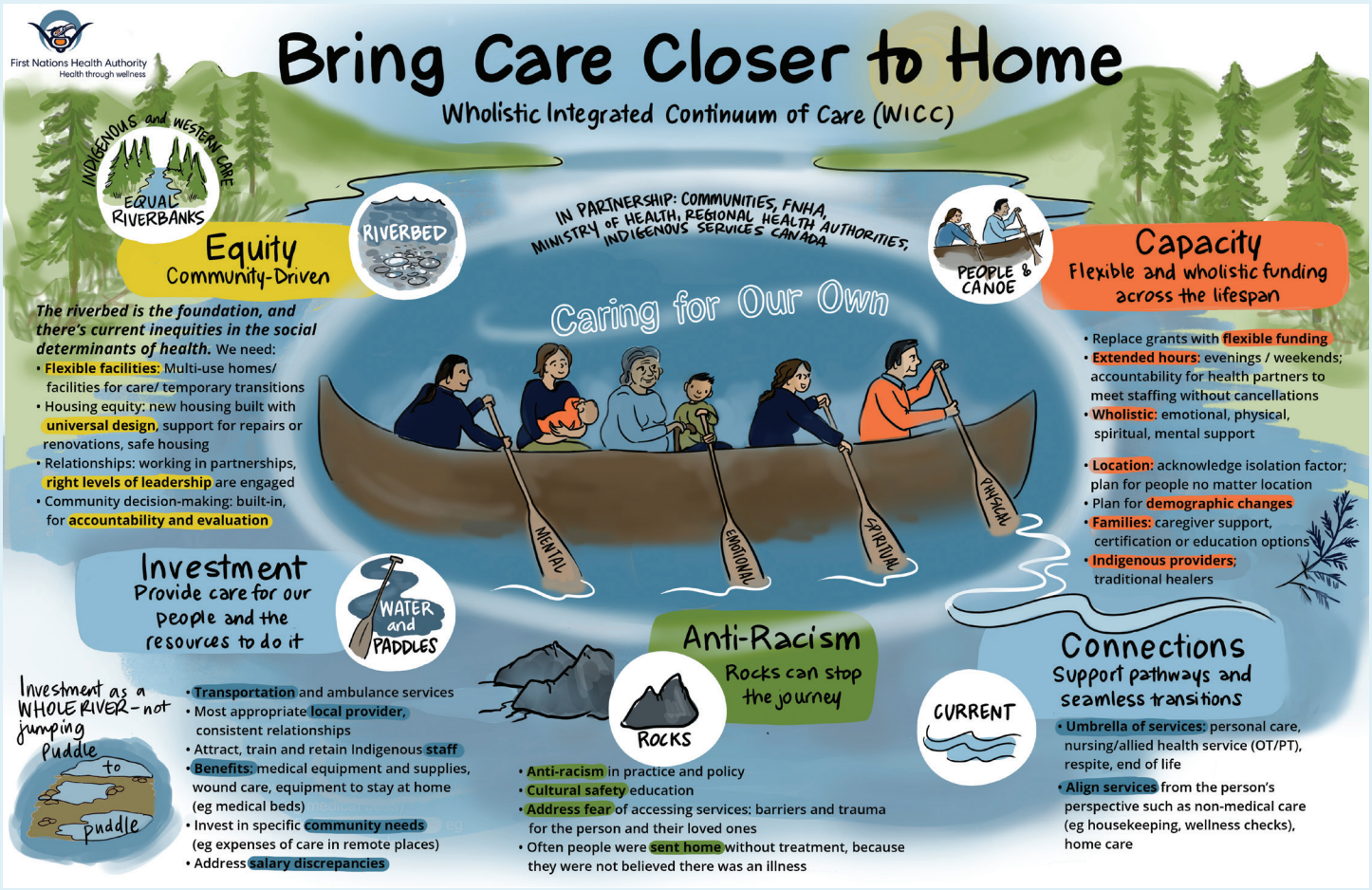
First Nations Health Authority
Health through wellness

Engagement and Validation Report 2023

BRINGING CARE CLOSER TO HOME

PHASE TWO

Office of chief nursing officer,
wholistic integrated continuum of care (WICC)



Contents

Executive Summary

Background

The First Nations Health Authority (FNHA) undertook engagement and validation with 291 people reflecting 139 communities in all regions of British Columbia. The intention of the sharing sessions was to learn if current community health systems are working and if not, what is needed to improve the system. Phase one included engagement to hear about successes and opportunities. This report highlights phase two which included validation of the results from phase one and a new engagement on the draft provincial home health policy. For a copy of phase one report, email WICC@fnha.ca

Results

Phase two, between February to July 2023, included both validation of phase one and engagement on BC Ministry of Health draft home care policy through focus groups and Indigenous health gatherings. We confirmed that people want to bring care closer to home, while incorporating spiritual and emotional wellness into health programs. The four key themes from phase one, continue to resonate in phase two, with the addition of stories describing experiences of Indigenous-specific racism in the health care system.

A proposed model, based on feedback from community, was validated. Two short term capacity building projects informed by this model have received funding for three years, focusing on the themes of connection and capacity.

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 during the validation process.

The validation included a graphic artist independently listening to the consultation recordings to create a visual depiction located on the front of this report. Appendix C is the comparison visual from phase one.

Bring Care Closer to Home

1. Equity	2. Connection	3. Capacity	4. Investment
Housing Food Cost of living Transportation	Pathways Anti-racism MoH Home Care Policy	Traditional medicine Recruit & retain Family caregivers	Flexible needs-based funding

In Appreciation

The First Nations Health Authority is grateful for the wisdom shared in the engagement and validation sessions. The support we felt, knowledge we gathered and readiness for change will be invaluable in building future culturally safe, accessible health programs and services reflecting First Nations ways.

Introduction

The First Nations Health Authority (FNHA) used a strength-based approach to engage with people living and working in BC First Nations communities about successes and opportunities in long-term and continuing care[1]. This was phase one of the project. This report highlights phase two which included:

- **WICC Validation:** Validating what we heard during the Wholistic Integrated Continuum of Care (aka LTCC) phase one engagement in regards to themes and strategies to bring care closer to home.
- **Home Care Policy Engagement:** Engaging on the Ministry of Health draft Home Care Policy to determine if it will meet the needs of community to support care closer to home.

In phase one, the intention was to learn about the successes in community and if current community health systems are working and if not, what would improve the system. In phase two, we returned to validate the results. The findings of these engagement and validation sessions will inform options for the future development of a wellness continuum for First Nations Living in BC communities.

All work is guided by the First Nations Perspective on Health and Wellness and FNHA's vision, mission statements and seven directions. For further description, see Appendix A.

Method for Data Collection

The method used for engagement and validation in phase two followed OCAP™ principles of ownership, control access and possession. Phase One learnings were shared back to community health leaders for validation. Engagement around new topics followed regional protocol using a variety of strategies under the guidance of central and regional directors of engagement. Validation and engagement data was gathered during regional online focus groups, in person focus groups and face-to-face conversations at three health gatherings. In addition, surveys at the health gatherings were available and attached to a random daily draw prize. Phase two activities occurred between February 1, 2023 and July 5, 2023. Figure 1 summarizes the activities.

North	Interior	Fraser Salish	Vancouver Coastal	Vancouver Island	Other
6 Virtual sessions	4 Virtual sessions	2 Virtual sessions	2 Virtual sessions	Spring caucus	Gathering Wisdom Health Summit

Figure 1: Phase Two Validation and Engagement Activities

[1] Long term and Continuing Care refers to support provided to individuals and families of all ages. The services can be episodic or ongoing. Recipients of care include children with disabilities, adults with chronic illness, elders and those at the end of life. Regulated and unregulated healthcare providers offer services within a range of program areas and geographic locations (urban, rural, and remote).

Phase Two: Wholistic Integrated Care Continuum *Validation*[2]

Figure 2: What we heard in phase one about Bringing Care Closer to Home

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 or social determinants of health. We heard that housing, food, money to pay bills and transportation were generally insufficient yet foundational to health and wellness.

INVESTMENT = Water

Water represents investment. The smaller the amount of water in the riverbed, the more restricted and difficult the journey. We heard that many communities are frustrated by the 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 strengths. The canoe is important to transform funding into positive outcomes. In the canoe, there is representation of life from womb to spirit. 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.

[2] For phase one report, email WICC@FNHA.ca

CONNECTIONS = Environment, Wind, Rocks and Currents

The environment, wind, rocks and currents represent connections outside the community and how these impact the canoe to move forward easily or with challenges. Rocks represent racism within the health care system. Hitting a rock can stop the wellness journey in the same way that accessing unsafe care results in no care being accessed. This component was added during validation (phase two) as many disturbing experiences were shared. Where communities described strong connections with their regional health authority and other nonprofit organizations, the system supported pathways towards seamless, culturally safe and accessible care.

Wholistic Integrated Continuum of Care Model

A proposed model, based on ideas and stories from community, was created and presented for validation. See Figure 3.

Figure 3: Phase Two Community Inspired Strategies and Solutions Moving Forward

The inner circle depicts the individual/family on their wellness journey from womb to spirit wrapped in the strong value of care close to home. The second circle surrounds the individual/family with four guiding objectives to support care close to home. The outer ring of paddles indicate how partner collaboration is essential to provide appropriate and accessible health programs and services.

Phase Two Wholistic Integrated Care Continuum Engagement

Ministry of Health Home Care Policy

All BC First Nations communities are rightfully located in their ancestral territories. Rural, Remote and Indigenous communities are 'communities on the edge' often challenged with limited access to health care services and transport challenges to higher-levels of care. FNHA partnered with Ministry of Health (MOH) to conduct extensive engagement using a strength-based approach with First Nations' health leaders. It is envisioned that through this work, health authorities and the First Nations communities in their region will build and nurture relationships to foster equitable, accessible and appropriate care delivered close to home. The policy applies to all publicly subsidized provincial home health services delivered by the regional health authorities (RHA). Services encompass home support, professional services (nursing, rehabilitation, social work) and supports for caregivers (respite, day programs).

The objective of the policy is to outline the role of RHA in providing and supporting home health services for individuals living within BC First Nations communities. Regional Health Authorities will support and/or provide home health service in BC First Nations communities in accordance with the following foundational principles:

Figure 4: Ministry of Health Draft Home Care Policy Foundational Principles

Three values that underlie the framework for expected behavior and decision-making throughout the policy include:

- anti-racism,
- no tolerance to delay services due to health authority jurisdictional boundaries,
- cultural safety and humility.

Other foundational principles include:

- The community's health and wellness plan directs priorities for care and is adjusted, as the community's needs change. Annual reviews at minimum are to take place between regional health authority (RHA) and community. This is Community Driven.
- Information sharing between the RHA and community health staff is essential to promote wraparound care, including smooth access and transitions.
- Interprofessional consultation offered by the RHA (i.e., wound care clinicians, complex care planners, diabetes specialists, palliative care staff) will support the community health care team.
- Relationship building is the backbone of this work. For example, both community and RHA are encouraged to extend invitations to relevant activities.
- Education Support to build new skills and teachings offered through the RHA would include invitation to First Nation community health staff to also attend.

For more detail on the questions posed, see Appendix B.

Method for Data Analysis

The findings come from listening to the voices of 291 people who reflect 139 First Nations communities across BC. Figures 5 and 6 break down the number of communities by region for both phase one and two and Table 1 describes the various participant roles in phase two only.

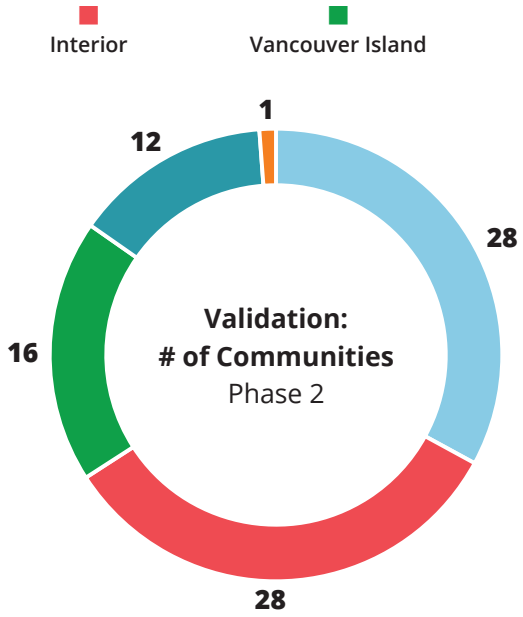


Figure 5: Phase Two WICC Validation and Home Health Policy Engagement Participation by Region

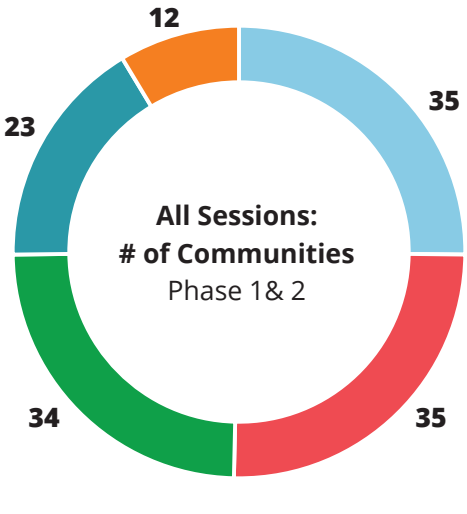


Figure 6: Combined Phase one and Phase Two Engagement and Validation Participation by Region

Table 1: Phase Two Participant Roles by Region

	Chief & Council	Elder	FNHA staff	Health Director	Health Lead	Nursing staff	Regional Health Authority staff
Van. Island	6	0	7	12	7	3	3
North	2	0	1	27	9	8	3
Van. Coastal	0	2	5	7	?	3	0
FS	3	0	5	9	4	0	1
Interior	2	1	6	26	13	4	1

For a geographical visual of the First Nations communities with staff who participated in engagement in both phases, contact WICC@FNHA.ca for access to the interactive map

The FNHA clinical team analyzed anonymized qualitative data, collected between February and July 2023. Data were carefully reviewed to identify recurring or contradictory themes and any new patterns. During the analysis, coding categories were refined and transcribed as a conceptual representation of themes pertaining to the impact and implications of community health programs and services. Adding components to the original canoe sketch helped distill new data plus validate what was previously heard (see Figure 1). To ensure any biases were minimized, an independent professional graphic artist consolidated what was written and recorded into a sketch. The graphic artist is familiar with FNHA and collaborated with an Indigenous graphic artist to ensure the work was culturally appropriate. See title page for graphic artist summary of phase two results. See Appendix C, phase one results for comparison.

Limitations

Because we did not engage with people living urban and away from home, the results cannot be generalized to every BC First Nations geographical context.

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.

Results of Wholistic Integrated Care Continuum *Validation*

Themes

During validation we heard more detail about racism in health care, - especially for remote communities and the impacts of geographic isolation. Racism, although not specific to remote communities, presents unique challenges because choices and options are limited. One community member described needing to see a dentist but the closest approved professional was not experienced as culturally safe. Because there was no other known option for dental service, no dental care was received for years. We also heard about members feeling unsafe during hospitalization and fear of even going to the hospital. People described keeping family on the phone or asking family to watch their children if anything happens to them and they don't return home.

We heard there are greater costs for rural and remote communities and that their funding models do not factor in this cost.

Staff retention is challenging in part, related to inequities of salaries for health staff. We heard the difficulty in matching salaries offered by larger institutions/health authorities. Even within a health authority, for example, care aides have a higher salary if they work in an institution versus community. This is often compounded by the complexity of no housing for health staff, which is a particular issue when the provider has travelled several hours. If there was a space to remain in the community overnight, a full day for assessments and follow up could replace the quick in and out that presently exists.

Wholistic Integrated Continuum of Care Model

The proposed model, based on feedback from community, was enthusiastically validated. Comments like "right on"; "yes, yes, yes"; and "I agree with all of it" was frequently heard before participants expanded on specific sections of the model.

Results of Home Care Policy Engagement

The BC Ministry of Health draft Home Care Policy was generally well received. Many people came to the sessions to discuss this long awaited documented support. The value of the policy spoke loudly in the sessions. The foundational principles were accepted with numerous voices affirming their importance. The following are quotes from participants.

"I'm feeling again, just really satisfied and really grateful that the time has been taken to articulate some of the challenges that we have, and I think this will provide this will definitely provide a foundation for the relationship that I would like to see us having with our you know, with our local hospitals and clinics and with the Health Authority."

"Just looking at the policy as it is it talking about sort of this idea of Jordan's principles, theory in there. And that, I mean, I like to see that there. And I hope it means what I think it might mean, in that care gets delivered when it's needed".

"I think we've all experienced this as First Nations people or healthcare workers in First Nations communities or organizations, the cultural safety piece, and the difficulty in even accessing services, and getting refused, and because there hasn't been clarity before about those services coming from regional health authorities. And so, you know, I am just so actually amazed and excited that this is being looked at and that this policy is being created."

"Happy to hear that you're working on it, this is a big important change, I'm so glad to hear it. We're beginning to be seen and heard. I'm really grateful that you're here."

Three Emerging Themes

In regards to the draft policy, each region expressed areas of strength and also of opportunity. The feedback has been themed and represented visually (responsibility, relationship and resiliency).

Bears within the Indigenous worldview hold different meanings, some of these include courage, strength, family and health. Some Indigenous people believe that bears are our closest ancestors and others suggest that bears are able to see in both worlds. Bear medicine is often referred to as the strongest medicine.

Responsibility

An example of bear governance is highlighted while salmon fishing. We reflect on how solitary bears will fish the river for salmon while respecting other bears who also fish the river. Bears spread themselves out across the territory to co-exist and share resources.

We heard from community health leaders that there is a desire to be self-determining but to do this requires a sharing of resources and support. Sharing of resources must be guided by the community health and wellness plans (community directed), not randomly offered when there is excess. We also heard the necessity for a framework to hold health authorities accountable for providing service. Two regions encouraged further policy discussion between their Nations' governance and the provincial health governance.

"the policy states performance indicators, but there's no mechanism to hold the ministry or the regional health authorities accountable. All it says is that it will be done in consultation, as to whether the indicators are met. So, there's not even a framework identified as to how we would evaluate. Let alone how we would hold things accountable when they do go wrong"

"Government-to-government basis in accordance with DRIPPA. Decision making at all levels – involved from the start – nothing for us without us."

"... when I did first get the very first draft, I will say I was really disappointed in that very first sentence wording about supporting, I just really feel that it was taking away the responsibility from the province and pushing it on to First Nations without any financial support or resources."

"So my recommendation is if the ministry is approving any kind of documents that affect First Nations communities, that first nations Chief and Council and leadership have government to government discussions. So the ministry should be bringing this draft policy to our leaderships and getting approval from our leaderships. In my opinion, whoever is the decision maker for signing off on these policies should be communicating with Chief and Council."

"Our self-determination is demanding that organizations end the systemic racism and provide the supports that are being asked for."

Relationship

Bears have a strong connection to the land and waters, their cubs, the seasons and landscapes. In the BC coastal regions it is said that bears are a key piece of balance for the ecosystem.

Relationships are critical to the success of this policy in bringing care closer to home. Not everyone described positive, helpful relationships between the community's health center and their regional health authority. However, each region described a strong desire to work collaboratively with their regional health authority. In fact, the development of a meaningful relationship was seen as the first step forward when enacting the new policy.

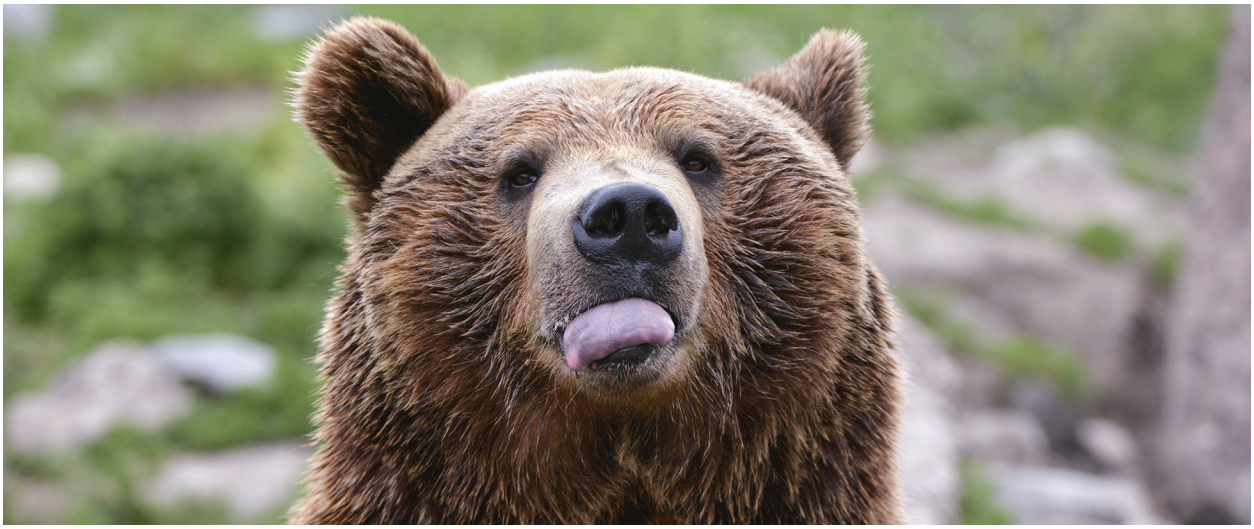
"Transforming health means transformation of the relationship with regional health authorities"

"Success is meaningful relationships and partnerships between health authorities and communities – wrap around"

"Those who work in that field, how do we do this well? What is the breadth of partnership needed to do it right?"

"There is need and space to learn from each other."

Resiliency



For many decades, humans have forced bears to relocate away from their home territory, which has resulted in a decline in the North American bear population. Nevertheless, bears demonstrate resiliency and resourcefulness through their connection to the land and survive. In much the same way bears have shown resilience in their changing environment over the centuries, so too have First Nations people. The imposed colonialism, racism, historical and intergenerational trauma in the health care system have negative impacts on the health and wellness of First Nations people.

Some Indigenous people believe that the bear spirit indicates a time for healing. Healing was reflected throughout our conversations with the health leaders, for despite past harms, there is willingness to move forward together in wellness. Communities are standing up and showing strong resilience in voicing the way forward with a focus on providing care for their own.

There is desire to replace the illness model and work within a wellness model. This resilience is paving the path to moving forward.

"I hear all this education, maybe it's to our health authority more than you guys, but I hear all this education and stuff sending people to understand us and help make our health better. Who's helping us, training us, helping us be the champions for our own health? Have we thought about that?"

"It's them [nurses] stacking their workload to be able to provide all this amazing care that our partners are supposed to be providing. Our nurse is a discharge nurse, our nurse is a palliative, our nurse is a home care and our nurse is intake. Our nurse- One nurse. When Vancouver Coastal Health has a position for each of those areas. And I'm tired, because I have to keep continuing to say that."

"... we've been stuck in trauma for so long, if my doctor tells me something I'm just doing it. I don't have it in me to ask my doctor 'are you sure that meets my needs'. Without us being able to stand ourselves up, be our own champions, understand the language used out there, I think that's really important "

Community health leaders, although thankful for the promise to be in writing, shared that this policy must respect First Nations' perspectives, cultures and approaches to wellness. The strength and courage shown to adapt to the barriers and work together, again reflects attributes of the bear.

> *"We don't have the human resources really in our community, we have people that work as home support workers, but they aren't certified. So they're limited in their scope of care. I have a home-care nurse that travels to the community but doesn't you know, it's not enough work to keep a person here full time. So there's, you know, like travel in and out. … we currently have an elder who, you know, probably would qualify for some assisted living or extended care but wishes to return home, but we don't have the services for that person here. So the family and that person's health struggles continuously with trying to manage at home and not having, you know, the certified home support worker help and home care nursing help when it's needed in our community. Yeah, it's a big gap for us mostly about human resources and capacity to provide those kinds of services here, but our people very much prioritize and want to be in their home community and stay at home. But there's almost a complete lack of services for them around home care. There's really just lack of capacity in our tiny little community, and, you know, being able to get those services into our community to not only provide the service when it's needed, in the moment, but also to, to provide some mentoring and training and support of staff that are in community and having that hands on education and support from people who have that higher certification and scope."*

The Path Forward

Over the next three years, three short term-capacity-building projects are partially funded by Indigenous Services Canada. The approved topics of inquiry emerged from community solutions during engagement and validation sessions. The scope of the projects will focus on First Nations people living in BC First Nations communities, with attention to the voices of those experiencing gender diversity.

> *"As humans, we're a complex of many identities and social, economic influences … it is the tapestries of intersectional identities that bring richness to our work."*
>
> **– Alies Maybee, Patient Partner, Equity-Mobilizing Partnerships in Community (EMPaCT)**

> *"By sharing our truths with people who have lived experiences much different than our own … we can all come to see the humanity of people who we may have formerly met with judgment or misunderstanding or derision."*
>
> **– Laura "LT" Todd, Patient Partner, BC Mental Health and Substance Use Services**

The first project is about and for caregivers.

1. Family Care Givers

In a recent BC Seniors Advocate report, it was described that "At 34%, B.C. has the third highest level of caregiver distress in Canada." p 3." Last year, family caregivers provided on average, over 1,300 caregiver hours per year per client, an 11% increase from five years ago. Nearly 20% of family caregivers provide 36 hours or more each week." p 22. The provincial Home and Community Care program has three options to alleviate caregiver distress. These options include:

- In-home respite
- Adult Day Programs
- Facility-based respite

During engagement and validation, there was a desire to stay home in community however, there exists a lack of paid caregivers. Traditionally, the roles in community include providing care and supporting 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, such as the financial impact when family leave a job to provide care. Few participants could identify formal supports in community for family caregivers which address emotional, spiritual, mental, physical and/or financial stress.

What is the experience for Indigenous family caregivers? Throughout our engagement, we did not hear examples of caregivers receiving any of the three provincial options for support, education or respite. Caregiver distress continues to be one of the deciding factors between many people being able to remain safely in their own homes or forced to move away. The project will explore caregiving for First Nations people, the traditional ways, what Indigenous caregivers need and what would it take to increase support options. A key element of this project will be acknowledging and addressing the impacts of intergenerational trauma on respite, including the impacts of residential school. Today, in an environment of reduced numbers of health care providers, family caregivers are essential to keep people of all ages, who require care, in their homes.

"… the people in the community that want to be cared for in the home, they want to pass on to homes, you want to be surrounded by family, traditional healers as well. So I think we've got a lot of education for the community members. … Because really, we should be part of a culture of care for our own people. They can't do that because they don't have any education."

The second project is about bringing care closer to home

2. Bringing Care Closer to Home

During engagement and validation, we heard about the importance First Nations people in British Columbia (BC) place on having relationship-based, accessible care closer to home. We also heard about barriers to receiving care closer to home; barriers which generally do not exist for non-Indigenous British Columbians. For example, we were told about hospital discharges where Indigenous patients were left at the hospital front door with no shoes, coat, wallet or ride home. The goal of this project is to start to create a system which supports seamless, supported transitions in care as close to home as possible. This project will focus on:

Hours of Care

Medical Equipment and Supplies

Wound Care

Seamless Transitions in Care

BC Home Health Policy

Hours of Care

A lack of nursing hours available in community to support people to receive care in their homes, resulting in people leaving community and moving to an unfamiliar setting or care home.

Medical Equipment and Supplies

Issues with health equipment and supplies make it harder to support a person to remain at home. For example, when equipment like grab bars are installed improperly, harm is caused. During hospital discharges, we heard about people returning to community without the required equipment or supplies (e.g., dressing supplies) and without appropriate communication to the receiving health care provider. The result is the person and their caregivers are not set up for a successful transition.

Wound Care

Wound care is often a chronic, time consuming and life altering experience for clients and health care providers. Nurses working in BC First Nations communities are generalists with knowledge about prevention, health promotion and chronic disease. However, they are unable to maintain specialized knowledge as is required to create comprehensive care plans for chronic wounds. Regional Health Authorities employ health care providers with Nurse (RN) Specializing in Wound Ostomy Continence (NSWOC) certification. These nurses focus entirely on specialized care. Safe transitions for wound care requires support from NSWOC clinicians. Support includes care plans, education and dressing supplies to prevent any delay in receiving care.

Seamless Transitions in Care

There is a need for seamless care transitions, showcased by nurses working in First Nations communities who had previously worked at the local hospital and still maintained relationships with acute care staff. Clearly, there is a need for transparent, culturally safe formal pathways so all community nurses know who, when and where to contact Regional Health Authority staff for hospital admissions and discharges, treatments, medical equipment and supplies and wound healing care plans. Likewise, Regional Health Authority staff need to know who to contact as part of the circle of care for individuals living and receiving care in First Nations communities. Relationships are important but where they do not yet exist, a formal pathway will ensure care. Often the transitions in care are negatively impacted by discharges that do not include the health team in community or no supplies were sent home with the person in need or no equipment was arranged to be home in advance of the person. There is one key strategy FNHA is involved in co- developing and co-implementing which links these focus areas.

BC Home Health Policy

The approval and implementation of the draft BC Home Health Policy will be critical in supporting care closer to home. It is envisioned that through this policy, health authorities and their staff, (with community members and community health staff), will build and nurture relationships together. Collaboration will foster equitable, accessible and appropriate care ensuring safe, supported transitions in care.

A third unfunded project, Multi-Use Wellness Hubs, would support a unique care approach and decrease the risk of iatrogenic harm from the current system.

3. Multi-Use Wellness Hubs

There is opportunity to work with our health care partners in a different way, one that is Indigenous led and reflects the Indigenous ways of knowing. The services offered by the wellness hub would be supported by regional health authorities, community partners, Indigenous Services Canada and FNHA but directed by the community. Examples of services could include support for:

- elder with a chronic condition exacerbation
- person with a high risk pregnancy
- youth in transition
- person working on substance use
- child with high care needs

The wellness hub combines community/regional/provincial services and offers a wraparound family centered, culturally safe care approach. The services could include traditional medicines, traditional healers, primary care, community health, home care, mental health, substance use support, adult day programming, meals, specialist visits and short term 24 hour care. Virtual and travelling team services are maximized. Bringing all services together creates accessible, seamless and cost effective wellness support for individuals, family and care providers.

Discussion

What we have heard is the desire for a wellness/health care system where no First Nations person living in British Columbian is left behind - no matter where they live. This could be achieved if we work alongside Nations to create a better system together.

Improvement can be enhanced and retained with supporting data. Data systems are needed to further data sovereignty and uphold First Nations led data strategies. We can't continue the status quo of collecting comparison data of Indigenous against non-Indigenous peoples. The concept of equity explains the need for this change in perspective. Whereas equality means providing the same to all, equity means recognizing that we do not all start from the same place and must acknowledge and make adjustments to imbalances. See Figure 8 for a visual depiction of the two definitions.

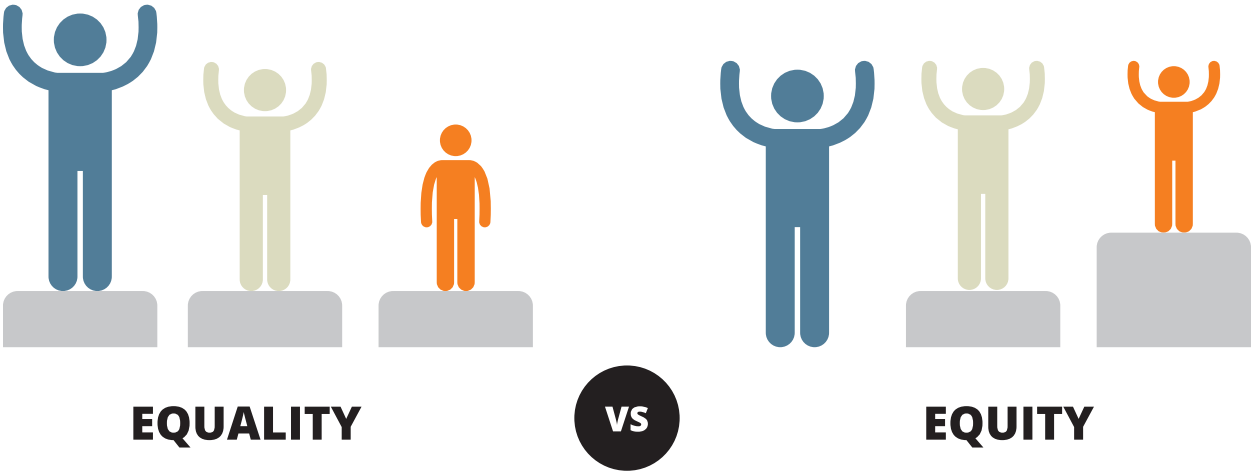


Figure 8: Equality versus Equity

Indigenous Services Canada (ISC) engaged the Assembly of First Nations (AFN) to review all Long term and continuing care (LTCC) engagements from across the country. From the review, seven priorities with proposed policy recommendations were developed and will be submitted to Canadian members of cabinet for approval. These seven priorities include:

1. Culture as foundation for services
2. Wholistic care from womb to end of life
3. Restructuring and advancing infrastructure
4. Scalable and sustainable resources
5. Building and supporting health human resources
6. Governance and First Nation determination
7. Equitable access

For additional information on each of these priorities and the proposed policy options see: Long-term and Continuing Care: Virtual National Focus Group - Assembly of First Nations (afn.ca)

Conclusion

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 wellness and health 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 offer opportunity.

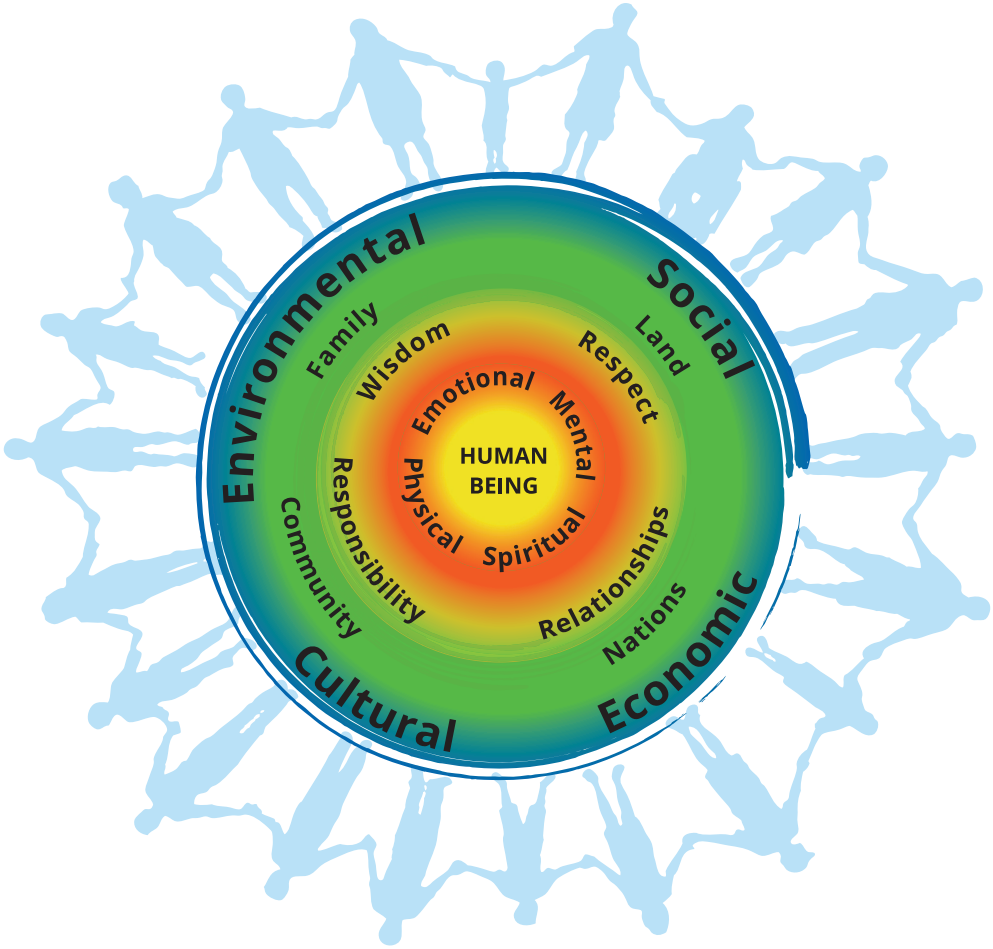
In conclusion, the best approach moving forward involves the creation of a wraparound system with all partners working together to meet communities where they are under the guidance of First Nations. Every part of the health system plays a critical role in each step moving forward.

The engagement findings are nicely summarized by the following words of Evan Adams, 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."

[4] Indigenous Health Lecture – @theU (utah.edu)

Appendix A:
First Nations Perspective on Health and Wellness



First Nations Perspective on Health and Wellness [5]

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.

[5] First Nations Health Authority. (N.D.) First Nations Perspective on Health and Wellness
[6] First Nations Health Authority Mission and Vision. (N.D.) Vision, Mission and Values (fnha.ca)

Appendix B:
Phase Two Questions for Validation and Engagement

Health Forums

Gathering Wisdom, Health Summit, Vancouver Island Regional Spring Caucus

1. What are your top priorities to keep care close to home for First Nations people?

2. How should FNHA prioritize care close to home? (Please circle one)

a. Strategies to support family caregivers
b. Strategies to improve funding process
c. Strategies to strengthen relationship with other health services (e.g., Regional health authority)
d. Strategies to recruit and retain staff

3. How would you see working with your regional health authority around home care?

Regional Focus Groups

Online focus groups per region – questions taken from power points

1. Is anything missing from the themes?

2. How does the summary of what we heard sit with you?

3. What do you hear are community's top priorities for care closer to home?

4. How do you think FNHA should support/prioritize this work?

5. What do you think are the top priorities for wholistic, integrated, cultural care closer to home?

6. Is there anything else you want us to know?

Appendix C:
December 2022 Phase One Graphic Artist