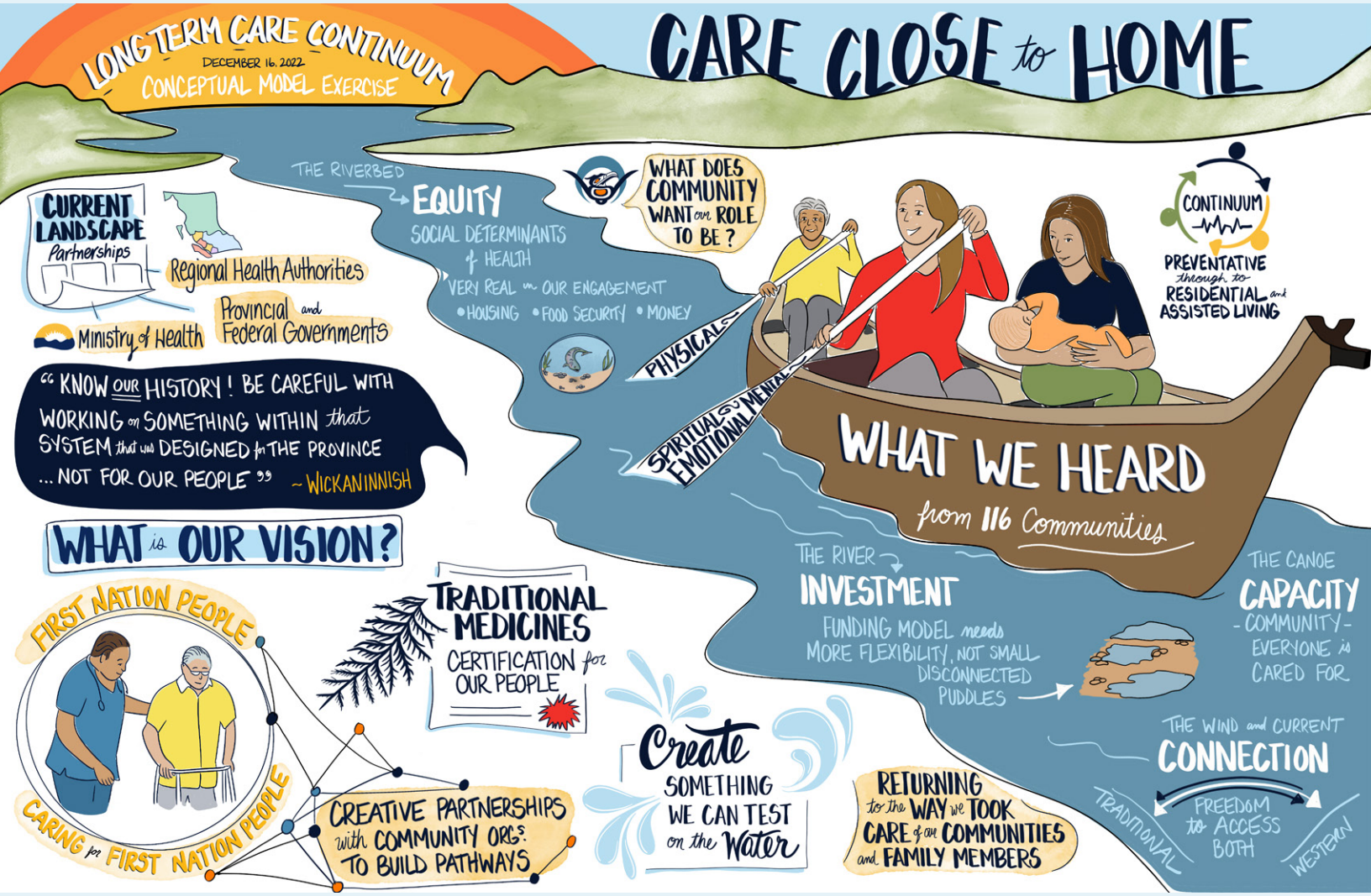
Engagement Report 2022

First Nations Health Authority
Health through wellness

CARE CLOSE TO HOME

OFFICE OF CHIEF NURSING OFFICER,
FIRST NATIONS HEALTH AUTHORITY



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Executive Summary

Background

In 2022, the First Nations Health Authority (FNHA) undertook engagement with community health staff in all five regions in British Columbia. The intention of the engagement was to learn if current community health systems are working and if not, what would improve the system. This report highlights what was heard from community.

Results

The FNHA project team received 301 responses from 129 communities via focus groups and surveys. We heard that people want to be supported to remain at home, incorporating spiritual and emotional wellness in health programs. Communities identified challenges but also shared their unique solutions. Analysis of the responses identify four key themes:

With the exception of communities situated in urban versus remote areas, there was no significant variance in the responses from the FNHA's five regions.

CARE CLOSE TO HOME

1. Equity	2. Connection	3. Capacity	4. Investment
housing food security cost of living transportation	health system partners & pathways	wellness through culture recruit & retain family caregivers community relationships	flexible funding

A model, based on feedback from community, is proposed as a path forward for future possibilities; however, validation with community is needed.

The following are suggested possibilities:

- FNHA could create opportunities with its partnerships and connections to improve housing (remediation, modifications, and new builds) through flexible housing solutions.
- FNHA could collaborate with communities and partners to develop strategies to integrate the acceptance and financial support of Traditional Healers, Medicine Person and Knowledge Keepers within the circle of care and funded services.
- FNHA could work with communities and service partners (RHA, MOH, FNHA, and education systems) to develop creative strategies to retain, recruit and train health care workers for First Nations communities.
- FNHA could work with partners to ensure respite services are accessible for family caregivers.
- FNHA could work with partners to eradicate the inequity within First Nation communities to access foods -including traditional.
- FNHA in partnership with ISC, Health Canada and AFN could ensure creative funding allocations addressing remoteness factor, to expand health care services in communities and embed funding flexibility to support a community-driven, Nation-based approach to service delivery and design that meets the unique and evolving needs of communities.
- FNHA will strengthen and support virtual service delivery and general connectivity for First Nations communities, particularly those who live in remote and rural settings.

Introduction

The First Nations Health Authority (FNHA) engaged First Nations living in BC on issues and gaps in long-term and continuing care using a strength based approach. The findings of these engagements will inform options for the co-development of wholistic integrated cultural health and wellness care close to home for First Nations. The project is guided by the First Nations Perspective on Health and Wellness and FNHA's vision, mission statements and seven directives. For further description, see Appendix A.

According to First Nations perspective, shifting to a continuum of care approach means looking beyond the focus on disease and illness to a suite of programs and services that put health and wellness at the center across the lifespan from womb to spirit. We hope that community voices highlighted in this document will offer a clearer understanding of current community health systems that are working well and those that could be improved.

Method

Engagement data reflects the history and context of BC First Nations wholistic view of health, the challenges, strengths and possibilities for change. To gather this data, the project team created a variety of strategies and also worked with regional engagement directors, using an engagement framework [1] (see table 1 below). A mixed methods design was employed to learn from First Nations of BC through qualitative and quantitative data collection. Engagement activities occurred between May 1, 2022 and December 1, 2022.

Table 1: Engagement Participation

ENGAGEMENT TYPE	NUMBER OF PARTICIPANTS	DATE	PARTICIPANT REPRESENTATION
Health Care Assistant conference	62	May 2022	Health care assistants
Clinical Expert Interviews	2	Aug-Sept 2022	FNHDA, FNHA
Regional Focus Groups	97	Aug-Sept 2022	Community Health Staff, Chiefs & Council
Provincial Focus Groups	3	August	FNHA Regional Nurse Managers
Community-Facing Survey	81	Aug-Sept 2022	Community Health Staff
Health Education forum	56	Nov-Dec 2022	Community Health/ Home Care Nurses
TOTAL	301		

The two surveys emphasized the voluntary and confidential commitment of the project team to any feedback received online. Online feedback questions included multiple choice, Likert scale and free flowing options. All questions were strength-based.

For more detail on the method and specifically the questions, see Appendix B, Appendix C and Appendix D.

Analysis of Data

The analysis and findings come from listening to the voices of 301 people who reflect 129 First Nations communities across BC. Table 2 breaks down the number of participants and communities by region.

1 IAP2 Spectrum of Participation

Table 2: Engagement Participation by Region

REGION	NUMBER OF PARTICIPANTS	NUMBER OF FIRST NATIONS COMMUNITIES
Vancouver Island	68	36
Interior	84	32
Vancouver Costal	43	13
Northern	65	28
Fraser Salish	37	20
Other	4	
TOTAL	301	129

For a geographical visual of the First Nations staff who participated in engagement, see this interactive map :

FNHA Long Term Care - Community Consultations – Google My Maps

The clinical team analyzed anonymized qualitative and quantitative data, drawing on three types of data collected concurrently between May and December: regional online focus groups, online surveys and face-to-face conference sessions. An interpretive thematic analysis was conducted of the interview and survey data. Wise practices, quotes, recommendations and gaps were organized under the ISC issues (see Appendix E for issue list). Data were carefully reviewed to identify recurring and contradictory patterns, and possible linkages to the First Nations perspective on health and wellness (see Appendix A). As data were analyzed, coding categories were refined and the analysis shifted to a conceptual representation of themes pertaining to the impact and implications of community health programs and services. Sketching the data as a canoe on a river further helped distill the data into four themes (see Figure 2).

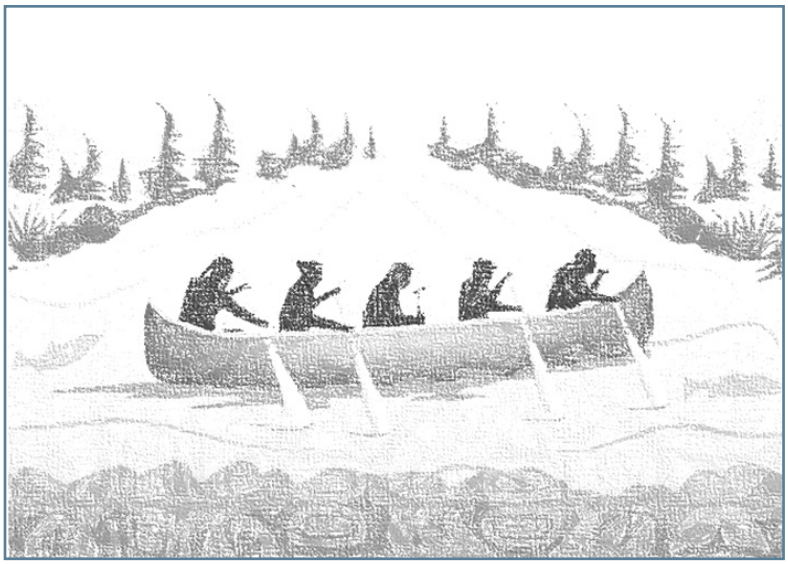


Figure 1: What was Heard during Engagement

EQUITY = Riverbed

The riverbed represents equity and is the foundation for health and wellness. The riverbed is essential to contain the river, the life within the river and the canoe. The riverbed represents basic human needs. We heard that housing, food security, cost of living and transportation makes a difference to health and wellness for First Nations people.

INVESTMENT = Water

Water represents investment. The smaller the amount of water in the riverbed, the more restricted and difficult the journey. We heard many frustrated people describe funding like small, disconnected inaccessible puddles and that there is more opportunity in a river full of water.

CAPACITY = Canoe

The canoe, paddlers and paddles reflects the community. The canoe is important to transform funding into positive outcomes. In the canoe, there is representation of the full spectrum of life from womb to spirit world. All members are valued on the wellness journey. Paddles represent the mental, emotional, spiritual and physical aspects of the wellness journey. How members are able to move these paddles and canoe through the water is affected by the environment, wind and currents.

CONNECTIONS = Environment, Wind and Currents

The environment, wind and currents represent connections outside the community which can impact the canoe to move forward easily or with challenges on the wellness journey. We heard communities describe connections with their regional health authority and other nonprofit organizations. These connections support the pathways to seamless, culturally safe and accessible care.

Limitations

Because we did not engage with people living urban and away from home, the results cannot be generalized to every BC First Nations context. Furthermore, many people declined invitations to provide feedback. Upon exploration, we heard that the project title from Indigenous Services Canada (ISC) *Long Term Continuum of Care* is confusing and suggests that that the engagement is only about older people and long-term care facilities. After the engagement, an Elder gifted us the more inclusive title, *Wholistic Integrated Cultural Health and Wellness.*

Our focus for engagement was with First Nations community health staff, including those who do not identify as Indigenous and those who are not members of the communities they serve.

We also heard from regional engagement teams that community commitment to attend was challenging, given the seasonal activities, multiple competing requests for engagement and continued restrictions imposed by the pandemic. Further engagement and validation could help better understand and provide considerations and recommendations.

Results

67%
do not have access to speech pathologists

52%
do not have access to occupational therapists

46%
do not have access to physiotherapists

25%
do not have access to a family physician

35%
do not have access to a dentist

32%
do not have access to an optometrist

17%
do not have access to health care aides

21%
do not have access to home care nurses

26%
have no access to foot care nurses

Care Close to Home

Participants want programs and services to support all First Nations people to remain safely at home- from womb to spirit. Many participants described the lack of access to services in their communities as a core challenge to remaining at home or in community. Services available in community were variable and highly dependent on infrastructure, geographic location (remote versus urban), and financial support in community. Those who are not able to receive services at home generally face long distances to seek the care they require. Access to services was also limited due to inadequate transportation and availability.

"Most times, there is nobody available to bring them to appointment because that means taking time off work, and if unpaid, that is not an option due to high cost of living. More remote communities have added challenges due to their vehicles not being in good shape to make the trip. An additional 1- 3 hours' drive for the appointment"

One example of people needing to leave their families and land is for admission into a long-term care facility. According to BC Ministry of Health, there are five assisted living and/or complex care facilities on reserve land in BC. For a list of facilities, see table 3.

Table 3: Assisted Living (AL) and Complex Care (CC) Homes on BC Reserve Land [2]

FACILITY NAME	FACILITY TYPE	HA NAME	CITY	ADDRESS	POSTAL CODE
Lakeview Lodge	CC	Interior	West Kelowna	2337 Butt Road	V4T3L3
Tsawaayuus (Rainbow Gardens)	10 AL 44 CC	Vancouver Island	Port Alberni	6151 Russell Place	V9Y7W3
R. W. Large Memorial Hospital	CC	Vancouver Coastal	Bella Bella	88 Waglisla Street	V0T1Z0
Ts'i'ts'uwatul' Lelum	AL	Vancouver Island	Duncan	5755 Allenby Road	V9L0E6
Jesken Aerie (Golden eagle nest)	60 AL	Vancouver Island	Langford	817 Goldstream Ave	V9B2X8
Cormorant Island Health Centre	CC	Vancouver Island	Alert Bay	49 School Road	V0N1A0

FNHA Health Surveillance team created an online interactive map to understand the distances communities face when seeking health care[3].

Figure 2: Screenshot of Interactive Map showing distances to services for Ahousaht as an example.

Facility	Name	Operator	City	km	hr
Mental Health	Ahousaht	Columbian Centre Society	Nanaimo	200.8	3.2
Hospice	Ahousaht	Vancouver Island Health Authority - Home & Community Care	Port Alberni	127.6	2
Substance Use	Ahousaht	Edgewood Holdings 2013 Ltd.	Nanaimo	201.9	3.1
Long Term Care	Ahousaht	Westcoast Native Health Care Society	Port Alberni	121.3	1.9
Community Living	Ahousaht	Port Alberni Association For Community Living	Port Alberni	121.8	2
Acquired Brain Injury	Ahousaht	HD Management Inc.	Nanaimo	205.5	3.2

"In order to remain living at home, members need a safe environment/home, retain mobility, consistent safe caregivers, good nutrition, and a way to engage/socialize with the larger community"

In order to explore programs and services to support care close to home, feedback and sharing was broken down into the following themes of Equity, Connection, Capacity and Investment with detailed descriptions.

2 Office of the Senior Advocate (OSA) facility directory: https://www.seniorsadvocatebc.ca/quickfacts/location/

3 The link is too large to share in this report but a zip drive can be provided upon request.

Theme 1: Equity

Engagement feedback highlighted the need to address social determinants of health through system changes. The FNHA engagement sessions illuminated inequities for those living in BC First Nations communities, which negatively influences an individual's ability to attain a reasonable standard for health and wellness. These inequities fall under social determinants of health (food security, cost of living, transportation and housing). Meeting basic needs provides the foundation to health. The following sections (housing, food and cost of living) will highlight what we heard.

Housing

Without a safe place to call home, focusing on health and wellness is difficult. Some engagement participants noted that members have been moving back to community due to the impact of high cost of living in urban centers. The influx of members is further straining housing accessibility in community where there is already a housing shortage, especially homes large enough for multigenerational families. For those requiring care, remaining at home often means home renovations to maintain mobility and independence (e.g., grab bars). In some instances, members must first remediate their home to address mold or structural damage to ensure the safe installation of medical aids and equipment. There is limited support for home remediation. Although medical equipment can be provided through FNHA's Health Benefits, finding and paying professionals to install the equipment is not covered.

When asked about home renovations

40%

of survey respondents shared that it is not possible to do home renovations or adaptations.

Participants shared creative ways First Nations have been providing housing supports to members including installing a shower, washer and dryer in the health center for anyone to use, using recreational vehicles during the summer months to provide homes to under housed members, paying for home renovations such as ramps, and using hotels for convalescence. Some First Nations communities provide support for remediation.

One community is embedding accessibility into housing plans by requiring all new houses be built without stairs. Some communities described a need for multi-use housing grounded in the flexibility to meet evolving community needs and supported by visits from the health care providers (e.g., elders, youth aging out of care, people in crisis, people seeking safety, people in transition, waiting for home renovations, convalescent care, fluctuations in health for stabilization, etc.).

"The past 6 months have been a dramatic shift. I know that the nation housing waitlist has kind of exploded. With many people in urban centres being displaced and looking to home and looking and wanting to come home."

"Perhaps transition planning for homes is an idea; as community members age homes are visited and accessed for the home owners and modifications made to avoid accidents i.e. Ramps vs stairs, arm rails in hallways, toilet and bathroom modifications. At times families cannot afford the financial burden and the client ends up in an institution. If there was a gradual modification looking at prevention rather than after the fact situations families may be better able to cope."

Living Costs

Participants reported a number of creative ways in which communities are supporting members to meet basic costs of living. For example, one community provides a new pair of shoes annually to all members while another community offers a stipend. Transportation represents a significant out-of-pocket expense for medical appointments so some communities enhance where health benefits support is insufficient. Many communities provide gift cards and gift baskets for people with chronic issues, pregnant and new parents. Meals are often provided at a community level on a regular basis.

"Our community members do request for patient travel which covers maybe half the cost it actually takes. Often community members have to hire a driver and they charge much more than what patient travel gives. Some are fortunate enough to have family members or friends to take them out of the community, but there are a lot who miss specialist appointments because they can't secure transportation to the visit."

Foods

Access to healthy food on a regular basis can be challenging for people living in remote and rural communities. There is a wide variety of provincial and regional grants for food access, including traditional foods. The challenge with grants is having the resource to locate, complete, coordinate and follow up on the grant applications. During regional focus groups, we heard community health staff asking one another about how and where to locate grants.

Participants described programs in community, which offers access to nutrient dense and traditional foods. For example, one community started a program to distribute healthy food for expectant or new parents, and many communities have gardens where vegetables are grown and distributed during summer.

"Traditional Healing is Traditional Foods"

Theme 2: Connections with Health Partners

The value of strong connections between communities and health system partners were shared. For example, nurses with prior employment with the regional health authority described drawing upon their past relationships to advocate for seamless transitions between hospital and home. One nurse described access to the electronic medical record, which enhanced the ability to offer the same care as the regional health authority. Another nurse identified the value of having regional health authority staff hold clinic in the community. Formalized lines of communication or standardized pathways between regional health authorities and community health staff were highlighted as a potential significant benefit.

> *"I have experience working in [RHA] as well … we need standardization in First Nations communities. We need access to EMR [electronic medical record] and other technology. We are not efficient and considering the current staff shortages, we can be more efficient so we can spend more time with clients"*

> *"RHA providing services on reserve. Going to the health centre and holding space there for appointments. Community does not want to access the RHA buildings because of negative experiences in the past or fear of bad treatment. But community feels safer at the health centres surrounded by their people".*

Virtual Services

Ten percent (10%) of survey respondents indicated that attending medical appointments away from home is generally not possible. Virtual services are seen as a helpful opportunity to connect clients to the services they require, especially those that are not easily accessible in communities. The FNHA Virtual Doctor of the Day was specifically identified as a core beneficial support, which connects clients to care.

> *"We do not have access to telehealth equipment"*

Theme 3: Capacity

Community driven resources are needed in communities to respond to the unique and evolving needs. Participants described a need for additional funding to support land-based healers, youth coordinators, elder coordinators, drivers and traditional wellness practitioners who can support people to remain at home and in community for as long as possible.

Wellness through Culture

Participants want access to not only conventional (western) medicine but also to traditional healers and medicine. Many voices asked that there not be an either/or approach but to hold both perspectives in equal regard. Participants imagined a system level transformation where all health care providers understand and accept traditional wellness and medicines alongside western medicinal practice.

36%
of survey respondants did not have access to traditional healers

32%
did not have access to traditional medicines

74%
did not have access to an Indigenous End of Life Guide

"In my view, the term 'traditional healing' is fluid and actually a way of being or living one's life. It is not only one form of plants, or medicines, or drumming/ smudging .. it takes on many nuances, sometimes very subtle activities that IS traditional by being passed down within a family or everyday wellness. 'Traditional Medicine' to me is connecting with land based harvesting, hunting and out spending the day in the mountains with family and fresh air etc. There is a sense of accomplishment in preserving food, hunting, storing for one's family. This is connection, this is health/wealth"

"We have elders, knowledge keepers and traditional healers as a part of our primary care team who incorporate these teachings in their time with community members. Assistance in supporting them to create programs would be fantastic".

Recruit and Retain

We heard from participants about recruitment, retention and capacity. Fist Nations are often unable to offer competitive salaries, which contributes to recruitment and retention challenges. Participants were clear that providing wages equal to other health service organizations (e.g., RHAs) in the province would help support increased recruitment and retention.

Participants also clearly identified the desire to be cared for "by their own". Creative strategies, such as pathways for community members to choose careers in health care in their home communities, can reduce staff turnover and strengthen services available closer to home. One health director shared that 97% of community health staff are First Nation members of the local community. As a result, cultural safety training is not required, staff freely participate in celebrations and there is minimal staff turnover in this community.

> ***"If the health care system in community has the proper leadership/ management in place, with optimal resources, and clear process/ procedures, content staff, then yes it can work well. If not, there is no consistency of care, unhappy staff, and client dissatisfaction."***

Family Care Givers

There was a clear preference for family to provide care to support community members to remain at home for as long as possible. Participants shared that families often understand their role in caring for one another; however, doing so can cause stress, for example, in cases where people leave a job to provide care and the financial impact that may have. Few participants could identify formal supports for family caregivers available in community to alleviate burn out and increase the well-being of the families and clients.

> ***"More support for respite services … you witness changes and burnout among family members. Along with isolation among our elderly clients, a respite worker can help alleviate family burden and increase the well-being of client and family."***
>
> ***"Offering financial support to caregivers would increase care, decrease distress, and help people stay at home."***

Community Relationships

Building trust with both communities and individuals sets the foundation for care.

For example, we heard one story from a participant who described a frail community member who refused health services. The participant would bring a daily meal to the client in order to establish a trusting relationship. Once the trust between the provider and the client was established, nursing services were accepted. A participant described the importance of mutual respect between members and health care providers. She described how she explains to members what they can expect when they go to an emergency department so they are less likely to think they are being ignored during long wait times. In her words *"All it is, is being a kind human being."*

> ***"[…] a lot of community members are reluctant to seek care at [hospital] due to bad hospital experiences. Something to improve the care Indigenous people receive at [hospital] would be better or having an alternative option to seek urgent care. I have seen one too many clients that should be receiving urgent care but are reluctant due to stigmas etc. I think having more Indigenous approach for urgent care is necessary, and would help diagnose issues before they worsen to the point that someone is incapacitated to care for themselves."***

Theme 4: Investment

Participants described frustration for the process of grant finding, writing and submitting. Throughout the focus groups, community health staff were interested to learn how other communities managed to pay for different strategies.

A request frequently heard from health care assistants was for flexible funding so their hours of work can match the changing health needs of the member. For example, there is presently no flexibility for staff to visit members after four o'clock nor on weekends nor statutory holidays. In instances where there is no family in community available to support, the health care assistant often finds the member in difficult circumstances Monday morning after two days with no home support.

> ***"Have one go to place to get assessments and funding rather than jumping through multiple hoops and having to go through multiple people"***

Discussion

With the exception of communities situated in urban versus remote areas, there was no significant variance in the responses from the FNHA's five regions. Some participants suggested creating a remoteness factor in the funding calculation to ensure an equitable approach to resource allocation. Another health leader requested provincial meetings based upon size of community (small, medium and large).

Current conventional programs support mental and physical health. Engagement participants identified the importance of ensuring resource support also be available for spiritual and emotional wellness. This would be integral to the cultural traditions and ways of the community. According to Greenwood and colleagues, *"Spiritual Health is also crucial to the healing necessary to overcome the traumas of colonization that have manifested in a wide range of physical and mental health problems prevalent in indigenous communities."*[4]

The Path Forward

To reflect the many voices from community and envision a path forward, the project team created a model. This model remains a draft until validation with community can occur.

4 Greenwood, M., de Leeuw, S., and, Lindsey, N., Reading, C. Eds. (2015) Determinants of Indigenous Peoples' Health in Canada: Beyond the Social. Canada Scholars Press, Toronto :xviii.

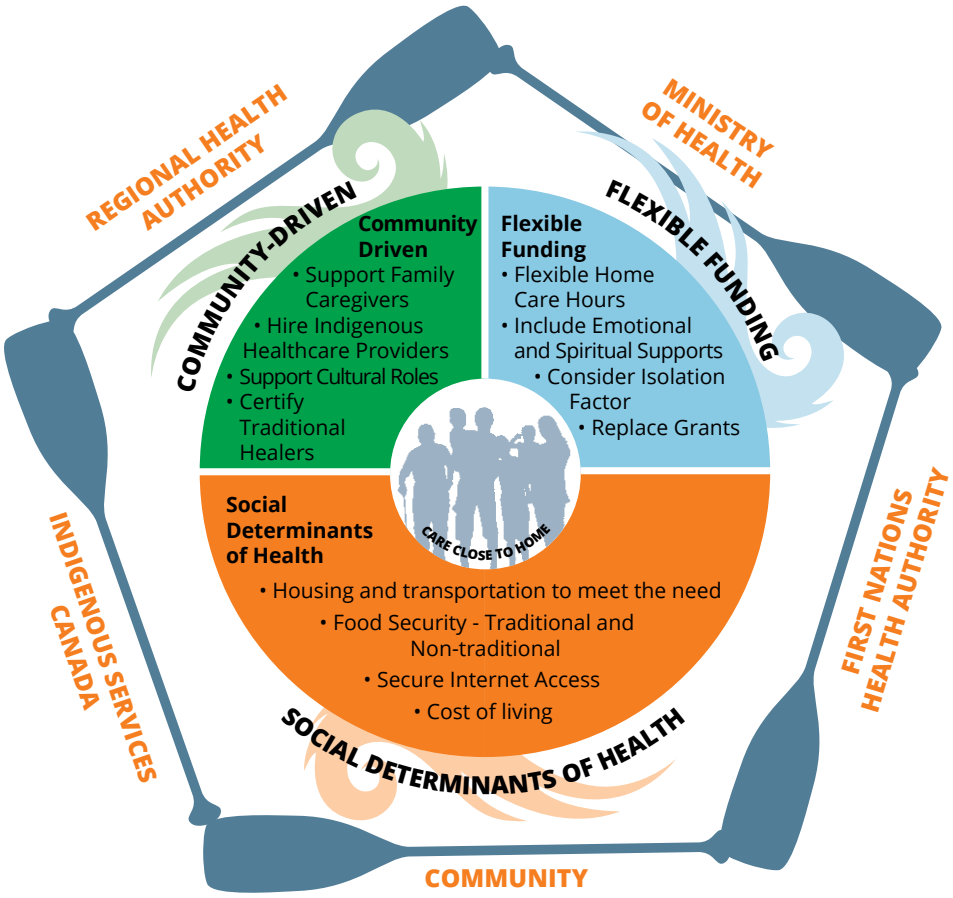


Figure 3: *Wholistic Integrated Cultural* Health and Wellness Care across Lifespan: What we Heard

The new title is described by the following definitions, which were frequently shared by engagement participants. *Wholistic* refers to the BC First Nations perspective on health and wellness. *Integrated* highlights the importance of partnerships with other health services. *Cultural* underscores the high value placed on traditional medicines and healers.

The inner circle depicts the individual / family on their wellness journey across the lifespan. From womb to spirit, care close to home is a strong value.

The second circle surrounds the individual / family with three guiding objectives to support care close to home, which include:

- Equity with social determinants of health (specifically housing, food, personal funds, transportation and internet) is important for foundational wellness. This is a priority and therefore occupies 50% of the circle
- Community driven support, recognizes that the path forward is not one solution for all
- Flexible funding, supports unique solutions that best meet community health needs

Community- identified opportunities are listed within each of the guiding objectives.

The outer ring are paddles that depict a wraparound model of health partners working collaboratively to provide appropriate and accessible health programs and services. It is through collaboration, connection and relationship that today's system can transform and improve the health outcomes and wellness journey of First Nations people in BC.

Conclusion

In conclusion, the best approach moving forward has two components.

1. Design programs, services and resources with community to ensure equity using social determinants of health lens.

2. Create a wraparound system with all partners working together to meet communities where they are. Every part of the health system plays a critical role in each step moving forward.

The engagement findings are nicely summarized by the following words of Evan Adams, former FNHA Chief Medical Health Officer:

> *"So when you look at the circle of care, or the health care system, my thoughts are not necessarily just around getting those within the circle of care to do better, but to expand that circle of care so that there are more of us who should be there. Let's expand the circle. Let's open the door. Let's invite people in. Let's expand our idea of who's helpful, and let's have a circle, not a hierarchy, but a circle. And as many of you know, it's not just doctors and nurses who give us wellbeing. It can be family members. It can be those who help our elderly. It can be educators. It can even be a coach who helps our younger family members. So, I've talked about the social determinants of Indigenous health, and how we're not just looking at physical bodies and diseases. We're looking at community health."*[5]

The First Nations Health Authority clinical project team is grateful for the wisdom shared in the engagement sessions. The knowledge we have gathered will be invaluable to informing subsequent stages of the project and building future changes to health programs and services.

5 Indigenous Health Lecture – @theU (utah.edu). https://attheu.utah.edu/facultystaff/indigenous-health-lecture/

Preliminary Recommendations

Each possibility listed is considered to assist in transitioning towards Wholistic Integrated Cultural Health and Wellness Care across the lifespan. The list is categorized short-term opportunities that could be initiated in the near future and longer-term initiatives that are considered to have greater scope. Once validated by community, further work could include a prioritization approach and a detailed plan of action, including working together with our partners. All recommendations are designed to enhance or build upon (from a strengths/ asset-based perspective) community-based solutions and innovations. See Appendix F for more detailed suggestions.

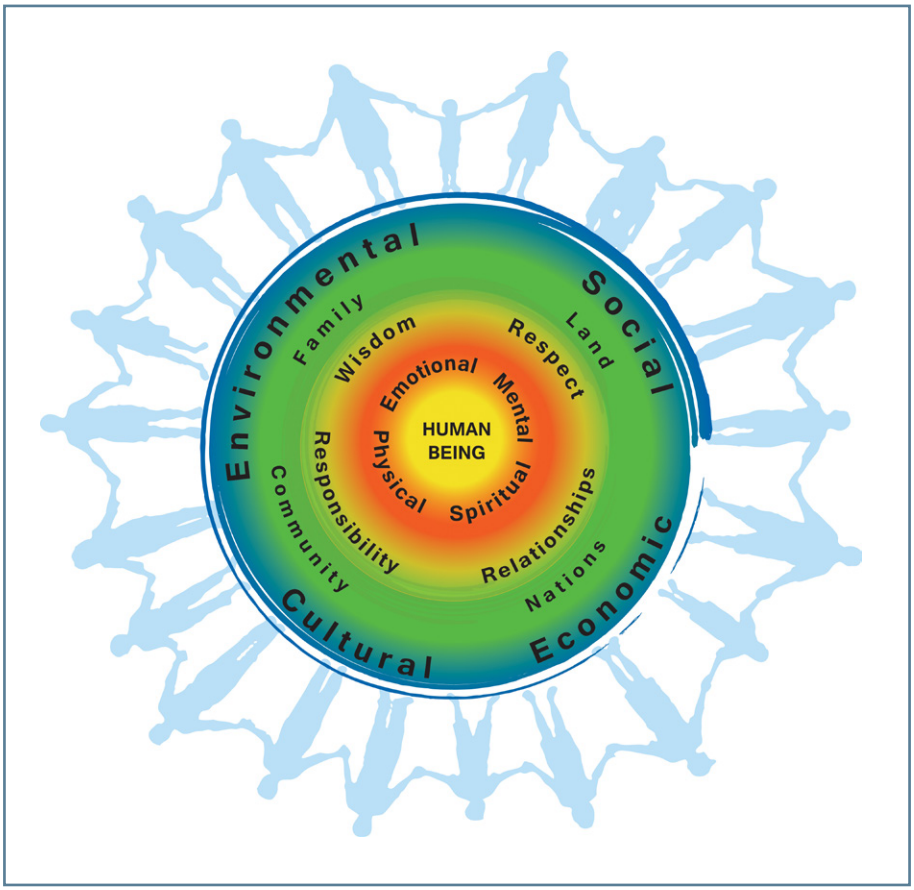
Short Term

- FNHA could create opportunities with its partnerships and connections to improve housing (remediation, modifications, and new builds including multiuse) through flexible housing solutions.
- FNHA could collaborate with communities and partners to develop strategies to integrate the acceptance and financial support of Traditional Healers, Medicine Person and Knowledge Keepers within the circle of care and funded services.
- FNHA could work with communities and service partners (RHA, MOH, FNHA, and education systems) to increase the profile to retain, recruit and train health care workers for First Nation communities.
- FNHA could work with partners to ensure respite services are accessible for family caregivers.

Long Term

- FNHA could work with partners to eradicate the inequity within First Nation communities to access foods -including traditional.
- FNHA in partnership with ISC, Health Canada and AFN could ensure creative funding allocations addressing remoteness factor, to expand health care services in communities and embed funding flexibility to support a community-driven, Nation-based approach to service delivery and design that meets the unique and evolving needs of communities.
- FNHA could strengthen and support virtual service delivery and general connectivity for First Nations communities, particularly those who live in remote and rural settings.

Appendix A: First Nations Perspective on Health and Wellness



First Nations Perspective on Health and Wellness[6]

FNHA vision: *Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities.*

FNHA mission. *To support BC First Nations individuals, families and communities to achieve and enjoy the highest level of health and wellness by: working with them on their health and wellness journeys; honouring traditions and cultures; and championing First Nations health and wellness within the FNHA organization and with all of our partners.*[7]

6 First Nations Health Authority. (N.D.) First Nations Perspective on Health and Wellness. https://www.fnha.ca/wellness/wellness-for-first-nations/first-nations-perspective-on-health-and-wellness

7 First Nations Health Authority Mission and Vision. (N.D.) Vision, Mission and Values (fnha.ca) https://www.fnha.ca/about/fnha-overview/vision-mission-and-values

Appendix B: Focus Groups and Interviews

Regional Focus Groups

The process for regional focus groups followed FNHA regional engagement pathways. For the purpose of data analysis, each virtual focus group was recorded with permission from the participants. Three FNHA staff also took notes. The recordings were later transcribed. Sessions were from one to two hours in length and consisted of the following questions.

1. In your community, what are some examples of success (e.g. clinics, relationships, programs, supports) for long-term care of community members?
2. From your perspective, what happens in your community to support culturally safe and trauma informed long-term care for community members?
3. How does your community integrate traditional healing practices into long-term care?
4. Is there anything else you would like to share about what supports community members to remain living in community? Regional Focus Groups and 1:1 Interviews

Health Care Assistant Conference

The Health Care Assistant (HCA) Conference was an in-person event held in Surrey, BC in May 2022. The primary audience in attendance were Health Care Assistants working in BC First Nations Communities. To facilitate discussion, regional breakout rooms were organized for participants. Each breakout group spent two hours sharing thoughts guided by discussion questions, with comments captured on flip charts. Furthermore, the question "What would your Elders tell you they need to remain living at home?" was distributed each of the three days on a colour-coded 8 ½ x 11 piece of paper. Each response was included in a daily draw for a door prize.

Health Education Forum- focus group and online survey number two

Each year the FNHA Office of the Chief Nursing Officer organizes and executes the FNHA Inter-professional Health Care Education Forum (HEF), formally the Nursing Education Forum (NEF). This 2.5-day educational event is in support of health care professionals working with First Nations communities across BC. A booth was available for participants to connect, learn about the project and scan a QR code to complete a voluntary survey. Each response was entered into a daily draw for a door prize. Furthermore, a brief face-to-face presentation with an overview of the project and an opportunity for participants to provide feedback were provided. The face-to-face session was not recorded but notes were taken by the facilitators.

Appendix C: Online Survey #1

The surveys emphasized the voluntary and confidential commitment of the project team to any feedback received online. Online feedback questions were multiple choice, Likert scale and optional free flowing. All questions used a strength-based focus.

The first online survey (August 25 - September 9, 2022) request for feedback was designed for community health staff. FNHA communications distributed the invitation to the survey link through the bi-weekly newsletter. A random draw for a gift card per region was offered for both surveys as a token of appreciation for those who chose to reveal their e-mail. The following questions were asked in the first survey.

- Do you identify as Indigenous: [Yes/No]
  - If yes, please specify: [Dropdown; First Nations, Inuit, Metis, Other]
- Paid role in the community: [Dropdown; Health Director, Care Aide, Nurse, Home Maker, Community Health Representative, Indigenous End of Life Guide, Other]
  - If other, please specify: [free text space]
- Length of time (years) in this role: [Dropdown; 0-2, 3-5, 5-10, 11-20, 20+]
- Region located: [Dropdown; Northern, Interior, Vancouver Coastal, Vancouver Island, Fraser Salish]
- [Optional] Name of community: [Dropdown]

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1. How do members of your community access medical equipment and supplies? [Select all that apply]
   a. First Nations Health Authority Health Benefits
   b. Regional Health Authority
   c. Red Cross loan cupboard
   d. Community has a loan cupboard
   e. There is no access
   f. Other
   - Please tell us if this works well and if you see other opportunities? [Free Text Space]

2. What happens when a community member needs home adaptations/renovations to remain living safely at home? [Select all that apply]
   a. The family pays and makes the changes
   b. The band pays and arranges for the changes
   c. A third party pays and arranges for the changes
   d. Adaptations and renovations are generally not possible
   - Please tell us if this works well and if you see other opportunities? [Free Text Space]

3. How do community members get to medical appointments out of community? [Select all that apply]
    a. Family drives or person makes arrangements
    b. Public transportation
    c. Band hired staff makes arrangements
    d. Other
    e. Attending medical appointments off reserve is generally not possible
    > Please tell us if this works well and if you see other opportunities? [Free Text Space]

4. If the person desires, is there opportunity to access traditional healing? [Scale 1-3 for each; 1= no access, 3=readily accessible]
    a. Smudging
    b. Ceremony
    c. Drumming
    d. Access to traditional healer
    e. Access to traditional medicines
    f. Other
    > Please comment if you are able to access these healing practices outside of community (i.e. hospital)? [Free Text Space]

5. What access do people in your community have to the following health care providers? [Scale 1-3 for each; 1= no access, 3=readily accessible]
    a. Home care aide
    b. Home care nurse
    c. Nurse Practitioner
    d. Family Doctor
    e. Foot care nurse
    f. Occupational therapist
    g. Physiotherapist
    h. Speech therapist
    i. Dentist
    j. Optometrist
    k. Indigenous End of Life Guide
    l. Other
    > Please comment on the frequency and what is the ideal frequency? [Free Text Space]
    > Are the health visits face-to-face or virtual or both? [Dropdown]

6. From your perspective how does your team support a culturally safe experience for community members when accessing clinics, hospitals, and doctor's appointments? [Free Text Space]

7. From your perspective what role does family generally play in community when someone requires long-term care – from child to older adult? [Free Text Space]

8. What support is available to family caregivers? [Select all that apply]
   a. Respite
   b. Financial
   c. Support Group
   d. Meals
   e. Daycare
   f. Health Information
   g. Navigation of System
   h. Other
   > Please tell us if this works well and if you see other opportunities? [Free Text Space]

9. Finally, if you had one wish, what other opportunities would you like to see for people with long-term care needs (including children and adults with special needs, autism, fetal alcohol syndrome, brain injury, chronic condition)? [Free Text Space]

10. Is there anything else you would like to share about what supports community members to remain living at home? [Free Text Space]

11. [Optional] Please enter your email address below to be entered in a draw for a gift card. [Free Text Space]

Appendix D: Online Survey #2

The second online survey request for feedback (November 22- 30, 2022) was designed for community health staff attending the Health Education Forum in Vancouver. The surveys emphasized the voluntary and confidential commitment of the project team to any feedback received online. Online feedback questions were free flowing. All questions used a strength-based focus. A random draw for a gift card per region was offered for both surveys as a token of appreciation for those who chose to reveal their e-mail. The following questions were asked in the second survey.

Preamble included a brief description of the survey and the demographic questions in the boxes below followed by the list of questions.

Paid role in the community	Paid role in the community - Other - Specify	What region are you located in?	What is the name of your community (optional)?	Are you Indigenous?	Please enter your email address below to be entered in a draw (Optional)

1.0 Equity

1.1 How can we streamline funding for medical equipment, safe equipment installation and home renovations (e.g., mold removal, structural issues)?

1.2 Share with us how you are or how you would like to learn about the traditional foods and medicines of the community you serve?

2.0 Capacity

2.1 What strategies would you suggest to increase the inclusion of cultural healers and sacred knowledge keepers in the health care system and truly embed Indigenous ways of being as a system wide norm?

2.2 How can we better support family caregivers?

2.3 Can you suggest creative strategies to encourage and retain health care workers?

2.5 If RHA start to provide more service, how would the people you serve want to receive them? (HCW comes to community or person goes to their office or would not want to access.)

2.6 In what ways does your health care team support the social, emotional and spiritual needs of your community members in their journey of wellness?

3.0 Connection

3.1 How can we improve lines of communication between regional health authorities and your health care team services for successful, seamless transitions in care?

Appendix E: Indigenous Services Canada Background Issues[8]

- Integration of health and social systems
- Human resources to support a continuum of care
- Support for informal caregivers
- Cultural appropriateness for long-term care
- Information systems to support a continuum of care
- Construction and maintenance of long term care facilities
- Home adaptations for elders and people with disabilities
- Group homes and family group homes
- Home and community care
- Disability specific income supports
- Respite care
- Dementia care
- Palliative end of life care
- Social isolation

8 GCDocs #76087532 p21-68 unpublished

Appendix F: Ideas for Detailed Action Plans

Housing

- Prompt access to medical equipment and supplies, including correct installation
- Improve home accessibility (e.g., ramps, stair lift, and mold/mildew remediation)
- Offer multi-use (womb to spirit) community housing with home support
- Provide affordable hospice or a transparent procedure to waive cost
- Take responsibility for existing houses to be maintained as safe (for example, mold, rodents, medical adaptations, and hoarding issues)
- Support to build enough homes for all members in community and eliminate crowding

Food

- Permanently fund access to food- including traditional food for remote communities

Transportation

- Ensure access to transportation to medical appointments

Wellness through Culture

- Provide culturally sensitive primary health care; include traditional healer in primary care clinic
- Create a central registry for Nation Certified Traditional Healers
- Formalize and fund Elder support to preserve cultural teachings
- Connect Elders with youth, intergenerational mentorship (culture focused)
- Work with partners to ensure all long-term and continuing care standards align with the Cultural Safety Standard
- Work with partners to engage Indigenous awareness when writing policies and procedures

Recruit and Retain

- Work with partners to create pathways for community members to pursue careers in health care (e.g., HCAP, bridging programs, mentor high school students)
- Provide competitive salaries for health care positions in community
- Provide funding for Elder to offer cultural teachings for non-community staff
- Understand the roles the person has in their family and community and create supports to ensure success
- Work with partners to offer mentor support within the colonial education system
- Continue to fund Indigenous End of Life Guide Course and fund the role, especially in remote locations where there are no other options

Family

- Offer financial support, education and respite for family caregivers, (e.g., CISL new policy)
- Provide family caregiver education (e.g., how to transfer, feed, mouth care etc.)
- Offer education for family about mental, spiritual, physical changes during dying phase
- Follow up with grieving family after death and support grief programs
- Initiate advanced care planning (values) conversations amongst family
- Support choices for end of life (e.g., Medical Assistance in Dying, cultural protocols)

Virtual Access

- Consistent secure internet access for online assessments, virtual service delivery.
- Provide community health nurse Electronic Medical Record access

Partnerships

- Strengthen partnerships between regional health authority, (e.g., home care, palliative care specialists, home care nurses) and community health nurse so same care is available no matter location of home
- Build stronger connections between FNHA and regional health authorities' Indigenous departments
- Formalize lines of communication between hospital, hospice, primary care providers and community staff for successful, seamless transitions (e.g., discharge planning) across the province
- Develop partnerships with regional health authorities to support community home care services
- Support the education and implementation of the New Home Care Policy held at the Regional Health Authority around services within First Nation Communities
- Create a pathway so communities can learn about new access to mobile screening/testing services in a timely fashion

Funding

- Flexible home care hours (e.g., after 4:00pm, weekends); hours determined in collaboration with community health care team/family/individual, with funding to support the increased service hours.
- Funding for health and wellness services and programs support mental, physical, emotional, and spiritual wellness for individual and families within the health budget
- Encourage the separation of health budget from chief and council and place with health department