 2020a).

According to Greenwood's (2019) change model, real transformation of the health system requires change at three interconnected levels: structural (policy), systemic (organizational), and interpersonal (provider and service delivery). This standard outlines the responsibilities of BC health systems and organizations, and their organizational leaders and service providers, to support cultural safety and humility within health systems. By specifying the responsibilities of BC health systems and organizations to address cultural safety and humility, and Indigenous-specific racism, this standard has the potential to guide short- and long-term transformative change in BC health systems and organizations.

The First Nations Health Authority (FNHA) partnered with HSO to bring together a Cultural Safety and Humility Technical Committee to oversee the development of this standard. In addition, Métis Nation BC provided input to the standard prior to public review, and also contributed to the public review and the decisions made related to feedback from the public review.

HSO 75000:2022(E) *British Columbia Cultural Safety and Humility* standard uses the term "First Nations, Métis, and Inuit peoples and communities" to describe First Nations, Métis, and Inuit populations within an interconnected, supportive network who participate in, and benefit from, the health system and the health and social service organization's programs and services as co-producers of health. Depending on the service setting or context, First Nations, Métis, and Inuit peoples and communities may be served on an individual basis, or at the community or population levels. In this standard, First Nations, Métis, and Inuit peoples and communities include those who originate from the land or territory upon which a facility is located, as well as the First Nations, Métis, and Inuit peoples and communities living on the territory but who are away from their ancestral territories. The standard also uses the term Indigenous to refer to First Nations, Métis, and Inuit peoples. The term Aboriginal is used where appropriate, such as when referring to rights and obligations.

The standard takes a distinctions-based approach to working with First Nations, Métis, and Inuit peoples and communities. This approach acknowledges that there are three recognized groups of Indigenous peoples in Canada: First Nations, Métis, and Inuit. It recognizes that collaborations with First Nations, Métis, and Inuit peoples and communities must occur at the outset, when legislation, standards, policies, or programs are developed, in order to create inclusive services that respect and meet the diverse priorities of each community (Assembly of First Nations, 2021; Indigenous Services Canada, 2021; National Association of Friendship Centres, 2020).

The standard also recommends a strengths-based approach to working with First Nations, Métis, and Inuit peoples and communities. This approach focuses on First Nations, Métis, and Inuit peoples' individual and community strengths and resilience to positively adapt despite significant hardships or trauma, as opposed to concentrating solely on remedying the historical, social, health, and health care disparities they face. Calls for a strengths-based approach derive mainly from First Nations, Métis, and Inuit peoples and communities and occur mostly in the context of health, education, and support for children and families. A strengths-based approach is considered not only a culturally appropriate way of engaging with Indigenous communities; it is also considered to be the only way (Askew et al., 2020; Public Health Agency of Canada, 2018).

The standard is organized into eight sections:

1. Support Social, Public, and Reciprocal Accountability
2. Establish Inclusive and Meaningful Partnerships
3. Share Governance and Implement Responsible Leadership
4. Invest in Financial and Physical Infrastructure
5. Develop Human Capacity
6. Build a Culture of Quality and Safety
7. Design and Deliver Culturally Safe Services
8. Collect Evidence and Conduct Research and Evaluation

It is important to note that organizations need to develop and/or adapt their policies and processes to reflect the principles and criteria in the standard. The standard does not provide a detailed description of specific ways to apply the criteria. In addition, the standard considers OCAP® (ownership, control, access, and possession) principles when referring to gathering data and information. There is an emphasis on the OCAP® principles in section 8.

Guided by this standard, it is expected that BC health systems and organizations will begin to fundamentally shift the paradigms that perpetuate racism and discrimination against Indigenous peoples and start the work needed to uphold cultural safety, cultural humility, and reconciliation for all Canadians.

Scope

Purpose

This standard specifies the requirements for governing bodies, organizational leaders, teams, and the workforce from health authorities and health and social services organizations to address Indigenous-specific racism in service delivery and provide culturally safe services to First Nations, Métis, and Inuit peoples and communities in BC.

The standard applies to First Nations, Métis, and Inuit peoples' health and wellness journeys across the health system, including health promotion and disease prevention, access to health and social services, admission, assessment, treatment, discharge, and end-of-life care. The standard provides guidance as to the organizational structures and procedures that are required in governance, leadership, and service provision to support anti-racism and cultural safety and humility and ensure the delivery of health and social services that are aligned with Indigenous traditions and values.

Applicability

This standard is intended to be used by governing bodies, organizational leaders, teams, and the workforce from health authorities and health and social services organizations in the province of British Columbia (BC) to support the design, development, and implementation of health and social services and care delivery that respects cultural safety and humility principles.

Normative References

There are no normative references in this standard.

Terms and Definitions

Definitions

Below is a list of terms and definitions that are used throughout this standard. For additional terms and definitions commonly used throughout all HSO standards please refer to our master glossary, HSO 0400 - *HSO Terms and Definitions* found here: https://healthstandards.org/files/HSO-MasterGlossaryList-2018E.pdf.

Accessible communication: Communication that uses plain language and provides information in languages that the intended audience is able to easily and unambiguously understand (Public Works and Government Services Canada, 2015), and is available in a variety of formats (i.e., oral, written, online). Accessible communication benefits all audiences by making information clear, direct, and easy to understand. It takes into consideration the various barriers to accessing information, and provides opportunities for feedback (Communication Canada, 2003).

Accountability: Having responsibility for, and being able to answer to, a person or group regarding assigned obligations (Mihalicz, 2017). Accountability in integrated health systems is shared among policy makers, system partners, and parties affected. It includes financial accountability (e.g., system sustainability, budget allocation), public accountability (e.g., engagement, transparency), accountability to deliver comprehensive services (e.g., those that address the social determinants of health), reciprocal accountability, and evaluation accountability (e.g., evaluating health system performance).

Anti-racism: Anti-racism is more than just “not being racist.” It involves taking action to create conditions of greater inclusion, equality, and justice. It is the practice of actively identifying, challenging, preventing, and eliminating racist ideologies, and changing the values, structures, policies, programs, practices, and behaviours that perpetuate racism (Turpel-Lafond, 2020a). In the context of the standard, the anti-racism policies, programs, and practices are specific to First Nations, Métis, and Inuit peoples and communities.

Best practice: A procedure that has been shown by research and experience to produce optimal results and that is established or proposed as a standard suitable for widespread adoption (Merriam-Webster, n.d.).

Client (patient): Individuals who participate in, and benefit from health systems and services, as co-producers of health. Depending on the health setting or context, a client may be a patient, a resident, or a community member. Individuals could include carers and families when desired by the client. When the organization does not provide services directly to individuals, client refers to the community or population served by the organization.

Collaboration: A recognized relationship between an organization and First Nations, Métis, and Inuit peoples and communities that has been formed to take action on an issue in a way that is more effective or sustainable than might be achieved by the organization or public health sector acting alone. Collaboration in this sense encompasses a full spectrum of activities, from coordinating culturally safe services and sharing information to integrating services through shared delivery and shared accountability for outcomes. During collaboration, engagement is ongoing and respectful.

Colonialism: Policies or practices whereby groups or countries partially or fully steal land and resources from Indigenous peoples, occupy the land, and exploit the people and the land by racist policy and law for economic privileges. Following the acquisition of land and resources, colonizers establish laws and processes that continuously violate the human rights of Indigenous peoples; violently suppress their governance, legal, social, and cultural structures; and force them to conform to the newly established laws and processes of the colonial state (Turpel-Lafond, 2020a).

Community: Indigenous communities “are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them” (United Nations, 2004, p. 2).

Community-based participatory research: Research that “takes place in community settings and involves community members in the design and implementation of research projects, demonstrates respect for the contributions of success

that are made by community partners, as well as respect for the principle of 'doing no harm' to the communities involved" (San Francisco State University Institute for Civic and Community Engagement, n.d., p. 1).

Cultural humility: A life-long process of self-reflection and self-critique to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience. It is foundational to achieving a culturally safe environment. "While western models of medicine typically begin with an examination of the patient, cultural humility begins with an in-depth examination of the provider's assumptions, beliefs and privilege embedded in their own understanding and practice, as well as the goals of the patient-provider relationship" (College of Physicians and Surgeons of British Columbia, 2022; p. 1). Undertaking cultural humility ensures Indigenous peoples are partners in the choices that impact them throughout their care (FNHA, 2016a; Turpel-Lafond, 2020a).

Culturally and linguistically appropriate: Responding effectively to the cultural and linguistic needs of the client.

Cultural safety: An outcome of respectful engagement based on recognition of the power imbalances inherent in the health system, and the work to address these imbalances (FNHA, 2016a). In this standard, cultural safety means Indigenous cultural safety. A culturally safe environment for Indigenous peoples is one that is physically, socially, emotionally, and spiritually safe without challenge, ignorance, or denial of an individual's identity (Turpel-Lafond, 2020a). Practicing cultural safety requires having knowledge of the colonial, sociopolitical, and historical events that trigger the health disparities encountered by Indigenous peoples and perpetuate and maintain ongoing racism and unequal treatment (Allan & Smylie, 2015).

Decolonizing: A decolonizing approach aims to resist and undo the forces of colonialism and re-establish Indigenous Nationhood. It is rooted in Indigenous values, philosophies, and knowledge systems. It is a way of doing things differently that challenges colonial influences by making space for marginalized Indigenous perspectives.

Determinants of health: Personal, social, economic, and environmental factors that determine health at individual and population levels (Health Canada, 2020). Social determinants of health are "the conditions in which people are born, grow, work, live, and age, as well as the wider set of forces and systems shaping the conditions of daily life. The social determinants of health include culture and language; social support networks; income and social status; employment and working conditions; physical environment (housing, land, water, food security); personal health practices and coping skills; early childhood development; access to health services; genetics; gender; and social inclusion" (FNHA, 2018, p. 3).

Discrimination: Targeting an individual or group of people for negative treatment because of specific characteristics such as race, religion, sex, gender identity, sexual orientation, disability, or other protected characteristics (Canadian Human Rights Commission, n.d.). Discrimination can occur at an individual, organizational, or societal levels. It occurs when a particular social group is denied access to goods, resources, and services, either through action or inaction (Turpel-Lafond, 2020a).

Distinctions-based approach: An approach to working with Indigenous peoples in Canada that acknowledges three recognized groups of Indigenous peoples: First Nations, Métis, and Inuit. This approach recognizes that collaborations with First Nations, Métis, and Inuit peoples must occur from the outset when developing legislation, standards, policies, or programs in order to ensure that services are inclusive, and respect and meet the diverse priorities of each group (Assembly of First Nations, 2021; Indigenous Services Canada, 2021; National Association of Friendship Centres, 2020).

Elders: Leaders, teachers, role models, mentors, and Healers who are recognized by their Indigenous communities and who play a pivotal role in the health and wellness of their communities (FNHA, 2014b). In First Nations, Métis, and Inuit cultures, Elders play a prominent, vital, and respected role. They are held in high regard as Knowledge Keepers who carry traditional teachings and information that has been passed down through oral history, customs, and traditions, which encompass beliefs, values, worldviews, language, and spiritual ways of life. First Nations, Métis, and Inuit Elders are acknowledged by their respective communities as an Elder through a lifetime of learned teachings and earned respect. Many communities have a defined protocol and process for becoming an Elder. Gender and age are not factors in determining who is an Elder (Carleton University, n.d.).

Executive leader: The senior-most leader of the organization (e.g., the chief executive officer) and head of the senior leaders. The executive leader reports to the governing body.

First Nations: The preferred terminology for Indigenous peoples of what is now Canada, and their descendants, who are neither Métis nor Inuit. First Nations people who are legally registered as Indian under the Indian Act are considered

"status," while those who are not are considered "non status." A First Nations person's status can have many implications, including on their health and wellness (Indigenous Corporate Training Inc., 2016).

First Nations, Métis, and Inuit partners: First Nations, Métis, and Inuit organizations and service providers with which the health or social services organization has partnership agreements.

Governing body: The legitimate body that holds authority, ultimate decision-making power, and accountability for an organization and its services. This may be a board of directors, a health advisory council, a Chief and Council, or other decision-making body. Governing bodies may work independently or with government in jurisdictions where government is responsible for one or more governance functions.

Indigenous peoples and communities: The First Nations, Métis, and Inuit populations within an interconnected, supportive network who participate in, and benefit from, the health system and the organization's programs and services as co-producers of health. Depending on the service setting or context, First Nations, Métis, and Inuit peoples and communities may be served on an individual basis or at the local, community, or population levels. First Nations, Métis, and Inuit peoples and communities include First Nations peoples and communities who originate from the land or territory upon which a health facility is located, as well as the First Nations, Métis, and Inuit peoples and communities living within the territory.

Healer or Indigenous Traditional Healer: Those recognized by their community for providing traditional health practices, approaches, knowledge, and beliefs rooted in Indigenous healing and wellness while using ceremonies; plant, animal, or mineral-based medicines; energetic therapies; or physical, hands-on techniques (FNHA, 2021b; FNHA, n.d.-e). Healers provide "an important entry point on the pathway to care for people who use traditional health services" (FNHA, 2014a, p.15)

Health equity: Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other means of stratification. Health equity implies that all individuals have an equitable opportunity to reach their full health and wellness goals. Health equity can be impacted by a variety of factors including a person's culture, geography, and socioeconomic status (World Health Organization, 2021b).

Health literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (Ratzan & Parker, 2000), and the degree to which organizations implement strategies to make it easier for patients to understand health information, navigate the health care system, engage in the health care process, and manage their health (Brach et al., 2012). Both at the individual level and within organizations, health literacy involves an understanding and recognition of the power imbalances inherent in the health system.

Health system: The organizations, institutions (including governments), resources, and people whose primary purpose is to improve health. This includes efforts to influence determinants of health as well as more direct health improvement activities. Health systems deliver preventive, promotive, curative, and rehabilitative interventions. The actions of the health system should be responsive and financially equitable, while treating people with respect. A health system needs staff, funds, information, supplies, transport, communications, and overall guidance and direction to function. Strengthening health systems thus means addressing key constraints in each of these areas (World Health Organization, 2010).

Indigenous client navigator: A person who provides culturally safe support and facilitates access to services and resources, both traditional and Western (FNHA, 2016a). May also be known as an Indigenous client liaison, wellness coach, Elder in residence, or cultural navigator.

Indigenous ways of knowing: The complex and diverse ways in which Indigenous peoples learn and teach. Learning and teaching are not limited to human interactions; they encompass all elements that can teach individuals, from flora and fauna to objects in the environment that many consider inanimate (Office of Indigenous Initiatives, n.d.).

Indigenous: The first peoples of Canada, who identify as First Nations, Métis, or Inuit. *The Declaration on the Rights of Indigenous Peoples Act* defines Indigenous with the same definition as Aboriginal in the *Constitution Act, 1982*. First Nations and Métis peoples in the Interior region of BC prefer the use of the term Aboriginal.

Infrastructure: The built environment and its supporting elements such as equipment, information technology, systems and processes, sustainability initiatives, and staff required to deliver integrated health and wellness services (Luxon, 2015).

Intervention: An act performed for, with, or on behalf of a person or population. The purpose is to assess, improve, maintain, promote, or modify health, functioning, or health conditions (World Health Organization, 2021a).

Inuit: An Inuktitut term meaning the people who live in communities across the Inuvialuit Settlement Region (Northwest Territories), Nunavut, Nunavik (Northern Quebec), and Nunatsiavut (Northern Labrador) land claim regions. They share a common cultural heritage and language. Inuit are one of three recognized Indigenous peoples in Canada: the others are First Nations and Métis (Library and Archives Canada, 2020).

Jordan's Principle: A commitment that First Nations children would get the products, services, and supports they need, when they need them, to address a wide range of health, social, and educational needs. Jordan's Principle is named in memory of Jordan River Anderson, a young boy from Norway House Cree Nation in Manitoba, Canada. Jordan was born in 1999 with multiple disabilities and stayed in the hospital from birth. When he was two years old, doctors said he could move to a special home that could accommodate his medical needs. However, the federal and provincial governments could not agree on who should pay for his home-based care. Jordan stayed in the hospital until he passed away at the age of five. In 2007, the House of Commons passed Jordan's Principle in memory of Jordan (FNHA, n.d.-b).

Knowledge Keeper or Indigenous Knowledge Keeper: An Indigenous person who is recognized by their community as holding traditional knowledge and teachings taught by an Elder or senior Knowledge Keeper within their community (Office of Indigenous Initiatives, n.d.).

Lateral kindness: An approach based on Indigenous values that addresses lateral violence. It promotes social harmony and healthy relationships. Many Indigenous cultural teachings include the message that everyone is connected. Healing and decolonizing from the effects of colonialism means acting with lateral kindness to each other to honour these teachings (FNHA, 2020).

Lateral violence: Behaviours such as gossip, passive aggressive behaviour, blaming, shaming, demeaning activities, bullying, threatening or intimidating behaviour, verbal and physical assault, and attempts to socially isolate others (FNHA, n.d.-f).

Métis: A person who self-identifies as Métis, is of historic Métis ancestry, is distinct from other Aboriginal peoples, and is accepted by the Métis Nation (Métis Nation British Columbia, 2003).

Métis Chartered Communities: The base unit of the Métis government. No geographic area (city, town, municipality, or unincorporated municipal unit) has more than one community. A community is made up of at least twenty-five (25) members who are Métis citizens who are 18 years of age or older. Métis Chartered Communities recognized by Métis Nation British Columbia are required to enter into Community Governance Charters that define an affiliated relationship for financial and political accountability, mutual recognition, and dispute resolution. All communities must implement a constitution that is consistent with the Métis Nation British Columbia Constitution and legislation (Métis Nation British Columbia, 2003).

Métis community: For the purpose of this standard, a group of Métis citizens and self-identified Métis people living in Métis Nation British Columbia's seven defined regions.

Organizational leaders: Individuals in an organization who work in a formal or informal management capacity to guide, manage, or improve their team, unit, organization, or system (Dickson & Tholl, 2014). Leaders include executive and senior leaders. For the purpose of this standard, an organization's governing body is not included in the term organizational leaders.

OCAP® principles/First Nations OCAP® principles: The First Nations principles of ownership, control, access, and possession (OCAP®) are a set of standards that establish how First Nations data and information should be collected, protected, used, or shared (First Nations Information Governance Centre, 1998).

Prejudice: A negative way of thinking and holding negative attitudes about a socially defined group and toward any person perceived to be a member of the group.

Privilege: Unearned social advantages, favours, and benefits afforded to non-racialized people in comparison to racialized groups. Privilege occurs at many levels of society, including personal, interpersonal, cultural, and institutional (Turpel-Lafond, 2020a).

Program: A co-ordinated and comprehensive set of health promotion and protection strategies, policies, benefits, supports, services, and community links that respond to community needs and are designed to encourage health and wellness.

Profiling: Creating or promoting a pre-determined idea of the values, beliefs, and actions of a group and treating individuals who are members of that group as if they fit those pre-determined values, beliefs, or actions. Profiling often leads to different and discriminatory treatment.

Racism: A belief that racialized groups are inferior to their non-racialized counterparts because of their race, religion, culture, or spirituality. The outcome of racism can include discriminatory behaviours and policies that endorse the notion of racialized groups being "less than" in comparison to their non-racialized counterparts (Turpel-Lafond, 2020a).

- **Indigenous-specific racism:** The unique nature of stereotyping, bias, and prejudice about Indigenous peoples in Canada that is rooted in the history of settler colonialism. It is the ongoing race-based discrimination, negative stereotyping and injustice experienced by Indigenous peoples that perpetuates power imbalances, systemic discrimination, and inequitable outcomes stemming from the colonial policies and practices (Turpel-Lafond, 2020a). Examples of Indigenous-specific racism at the systemic level include chronic underfunding of health services in rural and remote Indigenous communities, the exclusion of Indigenous content from settler-imposed elementary and secondary school curricula, and the exclusion or dismissal of Indigenous approaches to health and health care in the mainstream health care system. This last example can also be interpreted as a form of epistemic racism (Provincial Health Services Authority, 2019).
- **Epistemic racism:** The practice of knowledge domination (e.g., favouring Western perspectives on health and wellness) that is rooted in the belief that the knowledge of one racialized group is inferior to their non-racialized counterparts (Turpel-Lafond, 2020a; Reading, 2013).
- **Interpersonal (or relational) racism:** The most apparent form of racism. It is often displayed during day-to-day interactions and can include a spectrum of discriminatory behaviours such as name calling, racial slurs, microaggressions, and violence (Turpel-Lafond, 2020a; Provincial Health Services Authority, 2019).
- **Microaggressions:** Brief and commonplace verbal, behavioural, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of colour (Sue et al., 2007).
- **Organizational racism**: Organizational policies, practices, and workplace cultures that consistently penalize, disadvantage, or otherwise harm Indigenous people, such as a lack of accountability for incidents of interpersonal racism (e.g., a lack of mechanisms to report or follow up on incidents), a workplace culture that normalizes stereotyping or racist remarks about Indigenous people, or policies that are not designed with Indigenous people in mind or are not enforced equally across racialized groups (Provincial Health Services Authority, 2019).
- **Systemic racism (also referred to as structural or institutional racism):** A form of racism that is embedded and enacted into societal structures, institutions, and systems (e.g., practices, policies, legislation) and results in perpetuating inequities such as profiling, stereotyping, social exclusion, and discrimination for racial groups (Turpel-Lafond, 2020a; Reading, 2013).
- **Explicit racism:** Overt and often intentional racism practiced by "individuals and institutions that openly embrace racial discrimination and hold prejudicial attitudes towards racially defined groups" (Moore, 2008, p. 156).
- **Implicit racism:** "An individual's utilization of unconscious biases when making judgements about people from different racial and ethnic groups" (Moore, 2008, p.156).

Reciprocal accountability: The foundation of First Nations' traditional social systems whereby each member is held accountable for their actions and contributions to the community (Institute on Governance, 2017).

Recognition of structural factors: A process of understanding that is critical to understanding Indigenous health and wellness (e.g., imposed settler colonial worldviews, laws, policies, institutions, systems, and governments).

Reconciliation: Ongoing, collective efforts of all Canadians to revitalize the relationship between Indigenous peoples and Canadian society. Reconciliation involves "repairing damaged trust by making apologies, providing individual and collective reparations, and following through with concrete actions that demonstrate real societal change" (Truth and Reconciliation Commission of Canada, 2015a, p.16).

Senior leaders: Organizational leaders in the senior positions. They are accountable at the highest levels for the management and smooth working of the organization. Senior leaders include the executive leader.

Service provider: An individual or organization that provides preventive, curative, promotional, or rehabilitative health and social services in a systematic way to people and communities. For example, individual providers may be health professionals or social service workers, while organizational providers may be service delivery organizations such as hospitals, primary care centres, or social service organizations.

Services: A range of medical, social, and preventive care or treatment provided to people and communities by government, for-profit, and not-for profit organizations. Services cover the spectrum of care from health promotion and disease prevention to diagnostic, treatment, rehabilitation, and palliative care and are provided in a variety of settings.

Settlers: Those who "occupy lands previously stolen or in the process of being taken from their Indigenous inhabitants or who are otherwise members of the 'Settler society,' which is founded on co-opted lands and resources. While this definition is far from comprehensive, in the contemporary sense Settler increasingly includes peoples from around the globe who intentionally come to live in occupied Indigenous territories to seek enhanced privileges" (Barker, 2009, p. 328).

Speak-up culture: A safe space for people to speak up and speak out, where they can feel emboldened to point out both challenging areas and opportunities for new disruptions and innovations (Finnie, 2019).

Strengths-based approach: An approach that focuses on Indigenous peoples' individual and community strengths and resilience to positively adapt despite significant hardships or trauma, rather than concentrating solely on remedying the historical, social, health, and health care disparities faced by First Nations, Métis, and Inuit peoples and communities. Calls for strengths-based approaches come mainly from Indigenous peoples and mostly in the context of health, education, and support for children and families. A strengths-based approach is considered to be not only a culturally appropriate way to engage with Indigenous peoples and communities; it is also the only way (Askew et al., 2020; Health Canada, 2015).

Team: All individuals working, volunteering, or learning together within the organization to meet the needs of clients, families, and the community, including leaders, management, staff, clients, social and health care professionals who hold privileges, contracted providers, volunteers, and students. As partners in care, clients are recognized and treated as members of the team who share in decision making and accountability. The specific composition of a team depends on the type(s) of service(s) provided and/or the activity performed. (*Modified from team in HSO 0400 – HSO Terms and Definitions: https://healthstandards.org/files/HSO-MasterGlossaryList-2018E.pdf.)*

Traditional Indigenous) healing practices: A broad term that describes the many different healing traditions within the different belief systems in Indigenous cultures in Canada. Indigenous traditional healing has been used by Indigenous peoples for thousands of years (Canadian Cancer Society, n.d.).

Trauma- and violence-informed approaches: Approaches that focus on minimizing the potential for harm and re-traumatization and enhancing safety, control, and resilience for those involved with systems or programs. These approaches benefit everyone, regardless of whether they have experienced trauma or whether their personal history is known to service providers. Service providers and organizations who do not understand the complex and lasting impacts of violence and trauma may unintentionally re-traumatize. Embedding trauma- and violence-informed approaches into all aspects of policy and practice can create universal trauma precautions that provide positive support for everyone. They also provide a common platform that helps integrate services within and across systems and offers a basis for consistent ways of responding to people with such experiences (Public Health Agency of Canada, 2018).

Trauma or colonial trauma: The historical impacts of political processes and systemic violence (e.g., colonialism, cultural genocide) on individuals. Intergenerational trauma is an outcome of colonial trauma, whereby the effects of colonial trauma (e.g., physical, psychological, and economic disparities) on Indigenous populations are compounded and passed from one generation to the next (Public Health Agency of Canada, 2018; Turpel-Lafond, 2020a).

Trigger: A stimulus that sets off a memory of a trauma or a portion of a traumatic experience. A trigger is any sensory reminder of the traumatic event: noise, smell, temperature, and/or other physical sensations or visual scenes. Triggers

can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having children reach the age the person was when the trauma occurred, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event (Center for Substance Abuse Treatment, 2014).

Truth telling: Telling the story of residential schools and Canada's history as they have affected and continue to affect First Nations, Métis, and Inuit children, youth, families, and communities (First Nations Child & Family Caring Society, 2020)

Urban and away-from-home: A term that acknowledges that First Nations peoples were displaced from their home communities due to colonialism, or for economic, educational, or other opportunities. Not all First Nations peoples living in a city identify themselves as away from home; for some, the city is their home and is sometimes part of their traditional territory. The First Nations urban and away-from-home population includes status and non-status First Nations people who live in any of the following areas:

- An urban area or city
- A rural, remote, or isolated area that is not in a First Nations community or on a reserve
- A reserve that is away from their home community

Virtual health services: Any interaction between patients and/or family members and members of their circle of care that occur remotely using any form of communication or information technology, with the aim of facilitating or maximizing the quality and effectiveness of patient care (Shaw et al., 2018).

Wellness: The presence of positive emotions and moods; the absence of negative emotions; and feelings of satisfaction with life, fulfillment, and positive functioning. Wellness is an individual state related to what is meaningful for each person and results from a combination of factors including physical wellness, economic wellness, social wellness, emotional wellness, psychological wellness, meaningful activities, and life satisfaction (Centers for Disease Control and Prevention, 2018). According to the First Nations Perspective on Health and Wellness, the balance between the mental, emotional, spiritual, and physical aspects of life is crucial for wellness. These aspects work together to nurture a holistic level of well-being (FNHA, n.d.-e).

Wise practices: Strengths-based actions, tools, principles, or decisions that are culturally appropriate and community driven. Wise practices recognize the wisdom in each Indigenous community and in the community's own stories of achieving success. The concept of wise practices recognizes that culture matters (Wesley-Esquimaux & Calliou, 2010**).**

Workforce: Everyone working in or on behalf of an organization on one or more teams, including those who are salaried and hourly paid, in temporary, term or contract positions, clinical and non-clinical roles, physicians, regulated and non-regulated healthcare professionals, and all support personnel who are involved in delivering services in the organization.

Abbreviations

2SLGBTQQIA – Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual

BC – British Columbia

DRIPA – Declaration on the Rights of Indigenous Peoples Act

FN/M/I – First Nations, Métis, and Inuit

FNHA – First Nations Health Authority

FNHC – First Nations Health Council

HSO – Health Standards Organization

MMWIG – Missing and Murdered Indigenous Women and Girls

MNBC – Métis Nation British Columbia

OCAP® – Ownership Control Access and Possession

OCAS® – Ownership Control Access and Stewardship

PCC – People-centred care

PHSA – Provincial Health Services Authority

PIDA – Public Interest Disclosure Act

RCAP –Royal Commission on Aboriginal Peoples

RHS – Regional Health Survey

TCPS – Tri-Council Policy Statement

TRC – Truth and Reconciliation Commission

UN – United Nations

UDHR – Universal Declaration of Human Rights

UNDRIP – United Nations Declaration on the Rights of Indigenous People

WHO – World Health Organization

HSO Quality Dimensions

HSO Standards are based on eight-quality dimensions. Each dimension highlights themes of safety and high-quality care in all health and social services sectors. Each criterion within the standard is defined by one of the eight quality dimensions.

Population Focus: Work with my community to anticipate and meet our needs

Accessibility: Give me timely and equitable services

Safety: Keep me safe

Worklife: Take care of those who take care of me

Client-centred Services: Partner with me and my family in our care

Continuity of Services: Coordinate my care across the continuum

Appropriateness: Do the right thing to achieve the best results

Efficiency: Make the best use of resources

1 Support Social, Public, and Reciprocal Accountability

1.1 The organizational leaders are accountable for the organization's commitment to anti-racism and cultural safety and humility.

1.1.1 The organizational leaders develop an anti-racism and cultural safety and humility position statement that acknowledges the harm done to First Nations, Métis, and Inuit peoples by racism and discrimination and outlines the organization's commitment to addressing Indigenous-specific racism and discrimination.

Guidelines:

The organizational leaders work collaboratively with First Nations, Métis, and Inuit peoples and communities to develop a position statement that outlines the organization's commitment to addressing Indigenous-specific systemic, structural, and interpersonal biases within the organization's structures and processes. The position statement also outlines how the organizational leaders will promote cultural safety. The commitment addresses the organization's aspirations and expectations related to anti-racism and cultural safety and humility.

The organizational leaders share the position statement publicly, including with affected internal and external parties, partners, and the workforce, and use the position statement to inform strategic and operational planning.

The key documents listed below reflect the importance of a commitment toward Indigenous rights and cultural safety. These documents are listed for reference and as supporting evidence. The organization holds itself accountable to these documents and uses them to inform the development of the organizational position statement.

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Full Report) (Turpel-Lafond, 2020a)
- Expanding Our Vision: Cultural Equality & Indigenous Peoples' Human Rights (Walkem, 2020)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls. (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
- Métis Nation British Columbia Letters of Understanding with Health Authorities (Métis Nation British Columbia & Island Health, 2019)
- Métis Nation Relationship Accord II (Government of British Columbia, 2016)
- Declaration on Cultural Safety and Humility (Northern Health Indigenous Health, 2016)
- BC Tripartite Framework Agreement on First Nations Health Governance (First Nations Health Authority, 2011b)
- Truth and Reconciliation Commission of Canada: Calls to Action (Truth and Reconciliation Commission of Canada (2015a)
- Navigating the Currents of Change: Transitioning to a New First Nations Health Governance Structure (Interim First Nations Health Authority, 2012)
- BC First Nations Perspectives on a New Health Governance Arrangement Consensus Paper (First Nations Health Authority, 2011a)
- United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007)
- Report of the Royal Commission on Aboriginal Peoples (Canada et al.,1996)
- Transformative Change Accord (British Columbia Ministry of Health, 2015)

- Partnership Accord 2019 (Interim Region Nations & Interior Health Authority, 2019)
- Declaration on the Rights of Indigenous Peoples Act (2019)
- Remembering Keegan: A BC First Nations Case Study Reflection (First Nations Health Authority, 2022)

Legislative commitments:

- Universal Declaration of Human Rights, Article 1 (United Nations, n.d.)

1.1.2 The organizational leaders report to the appropriate entity on their commitments to respecting and upholding the rights of First Nations, Métis, and Inuit peoples and communities, including the rights to health and self-determination, by adopting recommendations and learnings derived from key documents.

Guidelines:

Reporting entities differ according to jurisdictions. The reporting could be to the organization's workforce or board, Indigenous committees or Nations, or broader communities served by the organization. The reporting processes and methods of communication (e.g., annual report) may also vary.

The organizational leaders use the following key documents regarding Indigenous rights to health and self-determination to determine monitoring and reporting needs and requirements:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Full Report) (Turpel-Lafond, 2020a)
- Expanding Our Vision: Cultural Equality & Indigenous Peoples' Human Rights (Walkem, 2020)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls. (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
- Métis Nation British Columbia Letters of Understanding with Health Authorities (Métis Nation British Columbia & Island Health, 2019)
- Métis Nation Relationship Accord II (Government of British Columbia, 2016)
- Declaration on Cultural Safety and Humility (Northern Health Indigenous Health, 2016)
- BC Tripartite Framework Agreement on First Nations Health Governance (First Nations Health Authority, 2011b)
- Truth and Reconciliation Commission of Canada: Calls to Action (Truth and Reconciliation Commission of Canada (2015a)
- Navigating the Currents of Change: Transitioning to a New First Nations Health Governance Structure (Interim First Nations Health Authority, 2012)
- BC First Nations Perspectives on a New Health Governance Arrangement Consensus Paper ((First Nations Health Authority, 2011a)
- United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007)
- Report of the Royal Commission on Aboriginal Peoples (Canada et al.,1996)
- Transformative Change Accord (British Columbia Ministry of Health, 2015)
- Partnership Accord 2019 (Interim Region Nations & Interior Health Authority, 2019)
- Declaration on the Rights of Indigenous Peoples Act (2019)
- Regional Health and Wellness Plan (First Nations Health Authority, 2014c)

- Anti-racism, Cultural Safety & Humility Action Plan (First Nations Health Authority, 2021c)

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 6 & 16 (Turpel-Lafond, 2020b)
- Truth and Reconciliation Commission of Canada: Call to Action 18 (Truth and Reconciliation Commission of Canada (2015a)

Legislative commitments:

- Universal Declaration of Human Rights, Article 1 (United Nations, n.d.)

1.1.3 The organizational leaders establish a culture of accountability that includes zero tolerance for Indigenous-specific racism and discrimination, to advance anti-racism and cultural safety and humility.

Guidelines:

The organizational leaders establish concrete and observable expectations and accountabilities for the organization's anti-racism and cultural safety and humility goals and objectives throughout the organization, including within organizational reporting relationships and accountability structures.

Legislative commitments:

- Universal Declaration of Human Rights, Article 5 (United Nations, n.d.)

1.1.4 The organizational leaders support and encourage a speak-up culture in the workforce by developing a policy on Indigenous-specific racism and discrimination in the workplace, as outlined in the organization's policies, code of conduct, and professional standards of practice.

Guidelines:

The organizational leaders affirm the organization's commitment to anti-racism and anti-discrimination in all strategic documents. The organizational leaders actively demonstrate anti-racism and anti-discrimination behaviours, and ensure all workforce members are aware that widespread, systemic racism toward First Nations, Métis, and Inuit peoples and communities will not be tolerated. They promote a speak-up culture throughout the organization (e.g., in orientation, ongoing training, staff meetings).

The organizational leaders implement the requirements in the British Columbia cultural safety and humility standard. As a result, the workforce can identify Indigenous-specific racism and discrimination and knows how and to whom to disclose it.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 11 (Turpel-Lafond, 2020b)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 15.1 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

- Partnership Accord 2019 (Interim Region Nations & Interior Health Authority, 2019)

2 Establish Inclusive and Meaningful Partnerships

2.1 The governing body and organizational leaders engage in purposeful, ongoing, and inclusive partnerships and effective communication with First Nations, Métis, and Inuit peoples and communities.

2.1.1 The organizational leaders appoint a lead or a position to collaborate with First Nations, Métis, and Inuit peoples and communities to identify First Nations, Métis, and Inuit organizations and service providers with which the organization can partner to address First Nations, Métis, and Inuit determinants of health.

Guidelines:

The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to identify First Nations, Métis, and Inuit organizations and service providers with whom to collaborate and/or partner with to address First Nations, Métis, and Inuit priority determinants of health.

Legislative commitments:

- Constitution Act, Part II, Rights of the Aboriginal Peoples of Canada, Section 35 (1982)
- Universal Declaration of Human Rights, Article 21(1) (United Nations, n.d.)

2.1.2 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to co-design partnership agreements with First Nations, Métis, and Inuit organizations and service providers to address First Nations, Métis, and Inuit determinants of health.

Guidelines:

The organization's partnerships with First Nations, Métis, and Inuit organizations and service providers (i.e., its First Nations, Métis, and Inuit partners), as with its relationships with First Nations, Métis, and Inuit peoples and communities, depend on strong, reciprocal relationships and shared decision making. The organizational leaders recognize that partnerships are complex and that power dynamics between partners may shift over time.

Partnerships are protected and enhanced through, for example, coordinated planning, management, design, and delivery of services that, together, result in an integrated health system that meets health and wellness goals and objectives for First Nations, Métis, and Inuit peoples and communities.

Partnership agreements are available in writing.

Each partnership agreement outlines:

- Specific and defined roles and responsibilities for each party to the agreement
- First Nations, Métis, and Inuit health and wellness goals and objectives
- Ways in which the partners will work to collectively achieve the goals and objectives as per the defined roles and responsibilities
- Reciprocal accountabilities and reporting requirements

- Engagement processes that meet the principles of anti-racism, cultural safety and humility, and related legislation
- Communication methods and processes that are accessible to all partners (e.g., in-person meetings, email)
- Regular engagement (e.g., quarterly, bi-annual, annual)
- Requirements to evaluate the effectiveness of the partnership agreement (e.g., identifying indicators related to the quality of the partnership and the achievement of the collective goals and objectives; collecting indicator data; gathering feedback; recognizing achievements and challenges)
- A commitment to using evaluation results for quality improvement

Reports on evaluation findings are submitted to the senior leaders.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 7 (Turpel-Lafond, 2020b)

Legislative commitments:

- United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007)

2.1.3 The organizational leaders collaborate directly with First Nations, Métis, and Inuit peoples, communities, and partners to co-design and implement programs and services that collectively achieve the First Nations, Métis, and Inuit health and wellness goals and objectives defined in the partnership agreements.

Guidelines:

The organizational leaders work with First Nations, Métis, and Inuit peoples, communities, and partners to ensure their input is used to inform and agree on the design, implementation, and evaluation of the programs and services that the organization develops to achieve collective First Nations, Métis, and Inuit health and wellness goals and objectives.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 20 (Truth and Reconciliation Commission of Canada, 2015a)

2.1.4 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, and partners to define each partner's reciprocal accountabilities to collectively achieve the First Nations, Métis, and Inuit health and wellness goals and objectives outlined in the partnership agreements.

Guidelines:

The organizational leaders ensure that partnership agreements clearly state each partner's reciprocal accountabilities and include clear, regular, and transparent reporting requirements, including frequency and reporting mechanisms. The partnership agreements also address circumstances where accountability expectations are not being met. They identify how the organization and First Nations, Métis, and Inuit partners work together to identify and implement corrective action to achieve accountabilities, and the goals and objectives of the partnership.

These expectations are linked to each partner's individual capacity, as well as all partners' collective capacity to deliver programs and services to achieve the First Nations, Métis, and Inuit health and wellness goals and objectives outlined in the partnership agreements.

2.1.5 The organizational leaders allocate resources for the workforce to meaningfully engage in building and sustaining relationships with First Nations, Métis, and Inuit peoples and communities to take collective action on achieving First Nations, Métis, and Inuit health and wellness goals and objectives.

Guidelines:

The organizational leaders dedicate resources to ensure the organization's workforce engages with First Nations, Métis, and Inuit peoples and communities in ways that relate to what matters to First Nations, Métis, and Inuit peoples and communities.

The organizational leaders dedicate resources to train the workforce in anti-racism and cultural safety and humility. These skills enable strong relationships and opportunities for Indigenous and non-Indigenous peoples and communities to take collective action toward achieving First Nations, Métis, and Inuit health and wellness goals and objectives, such as working together to eliminate Indigenous-specific racism in the health system.

The organizational leaders also dedicate resources to support First Nations, Métis, and Inuit peoples and communities to fully participate and engage in building relationships with the organization and its workforce to support reconciliation and collective action on First Nations, Métis, and Inuit health and wellness goals and objectives.

Supporting documentation:

- Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 15.7 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

2.1.6 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, and partners to create an environment for culturally safe truth telling and reconciliation.

Guidelines:

The organizational leaders engage with First Nations, Métis, and Inuit peoples, communities, and partners to create a respectful social, psychological, and physical environment that supports truth telling, and acknowledges Canada's colonial history and its ongoing negative impacts on First Nations, Métis, and Inuit health and wellness. The organizational leaders create an environment that respects the importance of truth in the reconciliation journey, to improve the relationship between Indigenous and non-Indigenous people served by the organization.

The organizational leaders offer space and support for reflection following difficult conversations that may be triggering, and work with the First Nations, Métis, and Inuit partners to access cultural support.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 22 (Turpel-Lafond, 2020b)

2.1.7 The organizational leaders partner with First Nations, Métis, and Inuit peoples and communities to actively participate in events that celebrate First Nations, Métis, and Inuit traditions.

Guidelines:

The organizational leaders partner with First Nations, Métis, and Inuit peoples and communities to regularly recognize and celebrate significant traditions that promote First Nations, Métis, and Inuit healing, decolonization, and reconciliation among the workforce and the community at large. As part of this process, the organization takes the time to celebrate, engage with, and learn from First Nations, Métis, and Inuit peoples and communities, including Indigenous leaders, Elders, and the workforce. Examples of events include National Indigenous Peoples Day, Louis Riel Day, Orange Shirt Day, Inuit Day, National Day for Truth and Reconciliation, and National Day of Action for Missing and Murdered Indigenous Women and Girls.

Supporting documentation:

- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 15.2 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

2.1.8 The governing body reports to and shares its learnings with First Nations, Métis, and Inuit peoples, communities, and partners on the organization's engagement activities and the resulting actions taken to achieve the First Nations, Métis, and Inuit health and wellness goals and objectives defined in the partnership agreements.

Guidelines:

The governing body openly and regularly reports to First Nations, Métis, and Inuit peoples, communities, and partners on the results of engagement activities, to receive their feedback on whether the organization is on the right path, and to adjust its course if necessary.

2.1.9 The governing body communicates the organization's aspirations and commitments related to First Nations, Métis, and Inuit health and wellness to internal and external stakeholders, including the public, to raise awareness about First Nations, Métis, and Inuit health and wellness programs and services.

Guidelines:

The governing body publicly communicates the organization's aspirations and commitments, including expectations when working with First Nations, Métis, and Inuit peoples, communities, and partners to eliminate Indigenous-specific racism in the health system, and achieve First Nations, Métis, and Inuit health and wellness goals and objectives. The organization communicates this in a variety of ways to the public, such as on its website and through newsletters, as well as in strategic and operational documents.

Communication may include information about the organization's engagement activities with First Nations, Métis, and Inuit peoples and communities; its collective goals and

objectives with First Nations, Métis, and Inuit partners; and progress made toward implementing programs and services that are culturally safe and adapted to address systemic barriers and integrate First Nations, Métis, and Inuit approaches and traditional healing practices.

Legislative commitments:

- United Nations Declaration on the Rights of Indigenous Peoples, Article 16 (United Nations, 2007)

3 Share Governance and Implement Responsible Leadership

3.1 The organizational leaders work with the governing body to establish governance and leadership structures that uphold the eradication of Indigenous-specific racism

3.1.1 The organizational leaders uphold established governance processes with First Nations, Métis, and Inuit peoples and communities to respect their rights to self-determination.

Guidelines:

The organizational leaders understand and recognize the impact of colonialism and racism on First Nations, Métis, and Inuit peoples and communities. The organizational leaders acknowledge the long-term work of First Nations, Métis, and Inuit leaders to assert the inherent right to self-determination that is now enshrined in Canadian provincial and federal law, as well as in international law.

The organizational leaders recognize that governance is community driven and Nation-based within the territory where the organization is located. They take direction from local First Nations, Métis, and Inuit peoples and communities to determine which governance processes are legitimate. For example, the organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities, in accordance with local First Nations, Métis, and Inuit governance and protocols, to increase First Nations, Métis, and Inuit decision making and control; foster meaningful partnerships; develop transparent, reciprocal relationships; and outline clear accountabilities. This collaboration can be reflected by signing letters of understanding with local First Nations, Métis, and Inuit organizations and communities or involving First Nations, Métis, and Inuit peoples and communities in governance through the board of directors and advisory or steering committees.

The organizational leaders uphold contractual arrangements with First Nations, Métis, and Inuit communities, including BC First Nations and Métis Chartered Communities, and acknowledges land, treaty, Aboriginal title, and Aboriginal rights and obligations.

The organizational leaders communicate effectively with service providers to ensure they are aware of and uphold contractual arrangements in their daily practice.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 2 (Turpel-Lafond, 2020b)

Legislative commitments:

- Constitution Act, Part II, Rights of the Aboriginal Peoples of Canada, Section 35 (1982)
- Declaration on the Rights of Indigenous Peoples Act (2019)

- Universal Declaration of Human Rights, Article 21(1) (United Nations, n.d.)
- United Nations Declaration on the Rights of Indigenous Peoples, Article 3 (United Nations, 2007)

3.1.2 The organizational leaders maintain governing body and leadership positions in the organization for First Nations, Métis, and Inuit peoples.

Guidelines:

The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities on leadership and governance decisions to expand organizational knowledge; understand First Nations, Métis, and Inuit priorities; identify opportunities to meaningfully integrate First Nations, Métis, and Inuit truth and reconciliation calls to action into strategic and operational planning; and ensure accountability to First Nations, Métis, and Inuit peoples and communities.

The organizational leaders recruit and retain First Nations, Métis, and Inuit peoples who represent the clients and populations served by the organization for the governing body and other governance mechanisms (e.g., board committees, steering committees). The organization also facilitates First Nations, Métis, and Inuit membership within governance and leadership structures, so membership determination is led and directed by First Nations, Métis, and Inuit leadership.

The organization's human resources policies and procedures, including those related to leadership recruitment, retention, and dismissal, ensure diversity and address conscious and unconscious bias and inequities in the organization's recruitment and selection procedures. The organizational leaders publicly expresses its commitment to employment equity for First Nations, Métis, and Inuit peoples in its strategic documents, and its human resources policies support and ensure equal opportunities for advancement to leadership positions for the First Nations, Métis, and Inuit workforce.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 14 (Turpel-Lafond, 2020b)

3.1.3 The organizational leaders actively establish strategic and operational plans to support the delivery of culturally safe care.

Guidelines:

The organizational leaders recognize and acknowledge that widespread systemic racism, stereotyping, and discrimination against First Nations, Métis, and Inuit peoples in the health care system result in a range of negative impacts up to and including death. Indigenous-specific racism and discrimination are key determinants for First Nations, Métis, and Inuit peoples and communities, and the resulting negative or traumatic experiences can lead to physical, emotional, and/or mental harm to First Nations, Métis, and Inuit peoples and communities.

The organizational leaders recognize that anti-racism and cultural safety and humility are essential elements to enable the organization to deliver high quality, safe services. As a result, the organizational leaders incorporate the following into the organization's strategic and operational plans:

- Goals and objectives related to First Nations, Métis, and Inuit health and wellness, anti-racism, and cultural safety and humility
- Indicators to measure and evaluate the achievement of the goals and objectives

- Dedicated resources to achieve the goals and objectives
- Reporting requirements on progress toward the goals and objectives

To achieve the anti-racism and cultural safety and humility goals and objectives, the organizational leaders outline strategies and initiatives, from the executive level to front-line services, to address Indigenous-specific racism and discrimination in the organization. They also develop and deliver a range of culturally safe services that respond to and meet the needs of First Nations, Métis, and Inuit peoples and communities (e.g., incorporating traditional healing practices into programs and services).

The organizational leaders acknowledge and incorporate Indigenous ways of knowing as part of evaluating organizational goals and objectives related to First Nations, Métis, and Inuit health and wellness, anti-racism, and cultural safety and humility.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 10 (Turpel-Lafond, 2020b)
- Truth and Reconciliation Commission of Canada: Call to Action 19 (Truth and Reconciliation Commission of Canada, 2015a)

Legislative commitments:

- Declaration on the Rights of Indigenous Peoples Act (2019)
- United Nations Declaration on the Rights of Indigenous Peoples, Article 24 (United Nations, 2007)

3.1.4 The organizational leaders identify a senior leader who is accountable for the organization's anti-racism and cultural safety and humility initiatives.

Guidelines:

The organizational leaders designate a senior leader who is familiar, through training or lived experiences, with anti-racism and cultural safety and humility initiatives. The senior leader is accountable for collaborating with First Nations, Métis, and Inuit peoples and communities to oversee the systematic design, implementation, and evaluation of the organization's anti-racism and cultural safety and humility initiatives, and for achieving the target goals and objectives. The organizational leaders may designate a team to manage and oversee these initiatives, in which case the team is led by the senior leader. First Nations, Métis, and Inuit peoples and communities have access to the senior leader for prompt action on complaints or grievances.

The organizational leaders dedicate adequate budget funds to the designated senior leader or team. The designated leader or team champions and coordinates the initiatives; oversees the budget and other resources for the initiatives; and uses feedback from the First Nations, Métis, and Inuit workforce and First Nations, Métis, and Inuit peoples and communities to inform the evaluation of the initiatives. The designated leader or team may also identify and seek support from First Nations, Métis, and Inuit organizations and communities to support the anti-racism and cultural safety and humility initiatives.

The designated leader or team reports to the executive leader and the governing body on the organization's progress toward achieving the anti-racism and cultural safety and humility goals and objectives. The designated leader is also accountable for reporting on the organization's recruitment results and the number of First Nations, Métis, and Inuit people in leadership positions.

The organizational leaders implement a knowledge translation plan to share best and wise practices regarding anti-racism and cultural safety and humility with other organizations.

3.2 The organizational leaders work with the governing body to establish governance and leadership structures that demonstrate a commitment to anti-racism and cultural safety and humility.

3.2.1 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to establish processes to engage with First Nations, Métis, and Inuit peoples, communities, and partners, to inform the quality and safety of the organization's services.

Guidelines:

The organizational leaders proactively form and nurture strong partnerships with First Nations, Métis, and Inuit peoples and communities by engaging them in organizational and clinical governance as well as in service planning, design, and delivery.

The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to establish culturally safe and humble processes and learn about First Nations, Métis, and Inuit experiences of care. This includes establishing culturally safe participation and feedback mechanisms (e.g., First Nations, Métis, and Inuit client and community advisory committees; client experience surveys; client navigators) to gather information about and understand First Nations, Métis, and Inuit health and wellness needs, concerns, and priorities; obtain feedback about the organization's programs and services; and identify areas for improvement.

The organizational leaders actively invite and support at-home, urban, and away-from-home First Nations, Métis, and Inuit peoples and communities to use the participation and feedback mechanisms. The organization trains its workforce on relevant engagement principles, including on how to best engage with First Nations, Métis, and Inuit peoples and communities.

The organizational leaders consult with and leverage internal knowledge and experience (e.g., Indigenous health teams, health departments, client navigators), and support existing engagement processes.

Recognizing that no one sector can achieve the societal change required, the organizational leaders establish cross-agency and cross-sector forums and decision-making bodies that include First Nations, Métis, and Inuit peoples, communities, organizations, and agencies, to share information, make decisions, and develop networks and trust.

When engaging with First Nations, Métis, and Inuit peoples and communities, the organizational leaders include representatives from relevant and interested First Nations, Métis, and Inuit partners. The organization collaborates with First Nations, Métis, and Inuit peoples and communities to identify interested parties. It also considers which Indigenous organizations or Nations to include and collaborates as needed with the relevant First Nations, Métis, and Inuit peoples and communities when making these decisions.

The organizational leaders use validated evaluation tools to evaluate the organization's engagement approach with First Nations, Métis, and Inuit peoples and communities, facilitate their participation in organizational processes, gather their feedback, and implement changes in response to the feedback received. This can help sustain and

further improve engagement with First Nations, Métis, and Inuit peoples and communities. Evaluation also helps ensure engagement is meaningful and purposeful, and that the First Nations, Métis, and Inuit peoples and communities do not feel they are merely serving as tokens throughout the process.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 20 (Truth and Reconciliation Commission of Canada, 2015a)

3.2.2 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, and partners to inform the organization's direction and priorities.

Guidelines:

The organization's direction includes its:

- Vision, mission, and values
- Strategic and operational plans, including goals and objectives
- Quality improvement agenda
- Resource allocations
- Client rights and responsibilities
- Codes of conduct

The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, and partners to identify, understand, and address First Nations, Métis, and Inuit health and wellness goals and objectives, and incorporate them into the organization's vision, mission, values, strategic plans, and quality improvement agenda. This facilitates the participation of First Nations, Métis, and Inuit peoples, communities, and partners in the organization's decision-making processes.

The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to define First Nations, Métis, and Inuit client rights and responsibilities. The organization acknowledges and recognizes First Nations, Métis, and Inuit peoples' right to health, meaning they should have full access to health care services in ways that reflect and are responsive to Indigenous worldviews and conceptions of health, without discrimination and in ways that respect their right to self-determination. First Nations, Métis, and Inuit peoples' rights also include the right to discuss their holistic (e.g., cultural, health, wellness) priorities.

To facilitate participation, the organizational leaders establish mechanisms for systematic and ongoing two-way communication with First Nations, Métis, and Inuit peoples, communities, and partners regarding policy development, program planning, service delivery, evaluation of services, and quality improvement. The organizational leaders may seek guidance from diverse resources (e.g., reports, publications, best practices, guidelines) on how to engage and build relationships with First Nations, Métis, and Inuit peoples and communities.

Legislative commitments:

- Universal Declaration of Human Rights, Articles 18 & 26 (United Nations, n.d.)

3.2.3 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to embed anti-racism and cultural safety and humility into organizational values.

Guidelines:

The organizational leaders demonstrate a commitment to anti-racism and anti-discrimination as part of creating an organizational culture of quality and safety. They show respect for Indigenous rights, protocols, and practices, and demonstrate anti-racism and anti-discrimination behaviours. They embed anti-racism and cultural safety and humility into the organization's quality and safety goals and objectives, as part of the ongoing commitment to First Nations, Métis, and Inuit peoples and communities to deliver culturally safe services.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 2 (Turpel-Lafond, 2020b)

3.2.4 The organizational leaders use quantitative and qualitative data that are endorsed by First Nations, Métis, and Inuit peoples and communities to inform the organization's strategic and operational plans.

Guidelines:

The organizational leaders ensure the strategic and operational plans are informed by First Nations, Métis, and Inuit population health data, complaints, and feedback; service use and access information; principles of ownership, control, access, and possession (OCAP®); and other sources of data and information. The organizational leaders take direction from First Nations, Métis, and Inuit leaders on who to collaborate with and how it should be done.

3.2.5 The organizational leaders recognize and acknowledge the territories of First Nations who live in the territory where the organization is located.

Guidelines:

The organizational leaders use a variety of ways to acknowledge the presence and the land rights of First Nations, Métis, and Inuit peoples and communities, such as in daily meetings and communications (e.g., agendas, minutes). The organizational leaders add meaning and intention to the land acknowledgements by, for example, providing a history of the territory where the organization is located, acknowledging the impact of colonialism and its relationship to the territory, and emphasizing their intention to dismantle and disrupt colonialism.

Prior to a meeting or an event, the organizational leaders work with First Nations, Métis, and Inuit peoples and communities to identify appropriate ways to acknowledge First Nations, Métis, and Inuit rights to and/or presence on the land where the meeting or event takes place. The governing body establishes protocols with the First Nations, Métis, and Inuit community or territory and specifies if an Indigenous leader is presenting or if a Knowledge Keeper or Elder is offering the opening/welcoming prayer. In meetings or events where an Indigenous Elder or Knowledge Keeper has been invited to provide an opening and welcoming prayer, the organizational leaders meet with the Elder to

review the meeting outline, intent, and confirm the length of time required. The organizational leaders ensure they introduce Indigenous speakers and that the speakers are compensated appropriately.

Supporting documentation:

- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 15.2 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

4 Invest in Financial and Physical Infrastructure

4.1 The organizational leaders work with the governing body to invest in anti-racism and cultural safety and humility by establishing the financial and physical infrastructure necessary to ensure a respectful and welcoming environment for First Nations, Métis, and Inuit peoples and communities.

4.1.1 The governing body demonstrates the organization's commitment to anti-racism and cultural safety and humility by earmarking a dedicated and adequate budget for anti-racism and cultural safety and humility initiatives, including First Nations, Métis, and Inuit health and wellness programs and services.

Guidelines:

The governing body shows its commitment to anti-racism and cultural safety and humility by dedicating resources to design, implement, and evaluate First Nations, Métis, and Inuit anti-racism and cultural safety and humility initiatives and health and wellness programs and services. The budget includes resources dedicated to collaboration with First Nations, Métis, and Inuit peoples and communities as part of the design, implementation, and evaluation of such initiatives, programs, and services.

The design and implementation of, programs, and services may include an iterative process of research, testing, and redesign. To critically evaluate its First Nations, Métis, and Inuit initiatives, programs, and services, the organization works with First Nations, Métis, and Inuit peoples and communities to collect and analyze data and information about the activities, characteristics, and outcomes of the initiatives, programs, and services.

The budget is formalized as base funding, similar to dedicated budgets for other core activities, to sustainably and sufficiently support the commitment to anti-racism and cultural safety and humility and First Nations, Métis, and Inuit health and wellness.

The governing body dedicates the resources required to:

- Design and implement First Nations, Métis, and Inuit health and wellness programs and services that meet the needs of First Nations, Métis, and Inuit peoples and communities
- Develop and implement policies and procedures to support anti-racism and cultural safety and humility in the organization, including supporting engagement for related initiatives and First Nations, Métis, and Inuit health and wellness programs and services (e.g., honorarium or gifting policies)
- Provide regular, mandatory anti-racism, cultural safety and humility, and trauma- and violence-informed education and training to the workforce

- Support and sustain long-term awareness of, and commitment to, the First Nations, Métis, and Inuit anti-racism and cultural safety and humility initiatives, thus creating a system where Indigenous rights are upheld; anti-racist mindsets and skillsets are the norm; and changes in systems, behaviours, and beliefs are promoted
- Provide First Nations, Métis, and Inuit support persons to internal teams and initiatives related to anti-racism, cultural safety and humility, and First Nations, Métis, and Inuit health and wellness programs and services (e.g., Indigenous health teams and health departments; client navigators; Elders, Healers, and Knowledge Keepers who are recognized by their communities)
- Promote anti-racism and cultural safety and humility within and beyond the organization, including co-creating networks and partnerships with Indigenous and non-Indigenous organizations, service providers, and clients and families to share data, information, and learnings to achieve anti-racism and cultural safety and humility goals and objectives

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 20 (Truth and Reconciliation Commission of Canada, 2015a)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Articles 7.4 & 7.7 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

4.1.2 The organizational leaders allocate adequate budgetary and financial resources to ensure programs and services are sustainable over the long term.

Guidelines:

The governing body formalizes the budget as base funding, similar to dedicated budgets for other core activities, to sustainably and sufficiently support the commitment to anti-racism and cultural safety and humility and First Nations, Métis, and Inuit health and wellness.

Supporting documentation:

- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Articles 7.4 & 7.7 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019

4.1.3 The organizational leaders co-design the physical environments with First Nations peoples and communities who originate from the land or territory where the organization is located.

Guidelines:

The organizational leaders recognize the land rights of First Nations peoples and communities who originate from the land or territory where the organization is located. The organizational leaders collaborate with the First Nations peoples and communities of the territory and seek input about the environment from the First Nations, Métis, and Inuit peoples and communities as well as from other First Nations, Métis, and Inuit groups, such as recognized Métis communities or First Nations, Métis, and Inuit peoples who are urban or away from home and those who are living on the territory.

Co-designing the physical environment in existing and new facilities includes using land acknowledgements, having appropriate space for ceremonies and gatherings, integrating

local artwork, and considering appropriate language and location of signs. The organizational leaders follow First Nations, Métis, and Inuit guidelines with regard to information desks, welcome poles, and building exteriors. When creating new facilities, the organization uses innovative and transformative approaches to enhance cultural safety and humility in the design.

The organizational leaders foster effective collaboration by building strong, lasting relationships and maintaining ongoing dialogue with the First Nations peoples and communities of the territory and the First Nations, Métis, and Inuit peoples within the territory. The organization conducts in-person meetings in the community to the extent possible.

Buildings and locations with historical and organizational significance (e.g., building names) are considered before designating a meeting space, to recognize truth and history, and to support healing for First Nations, Métis, and Inuit peoples. The organizational leaders also consider whether changes or ceremonies (e.g., brushing ceremonies) may be needed prior to using these locations.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 10 (Turpel-Lafond, 2020b)

4.1.4 The organizational leaders provide culturally safe spaces that reflect First Nations, Métis, and Inuit values for First Nations, Métis, and Inuit clients, families, and workforce members to gather.

Guidelines:

The organizational leaders provide a First Nations, Métis, and Inuit people-centred environment that is welcoming and culturally appropriate. The environment includes dedicated sacred and protected spaces where First Nations, Métis, and Inuit clients, families, and workforce members may gather. These dedicated spaces are available on an ongoing basis. The organizational leaders ensure that First Nations, Métis, and Inuit clients, families, and workforce members are aware of, and have access to, these spaces.

The spaces may be outside or inside (e.g., traditional medicine gardens, places for smudging and sweat ceremonies). They are safe, inviting, accessible, and available for First Nations, Métis, and Inuit cultural practices and protocols.

First Nations, Métis, and Inuit traditional Healers and First Nations, Métis, and Inuit peoples and communities lead the process to design the sacred spaces, to help First Nations, Métis, and Inuit clients, families, and workforce members feel more comfortable, such as by using artwork by local First Nations, Métis, and Inuit artists. If the organization is too small to have a dedicated sacred space, it offers a space that can be reserved for sacred ceremonies and informs people to that effect, such as through appropriate signage.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 2 & 10 (Turpel-Lafond, 2020b)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 7.2 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

Legislative commitments:

- Universal Declaration of Human Rights, Article 18 (United Nations, n.d.)

5 Develop Human Capacity

5.1 **The organization's human resources policies and practices address racism and discrimination and are developed in partnership with First Nations, Métis, and Inuit peoples and communities.**

5.1.1 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to implement an anti-racism and discrimination policy.

Guidelines:

The organizational leaders ensure the organization's policies take race into account in a meaningful way, to avoid racism being invisible or deemed nonexistent and thereby allowing it to persist and potentially increase.

The organizational leaders develop an anti-racism and discrimination policy, in collaboration with First Nations, Métis, and Inuit peoples and communities, to recognize and address racial harassment, racism, discrimination, and vilification throughout the organization. The policy addresses the history of colonization, dispossession, enslavement, genocide, and their legacies; ongoing settler colonial projects; and the physical, emotional, and spiritual harm caused to Indigenous peoples as a result of racism and discrimination. It also affirms the humanity, rights, dignity, and safety of First Nations, Métis, and Inuit clients, families, and workforce members.

The purpose of the policy is to:

- Create a zero-tolerance environment for racism and promote a speak-up culture throughout the organization, with protection from negative consequences
- Define the forms of Indigenous-specific racism that exist in the organization and set out procedures to report and disrupt racism
- Affirm the organization's responsibility to implement policies, procedures, education, and training to create a zero-tolerance environment and eliminate the expression of racism in any form
- Describe the commitments and proactive steps being taken to foster learning and work environments that fully respect First Nations, Métis, and Inuit peoples' rights, values, and beliefs, including their right to be free from racism, discrimination, violence, intergenerational trauma, harassment, or vilification
- Set out requirements for the workforce about respectful conduct, especially for those in instructional, supervisory, or managerial and leadership positions who have a duty to educate, intervene when they observe racism impacting anyone in the organization, and deal appropriately with allegations regarding violations of the policy
- Complement and build on related policies by clarifying expectations for recognizing and reporting incidents safely and with protection from negative consequences

The organization's anti-racism and discrimination policy outlines the strategies, structures, and mechanisms that support prompt action and protection from negative

consequences when Indigenous-specific racism and discrimination is reported. The policy is consistent with applicable collective agreements.

The organizational leaders recognize that everyone associated with the organization needs to be involved in, and committed to, the development and implementation of an effective anti-racism and discrimination policy that promotes equity and diversity, limits harm, and reduces liability. The organization monitors compliance with the policy and provides regular reports to its workforce, clients, families, and communities about compliance with the policy and the policy's effectiveness in addressing Indigenous-specific racism and discrimination. This assures the workforce, clients, families, and communities that the organization takes Indigenous-specific racism and discrimination seriously.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 2 & 20 (Turpel-Lafond, 2020b)

5.1.2 The organizational leaders collaborate with unions and regulatory bodies to develop collective or other applicable employment agreements that outline the procedures to address Indigenous-specific racism and discrimination in the workplace, in accordance with the organization's anti-racism and discrimination policy.

Guidelines:

Strong support from unions and regulatory bodies is essential to an effective anti-racism and discrimination policy. The organization collaborates with health care unions (e.g., Hospital Employees' Union, British Columbia Nurses' Union) and regulatory bodies (e.g., Health Sciences Association, College of Physicians and Surgeons) to develop collective or other applicable employment agreements that support a zero-tolerance and stepwise organizational approach to acknowledge and eliminate Indigenous-specific racism and discrimination in the workplace. To do this, the organization:

- Creates awareness by ensuring that procedures in the collective or other applicable employment agreements reflect the organization's role in building workforce awareness through opportunities for education and awareness about Indigenous-specific racism. This includes education about the history of colonialization in Canada and how it has impacted First Nations, Métis, and Inuit peoples and communities who access health services at community, regional, and provincial levels.
- Creates experiential learning opportunities and resources to support peer-to-peer coaching and mentoring, to encourage behavioural change by ensuring that procedures in the collective agreements reflect the organization's role in creating culturally safe opportunities for learning and having uncomfortable conversations about Indigenous-specific racism.
- Addresses remediation by ensuring that procedures in the collective or other applicable employment agreements permit the organization to follow its anti-racism and discrimination policy to address incidents of Indigenous-specific racism and discrimination by taking remedial action where required and as outlined in policy.
- Addresses dismissal by ensuring that procedures in the collective or other applicable employment agreements permit the organization to follow its anti-racism and discrimination policy to address incidents of Indigenous-specific racism and discrimination by moving to dismissal where required and as outlined

in policy. This could include situations such as repeat offenders where remediation efforts have not been successful, or racist conduct resulting in severe harm.

The organizational leaders document the process and how it is to be followed in the collective or other applicable employment agreements, to ensure compliance.

5.1.3 The organizational leaders implement protocols to protect individuals from negative consequences when an individual reports an incident of direct or indirect Indigenous-specific racism and discrimination associated with the organization.

Guidelines:

The organizational leaders inform First Nations, Métis, and Inuit peoples and communities, as well as its workforce, clients, families, partners, and the public, about how to safely and confidentially report incidents of Indigenous-specific racism and discrimination associated with the organization. The organization ensures its protocols to report an incident are accessible and outlined clearly, and the workforce understands the process. The protocols also encourage colleagues, clients, and families to report an incident.

The protocols are aligned with the organization's anti-racism and discrimination policy and protect whistleblowers from negative consequences, such as blocking opportunities for advancement in the organization.

5.1.4 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to ensure the anti-racism and discrimination policy defines and applies a spectrum of consequences for Indigenous-specific racism and discrimination, in accordance with the organization's collective and other employment agreements.

Guidelines:

The organization's anti-racism and discrimination policy outlines the prompt and consequent actions that will be taken when incidents of Indigenous-specific racism and discrimination occur. The actions are defined along a spectrum depending on the severity of the incident.

Consequences can range from providing remedial support and training to workforce members to support learning and behaviour change to suspensions, terminations, and formal complaints to the regulatory body. The organization collaborates with First Nations, Métis, and Inuit peoples and communities to reflect the concept of restorative justice within the spectrum of consequences, where the person whose actions caused harm may take responsibility and, in discussion with those harmed, establish a suitable way to address the incident.

5.1.5 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to implement procedures to respond to incidents of Indigenous-specific racism and discrimination in a timely and transparent manner.

Guidelines:
The organizational leaders are transparent with First Nations, Métis, and Inuit peoples and communities and its workforce, clients, and families about the process followed to review and investigate a complaint about an incident of Indigenous-specific racism or discrimination. The organizational leaders provide the complainant with information to pursue a complaint with the regulatory body and/or human rights tribunal if the complainant so wishes.

The organizational leaders provide the complainant with the name of a contact person for the complaint, and estimated timelines for when the complaint will be reviewed and investigated and when a resolution will be available.

The organizational leaders follow the anti-racism and discrimination policy to determine appropriate actions to be taken in response to an incident. The response process includes providing cultural support to the complainant and connecting them with additional support (e.g., Indigenous client navigators, health representatives, advocates) if needed.

When a workforce member is involved in the incident, the organizational leaders inform the workforce member about the complaint and the possible consequences (e.g., remedial support, training, suspension, dismissal). The incident and the result are recorded in the workforce member's human resources file, in accordance with regulatory requirements and collective agreements.

The organizational leaders evaluate incidents to look for opportunities to promote cultural humility, reflection, learning, and improvement as a foundation to achieving a culturally safe environment.

5.1.6 The organizational leaders incorporate competency requirements related to anti-racism and cultural safety and humility into the organization's recruitment and selection procedures.

Guidelines:

The organizational leaders define competency requirements related to anti-racism and cultural safety and humility in accordance with the organization's anti-racism and discrimination policy. This includes requirements for a basic understanding of Indigenous rights, protocols, and practices. The organizational leaders incorporate the competency requirements into position descriptions and job postings as well as procedures to recruit and select candidates.

5.1.7 The organizational leaders define the roles, responsibilities, and accountabilities of the workforce to create safe spaces for First Nations, Métis, and Inuit peoples and uphold anti-racism and cultural safety and humility principles in the workplace.

Guidelines:

The organizational leaders incorporate roles, responsibilities, and accountabilities for creating safe spaces for First Nations, Métis, and Inuit peoples into position descriptions and workforce performance appraisal procedures, to create anti-racist mindsets and skillsets as the norm. The roles, responsibilities, and accountabilities align with the organization's quality and safety processes and frameworks as well as its strategic goals and values.

5.1.8 The organizational leaders publicly share the organization's anti-racism and cultural safety and humility policies, including the anti-racism and discrimination policy.

Guidelines:

The organizational leaders make the policies on anti-racism, discrimination, and cultural safety and humility available to the public through various means, such as ensuring they

are posted on the organization's website and included in social media posts and recruitment and other general information about the organization.

5.2 The organizational leaders regularly provide the workforce with cultural safety and humility education and training that incorporates the views and experiences of First Nations, Métis, and Inuit peoples and communities.

5.2.1 The organizational leaders provide an orientation to the workforce on the organization's anti-racism and cultural safety and humility policies and commitments.

Guidelines:

The organizational leaders include information about the following in the orientation to anti-racism and cultural safety and humility:

- The complex, cumulative way in which social identities such as race, religion, sex, gender identity, sexual orientation, disability, or other protected characteristics contribute to systemic oppression and discrimination
- Commitments to anti-racism and cultural safety and humility, including those related to:
  - Declaration of Commitment to Advancing Cultural Humility and Cultural Safety Within Health Services ((First Nations Health Authority, 2015)
  - Declaration of Commitment: Cultural Safety and Humility in the Regulation of Health Professionals Serving First Nations and Aboriginal People in British Columbia (British Columbia Health Regulators, 2017)
  - Declaration on the Rights of Indigenous Peoples Act (2019)
  - In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Full Report) (Turpel-Lafond, 2020a)
  - Related letters or memoranda of understanding, or other service-level agreements
  - Métis Nation British Columbia letters of understanding with health authorities
  - Canada-Métis Nation Accord (Office of the Prime Minister, 2017)
  - Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
  - Partnership Accord 2019 (Interim Region Nations & Interior Health Authority, 2019)
  - Report of the Royal Commission on Aboriginal Peoples (Canada et al.,1996)
  - Transformative Change Accord (British Columbia Ministry of Health, 2015)
  - Truth and Reconciliation Commission of Canada: Calls to Action (Truth and Reconciliation Commission of Canada (2015a)
  - Kaa-wiichitoyaahk: We Take Care of Each Other— Métis Perspectives on Cultural Wellness (Métis Nation British Columbia, 2019)
  - Constitution of the Métis Nation British Columbia (Métis Nation British Columbia, 2003)
  - Anti-racism, Cultural Safety & Humility Action Plan (First Nations Health Authority, 2021c)
  - Declaration on the Rights of Indigenous Peoples Act (2019)
- The organization's anti-racism and cultural safety and humility accountabilities, goals, and objectives, including:

- Anti-racism and discrimination policy and procedures related to creating a zero-tolerance environment for racism and discrimination and the procedures to report and respond to incidents
- Commitments to respecting Indigenous rights, protocols, and practices, and to health and wellness for First Nations, Métis, and Inuit peoples and communities

The orientation also outlines the tools and resources that are available to help the workforce learn about cultural safety and humility, and participate in decolonization, by learning about the history of colonialism in Canada and the systemic racism that exists against Indigenous people in the health care system in BC. This can support the workforce's understanding of how racism and discrimination in the health care system is demonstrated through a lack of respect for and implementation of the basic human rights of First Nations, Métis, and Inuit peoples, both of which affect their ability to access health services.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)

5.2.2 The organizational leaders provide regular, mandatory anti-racism and cultural safety and humility education and training to the workforce.

Guidelines:

The organizational leaders use a combination of Indigenous-led didactic and/or online training, community engagement, and reflective practice to increase the cultural knowledge and skills of the organization's workforce, including service providers, maintenance staff, organizational leaders, and the governing body. The training and education are tailored to the specific audiences.

The organizational leaders use available resources (e.g., from other health systems or organizations; international resources; internal curriculum; First Nations, Métis, and Inuit community resources) to provide mandatory education on anti-racism and cultural safety and humility. The organization collaborates with First Nations, Métis, and Inuit communities to determine how frequently the education is offered.

The organization evaluates First Nations, Métis, and Inuit organizations to ensure they are representative of the First Nations, Métis, and Inuit population in the area by consulting with local First Nations, Métis, and Inuit communities.

The organizational leaders identify and work with local First Nations, Métis, and Inuit communities to identify an educator who is recognized by the Nation or community.

The organizational leaders ensure the orientation is Indigenous-led and developed with First Nations, Métis, and Inuit peoples and communities. The organization includes information about the following in its orientation, education, and training about anti-racism and cultural safety and humility:

- First Nations, Métis, and Inuit peoples and communities with whom the organization works
- Distinctions-based approaches to health care, explaining the unique needs of First Nations, Métis, and Inuit communities and the differences among them

- The interrelated concepts of colonialism, power, privilege, racism, discrimination, prejudice, and bias in settler societies in Canada, from a First Nations, Métis, and Inuit perspective
- How First Nations, Métis, and Inuit women, girls, and gender-diverse people face disproportionately negative impacts of colonialism, racism, and violence in the healthcare system, using a gendered-lens approach
- How racism in the health care system reflects a lack of respect for and a lack of implementation of the basic human rights of First Nations, Métis, and Inuit peoples
- The Indigenous right to health which means that First Nations, Métis, and Inuit peoples have full access to health care services, without discrimination and in ways that reflect and respond to Indigenous worldviews and conceptions of health
- The structures and systems that produce and perpetuate First Nations, Métis, and Inuit health inequities
- Trauma- and violence-informed care, harm reduction, and lateral kindness
- The meaning of anti-racism and cultural safety and humility, as well as strategies for applying the concepts in practice
- Partnership development with First Nations, Métis, and Inuit peoples and communities and organizations
- The ways in which stereotyping and discrimination manifest in health care and strategies to interrupt discrimination
- Protocols for whistleblowers so they can safely and confidentially report incidents of direct or indirect Indigenous-specific racism and discrimination associated with the organization, without fear of negative consequences
- The concept of speak-up culture and how it is promoted in the organization's daily work
- Key documents such as the In Plain Sight reports, the Truth and Reconciliation Committee's Calls to Action, the United Nations Declaration on the Rights of Indigenous Peoples, the Missing and Murdered Indigenous Women and Girls Calls for Justice, the Declaration on the Rights of Indigenous Peoples Act, and the Indian Act including its negative impacts

Through continued education and training, the organization builds its workforce competencies related to anti-racism and cultural safety and humility. It creates and grows a knowledge base of teachings and learnings from the First Nations, Métis, and Inuit peoples and communities it serves. It ensures service providers understand the determinants of health of First Nations, Métis, and Inuit peoples and communities that are rooted in colonialism and develops strategies to counter systemic health inequities.

The organizational leaders help service providers develop core competencies related to anti-racism and cultural safety and humility as well as First Nations, Métis, and Inuit health and wellness (e.g., the impacts of colonialism, culturally safe and humble communication, respectfully learning about and understanding cultures different from their own). The organizational leaders also advocate for these core competencies to be incorporated into education programs and professional development courses offered by training institutions and professional bodies, to help embed these core competencies into practice.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 20 (Turpel-Lafond, 2020b)

- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Articles 7.6 &15.2 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)

Legislative commitments:

- Universal Declaration of Human Rights, Article 26 (United Nations, n.d.)

5.2.3 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to ensure the organization's anti-racism and cultural safety and humility education and training incorporates the views, protocols, experiences, and contexts of local First Nations, Métis, and Inuit peoples and communities in a culturally safe way.

Guidelines:

As part of its anti-racism and cultural safety and humility education and training, the organization supports ongoing opportunities for community engagement with First Nations, Métis, and Inuit peoples and communities, and Elders in particular, as part of workforce members' learning plans.

The organization honours and respects First Nations, Métis, and Inuit peoples by embedding First Nations, Métis, and Inuit protocols such as gifting and/or honorariums for these learning sessions in its policies.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 20 (Turpel-Lafond, 2020b)

5.2.4 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to regularly evaluate the effectiveness of the organization's anti-racism and cultural safety and humility education and training.

Guidelines:

The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to define indicators and targets that are relevant and important to them and uses them to evaluate its education and training (e.g., First Nations, Métis, and Inuit client-reported experience measures, client feedback). The results of the evaluation of the anti-racism and cultural safety and humility education and training are used to identify and address areas for improvement.

5.2.5 The organizational leaders maintain records of each workforce member's completion of the anti-racism and cultural safety and humility orientation, education, and training.

Guidelines:

The organizational leaders record the completion of the orientation, education, and training in each workforce member's human resource file and uses it as part of performance management, in accordance with its human resource policies and procedures.

5.3 The organizational leaders embed cultural safety and humility into professional development opportunities and performance appraisals.

5.3.1 The organizational leaders implement processes that enable the workforce to develop cultural safety and humility through ongoing learning and critical self-reflection.

Guidelines:

The organizational leaders encourage workforce to engage in critical self-reflection related to:

- Their experiences and how they can play their roles and responsibilities as leaders in the health system and be agents of change to improve service delivery and the experiences of First Nations, Métis, and Inuit peoples and communities who access the organization's services
- The values, assumptions, and belief structures they bring to interactions with First Nations, Métis, and Inuit clients
- How a person's race, religion, sex, gender identity, sexual orientation, disability, or other protected characteristics can impact and compound their experiences of racism and discrimination
- Recognizing how various forms of racism are unknowingly perpetuated
- Recognizing how their engagement with First Nations, Métis, and Inuit clients can be done in a timely manner, including discovering the purpose of the visit and the services that are required
- Their willingness to advocate for additional support for First Nations, Métis, and Inuit clients if required (e.g., specialists, second opinions, follow-up, social workers, requests for traditional ceremonies, or the involvement of a traditional Healer on the care team)

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 20 (Turpel-Lafond, 2020b)
- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)
- Inclusion Self-Assessment Tool (University of British Columbia Equity and Inclusion Office, n.d.)
- #itstartswithme campaign, Creating a climate for change (First Nations Health Authority, 2016a)

5.3.2 The organizational leaders require the workforce to establish performance and learning objectives related to anti-racism and cultural safety and humility, as part of their performance appraisal.

Guidelines:

The organizational leaders require the workforce to complete a cultural safety and humility self-assessment that includes:

- An acknowledgement that cultural safety and humility is a lifelong learning journey

- A requirement to self-reflect on their cultural safety and humility competencies as a baseline for ongoing evaluations of their learning journey
- A requirement to identify what they want to learn more about as the next step in their learning journey

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)

5.3.3 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to provide the workforce with opportunities for mentorship and exposure to community experiences and community interactions that promote recognition of, and respect for, First Nations, Métis, and Inuit rights, cultural values, protocols, and traditional medicines.

Guidelines:

There is often a lack of recognition of and respect for First Nations, Métis, and Inuit rights, cultural values, protocols, and traditional medicines, which can include protocols related to birth and death; and the importance of cultural ceremonies and mores such as smudging, drumming, history, languages, names, and hair care.

The organizational leaders partner with First Nations, Métis, and Inuit peoples and communities to provide, all levels of the workforce including service providers, organizational leaders, and the governing body, opportunities to be actively mentored about engaging in respectful, reflective, and collaborative practice. Through such opportunities, the workforce gains experience, understanding, and knowledge about providing culturally safe and humble care, designing culturally safe and humble programs and services, building relationships, and more.

The organizational leaders establish policies and dedicates a budget and resources for providing mentorship opportunities to its workforce as part of ongoing professional development. The allocated budget accounts not only for the time of the mentees but also appropriately compensates the time and energy of the community Elders and educators who are participating as mentors.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)

5.4 The organizational leaders develop a First Nations, Métis, and Inuit workforce strategy.

5.4.1 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to identify First Nations, Métis, and Inuit workforce goals and objectives, including ensuring the workforce is representative of the population served.

Guidelines:

The organizational leaders outline First Nations, Métis, and Inuit workforce goals and objectives to create a workforce that is representative of the First Nations, Métis, and Inuit peoples and communities served. Additionally, the organization's workforce has the necessary skills and capabilities to provide culturally safe and humble services to achieve

First Nations, Métis, and Inuit health and wellness goals and objectives. This includes establishing targets for First Nations, Métis, and Inuit representation, and actively recruiting and retaining First Nations, Métis, and Inuit peoples for positions at all levels of the organization, including at senior leadership levels.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)

5.4.2 The organizational leaders collaborate with First Nations, Métis, and Inuit professionals who have expertise in cultural safety and humility and education to develop a fair, equitable, and inclusive workforce development plan or strategy.

Guidelines:

The organizational leaders commit to providing a culturally safe environment for First Nations, Métis, and Inuit peoples and communities and work with them to develop strategies and plans to achieve the organization's First Nations, Métis, and Inuit workforce goals and objectives (e.g., recruitment and retention; education and training; support including at the senior leader levels; advocacy and support for jurisdictional strategies for more trained First Nations, Métis, and Inuit professionals including at the senior leader levels).

To achieve the goal of a First Nations, Métis, and Inuit representative workforce, the organizational leaders ensure the workplace is a culturally safe environment. They work with First Nations, Métis, and Inuit peoples and communities to find ways to actively recruit, retain, and develop First Nations, Métis, and Inuit candidates for positions in the organization, including leadership, clinical services, administration, and information technology. Once recruited, they engage First Nations, Métis, and Inuit workforce members in professional development opportunities to encourage their retention and growth.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)

5.4.3 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to gather data and information that can be used to regularly inform, monitor, and evaluate the achievement of the First Nations, Métis, and Inuit workforce strategy goals and objectives.

Guidelines:

The organizational leaders use transparent and culturally safe methods to collect data and information about the composition, diversity, competencies, and other aspects of the workforce, to assess the organization's ability to meet the needs of First Nations, Métis, and Inuit peoples and communities. This could include data related to race, age, education, practice locations, number of care hours at each location, and populations served.

The organizational leaders also collect data, information, and feedback from current and potential First Nations, Métis, and Inuit workforce members. They use the data,

information, and feedback to inform the First Nations, Métis, and Inuit workforce goals, objectives, and strategy and to define process and outcome indicators to regularly monitor and evaluate the effectiveness of the strategy. They use the results of the evaluations to identify, share, and address areas for improvement in the organization's strategy.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)
- The First Nations Principles of Ownership Control Access and Possession [OCAP®] (First Nations Information Governance Centre, 1998)

5.4.4 The organizational leaders ensure the First Nations, Métis, and Inuit workforce strategy includes plans for First Nations, Métis, and Inuit recruitment, retention, professional development, and mentorship.

Guidelines:

The organizational leaders actively recruit First Nations, Métis, and Inuit peoples to help bridge the divide between western and First Nations, Métis, and Inuit health care and social service practices, and to help the organization understand the unique considerations associated with remote, rural, urban, and northern communities. They educate and train non-Indigenous workforce members to be more culturally safe and culturally aware, while also recognizing the positive impact that comes from having the First Nations, Métis, and Inuit workforce provide culturally responsive health care, services, and programs. Indigenous workforce members may also be involved in helping to educate colleagues and mediate cultural issues when they arise, and in bridging the cultural divide between the two systems.

The organization's First Nations, Métis, and Inuit workforce retention strategy includes supporting a culture of safety and offering culturally relevant support mechanisms to increase First Nations, Métis, and Inuit workforce satisfaction (e.g., First Nations, Métis, and Inuit peer support networks, mentoring opportunities, professional development, access to Elders and trauma therapists, Indigenous workplace culture advisory councils).

The organizational leaders provide professional development and First Nations, Métis, and Inuit peer mentorship opportunities for the First Nations, Métis, and Inuit workforce, as part of its First Nations, Métis, and Inuit workforce strategy.

The organizational leaders collaborate with the First Nations, Métis, and Inuit workforce to select and monitor relevant workforce satisfaction indicators.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 14 (Turpel-Lafond, 2020b)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Articles 7.7 & 7.8 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)

Legislative commitments:

- Canadian Human Rights Act, 1985, Article 9(1)
- Constitution Act, 1982, Article 36(1)

5.4.5 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, organizations, and service providers to identify Elders, Healers, and Knowledge Keepers who are recognized by their communities.

Guidelines:

The organizational leaders work with First Nations, Métis, and Inuit peoples, communities, organizations, and service providers to identify Elders, Healers, and Knowledge Keepers who are recognized by their communities and who can help meet First Nations, Métis, and Inuit health and social service needs; participate as team members and support team development; support the First Nations, Métis, and Inuit workforce; and participate in the governance of the organization.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 22 (Truth and Reconciliation Commission of Canada, 2015a)

5.4.6 The organizational leaders acknowledge the expertise of Elders, Healers, and Knowledge Keepers by integrating them into the team.

Guidelines:

The organizational leaders work with First Nations, Métis, and Inuit peoples, communities, organizations, and service providers to define the roles and responsibilities of Elders, Healers, and Knowledge Keepers on teams to enable them to support the First Nations, Métis, and Inuit peoples and communities served by the organization, and the First Nations, Métis, and Inuit workforce.

The organization provides Elders, Healers, and Knowledge Keepers with tools and resources (e.g., education, orientation, equal membership in the team, collaboration, attendance at meetings and other forums) so they can participate on the team in an integrated way.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 22 (Truth and Reconciliation Commission of Canada, 2015a)

5.4.7 The organizational leaders adequately compensate Elders, Healers, and Knowledge Keepers for their work.

Guidelines:

The organizational leaders work with the Elder, Healer, or Knowledge Keeper to establish appropriate and adequate compensation for their, work in accordance with First Nations, Métis, and Inuit protocols.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 22 (Truth and Reconciliation Commission of Canada, 2015a)

5.4.8 The organizational leaders engage Elders, Healers, and Knowledge Keepers to provide cultural programs and services to First Nations, Métis, and Inuit peoples, communities, and the workforce.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 22 (Truth and Reconciliation Commission of Canada, 2015a)

5.4.9 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities, organizations, and service providers to facilitate access to programs and services that support First Nations, Métis, and Inuit workforce members who are experiencing trauma, racism, and discrimination in their personal or professional lives.

Guidelines:

The organizational leaders ensure and support the physical, mental, spiritual, and emotional safety of the First Nations, Métis, and Inuit workforce members who are dealing with trauma.

The organizational leaders ensure that culturally relevant supports (e.g., an Elder or someone similar) are available to the First Nations, Métis, and Inuit workforce. They also provide First Nations, Métis, and Inuit workforce members with opportunities for constructive debriefing with appropriate persons, without blame or shame.

Supporting documentation:

- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 7.2 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
- Truth and Reconciliation Commission of Canada: Call to Action 23 (Truth and Reconciliation Commission of Canada, 2015a)

5.4.10 The organizational leaders ensure the organization's human resources policies and practices are respectful of and responsive to First Nations, Métis, and Inuit rights, values, protocols, and practices.

Guidelines:

The organizational leaders work in partnership with First Nations, Métis, and Inuit communities to review the organization's human resources policies and practices to ensure they are responsive to and respectful of the First Nations, Métis, and Inuit workforce and First Nations, Métis, and Inuit peoples and communities' priorities and values, and that the policies support First Nations, Métis, and Inuit workforce growth and advancement throughout the organization.

5.4.11 The organizational leaders establish mechanisms for First Nations, Métis, and Inuit workforce members to provide confidential feedback about the organization's human resources policies and practices, with protection from negative consequences.

Guidelines:

The organizational leaders use qualitative and quantitative feedback from the First Nations, Métis, and Inuit workforce to identify and address opportunities to improve its human resources policies and practices.

6 Build a Culture of Quality and Safety

6.1 The organizational leaders and teams build a culture of anti-racism, quality, safety, and cultural safety and humility by establishing culturally safe processes to manage feedback and address safety incidents.

6.1.1 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities and the workforce to design culturally safe processes to report on the quality and safety of the organization's services.

Guidelines:

The organizational leaders recognize that Indigenous-specific racism and discrimination may be embedded in the organization's feedback and safety incident reporting processes. They also recognize there may be risks for First Nations, Métis, and Inuit peoples and communities who provide feedback and/or report safety incidents due to negative experiences or lack of trust in the health care system.

The organizational leaders provide First Nations, Métis, and Inuit peoples and communities and the First Nations, Métis, and Inuit workforce with culturally safe ways to report safety incidents and provide feedback on quality to improve the organization's programs and services.

The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities and the First Nations, Métis, and Inuit workforce in a culturally safe and humble way to design accessible, culturally safe, and linguistically appropriate reporting processes. The organizational leaders make it clear that First Nations, Métis, and Inuit peoples are welcome to confidentially report safety incidents themselves, or through other workforce members. The complainant may also involve other individuals (e.g., family members, a speaker or representative) to support them or be their proxy during parts of the feedback and/or safety incident reporting process.

The organizational leaders are transparent with First Nations, Métis, and Inuit peoples and communities at all stages of designing the organization's processes. They ensure the organization's processes for clients to provide feedback on quality of services apply to all service providers and other members of the workforce, including consultants and contracted staff.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 5 (Turpel-Lafond, 2020b)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 7.1 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

6.1.2 The organizational leaders ensure the processes to report on the quality and safety of the organization's services include a safe and confidential option to self-identify as First Nations, Métis, or Inuit.

Guidelines:

The organizational leaders include First Nations, Métis, and Inuit self-identification as part of the quality and safety incident reporting processes. Feedback and safety incident processes provide an avenue for First Nations, Métis, and Inuit peoples and communities to, for example, anonymously share their diversity data so the organization can identity if its programs and services are meeting the health and wellness goals of First Nations, Métis, and Inuit peoples and communities and where they are not. If the organization is not meeting the health and wellness goals of First Nations, Métis, and Inuit peoples and communities, the organizational leaders identify root causes, take action to improve, and continue to measure progress.

The organizational leaders acknowledge that historically the health care system has been culturally unsafe for First Nations, Métis, and Inuit peoples and communities. Including an option for self-identification requires consideration of, and partnership with, First Nations, Métis, and Inuit peoples and communities to incorporate a change management strategy to build trust, transparency, and an understanding of how the data will be used. The organizational leaders consult with First Nations, Métis, and Inuit communities and other organizational leaders on how to best approach and manage self-identification data collection to ensure the process is culturally safe and accessible to First Nations, Métis, and Inuit peoples.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care. (Summary Report), Recommendation 5 (Turpel-Lafond, 2020b)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 7.3 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

6.1.3 The team ensures First Nations, Métis, and Inuit clients are informed about how to access the organization's process to report on the quality and safety of its services.

Guidelines:

Within the team, service providers work with First Nations, Métis, and Inuit clients to answer questions and ensure they are informed about the organization's zero-tolerance approach to racism and discrimination as well as how to provide feedback with protection from negative consequences. The team encourages First Nations, Métis, and Inuit clients to give feedback about their experience with the organization and the care they receive as way to improve service delivery and quality of care.

To enhance clients' comfort in providing feedback and reporting safety incidents, service providers work with the client, who is part of the team, to create an environment that is safe; open; respectful; welcoming; and free of Indigenous-specific racism, discrimination, assumptions, and judgement. The team ensures the client has access to an Indigenous representative who can assist them in this process.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 5 (Turpel-Lafond, 2020b)

6.1.4 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to use their feedback in culturally safe ways that will improve the quality of the organization's services.

Guidelines:

The organizational leaders develop and sustain, in a culturally safe way, ongoing relationships and respectful communication with First Nations, Métis, and Inuit peoples and communities, to better understand their experiences of the quality of the organization's programs and services, and to use their feedback to identify opportunities for improvement. The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to address opportunities for improvement through continuous cycles of improvement, tests of change, and evaluation, all of which are reinforced by Indigenous methodologies.

The organizational leaders report back to the First Nations, Métis, and Inuit peoples and communities about the results of the improvement efforts.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 11 (Turpel-Lafond, 2020b)

6.1.5 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to design culturally safe processes to manage and learn from safety incidents.

Guidelines:

To follow up on and learn from safety incidents, the organizational leaders create a culturally safe space to collect information about the impact of a safety incident on a First Nations, Métis, and Inuit individual, family, and/or community; the circumstances surrounding the incident; and contributing factors.

The organizational leaders ask First Nations, Métis, and Inuit peoples to identify how they wish to proceed and understand that they may choose to involve other individuals (e.g., family members, a speaker or representative) to be a support or their proxy during the process. The organizational leaders work in collaboration with First Nations, Métis, and Inuit peoples and communities to come to a shared understanding about how to proceed, which includes respecting cultural protocols and practices, learning from the experience, and improving safety.

The organizational leaders use feedback on the quality of the organization's services to identify, learn from, and address opportunities for quality improvement.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 5 & 11 (Turpel-Lafond, 2020b)

6.1.6 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, and organizations to incorporate recognition of the harms caused by Indigenous-specific racism into the organization's safety incident reporting and management processes.

Guidelines:

The organizational leaders acknowledge that Indigenous-specific racism and discrimination in the health care system is the result of a lack of respect for, and a lack of implementation of, the basic human rights of Indigenous peoples. Racism poses a serious danger and is considered a safety incident.

The organizational leaders use a broad lens to define Indigenous-specific racism and discrimination, recognizing that all types of racism (e.g., structural, systemic, interpersonal) pose safety risks and can cause harm. The organizational leaders include all types of racism in the organization's safety incident reporting management and learning processes.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 5 & 11 (Turpel-Lafond, 2020b)

6.1.7 The organizational leaders prioritize safety incidents related to Indigenous-specific racism and discrimination, in accordance with its anti-racism and discrimination policy.

Guidelines:

As part of its safety incident management processes, the organization has processes to prioritize and act on safety incidents related to Indigenous-specific racism and discrimination, in accordance with its anti-racism and discrimination policy.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 5 & 11 (Turpel-Lafond, 2020b)

6.1.8 The organizational leaders provide the workforce with education and training about how to receive and manage, in culturally safe ways, reports from First Nations, Métis, and Inuit peoples and communities on the quality and safety of the organization's services.

Guidelines:

The organizational leaders work to create a culturally safe environment where First Nations, Métis, and Inuit peoples and communities feel safe and are encouraged to provide feedback on the quality of services and report safety incidents with protection from negative consequences. To do so, the organizational leaders provide the Indigenous and non-Indigenous workforce with education and trauma-informed training about how to confidentially receive and manage information from First Nations, Métis, and Inuit peoples about their service experiences in a culturally safe manner. To make the experience of providing feedback as safe and accessible as possible, the organizational leaders strive to create an Indigenous-led and Indigenous-offered approach, to give First Nations, Métis, and Inuit peoples and communities the option of providing their feedback to Indigenous persons.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 5 & 11 (Turpel-Lafond, 2020b)

6.1.9 The organizational leaders share positive feedback from First Nations, Métis, and Inuit peoples and communities with the workforce to promote good practice and build a culture of quality and safety.

Guidelines:

The organizational leaders recognize the value of sharing and celebrating positive feedback from First Nations, Métis, and Inuit peoples and communities with the workforce. The feedback may be about programs and services, client experiences and outcomes, or general organizational culture.

The organizational leaders understand that sharing positive feedback helps demonstrate that the organization values the workforce's contributions to a building culture that promotes quality and safety.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 4 & 12 (Turpel-Lafond, 2020b)

6.1.10 The organizational leaders incorporate First Nations, Métis, and Inuit peoples' rights, cultural protocols, practices, and approaches to addressing harm into the organization's safety incident management processes.

Guidelines:

The organizational leaders embed a variety of First Nations, Métis, and Inuit rights and protocols into the organization's safety incident management processes, to address and promote healing from harm caused by racism and discrimination. For example, the organizational leaders may embed opportunities for First Nations, Métis, and Inuit peoples and communities and the workforce to access cultural support from First Nations, Métis, and Inuit ceremonies as well as from Elders, Healers, and Knowledge Keepers.

By embedding First Nations, Métis, and Inuit ways to address and heal from harm in safety incident management processes, the organizational leaders promote restorative justice. As part of this process, the organizational leaders also account for the legal and/or regulatory requirements placed on service providers by their regulatory bodies, unions, medical protection agencies, and other similar groups.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 5 (Turpel-Lafond, 2020b)

6.1.11 The organizational leaders facilitate access for First Nations, Métis, and Inuit peoples, communities, and workforce members to the jurisdictional ombudsperson, or equivalent, to provide support to address complaints of Indigenous-specific racism.

Guidelines:

The organizational leaders ensure the jurisdictional ombudsperson (e.g., BC ombudsperson and representative) or equivalent (i.e., the person responsible for receiving, investigating, and responding to safety incidents, including Indigenous-specific

racism incidents) is available without discrimination to all First Nations, Métis, and Inuit peoples, communities, and the workforce.

The organizational leaders advocate for the ombudsperson to prioritize safety incidents related to Indigenous-specific racism and discrimination through:

- Engagement with First Nations, Métis, and Inuit peoples and communities
- Specialized activities to promote equitable access to and greater fairness in health and social services to Indigenous peoples
- Reporting progress to the public

The organization may also provide information about how to pursue a complaint with regulatory bodies and/or human rights tribunals.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 4 & 12 (Turpel-Lafond, 2020b)

7 Design and Deliver Culturally Safe Services

7.1 The organizational leaders ensure culturally safe programs and services are developed, implemented, and sustained.

7.1.1 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to incorporate a holistic approach to health and wellness into the organization's models of care.

Guidelines:

The organizational leaders engage with First Nations, Métis, and Inuit peoples and communities to learn about their approaches to, and perspectives on, health and wellness. They use what they learn to drive systematic change in service delivery through integration, transformation, and collaboration.

The organizational leaders ensure that service providers work with First Nations, Métis, and Inuit clients to take a holistic approach to care that looks beyond illness to understand First Nations, Métis, and Inuit peoples' perspectives on health and wellness. This includes understanding the balance between physical, mental, emotional, and spiritual health and the importance of social determinants on individual, family, and community health and wellness. This holistic approach is a key element in traditional First Nations, Métis, and Inuit health and wellness practices.

To enable a holistic approach, the organizational leaders work with First Nations, Métis, and Inuit peoples and communities to develop culturally safe and humble care processes that respect traditional First Nations, Métis, and Inuit protocols, practices, and ways of healing, including the use of sacred space, language, ceremonies, family, and art. The organizational leaders update the policies and advocate for government policies to support First Nations, Métis, and Inuit healing practices and increase access to Elders, Healers, Knowledge Keepers, and ceremonies that are recognized by First Nations, Métis, and Inuit peoples and communities. They also work in partnership with First Nations, Métis, and Inuit peoples and communities to update the model of care. All updates are included the orientation for new service providers and workforce members.

The organizational leaders work with service providers and First Nations, Métis, and Inuit peoples and communities to increase service providers' understanding and health literacy about First Nations, Métis, and Inuit rights and health and wellness knowledge and practices. They encourage service providers to move beyond a biomedical model to include Indigenous knowledge and practice in their provision of care.

The organizational leaders work with service providers to increase the service providers' understanding of the importance of social determinants of health in health promotion and healing. They also work to increase the service providers' understanding of the significant impact of colonialism on First Nations, Métis, and Inuit health and wellness and the need to rebuild intergenerational connections that were disrupted by colonialism.

The organizational leaders encourage First Nations, Métis, and Inuit service providers to share their learnings and cultural awareness, to facilitate communication and knowledge transfer among all service providers.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 17 (Turpel-Lafond, 2020b)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 7.1 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

7.1.2 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, organizations, and service providers to design culturally safe programs and services to achieve First Nations, Métis, and Inuit health and wellness goals and objectives.

Guidelines:

The organizational leaders work with First Nations, Métis, and Inuit communities and organizations to uphold the organization's commitments to support First Nations, Métis, and Inuit peoples and communities in designing and creating their own health and wellness goals, strategies, and solutions. This includes developing and establishing processes and protocols to engage Elders and Knowledge Keepers.

The organizational leaders proactively form and nurture strong partnerships with First Nations, Métis, and Inuit peoples and communities, collaborating with them to plan, design, and oversee First Nations, Métis, and Inuit health and wellness programs and services including virtual health services and associated materials. The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, organizations, and service providers to adapt and validate existing programs and services to meet the needs of First Nations, Métis, and Inuit clients. The organizational leaders consult with Elders, Healers, and Knowledge Keepers who are recognized by First Nations, Métis, and Inuit peoples and communities to ensure Indigenous rights, protocols, and practices are followed.

The organizational leaders engage with First Nations, Métis, and Inuit peoples and communities to create a variety of avenues by which First Nations, Métis, and Inuit peoples and communities can provide information, guidance, advice, and direction to plan, implement, and evaluate culturally and linguistically appropriate programs and services. Evaluations are done using culturally relevant tools and methods of evaluation and, wherever possible, are facilitated by First Nations, Métis, and Inuit peoples.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendations 16 & 17 (Turpel-Lafond, 2020b)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 7.3 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

7.1.3 The organizational leaders and teams use a strengths-based approach to achieve First Nations, Métis, and Inuit clients' health and wellness goals.

Guidelines:

The team collaborates with the First Nations, Métis, and Inuit clients to support the clients achieve their health and wellness goals, as defined by the clients.

By supporting the First Nations, Métis, and Inuit clients with community-led strategies, the team demonstrates the value of the knowledge, capacity, and skills of First Nations, Métis, and Inuit peoples and communities. Through education and training, the team increases its knowledge about Indigenous rights and the value of a strengths-based approach and how to integrate this approach into their practice. The team works with the First Nations, Métis, and Inuit clients to identify and incorporate personal and community strengths (e.g., extended family, commitment to community, neighbourhood networks, community organizations, community events) into the care plan. Service providers recognize the First Nations, Métis, and Inuit clients' right to make important decisions about their health to meet their health and wellness goals.

7.1.4 The organizational leaders and teams integrate First Nations, Métis, and Inuit practitioners such as Elders, Healers, and Knowledge Keepers into First Nations, Métis, and Inuit client care plan at the client's request, to help the clients achieve their health and wellness goals.

Guidelines:

The team understands and respects cultural knowledge and traditional health practices and medicines as integral to the wellness of First Nations, Métis, and Inuit peoples and communities. The organization's systems and processes enable the recording, safekeeping, and communication of those components within the circle of care and across the care continuum, while recognizing the sacredness of ceremony and traditional protocols.

Service providers who understand Indigenous rights, protocols, and practices can better serve First Nations, Métis, and Inuit clients by recognizing and understanding the role of Elders, Healers, and Knowledge Keepers who provide valuable Indigenous knowledge, expertise, and healing practices (e.g., herbal medicines and other remedies; psychological and spiritual wellness through ceremony, counselling, teachings, and accumulated wisdom). This understanding may help service providers and First Nations, Métis, and Inuit clients work together to integrate holistic and culturally safe and humble care into the care plan. To that end, service providers are expected to show respect for and develop skills in working collaboratively with Elders, Healers, and Knowledge Keepers, including in providing clinical care.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 17 (Turpel-Lafond, 2020b)
- Truth and Reconciliation Commission of Canada: Call to Action 22 (Truth and Reconciliation Commission of Canada, 2015a)

7.1.5 The organizational leaders implement policies and procedures that support the provision of culturally safe virtual health and community outreach services for First Nations, Métis, and Inuit peoples and communities.

Guidelines:

Virtual health services (e.g., virtual doctor of the day, virtual addiction medicine and psychiatry services) can increase access to culturally safe and humble care and reduce the burden of travel for First Nations, Métis, and Inuit peoples, especially those who live in rural or remote communities. The organization has policies and procedures on how to provide virtual health services in a culturally safe and humble way. The organization allocates sufficient funding to support culturally appropriate virtual health services.

The organizational leaders work with First Nations, Métis, and Inuit peoples and communities to ensure virtual health services are accessible and culturally safe (e.g., welcoming a client's family or friend to join as support; using principles of accessible communication when needed; using oral, written, or online formats as well as languages that meet client needs). The organizational leaders ensure service providers have cultural safety and humility training and can collaborate with First Nations, Métis, and Inuit peoples and communities to provide culturally safe virtual health care in accordance with the organization's policies and procedures.

To implement virtual health policies and procedures, the organization provides tools to help service providers and the First Nations, Métis, and Inuit client incorporate virtual follow-up into the care plan. This could include tools to virtually transmit health care data from the client to the service provider, and tools and information so the client can follow up and ask questions.

7.1.6 The organizational leaders implement policies and procedures that support the provision of culturally safe community outreach services for First Nations, Métis, and Inuit peoples and communities.

Guidelines:

Outreach services bring services to and provide care in the First Nations, Métis, or Inuit client's home and/or community, thus enhancing support and access for those who cannot access these services.

The organization has adequate funding, policies, and procedures on how to organize and provide community outreach services in a culturally safe and humble way.

7.2 The team ensures the delivery of care and provision of services are culturally safe.

7.2.1 The team establishes transparent, respectful, and reciprocally accountable relationships to support culturally safe care.

Guidelines:

Within the team, service providers can help create an anti-racist environment and build working relationships with First Nations, Métis, and Inuit clients that are respectful, transparent, reciprocally accountable, trauma-informed, and culturally safe by:

- Equalizing power imbalances in client/provider relationships
- Introducing themselves to First Nations, Métis, and Inuit clients and explaining their role
- Self-reflecting on the values, assumptions, and belief structures they bring to interactions with First Nations, Métis, and Inuit clients
- Explaining how the service or unit operates so clients understand how and when to access services
- Taking the time to get to know clients and their communities, being genuine, listening respectfully, being collaborative, being aware of stereotypes, being attentive, and acknowledging clients' lived experiences
- Providing time for clients to tell their stories
- If a physical exam is necessary, explaining the procedure, answering questions, and obtaining informed consent prior to beginning an examination and during if multiple areas are being examined
- Allowing a support person to be present if a sensitive physical examination is performed (e.g., a gynecological procedure)
- Asking clients' permission before performing tasks
- Using a respectful tone
- Practicing open communication by using accessible language and expressing concern or reassurance, and allowing clients to express their feelings and talk about their experiences without fear of judgement
- Asking questions and providing input and feedback
- Respecting clients' cultural beliefs, lifestyles, and privacy and confidentiality

To foster their relationships with First Nations, Métis, and Inuit peoples and communities, service providers develop self-awareness of their privileges and biases, to avoid giving offense or making assumptions that can manifest in harmful approaches to First Nations, Métis, and Inuit client care; negatively impact First Nations, Métis, and Inuit client experiences and outcomes; or jeopardize the service provider's relationship with First Nations, Métis, and Inuit peoples and communities.

Legislative commitments:

- Universal Declaration of Human Rights, Articles 1 & 5 (United Nations, n.d.)

7.2.2 The team ensures that First Nations, Métis, and Inuit clients have information about client rights and responsibilities when accessing health services.

Guidelines:

The team works with Indigenous client liaisons/navigators, when available, to ensure First Nations, Métis, and Inuit clients receive information about client rights and responsibilities and where they can access relevant resources and cultural supports (e.g., Elders, Healers, Knowledge Keepers, interpreters, other similar support). The team ensures clients receive this information at intake or at the earliest opportunity and in a language that meets their needs, using interpreters as necessary.

Service providers document in the client record when the client received the information and ensures the client has enough time to review the information and ask questions.

The organization develops information about client rights and responsibilities in collaboration with jurisdictional Indigenous health departments and First Nations, Métis,

and Inuit peoples and communities. The resources include information about First Nations, Métis, and Inuit client rights, appropriate engagement processes, and feedback mechanisms and/or courses of action during culturally unsafe experiences or services.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 18

Legislative commitments:

- Declaration on the Rights of Indigenous Peoples Act (2019)
- Universal Declaration of Human Rights, Article 21 (United Nations, n.d.)

7.2.3 The team assesses First Nations, Métis, and Inuit clients' health in a culturally safe and trauma- and violence-informed way.

Guidelines:

Within the team, which includes service providers and the First Nations, Métis, and Inuit client, service providers acknowledge that systemic Indigenous-specific racism, stereotyping, and discrimination against First Nations, Métis, and Inuit peoples and communities results in negative or traumatic experiences. Service providers collaborate with First Nations, Métis, and Inuit clients to conduct an assessment (e.g., emergency department admissions and triage, palliative care assessments) that aligns with the client's values and care goals, and is culturally safe, people centred, and trauma- and violence-informed. This includes the sensitive process of gathering information about clients' personal, social, economic, and environmental determinants of health.

When conducting an assessment, the team collaborates with the client's family and community as well as with Elders and Indigenous client navigators and interpreters as needed and requested by the client.

The team regularly assesses and documents First Nations, Métis, and Inuit clients' health status, to monitor changes over time.

7.2.4 The team takes a holistic approach to First Nations, Métis, and Inuit client care plans, to demonstrate respect for First Nations, Métis, and Inuit clients' values and rights, including their right to access cultural ceremonies, practices, and supports.

Guidelines:

Within the team, service providers work with First Nations, Métis, and Inuit clients to incorporate a holistic wellness approach into the care plan. Service providers work with the client to understand the client's values and rights. As part of people-centred, team-based care, service providers respect the First Nations, Métis, and Inuit client's right to access cultural ceremonies, practices, and supports (e.g., traditional healing practices and ceremonies, Elders, Healers, Knowledge Keepers, Indigenous client navigators).

Service providers work with the client to incorporate ceremonies, practices, and supports into the client's care plan if requested and help the client access them. The service provider documents this information in the client record as appropriate. For example, in the case of palliative and end-of-life care, service providers and the First Nations, Métis, and Inuit client may identify the need to connect the First Nations, Métis, and Inuit client and family members with culturally appropriate services that align with their rights, values, practices, and ceremonies. Similarly, with regard to death, dying, medical

assistance in dying, and end-of-life discussions, service providers and the First Nations, Métis, and Inuit client work as a team to incorporate cultural values, practices, and ceremonies into advanced care planning.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 17 (Turpel-Lafond, 2020b)
- Truth and Reconciliation Commission of Canada: Call to Action 22 (Truth and Reconciliation Commission of Canada (2015a)

Legislative commitments:

- Declaration on the Rights of Indigenous Peoples Act (2019)
- United Nations Declaration on the Rights of Indigenous Peoples, Articles 24 & 31 (United Nations, 2007)
- Universal Declaration of Human Rights, Article 27 (United Nations, n.d.)

7.2.5 The team facilitates access to cultural practices, ceremonies, resources, and supports including Elders, Healers, and Knowledge Keepers as requested by the First Nations, Métis, and Inuit client.

Guidelines:

The team acknowledges the First Nations, Métis, and Inuit client's rights and priorities and works together to access without discrimination traditional medicines and healing practices, including physical, mental, social, spiritual, and economic support to meet the client's health and wellness goals. The team respects the informed choice and right of First Nations, Métis, and Inuit clients to use holistic treatments such as ceremonies, traditional medicines, and healing practices and protocols provided by Elders and Healers.

The team works with the First Nations, Métis, and Inuit client to create an integrated approach to health care that combines traditional and western approaches to health. The team respects First Nations, Métis, and Inuit peoples and communities' established ways of accessing Elders and Healers.

Supportive documentation:

- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice, Article 7.4 (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
- Truth and Reconciliation Commission of Canada: Call to Action 22 (Truth and Reconciliation Commission of Canada (2015a)

Legislative commitments:

- Declaration on the Rights of Indigenous Peoples Act (2019)
- United Nations Declaration on the Rights of Indigenous Peoples, Article 16 (United Nations, 2007)

7.2.6 The team facilitates access to First Nations, Métis, and Inuit interpretation and accessibility services and support, as needed, to enable communication with the First Nations, Métis, and Inuit client at the point of care.

Guidelines:

Within the team, service providers know how to access organizational and community interpretation resources to facilitate timely and equitable access to the right care. They recognize that this varies by client.

Service providers work with the First Nations, Métis, and Inuit client to identify language, interpretation, and accessibility needs to ensure clear communication between service providers and the First Nations, Métis, and Inuit client. Service providers facilitate timely access to the required services and ensure there is a support person with the First Nations, Métis, and Inuit client if requested.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 17 (Turpel-Lafond, 2020b)

7.2.7 The team continually improves its health literacy skills through continuing professional education to ensure its members make well-informed decisions to help First Nations, Métis, and Inuit clients achieve their health and wellness goals.

Guidelines:

Within the team, service providers and the First Nations, Métis, and Inuit client work together to ensure the client understands the health information they receive (e.g., information about assessment, diagnosis, and care plans). This can be done by ensuring the First Nations, Métis, and Inuit client has the time to review and process the information and ask questions. The team includes appropriate supports as needed (e.g., family members, Indigenous client liaisons/navigators) to communicate and exchange health information with all members of the team.

Service providers understand, use, and enhance their own health literacy skills to improve the experience of care for First Nations, Métis, and Inuit clients. For example, service providers increase their health literacy by working with First Nations, Métis, and Inuit peoples and communities to better understand what health and wellness means from the First Nations, Métis, and Inuit perspective. This includes understanding the factors that may impact the First Nations, Métis, and Inuit client health (e.g., intergenerational trauma, abuse, violence, neglect, poverty, education, housing deficits) as well as protective factors that can contribute to a strengths-based approach.

8 Collect Evidence and Conduct Research and Evaluation

8.1 The organizational leaders use a distinctions-based approach to collect data related to First Nations, Métis, and Inuit peoples and communities.

8.1.1 The organizational leaders adopt First Nations, Métis, and Inuit data governance protocols to collect, analyze, interpret, and release First Nations, Métis, and Inuit data.

Guidelines:

Data and information governance protocols protect individual and collective data or information, as well as rights. The organizational leaders acknowledge First Nations, Métis, and Inuit peoples and communities' ownership of their data and information. The organizational leaders recognize the inherent rights of First Nations, Métis, and Inuit peoples and communities to control how information about them is collected, used, and disclosed throughout the information lifecycle. The organizational leaders develop rules, regulations, policies, and protocols to define how population data are collected, shared, and protected (e.g., data stewardship, data sharing agreements).

The organizational leaders understand and adopt the local First Nations, Métis, and Inuit data and information governance protocols based on existing distinctions-based guidelines (e.g., principles of ownership control access and possession [OCAP®] and ownership control access and stewardship [OCAS®], protocols of the Métis Data Governance Council and National Inuit Strategy on Research). They work with First Nations, Métis, and Inuit peoples and communities to determine the best approaches around control and ownership of their health data and information.

The organizational leaders:

- Provide ready access for First Nations, Métis, and Inuit peoples and communities to the information and aggregated data about them and their communities, on request
- Have protocols to consider requests from First Nations, Métis, and Inuit peoples and communities to access their data
- Have protocols for First Nations, Métis, and Inuit peoples and communities to assert and protect ownership and control of their data and information
- Have protocols for First Nations, Métis, and Inuit peoples and communities to terminate data and information governance agreements at any time and to have their data removed
- Have protocols for the permanent and complete removal or destruction of First Nations, Métis, and Inuit data at the end of the information lifecycle
- Complete a privacy impact assessment to identify potential privacy and security risks to First Nations, Métis, and Inuit data and information, provide mitigation strategies, and implement and regularly review privacy procedures and training
- Develop comprehensive legal and service agreements that protect personal and community First Nations, Métis, and Inuit information
- Collaborate with government to reduce and remove structural barriers to the application of the First Nations, Métis, and Inuit data and information governance protocols and distinctions-based guidelines

The organizational leaders ensure that service providers who participate in data collection and interpretation (e.g., through knowledge translation platforms such as webinars and resource pages) complete training on adherence to local First Nations, Métis, and Inuit data and information governance protocols and distinctions-based guidelines. Training can also include:

- Cultural safety and humility training
- General information management
- Information about how data and information have historically been misused
- How to work with First Nations, Métis, and Inuit peoples and communities to understand their interpretation of the protocols

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 9 (Turpel-Lafond, 2020b)

- The First Nations Principles of Ownership Control Access and Possession [OCAP®] (First Nations Information Governance Centre, 1998)

8.1.2 The organizational leaders consult with First Nations, Métis, and Inuit peoples, communities, and organizations to ensure the organization's processes to identify, collect, and analyze First Nations, Métis, and Inuit data align with First Nations, Métis, and Inuit perspectives.

Guidelines:

The organizational leaders confirm that the data the organization identifies, collects, and analyzes are from sources that are recognized by First Nations, Métis, and Inuit peoples, communities, and organizations.

The organization follows First Nations, Métis, and Inuit data governance protocols, such as the principles of ownership control access and possession (OCAP®), and the protocols of the Métis Data Governance Council and the National Inuit Strategy on Research.

The organizational leaders seek guidance from the organization's First Nations, Métis, and Inuit partners about the appropriate use of a distinctions-based approach to data analysis and interpretation, to ensure the approach is sound from a First Nations, Métis, and Inuit perspective.

8.2 The organizational leaders conduct research in partnership with First Nations, Métis, and Inuit peoples and communities.

8.2.1 The organizational leaders adhere to Chapter 9 of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

Guidelines:

Chapter 9 of the *Tri-Council Policy Statement*, which is a framework that governs ethical conduct in research, addresses research involving First Nations, Inuit, and Métis peoples of Canada. Indigenous policies and positions (OCAP® and other Métis protocols, quality improvement or Inuit research policy) are additional documents that guide research.

In all its research activities, the organization complies with the provisions in chapter 9 and the codes of research practice established by Indigenous communities. Chapter 9 emphasizes the need for equitable partnerships and provides safeguards specific to First Nations, Métis, and Inuit peoples and communities. It highlights that research needs to be culturally responsive and beneficial to First Nations, Métis, and Inuit peoples and communities as well as government agencies.

Supporting documentation:

- Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research et al., 2018)

8.2.2 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to design or adapt protocols or research agreements.

Guidelines:

The organizational leaders ensure research groups involve and work with First Nations, Métis, and Inuit peoples and communities from the beginning to the end of the research

project. This may include collaborating with Elders to ceremoniously open and close the project and provide ongoing guidance throughout; receiving a Spirit name for the study from a Knowledge Keeper; and offering a sacred gift to participants to bind their commitment. If community-specific research protocols exist for use in other communities, they are adapted to the individual community as necessary.

Research teams collaborate with First Nations, Métis, and Inuit peoples and communities to use First Nations, Métis, and Inuit population health data to inform research protocols. The teams keep First Nations, Métis, and Inuit peoples and communities informed throughout the process (e.g., providing drafts of research reports for review and approval). The organization ensures there is Indigenous oversight or participation on its research boards or committees, and that the research considers cultural diversity throughout the research endeavour. Collaboration may occur with not just with universities but also with other organizations (e.g., health authorities).

8.2.3 The organizational leaders ensure the organization's research agenda responds to the priorities and contexts of First Nations, Métis, and Inuit peoples and communities.

Guidelines:

The organizational leaders ensure the research teams understand the broad contexts and priorities of First Nations, Métis, and Inuit peoples and communities to ensure an informed health equity lens is applied to the research agenda and priorities, in accordance with local First Nations, Métis, and Inuit data governance protocols. The organizational leaders may also establish an Indigenous advisory or steering committee with members from First Nations, Métis, and Inuit peoples and communities being involved in informing and guiding the organization's research agenda. In addition, research ethics boards include Indigenous peoples as members.

Wherever possible and appropriate, Indigenous knowledge is incorporated into the ethics and review processes.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 17 (Turpel-Lafond, 2020b)

8.2.4 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to co-design and co-produce research that involves First Nations, Métis, and Inuit peoples and communities.

Guidelines:

In accordance with local First Nations, Métis, and Inuit data governance protocols, the organizational leaders support research teams to collaborate and establish partnerships with First Nations, Métis, and Inuit peoples and communities, to incorporate Indigenous methodologies into the design and conduct of the research. This includes developing respectful partnerships between Indigenous and non-Indigenous researchers and including Indigenous-led and community-based participatory research with First Nations, Métis, and Inuit peoples and communities as part of research grants or proposals, or research ethic board approval requirements.

Supporting documentation:

- Truth and Reconciliation Commission of Canada: Call to Action 7.8 (Truth and Reconciliation Commission of Canada (2015a)

Legislative commitments:

- Universal Declaration of Human Rights, Article 27 (United Nations, n.d.)

8.2.5 The organizational leaders compensate First Nations, Métis, and Inuit community members who are involved in data collection.

Guidelines:

First Nations, Métis, and Inuit community members and organizations involved in data collection are compensated for their work. The organizational leaders recognize their responsibility to discuss appropriate compensation, costs, fees, and other expenses with First Nations, Métis, and Inuit peoples and communities when engaging them in research.

8.3 The organizational leaders evaluate the organization's commitments to anti-racism and cultural safety and humility and use the results for quality improvement.

8.3.1 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to co-create an evaluation framework for the organization's anti-racism and cultural safety and humility initiatives.

Guidelines:

The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, and organizations to develop or adapt a cultural safety and humility evaluation framework (e.g., jurisdictional frameworks inspired by jurisdictional wise practices through knowledge translation platforms). To guide this work, the organizational leaders may create a cultural safety and humility oversight committee that includes First Nations, Métis, and Inuit peoples and communities.

The framework is intended to evaluate the organization's achievement of the goals and objectives associated with the anti-racism and cultural safety and humility initiatives. The cultural safety and humility evaluation framework is aligned with broader organizational performance measures and strategic plans.

The organizational leaders build cultural safety and humility outcomes into the organization's quality framework and quality improvement plan.

The organizational leaders ensure the organization's anti-racism and cultural safety and humility evaluation framework is adopted throughout the organization, including by service providers in their practice. The organizational leaders provide the workforce with resources to support the adoption of the framework.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 9 (Turpel-Lafond, 2020b)

8.3.2 The organizational leaders incorporate First Nations, Métis, and Inuit methodologies into the organization's cultural safety and humility evaluation framework.

Guidelines:

The organizational leaders, in partnership with First Nations, Métis, and Inuit peoples and communities, identify Indigenous methodologies to support a cultural safety and humility evaluation framework.

8.3.3 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to identify indicators that measure the impact of the organization's anti-racism and cultural safety and humility initiatives on the quality and safety of its First Nations, Métis, and Inuit health and wellness programs and services.

Guidelines:

In collaboration with First Nations, Métis, and Inuit peoples and communities, the organizational leaders identify indicators for the organization's anti-racism and cultural safety and humility evaluation framework (e.g., complaints received from those identifying as First Nations, Métis, and Inuit; incidents that caused serious harm; requests to access Elders). They also work with policy makers to include indicators that align with the jurisdiction's impact-based performance measurement framework as well as mandatory cultural safety indicators collected and reported across the jurisdictional health authority (e.g., data on the number of practicing certified First Nations, Métis, and Inuit FN/M/I health care providers; incidents related to Jordan's Principle; data from home and away-from-home populations; other process, structural, and outcome measures related to cultural safety). The Canadian Institute for Health Information has a list of indicators to measure cultural safety in health systems that could be used to assess the impact of cultural safety initiatives.

The organizational leaders use jurisdictional guidance to identify how the indicators could be used to measure the impact of the organization's anti-racism and cultural safety and humility initiatives on the quality of First Nations, Métis, and Inuit health and wellness programs and services and the achievement of the associated goals and objectives. This includes determining how to collect and monitor improvements against baseline data. Establishing a baseline reference point makes it possible to monitor progress toward meeting objectives by comparing pre- and post-activity data and noting changes. Establishing a baseline may require one or many data points and occurs over a defined period. Once the baseline is established, the organization re-evaluates its established outcomes, outputs, and transformation drivers as necessary to ensure they remain feasible and relevant.

The organizational leaders conduct client journey mapping of First Nations, Métis, and Inuit clients through the system to identify relevant indicators that support continuous quality improvement.

8.3.4 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples, communities, and organizations to collect anti-racism and cultural safety and humility indicator data in culturally safe ways and from sources recognized by First Nations, Métis, and Inuit peoples and communities.

Guidelines:

The organizational leaders engage with First Nations, Métis, and Inuit peoples, communities, and organizations to design and/or identify sources of information (e.g., feedback mechanisms, surveys, focus groups, complaint records, client and family

satisfaction or experience data, incident analysis information, financial reports) to collect data and monitor progress on the anti-racism and cultural safety and humility indicators. The organizational leaders train service providers on how to capture indicator data in a respectful and culturally safe and humble way. The organizational leaders seek help from First Nations, Métis, and Inuit peoples and communities to identify gaps that hinder accurate and meaningful data collection.

The organizational leaders participate in the jurisdictional health authority's indicator data collection process to help monitor progress toward the jurisdiction's cultural safety and humility goals and objectives.

The organizational leaders ensure the organization has the appropriate infrastructure and processes to effectively collect and analyze cultural safety and humility indicator data. The organizational leaders follow local First Nations, Métis, and Inuit data governance protocols and distinctions-based guidelines when working with First Nations, Métis, and Inuit peoples and communities, to determine how data will be collected and how often.

In accordance with local First Nations, Métis, and Inuit data governance protocols and distinctions-based guidelines, where possible the organization has a system to compile data in a central data repository that can be used, with appropriate authorization controls, throughout the organization and by partners. The organizational leaders may include a visual analytics dashboard (e.g., Tableau) so partners can see in real time the impact of the information they are sharing. This reduces the administrative burden and increases the accuracy, timeliness, and security of the information.

8.3.5 The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to use anti-racism and cultural safety and humility indicator data to regularly evaluate the organization's anti-racism and cultural safety and humility initiatives and to act on what is learned from the evaluation.

Guidelines:

The organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to analyze indicator data and assess the effectiveness of the anti-racism and cultural safety and humility initiatives on First Nations, Métis, and Inuit health and wellness programs and services. They use the results of the evaluations to identify and address opportunities for quality improvement.

The organization demonstrates how the information gathered has been acted upon to improve services.

8.3.6 The organizational leaders regularly update service design and delivery based on up-to-date health data from First Nations, Métis, and Inuit peoples and communities.

Guidelines:

The organizational leaders use First Nations, Métis, and Inuit population health data, including quantitative and qualitative data and feedback. Data include Indigenous ways of knowing and traditional knowledge systems (e.g., oral histories, stories of Indigenous peoples). The organization uses both collective and disaggregated or distinctions-based data to ensure service design and delivery meets First Nations, Métis, and Inuit health and wellness goals and objectives. The organization uses these data to identify defined and underserved populations and health inequities and disparities.

8.3.7 The organizational leaders regularly report on the impact of the organization's anti-racism and cultural safety and humility initiatives to the governing body, senior leaders, the workforce, and First Nations, Métis, and Inuit peoples, communities, and partners.

Guidelines:

In accordance with local First Nations, Métis, and Inuit data governance protocols and distinctions-based guidelines, the organizational leaders report to First Nations, Métis, and Inuit peoples and communities, and other affected internal and external parties to keep them informed about the anti-racism and cultural safety and humility initiatives and the evaluation of the impact on the organization's programs and services. Sharing results, lessons learned, and information about continuous improvement efforts as well as celebrating positive results helps foster a culture of quality improvement and accountability.

Where information is collected about specific communities, the findings are shared with that community.

Displaying and reporting trends demonstrates progress, even if it is at a slower pace. Findings are evaluated and shared in a timely way to ensure the results are still relevant and actionable. The organization has mechanisms to ensure meaningful action has been taken on the recommendations of the evaluation and track their implementation.

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Summary Report), Recommendation 17 (Turpel-Lafond, 2020b)

8.3.8 The organizational leaders demonstrate reciprocal accountability by participating in an inclusive and transparent process to evaluate established relationships and partnerships with First Nations, Métis, and Inuit peoples, communities, and organizations.

Guidelines:

The organizational leaders evaluate the First Nations, Métis, and Inuit partnership agreements and other relationships to assess progress on the organization's commitment to anti-racism, anti-discrimination, and cultural safety and humility. The organizational leaders assess the effectiveness of the partnerships with First Nations, Métis, and Inuit peoples, communities, and service providers to improve First Nations, Métis, and Inuit health services and health and wellness outcomes.

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Annex A (Informative)

Supporting documentation:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care (Full Report) (Turpel-Lafond, 2020a)
- Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Calls for Justice (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
- Truth and Reconciliation Commission of Canada: Calls to Action (Truth and Reconciliation Commission of Canada, 2015a)

Legislative commitments:

- Declaration on the Rights of Indigenous Peoples Act (2019)
- Canadian Human Rights Act (1985)
- Constitution Act, Part II, Rights of the Aboriginal Peoples of Canada (1982)
- United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007)
- Universal Declaration of Human Rights (United Nations, n.d.)

Document name	Reference number #	Full text	Criteria where it is referenced
Supporting documentation			
In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care	2	That the B.C. government, in collaboration and cooperation with Indigenous peoples in B.C., develop appropriate policy foundations and implement legislative changes to require anti-racism and "hard-wire" cultural safety, including an Anti-Racism Act and other critical changes in existing laws, policies, regulations and practices, ensuring that this effort aligns with the UN Declaration as required by DRIPA.	3.1.1, 3.2.3, 4.1.4, 5.1.1
	4	That the B.C. government, First Nations governing bodies and representative organizations, and MNBC jointly establish the Office of the Indigenous Health Representative and Advocate with legislative recognition and authority to provide a single, accessible, supportive, adequately funded resource for early intervention and dispute resolution for Indigenous people who require assistance to navigate, fully benefit from, and to resolve problems within, B.C.'s health care	6.1.9, 6.1.11

		system including all health authorities, regulatory colleges and other health providers. The position should be reviewed in five years after establishment to determine if it has been effective in rooting out racism in the health care system in B.C.	
	5	That the B.C. government, First Nations governing bodies and representative organizations, and MNBC jointly develop a strategy to improve the patient complaint processes to address individual and systemic Indigenous-specific racism.	6.1.1, 6.1.2, 6.1.3, 6.1.5, 6.1.6, 6.1.7, 6.1.8, 1.1.10
	6	That the parties to the bilateral and tripartite First Nations health plans and agreements work in co-operation with B.C. First Nations to establish expectations for addressing commitments in those agreements that have not been honoured, and for how those expectations will be met through renewed structures and agreements that are consistent with the implementation of DRIPA.	1.1.2
	7	That the Ministry of Health establish a structured senior level health relationship table with MNBC, and direct health authorities to enter into Letters of Understanding with MNBC and Métis Chartered Communities that establish a collaborative relationship with clear and measurable outcomes	2.1.2
	8	That all health policy-makers, health authorities, health regulatory bodies, health organizations, health facilities, patient care quality review boards and health education programs in B.C. adopt an accreditation standard for achieving Indigenous cultural safety through cultural humility and eliminating Indigenous-specific racism that has been developed in collaboration and cooperation with Indigenous peoples.	Applies to overall standard
	9	That the B.C. government establish a system-wide measurement framework on Indigenous cultural safety, Indigenous rights to health and Indigenous-specific racism, and work with First Nations governing bodies and representative organizations, MNBC, the Indigenous Health Officer, and the Indigenous Health Representative and Advocate to ensure appropriate processes of Indigenous data governance are followed throughout required data acquisition, access, analysis and reporting.	8.3.1

	10	That design of hospital facilities in B.C. include partnership with local Indigenous peoples and the Nations on whose territories these facilities are located, so that health authorities create culturally-appropriate, dedicated physical spaces in health facilities for ceremony and cultural protocol, and visibly include Indigenous artwork, signage and territorial acknowledgement throughout these facilities.	3.1.3, 4.1.3, 4.1.4, 7.1.1
	11	That the B.C. government continue efforts to strengthen employee “speak-up” culture throughout the entire health care system so employees can identify and disclose information relating to Indigenous specific racism or any other matter, by applying the Public Interest Disclosure Act (PIDA) to employees throughout the health care sector without further delay	1.1.4, 6.1.4, 6.1.5, 6.1.6, 6.1.7, 6.1.8
	12	That the Ombudsperson consider including a focus on Indigenous-specific racism in the health care system as a key priority and seek input from appropriate partners on current plans to strengthen this priority through engagement, special activities to promote greater fairness in public services to Indigenous peoples, and reporting to the public on progress.	6.1.9, 6.1.11
	14	That the B.C. government, PHSA, the five regional health authorities, B.C. colleges and universities with health programs, health regulators, and all health service organizations, providers and facilities recruit Indigenous individuals to senior positions to oversee and promote needed system change	3.1.2, 5.4.4
	16	That the B.C. government implement immediate measures to respond to the MMIWG Calls for Justice and the specific experiences and needs of Indigenous women as outlined in this Review.	7.1.2
	17	That the B.C. government and FNHA demonstrate progress on commitments to increase access to culturally safe mental health and wellness and substance use services.	7.1.1, 7.1.2, 7.1.4, 7.2.4, 7.2.6, 8.2.3
	20	That a refreshed approach to anti-racism, cultural humility and trauma-informed training for health workers be developed and implemented, including standardized	5.1.1, 5.2.3

		learning expectations for health workers at all levels, and mandatory, low-barrier components. This approach, co-developed with First Nations governing bodies and representative organizations, MNBC, health authorities and appropriate educational institutions, to absorb existing San'yas Indigenous Cultural Safety training.	
	22	That the B.C. government, in consultation and cooperation with Indigenous peoples, consider further truth-telling and that build understanding and support for action to address Indigenous-specific racism in the health care system; supplemented by a series of educational resources, including for use in classrooms of all ages and for the public, on the history of Indigenous health and wellness prior to the arrival of Europeans, and since that time.	2.1.6
Missing and Murdered Indigenous Women and Girls – Calls for Justice (MMIWG Calls for Justice)	7.1	We call upon all governments and health service providers to recognize that Indigenous Peoples – First Nations, Inuit, and Métis, including 2SLGBTQQIA people – are the experts in caring for and healing themselves, and that health and wellness services are most effective when they are designed and delivered by the Indigenous Peoples they are supposed to serve, in a manner consistent with and grounded in the practices, world views, cultures, languages, and values of the diverse Inuit, Métis, and First Nations communities they serve.	6.1.1, 7.1.1
	7.2	We call upon all governments and health service providers to ensure that health and wellness services for Indigenous Peoples include supports for healing from all forms of unresolved trauma, including intergenerational, multigenerational, and complex trauma. Health and wellness programs addressing trauma should be Indigenous-led, or in partnership with Indigenous communities, and should not be limited in time or approaches	4.1.4
	7.3	We call upon all governments and health service providers to support Indigenous-led prevention initiatives in the areas of health and community awareness, including, but not limited to programming: • for Indigenous men and boys • related to suicide prevention strategies for youth and adults	6.1.2, 7.1.2

		• related to sexual trafficking awareness and no-barrier exiting • specific to safe and healthy relationships • specific to mental health awareness related to 2SLGBTQQIA issues and sex positivity	
	7.4	We call upon all governments and health service providers to provide necessary resources, including funding, to support the revitalization of Indigenous health, wellness, and child and Elder care practices. For healing, this includes teachings that are land-based and about harvesting and the use of Indigenous medicines for both ceremony and health issues. This may also include: matriarchal teachings on midwifery and postnatal care for both woman and child; early childhood health care; palliative care; Elder care and care homes to keep Elders in their home communities as valued Knowledge Keepers; and other measures. Specific programs may include but are not limited to correctional facilities, healing centres, hospitals, and rehabilitation centres.	4.1.1, 4.1.2, 7.2.5
	7.6	We call upon institutions and health service providers to ensure that all persons involved in the provision of health services to Indigenous Peoples receive ongoing training, education, and awareness in areas including, but not limited to: • the history of colonialism in the oppression and genocide of Inuit, Métis, and First Nations Peoples; • anti-bias and anti-racism; • local language and culture; and • local health and healing practices	5.2.2
	7.7	We call upon all governments, educational institutions, and health and wellness professional bodies to encourage, support, and equitably fund Indigenous people to train and work in the area of health and wellness	4.1.1, 4.1.2, 5.4.4
	7.8	We call upon all governments and health service providers to create effective and well funded opportunities, and to provide socio-economic incentives, to encourage Indigenous people to work within the health and wellness field and within their communities. This includes taking positive action to recruit, hire, train, and retain long-term staff and local Indigenous community	5.4.4, 8.2.4

		members for health and wellness services offered in all Indigenous communities	
	15.1	Denounce and speak out against violence against FN/M/I peoples	1.1.4
	15.2	Learn about and celebrate FN/M/I history, cultures, pride, and diversity, acknowledging the land you live on and its importance to local Indigenous communities, both historically and today	2.1.7, 3.2.5, 5.2.2
	15.7	Create time and space for relationships based on respect as human beings, supporting and embracing differences with kindness, love, and respect. Learn about Indigenous principles of relationship specific to those Nations or communities in your local area and work, and put them into practice in all of your relationships with Indigenous Peoples.	2.1.5
Truth and Reconciliation Commission of Canada: Calls to Action	18	We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.	1.1.2, 7.2.2
	19	We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.	3.1.3
	20	In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.	2.1.3, 3.2.1 4.1.1
	22	We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing	5.4.5, 5.4.6, 5.4.7, 5.4.8,

		practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.	7.1.4, 7.2.4, 7.2.5
	23	We call upon all levels of government to: i. Increase the number of Aboriginal professionals working in the health-care field. ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities. iii. Provide cultural competency training for all healthcare professionals	5.2.1, 5.2.2, 5.3.1, 5.3.2, 5.3.3, 5.4.1, 5.4.2, 5.4.3, 5.4.4, 5.4.9
	78	Policy makers fund and empower FN/M/i communities to conduct their own research.	8.2.4
Legislative commitments			
Canadian Human Rights Act	9(1) R.S., 1985, c. H-6, s. 9, 1998, c. 9, s. 12, 2011, c. 24, s. 165)	It is a discriminatory practice for an employee organization on a prohibited ground of discrimination (a) to exclude an individual from full membership in the organization. (b) to expel or suspend a member of the organization; or (c) to limit, segregate, classify or otherwise act in relation to an individual in a way that would deprive the individual of employment opportunities, or limit employment opportunities or otherwise adversely affect the status of the individual, where the individual is a member of the organization or where any of the obligations of the organization pursuant to a collective agreement relate to the individual.	5.4.4
Constitution Act, 1982 (Article)	35	The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed	2.1.1
	36 (1)	[…] “Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to:	5.4.4

		(a) promoting equal opportunities for the well-being of Canadian; (b) furthering economic development to reduce disparity in opportunities”	
United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)	16	Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services	2.1.9, 7.2.5
	24	1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services. 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right	3.1.3, 7.2.4
	31	In conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights	2.1.2, 7.2.4
Universal Declaration of Human Rights (UDHR)	1	All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood	1.1.1, 1.1.2, 7.2.1
	5	No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment	1.1.3,7.2.1
	18	Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance	3.2.2, 4.1.4
	21	Everyone has the right to equal access to public service in his country	7.2.2

	21 (1)	Everyone has the right to take part in the government of his country, directly or through freely chosen representatives	2.1.1, 3.1.1
	26	Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace	3.2.2, 5.2.2
	27	Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits	7.2.4, 8.2.4

Annex B (Informative)

Early in their partnership, HSO and FNHA agreed on the need to incorporate Indigenous voices into the standard development process. As the Technical Committee (TC) was being formed, members suggested incorporating a decolonizing perspective into the development of the standard. Based on this suggestion, it was decided to incorporate Indigenous methodology with a decolonizing framework into the Western standard development process to produce an authentic product.

With guidance from FNHA, HSO worked from an *Etuaptmumk* or Two-Eyed Seeing approach (Institute for Integrative Science and Health, n.d.), a concept proposed in 2004 by Mi'kmaw Elder Albert Marshall. This approach merges the strengths of Indigenous knowledge and teachings with the strengths of Western knowledge and practices, working toward harmony between the two while also honouring differences.

In a health systems context, the goal of the Two-Eyed Seeing approach is to better support Indigenous populations and achieve healthier outcomes. The expectation is that this mixed (Indigenous and Western) methodology will improve long-term outcomes. The table below shows key features of how the mixed methodology approach was applied at each stage of the standard development process.

Stage code	Standard development stage	How the stage was adapted using the mixed methodology
00	Standard development proposal	• The standard development proposal was outlined in a contract between HSO and FNHA. • The contract between HSO and FNHA was adapted to include OCAP™ (ownership, control, access, possession) principles from the First Nations Information Governance Centre (1998) throughout the standard development process. • The contract outlined how the standard development process may prioritize, as applicable, Indigenous research methodologies for literature reviews, environmental scans, or data collection.
10	TC formation	• Formation of the Technical Committee (TC) was guided by FNHA and HSO, with the goal of assembling a TC with representation from the five BC health regions, a variety of First Nations from across BC, and Métis and Inuit if possible. • The TC included a representative from the First Nations Health Council as the political leadership body, and two representatives from First Nations Health Directors Association as the body providing technical advice. • HSO and FNHA drafted a list of potential TC members from health care leaders across BC and recruited Indigenous patients through the Patient Voice Network.

		• A decolonizing lens was used in the selection process for TC members with FNHA and HSO staff conducting the interviews jointly. • HSO, FNHA, and the TC agreed that TC meetings would be led by a First Nation Elder to ensure the process incorporated Indigenous methodology, ways of knowing, and relationships. • Elder Gerry Oleman accepted the invitation to join the TC as a co-chair.

	TC orientation on HSO standards development in general	• HSO provided general orientation to the TC on the adapted standards development process.
		• HSO revised its orientation to reflect the context and needs of an Indigenous-led TC. This included a review of the orientation cover letter, the member participation agreement, the general terms, and the Terms of Reference. This also included the elimination of the classification of TC members into HSO's five standardized categories (i.e., patients (client), family or community member, product users, policy makers, general interest).
		• All parties agreed that the concept of voting does not reflect Indigenous methodology and this step was changed to "by consensus development."
		• TC members identified and defined the group values that would be used to guide the standard development process, as follows:
		  ○ **Respect:** Treating each other with respect; taking responsibility for our actions; and being accountable for our actions, words, and behaviours. "We are all connected. One."
		  ○ **Courage:** Being courageous in our work and having the strength to share our truths openly and honestly and work towards achieving our purpose. "The pride of one is the pride of all."
		  ○ **Generosity:** Embodying the kindness, empathy, appreciation, and grace needed to be generous with our time, presence, and treatment of each other. "The richest among us give the most."

20	TC orientation specific to the purpose and scope of the *British Columbia Cultural Safety and Humility* standard	• The TC discussed its preferred ways of working as part of the orientation. • The TC determined that it preferred in-person meetings over online meetings or videoconferences. • When members are unable to attend meetings, HSO and FNHA would invite those members to participate in pre- and post-

		briefing calls to keep them abreast of the work.
	Development and implementation of the literature review search strategy	• HSO started with existing research on the topic of cultural safety to create and implement its initial search strategy. HSO also incorporated themes identified through preliminary interviews with TC members. • Initial findings were sent to FNHA and a subset of TC members for feedback. • HSO consulted with TC members and sought guidance from FNHA about how to search, prioritize, and screen relevant literature sources related to the Indigenous methodologies. • FNHA suggested that “evidence-based literature” is a Westernized view that often discredits traditional knowledge. It was agreed that traditional knowledge would be incorporated into the content of the standard through methods such as storytelling.
	Sorting of results	• Peer-reviewed articles and grey literature were organized based on six organizational domains used by Interior Health and Provincial Health Services Authority. These provided a basis for understanding the themes identified in the literature review. • HSO incorporated Greenwood’s (2019) change model as a secondary way of organizing the themes identified in the literature review. • Inclusion criteria for the literature: o Published in the last five years o Published in English o Related to Indigenous peoples/cultures o Related to indicators and/or measurement o Related to one of the three levels within the project scope (i.e., structural, system, provider) o Related to traditional healing or medicines, and social care • Exclusion criteria for the literature: o Older than five years o Not in English o Non-Indigenous (e.g., African-Caribbean, Asian)
	Drafting the literature review	• Both Indigenous and non-Indigenous authors were included and identified in the final draft of the literature review. Indigenous-led research was prioritized to provide validation and encourage buy-in from the Indigenous community.

	First in-person TC meeting	• The agenda included opening remarks from the Elder. • The goal was to: o Discuss and set the context, and acknowledge historical and individual contexts o Reach a common understanding about cultural safety in the health system o Share reflections on the findings from the literature review o Start building draft content in accordance with HSO's standards writing guidelines • TC members emphasized the importance of mutual trust and respect, incorporation of common language and understanding, acceptance of personal biases, and the need for meaningful engagement. • TC members emphasized the need for transparency in communication and processes, as well as adequate time to plan and prepare for meetings. • TC members discussed key principles about how to incorporate Indigenous methodology throughout the standard including acknowledgement, witnessing, and involvement.
30	Iterative reviews and revisions of the working draft until it is ready for public review	• HSO and FNHA prioritized in-person meetings to facilitate consensus building as the draft standard was being created and prepared for public review. • Content development: o The TC discussed how Indigenous methodology can be further incorporated into the standard. The TC emphasized the importance of concise and clear writing, particularly of the guidelines, to avoid misinterpretation and ensure the standard is understood. The TC asks that consistent, clear language and terms be used. o Traditional knowledge was incorporated into the standard through stories which is one aspect of a Two-Eyed Seeing approach and an Indigenous way of disseminating knowledge in a Western context. Storytelling includes having consent from the Nation where a story originates. As per Elder Gerry Oleman's request, the stories chosen have a conclusion and feature some kind of change. Rather than pan-

		Indigenous perspectives, the specific Nation(s) or communities where the stories originate were acknowledged. Stories focus on “where we are at” in the present day and end with “how we can improve together.” • Métis Nation BC provided feedback on the draft standard prior to public review, and this feedback was incorporated.
	TC consensus on the readiness of the draft standard for public review	• Rather than using the typical voting step to determine whether the draft standard is ready for public review, consensus development steps were used. • Although the requirement to classify members into HSO’s four standardized categories was eliminated, a balance of interest on the TC was still maintained to arrive at consensus. Balance of interest means that no members or interest groups have a stronger voice than others. The consensus development steps address the balance of interest. • The consensus development steps respect Indigenous values and frameworks, where knowledge is viewed as relational and not belonging to one person over another but instead to the cosmos or greater whole. • An online survey was sent to all TC members to identify areas that needed further discussion prior to consensus. • A talking circle approach, which is forward-focused and rooted in the BC friendship centre model, was used to achieve consensus. In this approach, each member participated and had a voice, minimizing the tendency for only a few powerful voices to be heard. The goal is for all members to feel ownership of the standard. Given the circumstances of the pandemic, the circle was held virtually and led by Elder Gerry Oleman. • In the case of disagreements, members were encouraged to reflect on their decisions (e.g., members may be asked to describe what makes them feel unable to champion the standard, as opposed to what may be a minor disagreement that they may find acceptable). If there were an impasse, the TC would work to understand the reason for it. If the TC were still unable to achieve consensus, a council of Elders would be consulted to advise on the issue.
40	Public review data collection and communication planning	• Throughout public review planning and public review, communications were coordinated between HSO and FNHA.

		• As a result of the TC's request that the methodology and the literature review results be widely shared with First Nations communities to build respect and approval, the methodology was included in the standard as Annex B and the bibliography was presented to show both Indigenous and non-Indigenous sources. • To involve communities in the public review process, TC members were asked to communicate with their respective networks, and communication was sent to all members of the First Nations Health Directors Association. • To include the feedback from Indigenous patients, a focus group was organized through the Patient Voice Network, and the announcement included the link for written feedback directly to HSO. • To maintain a relational methodology through the collection of feedback, the TC members who worked in BC health authorities connected with their teams, and health authorities with no representation on the TC were contacted by FNHA. • To distinguish comments from Indigenous and non-Indigenous people or organizations, an optional demographic question in the public review survey asked about Indigenous self-identification. Privacy laws as well as the OCAP™ principles were respected by not including names of individuals in the review of the comments by the TC members. However, a colour coding system was used to identify the comments that came from self-identified Indigenous people. • To provide an alternative to providing feedback in a written format, HSO held three virtual focus groups that were open Canada-wide (two in English, one in French) which were preceded one week before by a presentation of the standard (one in English, one in French).
	Public review launch and mid-review meeting	• To reach the desired groups, the TC was asked to provide names and contact information of those they would like to reach during the consultation period. These people or organizations were included in the communications at the time of public review launch. • The public review specifically targeted Indigenous groups and organizations in BC and across Canada. • Regulatory boards in BC were also included.

		• A joint HSO-FNHA news release was published on each organization's website at the time of launch, with the link to HSO's webpage to provide written feedback. • The public review was originally launched for 60 days, but to increase the response rate and in response to many key potential respondents requesting additional time, the public review period was extended by 30 days.
	Public review feedback analysis	• The TC received an Excel spreadsheet called Disposition of Comments that provided a decision log for each public review comment. • Prior to meeting with the TC, the comments were assessed using feedback analysis, summarization, and triage techniques, to optimize the time for discussion. • Analysis of the feedback was shared with the TC ahead of time.
50	TC discussion of public review feedback	• Given the pandemic, following HSO's analysis of the public review comments, virtual meetings were planned with the full TC to discuss the comments with greater impact. • Because of the high number and variety of comments, three TC sub-groups met separately to either resolve the comments or determine the need to bring them back to the TC for discussion. The decision log remained available to all TC members throughout. • TC co-chairs reviewed with Métis Nation BC the disposition of their comments.
	Standard revision as per TC direction	• Edits to the standard were made visible to the Technical Committee in track changes.
	TC consensus and approval of the standard for publication	• The consensus development steps followed the approach used at stage 30, with an online survey followed by a virtual consensus meeting.
	Endorsement by First Nations Health Council and First Nations Health Directors Association	• In upholding the First Nations health governance structure developed by and for BC First Nations, the First Nations Health Council as the political leadership body and the Board of the First Nations Health Directors Association as the body providing technical advice both endorsed the standard. Both entities had representation on the TC.
60	Publication with supporting resources	• The standard was published as a reference document. • A joint FNHA-HSO webinar led by the TC co-chairs was made available in support of the

		standard on HSO's website, along with an overview of the standard for patients and families.

At HSO we value your feedback. Please let us know if you would recommend this standard to a friend or colleague, by navigating to the following link and completing the short survey:
https://www.research.net/r/STDHSO

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