Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

Equitable Access

Co-Designing an Integrated Primary and Community Health Care Framework

Accès équitable :

conception conjointe d'un cadre de soins primaires et communautaires intégrés

Le présent document contient la traduction française de l'aperçu.

K’áhshó got’ı̨ne xədə k’é hederı ɂedı̨htl’é yerınıwę nı́ dé dúle.
Dene Kədə́

ʔerıhtł’ís Dëne Sųłıné yatı t’a huts’elkër xa beyáyatı theɔ́ą ɔ́at’e, nuwe ts’ën yółtı.
Dëne Sųłıné

Edı gondı dehgáh got’ı̨e zhatıé k’ę́é edatł’éh enahddhę nıde naxets’é edahłí.
Dene Zhatıé

Jii gwandak izhii ginjìk vat’atr’ijąhch’uu zhit yinohthan jì’, diits’àt ginohkhìi.
Dinjii Zhu’ Ginjik

Uvanittuaq ilitchurisukupku Inuvialuktun, ququaqluta.
Inuvialuktun

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Inuktitut

Hapkua titiqqat pijumagupkit Inuinnaqtun, uvaptinnut hivajarlutit.
Inuinnaqtun

kīspin ki nitawihtīn ē nīhīyawihk ōma ācimōwin, tipwāsinān.
nēhiyawēwin

Tłı̨chǫ yatı k’ę̀è. Dı wegodı newǫ dè, gots’o gonede.
Tłı̨chǫ

Indigenous Languages
request_Indigenous_languages@gov.nt.ca

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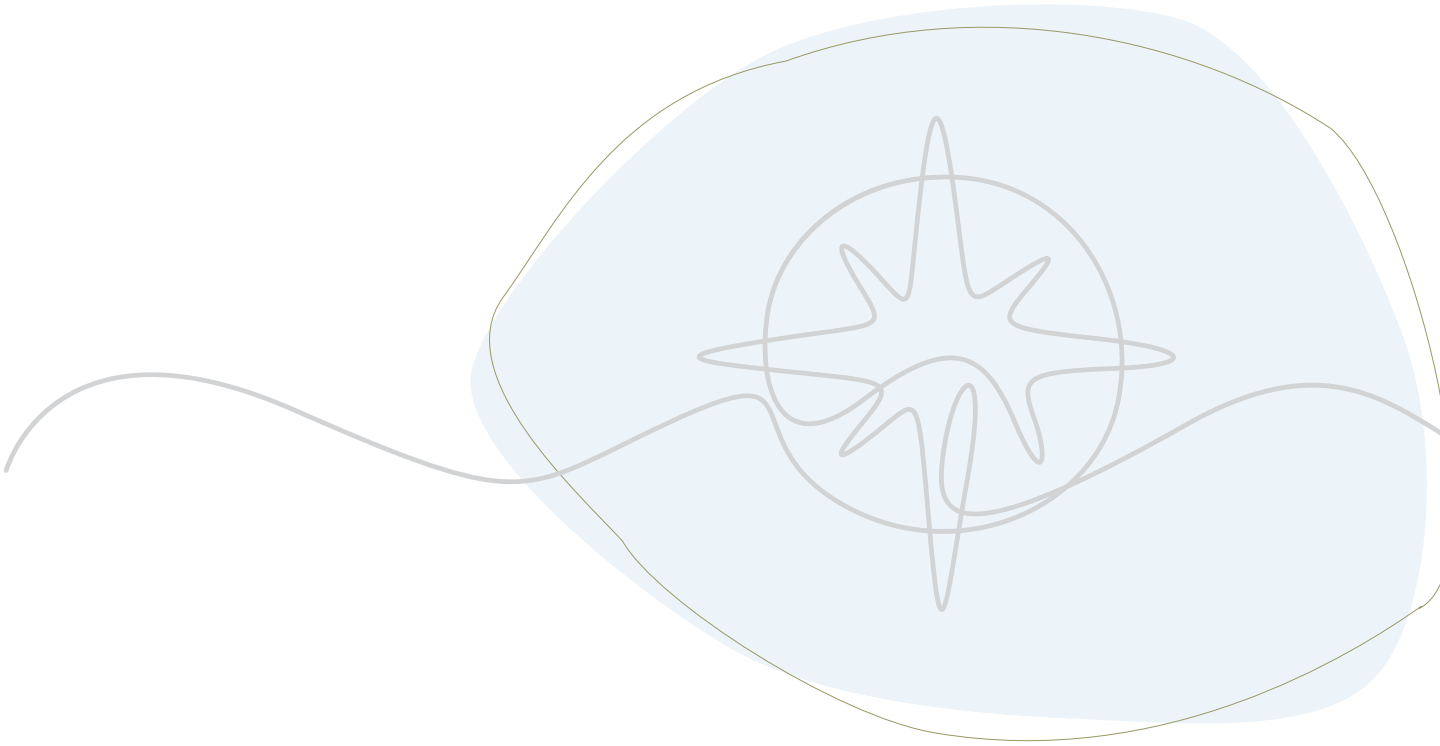


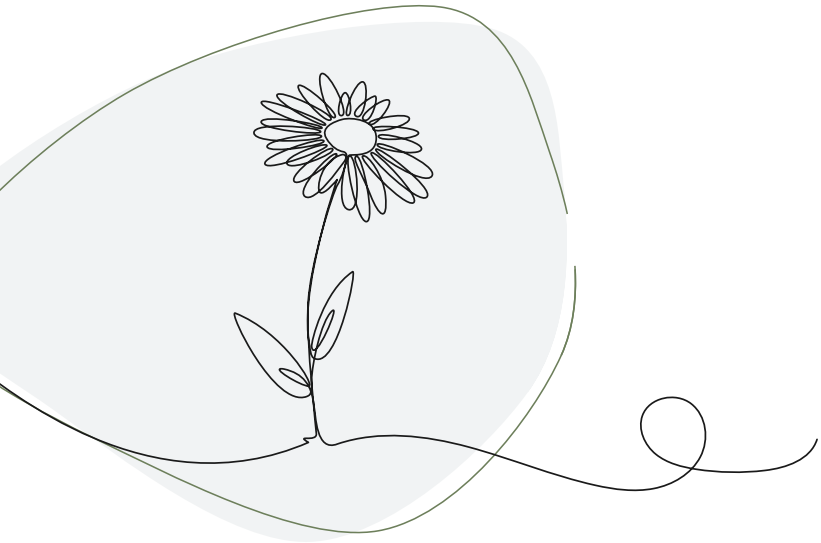
Overview

Purpose and Intent

The Primary Health Care Reform (PHCR) initiative in the Northwest Territories (NWT) is an effort to redesign the health system so that it is equitable, culturally safe, community-led, and responsive to the unique needs of Indigenous Peoples and all residents. Rooted in reconciliation and cultural safety, PHCR aims to shift away from a one-size-fits-all model toward a collaboratively designed approach that values relationships, local knowledge, and holistic wellness.

At its heart, PHCR is guided by the vision of a territory where Indigenous Peoples and all residents can feel healthy in body, mind, heart, and spirit. Where people understand how things like housing, income, and other life experiences affect their health and wellness.

Primary care is evolving, and we have a powerful opportunity to shape its future. By centering Indigenous communities in the redesign, we can build a system that is more responsive, inclusive and grounded in the strengths and knowledge of those it serves.



The Framework will focus on activities to make change happen. The enablers are:

1. **A positive and supportive workplace.**
2. **Putting people first.**
3. **Smart use of technology.**
4. **Focus on prevention.**
5. **Using data and flexible funding.**
6. **Well-trained and connected teams.**
7. **Strong and lasting workforce.**

Research Questions

- What key design elements define Indigenous-centered primary and community team-based care models?
- What outcomes should Indigenous-centered team-based models of primary and community care strive to achieve?
- How do these models incorporate Indigenous knowledge and practices into everyday primary and community care?

Framework for Transformation

To create a system that is equitable, high-quality, and culturally safe, the PHCR will conduct work at three interconnected levels of change: micro-level, meso-level and macro-level.

Overview

Three Levels of System Change

1. **Where Care Happens (Micro-Level)**: This is where people meet directly with doctors, nurses and care providers. This level is about building trust, safety, and respect between clients and caregivers.
2. **Community & Regional Support (Meso-Level):** This level connects everyday experiences with broader planning and it is also where innovation happens. It encourages teamwork and shared decision-making.
3. **Policy & Leadership (Macro-Level)**: This level is about the policies, funding, and leadership that shape the whole system. This supports Indigenous leadership and decision-making. It also makes cultural safety a part of standards, laws, and data systems.

Three Lenses of System Design

1. **Access** means making sure everyone can get the care they need.
2. **Quality** means making sure care is safe, works well, and respects all cultures.
3. **Sustainability** means the system can keep going strong over time and handle future challenges.

All the above lenses are connected, and equity is the cross-cutting principle that connects them. It means designing care that meets people where they are, considering intersecting identities and systemic barriers.

Co-Design and Community Leadership

PHCR uses a co-design approach with Indigenous governments and leaders sharing power and decisions through a variety of Indigenous-led councils and advisory bodies.

In the process of PHCR, the following are core outputs of the initiative that will guide the long-term transformation of the healthcare system in the NWT:

- **Integrated Primary and Community Care Framework**: A roadmap to guide the work.
- **Co-Design Toolkit**: Practical tools for regional teams to build culturally safe, community-led models of care.
- **Shared Governance**: Indigenous governments co-lead decision-making through structured bodies like the Indigenous Advisory Body, and Council of Leaders Health and Social Services working group.

PHCR is not just a policy shift; it is a movement toward improved healthcare service delivery. By centering Indigenous strengths and values, and working closely with staff and Indigenous Government Organizations, PHCR aims to build a health system that truly works for Indigenous Peoples and everyone in the Northwest Territories.

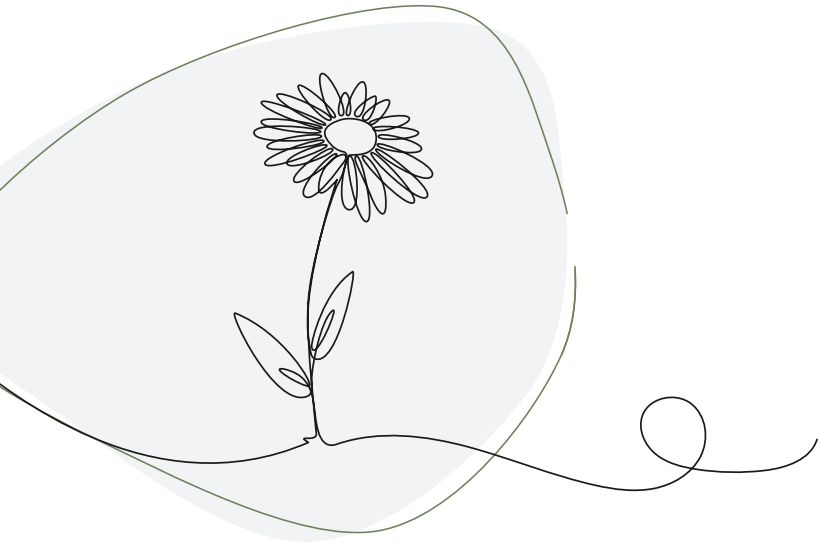
Aperçu

Objectif

L'initiative de réforme des soins primaires (IRSP) des Territoires du Nord-Ouest (TNO) vise à réorganiser le système de santé pour qu'il soit équitable, adapté à la culture et mené par la communauté, et pour qu'il réponde aux besoins uniques des peuples autochtones et de tous les résidents des TNO. Ancrée dans la réconciliation et la sécurité culturelle, l'IRSP vise à délaisser le modèle universel au profit d'une approche plus collaborative qui privilégie les relations, les connaissances locales et le bien-être holistique.

Fondamentalement, l'objectif de l'IRSP est d'offrir aux peuples autochtones et à tous les résidents des TNO un territoire où ils se sentent en bonne santé physique, mentale, émotionnelle et spirituelle. Un endroit où les gens sont conscients de l'incidence que le logement, le revenu et d'autres facteurs liés à leur vie peuvent avoir sur leur santé et leur bien-être.

Les soins primaires évoluent, et nous avons une formidable occasion de façonner leur avenir. En plaçant les communautés autochtones au cœur de la réforme, nous pouvons mettre en place un système plus réactif, plus inclusif et fondé sur les forces et les connaissances des personnes qu'il sert.



Le cadre de travail se concentrera principalement sur les activités permettant de faire évoluer les choses. Voici les facteurs clés pris en compte :

1. **Un milieu de travail positif et favorable**
2. **Les gens d'abord**
3. **Une utilisation intelligente de la technologie**
4. **Un accent mis sur la prévention**
5. **Une utilisation des données et de mécanismes de financement souples**
6. **Des équipes bien formées et solidaires**
7. **Une main-d'œuvre forte et stable**

Questions de recherche

- Quels sont les éléments clés qui définissent les modèles de soins primaires et communautaires axés sur les populations autochtones et fondés sur le travail d'équipe?
- Quels objectifs devrait-on fixer pour les modèles de soins primaires et communautaires (axés sur les communautés autochtones et fondés sur le travail d'équipe)?
- Au quotidien, comment ces modèles intègrent-ils les connaissances et les pratiques autochtones dans la prestation des soins primaires et communautaires?

Un cadre propice à la transformation

Afin de créer un système équitable, de haute qualité et adapté à la culture, les activités de l'IRSP s'articuleront autour de trois niveaux de changement interdépendants : micro, méso et macro.

Aperçu

Trois niveaux de changement systémique

1. **Lieu de prestation des soins (niveau micro)** : Lieu où les personnes rencontrent directement les médecins, les infirmiers et les professionnels de la santé. À ce niveau, il s'agit d'instaurer un climat de confiance, de sécurité et de respect entre les clients et les soignants.
2. **Soutien communautaire et régional (niveau méso)** : À ce niveau, on relie les expériences quotidiennes à un plan plus large, on favorise l'innovation et on encourage le travail d'équipe ainsi que le partage du pouvoir de décision.
3. **Politiques et leadership (niveau macro)** : À ce niveau, on s'intéresse aux politiques, au financement et au leadership qui façonnent l'ensemble du système; on soutient le leadership et la prise de décision autochtones, et on intègre le concept de sécurité culturelle dans les normes, les lois et les systèmes de données.

Trois aspects relatifs à la conception du système

1. **Accès** : faire en sorte que chaque personne reçoive les soins dont elle a besoin.
2. **Qualité** : faire en sorte que les soins soient sûrs, efficaces et respectueux de toutes les cultures.
3. **Durabilité** : faire en sorte que le système puisse continuer à fonctionner correctement au fil du temps et faire face aux difficultés à venir.

Tous les aspects mentionnés ci-dessus sont interreliés, et l'équité est le principe fondamental qui sert de fil rouge. Autrement dit, les soins doivent être adaptés à la situation de chaque personne, en tenant compte des intersectionnalités et des obstacles systémiques.

Conception collaborative et leadership communautaire

L'IRSP utilise une approche de conception collaborative avec les gouvernements et les dirigeants autochtones, qui partagent le pouvoir et les décisions grâce à la participation de divers conseils et organismes consultatifs dirigés par des Autochtones.

Les points suivants, obtenus dans le cadre de l'IRSP, constituent les principaux résultats qui guideront la transformation à long terme du système de santé aux TNO :

- **Cadre de soins primaires et communautaires intégrés** : une feuille de route pour orienter les travaux.
- **Boîte à outils pour la conception collaborative** : outils pratiques destinés aux équipes régionales pour mettre en place des modèles de soins adaptés à la culture et dirigés par la communauté.
- **Gouvernance partagée** : Les gouvernements autochtones participent à la prise de décisions par l'intermédiaire d'organismes structurés comme le Comité consultatif autochtone et le Groupe de travail sur la santé et les services sociaux relevant du Conseil des dirigeants.

L'IRSP n'est pas seulement un changement de politique, mais aussi un mouvement visant à améliorer la prestation des services de santé. En mettant l'accent sur les forces et les valeurs autochtones, et en travaillant en étroite collaboration avec le personnel et les organisations gouvernementales autochtones, l'IRSP vise à mettre en place un système de santé qui fonctionne bien pour les peuples autochtones et tous les résidents des TNO.

Following the North Star

Imagine trying to travel across the Northwest Territories following the North Star, navigating trails, finding landmarks, or reading snow features. You know where you want to go, even if the road is tricky sometimes. That's what it's like trying to change how primary health care works. We have a clear goal: to make care fair, welcoming, culturally safe, and easy to access for everyone. This goal is like our North Star - it guides us, shows us the way, and reminds us what people in the North care about.

Can Our System Find A New Path?

Changing health care isn't just about how doctors and nurses do their jobs. It's about changing the whole health system. But can a system that was built without listening to everyone, and that was built on a painful history of colonization, really change for the better?

Western health care often focuses on steps, checklists, and results. It treats care like a product, giving everyone the same thing. Indigenous ways are different. They focus on relationships, storytelling, giving, sharing, and caring for the whole community.

Health systems aren't machines. They are made up of people, power relations, stories, and generations of experience. Real change will only come when we understand how these parts connect to and affect each other.

We've Lost Our Way

We know where we want to go. Our goal is care that respects all cultures, welcomes everyone, and is easy to access in the Northwest Territories. But our health system can't get there because we can't find our way.

Our health care has always followed one way of doing things, made for one type of person. Right now, the system works for some people but leaves others out. This causes harm and breaks trust. Our health system focuses too much on tasks and policies, instead of on people and relationships. It tries to be fast and offer the same services in every situation - but that doesn't meet everyone's unique needs. The system is moving, but not in the right direction for everyone.

Finding Our Way

Change is already happening. Across Canada and around the world, there are fewer health workers, more people leaving their jobs, and more job competition. These are big challenges, but they also give us a chance to try something new. This is where Primary Health Care Reform comes in. It is about going from reacting to problems to planning better care. It's a way to build a system that includes everyone and works better for the North. Only people from the North can guide this new path.

What is Co-Design?

Co-design is how we can navigate. It's not a strict path or map. It's a way for each community to create their own path toward the North Star - better care that meets their needs. The new Primary and Community Care Framework and Co-Design Toolkit will offer flexible paths and choices, so each community can lead in ways that are based in what they know, need, and value. This is our chance to build a new and better health care system together.

The North Star

- **Vision:** A territory where Indigenous Peoples and all residents can feel healthy in body, mind, heart, and spirit. People understand how things like housing, income, and other life experiences affect their health and wellness.
- **Mission:** In the next five years, we want to build a health system that places Indigenous Peoples, families, and communities at the center. We will work to make care fair, respectful, culturally safe, and anti-racist. We will do this by listening, learning, and making changes that mean no one is treated unfairly because of who they are.

Equitable Access

means making sure that everyone has a fair chance to get the care they need to be healthy in their own way. This means removing barriers like racism, gender inequality, lower income, where someone lives, and the ongoing impacts of colonialism. When these barriers are addressed, the health system works better for everyone.

1.0

Background and Case for Change

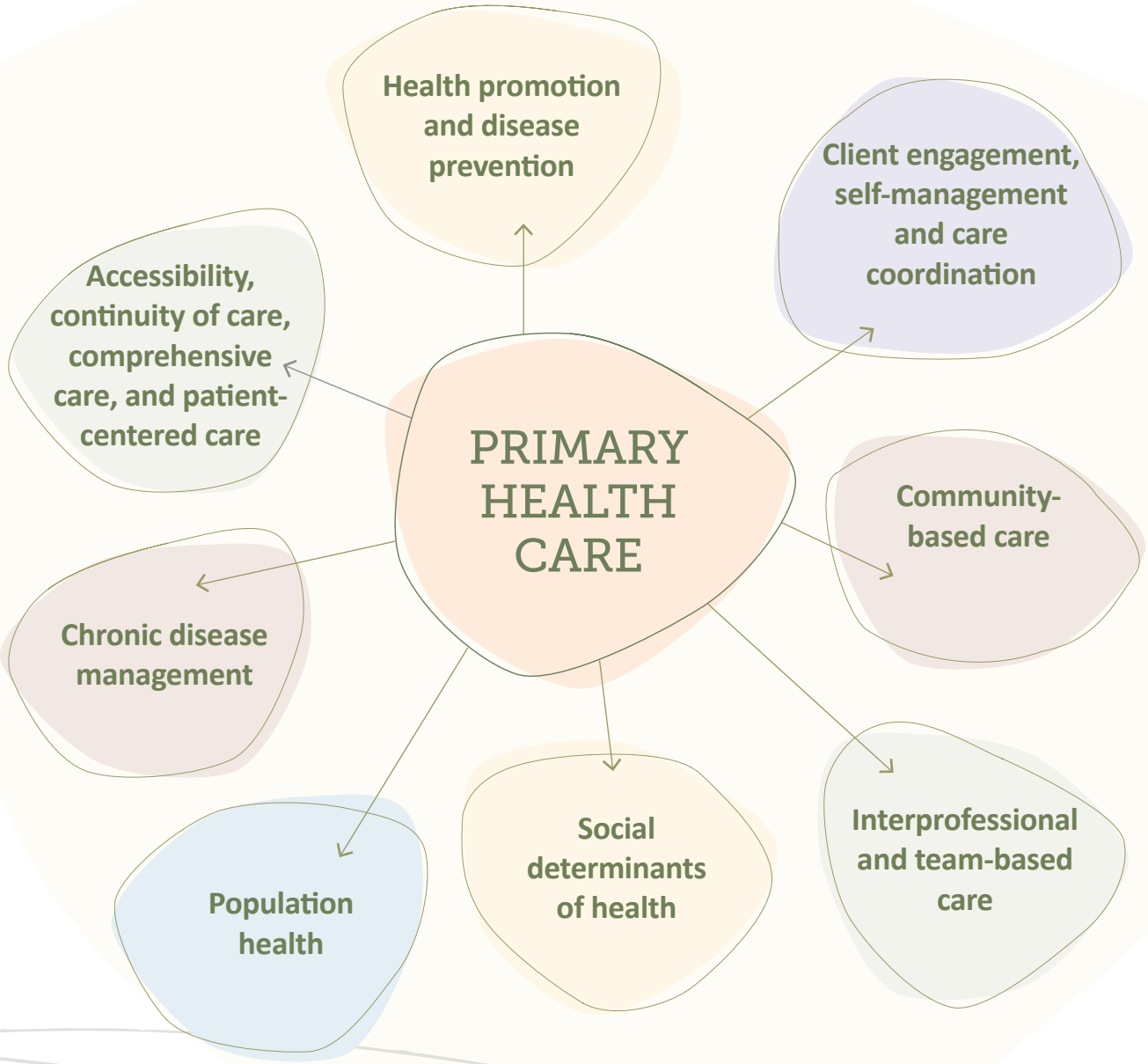
This section describes the challenges in our health system. It shows where there are gaps, what makes it hard for people to get care, and how some services have left people out, especially Indigenous people.

1.1
Health Inequities

Understanding Primary Health Care

Definition of Primary Care

The Health Standards Organization defines primary health care as encompassing a broad spectrum of services, including:



Primary health care is an approach to organizing health services that puts people first[1]. When it works, it brings care closer to where people live and supports them throughout their lives. This approach is based on three main ideas[1]:

1. Offering a wide range of services that work together.
2. Working with other services like housing, social services, or education to support health and wellness.
3. Supporting communities to stay healthy and well.

Primary health care includes things like preventing illness, promoting wellness, treating sickness, helping people recover, and caring for people at the end of life.

Across the world, primary health care is seen as one of the best and most fair ways to give everyone health care[1,2]. It helps our health system be more resilient and keep services available during hard times. It helps build trust between people and the health system.

Primary health care is more than just seeing a doctor or nurse. It's part of an entire health system. The goal is to make sure this whole health system works well for everyone. To do that, we need strong leadership, good planning, and people in the system who listen to what communities really need. When done right, primary care won't just treat illness. It will help prevent and manage illness, support mental health, and build stronger families and communities.

The Northwest Territories Context

In the Northwest Territories, the ideal kind of health system described above is still not available to everyone - especially Indigenous people[3–5]. Many people have to wait weeks for basic care, use the emergency room for things that aren't emergencies, or travel long distances for care that should be closer to home[6]. Processes are often seen as confusing, and support and care is often unavailable after hours. Some people say they don't feel safe or respected when they get care[6]. These problems add to the distrust that many Indigenous people have felt for generations towards the health system.

In many parts of the Northwest Territories, the most important parts of primary care, called the 4 Cs, are missing. These include[7]:

1. **First Contact** - people can access care close to home, when they need it.
2. **Continuity** – people can see the same provider over time, building relationships and understanding of health history and needs.
3. **Comprehensiveness** – availability of many types of physical, mental, and social health services.
4. **Coordination** - providers work together and make sure people are continually supported.

To meet these goals, primary health care is changing. It's not just about doctors anymore - it includes teams of different health workers who are supposed to work together to give people the care they need[8,9]. In the Northwest Territories, this team approach isn't always available. In small communities, care is often provided by Community Health Nurses, who provide primary health care, offer programs like child wellness visits, and handle emergencies - sometimes with help over the phone from a doctor[4]. Still, many people in rural and remote areas can't get the care they need close to home, and this causes unfair gaps in care and impacts health[3–6].

Even though people are trying new models of care, the national plan for how primary health care should work is still unclear[9]. This means team-based care looks different in different places, and there's no consistent way to measure progress or compare policies and models[9]. While changes have been made to improve these systems, it's not always clear if they're working[9,10]. Best practices show that care should be based on what the community needs[11]. But in many cases, care does not focus on equity, anti-racism, cultural safety, or Indigenous knowledge, values, and practices[4,6,12,13].

The Need for System Change

To truly fix primary health care in the Northwest Territories, we must acknowledge that racism is built into the system[14–16]. These problems were caused by systems created long ago that still harm Indigenous people today[15]. Current health care often focuses only on medical treatments and leaves out community-led and land-based ways of living and healing[17]. This makes it harder for people to get care in ways that are meaningful to them. These problems aren't new. They are part of ongoing colonial harm, like residential schools, the Sixties Scoop, and racism in health and social systems[16]. These have caused deep and lasting harm that has been passed down through generations. The barriers created by colonial systems are so engrained that it can be hard to see that they are built on racism[15,18].

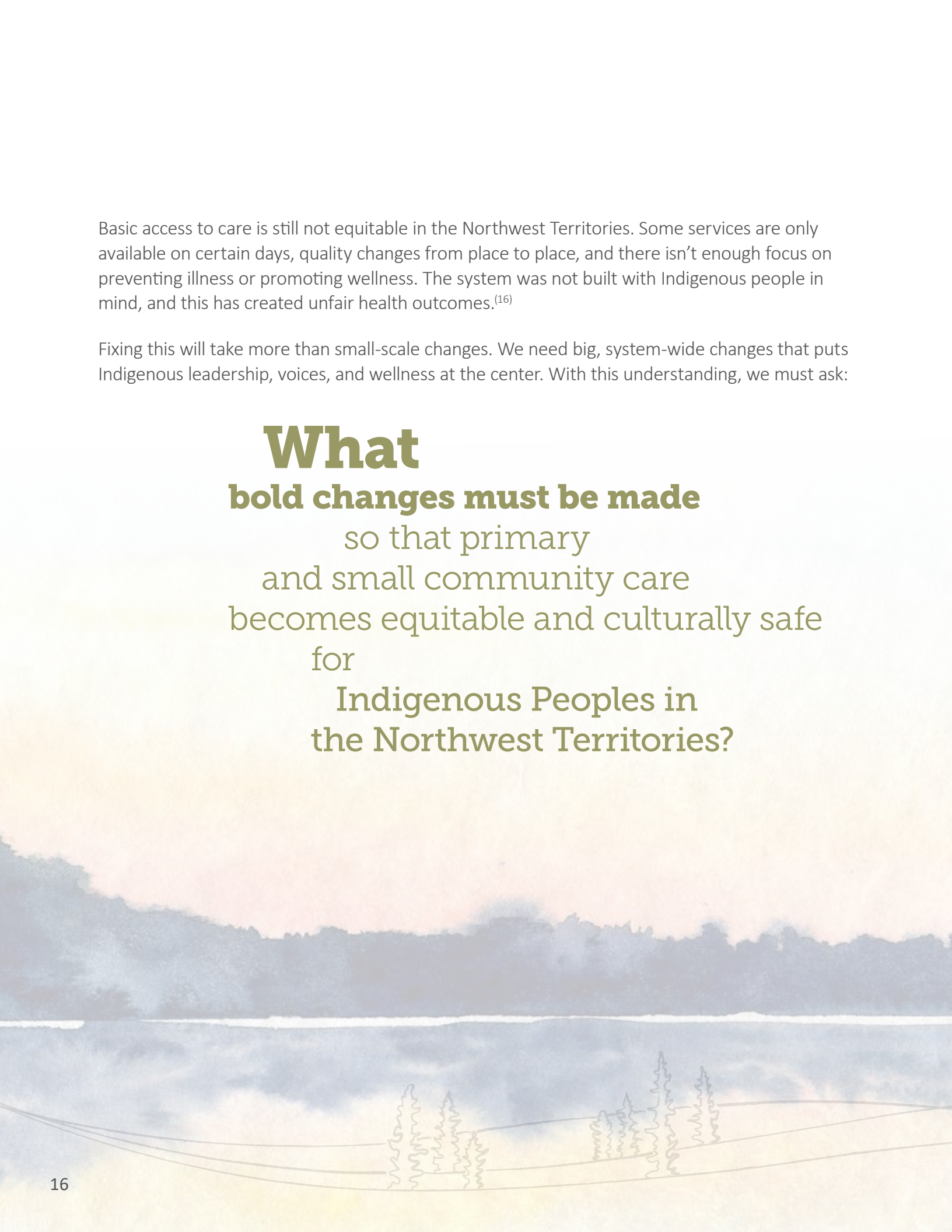
Anti-racism
is the ongoing action to identify, address, and prevent racism

Cultural safety
is when Indigenous peoples feel safe and respected and free of racism and discrimination, when accessing health and social services and programs.[12]

Basic access to care is still not equitable in the Northwest Territories. Some services are only available on certain days, quality changes from place to place, and there isn't enough focus on preventing illness or promoting wellness. The system was not built with Indigenous people in mind, and this has created unfair health outcomes.[16]

Fixing this will take more than small-scale changes. We need big, system-wide changes that puts Indigenous leadership, voices, and wellness at the center. With this understanding, we must ask:

What
bold changes must be made
so that primary
and small community care
becomes equitable and culturally safe
for
Indigenous Peoples in
the Northwest Territories?



1.2
The Case for Change in the Northwest Territories:

Indigenous Strengths Can Transform and Heal the Health System

Indigenous communities in the Northwest Territories have many strengths that are important to healing and reimagining the health system.[19] These strengths come from deep cultural traditions and land-based ways of life. They are key to personal and community well-being.

- **Connection to Land:** Indigenous Peoples have a deep spiritual and cultural bond to the land. Land is a source of identity, healing, and wellness. Activities such as hunting, fishing, and harvesting support physical, mental, and spiritual health.
- **Belonging and Identity:** Indigenous communities value sharing knowledge across generations, strong relationships, and passing down language and culture. These traditions build mental wellness, community resilience, and a sense of belonging.
- **Cultural Safety and Healing:** Indigenous-led health programs, like land-based healing camps and community-driven wellness plans, helps with mental health, substance use recovery, and managing long-term illness.
- **Indigenous Leadership in Health:** When Indigenous Government Organizations and communities are in charge of health decisions, services can better match their values, traditions, and needs.

These strengths can support real change. But the current health system still doesn't use these strengths properly when creating and delivering services.

Barriers in the Current System

The health and social services system has many problems that make it hard for Indigenous Peoples, especially those in small and remote communities, to get the care they need.[6,20] These problems are not just about how the system works, but about how it was built without Indigenous voices or priorities in mind.

Some of the key challenges are[6,20,21]:

1. **There aren't enough workers, and they're not well-supported:** Health workers often don't have clear roles or the help they need. Staff leave often, especially in small communities. This makes it hard to build strong teams and relationships. There also aren't enough Indigenous Peoples in health jobs.

2. **Budgets don't meet community needs:** Funding rules are strict and not based on what communities need. Money is not often used for whole-person care or for what communities say is important to them.

3. **Care and information are hard to access:** Many people don't have regular access to health services. Medical travel systems are not working well. There isn't enough data to plan better services.

4. **There are too many changes, and not enough support:** Changes are often made without clear planning or communication. Staff feel overwhelmed and unsupported, which affects the quality of care.

5. **Systems are outdated and don't work well together:** Health care models are outdated, short-term, and tend to react to problems instead of preventing them. Care isn't well-coordinated between regions, and there isn't enough focus on team-based and culturally safe care.

6. **There isn't enough trust and connection:** Many people feel that care is impersonal and not trustworthy. Fly-in health workers make it hard to build relationships with communities.

7. **There is no shared vision:** There is no clear, shared plan for what primary health care should look like in the Northwest Territories. Without a strong focus on equity, anti-racism, and cultural safety, current changes could continue to leave Indigenous Peoples behind.

These aren't just small issues. They show that the system wasn't designed to meet the needs, knowledge, or values of Indigenous Peoples.

Change Needs a Different Approach

Changing a huge, complex system, like health care, takes more than just simple fixes. As Dr. Nicole Redvers says,

> "We cannot solve complex problems from the same worldview that created them in the first place."[22]

We need a new way of understanding and working together.

The Department of Health and Social Services understands that making health care work for everyone is a complex problem. Health equity is also a complex problem because it involves many people, systems, and issues that are all connected. The causes and solutions aren't always clear, so we need to work together, keep learning, and adapt as we go.

Too often, system changes try to use quick or one-size-fits-all fixes. But these don't work well for deep, structural problems like racism, inequity, or cultural safety. When the wrong approaches are used, it can lead to burnout, frustration, and initiatives that fail to stick.

To deal with complex problems, we need to:

- **Understand the system and its barriers**
- **Work at multiple levels (services, government, and communities)**
- **Use leadership that brings people together and encourages creative teamwork**
- **Build strong relationships and listen to feedback**

A Chance to Transform the System

To make the health system work for everyone, we need to stop reacting to problems and start finding long-term solutions based on:

- **Building relationships, not just providing services**
- **Sharing power, instead of keeping control at the top**
- **Creating safe, anti-racist spaces**

We also need to rethink how primary and community care is planned, funded, and measured. The typical ways of measuring health care often don't reflect what really matters in remote and Indigenous communities. This keeps unfair systems in place and doesn't help improve health outcomes.

Real changes starts by centering Indigenous strengths, looking at the root causes of problems, and working in new ways that are fair, respectful, and focused on relationships.

1.3
What We Heard So Far:
Indigenous Communities

Primary Health Care Reform in the Northwest Territories needs to be built on what is important to Indigenous communities. We reviewed twenty-seven community wellness plans developed by Indigenous communities in 2024 to understand what matters most when it comes to health and wellness [19].

These wellness plans were developed through community engagement and reflect the unique strengths and goals of each community. They set out a community vision for wellness, healing, and belonging. Common priorities found in these plans include:

1

Building community capacity means supporting Indigenous communities and Government Organizations to grow and lead their own wellness efforts. This work is supported by:

- Talking and listening to community members
- Working together and communicating clearly
- Improving programs
- Holding wellness gatherings
- Providing easy-to-access resources and training
- Creating good partnerships
- Having strong leadership and planning

2

Celebrating land, culture, and ceremony:
Indigenous communities believe that being connected to land, culture, and language is very important for passing down knowledge and promoting wellness. Going back generations, Indigenous Peoples have always had strong spiritual and physical bonds with the land. Being on the land supports wellness in many ways, including sharing important knowledge, participating in healthy practices, and being in culture. To support individuals and communities, the health system must understand and prioritize these land-based relationships.

3

Focusing on families, children, youth, men, and Elders:
True change in a community starts with the next generation. All community wellness plans focus on helping children and youth grow up well, learn in safe places, and spend time with Elders. It's also important to support different groups like men and Elders in ways that meet their needs. Programs designed for different groups are key. Including culture in health education will help people learn that they can make good choices for their own health and for their whole community.

4

Healthy living, prevention, and promotion:
In all community wellness plans, healthy and well individuals and families are at the forefront. Being well is about more than just not being sick. Wellness is connected to feeling safe and secure. To fully meet people's needs, health care needs to include:

- Local, steady jobs
- Access to education and training
- Safe homes and safe spaces
- Food security
- Health care
- Mental wellness support
- Dental care

Helping communities make their wellness plans a reality can make a real difference in the health system. We will use the information from these community wellness plans to engage Indigenous Peoples and all residents to learn more about their experiences in the health system.

5

Mental wellness and healing trauma: Mental health and addictions are a priority in every community wellness plan. Individuals and families are still feeling the impacts of residential school and its ongoing effects. Communities know healing is needed and that mental wellness is an essential part of that. Mental health care includes:

- More counselling
- Better access to addictions treatment
- Support at the local and territorial levels

1.4
What We Heard So Far:
Health and Social Services Staff

We can't make real changes to the health system without listening to the frontline staff who work in it every day. In engagement sessions in the Yellowknife region, health staff shared their experiences - the pressures they face, and what could be better. Their stories help us see what's not working and give us ideas for real, lasting changes.

Staff shared that their challenges aren't just about day-to-day tasks. Many problems come from deeper issues in the system and how people work together. The Integrated Care Team model could help, but only if it reflects what care is really like and includes the voices of Indigenous communities. These aren't complaints - they're important insights that show how much staff care about their work and the people they serve.

The health system is under a lot of pressure. It's being held back by things like poor communication, staff shortages, and policies that don't fit the realities of working in the Northwest Territories. Even with these challenges, staff still believe in team-based, holistic and culturally safe care and are ready to help make it happen.

Health providers, support teams, and administrators are the people who know what it takes to deliver health care. They see every day where the system isn't working and where it can be improved. Often, they have to work in ways that go against their values and don't have the tools or power to make changes.

People-centred care means putting people first - but that can't happen unless workers are supported too. But they're frustrated because the system isn't doing a good job of putting those ideas into action. Some of the key takeaways from staff are:

1

Making the vision into reality:

Staff agree with the idea of integrated team-based care, but they say it isn't being done well. The way it's set up now doesn't match the vision. To work properly, the system needs:

- Better planning
- More support and resources
- Clear structure
- Strong and supportive leadership

3

Strengthening leadership and accountability: Because leaders change often or aren't consistent, teams can feel lost and unsupported. Staff want stronger, more accountable leadership. This means:

- Leaders who are present and involved in day-to-day work
- Indigenous leaders and community members in decision-making roles
- Cultural safety built into governance
- Accountability measures

2

Supporting role clarity and teamwork: Many staff aren't sure what their exact job is, what others are supposed to do, and how they can work together. This leads to confusion and slows things down. For teams to work well together, there needs to be:

- Proper orientation and ongoing training
- Clear information about roles
- Chances to learn with and from each other

4

Improving tools and learning culture: Outdated or disconnected technology, like electronic medical records or inconsistent data systems, makes people's jobs harder. Staff need:

- Better tools
- Real-time feedback and information
- Opportunities to learn and improve practice

5

Improving equity and Indigenous leadership: Staff noted that health services don't match what people in the community actually need. Indigenous leadership and cultural safety need to be an essential part of how care is planned, delivered, and led.

If communities are supported to make their wellness plans a reality, there is a real opportunity for positive change in the Northwest Territories in the coming years and to **have a new generation lead the future from a place of wellness and joy.**

1.5
What We Heard So Far:
System Leadership

Leaders from the health and social services system met to talk about the vision for Primary Health Care Reform [23]. They agreed that the system should focus on Indigenous Peoples, families, and communities, and make sure the system is fair, accessible, culturally safe, and anti-racist. To do this, we need to thoughtfully and intentionally remove barriers.

To make changes, the system needs strong supports, called 'enablers'. Enablers are tools, ideas, or actions that help make big changes in health care possible. They guide and help the system grow and improve. The leadership team identified seven system enablers, which are:

1. **A Positive and supportive workplace:** A learning health system starts with a workplace that supports learning, clear communication, and fairness. It should value culture and work together towards a clear vision.
2. **Putting people first:** Our system needs to be built around the needs of each person or family. This means working with Indigenous Peoples and communities in a respectful and meaningful way.
3. **Smart use of technology:** The health system should use up-to-date medical information technology systems. These systems should streamline processes and make care easier to access, while making sure information stays private.
4. **Focus on prevention:** The system should focus on preventing illness, not just treating it. It should be flexible enough to meet the changing needs of people and communities.
5. **Using data and flexible funding:** Funding decisions should be made using good, up-to-date information. Funding policies should be flexible and support new ideas and better services.
6. **Well-trained and connected teams:** Health staff need proper training and clear roles so they can do their jobs and work together well. This takes robust planning.
7. **Strong and lasting workforce:** The system needs to plan ahead to hire the right people for the right jobs and support their growth. We need to create opportunities for Indigenous staff and make sure we support them well.

1.6
The Mandate for Change

A Commitment to Fair and Accessible Care

The 20th Legislative Assembly of the Northwest Territories has promised to make health care more fair and easier to access in all communities.[24] Leaders understand that the current system does not work well for everyone, and that big changes are needed to fix it.

To meet this goal, the system needs to change in a way that respects reconciliation, equity, and listens to those most affected by unfair systems. This has to be done in a coordinated way across the health system.

Leadership for Transformation

Because of this promise, the Department of Health and Social Services asked the Community, Culture and Innovation team to lead this work. Their job is to help make health care more accessible and fair for Indigenous Peoples, support cultural safety, and bring different parts of the system together to work as a team.

This team supports innovation, especially led by Indigenous Peoples and communities. **They are creating a new plan called the Integrated Primary and Community Care Framework to guide these changes.**

Community, Culture and Innovation

The Community, Culture and Innovation team is guided by ideas approved by the Indigenous Advisory Body, an official group made up of senior members from Indigenous Government Organizations. This group gives advice and guidance on using Indigenous knowledge, traditions, language, culture, and healing practices into the health and social services system. The goal is to improve health care and outcomes for Indigenous Peoples by including Indigenous ways of knowing and doing throughout the system.

They are also responsible for reporting to and co-designing with the Council of Leaders Health and Social Services working group which includes Indigenous Government Organizations representatives.

Tools to Guide the Work

To meet the goals of the 20th Legislative Assembly, the team is creating two important tools:

- **Integrated Primary and Community Health Care Framework: This plan will guide how the system should change and improve.**
- **Performance Measurement Plan: This tool will track progress, support accountability, and show if the plan is creating real changes for communities.**

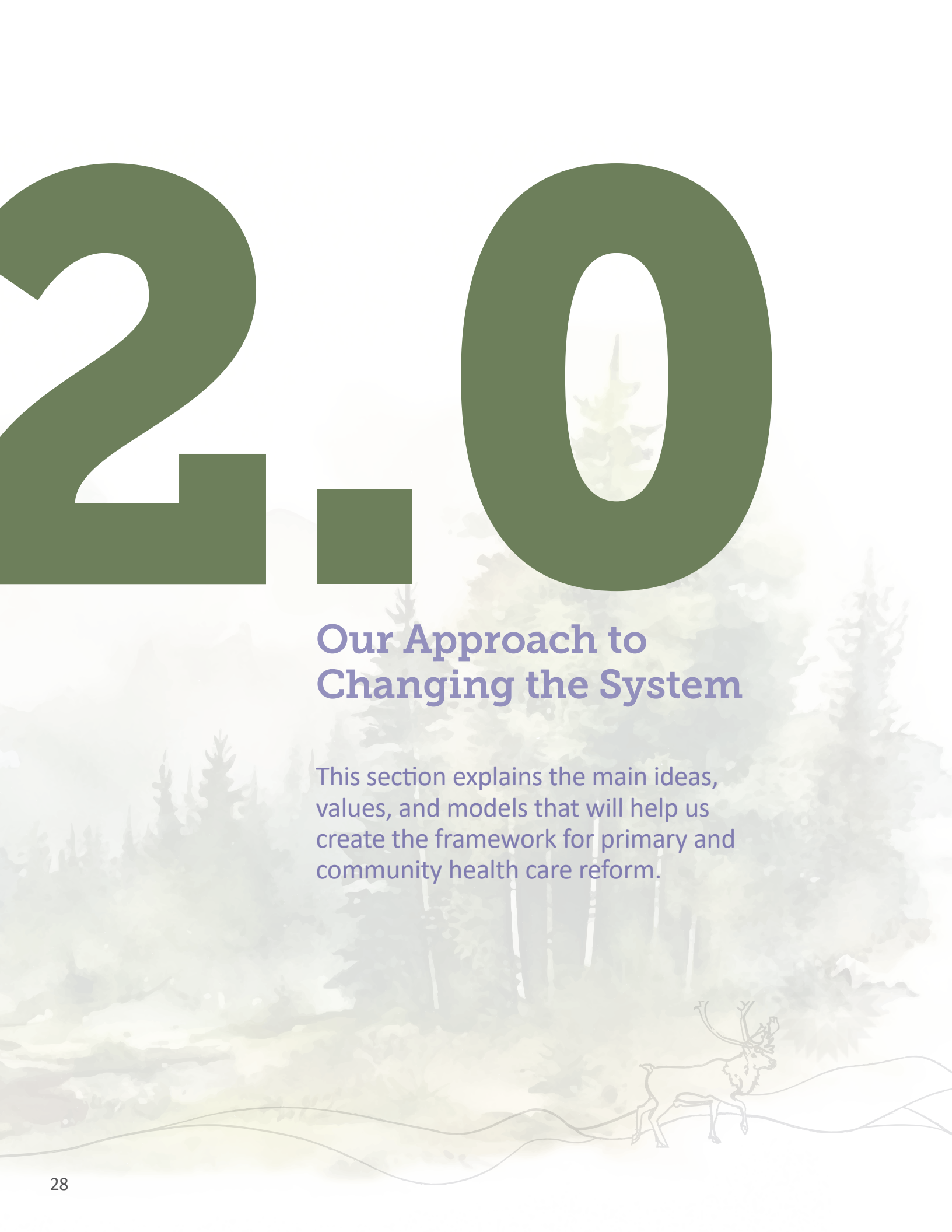
These tools are being created together with Indigenous Government Organizations, communities, frontline workers, and residents. This work is built on the belief that people most affected by problems in the system should help lead change.

The next sections will describe how the Community, Culture and Innovation team will build these tools, make sure there is accountability and transparency, and collect feedback along the way.

2.0

Our Approach to Changing the System

This section explains the main ideas, values, and models that will help us create the framework for primary and community health care reform.



2.1

Changing the System On Three Connected Levels

To help create the plan to improve the health system, we will use three main guidelines from the Health Standard Organizations (HSO):

- **HSO Standard on Integrated People-Centered Health Systems[1]**
- **HSO Standards on Cultural Safety and Humility[2]**
- **HSO Standard on Primary Health Care Services[3]**

These standards will work together to help create a system that is equitable, high-quality, and culturally safe. They show that change needs to happen at three connected levels[4,5]:

Micro-level: Where care happens

This is where people meet directly with doctors, nurses, and care providers. It's the part of the system that people experience the most. This level is about building trust, safety, and respect between clients and caregivers. This is where we see whether health services are easy-to-access.

Meso-level: Community and regional support

This level includes the organizations and teams that plan and deliver care in different communities and regions. It connects everyday experiences with broader planning and is where innovation happens. Changes at this level include:

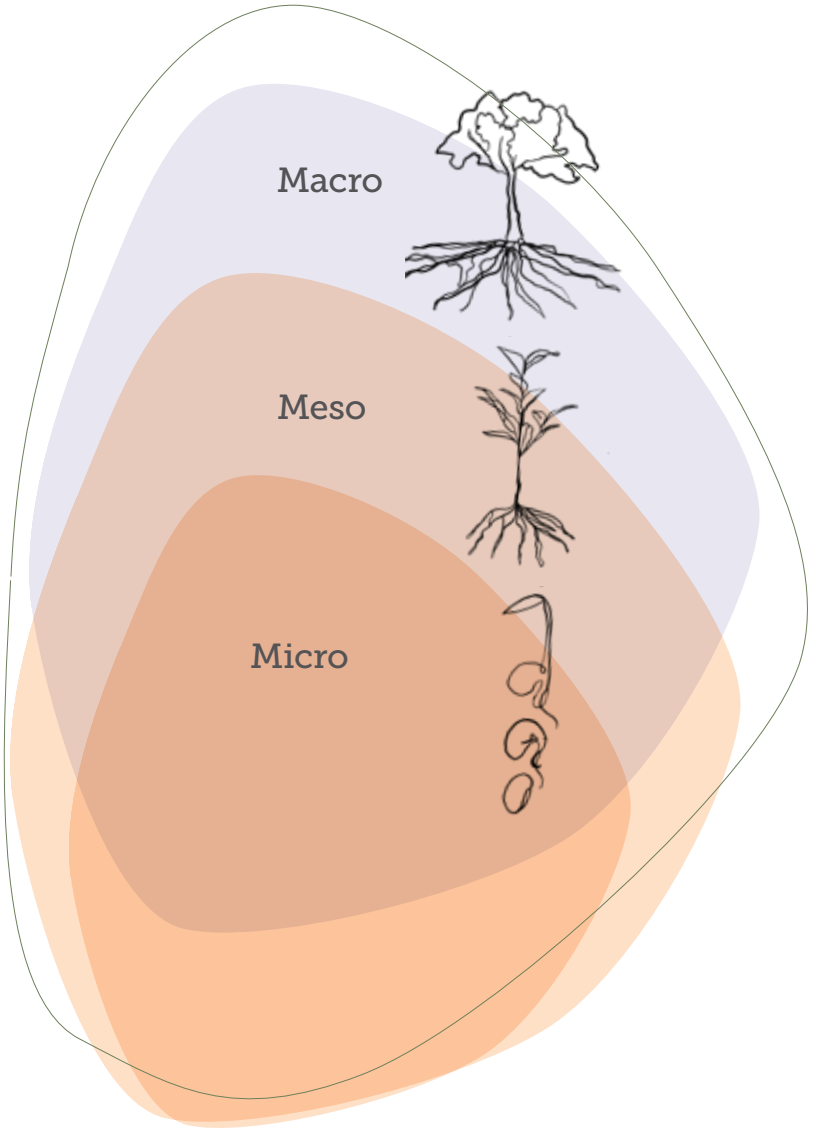
- **Creating integrated care models where services work together**
- **Supporting communities to help plan and evaluate care**
- **Encouraging teamwork and shared decision-making**

Macro-level: Big picture policies and leadership

This level is about the policies, funding, and leadership that shape the whole system. This is where structural change needs to happen to make transforming the health system possible. Key changes at this level include:

- **Making policy and funding fairer and more inclusive**
- **Supporting Indigenous leadership and decision-making**
- **Making cultural safety part of standards, laws, and data systems**

To truly fix the system, we need to change legislation and policy, support leadership, and how decisions are made, while respecting Indigenous rights and dismantling racism. We also need to invest in training and learning so that the system can keep improving over time.

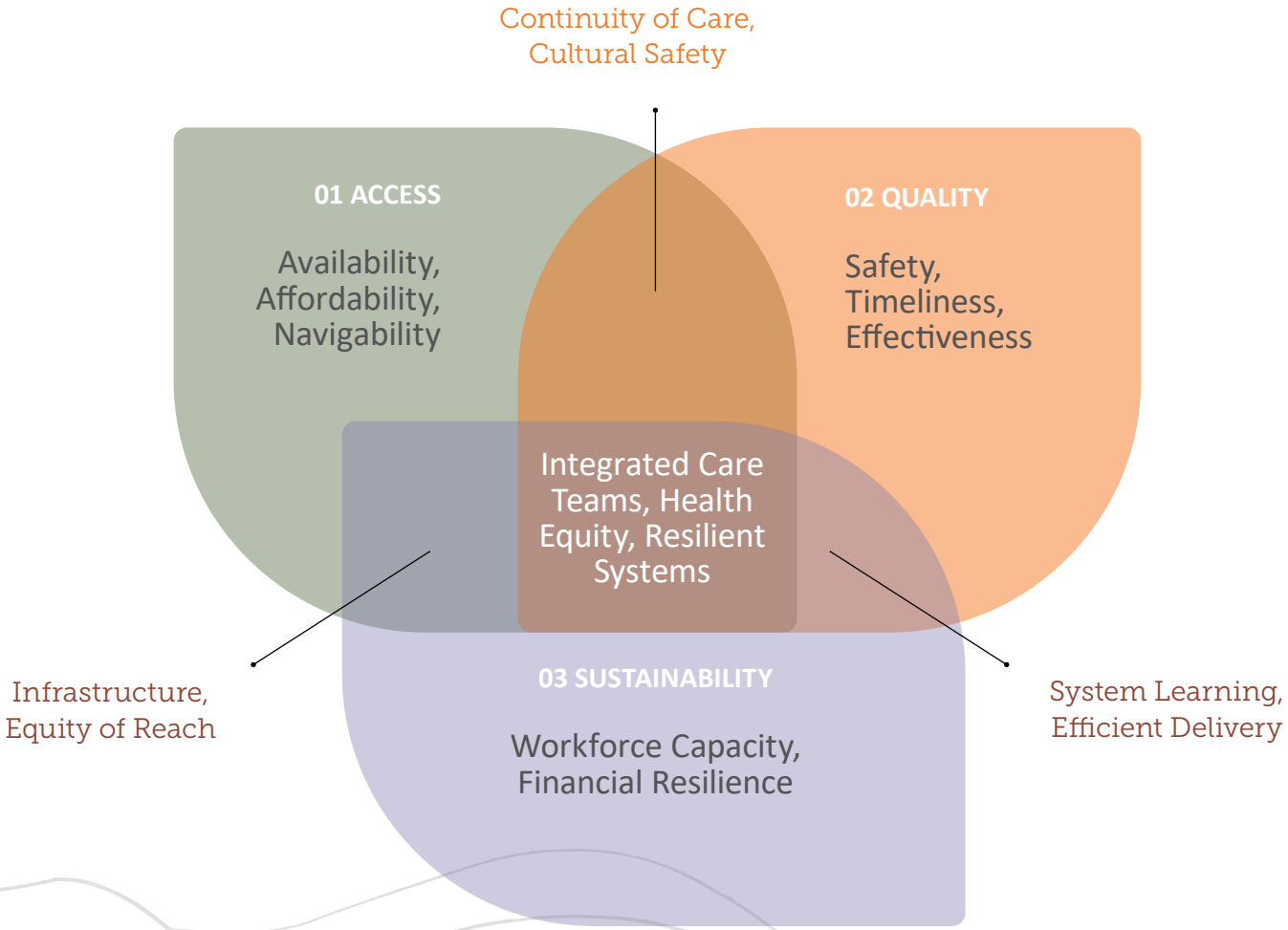


2.2
Changing the System by Looking Through Three Lenses

Improving primary and community health care isn't just about individual services. It means changing how people access care and how the system works behind the scenes. To guide this work, the framework will use **three important lenses (ways of looking at the system):**

- **Access** means making sure everyone can get the care they need.
- **Quality** means making sure care is safe, works well, and respects all cultures.
- **Sustainability** means the system can keep going strong over time and handle future challenges.

These three lenses work together to help shape planning, improve services, and transform the system.



Access

Equitable Access means making sure that everyone has a fair chance to get the care they need to be healthy in their own way. This means removing barriers like racism, gender inequality, lower income, where someone lives, and the ongoing impacts of colonialism. When these barriers are addressed, the health system works better for everyone.[6]

In the Northwest Territories, equitable access means:

- **Services are available:** Health care is available to everyone, in every community, when they need it - including evenings and weekends.
- **Services are adequate:** Health services meet the needs of each person throughout their health journey and respect a person's role in their own wellness.
- **Services are accessible:** Health services are easy to get, no matter what your community, housing situation, technical abilities, family needs, language, or culture.
- **Services are affordable:** Health care is affordable and doesn't cause financial stress.
- **Services are appropriate:** Health care is trauma-informed and person-centred and considers the unique context of community life in the Northwest Territories.

Quality

The Department of Health and Social Services and Northwest Territories Health and Social Services Authority measure health care quality to make sure its effective, learn areas for improvement, support accountability, and help guide policy and funding decisions. Health leaders use certain categories to evaluate the system. These evaluate if health care is:

- **Safe:** Care doesn't cause harm.
- **Effective:** Care is based on evidence and has the desired results.
- **Patient-Centered:** Care respects each person's preferences, needs, and values.
- **Timely:** Care is available without long waiting periods.
- **Efficient:** Care avoids wasting time, money, and resources.
- **Equitable:** Care is designed to support the health of everyone with the involvement of the communities they serve.

In many places, equity is treated as just one part of what makes a health system high-quality. In the Northwest Territories, there is a push to make equity a cross-cutting value across all areas of care.[7,8]

So far, the health and social services system hasn't had a shared or consistent way to define what quality care means. And Indigenous knowledge and experiences haven't been meaningfully included in evaluations of health care quality either. Indigenous Peoples often see health in a more holistic way, connected to relationships, land, and community.

The Primary and Community Health Care Framework will define **Domains of Quality** for the health care and social services system in a way that puts equity at the center of all health care decisions.[9] Indigenous ways of knowing and being will be centered, including Indigenous definitions of health and community wellbeing. Cultural safety, anti-racism, and self-determination will be embedded into the framework.

Sustainability

Sustainability means the health system can keep working well - even during pandemics, climate change and environmental emergencies, and staff shortages.

In the Northwest Territories, sustainability isn't just about money. It's also about strong relationships, a healthy and supported workforce, and caring for the land. This requires steady funding, eco-friendly practices, and strong leadership.

Building a resilient health system in the Northwest Territories means:

- **Supporting health care workers with training, mental health support, and good working conditions.**
- **Making sure funding is steady and matches the needs of communities.**
- **Improving services by cutting red tape, making things easier to understand, and encouraging new ideas.**
- **Helping the system adapt and improve by supporting learning, responsive policies, and continuous improvement.**
- **Shifting from a reactive model to an adaptive model that plans for change.**

Equity as the Cross-Cutting Feature

Often, the three lenses of access, quality, and sustainability are considered separately. But they're all connected, and equity is central to all three. Equity means giving everyone what they need to succeed, rather than treating everyone exactly the same.

To truly support equity, the system needs to understand intersectionality.[10] Intersectionality means that people can experience several forms of advantages or disadvantages at once - such as race, Indigeneity, gender, language, geography, disability, class, age, and 2SLGBTQIA+ identity. These types of discrimination overlap and compound each other.

The health system needs to understand these overlapping experiences and design services that are flexible and personalized. Evaluations need to collect data that shows how different groups are affected and involve people with lived experiences in creating solutions. This will help the system build care that meets real needs and avoid one-size-fits-all solutions.

Equity in health care means more than just including everyone. It means the system needs to understand where the problems are, know why they happen, and design services that meet the needs of those most affected. A **life-course approach** looks at how health is shaped over time, from early childhood through to older age.

It includes how big life changes, like pregnancy, chronic illness, or aging affect health and care needs. In the Northwest Territories context, this means we need to design health care by understanding the needs of Indigenous Peoples, racialized communities, people living in poverty, 2SLGBTQIA+ individuals, people with disabilities, and others who face systemic barriers to health.

Using a life-course approach will help us:

- **Identify key points where care can have a lasting positive impact.**
- **Build care plans and teams that fit the needs of different groups of people.**
- **Focus on helping people who face many challenges at once.**

By combining the life-course approach with a focus on equity, this framework will make sure that transformation is designed for not only who people are, but also when and how they need care. This approach supports the idea that everyone has the right to good health care at every stage of life, in all communities in the Northwest Territories.

Racism and Poverty

A person experiencing racism and poverty is more likely to receive delayed care and experience trauma while trying to access care. They are also less likely to be believed when seeking care and to have support navigating the system.

2.3
Building Strong Integrated Care Teams

Team-based care models, like Integrated Primary Care Teams, are a way to organize primary care so that it can better meet the needs of the people and communities it serves. It can also help address and improve areas where people face unfair barriers in the system[7,11,12]. When done well, these teams connect clients to a consistent group of providers who work together. This may include doctors, nurse practitioners, social workers, Elders, midwives, rehabilitation therapists, traditional healers, and other providers[13–15]. Together, they offer care that is coordinated, ongoing, and person-centered.

In the Northwest Territories, the goal is to build care teams that match the unique goals of each community. To achieve this, we are learning from the best models used in other parts of Canada, including Indigenous-led care models[9,16,17]. Health leaders including Chief Operating Officers, Area Medical Directors, and a regional planning team will work with Indigenous clients, Indigenous Governments Organizations, health staff, and administrators to design these teams. We hope to have fully functional integrated care teams by 2028.

To make this transformation work with equity as a core value, we need to create an anti-racist environment, both in how the system works and in how people are treated. We need to build respectful and transparent relationships rooted in trust and trauma-informed practice with First Nations, Métis, and Inuit clients.

To help guide this work, we will follow 10 design principles from the Integrated People-Centred Health Systems framework (created by the Health Standards Organization)[1]. These principles help make sure care is designed, delivered, and evaluated in a way that puts individuals and communities first.

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3.0

Methodology: Working Together in a Good Way

This section describes how we will create the Primary and Community Health Care Framework. We will bring together Indigenous and Western ways of knowing to engage people and organizations, create the framework, and put it into action.

3.1
Research as Way to Repair

In the past, research and systems have often harmed Indigenous communities. These harms happened when Indigenous voices were left out, Western ways of doing things were seen as more important, and colonial power structures were used to control others.[1–3]

To build a better health system, we need to do research differently. Research should not just be about writing reports - it should help build trust, relationships, and shared understanding[4,5,6]. That means we need to recognize past and current harms, question and challenge colonial power structures, and respect and include Indigenous knowledge and ways of knowing[7,8].

This new approach to creating a framework and measurement plan will combine numbers and statistics with stories, lived experiences, and Indigenous knowledge.

The way we do research is just as important as what we find. Māori scholar Linda Tuhiwai Smith says that

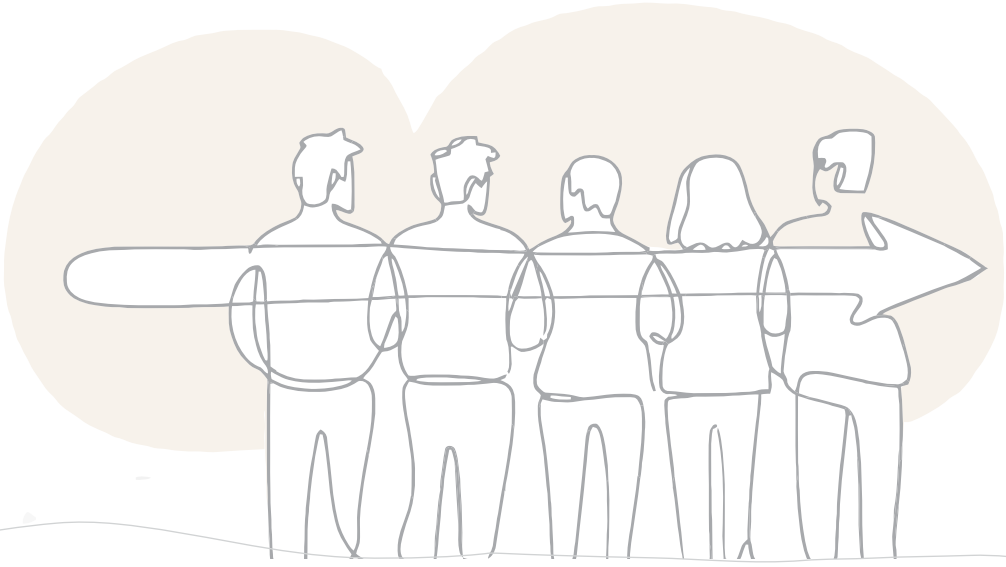
> "research should respect people, help communities heal, and support the right for Indigenous Peoples to make decisions about their own lives and futures.[9]

This means working with and for communities, not studying them. It means bringing Western and Indigenous sciences together in a shared learning space and holding people accountable[9,10]. When we do this, we will bring people together with honesty and a commitment to do better. This will:

- **Recognize and repair harms by supporting Indigenous leadership,**
- **Build long-term relationships, instead of just gathering information and leaving,**
- **Value different ways of knowing, without forcing Indigenous knowledge to fit Western models,**
- **Help us design programs and systems with communities, not just for them.**

We're moving away from old ways of doing research towards participatory approaches. The table below describes this shift.

Moving From ⇨	Moving Towards
Only addressing what we can see ⇨	**Exploring root causes and deeper sources of issues in health and wellness**
Taking information from communities ⇨	**Using information in a way that gives communities power over their health and wellness**
Working on issues as separate from the whole system ⇨	**Recognizing that all issues are interconnected and related to each other and the whole system**
Centering Western science and research methods ⇨	**Prioritizing Indigenous knowledge and ways of knowing, and working well with both Indigenous and Western science**
Relying on experts and bureaucrats to design systems ⇨	**Designing services for and with the people affected by the health care system**
Engaging communities repeatedly to design brand-new approaches ⇨	**Looking at old ways and seeing what has and hasn't worked, and adapting and improving systems**
Creating rigid programs and systems that can't change ⇨	**Creating a 'learning health system' that uses data and adapts in an ongoing way**



3.2
Guiding Principles for Change: A System Built on Trust, Equity, and Indigenous Leadership

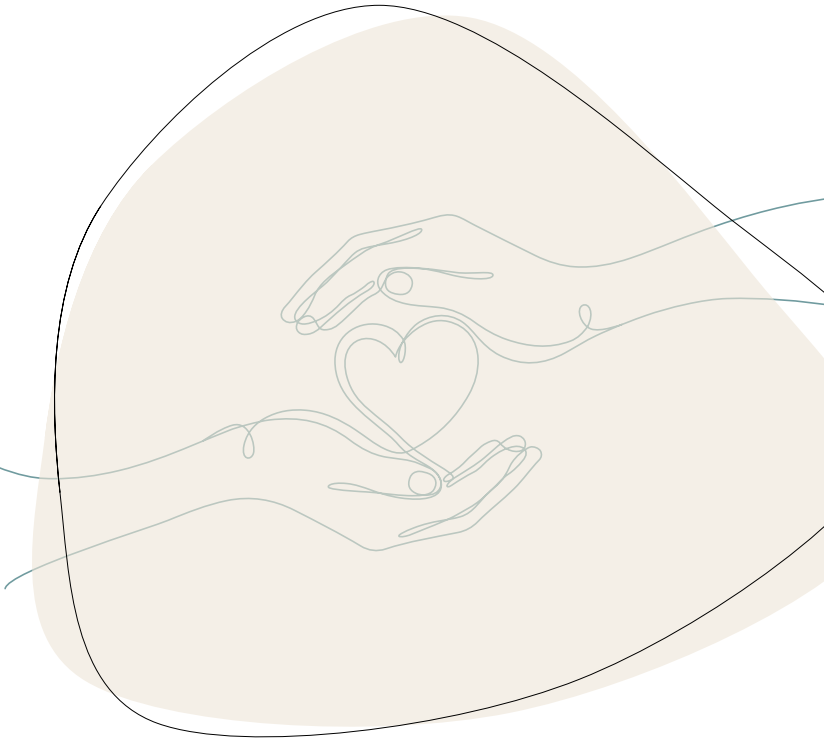
In the coming months, people across the Northwest Territories, including community members, health workers, Indigenous Government Organizations, and researchers, will work together to improve access to health care. The goal is to create a system built on trust, respect, and community leadership.

This means changing who holds power, how decisions are made, and what knowledge is valued. Indigenous governments will be co-leads in shaping the system. This includes:

- **Setting priorities**
- **Making decisions**
- **Making sure the system is doing what it promises**
- **Creating space for truth-telling and healing**
- **Using Indigenous values and lived experiences to co-design services**

It also means setting up ways to keep learning with and from each other, adapt to change, and rebuild trust when relationships are harmed.

The goal is a territory where Indigenous Peoples enjoy full wellness, including physical, mental, emotional, and spiritual health. To get there, we need to work together to remove barriers in the system. This means addressing unfair power imbalances, as well as making sure care is culturally safe and trauma-informed. It will take an anti-racist approach that honours Indigenous rights and leadership, and allows space for reflection and learning.



Design Process: How We'll Work Together

Work with Indigenous Government Organizations, the Regional Wellness Councils, Council of Client Experience, Indigenous Advisory Body, and the Council of Leaders Health and Social Services working group to define what the problems are and what success looks like.

Hold meetings in community-led spaces and use oral, visual, and land-based methods to learn and design together.

Include Indigenous co-leads in every step from design to project governance, through co-chair roles and shared decision-making.

Start every session with activities to build trust and create positive and safe working spaces.

Make sure to keep existing community and Indigenous practices, such as Traditional Healing or Indigenous midwifery.

3.3
Working Together Through Shared Governance

This transformation is being co-designed with Indigenous governments and leaders in structured and ongoing ways, sharing power and decisions.[11,12] It's being done by:

- **An Indigenous-led Council,** supported by the Office of Client Experience, holding special sessions on Primary Health Care Reform. In these sessions, people will build on research, engagement, and evidence reviews to develop shared understanding and turn what we learn into plans for system change.
- **Regular updates and shared decision-making will happen through the Indigenous Advisory Body**, the Council of Leaders Health and Social Services working group, and Regional Wellness Councils. These groups will make sure changes reflect what communities want and follow Indigenous ways of knowing.

3.4
Questions to Guide the Work

- What have Indigenous communities already told us about their vision, priorities, values, and needs for health and wellness?
- How can we make sure everyone, including and especially Indigenous Peoples, has equitable access to good-quality health care?

Rapid Scoping Review 1: Indigenous-Centred Team-Based Care Models

RESEARCH AIM: To identify and describe Indigenous-centered primary and community team-based care model (within Canada and internationally) that reflect a holistic understanding of health and wellness and can inform primary health care reform in the Northwest Territories.

Research Questions:

- **What key design elements** define Indigenous-centered primary and community team-based care models?
- **What outcomes** should Indigenous-centered team-based models of primary and community care strive to achieve?
- **How do these models** incorporate Indigenous knowledge and practices into everyday primary and community care?

Rapid Scoping Review 2: Patient Attachment, Rostering, and Registration

RESEARCH AIM: To clarify the meaning and implementation of patient attachment, rostering, and paneling in the NWT, and to identify equity-centred and culturally safe approaches that ensure equitable, effective, and practical access to primary care.

Research Questions:

- **How have jurisdictions** defined and operationalized attachment, rostering, and paneling in primary care, including the unit of attachment, triage processes, and enrollment workflows?
- **What promising practices** exist for assigning patients to integrated primary care teams that account for equity, complexity, cultural safety, and continuity of care?
- **What impacts** and unintended consequences do different attachment approaches have for Indigenous Peoples, particularly on access, continuity, experience, and equity?

Rapid Scoping Review 3: Domains of Health Quality

Research Question:

- **What frameworks** exist for defining and measuring health care quality from both Indigenous and Western worldviews, and what are their core domains and methods of evaluation?

4.0

Design Phases

This section describes the four overlapping phases we will use to build the framework:

1. Gathering Information
2. Engaging Indigenous Peoples and the Public
3. Building Understanding and Developing the Framework
4. Moving from Understanding to Taking Action

Design Phases

The methodology for developing the Primary and Community Health Care framework follows a cyclical and iterative process that reflects how knowledge is generated, shared, and applied in relationship with communities. This approach acknowledges the unique ecosystems and Arctic context of the Northwest Territories. Rather than a linear sequence, these phases are interwoven, allowing for real-time learning, and system responsiveness.

PHASE 01

Evidence Gathering and Synthesis

The evidence gathering phase involves systematically gathering and synthesizing evidence to inform the foundation of the framework, including understanding current challenges and gaps, assessing needs, and identifying opportunities that are context-specific and relevant to the Northwest Territories. This phase works to build a strong evidence base that is grounded in grounded in data, shareholder insights, and real-world context rather than being based on assumptions.

PHASE 02

Indigenous and Public Engagement

To develop a transformative primary and community care integrated framework requires that we prioritize communities and relationships by meaningfully involving those most impacted in the process and integrate lived experiences, expertise, values, and priorities of both communities and frontline staff. Meaningful engagement is essential to repair trust and foster shared ownership where clients and staff feel heard, supported and reflected in the new model. A multi-phased engagement approach will be undertaken to inform the PHCR transformation efforts with the intention to advance equity and inclusion for NWT residents and, in particular, Indigenous Peoples.

PHASE 03

Meaning-Making and Framework Development

This phase focuses on supporting co-design, drafting, and refining core components of the framework and performance measurement plan by integrating evidence with community engagement insights and system change strategies. Then research will be synthesized. Meaning-making tables will be established to oversee and validate the translation of evidence into practice. Rooted in relational and participatory practices, meaning-making tables serve as spaces for collective reflection, dialogue, and knowledge interpretation.

PHASE 04

From Meaning Making to Action-Applying Methodology in Real System

This phase focuses on the implementation of a living, actionable framework. It is common for large frameworks to articulate what needs to change, without clarity on how to make change happen at all three levels needed for transformation. Change management and principles of large-scale transformation will be embedded into both the framework content and the approach to developing it.

The Primary and Community Health Care framework is being created step-by-step with a focus on learning, testing ideas, and improving over time. This way of working helps everyone learn with and from each other, share ideas, and use what they learn in their communities as they go. This approach also respects the land, people, and unique ways of life in the Northwest Territories. These steps don't happen one at a time. Instead, they overlap and build on each other so the system can learn, grow, and adapt in real time.

4.1
Phase 1: Gathering Information

In this first phase, we collect and review information to help build a strong base for the framework. This means looking at current problems and gaps in health care, understanding what people need, and exploring what might work well in the Northwest Territories.

This step includes real data, lived experiences, and ideas from people involved to make sure the framework responds to the real needs of the system.

4.2
Phase 2: Engaging Indigenous People and the Public

To build a better health care system, we need to focus on strong relationships and meaningfully including the people most affected. This means listening to the experiences, values, and needs of both community members and health workers. When we include their voices, we can rebuild trust and create a sense of shared responsibility. This is a key step in making sure people feel heard, supported, and represented.

We are using a multi-step approach to make sure voices from all Northwest Territories residents are heard, especially Indigenous Peoples. This approach includes:

1. Indigenous Engagements: Working with Indigenous Government Organizations and Indigenous Peoples to listen and learn from their perspectives.
2. Public Engagements: Using surveys, questionnaires, online tools, and in-person engagement, including professionals, professional associations, Regional Wellness Councils, community wellness coordinators, and community organizations.
3. Health and Social Services Staff Engagements: Involving health and social services staff and leadership to understand what's working and what needs to change.

4.3
Phase 3: Building Understanding and Developing the Framework

In this phase, we start putting together the main parts of the framework using what we have learned from the earlier phases. We will track our progress using ongoing research and what we hear from communities, while actively making changes to improve the system.

This starts by turning what we learned from Phase 1 and 2 into draft framework sections, such as Indigenous-centered care models, definitions of health and wellness, and how to measure health care quality. These sections will be developed with GNWT leads, using plain-language summaries, templates, and visuals that match NWT priorities, values, and health system realities.

To make sure the research is designed together and inclusive of multiple perspectives, we will host “meaning-making tables.”

Meaning-making tables are spaces where people can come together to share stories and knowledge, reflect on what the research tells us, and make decisions together. They are a place where Indigenous and Western ways of understanding health will be combined. These tables are built on relationships, trust, and shared decision-making. They will include the Indigenous-led Council, supported by the Office of Client Experience.

4.4
Phase 4: Moving from Understanding to Taking Action

In this phase, we will begin using the framework to make real changes. In many cases, large frameworks are created that say what needs to change, without explaining how to make change happen. This phase will help teams gain skills and knowledge that will help them use the framework across communities and regions. The co-design toolkit (described in section 5) will help people work together to make changes in practice, planning, and policy that move us closer to the overall goal of a health system that works for everyone.

Action Plan

What is the action?	Where are we at now?	What is planned by March 2026?	How will it inform the Framework?
What We've Heard from Patients and Community Voices			
ACTION 1: Cancer Sharing Circles			
Facilitated gatherings for Indigenous Peoples with lived experience of cancer to share stories, knowledge and healing in community.	**Held in Yellowknife and Fort Good Hope.**	Summary report shared.	Adds patients voice and culturally grounded insights to "What We've Heard" and recommendations.
ACTION 2: Review Indigenous Wellness Plans and priorities			
Synthesizes community-owned wellness plans as foundational sources of health vision, priorities and actions.	**Themes summarized**.	Validated with Indigenous Advisory Body, and Council of Leaders Health and Social Services working group; report published.	Reflects Indigenous-defined priorities in "What We've Heard".

= **complete**

What is the action?	Where are we at now?	What is planned by March 2026?	How will it inform the Framework?
ACTION 3: Review past engagement reports (2015-2025)			
Analyzes over a decade of past engagement to surface existing truths, avoid engagement fatigue, and honour prior contributions.	**Reports reviewed and themed.**	Validated, summarized, and published both in a report and visually.	Strengthens legitimacy and continuity of "What We've Heard".
ACTION 4: Indigenous engagement activities			
Interactive pop-up booths for low-barrier, informal spaces in public venues to promote equitable care and gather feedback.	**Planning, arts-based tools, questions, and promotional materials completed.**	September – December 2025 in multiple communities across regions.	Add grounded, local knowledge to the "What We've Heard" section; supports equity-driven recommendations tailored to remote and Indigenous contexts.
Dehcho Journey Mapping to understand patient experiences across the continuum of care in remote communities including medical travel. Aligned with the Public Administrator's workplan.	Journey mapping tools selected; trauma-informed approaches and consent form under development.	Travel with patients in the Dehcho region; Fall 2025.	Add grounded, local knowledge to the "What We've Heard" section; identify barriers, delays, disconnections, and culturally unsafe touchpoints. Inform the redesign of care pathways and client navigator supports.

What is the action?	Where are we at now?	What is planned by March 2026?	How will it inform the Framework?
Culture-centered diabetes workshops in the Dehcho and Tłı̨chǫ regions to reimagine chronic disease management using land-based, intergenerational, and Indigenous-led wellness approaches.	**Collaborative planning underway with Dehcho First Nations; Contribution Agreement in place with Tłı̨chǫ Government**.	Community-based workshops, traditional food preparation, storytelling, physical activity, and knowledge sharing. Participant feedback and evaluation of key learning reported.	Demonstrates integrated, culturally appropriate models of care; inform the "Models of Care" and "Traditional Healing" sections with practical examples.
Community Wellness Fairs and Territorial Wellness Gathering to bring Indigenous communities together to share wellness resources, build relationships, and celebrate strengths.	Design concept on mental health and wellness completed, planning underway.	Wellness fairs through Fall 2025; Territorial Wellness Gathering in December 2025.	Build social cohesion and trust across communities and systems; supports community-specific input for Framework actions; respond to community priorities.
ACTION 5: Community organizations' roundtable and youth workshops			
Create spaces for equity-deserving groups to express health needs and ideas through facilitated dialogue and to center voices of youth, seniors, Elders, families, and equity-serving and equity-deserving groups.	**Roundtables completed; youth workshop held.**	Inuvik roundtable; public summary report.	"What We've Heard" section sharing diverse community voices.

What is the action?	Where are we at now?	What is planned by March 2026?	How will it inform the Framework?
Arts-based youth workshops.	**Urban youth arts-based engagement workshops hosted in Yellowknife.**	Public summary report.	Findings summarized in a "What We've Heard" section sharing youth priorities.
ACTION 6: Public engagement tools			
Encouraged territorial feedback and transparency.	***Our Care* survey supported; Patient Experience survey launched.**	Analyze and share NWT-specific data.	Broad public input, accessible and transparent communication.
Models of Care and Health System Innovation			
ACTION 7: Jurisdictional scan and small community care models			
Insights to explore new approaches to community health center service delivery models, including support from other health care providers.	**Final report completed.**	Share as evidence in Meaning Making Tables.	Shapes "Models of Care" section with examples, and comparative learning.
ACTION 8: Evaluation of virtual team-based care in Fort Good Hope			
Demonstration site with dedicated physician virtual and in-person support as part of a team; evaluation to understand experiences of patients and staff.	Evaluation framework developed; data collection underway.	Interviews with staff and patients November 2025; evaluation report published.	Contributes NWT insight to "Models of care"; determine scalability and patient/staff experience of virtual models.

What is the action?	Where are we at now?	What is planned by March 2026?	How will it inform the Framework?
ACTION 9: Scoping review of Indigenous-centered team-based care			
Explores international and national Indigenous-led team models, including design, roles, and community governance.	**Research questions completed.**	Scoping review completed and published.	Strengthens "Models of care" rooted in Indigenous innovation and team design.
ACTION 10: Scoping review of principles of attaching patients to integrated primary care teams			
Explore definitions of attachment, understanding the promising practices and understanding different approaches to patient attachment, related outcomes, and consideration for equity.	**Research questions completed.**	Complete review and publish findings.	Informs "Principles of attachment" with evidence and equity considerations.
ACTION 11: Scoping review of Indigenous Quality of Care			
Redefines what quality means in health care using Indigenous worldviews and evaluation methods.	**Research questions completed.**	Complete review and publish findings.	Shapes new domains and performance indicators in "Re-defining quality".

What is the action?	Where are we at now?	What is planned by March 2026?	How will it inform the Framework?
ACTION 12: Traditional Healing integration review			
Explore Traditional Healing practices and Indigenous knowledge integration into team-based approaches.	**Five reports and assessments completed.**	Host Indigenous Knowledge Holders gathering; identify system-level change.	Expands "Models of care" and Traditional Healing pathways.
ACTION 13: National study tour on Indigenous-led models of primary care			
Learn from Indigenous models that advance culturally safe, community-led, team-based primary care models.	**Phase one tour completed.**	Tour completed; learning shared publicly.	Supports "Models of care" and integration of Traditional Healing.
Staff Voices and Enablers for Change			
ACTION 14: Professional Associations engagement			
Gather insights from professionals on system enablers.	Outcome mapping tool selected.	Sessions held; report compiled.	"What We've Heard"; systems enablers from frontline and leadership perspectives.
ACTION 15: HSS staff workshops on PHCR enablers			
Create a space for staff to inform primary health care reform building blocks.	Outcome mapping tool selected.	Sessions held; report compiled.	Build shared ownership and grounds recommendations in frontline experiences.

What is the action?	Where are we at now?	What is planned by March 2026?	How will it inform the Framework?
ACTION 16: Revive governance of Client Experience Office			
Reactivates governance structure for the Office of Client Experience and Indigenous Patient Advocates.	Terms of References under review.	Meetings resumed; lessons learned reviewed.	Ensure governance perspective informs Meaning Making and implementation.
Meaning-Making			
ACTION 17: Indigenous Innovation Health Summit			
Host a collaborative, Indigenous-led event to synthesize learnings, define shared vision, and co-create priorities.	Summit concept, facilitation approach and interest confirmed.	Summit held; meaning made from Phase 1 and 2 evidence.	Phase 3; build co-ownership and a robust Framework and implementation.

5.0

Co-Design Toolkit: Community-Driven Transformation in Practice

This section presents a co-design toolkit as a foundational resource for supporting integrated primary health care reform. It will enable regional, interdisciplinary planning teams alongside community partners to redesign care in ways that reflect the lived experience, values, and priorities of Indigenous communities and frontline staff.

5.1
What is the Co-Design Toolkit?

The Co-Design Toolkit was made to create better health services that are culturally safe and respond to the unique needs and priorities of communities. This toolkit is more than a set of tools - it represents a way of thinking that will help our health system lead, collaborate, create, and adapt models that work well and reflect what communities value and need. It gives step-by-step guidance to Northwest Territories regional planning teams to plan for, build, test out, and evaluate locally developed models of care.

Regional teams include health workers from different fields and 1-2 community members who take part equally in the design process. This helps ground the process in lived experience and local knowledge. While the work is done at the regional level, it is rooted in the cultural and geographic realities of each community.

The toolkit is built on best practices in health care system change, cultural safety, and anti-racism. It includes support for two kinds of changes:

- **Technical:** how teams are set up, how care is delivered, and how people access services.
- **Relational:** building trust, improving cultural safety, dismantling racist structures, and strengthening relationships

The toolkit draws from the NUKA System of Care, which supports community ownership and ongoing learning, and the Health Standards Organization's ten principles of integrated service delivery. It was developed by representatives from seven GNWT departments, led by Health and Social Services and Education, Culture and Employment. It was tested and adapted for Primary Health Care Reform to make sure it aligns with the goals of regional teams and Indigenous community leadership.

The toolkit includes:

- **Session-based guides**
- **Activities to encourage reflection**
- **Presentations**
- **Planning templates**

Key pillars of the toolkit:

- Cultural safety: Making sure Indigenous people feel respected, valued, and free from racism and discrimination when getting care.
- Relationship-based care: Building trust and strong, ongoing connections between care providers and the individuals, families, and communities they serve.
- Anti-racism: Identifying and dismantling racism in all forms - in systems, organizations, and personal interactions.
- Access: Making sure Indigenous communities can get the health and social services they need, by addressing geographical, cultural, and systemic barriers.

5.2
Using the Toolkit

The co-design toolkit builds the conditions for trust, supports shared leadership, and gives power back to communities so they can decide what health and wellness should look like.

This way of working will help the Northwest Territories build integrated care models that not only work well but are also respectful of culture and based on strong relationships. It will help us design care from the ground up, with communities at the centre.

Working While Learning: Real-Time Change

This toolkit follows a "working while learning" approach, which means teams will start making changes as the framework continues to develop and adapt. Health systems that do this are called "learning health systems," because they can learn from feedback and adapt while continuing to provide care. This approach supports Indigenous self-determination and aims to repair past harms.

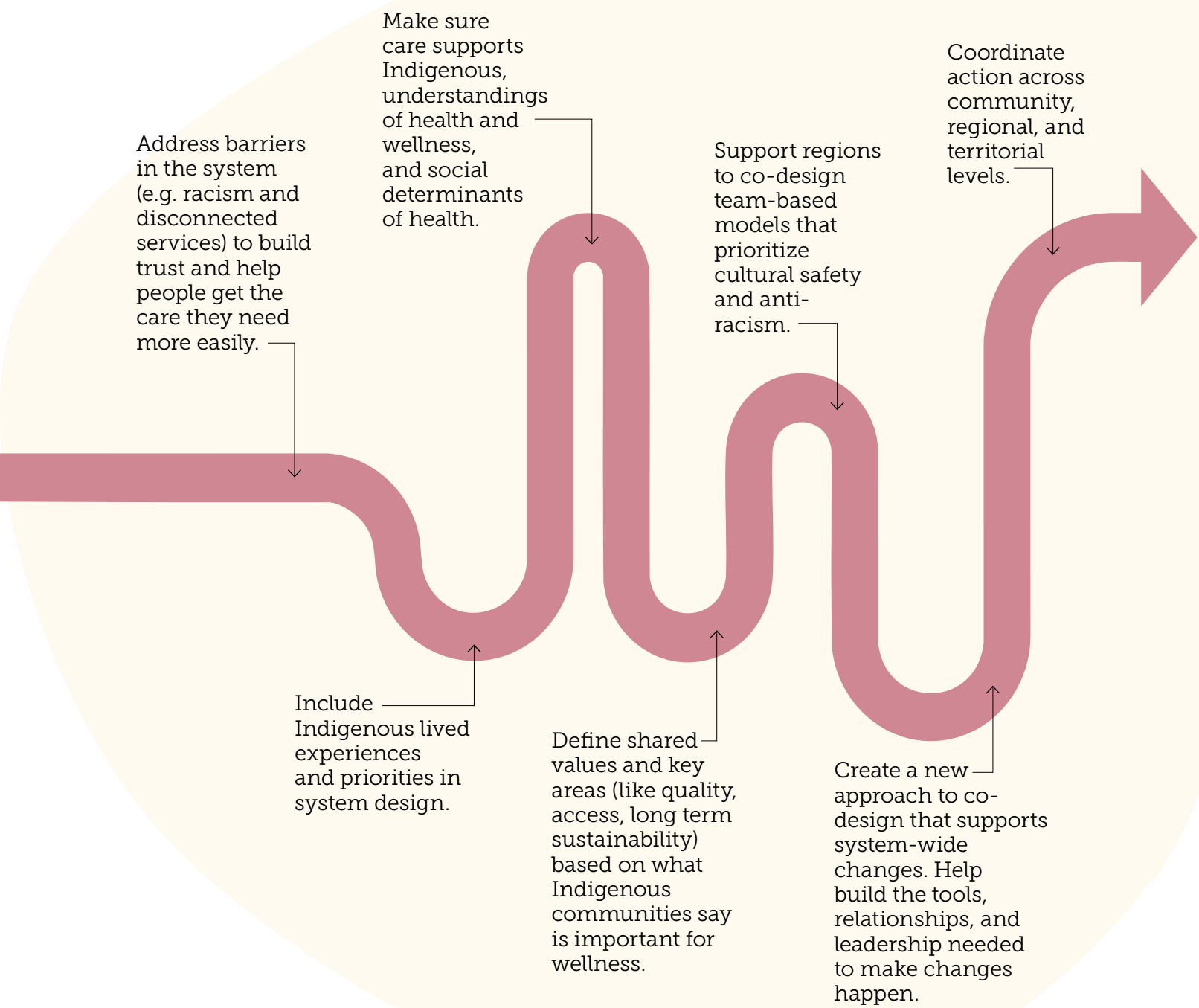
5.3
Implementation and Iteration

This toolkit will be rolled out in the following steps:

1. Two regional teams will start using the toolkit and share feedback to help improve it.
2. Skilled facilitators will guide teams through the co-design process using flexible session plans that meet local needs.
3. Toolkit materials will be available online to make them easy to access and use.
4. Progress will be reviewed and evaluated using participant feedback, facilitator reflections, and community case studies. This information will help us continually improve the toolkit.
5. The toolkit will be updated regularly by a working group that includes Indigenous voices, plain language editors, designers, and knowledge sharing experts.

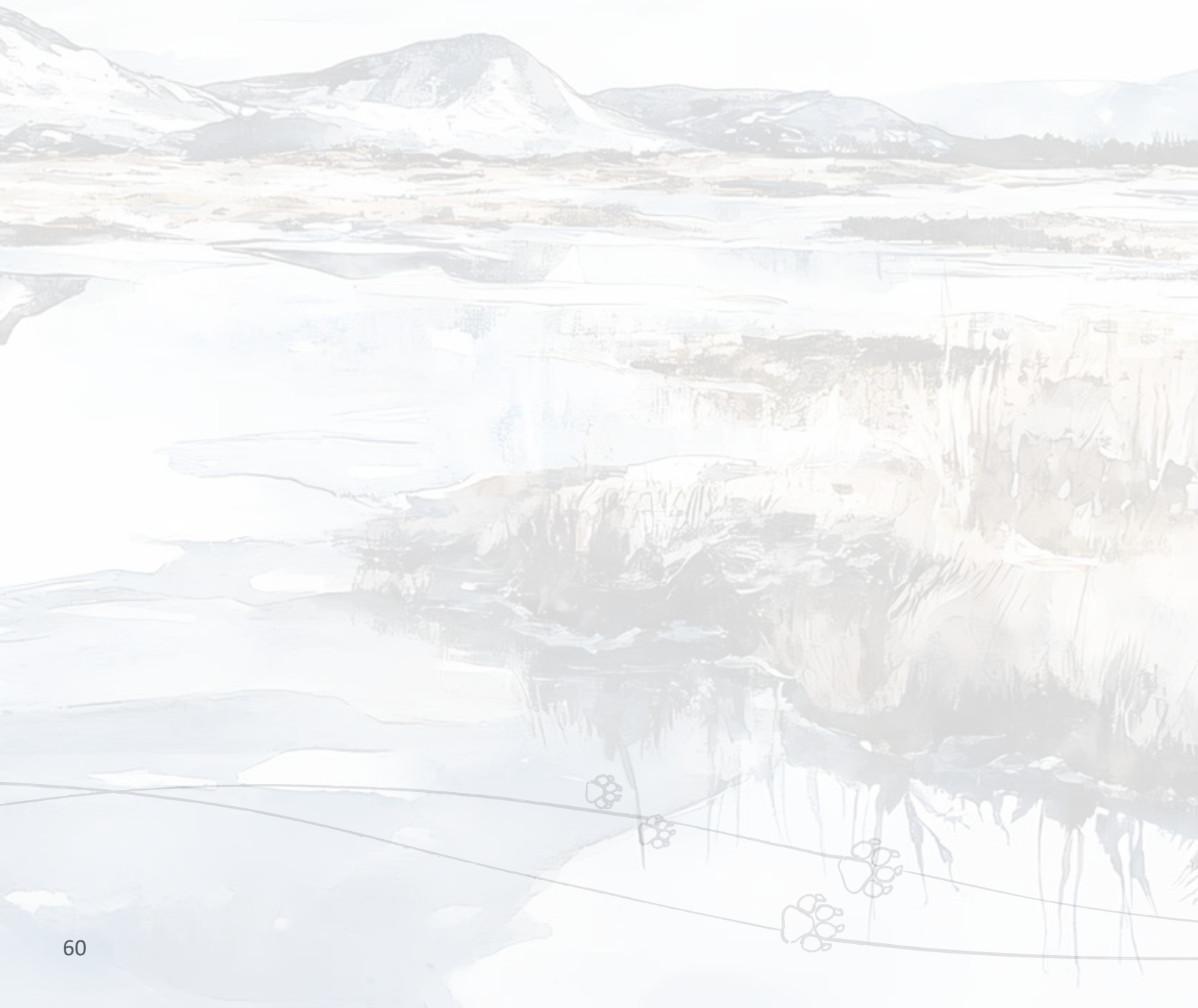
The Path Forward: Time For Transformative Change

What bold changes are needed to make sure primary and small community care is equitable and culturally safe for Indigenous people in the Northwest Territories?



Glossary

Appendix A
Glossary of Terms



Anti-racism means taking action to identify, stop, and prevent racism in all its forms.

Cultural safety is an outcome where Indigenous peoples feel safe, respected, and free of racism and discrimination when accessing health and social services.[1]

Equity means making sure everyone has what they need to be successful. It understands that everyone starts from different places and have different needs.[2]

Equitable Access means everyone has the opportunity to get the care they need to live a healthy life. It means removing barriers associated with socioeconomic status, race, gender, geographic location, and the ongoing and historic impacts of colonialism.

Equity-deserving group is a group of people who face barriers that prevent them from having the same access to the resources and opportunities as everyone else. (Government of Canada, Guide on EDI Terminology)

Equity-oriented health care is health care that tries to reduce the harm caused by (1) racism, discrimination and stigma,(2) systems set up in unfair ways, and (3) health services that don't meet the needs of people most impacted by health and social inequities.[3]

Ethical Space is when people from different backgrounds and worldviews work together with respect and fairness. It is about making a choice to engage with one another and address social and political inequities.[4,5]

Inclusion means creating spaces where many voices are heard, especially those most affected by unfair systems. Their ideas help define policy and practice and help shape organizational culture.

Primary health care is the first level of essential health and social care that people usually access. It is designed to bring health services as close as possible to where people live and work. It includes doctor and nurse visits, diagnosis and treatment, referrals to specialized service, population health, health promotion, preventative care, community-based care, chronic disease management, client engagement, virtual care, self-management and self-care, care coordination, social determinants of health, interprofessional and team-based care, mental health and wellness, cultural safety, and trauma-informed care.[6,7]

Person-centred care means putting an individual's needs, preferences, and values in the centre in health care. It shifts the focus from illness to one where individuals, families, and communities are active partners in their care and influence how care works. This approach emphasizes dignity, respect, and personalized care to support individuals in managing their health and well-being.[6]

Racism is when people are treated unfairly because of their race. It includes how power and systems are used to advantage white people based on race while oppressing Indigenous people, Black people and people of colour. It is a system designed to build and maintain white supremacy. There are different types of racism:

1. **Institutional Racism:** When resources, workplaces, practices, policies, and procedures favour whiteness and cause harm to Indigenous people, Black people, and people of color. Institutional racism relies on social and cultural norms, values, worldviews, habits, and expectations that favour white people.
2. **Cultural Racism:** When beliefs, narratives, standards, and norms reinforce the racial hierarchy. These are stories that make white people seem better and Indigenous people, Black people and people of colour as less than.
3. **Individual Racism:** When people hold personal attitudes and behaviours that consciously or unconsciously view racial groups negatively. This can come from learned ideas, beliefs and behaviours that say white people are better than others, and therefore should be treated differently.[8,9]

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