

# URBAN AND AWAY-FROM-HOME HEALTH AND WELLNESS FRAMEWORK

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First Nations Health Authority  
Health through wellness

This Framework aims to set the *Foundations for Success* to be a *Health and Wellness Partner* with urban and away-from-home First Nations people in BC and to bring health and wellness services *Closer To Home*



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## EXECUTIVE SUMMARY

The First Nations Health Authority (FNHA) strives to be a health and wellness partner to all First Nations people in British Columbia (BC), regardless of where they live or access their health services. The majority of First Nations people in BC live in urban areas or away from home. However, mainstream health services are not always accessible due to systemic, institutional, clinical and individual barriers. The Urban and Away-From-Home Health and Wellness Framework is an evergreen document that outlines high-level principles and strategic directions to expand the scope and function of the FNHA's responsibilities to support the urban and away-from-home population. It aims to advance the First Nations Perspective on Health and Wellness and the FNHA's broader vision of Healthy, Vibrant and Self-Determining First Nations Children, Families and Communities.

The Framework is divided into two parts. Part 1 provides an overview of the current health system landscape in which this Framework takes shape, recognizing the historical and modern contexts of health policy in BC. It summarizes the process undertaken to develop the Framework and reports on key themes from community (on-reserve) dialogues across BC's five health regions. It also situates the Framework within the available demographic data on the urban and away-from-home population, and provides an overview of the FNHA's current activities to support the urban and away-from-home population as a partner, advocate, funder and service provider.

Part 2 of the Framework puts forward a set of high-level principles, strategic directions and implications for moving forward to improve health and wellness services for the urban and away-from-home population, with a focus on enhancing First Nations participation and control in the health system. They are categorized into three streams that align with the objectives of the Framework to *Set the Foundations for Success* to be a *Health and Wellness Partner* with urban and away-from-home First Nations people in BC and to bring health and wellness services *Closer to Home*. Each stream identifies mutually reinforcing principles and strategic directions within the areas of work described below:

### **(1) Setting the Foundations for Success requires:**

- *Meaningful Representation* through developing sustainable and meaningful engagement pathways with the urban and away-from-home population across BC.
- *Research and Knowledge Development* through developing ethical and solution-oriented strategies to collect information and data on the urban and away-from-home population.
- *Partnerships* to be developed and nurtured with First Nations, provincial ministries, provincial and regional health authorities, Indigenous service organizations and health and wellness organizations.



## **(2) Being a Health and Wellness Partner requires:**

- *Coordinating Programs and Services* for the urban and away-from-home population to increase efficiency and avoid duplication.
- *Enhancing Programs and Services* through partnerships that operationalize a continuum of care that brings together the best of traditional and cultural approaches with western approaches, and encompasses a range of fully integrated programs and services.
- *Integrating the Social Determinants of Health* by acknowledging and recognizing the efficiency and equity in investing in upstream and preventative supports for the urban and away-from-home population.

## **(3) Bringing Wellness Closer to Home requires:**

- *Urban Participation (“With Us, Not For Us”)* through developing a strategy (or strategies) and a set of guiding principles for First Nations participation and inclusion in urban and away-from-home health and wellness services.
- *Nation-Based and Nation-Shared Services* through a comprehensive funding approach that enables long term Nation-based planning, and collaboration between communities and Nations, to efficiently deliver services within economies of scale.

The Framework highlights the need for health and wellness services that are informed by grassroots community engagement and responsive to the unique circumstances of the urban and away-from-home population. The principles and strategic directions of the Framework are intended to guide the development of regional and provincial-level strategies and action plans that support the urban and away-from-home population, to ensure that health system transformation is done hand-in-hand with First Nations and the FNHA’s provincial, federal and local health system partners.

## PART 1: BACKGROUND AND CONTEXT

### INTRODUCTION

This Framework outlines and guides the First Nations Health Authority's (FNHA) evolving functions to support the urban and away-from-home First Nations population in British Columbia, and provides guidance for developing regional and provincial-level strategies and action plans to advance the FNHA's scope of responsibility in its multiple roles as a partner, advocate, funder and provider of health and wellness services.

The Framework is divided into two sections. The first section summarizes the historical and policy contexts that have shaped the current health landscape in BC, along with background information on the urban and away-from-home population, and it summarizes the FNHA's current functions to support their health and wellness. The second section sets out high-level principles and strategic directions, and their implications for moving forward with the development of both regional and provincial strategic plans to support the urban and away-from-home population. These principles are categorized into three streams that align with the tagline of the Framework, to *"Set the Foundations for Success to be a Health and Wellness Partner with urban and away-from-home First Nations people in BC and to bring health and wellness services Closer To Home"*. While these are divided into discrete areas of work, it is important to note that they are intended to be read as mutually reinforcing objectives that should each be taken into consideration when developing strategic plans to support the urban and away-from-home population.

**Note:** The important and necessary discussions on cultural safety and humility<sup>1</sup> in BC's health systems are acknowledged, yet absent from this Framework. While the principles and strategic directions put forward in this Framework are meant to advance culturally safe, accessible and appropriate care, the discussion on embedding cultural humility into the health system, to achieve cultural safety, is currently being advanced through its own working groups, partnerships and policy development processes. Understanding that cultural safety and humility touches every aspect of the work we do together, it is fundamental to the development and implementation of this Framework. The scope and brevity of this Framework do not provide the space to adequately discuss the movement towards embedding cultural safety and humility throughout the entire health system; we therefore recommend that the FNHA's materials on cultural safety and humility be read as accompanying documents to this Framework and be used to inform any strategic plans that emerge.

<sup>1</sup>*"Cultural safety" describes an outcome in which First Nations people access culturally appropriate services in an environment free from racism, prejudice and discrimination. Cultural humility is the process through which this outcome can be achieved, and refers to a process of critical self-reflection to understand systemically conditioned internal biases, and to maintain respectful relationships based on mutual trust.*



## OUR PROCESS

This Framework is the culmination of two years of research and site visits to First Nations and Indigenous health and wellness services across BC, Ontario and Alaska as well as community dialogues across all five BC health regions. Following the FNHA's directive to be Community-Driven and Nations-Based, this Framework was informed by two consecutive rounds of conversations with First Nations community representatives through the engagement and approvals pathways process at regional caucus, sub-caucus and wellness gatherings and it included a polling question on levels of support for the FNHA investing in urban programming. However, a key principle highlighted in the second half of this Framework is the need to include the voice of those who were not captured in this engagement pathway and the urban First Nations population who are not represented by BC Nations. Moving forward, a key theme throughout this Framework and its recommendations is to ensure that each step along the way is informed by grassroots community engagement, with the broader aim of increasing First Nations representation and control throughout the entire health system. This Framework is an evergreen document that may change to reflect the inclusion of those voices that have not been heard.

Absent from this Framework is the broader discussion with our provincial, federal and local health system partners. While many Ministry and other Indigenous service organization partners were consulted or debriefed on this work, the Framework was developed as an internal guiding document and is not a prescriptive document for our health system partners. One of the key themes of this Framework, however, is to ensure that all of our health system partners are brought into this process of defining our individual and joint responsibilities to support the urban and away-from-home population, through reciprocal accountability.



## FNHA'S MANDATE AND VISION

This Framework is embedded within the broader vision of the FNHA, which is the realization of Healthy, Vibrant and Self-Determining First Nations Children, Families and Communities. We include those living away from home or in urban communities as a part of this vision. Ultimately, the FNHA strives to be a health and wellness partner to all First Nations people in BC, regardless of where they live or access their health services. When the FNHA was created, we inherited service-delivery responsibilities that were previously held by Health Canada's First Nations and Inuit Health Branch (FNIHB) BC, which were limited to on-reserve community services and contribution agreements. At the same time, the mandate of the FNHA has always been to "effectively meet the needs, priorities and interests of First Nations communities and First Nations individuals, regardless of their residency" (Tripartite First Nations Health Plan). This Framework sets out the high-level principles and strategic directives to expand the scope and function of the FNHA's responsibilities to support the urban and away-from-home population to achieve the mandate provided in the Tripartite First Nations Health Plan by the First Nations Leadership Council, the BC Assembly of First Nations, the First Nations Summit and the Union of BC Indian Chiefs as well as the governments of Canada and British Columbia.

The Framework is intended to represent the interests of First Nations people in BC. It is recommended that as the work to support urban and away-from-home First Nations wellness advances, partnerships with Indigenous organizations are used to strengthen our strategic support for the diverse communities of First Nations and Indigenous people across BC.

## FNHA'S URBAN AND AWAY-FROM-HOME MANDATE

"The Parties acknowledge that Federal Health Programs, other than the FNIHB Program, are aimed primarily at Status Indians resident on-reserve in BC, with the [Non-Insured Health Benefits] program being aimed at all Status Indians resident in BC. The Parties anticipate that as the FNHA enters into relationships with the BC Ministry of Health and the BC Health Authorities, including the provision of funding, such relationships may also benefit other First Nations persons in BC, the wider Aboriginal population of BC and potentially the non-aboriginal population of BC".

~ *Tripartite Framework Agreement on First Nations Health Governance*

"First Nations health services will be delivered in a manner that effectively meets the needs, priorities and interests of First Nations communities and First Nations individuals, regardless of their residency, and recognizes the fundamental importance of community solutions and approaches."

~ *Tripartite First Nations Health Plan*



## WHY NOW?

Systemic barriers, rooted in historical and ongoing colonial situations and attitudes, prevent many First Nations communities from enjoying healthy and full lives. The majority of First Nations people in BC live off-reserve, where it is assumed that because health services are often available that they are also accessible. But the health system has never been developed to meet the needs of the urban and away-from-home First Nations population, and along with myriad other barriers to care, the available mainstream health services are not always accessible. Key barriers to care are the perceived and real threats of racism and prejudice, and the fact that First Nations culture is rarely reflected in health and wellness services. For decades, Indigenous service organizations have highlighted their own struggles, and the struggles of their clients, to provide and receive quality, safe and appropriate care. The need for this Framework is self-evident in both the disproportional negative health outcomes of Indigenous people in BC as well as the ongoing exclusion of urban and away-from-home First Nations people within the development and delivery of their health and wellness services.

This Framework supports the goal of embedding the First Nations Perspective on Health and Wellness into the health system, which is an ongoing process that will take time, persistence and incremental changes at the structural, institutional and individual levels. The processes through which the health system is transformed will determine the form and function of the transformation. If the health system is to be truly transformed to be more culturally safe, inclusive and innovative, and to contribute to the decolonization processes outlined by the Truth and Reconciliation Commission, then the processes of transformation must also reflect these principles and aspirations. This Framework does not provide a full picture of what the final state of transformation will be. Instead, it looks at the processes and directions required to ensure that health system transformation is done hand-in-hand with First Nations – both the communities and Nations on-reserve, as well as the urban and away-from-home communities across BC.







## WHAT NEXT?

The health system is poised for transformation. The next step is to ensure that it is done together with First Nations leadership, community members and our partners. Over the two years in which this Framework was in development, the BC Ministry of Health initiated a health system transformation plan and primary care strategy, called the Integrated Primary and Community Care (IPCC) Strategy. At the heart of the IPCC is a commitment to team-based care models – specifically community health centres, patient medical homes and urgent primary care centres – which will be integrated with each other and with broader social services and supports through primary care networks. While these objectives for team-based models of care align with the First Nations Perspective on Health and Wellness, and some of these teams will be “built in partnership with the First Nations Health Authority and incorporate traditional and holistic models of wellness in primary, maternity, mental

health and substance use services,” the IPCC is not itself a First Nations-led transformative process. As a response to FNHA and community communication for greater First Nations inclusion and control over their health and wellness services, efforts have been made to include Nations within the primary care network planning process. In addition, the Ministry of Health, the regional health authorities and the FNHA have embarked upon the development of 15 First Nations-led primary health care initiatives across BC. These initiatives are both on- and off-reserve, and are being developed through a community-driven process coordinated by the FNHA. This is an opportunity to ensure that the urban and away-from-home population are full participants in the policy, planning, design and delivery of the wellness services they receive. At the same time, these 15 First Nations-led primary health care initiatives only represent the start of broader health system transformation in BC.

**“This Framework sets the foundation for the First Nations Health Authority to be a health and wellness partner to all First Nations people living in BC, whether they live on reserve, in urban areas or away from home. The Framework supports our collective continued journey to healthy, self-determining and vibrant First Nations children, families and communities.”**

*~ Richard Jock, Interim CEO of the FNHA*

## TERMINOLOGY

**Language is important. The terms we use are inherently embedded in a historical context with present-day connotations and implications for a vision of the future.**

There is a tendency to identify First Nations people by their residency on-reserve or off-reserve. There are significant institutional reasons for this distinction, as there are ongoing jurisdictional divides between on- and off-reserve services. But the terminology of on- and off-reserve has implications that stretch beyond the administration of programs and services. The linguistic distinction between on- and off-reserve First Nations is an outcome of colonization and the illegal removal of First Nations people from their traditional unceded territories onto Indian reserves. In addition, Indian reserves themselves were often relocated to be set apart from urban cities. Throughout the systemic exclusion of First Nations people and Indian reserves from Canadian cities, a public image of “Indians” was constructed to define “Indian” culture and life as incongruent with western culture and “modernity.” The present-day connotation is that First Nations people who live in urban centres have forfeited their right to experience their cultures and traditions in an active decision to assimilate into colonial culture. The implication of this attitude is that health and other services that are not located on-reserve do not need to reflect First Nations cultures and practices. It is for this reason that we use the term “urban and away-from-home” rather than “off-reserve First Nations.” While the terminology is currently shifting away from “on- and off-reserve First Nations,” a goal of this Framework is to develop terminology that resonates with First Nations people in BC, knowing that this terminology may change over time to reflect the most up-to-date thinking.

### **Away from Home**

The term “away from home” recognizes that many First Nations people have been pushed from their home communities or traditional territories for various reasons, or have been encouraged to migrate into urban and rural parts of BC in the pursuit of economic, educational or other opportunities.

### **Urban and Rural**

We include the term “urban” in “urban and away-from-home” to recognize that not all First Nations people living in urban centres consider themselves away from their home. For many, the city is their home, and is at times a part of their traditional territory. There are also many reserves located within major cities in BC. It is also important to note that “rural” is not synonymous with living on-reserve and is often a part of the “away-from-home” population.



## Community/Community-Based

It is common for “First Nations community” to refer to the community living on-reserve. Programs and services that are located on-reserve are also frequently referred to as “community-based” or “in-community.” But there are also communities of First Nations people not living on-reserve, both rurally and in urban centres. For continuity, “community-based” is used in this Framework to refer to on-reserve First Nations community services, while “community” is used in both on-reserve and the urban and away-from-home contexts.

## Client/Owner

There is often a power imbalance between patients and care providers that treats the patient as a passive recipient of care rather than a client who is in a reciprocal relationship with their care provider. The terms “client” or “client/owner” recognize the agency of those who access health and wellness services.

## HISTORICAL CONTEXT

The health landscape in BC is fundamentally shaped by ongoing and historical colonization, which created and has maintained a division between federal and provincial responsibility for First Nations programs and services. The jurisdictional dispute between the two levels of government is often cited as emanating from the conflict in the *Constitution Act* of 1867. Section 92(7) of the Act assigns exclusive powers over hospitals to the provinces, while section 91(24) assigns legislative authority over “Indians and lands reserved for Indians” to the federal government. Yet the division between on- and off-reserve jurisdiction and responsibility has deeper cultural roots in Canada’s colonial history that shapes our understanding of First Nations peoples, cultures and rights.



## FACTS:

- The *Royal Proclamation of 1763* established Aboriginal title as an inherent right that can only be extinguished through treaty. The Proclamation was subsequently enshrined in Section 25 of the *Constitution Act*.
- Throughout most of BC, treaties were never negotiated between the government and First Nations peoples, and Aboriginal title has never been legally extinguished.<sup>2</sup>
- In the 1850s, despite the Royal Proclamation, government authorities began to illegally remove “Indians” from their traditional territories onto “Indian reserves.” The reserves were typically small tracts of land, often unsuitable for hunting, gathering, agriculture or maintaining traditional practices.
- The *Indian Act* in 1876 established the bureaucratic apparatuses to enforce federal control over Indigenous governance, land use, health care and education, and it also established federal fiduciary responsibility for “Indians and lands reserved for Indians.”
- The *Indian Act* also introduced the status system – a race-based and gender-based classification system with the dual purpose of determining which individuals are entitled to Indigenous rights and then also bringing about the removal of those rights through assimilation.
- Amendments to the *Indian Act* entrenched the division of First Nations from urban spaces:
  - Amendments in 1911 gave territorial governments the legal authority to remove Indian reserves from an incorporated town or city, without the consent of the Nation.
  - Amendments in 1927 restricted the movement of First Nations people on- and off-reserves, made traditional cultural practices illegal, and pushed for the removal of First Nations status (the removal of federal fiduciary duty through removing First Nations status).
  - The *Indian Health Regulations* added in 1953 made it a crime to refuse to see a doctor or go to a hospital, or leave a hospital before being discharged. Patients at Indian hospitals were admitted based on their Indian status, and were often sent far distances from their homes, sometimes to remain in Indian hospitals for years at a time against their will.
- The legacy of residential schools is not distant history. The last residential school in Canada was operational until 1996, and the direct and intergenerational impacts are felt across all First Nations communities (on- and off-reserve) in Canada.

The jurisdictional division between on-reserve and off-reserve programs and services has had devastating impacts on the well-being of First Nations families and communities. An interim solution specifically for children and youth, Jordan's Principle, was implemented to ensure that jurisdictional disputes do not delay health and wellness services for those who need them. A long-term solution is needed to completely eliminate service barriers at all levels of the health system across the lifespan.

<sup>2</sup> The exceptions being the *Douglas Treaties*, the *Treaty 8 area* and modern agreements such as *Nisga'a*, *Tsawwassen*, *Maa-nulth* and *Tla'amin*.

## MODERN POLICY CONTEXT

Canadian policy has evolved over the centuries and the country has started to acknowledge colonial history, yet there is still little public awareness about the systemic exclusion of First Nations people from Canadian cities. Throughout the 20th century, Canadian policy was explicitly developed to facilitate the removal of First Nations people from urban spaces. Towards the late 1900s, the policies of segregation gave way to policies promoting “cultural assimilation.” By the 1980s the emphasis on assimilation went through a slight shift in tone to “adaptation,” which centered more on alleviating the challenges that First Nations people faced in urban spaces, such as employment, education, housing and income. Throughout this period, policy approaches were premised on the assumption that living off-reserve indicated a choice to assimilate or “adapt” to western colonial culture.

The Royal Commission on Aboriginal Peoples (RCAP) in 1996 and the Truth and Reconciliation Commission in 2015 both marked shifts in the approach to public policy, as they acknowledged urban Indigenous people as unique and thriving communities with their own cultural history and identity. They also explicitly recognized that First Nations people are not merely objects of public policy debates or victims of colonization. It is now more commonly recognized that First Nations people living off-reserve maintain strong connections to their home communities, and rather than assimilating into mainstream culture they have retained or developed their own unique cultural identity. The RCAP report highlighted that “maintaining that identity is an essential and self-validating pursuit for Aboriginal peoples in cities,”<sup>3</sup> but acknowledged that there is also a “heavy burden of pain and self-doubt that undermines their cultural identity” embedded in the struggles of First Nations people to participate in dominant society while at the same time honoring their heritage, spirituality and worldview. In addition to maintaining and developing distinct cultural identities, the RCAP report illustrated that the urban and away-from-home First Nations population has frequently demonstrated a desire to exercise significant governance over their lives as individuals and communities.

The FNHA views itself as a health and wellness partner to all First Nations people in BC, including those living in urban communities or away from home. The landscape in which the FNHA and our partners strive to provide culturally safe and appropriate services is built upon this complex history that has only recently moved from policies of gathering information on and providing services for urban Indigenous people, to a new approach of working with all First Nations people, regardless of residence.



<sup>3</sup> <http://data2.archives.ca/e/e448/e011188230-04.pdf> RCAP Volume 4: Perspectives and Realities p.385



## HEALTH SYSTEM BARRIERS AND CHALLENGES

The barriers to effective, culturally safe and appropriate wellness services for First Nations people in BC are myriad and systemic. These barriers exist at each level of the health system, from the systemic down to the institutional, clinical and individual (provider and patient). Targeted interventions can address clinical and individual barriers. Systemic and institutional barriers can only be addressed through transformative change.

- **Systemic Barriers:** Factors, often rooted in cultural norms, that limit the accessibility, availability and quality of First Nations health and wellness services. These may include the allocation of resources within the health system, inefficiencies in diseconomies of scale or short-term and unsustainable funding models, or systemic racism. Systemic racism refers here to both internalized biases as well as a situation in which the outcomes of a program are discriminatory even in the absence of individual acts of discrimination. In other words, systemic barriers have unequal impacts on minority populations even when functioning perfectly according to their design.
- **Institutional Barriers:** Factors that impede the effective, culturally safe and equitable delivery of health and wellness services. Institutional barriers are a collective failure of an organization to provide equitable services and may be the result of systemic barriers. But unlike systemic barriers, institutional barriers are those that result in unequal outcomes due to dysfunctional processes or practices within a system. The transformations to systemic barriers may not achieve their desired outcome if there are also barriers that remain at an institutional level.
- **Clinical Barriers:** Factors related to the care-delivery process or the structure of clinics. These could include insufficient staffing, irregular and inaccessible clinic hours, limited resources, or, in some cases, physician-centric models of clinical practice that limit the accessibility of available services. This also includes the lack of Indigenous culture reflected in the clinical care model for First Nations patients.
- **Provider-Related Barriers:** Factors that stem from the deficiencies of individual or groups of service providers. These could include a lack of cultural humility, unsafe clinical culture, lack of interest or time to understand and address a patient's social situation, or patient-directed rather than patient-centered care.
- **Patient-Related Barriers:** Factors often related to the social determinants of health, such as lack of housing and transportation, poverty or low health literacy. This may also include unwillingness to access available services due to the perceived and real threat of racism.

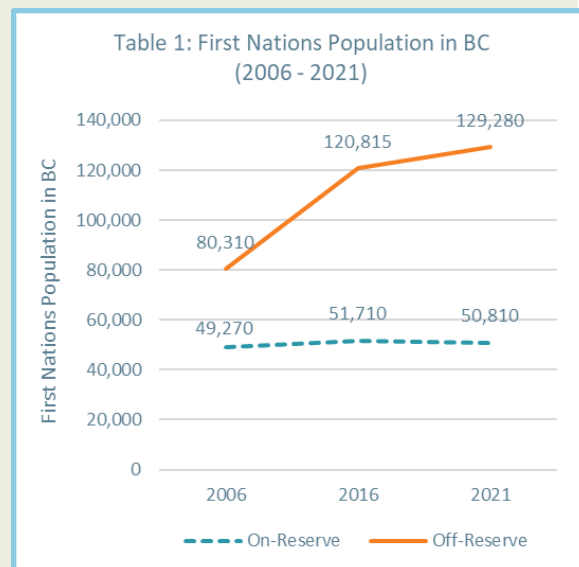
Some barriers fall into more than one – or all – of these categories, producing systemically entrenched challenges to health system transformation. For example, the unwillingness to access available health services due to the perceived and real threat of racism is a patient-related, provider-related, clinical, institutional and systemic barrier in the health system. These challenges require targeted actions at each level within and outside of the health system.

## THE URBAN AND AWAY-FROM-HOME POPULATION

The First Nations and Indigenous population – both the on-reserve and the urban and away-from-home population – has been steadily growing at a faster rate than the non-Indigenous population in BC.

### DID YOU KNOW?<sup>4</sup>

- In 2021, 72% of First Nations people in BC lived off-reserve (compared to 70% in 2016 and 62% in 2006).
- The First Nations population in BC rose by 39% between 2006 and 2021.
- The off-reserve population rose by 61% between 2006 and 2021.
- Youth age 0-24 are more likely to live off-reserve (75%) than middle-aged (25-64) First Nations people (71%).
- Senior First Nations people (65+) were the least likely to live off-reserve, yet the majority (60%) also live off-reserve.



It is important to note that this data from Statistics Canada may not accurately depict the size of the urban and away-from-home population in BC. A Toronto-based study found the off-reserve Indigenous population in the greater Toronto area to be between two and four times the size of that reported in the 2011 National Housing Survey (NHS).<sup>5</sup> The 2016 census data represents a rough estimate of the population, and is utilized here as the only large-scale data set currently available.

## GEOGRAPHIC COMPOSITION OF THE FIRST NATIONS POPULATION IN BC

The composition of the First Nations population in BC is complex, and a better understanding of who lives where can inform engagement strategies with the urban and away-from-home population. Table 2 provides an insight into the general composition of each FNHA health region in BC. This data is limited to Status First Nations people living in BC who are registered with FNHA to receive health benefits. This data shows us that, provincially, 16.1% of health benefits recipients living in BC in 2019 were from First Nations communities outside of BC. The Fraser Salish and Vancouver Coastal health regions show the highest percentage of FNHA clients residing in a different region from their home community, at 68% and 48.8%, respectively. On the other hand, the Northern health region has the highest percentage of clients living in the same region as their home community (83.8%), followed by Vancouver Island (76.5%) and Interior (67.9%).

<sup>4</sup> Statistics Canada. Table 98-10-0264-01, Indigenous identity by Registered or Treaty Indian status and residence by Indigenous geography: Canada, provinces and territories. <https://doi.org/10.25318/9810026401-eng>. Statistics Canada, 2016 Census of Population, Statistics Canada Catalogue no. 98-400-X2016154. Statistics Canada, 2006 Census of Population, Statistics Canada Catalogue no. 97-558-XCB2006006.

<sup>5</sup> [http://www.welllivinghouse.com/wp-content/uploads/2017/02/PrelimFindingsOHC\\_May2016\\_June7.pdf](http://www.welllivinghouse.com/wp-content/uploads/2017/02/PrelimFindingsOHC_May2016_June7.pdf)

The data tells us that, particularly in the Vancouver Coastal and Fraser Salish health regions, there are many First Nations people from outside of BC, or from a home community not located in the region, who are not directly represented in FNHA's engagement and approvals pathway process, which primarily engages with on-reserve community and Nation representatives. The clients reflected within this data include those eligible and registered for FNHA Health Benefits in 2019/20. This may underestimate the true population of First Nations people in BC, as some individuals may not be registered with FNHA Health Benefits.

**TABLE 2. GEOGRAPHICAL COMPOSITION OF FNHA CLIENTS:  
HOME COMMUNITY WITHIN VS. OUTSIDE OF RESIDENCE REGION**

| REGION OF RESIDENCE | HOME COMMUNITY WITHIN REGION OF RESIDENCE | UNKNOWN HOME COMMUNITY | HOME COMMUNITY OUTSIDE REGION OF RESIDENCE |            |        |
|---------------------|---|------------------------|--|------------|--------|
|                     |   |                        | OTHER BC REGIONS                           | OUTSIDE BC | TOTALS |
| INTERIOR            | 67.9%                                     | 1.4%                   | 15.6%                                      | 15.1%      | 30.6%  |
| FRASER              | 30.2%                                     | 1.8%                   | 41.1%                                      | 26.9%      | 68.0%  |
| VANCOUVER COASTAL   | 50.1%                                     | 1.1%                   | 28.2%                                      | 20.6%      | 48.8%  |
| VANCOUVER ISLAND    | 76.5%                                     | 1.9%                   | 12.1%                                      | 9.6%       | 21.7%  |
| NORTHERN            | 83.8%                                     | 1.9%                   | 5.9%                                       | 8.5%       | 14.3%  |

*\*Clients with unknown home community are not included in the calculation of the percentage of clients from home community outside region of residence*

## ADDITIONAL RESOURCES ON THE URBAN AND AWAY-FROM-HOME POPULATION

- [The Urban Aboriginal Peoples Study](#) and [Urban Aboriginal Peoples Study Vancouver Report](#)
- [First Nations Regional Longitudinal Health Survey \(RHS\)](#)
- [Aboriginal Peoples: Fact Sheet for British Columbia – Statistics Canada](#)
- [The Health of Aboriginal People Residing in Urban Areas](#)
- [Indigenous Wellness Indicators, City of Vancouver](#)
- [Aboriginal Peoples Survey](#)

## PRELIMINARY COMMUNITY FEEDBACK

As we developed this Framework, we presented our early thinking on the topic of urban and away-from-home to First Nations communities (on-reserve) across BC through FNHA's engagement and approvals pathway process. This preliminary communication sought feedback from First Nations community leaders and health directors to provide a perspective from on-reserve communities. A more robust engagement approach is required both with communities on-reserve and with the urban and away-from-home population directly.



## KEY THEMES

- Some communities (on-reserve) have a desire to support the urban and away-from-home population, but feel limited by contribution agreements that fund some programs through an on-reserve population-based funding formula.
- The divides in health service jurisdiction and funding can create cultural divides that separate those living on-reserve from the urban and away-from-home population in an “us versus them” relationship.
- There is support for FNHA investing in urban and away-from-home programming, but concern that funding for new programs must not come at the expense of community contribution agreements.
- There is a high degree of mobility on and off-reserve, and many people access health services outside of their home community.
- There are those who prefer to access health services located off-reserve.
- The lack of housing on-reserve pushes people out of the community.
- Systemic racism in the mainstream health system prevents people from seeking the health services they need.
- Partnerships and relationships with Indigenous service organizations vary by community, Nation and region, yet in each region these partnerships were presented as integral to supporting the urban and away-from-home population.

## POLLING QUESTION

*“I believe that the FNHA should invest in urban and away-from-home programming”*

- Interior Region: ..... 90%
- Northern Region: ..... 97%
- Vancouver Island Region: ..... 93%
- Fraser Salish Region: ..... 100%
- Vancouver Coastal Region: ..... TBD

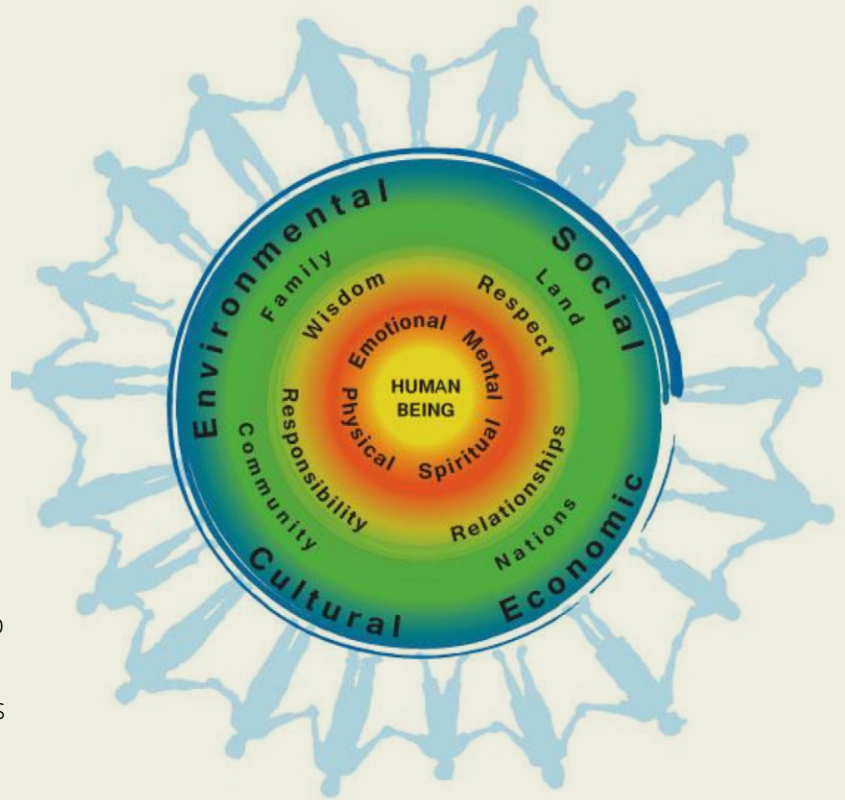
## CURRENT STATE TO IMPROVE UPON

The FNHA's vision is for Healthy, Self-Determining and Vibrant First Nations Children, Families, and Communities. This vision applies to all First Nations people in BC, including urban communities and those living away from home. The FNHA has multiple roles as a service provider, funder, partner and advocate to support the wellness journeys of all First Nations people and communities in BC, regardless of residency.

A fundamental goal of the FNHA is to embed the First Nations Perspective on Health and Wellness into all levels of the health system. The BC First Nations Perspective on Health and Wellness articulates a wholistic<sup>6</sup> view of well-being in which the health and wellness journeys of individual human beings are owned by those self-determining individuals. Importantly, it also reflects the values of First Nations people by representing the four dimensions of wellness – physical, mental, emotional and spiritual health – and acknowledges that we are influenced by external factors such as our families and communities, our environments and the social determinants of health. As an organization, we breathe life into this perspective in three key ways: as a champion, partner and by “living it.”

We champion this perspective among our communities and across the health system as a whole. Providers and health care systems need to understand how First Nations see their own health and wellness in order to provide appropriate care to First Nations. By embedding this philosophy throughout the health system and supporting the integration of traditional knowledge and approaches within mainstream health care, there will be improved cultural safety and humility across the health system and a repositioning of the current sickness-treatment system into one that supports wellness. This is the broader context in which this Framework is embedded, and to which it ultimately strives.

<sup>6</sup> *This spelling is deliberate as it implies “whole,” as recommended by Mi'kmaw Elder Murdena Marshall. Wholistic health includes supporting the whole person – that is, the physical, mental, emotional and spiritual aspects of their well-being.*



## CURRENT STATE: HEALTH SYSTEM OVERVIEW

The FNHA works with community (on-reserve), health service organizations and health system partners in BC to blend the “best of both worlds” to support First Nations access to culturally safe, quality care and services with the goal of improved health and wellness outcomes. In the landscape of primary health care, the FNHA intersects with Nations, the Ministry of Health and regional health authorities (as well as the 21 health care regulatory bodies in BC). The FNHA’s operations span multiple levels. In some ways, the FNHA is like the Ministry of Health and Health Canada in that the FNHA undertakes strategic policy and planning development for the full First Nations health system. In some ways, the FNHA is like the Provincial Health Services Authority in that the FNHA delivers some services to the entire First Nations population across the province and provides certain shared services across BC First Nations health centres. And in some ways, the FNHA is like regional health authorities in that the FNHA undertakes local and regional health services planning and delivery. FNHA uniquely occupies space at all levels of the health system simultaneously, which opens opportunities to identify issues, resolve barriers and implement solutions for the benefit of First Nations and with lessons learned for the broader health system.

- Sets policy direction, such as the Integrated System of Primary & Community Care
- Mandates and funds regional health authorities
- Supports health governance partnerships with First Nations

- Develops policy, planning, quality, and asset/evidence
- Delivers services directly via nursing stations and health centres on-reserve (and Joint Project Board initiatives on- and off-reserve)
- Funds community-run services and programs via contribution agreements
- Delivers province-wide health benefits
- With partners, improves services accessed by First Nations



- Distributes physician sessionals and salaried NPs, including to First Nations communities
- Provides Aboriginal Patient Liaison/Navigator services
- Leads cultural safety initiatives within the health authority region
- Delivers Aboriginal health programs
- Operates or funds Aboriginal primary care clinics off-reserve
- Oversees regional partnership accords

- Delivers community-run programs and services (which can include delivery for those living off-reserve).
- Participates in local primary care planning & initiatives

## CURRENT STATE: THE FNHA'S URBAN FOCUS

### URBAN AND AWAY-FROM-HOME PARTNERSHIPS

Since the transfer of services from the FNIHB to the FNHA, more than 80 health partnerships have been established with federal and provincial institutions, First Nations, universities and other agencies, which are aligning and leveraging additional resources to advance First Nations priorities. In addition to partnerships with the Ministry of Health and regional health authorities, some of these partnerships to support the urban and away-from-home population include:

- BC Association of Aboriginal Friendship Centres
- St. Paul's Hospital
- Simon Fraser University
- University of British Columbia
- Kilala Lelum (Urban Indigenous Health and Healing Cooperative)
- Crosstown Clinic
- Providence Health Care
- POUNDS, Prince George
- Kwakiutl District Council Health
- Indigenous Sport, Physical Activity and Recreation Council
- Urban Native Youth Association
- Portland Hotel Society
- Megaphone (Women's Speakers Bureau)

### TRIPARTITE AND BILATERAL PARTNERSHIPS

These foundational partnerships present key opportunities to influence health systems in BC. The urban and away-from-home context is an important point of discussion at these tables. Tripartite relationships provide opportunities to align strategic priorities and perspectives, and bilateral relationships between the FNHA and regional health authority CEOs set out shared agendas that support executive and operational leadership and the implementation of partnership accords. Each of these provincial- and federal-level relationships sets out shared values and interests and is integral to determining each partner's scope and role in urban and away-from-home First Nations wellness.



## PROVINCE-WIDE STRATEGIES

The FNHA has worked in collaboration with provincial ministries and other Indigenous partners in BC to develop strategies and frameworks to support all First Nations and Indigenous people in BC, regardless of their residency. For example:

- BC Indigenous Cancer Strategy
- Cultural Safety and Humility Framework and the Declaration of Commitment to Cultural Safety and Humility
- Traditional Wellness Framework
- Respecting Tobacco campaign



## DECLARATION of COMMITMENT MARCH 1, 2017

CULTURAL SAFETY AND HUMILITY IN THE REGULATION OF HEALTH PROFESSIONALS  
SERVING FIRST NATIONS AND ABORIGINAL PEOPLE IN BRITISH COLUMBIA

Our Declaration of Commitment is an important step towards advancing cultural safety and humility among regulated health professionals who are involved in the delivery of health services to First Nations and Aboriginal people in British Columbia. This commitment reflects the high priority we, as the designated BC health profession regulatory leaders, place on cultural safety and humility as quality and safety dimensions that are integral components of our public protection mandate.

This Declaration of Commitment is based on the following guiding principles of cultural safety and humility.

*Cultural humility is a life-long process of reflection to understand individual and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust.*

*Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. Cultural safety is the outcome of people feeling safe when receiving health care services.*

*Cultural safety must be understood, upheld and practiced at all levels of the health system including governance within health profession regulatory bodies and within individual professional practice.*

*All stakeholders, including First Nations and Aboriginal individuals, Elders, families, communities, and nations must be involved in co-development of action strategies and in the decision-making process with a commitment to reciprocal accountability.*

Strong leadership on concrete actions is essential to achieving our vision of a culturally safe health system for First Nations and Aboriginal people in our province. We, the undersigned representatives of BC's health profession regulators commit to:

### CREATE A CLIMATE FOR CHANGE BY:

*Articulating the pressing need to establish cultural safety as a framework to improve First Nations and Aboriginal health services in BC.*

*Opening an honest, informed and convincing dialogue with all stakeholders to show that change is necessary.*

*Farming a coalition of influential leaders and champions who are committed to the priority of embedding cultural humility and safety into the regulation of BC health professionals.*

*Contributing to the provincial vision of a culturally safe health system as a leading strategy to enhance professional regulation in BC.*

*Encouraging, supporting and enhancing cultural safety and cultural competency amongst health professionals in BC.*

### ENGAGE AND ENABLE STAKEHOLDERS BY:

*Communicating the vision of culturally safe health profession regulation for First Nations and Aboriginal people in BC and the critical need for commitment and understanding on behalf of all stakeholders, health professionals and clients.*

*Openly and honestly addressing concerns and leading by example. Identifying and removing barriers to progress.*

*Monitoring and visibly celebrating accomplishments.*

### IMPLEMENT AND SUSTAIN CHANGE BY:

*Encouraging and empowering our organizations' staffs, governors and volunteers to develop cultural humility and foster a culture of cultural safety.*

*Facilitating processes where organizations and individuals can raise and address problems without fear of reprisal.*

*Leading and enabling successive waves of actions until cultural humility and safety are embedded within all levels of health professional regulation.*

### REPORTING ON PROGRESS BY:

*Working with the Ministry of Health and the First Nations Health Authority to prepare a public annual report on strategic activities, outlining and demonstrating how the commitment is being met.*

Our signatures demonstrate our long-term commitment to the regulation of health professionals to promote and advance cultural safety and humility for First Nations and Aboriginal people in British Columbia and to championing the process required to achieve this vision.

This Declaration is endorsed by the Ministry of Health and the First Nations Health Authority and signed by their representatives and the members of the BC Health Regulators.

### SIGNED ON THIS DATE: March 1, 2017

|   |  |
|---|--|
| <br>First Nations Health Authority - Joe Gallagher, CEO, FNHA               | <br>Ministry of Health - Stephen Brown, Deputy Minister  |
| - and BC Health Regulators:   |  |
| <br>College of Instructors of BC - Michelle de Rosa, Registrar              | <br>College of Optometrists of BC - Robin Simpson, Registrar   |
| <br>College of Dental Hygienists of BC - Jennifer Lawrence, Registrar       | <br>College of Pharmacists of BC - Bob Nakagawa, Registrar   |
| <br>College of Dental Surgeons of BC - Jessica Marburg, Registrar           | <br>College of Physical Therapists of BC - Brenda Hudson, Registrar  |
| <br>College of Dental Technicians of BC - Harold Revell, Registrar          | <br>College of Physicians and Surgeons of BC - Heidi Dettler, Registrar  |
| <br>College of Denturists of BC - Louise Crowe, Registrar                   | <br>College of Podiatric Surgeons of BC - Valerie Osborne, Registrar   |
| <br>College of Chiropractors of BC - Fern Hubbard, Registrar                | <br>College of Psychologists of BC - Andrea Kovacs, Registrar  |
| <br>College of Licensed Practical Nurses of BC - Carina Herman, Registrar   | <br>College of Registered Nurses of BC - Cynthia Johnson, Registrar  |
| <br>College of Massage Therapists of BC - Eric Wrodenhagen, Registrar       | <br>College of Registered Psychiatric Nurses of BC - Kyung-ae Kim, CEO   |
| <br>College of Midwives of BC - Louise Aerts, Registrar                     | <br>College of Social Workers of BC - Chelsea Cooleidge, Registrar   |
| <br>College of Naturopathic Physicians of BC - Howard Greenstein, Registrar | <br>College of Speech and Hearing Health Professionals of BC - Cameron Cooper, Registrar                       |
| <br>College of Occupational Therapists of BC - Kathy Corbett, Registrar     | <br>College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC - Mary Watterson, Registrar |
| <br>College of Opticians - Connie Cheng, Registrar                          |  |

## FIRST NATIONS-LED PRIMARY CARE INITIATIVES

The FNHA has partnered with the Ministry of Health to develop First Nations-Led Primary Care initiatives across BC. The first project to be initiated was the Lu'ma Medical Centre, announced on September 15, 2019. The Lu'ma Medical Centre is located in East Vancouver, and as stated by its Clinical Director, Dr. Michael Dumont, they “provide culturally integrated care through an Indigenous lens, which enables us to take back control of our own health and wellness through self-determination.” At time of writing, sites have been selected for the next two projects in Williams Lake and Surrey, with 12 more locations yet to be determined for a total of 15 First Nations-led clinics across BC.



## MENTAL HEALTH AND WELLNESS

FNHA Health Benefits provide clients, regardless of residency, with access to counseling services from a qualified mental health provider. Crisis response investments have been made to support the mental health and wellness of all First Nations people in BC, regardless of residence. These include creating the Hope, Help, and Healing Suicide Prevention, Intervention and Post-vention Toolkit; funding the KUU-US Crisis Line to expand culturally safe crisis services across BC; formalizing crisis response protocols between the FNHA and health authorities; developing a trauma training curriculum for community-facing staff; and developing an urban and away-from-home focus in response to the opioid overdose public health emergency.


## JOINT PROJECT BOARD

The Joint Project Board is a partnership between the Ministry of Health and the FNHA to enhance primary care services and delivery by advancing strategic priorities, overcoming policy barriers, supporting priorities and initiatives of the regions, and supporting integration of services and initiatives of the province and the FNHA. Joint Project Board projects have helped overcome policy barriers such as the division of health services between on- and off-reserve jurisdiction, allowing for innovative models of health and wellness service integration.

## DATA AND KNOWLEDGE RESOURCES

### Events and Gatherings

The FNHA sponsors and hosts events to bring together First Nations people, Indigenous organizations and service providers, and other partners to learn from community members, front-line workers, and health leaders to support all First Nations and Indigenous people in BC, regardless of residence. For example, the FNHA partners with the BC Aboriginal Association



of Friendship Centres to support Gathering Our Voices, an Aboriginal youth conference that creates a supportive space for Indigenous youth to learn new skills, build relationships and make cultural connections among their peers. The FNHA also sponsors events like the Elders Gathering and Junior All Native Basketball Tournament.

### **Research and Knowledge Products**

The FNHA produces a number of data products to support urban and away-from-home health and wellness planning. Through the First Nations Client File, the Health System Matrix, Health Benefits data and linkages to provincial and federal data sets, the FNHA has the capacity to create a variety of data products on health system usage, health asset mapping and demographic compositions.

### **COMMUNITY CONTRIBUTION AGREEMENTS**

Since the transfer of services from the FNIHB to the FNHA, there have been significant changes to how community-based program funding is allocated. The FNHA has implemented a 5% increase to community program funding per year for five years, and some new programs developed post-transfer are funded based on total registered membership. However, many programs that were implemented before the transfer are still funded based on the on-reserve population. Some Nations and communities continue to provide services to all First Nations (and non-First Nations) people who enter their doors.

### **HEALTH BENEFITS**

In 2013, the FNHA assumed responsibility for programs and services formerly handled by Health Canada, including the administration of the Non-Insured Health Benefits program for all Status First Nations people in BC (on- or off-reserve). Guided by the direction provided by communities and in alignment with the FNHA's vision and plans, the Health Benefits Program is now provided in partnership with Pacific Blue Cross, which provides coverage for dental, vision care and medical supplies and equipment not covered by provincial, territorial or other third-party health insurance for First Nations people in BC. Since transfer, Indigenous Cultural Safety training has been made mandatory for all Health Benefits Assessors.

### **QUALITY, QUALITY IMPROVEMENT AND ACCREDITATION**

The FNHA's Community Accreditation and Quality Improvement program works directly with BC First Nations to support program participants in maintaining or achieving their accreditation status. Accreditation is an ongoing quality improvement process that organizations use to assess the quality and safety of their services against a pre-determined set of standards. Accreditation can further organizational and health service leadership, strength, sustainability and growth, and it can demonstrate to community members and partners that the organization is committed to a high standard of safety and service excellence.



## PART 2: MOVING FORWARD

# PRINCIPLES, STRATEGIC DIRECTIONS AND IMPLICATIONS

### DEFINING OUR TERMS

**Principles:** The principles are high-level policy positions intended to guide the strategic directions and actions recommended in this Framework.

**Strategic Directions:** The Strategic Directions are statements that outline suggested parameters for action based on feedback, information and priorities gathered.

**Implications:** The implications are suggested steps, considerations, risks or priorities to inform the development of provincial and regional strategies. This is an evergreen document, and it is likely that more implications will be added through ongoing community and regional engagement and planning processes.

**The Principles, Strategic Directions and Implications outlined in this Framework are divided into three sections:**

- **Setting the Foundations for Success;**
- **Being a Health and Wellness Partner; and**
- **Bringing Wellness Closer to Home.**



# FRAMEWORK AT A GLANCE



Being a Health and Wellness Partner



## MEANINGFUL REPRESENTATION

Develop sustainable and meaningful engagement pathways with the urban and away-from-home population across BC.

## RESEARCH AND KNOWLEDGE DEVELOPMENT

Develop ethical and solution-oriented strategies for urban and away-from-home research and knowledge development.

## PARTNERSHIPS

Develop and continue to nurture meaningful partnerships with First Nations, provincial ministries, provincial and regional health authorities, Indigenous service organizations and health and wellness organizations through engagement and implementation of this Framework

## COORDINATING PROGRAMS AND SERVICES

Coordinate new and ongoing urban and away-from-home programs and services to increase efficiency and avoid duplication

## ENHANCING PROGRAMS AND SERVICES

Through partnerships, operationalize a continuum of care that brings together the best of traditional and cultural approaches with western approaches, and encompasses a range of fully integrated programs and services

## INTEGRATING THE SOCIAL DETERMINANTS OF HEALTH

Partners acknowledge the social determinants of health and recognize the efficiency and equity in investing in upstream and preventative supports for the urban and away-from-home population

## URBAN PARTICIPATION: "WITH US, NOT FOR US"

Develop a strategy or strategies and set of guiding principles for First Nations participation and inclusion in urban and away-from-home health and wellness services.

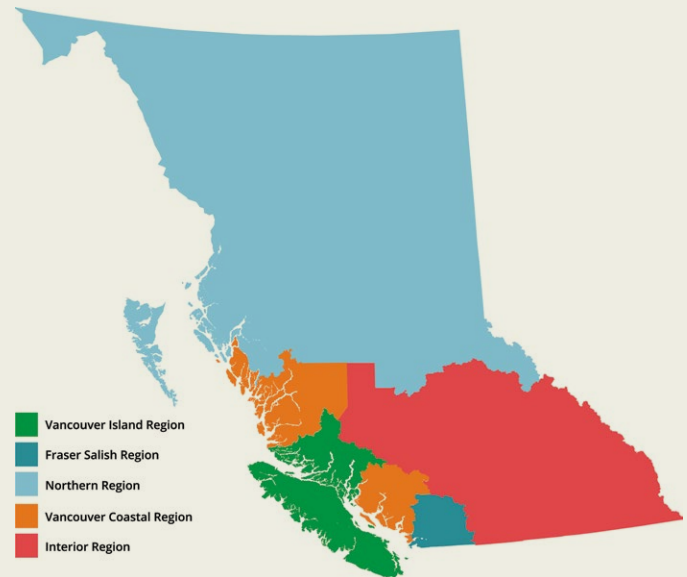
## NATION-BASED AND NATION-SHARED SERVICES

Comprehensive funding approach that enables long term Nation-based planning, and collaboration between communities and Nations, to efficiently deliver services within economies of scale

# SETTING THE FOUNDATIONS FOR SUCCESS

## 1. MEANINGFUL REPRESENTATION

**OVERVIEW:** Who speaks for the urban and away-from-home population? There is no simple answer to this question. Nations represent both their own members living home or away from home, as well as guests on their traditional territories. Yet as Table 2 (pg.16) demonstrates, there are areas in BC where the urban away-from-home First Nations population is not directly represented by BC Nations and communities. Engagement strategies require regional approaches to meet each regions' unique needs, relationships and contexts. The strategies to ensure meaningful representation need to account for local contexts. Each health region in BC has a unique demographic composition, its own Nation-based relationships and protocols, and a unique geography that demands different forms of engagement.



### PRINCIPLES

- a. Recognize the joint responsibility of the FNHA, the Province of BC and the Government of Canada to engage with and support the urban and away-from-home population in BC, who account for 72% of all First Nations people living in BC.
- b. Recognize the diversity of First Nations people living away from home, in urban centres or in remote parts of BC, understanding that they have unique cultural connections and relationships with Indigenous service organizations and Nations, and have agency in deciding who presents their interests.
- c. Support approaches to ensure that communities and Nations in the process of Nation building are able to connect with and represent their members living off-reserve as well as guests in their traditional territory, and to enhance Nation-to-Nation relationships.
- d. Support approaches that include the urban and away-from-home population who are not, or choose not to be, represented by Nations or on-reserve communities in BC.
- e. Recognize that not all communities and Nations currently have the capacity to engage with their off-reserve members, while others have the capacity and may already have established processes for engagement and inclusion in health and wellness service planning and implementation.

## STRATEGIC DIRECTIONS

- Develop processes for meaningful, sustainable and ethical engagement with the urban and away-from-home population across BC. “Meaningful and ethical” engagement acknowledges that measuring human suffering without taking actions to address it is immoral. Engagement processes need to be directly attached to wellness planning and enhancements.

## IMPLICATIONS

- Significant funding will be required to support provincial, regional and Nation-based engagement processes.
- As engagement moves forward, there is the implication that additional funding will be required to support the urban and away-from-home population, including funding for new and existing urban clinics as well as increased funding for Nations to support those who do not live on-reserve.
- Health system partners will be integral to this engagement process. Bring partners into this process early on to ensure full inclusion in the engagement process as well as subsequent strategies and actions that emerge from engagement.

## 2. RESEARCH AND KNOWLEDGE DEVELOPMENT

**OVERVIEW:** There is a paradox in the research and data on the urban and away-from-home population, in that there is both too much research being done and too little knowledge being used to support the well-being of First Nations people. Urban First Nations communities and service providers are the subjects of hundreds of studies, and yet there is still too little data for direct service planning purposes. The explanation for this paradox is that data indicators are often too broad in scope and often biased towards on-reserve communities, while qualitative surveys and single-issue engagement sessions are often too narrow in scope to apply to regional planning. The gaps in information result in barriers for Indigenous community leaders, service providers and health policy-makers responsible for evidence-based health and wellness planning. The only large-scale population data set of off-reserve First Nations people in BC is the federal census, which is limited by response bias and may underrepresent the actual population by a significant degree.

## PRINCIPLES

- a. First Nations communities, the FNHA and our health system partners require reliable and relevant information and data to effectively plan urban First Nations health and wellness programs, services and delivery.
- b. Acknowledge that measuring human suffering while not taking action to remedy it is immoral. Research must be connected to health system improvements and First Nations wellness.
- c. Indicators of wellness need to accurately reflect the First Nations Perspective on Health and Wellness and be solution-oriented rather than deficit-based.
- d. Recognize the “right to count and be counted” with high-quality data that is complete, current, accurate, appropriately standardized and consistent.

## STRATEGIC DIRECTIONS

- Develop a strategic approach to enhancing provincial, regional and local qualitative and quantitative knowledge on the urban and away-from-home population.
- Integrate data collection strategies into urban and away-from-home engagement processes.
- Incorporate Indigenous ways of knowing and being into data strategy as well as the principles of OCAP (ownership, control, access and possession).

## IMPLICATIONS

- Developing ethical and solution-oriented strategies for urban and away-from-home research and knowledge development is a large undertaking that will require buy-in from multiple partners.
- An ethical approach requires that a source of funding and a strategic direction to enhance First Nations wellness services be attached to the outcomes of the research.
- A comprehensive data and knowledge strategy will enable more inclusive and precise planning for First Nations-led primary health care projects and help build connections with the urban and away-from-home First Nations communities across BC.

## 3. PARTNERSHIPS

**OVERVIEW:** Strong partnerships and collaboration between the FNHA, First Nations communities, health system partners and urban Indigenous service organizations are needed to achieve the goals of this Framework as well as the broader goal of transforming and embedding cultural safety and humility into the health system. There are many First Nations service organizations, such as Aboriginal Friendship Centres, that have long-standing relationships with the urban and away-from-home First Nations population. It is important not to undermine or circumvent these relationships, but to build upon and support their strengths as health and wellness partners.

### PRINCIPLES

- a. Recognize that partnerships with First Nations, provincial ministries, provincial and regional health authorities and Indigenous service organizations are foundational to the success of this Framework and the FNHA's broader Vision.
- b. Acknowledge the voice and agency of the urban and away-from-home population in choosing their own health and wellness partners.
- c. Recognize the need to partner with governmental ministries, federal partners and organizations related to the social determinants of health (i.e., the Ministry of Education, Emergency Management BC, the Ministry of Municipal Affairs and Housing and Indigenous Services Canada).

## STRATEGIC DIRECTIONS

- Bring partners into a dialogue on urban and away-from-home First Nations health and wellness as an early first step, to involve them throughout the process of creating strategies and action plans.
- Advocate for upstream supports, particularly for children and youth, to provide foundational requirements for their health and wellness journeys.

## IMPLICATIONS

- Many of these partnerships have political implications. While this Framework is focused on service delivery, the First Nations Health Council (FNHC) has a role in advancing strategic partnerships to support the urban and away-from-home population.
- FNHA regional health authorities, as well as Nations, have long-standing partnerships with government ministries and First Nations organizations, each of which is unique and needs to be taken into account in developing the partnership approaches outlined in this Framework.



# BEING AN URBAN AND AWAY-FROM-HOME WELLNESS PARTNER

## 1. COORDINATING PROGRAMS AND SERVICES

**OVERVIEW:** After we set out to develop this Framework, the Ministry of Health instituted a number of changes to BC's health systems that align with the initial vision of this Framework, particularly with the new approach to primary health care that is built around team-based models of care integrated through primary care networks. In partnership with the FNHA and First Nations, the Ministry is leading the development of 15 First Nations-Led primary health care projects across BC. The FNHA and our partners have a number of other initiatives and programs to support the urban and away-from-home population, such as Joint Project Board projects, opioid overdose response, the cultural safety and humility campaign, supports for family members and loved ones impacted by Missing and Murdered Indigenous Women and Girls and the BC Indigenous Cancer Strategy. There is an opportunity to consolidate multiple initiatives and to expand many projects currently focused on on-reserve populations under one coordinated approach that also supports the urban and away-from-home population.

**“In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.”**

~ Truth and Reconciliation Commission

## PRINCIPLES

- a. Advance the First Nations Perspective on Health and Wellness, and the FNHA's PHC++ approach to primary health care programs and services for the urban and away-from-home population.
- b. Recognize economies of scale and the efficiency in coordinating care across multiple Nations, communities, government ministries and service organizations.
- c. Encourage approaches to urban and away-from-home program and service coordination that support Nation building.
- d. Integrate urban and away-from-home perspectives and plans across FNHA leadership, policy, program and partnership functions.
- e. Respond to the Truth and Reconciliation Commission's Call to Action #20, which states that “In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.”

## STRATEGIC DIRECTIONS

- Review current initiatives in urban and away-from-home primary health care projects for areas of duplication and opportunities for enhancing First Nations representation, and coordination with mental health and wellness and social determinants of health programs.
- Review BC's A Pathway to Hope mental health and addiction strategy for opportunities to coordinate and integrate mental health and wellness programs with urban and away-from-home primary health care programs and services.

## IMPLICATIONS

- The FNHC is advocating for a new approach to community funding agreements, in which all program and service funding would be consolidated into one social transfer payment. This would enable Nations to comprehensively plan for long-term and coordinated programs and services. Yet Nations do not always represent the urban and away-from-home population. There is an opportunity to reduce the administrative burden on urban Indigenous service organizations in a similar way, through long-term sustainable funding models with one fund holder, rather than short-term grant-based funding through multiple sources.

## 2. ENHANCING PROGRAMS AND SERVICES

**OVERVIEW:** The FNHA has multiple roles in urban and away-from-home health and wellness, as a service provider, a funder, a partner and an advocate for the systemic transformation of BC's health system(s) to support the wellness journeys of all First Nations people in BC. Many of the FNHA's programs and services are focused on the on-reserve population, and they lack the processes and resources to be inclusive of the urban and away-from-home population. As we seek to enhance programs and services for the broader First Nations and Indigenous population in BC, the FNHA continues to learn from best practices across Canada and internationally for methods of quality assurance and delivering innovative and integrated care models that align with the wholistic First Nations Perspective on Health and Wellness, through engagement and participation from our communities and Nations.

## PRINCIPLES

- a. Function at a high operational standard, using best practices from across Canada and internationally, to fund, support and deliver wholistic models of culturally safe and appropriate primary health care and mental health and wellness initiatives for the urban and away-from-home population.
- b. Recognize Nation-based and Nation-shared service approaches and acknowledge and support planning, design and delivery for urban and away-from-home services that contribute towards Nation building.

- c. Acknowledge the FNHA's multiple roles in BC's health system as a direct service provider, funder, partner and advocate, to balance and enhance each of these roles in context-dependent circumstances.
- d. Recognize the need to effectively communicate with the urban and away-from-home population to bring awareness of and increase access to culturally safe and appropriate health and wellness programs



### STRATEGIC DIRECTIONS

- Develop an internal understanding of the FNHA's multiple roles in urban and away-from-home health and wellness, and through this Framework develop strategies to enhance each of these roles to build up the FNHA's strengths and the strengths of health system partners.
- System change in BC is an integral aspect of this Framework, and many health system transformation pieces are already under way. Most significantly, the cultural safety and humility campaign is an integral part of this work to make services more culturally safe and accessible. This Framework does not intend to duplicate those efforts, but will support cultural safety and humility and other system-wide strategies.

### IMPLICATIONS

- Having the FNHA become a direct service provider off-reserve may be an effective way to assure the quality of First Nations primary health care and mental health and wellness programs and services. As the FNHA expands the scope of urban and away-from-home service delivery, it will require a partnered approach with government ministries, regional health authorities, service organizations and First Nations communities and partners.

## 3. INTEGRATING THE SOCIAL DETERMINANTS OF HEALTH

**OVERVIEW:** The social determinants of health are the conditions in which people are born, grow, work, live and age as well as the wider set of forces and systems shaping the conditions of daily life. The social determinants of health include:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Culture and language</li> <li>• Social support networks</li> <li>• Income and social status</li> <li>• Employment and working conditions</li> <li>• Physical environment (housing, land, water, food security)</li> </ul> | <ul style="list-style-type: none"> <li>• Personal health practices and coping skills</li> <li>• Early childhood experience</li> <li>• Access to health services</li> <li>• Genetics and gender</li> <li>• Social exclusion</li> </ul> |
|--|---|



This is not a new concept for First Nations. BC First Nations have always viewed health and wellness from a wholistic perspective. It is only more recently that western medical perspectives have adopted the view that health is largely determined by broader social, cultural, institutional, economic and environmental factors.

## PRINCIPLES

- a. Acknowledge the social determinants of health and recognize the efficiency and equity in investing in upstream and preventative supports (including cultural and language programs) for the urban and away-from-home population, and integrating social determinants supports in primary care teams.
- b. Recognize that changing BC's health system from an illness model to a wellness model requires early investment in children, youth and families to set a foundation for their wellness journeys.

## STRATEGIC DIRECTIONS

- Through partnerships, and in alignment with FNHA's Mental Health and Wellness policy, operationalize a continuum of care that brings together the best of traditional and cultural approaches with western approaches to mental health and wellness, and encompasses a range of fully integrated programs and services.
- Leverage opportunities through the Memorandum of Understanding between the FNHC, the Government of Canada and the Province of BC on the Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness.
- Work with BC's Ministry of Social Development and Poverty Reduction on systemic solutions to the multiple and interlocking crises of homelessness, poverty, substance use and mental health and wellness.

## IMPLICATIONS

- The social determinants of health are typically viewed as being too broad in scope, and too expensive or complex, and outside of the mandate of any one ministry or organization. Coordination of services across the social determinants of health spectrum, however, can have significant positive impacts.
- The care model utilized by the Lu'ma Medical Centre is helpful wise practice on integrating social determinants of health supports into primary care.



# BRINGING WELLNESS CLOSER TO HOME

## 1. URBAN PARTICIPATION: “WITH US NOT FOR US”

**OVERVIEW:** Throughout the history of First Nations-focused policy development in BC, it has been common for First Nations and Indigenous groups to be categorized as one of many “sites of cultural difference” or as one of many competing interest groups. The result is that First Nations people have been approached as one of many stakeholders in the existing structure of consultation. First Nations people in BC are not just another interest group, as they have a unique culture and connection to the unceded lands and territories that pre-dates the colonial government of Canada. In addition to approaching engagement in a new way, we advocate for the full participation of urban and away-from-home First Nations communities to enhance the accessibility and cultural appropriateness of First Nations health and wellness services.

### PRINCIPLES

- a. Recognize that “Community-Driven, Nation-Based” applies to urban and away-from-home First Nations communities, and enhance First Nations control by supporting urban and away-from-home participation in their health and wellness services.
- b. Acknowledge that the full participation of urban and away-from-home First Nations people and communities in their health and wellness services is an important aspect of embedding the First Nations Perspective on Health and Wellness into the health system and increasing local First Nations capacity and control.

### STRATEGIC DIRECTIVES

- Co-develop a set of guiding principles and strategies for First Nations participation in the development, design, planning, implementation and evaluation of urban and away-from-home health and wellness services.
- Work with health system partners to enhance First Nations participation within the health system and integrate culture into health services, including designated seats on the boards and governance bodies of clinics and hospitals.
- Adopt the principles of the community health centre model for primary health care and mental health and wellness services in which it is stipulated that the governance body of a clinic, such as a board, be comprised of members of the community to which it provides programs and services.



## IMPLICATIONS

- There is an opportunity to leverage partnerships with the signatories of the Declaration of Commitment to Cultural Safety and Humility (the 21 regulatory bodies in BC) to enhance urban and away-from-home First Nations participation in the health system.
- The Royal Commission on Aboriginal Peoples report offers significant insights into urban First Nations self-governance. See the sub-section titled “self-government in the city.”

## 2. NATION-BASED AND NATION-SHARED SERVICES

**OVERVIEW:** Directive #1 of the FNHA is to be “Community-Driven and Nation-Based.” A key challenge in Nation-based approaches to support the urban and away-from-home population is that funding mechanisms still focus on financing programs individually, sometimes with different funding models for each program. Some programs receive funding for all members of the community, while others are funded only for those who live on-reserve. This obstructs Nations from comprehensively planning for sustainable and long-term programs and services for all of their members or the broader population within the geographical area. This can create a harmful cycle where communities invest in a process of planning and establish expectations for change, only to find out that there are no resources available to support their implementation. Additionally, First Nations health services are most frequently administered through the Band structure, which creates competition for proposal-based funding, resulting in inefficiencies from the lack of economies of scale and heightened administrative burdens and inequities for smaller and more remote communities with fewer resources to apply for funding opportunities.

### PRINCIPLES

- a. Acknowledge that Nations and communities collaborating to create economies of scale are able to provide comprehensive and integrated health and wellness services to all of their members as well as other First Nations persons in BC, the wider Indigenous population in BC and potentially the non-Indigenous population living in their traditional territories.
- b. Enhance First Nations control over health and wellness services through Nation-based service delivery.

### STRATEGIC DIRECTIVES

- Learn from best practices (such as Ktunaxa, Stó:lō and the North Shore Tribal Council) to support Nations to provide services to the urban and away-from-home population, and review community contribution agreements to ensure that program funding aligns with the population being served.
- Continue discussions on the FNHC’s plan for a comprehensive funding approach that enables long term Nation-based planning and collaboration between communities and Nations to efficiently deliver services.



## IMPLICATIONS

- Nation-based and Nation-shared services may be more suitable in particular contexts. In densely populated urban areas such as Metro Vancouver or Surrey, where the First Nations population is more diverse and potentially less connected to BC Nations, the above approach to urban participation is likely better suited to meet the needs of the population.

## WISE PRACTICE: NATION-BASED SERVICE DELIVERY

### N'mnineoyaa Community Health Access Centre "Anishinabek culture is treatment and therapy"

The N'mnineoyaa Community Health Access Centre (N'mnineoyaa CHAC) is a multidisciplinary hub-and-spoke care centre that spans a 600 kilometre catchment area between Sudbury and Sault Ste. Marie. It uses community health facilities to bring services into each community, as well as Aboriginal Friendship Centre facilities to bring services to the urban population in Sault Ste. Marie.

N'mnineoyaa CHAC emerged out of the collaboration between the seven First Nations across Lake Huron (Serpent River, Batchewana, Garden River, Thessalon, Sagamok, Mississauga and Atikameksheng) who came together to create the Maamwesying North Shore Community Health Services (MNSCHS) through an agreement signed by North Shore Tribal Council Chiefs to renew and strengthen cooperation and coordination of services in a manner that promotes the cultural, spiritual, political, economic, environmental and social well-being of the member First Nations. Maamwesying is a non-profit corporation incorporated under the Ontario Corporations Act and is the administrative body for the N'Mninoeyaa CHAC, whose services include:

- **Primary Health Care**
- **Chronic Disease Prevention**
- **Community Support Services**
- **Mental Health and Addictions**
- **Traditional Health and Healing**

In 2011, the Mamaweswen North Shore Tribal Council also established the Baawaating Family Health Team located on the Batchewana First Nation. This move was to expand primary health care services to local and off-reserve Aboriginal people residing in Sault Ste. Marie who did not have a Family Practitioner.

N'mninoeyaa is modelled after Ontario's Community Health Centre (CHC) model, and was built upon Ontario's Aboriginal Health Policy (1992), which brought four ministries together to pool funding for team-based multidisciplinary care, with a clear mandate to provide services for all Indigenous people regardless of their residence on- or off-reserve, with a focus on marginalized and at risk populations.

Starting with only 15 employees, N'mninoeyaa has grown to have approximately 100 full-time, part-time, and casual employees providing primary health care and traditional health services through multidisciplinary care teams

in 11 clinics – one in each community, as well as one in Sault Ste. Marie. They also work in partnership with the hospitals in Sudbury and Sault Ste. Marie through referrals and discharge processes. N'mninoeyaa has an annual operating budget of approximately \$10 million, the majority (89.5%) of which comes from the Ontario Ministry of Health, with 7.8% from Health Canada and 2.5% from the Ministry of Child and Youth Services.

The growth of N'mninoeyaa CHAC was not without its challenges. In the early phases of their development, MNSCHS commissioned research on the health status of their member Nation citizens, which confirmed higher incidence of non-traditional tobacco use, alcohol and drug use, chronic disease health problem, and mental health issues within their communities. The data also highlighted the inequities in funding between communities of different sizes, and the barriers of access to culturally appropriate services. At the same time, provincial research also recommended that control over planning and service delivery was necessary to improve Indigenous health. The confluence of grassroots organizing and provincial policy opened up the opportunity for N'mninoeyaa to enjoy the success it sees today.



**Find more at:**  
[www.nmninoeyaa.ca/about us](http://www.nmninoeyaa.ca/about-us)

# URBAN AND AWAY-FROM-HOME PRINCIPLES

## SETTING THE FOUNDATION FOR SUCCESS

### 1. MEANINGFUL REPRESENTATION

- a. Recognize the joint responsibility of the FNHA, the Province of BC and the Government of Canada to engage with and support the urban and away-from-home population in BC, who account for 72% of all First Nations people living in BC.
- b. Recognize the diversity of First Nations people living away from home, in urban centres or in remote parts of BC, understanding that they have unique cultural connections and relationships with Indigenous service organizations and Nations, and have agency in deciding who presents their interests.
- c. Support approaches to ensure that communities and Nations in the process of Nation building are able to connect with and represent their members living off-reserve as well as guests in their traditional territory, and to enhance Nation-to-Nation relationships.
- d. Support approaches that include the urban and away-from-home population who are not, or choose not to be, represented by Nations or on-reserve communities in BC.
- e. Recognize that not all communities and Nations currently have the capacity to engage with their off-reserve members, while others have the capacity and may already have established processes for engagement and inclusion in health and wellness service planning and implementation.



### 2. RESEARCH AND KNOWLEDGE DEVELOPMENT

- a. First Nations communities, the FNHA and our health system partners require reliable and relevant information and data to effectively plan urban First Nations health and wellness programs, services and delivery.
- b. Acknowledge that measuring human suffering while not taking action to remedy it is immoral. Research must be connected to health system improvements and First Nations wellness.
- c. Indicators of wellness need to accurately reflect the First Nations Perspective on Health and Wellness and be solution-oriented rather than deficit-based.
- d. Recognize the “right to count and be counted” with high-quality data that is complete, current, accurate, appropriately standardized and consistent.

### 3. PARTNERSHIPS

- a. Recognize that partnerships with First Nations, provincial ministries, provincial and regional health authorities and Indigenous service organizations are foundational to the success of this Framework and the FNHA's broader Vision.
- b. Acknowledge the voice and agency of the urban and away-from-home population in choosing their own health and wellness partners.
- c. Recognize the need to partner with governmental ministries, federal partners and organizations related to the social determinants of health (i.e., the Ministry of Education, Emergency Management BC, the Ministry of Municipal Affairs and Housing and Indigenous Services Canada).

## BEING A HEALTH AND WELLNESS PARTNER

### 1. COORDINATING PROGRAMS AND SERVICES

- a. Advance the First Nations Perspective on Health and Wellness, and the FNHA's PHC++ approach to primary health care programs and services for the urban and away-from-home population.
- b. Recognize economies of scale and the efficiency in coordinating care across multiple Nations, communities, government ministries and service organizations.
- c. Encourage approaches to urban and away-from-home program and service coordination that support Nation building.
- d. Integrate urban and away-from-home perspectives and plans across FNHA leadership, policy, program and partnership functions.
- e. Respond to the Truth and Reconciliation Commission's Call to Action #20, which states that "In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples."

### 2. ENHANCING PROGRAMS AND SERVICES

- a. Function at a high operational standard, using best practices from across Canada and internationally, to fund, support and deliver wholistic models of culturally safe and appropriate primary health care and mental health and wellness initiatives for the urban and away-from-home population.
- b. Recognize Nation-based and Nation-shared service approaches and acknowledge and support planning, design and delivery for urban and away-from-home services that contribute towards Nation building.
- c. Acknowledge the FNHA's multiple roles in BC's health system as a direct service provider, funder, partner and advocate, to balance and enhance each of these roles in context-dependent circumstances.

- d. Recognize the need to effectively communicate with the urban and away-from-home population to bring awareness of and increase access to culturally safe and appropriate health and wellness programs

### **3. INTEGRATING THE SOCIAL DETERMINANTS OF HEALTH**

- a. Acknowledge the social determinants of health and recognize the efficiency and equity in investing in upstream and preventative supports (including cultural and language programs) for the urban and away-from-home population, and integrating social determinants supports in primary care teams.
- b. Recognize that changing BC's health system from an illness model to a wellness model requires early investment in children, youth and families to set a foundation for their wellness journeys.

## **BRINGING WELLNESS CLOSER TO HOME**

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- a. Acknowledge that Nations and communities collaborating to create economies of scale are able to provide comprehensive and integrated health and wellness services to all of their members as well as other First Nations persons in BC, the wider Indigenous population in BC and potentially the non-Indigenous population living in their traditional territories.
- b. Enhance First Nations control over health and wellness services through Nation-based service delivery.





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**Urban and Away-from-Home Framework**  
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Health through wellness