



GATHERING WISDOM V

for a Shared Journey



Vancouver, BC May 15-17, 2012 | Summary Report

Thank you to all the dedicated Chiefs, leaders, health professionals, and community members who attended Gathering Wisdom for a Shared Journey V, offered their leadership, and shared their wisdom, teachings, songs, prayers, and direction.

Thank You.

TABLE OF CONTENTS

- 05 **Background**
06 **Objectives of Gathering Wisdom V**

07 } **May 15th, 2012**

- 08 **Opening Remarks**
Jody Wilson-Raybould, Regional Chief, British Columbia Assembly of First Nations
Dan Smith, Political Executive, First Nations Summit Task Group
Grand Chief Stewart Phillip, President, Union of BC Indian Chiefs
Shawn A-in-chut Atleo, National Chief, Assembly of First Nations
Pierre Leduc, Vice-Chair, *interim* First Nations Health Authority
Jacki McPherson, President, First Nations Health Directors Association
- 10 **Opening Remarks and Progress Report**
Grand Chief Doug Kelly, Chair, First Nations Health Council
- 12 **Wellness Plenary and Launch (Doc Talk)**
Dr. Evan Adams, Deputy Provincial Health Officer, Ministry of Health, British Columbia
Dr. Georgia Kyba, Traditional Medicine Advisor
Dr. Shannon Waters, Director of Health Surveillance, and Dr. Naomi Dove, Director of Health Promotion and Prevention, First Nations and Inuit Health Branch, Health Canada, Pacific Region
- 16 **Final Ring of the Health and Wellness Model**
- 17 **Keynote Speaker: Lateral Violence**
Madeleine Dion Stout, Director, *interim* First Nations Health Authority Board of Directors
- 20 **Regional Caucus Sessions**

24 } **May 16th, 2012**

- 24 **Minister of Health - Video Message**
Minister Leona Aglukkaq, Minister of Health and Minister of the Canadian Northern Economic Development Agency, Government of Canada (Video Message)
- 24 **Navigating the Currents of Change - Leadership**
Cliff Atleo Sr. (FNHC Vancouver Island Region), Gwen Phillips (FNHC Interior Region), and Warner Adam (FNHC North Region)

Gathering
Wisdom
V
for a
Shared Journey

Vancouver, BC
May 15-17, 2012

- 29 Transition & the *interim* First Nations Health Authority**
Joe Gallagher, Chief Executive Officer, *interim* First Nations Health Authority
- 33 Navigating the Currents of Change - Panel Presentation: Success Stories (Nisga'a & Alaska)**
Dan Winkelman, Vice President for Administration and General Counsel, Yukon-Kuskokwim Health Corporation
James Moore, Chairperson, Nisga'a Valley Health Authority
- 38 Regional Partnership Accords**
Shana Manson (FNHC Vancouver Island Region)
- 41 Discussion/ Debate on Resolution 2012-01 & Consensus Paper**

42 } May 17th, 2012

- 42 Safer Nations Video Contest**
Dr. Evan Adams, Deputy Provincial Health Officer, Ministry of Health, British Columbia
Dr. Perry Kendall, Provincial Health Officer, Government of British Columbia
Laura Jamieson, Health Director, Skwlax Wellness Centre
- 44 Our Evolving Landscape - Physicians as Partners**
Dr. Perry Kendall, Provincial Health Officer, Government of British Columbia
Dr. Lloyd Oppel, Chair, Council on Health Promotion, British Columbia Medical Association
- 47 Introduction to Health Actions Dialogue Session**
Yousuf Ali, Regional Director, First Nations & Inuit Health Branch, Health Canada
Dr. Shannon McDonald, Executive Director, Aboriginal Health Branch, Ministry of Health
Michelle DeGroot, Executive Director, Health Actions, *interim* First Nations Health Authority
- 48 Tripartite Dialogue Sessions**
- 56 Closing Remarks & Prayer**
-
- 57 Acronym List**
- 58 APPENDIX A: List of Presentation and Resource Materials**
- 59 APPENDIX B: Holistic Vision of Wellness Diagram**
- 60 APPENDIX C: FNHC Resolution 2012-01 (abridged)**
- 62 APPENDIX D: Forum Feedback**

“We have to make sure our people, when they are sick, know how to navigate the system and get the best care possible.”

- Grand Chief Doug Kelly, Chair, First Nations Health Council

Background



Gathering Wisdom for a Shared Journey is an annual gathering of First Nations leadership, Health Directors and government partners. The forum provides a key engagement opportunity for Tripartite partners to communicate progress in the implementation of the Tripartite First Nations Health Plan (TFNHP) and to gain additional direction and feedback from BC First Nations to advance the health reform process.

The Gathering Wisdom Forums have been fundamental to shaping the work of the FNHC under the Transformative Change Accord: First Nations Health Plan (TCA:FNHP) and TFNHP. On May 20-21, 2008 the second annual Gathering Wisdom Forum convened in Vancouver, BC and offered opportunity for BC First Nations health professionals and their provincial and federal counterparts to discuss the significant progress made in the implementation of the TCA: FNHP and TFNHP actions, and to continue the conversation on BC First Nations' health. Gathering Wisdom for a Shared Journey III took place November 3-5, 2009, with further discussion on health governance and the actions in

the TCA: FNHP and TFNHP. This included discussions about the First Nations Health Society (FNHS) - created to take on the legal and financial responsibilities for implementing the health plans - and ratification of the establishment of the First Nations Health Directors Association (FNHDA).

At Gathering Wisdom for a Shared Journey IV held May 24-26, 2011, BC First Nations considered, debated and ratified Resolution 2011-01. Leadership voted to adopt the Consensus Paper, which describes First Nations' vision of a new health governance structure. Through the Resolution, First Nations endorsed a Tripartite Framework Agreement on First Nation Health Governance - a tripartite legal agreement to transfer the operations of Health Canada's First Nations and Inuit Health Branch-BC Region to a First Nations Health Authority and enter into a new health partnership with the federal and provincial governments. The BC Tripartite Framework Agreement on First Nation Health Governance was signed on October 13th, 2011.



OBJECTIVES OF GATHERING WISDOM V

At Gathering Wisdom for a Shared Journey (GWSJ) V, BC First Nations were invited to continue their collective journey toward First Nations control of the design and delivery of First Nations health programs and services, and a new health partnership with federal and provincial governments. Participants worked together to improve First Nations health and well-being through diverse sessions: from regional caucuses and presentations from communities that have undertaken similar initiatives, to health actions workshops and a resolution on the development of and transition to a First Nations health governance structure.

The input provided during GWSJ V will guide BC First Nations' collective efforts to achieve the vision of healthy, self-determining, and vibrant BC First Nations children, families, and communities. Everyone was encouraged to actively listen, share and bring all of their experiences and ideas to the table.

The following proceedings of GWSJ V provide a synopsis of the event, including narrative summaries of plenary presentations and discussions, as well as notes of Regional Caucus and Tripartite Dialogue sessions.

MAY 15th, 2012

REGIONAL PROCESSION AND ENTRANCE

Day One – May 15, 2012 of GWSJ V (2012) commenced at 8:40 a.m. with a Regional Procession in which participants representing Vancouver Coastal, Fraser, Interior, Northern and Vancouver Island regions entered the Forum.



WELCOME

Elder Leonard George

“Not very often in life do all the elements fall into place to make it successful but we are at the place, we have the time, we have the people, and now we set aside our apprehension, and we set aside our own lives to look to the health of all. This is the moment.”



OPENING REMARKS

Jody Wilson-Raybould

Regional Chief, British Columbia Assembly of First Nations

“Through the First Nations Health Authority Tripartite Agreement we have embarked on the most important and challenging work we will know in our lifetime as First Nations taking responsibility for our own health and health services.”

Dan Smith

Political Executive, First Nations Summit Task Group

“First Nations peoples know all medicine comes from plants. We believe in a balance of physical, mental and spiritual health. We need to provide psychology and mental health, solutions for obesity and our own lack of confidence. I see confidence here today, confidence is reflected in the number of leaders here today.”

“We have survived the colonist principals and persevered. I quote the late Dan George, ‘we have to persevere’. Encourage our young people to seek careers in the field of medical science.”

Grand Chief Stewart Phillip

President, Union of BC Indian Chiefs

“I am grateful to have the opportunity to be a firsthand witness to this incredible journey. I am overwhelmed with the beehive of activity and with the number of people here and how deeply committed you are to our health.”

“Our struggle and our way forward is not about right or wrong. It is about committing to forwarding the journey and the need to hold each other responsible for our own health and do our utmost to see our grandchild’s grandchild have the best health care possible.”



Shawn A-in-chut Atleo

National Chief, Assembly of First Nations

“We are still struggling, but the message today is that we do matter to each other. By your presence we are stronger together and reaching out we are stronger together. Yes, we are the Nations in BC and we are courageous to accept responsibility and reach out to other Nations.”

“Other Nations are watching. We are not the holder of treaty rights but we can advocate with you for region-led solutions and as we come together across Canada in the shared experience of hurt and trauma and disconnect with the Canadian population at large, we are the leaders in health care transformation.”

“The only way forward is for First Nations and governments to work together, for too long we have not had willing partners.”

“We are Nations on the come-back trail, we matter to one another, First Nations drive the solutions, First Nations come up with our own way forward.”



Pierre Leduc

Vice Chair, interim First Nations Health Authority

“We look forward to working with First Nations on a number of priorities to build the First Nations Health Authority under the direction of First Nations’ values and directives with positive health actions and health system transformation.”

Jacki McPherson

President, First Nations Health Directors Association

“We will be sharing best practices in holistic health, financial management, and technical advice to Councils and the iFNHA with a goal for vibrant children, vibrant families and vibrant communities.”

“[We use] accreditation to define, measure, and improve the quality of health services. [We need] leadership in communities to achieve the high standards of the accreditation process.”

OPENING REMARKS & PROGRESS REPORT

Grand Chief Doug Kelly

Chair, First Nations Health Council

Grand Chief Doug Kelly provided opening remarks and a brief progress report on where BC First Nations are in the creation of their new health governance model. Having been involved in BC First Nations health reform for many years, Kelly has a clear perspective on where the process has been and what lies ahead.

“Last year we gathered to achieve an informed decision, keep our unity and come to a consensus decision. On May 26, 2011 when through a sacred ceremony at the Capilano Longhouse, Hon. Michael de Jong, and Minister Leona Aglukkaq signed the agreement,” said Kelly.

“When we adopted the resolution we created our little blue book and I call it my bible – Health Canada is now carrying our bible, the Province of BC carries our bible - they know what you told us.”

First-hand experience has taught Kelly many lessons and he said the future is looking bright for First Nations in BC because of the integrity, accountability and Nation-Based decision making that guides the entire design.

“If we are going to do this we are going to do it together with our sacred ceremonies and our spiritual leaders and by taking care of our minds, our hearts and our spirits. Together we will overcome fear, doubts and lack of confidence; together we will develop clear directions on how we manage change. Change will not manage us,” he said.

“We created a learning organization. We learn from one another, and from others in the world, about their failures and successes. It is important to maintain committed leadership, and with 190 leaders and proxies of 203 present today I know commitment is present. We want to make sure we do this work together.”



Kelly spoke on how the whole health reform taking place for BC First Nations is guided by the direction set out by Chiefs and leaders. The consensus driven process is pushing the work forward and a separation between business and politics ensures the two worlds can operate independently and not interfere with each other.

“We have clear direction to keep politics separate from our business. In the last two years we have participated in this approval pathway. We do not do change without talking about it first, without listening and sharing first. We have created a pathway to ensure that you, citizens, Health Directors and councils have a clear path to proceed. You asked us to sign a Framework Agreement and we did on October 13, 2011. There are a number of sub agreements on planning how to implement the components of the tripartite agreement,” said Kelly.

“The discussions are to develop a plan to ensure transfer of control from Health Canada to your control April 1, 2013. You gave us direction to begin tackling what is our authority, what is the structure and this will continue. You told us to take the early steps for the iFNHA. We have structured a Framework Agreement and an Implementation Committee. We have an Interim Management Committee to work through issues that bubble up as we manage change. We are taking the next steps to be responsible for delivering health care to your citizens.”

Mr. Kelly spoke of the importance of BC First Nations taking greater control of their health at the individual, family and community levels while the First Nations Health Authority they are creating will build to deliver the best possible health care solutions available including leveraging current systems and integrating a number of traditional and holistic paths to wellness.

“We need your directions to move ahead. Our work will continue through this forum, to determine the structure of our structure and the authority of our authority. One of the things we learned early is that when it comes to health and the health system, we need to eradicate health illiteracy to understand the decisions we make, and

that we have to take responsibility for our own well-being. We cannot say to our health professionals, “fix me I’m broken”. We have to make sure our people, when they are sick, know how to navigate the system and get the best care possible.”

Kelly closed by touching on his own health assessment and how he will be working to ensure he is walking the path to healthy living and leading by example for all BC First Nations communities.

“I was participating in a self-health assessment and everyone heard my results. I want to be accountable and I can report that there is a bit too much of me to love. I just thought my wife’s arms were too short. My blood pressure is a bit high and next year I will be reporting better blood pressure and that my wife’s arms have grown longer. [I] look forward to engaging, participating and learning and making informed decisions.”

“We learn from one another, and from others in the world, about their failures and successes. It is important to maintain committed leadership, and with 190 leaders and proxies of 203 present today I know commitment is present. We want to make sure we do this work together.”

- Grand Chief Doug Kelly, Chair, FNHC

WELLNESS PLENARY & LAUNCH (Doc Talk)

Dr. Evan Adams

*Deputy Provincial Health Officer, Ministry of Health,
British Columbia*

Dr. Evan Adams shared that First Nations in BC are uniquely positioned to take on the lead role in the design and delivery of First Nations health services and to transform the health system for the benefit of all. The need for a blended health model that is based on a combination of western medicine, traditional medicines, ceremony, philosophy and protocol has been reinforced by BC First Nations. The model must be holistic and aim to keep people well, not just deal with illness.

“In an era of skyrocketing health costs, BC First Nations have an unprecedented opportunity to keep our health system sustainable and to transform health services for all,” he said.

“It is difficult for Health Authorities to lead when focusing on an acute care system. These services are necessary services that we will need to access at some point in the future but right now there is the opportunity to develop a system with the ability to invest

resources in enhanced primary care while holding traditional health wisdom close to our hearts.”

Prior to presenting the new iFNHA Health and Wellness Model,¹ Dr. Adams reiterated that the iFNHA cannot do the work alone, and needs to work collaboratively with willing partners who also acknowledge the need to invest resources into wellness, disease prevention, enhanced primary care, traditional approaches. It makes sense for the FNHA to lead this work as we are best positioned to do so and have a clear mandate to do that.

Chronic diseases affect many First Nations. There are five key areas that contribute to addressing wellness and preventing disease: maintaining a healthy weight; being active; respecting tobacco; eating healthy; and nurturing the spirit. Doing nothing but these five things would make First Nations a very different population within a single generation, and many First Nations are already doing these things for themselves and their families.

Dr. Adams presentation was followed by a game of Family Feud – The Health and Wellness Edition.



¹ APPENDIX B: Holistic Vision of Wellness Diagram , please refer to page 59

Dr. Georgia Kyba

Traditional Medicine Advisor, interim First Nations Health Authority

Dr. Kyba shared that the centre of the Model represents the individual, their need to take responsibility for their own health and wellness, and to heal themselves. Healthy families, communities, and Nations start with the individual and their relationship with themselves, others and the environment. The next ring of the Model represents the four aspects of being: physical, mental, spiritual and emotional. It is common for an individual to focus on one or two areas, but for true health and healing, individuals need to address all four areas. Combined, all four areas create wellness. They do not stand alone, but are influenced by the other aspects of the Model, which are integrated and relate to one another.

“I spent my summers in the Yukon to connect with my relations and the land. This shaped me to become a Naturopathic physician.”

- Dr. Georgia Kyba, Traditional Medicine Advisor, iFNHA



Dr. Shannon Waters

Director of Health Surveillance, First Nations and Inuit Health Branch, Health Canada, Pacific Region
and

Dr. Naomi Dove

Director of Health Promotion and Prevention, First Nations and Inuit Health Branch, Health Canada, Pacific Region

Dr. Shannon Waters discussed the next ring of the Model which features the wellness values of wisdom, respect, relationships and responsibility - things that all front line health workers kept in mind every day. Respect is about honouring wherever you come from, and is passed on through family. It is the driving force of the community. Wisdom is an understanding of that which is passed on from generation to generation. Responsibility is to self, our families, our communities and to the land. It extends to those we come into contact with, and into our roles in the family, work, and the world. Relationships are what sustain us – they go hand in hand with responsibility and involve mutual accountability and reciprocity.

“Wisdom is an understanding passed on from our ancestors. Responsibility is to self, families, communities and the land. Relationships are what sustain us hand in hand with responsibility, togetherness, nurturing sharing, and love.”

Dr. Sarah Williams

Senior Advisor, Health Services, interim First Nations Health Authority

Dr. Williams noted her honour to be discussing the ring of the Health and Wellness Model dealing with land, community, family and Nations. She acknowledged the land that GWSJ V (2012) is being held on, and those who had taken care of the land for time immemorial. She discussed walking a good road and a good path, and walking that path not “on” but “with” Mother Earth, communities, families and Nations.

“This model of primary health care represents the beginning, the philosophy of our people. It is living this path that has allowed our people to survive for time immemorial.”

Dr. David McLean

Head, Prevention Programs, BC Cancer Agency

Dr. McLean discussed the ring of the Model containing the social, cultural, economic and environmental determinants of our health and wellness. Dr. McLean shared that at least 50% of cancers could be prevented by implementing risk reduction measures that are known today. Dr. McLean relayed a number of facts:

- According to the World Health Agency, tobacco is the only product on the market that kills 50% of its regular users.
- 20% of all cancers are caused by tobacco misuse.
- Unhealthy weights/ obesity account for 15-20% of cancers.

What you eat is important. He encouraged eating “real and natural foods” because foods that come from a factory are generally, not good for you. He also encouraged an active lifestyle. Exercise can prevent bowel cancer, breast cancer and many other diseases. Dr. McLean encouraged delegates to consider an active lifestyle, watching what they eat in calories and content, and to guard against tobacco misuse. This wellness concept would lead to community health, which supports individual choices.

He concluded with note that the correct choice, the healthy choice, becomes the easy choice in a supportive environment. Leadership is important in making these changes, and BC Cancer Agency fully supports First Nations in that and can be counted as partners.

*“The healthy choice becomes
the easy choice in a supportive
environment.”*

*- Dr. David McLean, Head, Prevention
Programs, BC Cancer Agency*

FINAL RING OF THE HEALTH AND WELLNESS MODEL

Grand Chief Doug Kelly, FNHC Chair, noted that the FNHC has integrated personal health and wellness discussions into every meeting and they held a round table and discussed where they are at in their own health, and supported one another with trust and love. Health and wellness begins with understanding that each and every one of us has a gift and we should support each other in practicing using that gift. Every important agreement and accomplishment needs to be celebrated with ceremony, to call on the spirit of the ancestors to make sure the work that is done is grounded in who we are and where we come from.

“We believe that every important work, every accomplishment, has to be celebrated in ceremony to ensure that work is grounded in who we are and to ensure that the work is carried forward,” said Kelly.

Dr. Elizabeth Whynot, *i*FNHA Board Director, discussed the role of the *i*FNHA and the Board composition. She acknowledged Dr. Adams’ reference to an opportunity to foster a different approach to health, and she welcomed the opportunity to work in partnership to figure out how this could best be done. There had

been tremendous progress to date, and what had been done was tremendously inspiring. She looked forward to working with the *i*FNHA to make the next step a reality.

Dr. Adams invited delegates to provide feedback to the model, and to complete and submit their responses to the workbook questions. He continued with note that the proposed Health and Wellness Model teaches that our personal choices are symbolized by our individual well-being. Having commitment, discipline and knowledge are central, and there is need for support from our communities, which is symbolized by the people and places in the Model. We all have community around us and the FNHC, and FNHDA, and *i*FNHA are part of that community that wants to provide support. They provide resources, information and services to support individual and community wellness – there are friends and a peer group to help you.

Delegates were informed that there are also other partners and exhibitors in the area of health present at the GWSJ V (2012) who are willing to offer support, guidance and information. There are many resources to help you and others. He concluded with note that change does take time, but today we can start. The creator put us on the Earth to learn. It’s all a process.



KEYNOTE SPEAKER: LATERAL VIOLENCE

Madeleine Dion Stout

Board Director, interim First Nations Health Authority

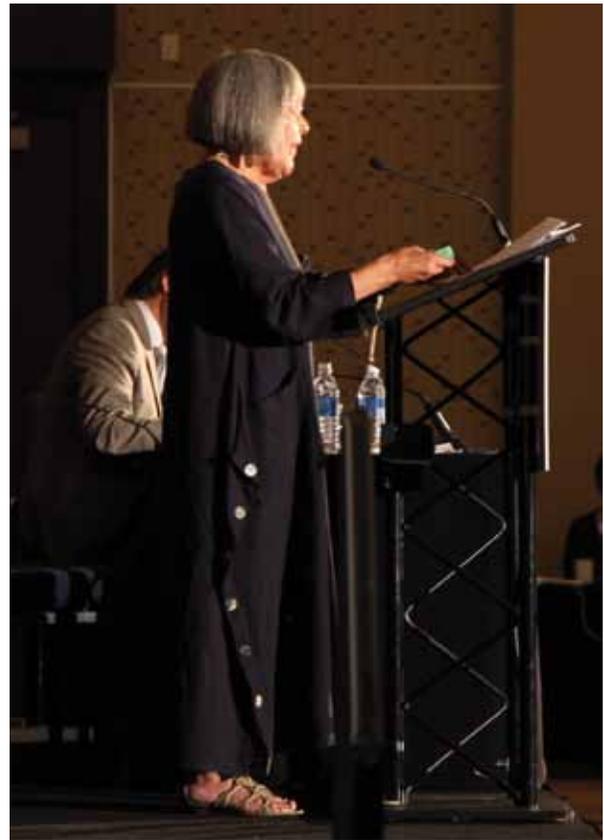
Ms. Dion Stout provided an overhead presentation titled “Kitimahitowin – Making one another poorer through lateral violence” in which she discussed the impacts of lateral violence.

“Lateral violence is no longer a sleeper issue when we can see the casualties out there. Lateral violence is a man-made disaster that needs our critical reflection now holistically and fearlessly.”

- Madeleine Dion Stout, BOD, iFNHA

Kitamahitowin: lateral violence mimics behavior that is not in keeping with our traditions and teachings. When we buy into lateral violence, we galvanize our power base by clawing back another person’s human reserves in a bucket of diminishing returns. This crab bucket is our new arena of struggle. It is filled with scarcity, hierarchical authority, guilt, blame, criticism, right and wrong thinking and polarizing positions.

There is urgency in dealing with lateral violence, if a dominator shuts us up, shuts us out and shuts us down, that individual or group makes us poorer kitamihikono. **Piko**—we have no choice—we have to name and own lateral violence kitamihitowin and be accountable for it. But accountability is a curious word when it is



broken up into account and ability. Account means we have to take our own inventory to deal with lateral violence and ability says we have to do our personal work to stop it.

Lateral violence works in four phases: iHurl, iHurt, iHelp and ekosi.

iHurl: incessant Humiliation and Harassment undercuts our relationships laterally

Colonization and historic trauma find expression in organized, collective humiliation and harassment today. But responding to past injustices by normalizing lateral violence only creates fertile conditions for **mōcopyōwin** acting out irrationally

so rage, anger; fear and terror are more easily vented on those closest to us.

When we subscribe to iHurl our weaponry is **pāstāhowin**: the transgression of taboos like preying on the weak and tearing down the other camp. The elderly and children are fragile and must be handled with care and camps are hallowed grounds where we live, work, play and pray. The manifest evidence **wāpātikosowin** of lateral violence threatens to collapse our communities through family feuds, gangs, foster care, school drop-outs, crime, runaways, sexual abuse, suicides and murders. Leaning heavily on **mamitonecikan**: mindfulness and reflection- will help us visualize self-acceptance, honest expression, empathetic listening. solidarity and compassion. And we will make a conscious decision to throw off the shackles of kitamihitowin lateral violence.

iHurt: intrusive Harms underdevelop our reserves and responses terminally

Mawimowin is the cry of pain caused by lateral violence marked by jealousy, bullying, blaming, shunning, back stabbing, gossip, sabotaging, spreading malicious rumors, verbal abuse, selective hiring and firing and sexual harassment. When burdened by this pain we actually feel like we're being strangled by grief and loss **tāpiscōc kipihkitonēhpitikoweyan**. Often we will be hurt to the point of dropping family obligations and community duties. Such unseemly withdrawal and cocooning is called āpaskēweýho.

Attacks on our person wear out our human reserves and the communities we used to call reserves. When we hurt too much and too often what sets in is **māýi-mamitonecikan** the wretched state of being that leads to poor mental health which usually co-exists with **māýi-mācihowin** poor physical health.

Spiritual help, assistance or counseling received by offering appropriate gifts to the drum, a song or ceremony **tipahikēwin**

eases the pain. Our cultural beliefs see to the cathartic release of our emotions and enhance our capacity to cope positively with the pain. The unholy power of lateral violence begins to pale in comparison to the higher power of the drum, songs and ceremonies.

iHelp: individual Harmony efforts lead to peace, productivity and prosperity

Human agency and pragmatism is critical for restoring balance especially when lateral violence strikes the workplace. **Pēyāhtakēyimowin** is tranquil repose and peace but when stress levels are high where we work, sick days increase, team work falls, morale is poor, resignations are frequent, addictions take hold and pay cheques are all that matter. When lateral violence creeps into our workplaces we are relieved if our fights break out into meetings.

We can't change what we do until we change how we think and act. Unless we plumb the depths of our relationships nisitohātowin in our work places, we will remain attached to our rightness and hard positions missing out on ready remedial measures like healthy work place policies, mediation and dispute resolution. The moment we think about the nobleness of our jobs and how our people are embedded in them sihtoskāto: the need to support one another occurs to us. Moments die only to rise up again when we pull hard together for work.

Instead of a “win-lose” approach where someone inevitably loses, it will be important to adopt the more peaceable alternative “fair-fair” nahi-nahi . Everyone kahkiyāw awiyak will have to become fair minded if we are to really honor the four directions.

Ekosi can roughly be translated into the following 9 english terms: in that way, right, alright, there, that's it, that is all, well, enough and goodbye. Using our own definitions and language for lateral violence will help us speak “truth to power” without doing further harm to one another.

Thinking well of self **pimēyimowin** will hasten good choices in our words and actions. We will speak about hurts and harms by focusing on behaviors not persons and we will make observations not judgments. And to conform to our cultural standards, we will re-set good examples beside our oral traditions. To make lateral violence history, the past, present and future can no longer be the same. Something eventful and essential has to happen to ramp up this change.

Witness the signing of the BC Tripartite Framework Agreement on First Nations Health Governance on October 13, 2011, on that day we signed a Script which we have read back to ourselves time and again. The people, distances and centuries it took to arrive at



this historical juncture is nothing short of awesome. Written into the Script are pakitinekēwina- give-aways- the most important being the surrender of our woundedness to the universe. The “take-aways” **otinikēmakana** are forgiveness, peace and trust. Naskomowin scored solutions and gratitude - stabilize all our relations whether they are at the top or bottom while **asonāmakana**- re-gifting- spreads this ethos from Big Houses to little tents; from one text to the next.

Should the process get punitive and pernicious a wise saying will light the right path:

ôma ka-nîpawisitamahk piko ka-wi-tapistamahk “What we stand by is what we sit in for.”

Kitimahitowin lateral violence will meet its match. It doesn't stand a chance against the tightly woven blanket that decorates and protects true warriors who go into the abyss of the unknown to transform lives by leaning heavily against lateral violence. Chief Dan George says so much in his book *My Heart Soars*:

“Already signs of new life are arising among my people after our sad winter has passed. We have discarded our broken arrows and empty quivers for we know what served us in the past can never serve us again.”

- Chief Dan George

REGIONAL CAUCUS SESSIONS

GWSJ V (2012) delegates were invited to meet separately in Regional Caucus Sessions for Vancouver Coastal, Fraser, Interior, Northern and Vancouver Island, to consider the draft “Consensus Paper 2012 – Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure,” and to debate the related Resolution 2012-01. Regional Caucuses were asked to identify their representative on the Resolutions Committee, and to identify any questions for the response of Panelists on Day Two of GWSJ V (2012).

On the afternoon of May 15, 2012, Gathering Wisdom delegates were invited to meet separately in Regional Caucus Sessions for the Northern, Interior, Fraser, Vancouver Coastal, and Vancouver Island regions to:

- Review the Draft Consensus Paper 2012 and Resolution 2012-01;
 - Appoint one individual to the Resolution Drafting Committee to consider amendments to the Consensus Paper and Resolution; and
 - Identify questions for Gathering Wisdom Panelists.
- Key points from each region included:



Vancouver Island: Vancouver Island delegates indicated their support for the draft Resolution, with an additional clause stating that an independent evaluation and assessment of the health transfer process be fully completed prior to the next forum. Delegates appointed Anne Mack (Toquaht Nation) to the Resolution Committee.

Interior: Interior delegates reviewed a first draft of “Partnership Accord: First Nations Health Council: Interior Region First Nations Executive (Interior Nations) and Interior Health Authority (Interior Health). With respect to the draft Consensus Paper and Resolution, the Seven Nations identified the following key concerns and questions: definition of holistic governance; regional representation; bureaucratic processes; greater clarity around the elder/advisor role; enhanced participation of First Nations Health Directors/ Leads in advisory roles; adopting regional health authority boundaries; interior representation on the Board of Directors; and legal and fiscal responsibility. Chief Byron Louis was appointed to the Resolution Committee.

Fraser: Fraser delegates indicated their support for the draft Resolution. The caucus discussed the need to separate business and politics, to mitigate bureaucratic structures and future work to amend existing Health Canada’s health agreements. Chief David Jimmie from the Squiala First Nation was appointed to the Resolution Committee.

Northern: Delegates from the Northern region wanted to ensure that the transfer of control will enable greater opportunities and funding support for their communities to deliver new health programs and services. Other key questions and concerns included: the need to have faith; appointing a male and female elder advisor; how a legislative model would be included in the overall holistic model of governance; and questions on how might the existing transfer agreements be affected in the overall transfer process; and risk assessment. The Northern Caucus appointed Chief Kathi Dickie to the Resolution Committee.

Vancouver Coastal: Vancouver Coastal delegates reviewed and approved the draft regional Partnership Accord which was scheduled to be signed in a ceremony on May 16th, 2012. Central Coast Sub-Region representatives elected Georgina Flamand from Wuikinuxw as their new FNHC representative. With respect to the Consensus Paper and Resolution, the delegates discussed the following: timelines and measurable outcomes attached to the resolution, and concern that the iFNHA is transforming into the permanent FNHA before a governance model is finalized. Chief Councillor Marilyn Slett was appointed to the Resolution Committee.





HEALTH FAIR





Speakers Corner Presentation

- 5:30 - 6:30 *First Nations Health Revolution!*
Gerald Oleman
- 6:30 - 7:30 *Traditional Medicine and Botanical Wild-Crafting*
Dr. Jeanne Paul
- 7:30 - 8:30 *Yoga - More than a Western Fad?*
Vina Brown



“It was great to see the Health Assessment as part of the forum & as leaders we need to be role models for our community members.”

- Survey Respondent



MAY 16th, 2012

MINISTER OF HEALTH – VIDEO MESSAGE

Leona Aglukkaq

Minister of Health and Minister of the Canadian Northern Economic Development Agency, Government of Canada (Video Message)

“We reinforced our long relationship with a more integrated and responsive health agreement and I acknowledge the efforts of all the partners.”

“First Nations in BC will have access to health services comparable to others across the country.”



NAVIGATING THE CURRENTS OF CHANGE – LEADERSHIP

Cliff Atleo Sr.

First Nations Health Council, Vancouver Island Region

Gwen Phillips

First Nations Health Council, Interior Region

Warner Adam

First Nations Health Council, North Region

With reference to a FNHC presentation titled “Gathering Wisdom for a Shared Journey V – Leadership and Navigating the Currents of Change,” Mr. Atleo Sr. noted that First Nations come from a very strong history of leadership and governance, based on social responsibility. All First Nations in BC have councils, leaders and advisors that they rely on. First Nations communities before contact were self-sustaining, with laws, keepers of the law, and councils. The history of First Nations is not just the last 150-200 years – it is thousands of years in which each and every First Nations community stood on its own, looked after their community, and knew how to do that. First Nations will take that back, and taking over health is very much a part of that.

Ms. Phillips discussed the leadership of all First Nations people as parents, grandparents, aunts, uncles and brothers and sisters, and spoke of going back to understand what true leadership is. BC First Nations are growing to that point again and recognize that leadership is about securing the foundation for what is going to be built. Many are anxious to see what the structure will look like, and to ensure that it is cost effective and community-based. Ms. Phillips shared her excitement to be part of this process, and the importance of governance and being governors.

Leadership's role is like navigating through a thick forest.

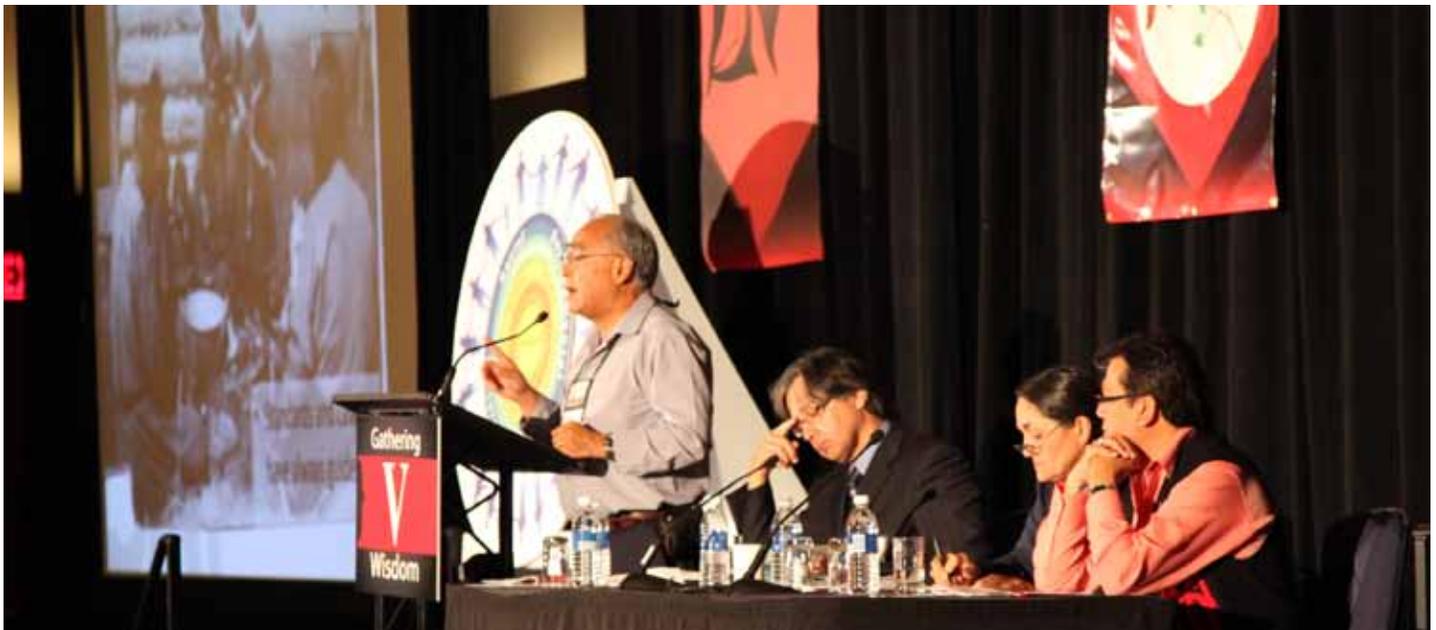
Leadership needs to envision where we are trying to get to, to see through the forest and what the threats are along the way. Once the path is envisioned it is everyone's job to begin cutting down those trees so that everyone can begin to walk forward together. If the one who is supposed to be steering and charting the way forward is not paying attention to that vision, they may not remember where they are going. It is not about only health care and medicine, we need to think about what health means to us.

FNHC is trying to create the right processes for everyone's voices to be heard. As children grow and learn with the patience, trust and support of those around them, they can walk steady and know what is right and what is wrong, and they grow into becoming leaders themselves and attract other people to them. We are trying to ensure that we are all leading in our own families in a good way, knowing that our Nation's health begins with us.

She hoped each one of the delegates understood their role to maintain the vision and stay true to the path and to not go sideways bringing in lateral violence, but to instead bring in healing. There is enough work for everyone to take on pieces, but there has to be trust that those that are taking on the work are doing it in a good way.

There is need for care in setting standards, and in determining what it is that First Nations want for themselves in the future, and that we are planning for them. Every time we set a plan in place, we have to set an evaluation side to that plan so that we can always look back and assess to make sure we are doing things right and can continue to grow and improve. Sometimes that means letting someone from the outside look in.

There is a lot of common underpinning among BC First Nations, such as our connectedness to the land, but how each First Nation lives is different because of our environments.





Systems have to respect and meet the needs of First Nations in each territory. Some sort of central office to house common things is needed, but more critically is the need to consider what we will do in our own back yards to make this a success in our communities.

The seven directives are very important but in no way are they defined. There has been a request for definitions because the clearer we are in our understanding, the more trust we can build. We can come together continually as regions. We are hopeful to see a rebuilding of all First Nations in BC. In First Nations history, everyone belonged to someone. Let us put politics in the back pocket and focus on our lives and futures and working together to rebuild good governance from the ground up.

Mr. Atleo Sr. discussed development of standards with training of the Chief for his position beginning at birth. His father's brother Richard was going to be Chief and he was raised differently than the other children. There were different teachings focused at leadership, and he learned at an early age through stories delivering lessons of life and First Nations laws, and that no one

was above the law. He shared the story of a Chief and his wife who had started stepping beyond the boundaries of their behavior and the keepers of the law cautioned them that they were taking and hoarding. The Chief and his wife kept on after the warning, so the keepers of the law dealt with them. You could not have the head of a house behaving that way. The laws did not allow it.

First Nations will be the ones that set the standards going forward – First Nations are in charge. We have dispute resolution mechanisms where you enter the room for the purpose of finding a solution and when you come to the solution you leave the room having solved it. How complicated can it be to find a way to resolve disputes in a good way?

Ms. Phillips discussed understanding the necessity of knowing our role, place and space and living up to that, and not trying to take on the responsibilities, roles and room of others. There are hereditary and resource specific Chiefs who were the standard setters and who said, for example, how many ducks to harvest and when to harvest them. If our hearts are weak our standards may be weak also. If our hearts are strong they will protect the

standards of the seven generations of the future and protect the standards of the ancestors of the past.

Human and economic capacity will be defined in each region in the work to start setting standards for each Nation, which will then be elevated, elevated, and elevated. This has to be home grown, community driven, and Nation based, so that no community gets left behind and no big community oppresses another. First Nations in BC will develop Nation-based activities and plans and the standards will evolve over time.

Ms. Phillips continued with note of the need to want to learn so that we have the ability to respond to the challenges coming. There is a need to look at competency and tools and instruments – the things needed to allow us to do our jobs. First Nations in BC have to make sure, as we create structures that we are thinking about separating various functions. Rather than using the word “power” which brings a funny feeling, we should talk about the function and responsibility of government, and put each First Nation’s values in the document so that people 100 years from now will have that in front of them.

Mr. Atleo Sr. shared that planning and patience would have to be exercised during this time of change. On October 13, 2011, with the signing of the Framework Agreement, the “plug” was pulled

from Health Canada, and strong signal was sent on the work to be done, and the change to how it would be done. BC First Nations are in the process of transformative change, planning, and engagement, and it is a huge challenge. There is need for input from First Nations, and for diligence and discipline in the foundational development in order for it to be rock solid. First Nations will be engaged to develop the strong foundation for the change to come. We are on a journey and a good path because it is for all of our First Nations children, grandchildren and great grandchildren. Politicians have to be better partners, and we will teach them how.

Mr. Warner Adam shared that the FNHC have worked very hard to make sure that we protect our health services and programs to meet and talk about how to fill the gaps that exist, including considering how we are going to define the human, capital and financial resources that are required. BC First Nations are in a transition stage of our work, during which time we will implement the Framework Agreement, which calls on BC First Nations to take control over the FNIH offices and to set the table for moving forward in cooperation with the provincial regional health authorities. Mr. Adam thanked FNIH staff for the good work they had done, and expressed that he looked forward to continuing to work alongside them in future.

“We have to focus on rebuilding good governance from the ground up.”

- Gwen Phillips, FNHC representative

There is need to make adjustments to how FNIH operates to meet the needs of the communities – collectively, we will define those adjustments. By 2013, there is need to dismantle the FNIH office and to move into a First Nations structure and authority. This would include examining the Board structure to meet the needs of BC First Nations regionally and provincially. There is also ongoing work on sub-agreements until October 2013.

In terms of the Implementation Committee, its responsibility is to complete sub-agreements on Non-Insured Health Benefits (NIHB), finance, office spaces, accounting, information management and information technology, in order to set the foundation for this process to be a success. As well, there is need to address human resources issues and the future for the 220 FNIH staff in the transition to the FNHA.

There is need for BC First Nations to take control of programs and services currently offered by FNIH. Many have said that some programs are good but that others are not meeting First Nations' needs. We will have a conversation about these and will transform the programs to meet our needs.

Implementation and evaluation of the partnership will be ongoing. Many regions are signing Partnership Accords with their regional health authorities, which will be a very important table to draw information on programs and services. Work will continue with the FNHC, FNHA and FNHDA to move the agenda forward. There is need to know the roles and responsibilities of each partner so that the foundation for the future remains strong. GWSJ V (2012) has nearly 100% participation of all Chiefs in BC. The FNHC has also committed to engage the communities through the regional caucuses, sub regional caucuses, and other forums as well, in order to align the important parts of the program review and redesign.

Every region has developed Terms of Reference to conduct business – it is a guide for how we will do our business and it indicates very clearly that we have to have representatives of each governance structure attending meetings. Each region will have its own representatives, and four additional members at large with staggered terms. There will be a transparent recruitment process, mentorship opportunities, and a nomination process for regional representation, which will belong to the regions.

BC First Nations had said that they want regional offices while at the same time keeping in mind the directive on fiscal responsibility and the need to reinvest all the savings into community services and health priorities. BC First Nations also believe in a holistic model – we cannot think in isolation but once we move forward in health, other areas will follow. Business plans need to be established, like in Bigstone where they have generated resources through pharmacies to generate savings back into their community.

Upholding commitments is important, as is making sure that there is continuous dialogue so that we do not lose sight of the objectives. Reciprocal accountability is important to keep ourselves in check and make sure that the work moves forward in a good way to achieve our common goals, and to reinstitute the values of our ancestors on good governance and strong foundations for the generations to come.

TRANSITION & THE *interim* FIRST NATIONS HEALTH AUTHORITY

Joe Gallagher

Chief Executive Officer, interim First Nations Health Authority

“As your wellness partner, we need to support each and every one of us wherever you live.”

“We need to hear from you what kind of things we can do to support communities on the ground and First Nations people on their individual wellness journeys.”

“The role of the First Nations Health Authority is evolving differently from what the First Nations Health Society was and taking on service responsibility. We are in the transition to move that way.”

Mr. Gallagher provided a presentation titled “*interim* First Nations Health Authority Transition” on the subjects of the context for implementation, mechanics of transition including transition priorities, the partnership piece, and the creation of the FNHA.

Mr. Gallagher discussed a timeline of milestones since the beginning of a new relationship with the Province of BC and the signing of the Leadership Accord on March 17, 2005 through to the Tripartite Framework Agreement of First Nations Health Governance signed October 13, 2011. He referenced the creation of the FNHS three years prior as the operational arm of the FNHC, noting that a lot of the then focus of the FNHS had been on implementing health plans in place, supporting the engagement process with First Nations communities beginning with HUBS, and later supporting the FNHC and the regional caucuses. The FNHA would continue to be an important part of the work going forward.

Delegates were informed that the transition work started after October 2011. What is being transferred are the operations of FNIH BC Region, and a portion of the headquarters function that supports the regional office in BC. FNIH BC Region operations takes care of its corporate services through the Office of the Director General, and the FNHA will receive a portion of that as well. BC First Nations are taking on BC FNIH Region and extra parts of the federal government, which adds a level of complexity to the transition.

“The role of the First Nations Health Authority is evolving differently from what the First Nations Health Society was and taking on service responsibility. We are in the transition to move that way.”

- Joe Gallagher, CEO iFNHA

The role of iFNHA is different than what the FNHS role was as an operational arm. The FNHA has to consider the notion of taking on service delivery responsibilities, and is in the transition to that. Discussion around the political oversight role of the FNHC is guiding how the work is moving forward. The legal obligations and service delivery responsibilities are part of what the FNHA will take on. In the case of dental therapists, there is a mechanism that allows them to operate in BC through the powers of the federal government, with the FNHA in place they will not be recognized in BC and so Health Canada will continue to provide that service until an alternate solution is found. This is an example of the legal authorities that need to be worked through to ensure business continuity and services moving forward. There is also need for the design of an accountability framework between the Board and the FNHA (FNHC) members. On April 1, 2013, the transfer will take place and the FNHA will officially take over the responsibility for health governance, but will remain in partnership with BC and Canada. The transformation

period will take place sometime in the future, subject to engagement with BC First Nations.

As we build the FNHA, we will look at the notion of establishing standards for health programs, and ensuring that we are fiscally responsible and accountable to First Nations people. A funding agreement with Health Canada will set out some of this. We are also looking at accreditation and ensuring that we will operate at a high standard. The Framework Agreement talks about creating an Implementation Committee that is responsible for the Implementation Plan in four streams: conclusion of sub-agreements; transition; interim management; and provincial partnerships.

The conclusion of sub-agreements is a key part to address human resources, records transfer, assets and software, information management and technology, contribution agreements, etc. in order to allow for the actual transfer to the FNHA. Transition is



an operational level discussion about the mechanism of moving something from point “a” to point “b” – the focus is on problem solving and ensuring quality in the area of work concerned. In regard to interim management, the *i*FNHA Chief Executive Officer meets with the regional director on a weekly basis to talk about what is happening. There is always a concern about the money, and the need to understand how we are doing to ensure that we are still ahead of the game. This includes a deficit reduction plan for the Government of Canada which this is outside of, but the implications are being felt in the work being done by other supporting departments. It provides a sense of understanding for the challenges of Health Canada in operating today, and provides First Nations with an opportunity to identify areas for improvements.

In terms of transition priorities, Mr. Gallagher shared that there are many areas where good plans are needed. There is an interesting balance between meeting the transition date, and ensuring due diligence to make sure it is doable and sustainable while meeting other demands. Transition can be challenging but will be managed as best we can. Transition priorities are to pay communities the funding that they have in place with Health Canada; ensure that there is no service disruption; pay staff; and to improve operations and services where practical through transition, i.e. an operational efficiency that reduces the reporting burden and makes things easier on the ground.

The current *i*FNHA organization current consists of a Board of Directors, Chief Executive Officer and Corporate Services and Implementation Support; Finance; Human Resources and Administration Support; Information Management/Information Technology; Policy, Planning and Strategic Initiatives; Communications; and Community Engagement. For those that follow the history of the FNHS, it was initially housed in the First Nations Summit offices, and started very much like a “Mom and Pop” operation that was very small, working towards implementation of health plans. The FNHA will be bringing in all federal First Nations health programs and services, 240

contribution agreements, approximately 100 contracts, and 250 full time equivalent (FTE) staff. The FNHA is currently facing a number of growth challenges as we build a First Nations health organization in the context of all the plans and the work that needs to be done in consultation with the communities.

Key transfer activities include an increase from 10 FNHS systems to over 50 Health Canada systems. Assets transfer including real property and accommodations as well as Health Canada finances and human resources. Programs and services transfer along with implementation and transition planning around legal implications and communications. To enable this is a \$17 million implementation fund was put in place to support the transition in order for the FNHA to be operational on Day 1. To this end, the *i*FNHA budget for 2013-2014 has been designed to address the funding areas as per the Framework Agreement.

In regard to partnerships, it is important to understand that this starts with how FNHA works with its communities. There is an opportunity for the FNHA to be different than other Health Authorities in the province, with a strong focus on the ability to look at the wellness indicators that make sense to First Nations and to bring the notion of individual responsibility for our own health and wellness journey forward. A FNHA will work towards delivering more than the current FNIH programs and services – the first in Canada to embark on an innovative approach to service delivery. Health Canada will remain a strategic governance and funding partner for future federal health initiatives. A FNHA will leverage its partnerships to support every First Nations person, wherever they live, including looking at eHealth options and an integrated primary care piece, which is critical in ensuring the care needed, is provided on the ground.

A FNHA will also bring to the table, learnings from Alaska in terms of primary care, which presents a model that works well for Indigenous peoples in Alaska and which BC First Nations could learn from moving forward. A lot of work is needed with



the senior executive from the Ministry of Health to improve First Nations' access to services, and the innovation and change agenda is something that is important to think about in terms of alignment with the goals and commitments in the Tripartite Plan. It identifies key results areas to inform the expectations of the health authorities and is an important part of the work starting to take place.

There is need to develop a health authority that is responsive to the First Nations in BC with the notion of reciprocal accountability and collectively being part of that. FNHA characteristics are to be responsive, establish standards for health programs, be fiscally responsible and accountable, and be accredited. The seven directives approved in the GWSJ IV (2011) Consensus Paper help reinforce what makes this a First Nations Health Authority. They guide who we are and what we do. Common values have also been identified relating to: respect, discipline, relationships, culture, excellence and fairness to guide us. As we move ahead, a FNHA will draft its own corporate values to ensure again that we are a First Nations health organization and that we align ourselves in a way that represents our values in terms of respect, tradition, balance, community, hospitality and humour on a day-to-day basis. We are also

developing operational principles using the word “wellness” to guide how to move forward.

Mr. Gallagher reiterated that the goal is to ensure that the transition occurs in a good way based on the seven directives and collective First Nations values. Until transfer day, Health Canada maintains the decision-making and service delivery responsibilities over current areas of responsibility. The FNHA will continue to implement the Health Actions agenda to achieve system transformation today, and will refine the First Nations Health Wellness Model launched the prior day, and continue to develop its role as a “your wellness partner”.

Mr. Gallagher concluded that this is an extremely important opportunity for BC First Nations. We have been working at health in a way for many years that has been dictated by the federal government, but now there is a space for First Nations to change that and it is up to us to make the most of that opportunity and to work together with our knowledge and expertise. He looked forward to continuing the work with focus on the start date of April 1, 2013.

NAVIGATING THE CURRENTS OF CHANGE – PANEL PRESENTATION: SUCCESS STORIES (Alaska) SUCCESS STORIES (Nisga'a)

Dan Winkelman

*Vice President for Administration and General Counsel,
Yukon-Kuskokwim Health Corporation*

*“100% of our Health Services is delivered by Native tribes in
Alaska”*

*“When we first started we didn't have a defined vision but what
First Nations Health Authority in British Columbia have done is to
take you light years ahead of where we were.”*

“You are going nowhere without happy and well employees.”

*“We are pushing the bar for patient satisfaction and always
looking at continuous improvement for delivery of services.”*

Mr. Winkelman provided an overhead presentation titled “Yukon-Kuskokwim Health Corporation” (YKHC), and discussed the establishment of the YKHC in 1969 when a group of concerned tribal members wanted to have a voice in how their health care was being delivered. YKHC was initially comprised of approximately 50 tribes; however, they were aggressive at signing up more tribes through tribal resolutions, which was important to achieve economies of scale in this remote area in order to be able to provide better services and improve health outcomes.

The YKHC has a Compact with Indian Health Service (HIS) under Title V of the Indian Self-Determination and Education Assistance Act, 25, U.S.C. 450, which allows tribal redesign



and reallocation authority. The Act allowed the YKHC to take over the management and operations of 100% of its health care delivery system. BC First Nations' Tripartite Framework Agreement is the first step towards BC First Nations being able to do that as well, so its negotiation was very important. The basis of the Tripartite Framework Agreement is the government-to-government negotiations and the sovereignty of the nations that have entered into negotiations with Canada to get better health outcomes for BC First Nations, which is incredibly important.

The YKHC service area is 75,000 square miles that are road-less except for one small road to the north of about 10 miles. It is essentially tundra, with a lot of water and some trees and hills in the territory farther east. Despite the geographic realities, every tribe and every person has a voice and no one is left out of the voice. A traditional subsistence lifestyle is what primarily supports the economy – it is a more traditional area with people following the seasons, although some money is required. Mostly the demographics are Yup'ik Eskimo, Athabaskan Indian and White, with English being a second language for most. The average per capita income is \$11,000; 46% of the population is under 18 years of age; and there is a 20% unemployment rate in villages.

Mr. Winkelman discussed the challenges associated with travel and access to a higher level of care. It had become even more expensive for patients to seek treatment given the prices of energy and oil, which affected the costs of air travel significantly. For decades the number one killer has been unintentional injury, however, cancer had increased to 30%, heart disease had increased to 22%, and suicide is increasing to a level that is 17 times the national average for 15-19 year olds. There have been 13 suicides this year, and the YKHC is working with focus on prevention activities.

1990 was the year before YKHC took over the management of the hospital in Bethel. At that time, there were 220 employees, a

\$6 million payroll, 50,000 units of service and a lot of focus on prevention. In 2012, YKHC now has 1,500+ employees (300 in villages, 1,200 at Bethel, and 20 in Anchorage) and is the largest economic and employer in the region with a \$150+ million budget, \$70+ million payroll, 300+ units of service, and many expanded services.

Mr. Winkelman discussed YKHC revenues, which is partly through IHS funding, but primarily from third party billing and federal and state construction grants. The YKHC four-tier health system includes sub-regional services, regional services, village services, and statewide services (Alaska Native Medical Centre and other tertiary care centers).

Delegates were informed that “Napartet” could mean many things. For the YKHC, Napartet related to its five goals for: growing employees; Alaska Native workforce development; patient centered excellence; community and partner satisfaction, all of which would lead to financial viability. This was the balanced approach taken by the YKHC, which identified five goals every year through a process that begins with a Tribal Gathering attended by over 70 people representing two from each of the tribes involved. The first day of the Gathering is spent updating on what has happened the prior year, and the second day



is spent on identifying the top 10 priorities – this year suicide and access jumped to number one, whereas for many years the number one priority had been long term care.

Information on activities under each of the five goals was provided. The goal of workforce development included plans to increase native managers by 5%. Patient Centered Excellence started out with a rating of 69% and is currently at 78%. There had been a focus on growing the YKHC for the first 15 years and although the patients said we were doing very good, we needed to do better. Benchmarked against 1,400 other centres, the YKHC found itself in the bottom 1 percentile in 2006. Napartet allowed greater focus and the creation of strategies and sub-teams of employees to make change. YKHC now receives a 90% patient satisfaction rating in the subregional centres and is striving for continual improvement, including increased access to cancer screening mammograms, and colonoscopies.

Mr. Winkelman shared that the concern should not only be on accreditation, which is about keeping the doors open, but should be about quality. When First Nations are running their

own organization, they would be able to push beyond minimum operational standards and push them higher.

YKHC telehealth happens in various ways, with tele-medicine carts in most village clinics, tele-psychiatry and distance learning opportunities that have dramatically increased access to the most remote areas.

Mr. Winkelman encouraged BC First Nations to embrace the Tripartite Framework Agreement and to be passionate and united in order to achieve a better outcome. It is not just the First Nations in the villages that will benefit, it is the whole region that will see improvements if First Nations can stay together and speak with one voice at the negotiation table. Alaska was able to stay together in one compact, with shared resources, and takes pride in that. 30 years from now when BC First Nations have the best healthcare network in Canada there will be detractors and you will need to remind them that you are government and that you have rights and responsibilities and that you will hold the country's government to that.

“We are pushing the bar for patient satisfaction and always looking at continuous improvement for delivery of services.”

- Dan Winkelman, Vice President for Administration and General Counsel, Yukon-Kuskokwim Health Corporation



James Moore

Chairperson, Nisga'a Valley Health Authority

"We are holding our hands high to our past leaders; we are indebted to them for establishing the way for our health care system."

Mr. Moore provided a presentation titled "Nisga'a Valley Health Authority (May 2012)", discussing the transition from a Board to the Nisga'a Valley Health Authority (NVHA). The Nisga'a hold their hands high to their past leaders and the debt owed to them. We are only travelling on the road that they have painstakingly paved for us and that we will never ever forget. In all doings, the NVHA tried to emulate the determination and the path laid out by its past leaders.

In the beginning there were virtually no health provisions after contact. Today, there are culturally relevant programs provided on a daily basis. Mr. Moore introduced a DVD showcasing how the NVHA separated politics from delivery, how culture is integrated into health, and outlining the health programs and services NVHA offers to First Nations and non-natives on their lands.

Corrine McKay, Director of Programs, NVHA, shared that the NVHA is funded through a Fiscal Funding Agreement (FAA) with the federal, provincial and Nisga's Lisims Government (NLG) with medical services plan premiums paid by NLG and treaty defined health services. NVHA was incorporated in 1984 as a health services society with governance by seven directors – an appointment from the NLG, from each village, and one at large position. There are 72 staff and six physicians under contract.

"The beauty of having your own health services is that you can be responsive in a compassionate and effective way." said McKay.

NVHA provides services to the residents of the valley and NIHB for Nisga'a citizens, regardless of where they live. Citizenship information on the approximately 7,000 citizens is provided by NLG. Staff oversee the programs for medical equipment and supplies, patient transportation, crisis intervention counselling, BC ambulance invoices, and baby's first fill. A slide of the Organizational Chart was displayed illustrating the departments overseen by the Chief Executive Officer, and those under the purview of the NIHB Manager.

The NVHA has a medical bus and there has been an increase in ridership every year since its inception. Challenges are the same as Health Canada's: software program upgrades with the Medical Transportation Record System (MTRS), Claims Record System and Vision program. Advantages include addressing issues as a team, i.e. on efficiencies. Opportunities include postings for three pharmaceutical positions, wheel-chair accessible home to meet demand, assisted living for Nass Valley, and life skills programs. NVHA is also looking at establishing a health foundation and upgrading medical equipment, and expanding service including oncology services, and seeking charitable status. NVHA staff are always busy but they can be responsive in a compassionate and respectful way to the needs of their citizens.

A DVD entitled "Nisga'a Valley Health Authority" was then played with Dr. Joseph Gosnell providing information on Fishery Bay BC in the 1800s. If a person became seriously ill at that time, they either died or got better. There were no health provisions. Nita Morven discussed the integration of western medical practices into Nisga'a traditions. At the same time that there were discussions ongoing on health, there was discussion about taking over the education of the children and the formation of School District 92. Despite the treaty, Nisga'a are still gearing up to the rest of Canadian society who take their education and health services for granted while many Aboriginal peoples are still receiving services at the level received in the 1950's.

Julia Adams, NVHA Chief Executive Officer, discussed the need for ongoing evaluation and changes, and the NVHA's work with elders to implement the rich Nisga'a culture in every step of their lives. She expressed appreciation for the opportunity to present the health plan for the Nisga'a people.

“Excellent! We all have to be aware that change takes time. The speakers were very good and everyone very helpful. I liked traditional healers or health practitioners gave us a chance to de-stress, while away from our community work.”

- Survey Respondent

REGIONAL PARTNERSHIP ACCORDS

Shana Manson

Vancouver Island Region Representative, First Nations Health Council

“It’s not a partnership if it is one sided, both sides have to contribute.”

“Partnerships are critical to a collaborative success.”

Ms. Manson provided an overhead presentation in which she discussed the Regional Partnership Accords and the great emphasis on partnerships to ensure BC First Nations are all working towards the common needs in the region. The partnerships created from working collaboratively will result in greater accomplishments than each group working on its own could ever hope to achieve, and will strengthen relationships and the regional hubs and regional caucus on their regional health and wellness plans in order to get beyond the sickness system and to focus on being well through a holistic approach.

Ms. Manson discussed Directive #4 – Foster Meaningful Collaboration and Partnership, to enable relationship-building between First Nations and regional health authorities and the FNHA with the goal of aligning health care with First Nations’ priorities and community health plans. Partnerships are critical to the collective success.

The Tripartite Framework Agreement sets out how provincial health authorities will work collaboratively with BC First Nations in their respective regions to develop and review Aboriginal health plans and First Nations community health and wellness plans to achieve better coordination in health planning; collaborate on delivery of health care services; discuss innovative service delivery; and where appropriate, establish funding arrangements at a local and regional level. The Resolution for

2011-01 Workplan was to target concluding regional partnership accords by November 2012, and we are well ahead of that target.

Ms. Manson reviewed the Fraser Region vision: “Blending the best of two worlds in health – modern medicine and ancestral teachings and ways” (signed December 2011); noted the Interior Region’s establishment of a Working Group in the fall of 2012; the Northern Region focus on “Innovative ways to improve health and meet the unique needs of the North”; Vancouver Coastal Region’s vision “includes commitment to jointly develop an urban health strategy and indicators”; and the Vancouver Island Region focus on “developing strong processes to support collaboration, innovation, improved health outcomes”.

Ceremonies then took place for signing of the Partnership Accords between the North Region and the Northern Health Authority; and between the Vancouver Coastal Region and the Vancouver Coastal Health Authority.





“Partnerships are critical to a collaborative success.”

- Shana Manson, FNHC





DISCUSSION/DEBATE ON RESOLUTION 2012-01 & CONSENSUS PAPER

Facilitator Harold Tarbell read aloud the proposed Resolution.

Gathering Wisdom for a Shared Journey V – First Nations Health Council Chiefs in Assembly – subject: “ADOPTION OF CONSENSUS PAPER 2012: NAVIGATING THE CURRENTS OF CHANGE – TRANSITIONING TO A NEW FIRST NATIONS HEALTH GOVERNANCE STRUCTURE” dated May 16, 2012.

RESOLUTION #2012-01

Moved: Chief Charlie Cootes, Uchucklesaht Tribal Government

Seconded: Chief Bill Cranmer, ‘Namgis First Nation

Abstentions: None

Disposition: Carried

- 148 in favour
- 10 opposed

Date: May 16, 2012

To read the resolution, please refer to:
APPENDIX C: Resolution #2012-01 on page 60.

OPENING PRAYER

Elder Leonard George, Tsleil-Wautuh First Nation, welcomed delegates to Day Three – May 17, 2012 of GWSJ V (2012) at 8:33a.m. He shared a story of the vision of his father for all First Nations to be united, and his happiness that the federal and provincial governments had stepped up and made some good changes – a decision that at the end of the day would benefit all. He then offered an Opening Prayer Eagle Song.



SAFER NATIONS VIDEO CONTEST

Dr. Evan Adams

Deputy Provincial Health Officer

Dr. Perry Kendall

Provincial Health Officer, Government of British Columbia

Laura Jamieson

Health Director, Skwllax Wellness Centre

“Who knew we would be trying to type on keyboards while we’re riding a bike or driving? I wonder what our Ancestors would say when they see us trying to type and drive at the same time,” Dr. Evan Adams

Dr. Adams introduced the subject of the video contest on injury prevention, noting that the FNHC and the iFNHA were pleased to sponsor the contest in order to provide an opportunity for First Nations to be involved from wherever they are – to message and support one another and say things in a way that we may be unable to in the field.

“Traditionally, First Nations have had very good health, and very athletic paths with fewer diseases pre-contact and better access to good food and resources from the land and diets

and activities that were better than today. First Nations also conducted themselves in a good way and kept each other safe because in order to succeed and to live there was need to be safe and to avoid unnecessary injuries and accidents that were waiting to happen because the welfare of our families and communities relied on our ability to be safe. Our ancestors shared teachings, customs and knowledge and taught us how to work and play with a minimum of risk and to pay attention to everything around us as we planned and executed our daily functions. We incorporated a physical and spiritual safety into all teachings and survived and thrived remarkably in very dangerous situations given the challenges of weather, geography and the wild world around us. It took considerable knowledge and skill to survive, and it still does.”

“The knowledge of our ancestors is still with us, protecting us from unnecessary harm. We have an obligation to share that, to protect one another, and to keep each other safe. Prevention of unnecessary death and injury will benefit us all in contending with a modern world and modern challenges. We can do better in health indicators around injury and injury outcomes, particularly around things like motor vehicle crashes, driver safety, outdoor and workplace and bike safety in order to reduce the incidence of accidents.”



The top six video contest submissions were played with scores awarded by the panel. Delegates were then invited to text in their votes in order to select the order of the finalists. Contest submissions were awarded as follows:

1st Place - \$5,000 to **Michelle Colyn** for “Stolen Moments”

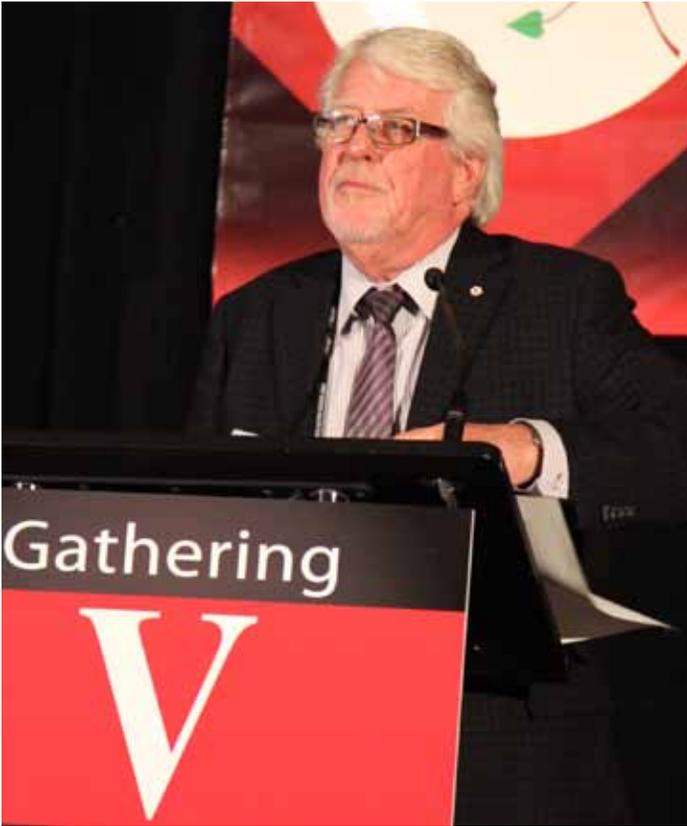
2nd Place - \$2,500 to **Trevor Mack** for “Safety is a Universal Language”

3rd Place - \$1,000 to **Candace Curr** for “Safe Body Honoured Spirit”

Honourable Mention - \$500 to **Dionne Jackson** for “The Masked Driver”

Audience Choice - \$1,000 to **Sandra Eustache** and **the Seabird Community School** for “Ride on – Be Safe”





OUR EVOLVING LANDSCAPE – PHYSICIANS AS PARTNERS

Dr. Perry Kendall

Provincial Health Officer, Government of British Columbia

“The province will have a significant role with FNHA officers as they develop their roles and establish reciprocal accountability, making sure we identify needs to develop programs to see improved health outcomes.”

Dr. Kendall expressed his appreciation for the opportunity to work with Dr. Evan Adams in his former role as the Aboriginal Physician Advisor, and that he looked forward to

working with Dr. Adams in his new appointment as the Deputy Provincial Health Officer (DPHO). This process started with the commitment of the government in 2005 to work with First Nations leadership to improve the lives of BC First Nations, which led to the BC Tripartite Framework Agreement on First Nation Health Governance, which included the commitment to appoint a First Nations DPHO. BC is the first jurisdiction in Canada to establish this position.

Roles and responsibilities of the DPHO would include reporting on health and wellbeing of First Nations and Aboriginal peoples in BC; informing policy development programming and other initiatives; developing provincial public health initiatives and strategies related to Aboriginal health; developing best practices and other documents on Aboriginal health; developing appropriate measures and indicators for Aboriginal health; and developing the next iteration of proposed First Nations health goals.

In addition, Dr. Adams would provide expert advice on the transition from the *i*FNHA to a FNHA; assist with transitional planning; provide expert advice on the statutory options for a FNHA under the Public Health Act; ensure linkages in the development of Annual Tripartite progress reports; and assist in the creation of a First Nations Health Research Agenda.

While the DPHO position is officially based in Victoria, Dr. Adams will spend significant amounts of time in the lower mainland. There is need for greater involvement, reciprocal accountability, and clear mechanisms for working together to ensure that we identify gaps and that they can be addressed with new programs and programming to result in First Nations having improved health outcomes. The big picture is that moving forward with this position gives another power for the goal of improved health status to actually be realized. Dr. Adams is a part of the national Ministry of Health Council, which had been extremely welcoming, and was very much looking forward to having a FNHA with powers and authorities under the Act.

“This is a rare chance to set up a health care system targeted to your specific needs... You have the opportunity to turn around major health challenges in a single generation.”

- Dr. Lloyd Oppel, Chair, Council on Health Promotion, British Columbia Medical Association



Dr. Lloyd Oppel, Chair
Council on Health Promotion, British Columbia Medical Association

First Nations have a younger population than the rest of BC, and have an opportunity to turn around major health challenges in a single generation.

Dr. Oppel discussed the importance of identifying that physicians are always trying to learn to be better. This is built into what they do every day, which means learning from patients and the people they serve. British Columbia Medical Association’s (BCMA) views on health promotion and how to work with First Nations means continuing to strive to do a better job. In medical education, it is woven into the fabric that students need to know about their patients, what their beliefs are, what is important to them, and how they view their place in the world. There is a lot of good work being done in this area. The challenge is in bringing it together to apply in the most effective way, and the BCMA is prepared to do its part.

BCMA was founded in 1990 as a voluntary organization with over 11,000 members of practicing, retired, student and residents. It is governed by a Board of Directors and is a member of the

Canadian Medical Association. BCMA is a trade organization, is the official representative of the medical profession in BC, and advocates for system changes and health promotion. BCMA works with government and health authorities, including the iFNHA, and negotiates physician compensation.

BCMA has done a lot of work on health promotion for over 100 years and looks at issues ranging from clinical prevention to screening. BCMA has played a key role in other issues such as smoking cessation, seatbelt use, and environmental issues around drinking water standards and monitoring. If there are things that the BCMA can do to help physicians not need to see a person that is good for us to work on.

The official BCMA position is that “there is no single change that will solve the challenges in the health care system. Rather, to sustain and transform our system, there will need to be a series of changes ranging from system wide to the individual daily choices by British Columbians”. The system has to continue to evolve from a reactive system to a system that is proactive and that acts early and often with healthy moms, babies, youth and adults, and that extra years of life gained are quality years by preventing illnesses. Screening and early intervention improves lifestyles for healthy Canadians.

Two things are needed:

- 1) to continue to impress a healthy lifestyle and,
- 2) a lifetime prevention plan.

BCMA has worked on the lifetime prevention plan initiative for several years with government. There are certain things that rob you of quality years of life, and BCMA wants to look for measures to affect the outcomes, to see what is being provided and what is not, and to take that information and apply it to other areas to bring bodies of knowledge together to create a “cradle to grave” plan to keep people as healthy as possible throughout their lifetimes. Prevention is something that doctors do every day in their offices and BCMA is trying to institutionalize that in the health care system in Canada.

The lifetime prevention program is a series of services provided to British Columbians over their lifetime to promote their health, detect disease earlier, and minimize disability and chronic illness. Most effective elements include discussion of daily aspirin use; smoking cessation; alcohol screening and counseling; hypertension screening and testing; colorectal cancer screening; influenza immunization; cholesterol screening and treatment; pneumococcal immunizations; cervical cancer screening and breast cancer screening.

In BC 1.3 million people have a chronic illness such as high blood pressure or diabetes. By 2036, it is expected that there will be more than one million new patients diagnosed with chronic diseases including depression, hypertension, osteoarthritis, diabetes and asthma. This risk of chronic disease can be reduced by 80% with a healthy lifestyle – eating well, exercising, and not smoking. We can also improve our quality of life in the areas of education and training, housing, employment and opportunity, supportive family environment and community, and food and clean water. Many of these things are outside of the health care system but have a great impact on the system.

First Nations have an opportunity with a First Nations Health Authority to set up a health care system that targets First Nations’ specific needs. First Nations have a younger population than the rest of BC, and have an opportunity to turn around major health challenges in a single generation. It is up to First Nations to drive the change – both individually as a people.

BCMA’s commitment is to continue to serve First Nations patients. BCMA is committed to working with First Nations and a FNHA as it moves forward, and to learn from you and sharing some of what we know, to together apply the lessons learned.

Gathering Wisdom Web-streaming Statistics

27,804 total viewer minutes
1,330 total streams
21 average time per viewer (minutes)
198 total unique viewers
15 (%) new visitors*

Geolocation
Canada 1277
USA 48
Germany 3
Argentina 2

* the new visitors are those whom have never been to the FNHC site or other pages that have the webcast stream embedded



Dr. Shannon McDonald

*Executive Director, Aboriginal Health Branch,
Ministry of Health*

“This is the only place that this work is being done and I am blessed to be a part of the freight train. We are running to keep up with the pace that has been set.”

Michelle DeGroot

Executive Director, Health Actions, interim First Nations Health Authority

“Health Actions moves forward on what communities need and what solutions are.”

“Tripartite opportunities will create a better forum for us to ensure communication goes both ways.”

**INTRODUCTION TO HEALTH ACTIONS
DIALOGUE SESSION**

Yousuf Ali

Regional Director, First Nations & Inuit Health Branch, Health Canada

“Today we are talking about health action, the third critical pillar in moving health improvement forward.”

“If First Nations don’t see any improvement to the services to them then we are not successful.”

“The idea of partnership with groups like the BC Medical Association is to be a part of a bigger system, to have a bigger voice and say what our priorities are.”

This is the only place that this work is being done and I am blessed to be a part of the freight train. We are running to keep up with the pace that has been set.”

- Dr. Shannon McDonald

Executive Director, Aboriginal Health Branch, Ministry of Health

TRIPARTITE DIALOGUE SESSIONS

The Forum held a series of three repeating Tripartite Dialogue Sessions on the seven subjects of: Maternal Child Health Care, Mental Wellness & Substance Use, Primary Care & Public Health, Health Knowledge & Information, Traditional Wellness, Health Human Resources, and eHealth.

Primary Care and Public Health

The Primary Care and Public Health Dialogue Sessions asked participants to discuss how the Tripartite Strategy Council for Primary Care and Public Health can better engage with First Nations communities. Facilitator Lori Sellars from the *interim* First Nations Health Authority introduced the Primary Care and Public Health Tripartite Strategy Council members and provided a quick overview of the proposed draft Holistic Vision of Wellness model. This model was first introduced to the Gathering Wisdom for a Shared Journey V delegates on May 15, 2012. She noted that it will be important to answer the question on how the model will be integrated into the work of Primary Care and Public Health.



It was also noted that there are four sub-committees:

1. Physicians/Nurses and Allied Health Professionals (includes integration of federal and provincial home and community care programs and services);
2. Communicable Diseases Prevention (e.g. HIV/AIDS, tuberculosis);
3. Healthy Lifestyles and Wellness Promotion (e.g. food security, smoking cessation, diabetes, cancer); and
4. Injury Prevention and Control.

During each dialogue session, participants led several small group discussions focused on these four questions:

1. What matters most to you as an individual, family, community, Nation about engaging with the Primary Care & Public Health, Tripartite Strategy Council?
2. How would you like the engagement process to work for you?
3. What type of engagement works for you?
4. Is there something about engagement that we didn't ask?

Some of the key ideas included:

- Hubs are effective mechanisms for the exchange of information.
- Many initiatives and decisions/communication are top down, and they need to be bottom up.
- Have as many brains as possible at the table: utilize expertise and community input at all levels.
- Establish where each community is: they are all at different stages/places and their needs will differ.
- Respect and deliver services in a culturally appropriate way, using community protocols.
- Improve relationships between the *i*FNHA and communities: *i*FNHA need to be out there visiting communities to learn about their specific needs.
- Need to improve continuity of health care providers to increase trust and access, remove barriers and improve utilization of services.
- Trust is a huge issue, even between health director and staff and community members.

The results from these discussions will be posted on the *interim* First Nations Health Authority website, and the Primary Care and Public Health Strategy Council will use the ideas from Gathering Wisdom to engage more effectively with First Nations communities.



Mental Wellness and Substance Use

The Mental Wellness and Substance Use (MWSU) strategy area hosted breakout sessions at Gathering Wisdom V held Friday, May 17, 2012 at the Hyatt Regency Hotel in Vancouver. The MWSU strategy area utilized the sessions to introduce and launch its Priority-Setting Tool: A Future First Nations and Aboriginal People's Mental Wellness and Substance Use Ten-Year Plan



The Priority-Setting Tool is intended to be utilized by the Tripartite Partners (Federal Government, Provincial Government, and the *interim* First Nations Health Authority together with its Aboriginal partners Metis Nation British Columbia and BC Association of Aboriginal Friendship Centers) to engage with their respective members, stakeholders and systems. The Vision, Goals, Strategic Directions and Actions proposed in the Priority-Setting Tool have been developed through input from First Nations and Aboriginal people through forums, reports, input requests, accumulated data and the Tripartite process.

The purpose of this Priority-Setting Tool is to collectively affirm the proposed Vision Statement, Goals, Strategic Directions, and Actions which will shape the development of a First Nations and Aboriginal Mental Wellness and Substance Use Ten-Year Plan (the “Plan”). The Plan is anticipated to be finalized in the fall of 2012. In the years that follow, the focus will be on the development of a shared Accountability Framework and then implementation of the Plan itself.

149 Chiefs/Proxies and health leads attended the MWSU breakout sessions and 125 Priority-Setting Tool booklets were completed and handed in. Some key issues that were provided by the participants of the break-out sessions:

- A coordinated Aboriginal MWSU research agenda is important
- People liked the introduction - the “how” did we get to this document

Traditional Wellness

During Gathering Wisdom IV's health action's session on Traditional Wellness, supportive discussions occurred around addressing Traditional Wellness into the current health systems. The session started with an overview of traditional wellness, initiatives taken on by the iFNHA, and a summary of the Traditional Healers' Gathering that was held in October 2011. The session then moved into close-ended questions that were done through text voting. The majority of the text voters positively responded to all three questions. However the text voters represented about half of the participants in the room. For all 3 sessions the following questions were asked:



- Do you see Traditional Wellness being woven into the health actions strategy areas?
95% of those who answered voted yes.
- Is Traditional Wellness important in community health?
99% of those who answered voted yes.
- Do you agree with the term "Traditional Wellness"?
76% of those who answered voted yes.

Next the group was broken up into café style discussions with the following questions to consider:

1. How do you see traditional Wellness incorporated into your health programs? (Making it more accessible?)
2. How do you see a traditional healing advisory committee helping your community?
3. How have you or could you increase awareness and acknowledgement of traditional healing practices

Many enthusiastic discussions were had on incorporating a more holistic model of health including traditional healing practices into the current system. Many participants discussed the need of traditional learning programs such as cultural camps, herbal medicine knowledge, and language programs, as well as the need for protection of non-timber forest products.

Here are some key themes that came out of the 3 session groups:

- A balance needs to be struck between ensuring that traditional healers are acknowledged and respected (accredited), AND protected, so that they are not exploited or treated in an intrusive manner
- Education and awareness, particularly through intergenerational strategies directed at the youth, are key to the success of traditional wellness programs
- The Traditional Healers' Advisory Committee has an important role to play in advocating, promoting, and serving as a link between practitioners and communities
- Communities are using and looking for creative ways to bring traditional wellness practices into the community
- Protection of traditional medicines and practices is a key factor in ensuring the success of traditional wellness
- Traditional wellness is a way of life and should be infused in all aspects of our lives, at the community and individual level
- Knowledge is sacred and "all encompassing," meaning that it involves not just the individual, but the family and community
- Access for those residing "outside" the community needs to be a focus for TW strategies
- The right to choose (both by the user and the healer) needs to be a central principle guiding the TW work
- TW strategies and work must be nation "controlled."

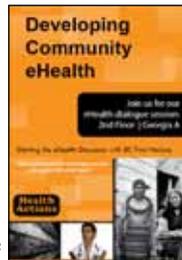
These discussions are to further the next steps from the Traditional Healer's Gathering including the formation of a traditional healers Advisory committee and to develop strategies on how to incorporate traditional healing practices into programs, communities and health systems, therefore ultimately supporting traditional healing practices and making it more accessible to community members.

For further information on the Traditional Healers Gathering Report please visit our website: www.fnhc.ca.



eHealth

Joseph Mendez, CIO of iFNHA, briefly discussed current First Nations eHealth projects. He also described the key challenges in First Nations communities related to health systems and information management that were identified by Health Directors/ Senior Health Leads in a recent survey (Health Centre Challenges in an eHealth Context: Report on Health Directors/ Senior Health Leads Feedback). Those challenges are:



- Accountability/Reporting burden
- Access to services
- Fragmented health record
- Service referrals
- Connectivity and infrastructure
- Interoperability

Following this overview, Karl Mallory, Project Manager for the First Nations Panorama Implementation Project gave an update including an overview of Panorama, the progress made to date in First Nations Health Organizations that are preparing to use Panorama, and the important lessons learned in implementing eHealth projects with a community-driven, Nation-based approach.

Dr. John Pawlovich then demonstrated a staged clinical Telehealth encounter with a volunteer patient and supporting nurse practitioner from Takla First Nation. Dr. Pawlovich currently lives in Abbotsford, but is able to provide primary care services to several Carrier Sekani communities from his home with the use of Telehealth technology.

Quotes/Questions:

- Question: In Quesnel and the rest of the north, there are often long gaps between physician visits to the community. Would Telehealth replace physician visits, or be in addition to the current services?

- o Answer: Telehealth would augment and complement services that are currently provided
- Question: Have you (Dr. Pawlovich) ever done Telehealth consults with a community that you've never visited before?
- o Answer: Yes, and patients have expressed that the quality of the consult is just the same as if it were in person.
- Question: Could Panorama be useful in integrating patient information and de-fragmenting the health record?
- o Answer: Panorama's use is limited to public health purposes, but it will ultimately align with the EHR vision for BC along with EMRs and other systems in order to provide a broader picture, or health record, of a patient and their history
- Question: Who needs to be on both ends to facilitate Telehealth sessions?
- o Answer: It's nice to have a nurse to work with, but it isn't necessary – Doctors could potentially do consults directly with patients without a nurse being present. Or, a Telehealth coordinator could be hired and trained to use the Telehealth equipment to assist in facilitating the sessions. However “it depends”. Different types of consults could require specific roles to be assisting depending on what instruments were being used, what support was required, etc.

Outcomes/follow-up work:

- Commence the First Nations Telehealth Expansion Project in the next few months in partnership with Tripartite partners, which will be a big first step towards completing Health Actions Action Item #23 – Create an integrated First Nations Telehealth Network
- Continued engagement with First Nations on the Panorama Implementation Project leading up to Group 1 implementation in 2013 to coincide with the Regional Health Authorities
- Continued planning and engagement in support of developing a First Nations Health Network
- Transfer and Transition of FNIHB to FNHA prior to April 1, 2013

Maternal Child Health

The Maternal and Child Health (MCH) strategy area held three breakout sessions during Day 3 of Gathering Wisdom. These sessions were facilitated by members of the MCH Strategy Council.



The first session was opened by the performance of a woman's warrior song. Within each of the sessions, Joan Geber and Hanna Scrivens, Lead and Co-Chair of the MCH strategy area, respectively, provided information on the purpose, scope and progress to date of the MCH strategy area. A 1-pager outlining the current scope and ongoing initiatives of the MCH strategy area was available for all participants to take away with them. Following this introductory presentation, participants formed small groups to discuss one of the following topics of their choice: women and girls' health, healthy pregnancy, infants and new mothers' health and childhood health (ages 0-6 years). Within these groups, participants discussed the greatest health issues in their communities, what needs to happen to address these needs and what methods and tools would give their communities the best opportunity to be engaged in further information sharing and priority setting.

Key points from these small group discussions were recorded onto flipcharts and have been transcribed and synthesized. Participants shared a lot of valuable information. Among many others, some of the recurring themes in the feedback were:

- The importance of elders to share knowledge on traditional practices for birthing, childrearing and parenting;
- The need for more education and awareness regarding health and wellbeing, sexual health, self-care, and parenting; and
- The need for more local maternity services and supports, including midwives, doulas and "Auntie Programs."

The MCH Committee also set up an information booth during all three days of Gathering Wisdom to share more detailed information about some of the specific initiatives that are ongoing within the strategy area and to discuss and gather more information from participants regarding their community's priorities.

The MCH Committee is grateful for the information that participants have shared and are using it to prioritize their strategies and inform work planning. Input from the participants regarding their preferred methods of engagement will also guide more effective communication and engagement with communities as this work moves forward to ensure that it continues to effectively reflect and respond to community priorities.



Health Human Resources

The Health Human Resources (HHR) strategy area held three breakout sessions during Day 3 of Gathering Wisdom. These sessions were facilitated by members of the HHR Strategy Council, as well as other staff of member organizations.



Christa Williams, Lead of the HHR strategy area, provided information on progress to date and the proposed priority areas developed with the assistance of past community input, environmental scans, and tripartite and stakeholder discussions:

- Health Career Promotion
- Training and Professional Development
- Workforce Recruitment and Retention
- Planning and Forecasting

Following this introductory presentation, participants participated in small group discussions regarding the proposed priority areas. Discussion centred on whether these priority areas are truly priorities within communities, if there are gaps in the identified priority areas, what the most critical priorities are for communities and how the participants thought their communities would be best engaged in HHR priority setting in the future.

A 1-pager outlining the progress and future direction of the HHR strategy council was available for all participants to take away with them. Worksheets were also provided for participants to give input on existing HHR initiatives and health service gaps within their communities, as well as preferred methods of engagement in further HHR priority setting.

A lot of great information was shared and discussed during these sessions. Participant feedback was very supportive of the priority areas that had been developed from past community input, environmental scans and stakeholder discussions. Among many others, some of the recurring themes in the feedback were:

- The importance of early childhood development, K-12 education and family for the future of a successful and effective First Nations health workforce. “The seed is planted early.”
- The need for increased community-based education opportunities and the importance of culture, identity, and traditional teachings.
- That adequate and sustainable program funding is necessary for effective recruitment and retention of health professionals in communities. Without this, wage inequities, overwhelming workload and a lack of jobs for community members to return to currently causes large barriers for the provision of effective, community-based health services.

The notes and information gathered during these sessions have been transcribed and synthesized. In the next few months, work will be done to develop the HHR planning committees who will employ the information that participants have provided as they move forward with the prioritization and development of strategies and plans to achieve the optimal number, skills mix and distribution of appropriately trained health care providers to meet the health service delivery needs of First Nations people in BC. Input from the participants regarding their preferred methods of engagement will also guide more effective communication and engagement with communities as this work moves forward to ensure that it continues to effectively reflect and respond to community priorities.

Health Knowledge and Information (HKI)

Health Knowledge and Information (HKI) strategy area held three sessions to engage with delegates on three areas of HKI work: Data Management, Surveillance and Health Indicators.



- Each session began with a brief (approximately 15 minute) introduction to HKI and the topic of that session, with one or two text voting questions available for audience participation.
- The presentation was followed by small group dialogues to receive feedback from delegates on the strategic goals and objectives, and to invite delegates to share their priorities and success stories in this area.
- Delegates were provided with a set of HKI factsheets (Data Management, Surveillance, Health Indicators, Academic Collaboration, Regional Health Survey) for more information and were invited to leave their contact information if they would like to engage further in the future (19 delegates indicated they would like to participate in future engagements).

Discussion/Comments

Although each session focused on a different topic (Data Management, Surveillance, and Health Indicators), some key themes emerged across all three sessions:

- There is a strong need for HKI education, awareness, tools and training for communities
- It is necessary for community members, including Chief and Council, to believe in the importance of this work
- Communities want their own local data for program planning and evaluation
- Communities want more support to do their own data collection, surveillance and research, communities may be able to train/advise each other as some communities have already engaged in their own projects

- There is a need for baseline data
- Communities are concerned about confidentiality, privacy, who has access to their data and how data are used
- Communities want to make access to their own data easier for patient care and the FNHA can help with this by streamlining systems (e.g., EMRs, creating linkages)
- There is a need for timely and accurate information in an appropriate and meaningful form to help communities with planning and decision-making
- This work should focus on holistic wellness and interconnectedness with our environment

A total of over sixty participants attended the HKI sessions with delegates from First Nations across BC holding a variety of positions (Chief, Council, Administrator, HUB Coordinator, Health Lead, Health Director, Executive Directors and Managers of Programs) as well as a few participants from partner organizations (e.g., Health Canada, Regional Health Authorities).

The feedback received will be brought back to the HKI Strategy Council and Planning Committees for review and discussion. This feedback will be used at an upcoming HKI work planning session to ensure that our work plans align with community priorities. The feedback and experiences from Gathering Wisdom V will inform future development of HKI communications materials and guide community engagement as this work progresses.

CLOSING REMARKS AND PRAYER

Joe Gallagher

Chief Executive Officer, interim First Nations Health Authority

Mr. Gallagher acknowledged the work of the iFNHA staff who had done an excellent job of organizing GWSJ V (2012). He shared feedback on the health screening results, noting that 255 people had been screened over the three days of GWSJ V (2012). The information gathered indicated the need for closer attention to cholesterol management and increased physical activity. There were no hypertension crises and only one individual had a sugar level too high. All of the delegates who set a personal goal indicated that they had 70% confidence that they could obtain their goal, and only a select few were advised to follow up with their family doctors. Many delegates mentioned that they would like health screening within their community for their members.

Gerry Oleman, “We come from a people who are very healthy – our bodies were straight, our eyes were clear, we were sound in mind body and spirit... Be like the people of old, be healthy.”

Grand Chief Doug Kelly, FNHC Chair, shared his pleasure that so many of the delegates had come together and made health their priority for these past three days. Delegates had attended sub-regional, regional and BC wide meetings to work towards creating a better place for BC First Nations’ children and grandchildren. BC First Nations have set out on a journey to eradicate health illiteracy, and it is the delegates’ commitment, dedication and desire to improve the well-being of First Nations peoples and to complete the health revolution. Grand Chief Kelly thanked all of the delegates, and noted his appreciation for all of the iFNHA staff.

Grand Chief Kelly presented officiating Elder George with a gift of appreciation, and led the delegation in acknowledging former FNHC members James Wilson, Marjorie McRae, and Charles Nelson for their service and outstanding leadership to contribute to the overall success of the last two years.

Elder Leonard George, Tsleil-Waututh First Nation, closed Day Three – May 17, 2012 of GWSJ V (2012) at 3:46 p.m. with the offer of a Celebration Drum Song.





ACRONYM LIST

The following acronyms were used throughout these proceedings:

AFN	Assembly of First Nations	GWL	Great West Life
BCAFN	British Columbia Assembly of First Nations	GWSJ	Gathering Wisdom for a Shared Journey
BCMA	British Columbia Medical Association	iFNHA	<i>interim</i> First Nations Health Authority
DPHO	Deputy Provincial Health Officer	HIS	Indian Health Service
FFA	Fiscal Funding Agreement	MOU	Memorandum of Understanding
FHA	Fraser Health Authority	MTRS	Medical Transportation Record System
FNHA	First Nations Health Authority	NIHB	Non-Insured Health Benefits
FNHC	First Nations Health Council	NLG	Nisga's Lisims Government
FNHDA	First Nations Health Directors Association	NVHA	Nisga'a Valley Health Authority
FNIH	First Nations and Inuit Health	TFNHP	Tripartite First Nations Health Plan
FNHS	First Nations Health Society	TRC	Truth and Reconciliation Commission
FNLC	First Nations Leadership Council	UBCIC	Union of British Columbia Indian Chiefs
FNS	First Nations Summit	VIHA	Vancouver Island Health Authority (VIHA)
FTE	Full Time Equivalent	YKHC	Yukon-Kuskokwim Health Corporation

APPENDIX A: List of Presentation and Resource Materials

The following items can be obtained by contacting the First Nations Health Council office:

1. *i*FNHA's Health and Wellness Workbook on the Health and Wellness Model
2. Little blue book titled "British Columbia First Nations Perspectives on a New Health Governance Arrangement – Consensus Paper".
3. Draft "Consensus Paper 2012 – Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure",
4. Document "Priority Setting: A Future First Nations and Aboriginal People's Mental Wellness and Substance Use Ten-Year Plan".
5. FNHC paper titled "Frequently asked questions".

PDF DOWNLOADS:

May 15th, 2012

1. Opening Remarks: Jacki McPherson, Vice President, FNHDA http://www.fnhc.ca/pdf/15_1030_JMcPherson_FNHDA_OpeningRemarks.pdf
2. Opening Remarks and Progress Report: Grand Chief Doug Kelly http://www.fnhc.ca/pdf/15_1035_GrandChiefDougKelly_OpeningRemarksandProgressReport.pdf
3. Wellness Plenary: Dr. Evan Adams, Dr. Naomi Dove, Dr. Shannon Waters, Dr. Georgia Kyba, Dr. David McLean, Dr. Sarah Williams http://www.fnhc.ca/pdf/15_1110_DrAdamsDrDoveDrWatersDrKybaDrDrMcLeanDrWilliams_WellnessPlenary.pdf
4. Keynote Speaker: Lateral Violence: Madeleine Dion Stout http://www.fnhc.ca/pdf/15_1330_©Madeleine_Dion_Stout_Kitimahitowin.pdf

May 16th, 2012

5. Leadership & Navigating the Currents of Change: Gwen Phillips (FNHC Interior Region), Warner Adam (FNHC North Region), Cliff Atleo (FNHC Vancouver Island Region http://www.fnhc.ca/pdf/Leadership_and_Navigating_the_Currents_of_Change-GP-CA-WA-FIN-REVISED_MAY15.pdf
6. Transition & the *i*FNHA - Joe Gallagher, Chief Executive Officer, *i*FNHA http://www.fnhc.ca/pdf/iFNHA_Transition_-_Joe_Gallagher.pdf
7. Navigating the Currents of Change - Success Stories: Dan Winkelman, Vice President for Administration and General Counsel of the Yukon-Kuskokwim Health Corporation http://www.fnhc.ca/pdf/16_1030_Yukon-Kuskokwim_Tribal_Self_Governance_4-18-12-FIN.pdf
8. Navigating the Currents of Change - Success Stories: James Moore, Chairperson, Nisga'a Valley Health Authority http://www.fnhc.ca/pdf/16_1030_NVHA_NIHB_May_10_2012.pdf
9. Regional Partnership Accords: Shana Manson, FNHC Representative, Vancouver Island Region [http://www.fnhc.ca/pdf/16_1300_Regional_Partnership_Accords_\(Shana_Manson_day_two_pm\).pdf](http://www.fnhc.ca/pdf/16_1300_Regional_Partnership_Accords_(Shana_Manson_day_two_pm).pdf)

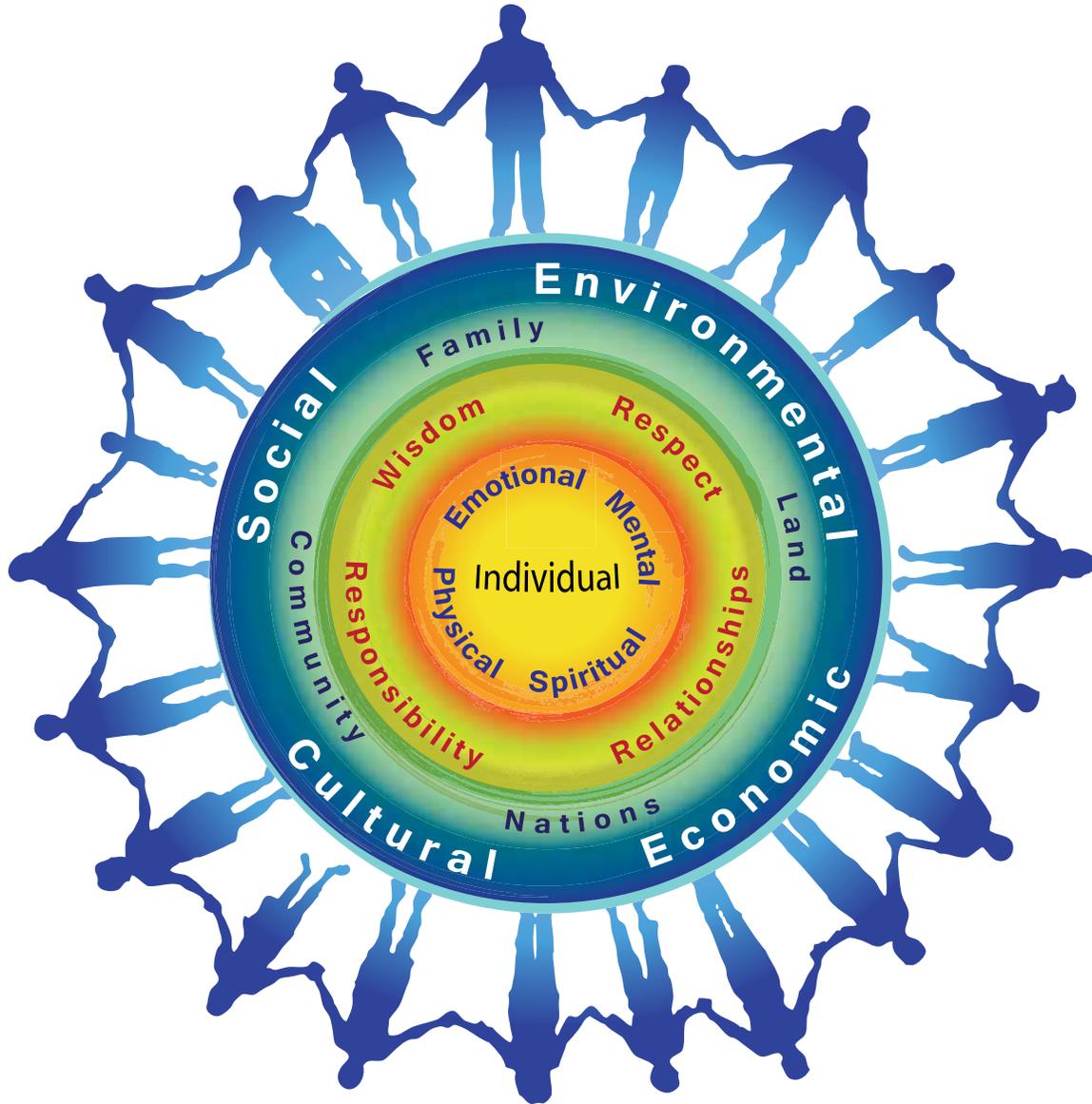
May 17th, 2012

10. Our Evolving Landscape: Dr. Perry Kendall, Provincial Health Officer http://www.fnhc.ca/pdf/17_935_DrPerryKendall_OurEvolvingLandscape.pdf
11. Physicians as Partners: Dr. Lloyd Oppel, Chair, Council on Health Promotion, BC Medical Association http://www.fnhc.ca/pdf/17_935_DrLloydOppel_PhysiciansAsPartners.pdf

Resources available at www.fnhc.ca

APPENDIX B: Holistic Vision of Wellness Diagram

Holistic Vision of Wellness



APPENDIX C: FNHC RESOLUTION 2012-01 (ABRIDGED*)

THEREFORE BE IT RESOLVED

1. That the Chiefs in Assembly at Gathering Wisdom for a Shared Journey V approve the enclosed Consensus Paper 2012: Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure, including the following key elements:
 - a. Setting the Standards: Affirming and implementing the 7 Directives, Corporate Governance Requirements, and Competencies for the Board of Directors of the interim and permanent First Nations Health Authority;
 - b. Setting the Stages: Ensuring a deliberate and planned approach to the work, in accordance with the key stages of Transition and Transformation;
 - c. Setting the Structure: Confirming the establishment of a regionally-representative Board of Directors, a holistic First Nations health governance model, and Regional Offices; and,
 - d. Upholding Our Commitments: Affirming that high standards of Reciprocal Accountability and Engagement are the foundation for our ongoing success.
2. That the Chiefs in Assembly at Gathering Wisdom for a Shared Journey V direct the First Nations Health Council to undertake the following next steps as outlined in, and consistent with, the Consensus Paper 2012: Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure:
 - a. Continue to implement the next steps outlined in the Consensus Paper 2011: BC First Nations Perspectives on a New Health Governance Arrangement;
 - b. Transition the interim FNHA to the permanent FNHA by implementing a regionally-representative Board of Directors, including: amending the bylaws to reflect a regionally-representative model respecting each Nation's uniqueness; creating a process within six months to support Regions to undertake Board posting, recruitment, evaluation, assessment, and nomination processes for 5 regionally-representative Board positions consistent with the competencies referred to in 1(a) above; and, creating mentorship materials for BC First Nations on Board membership, among other things;
 - c. Develop a rigorous orientation process for FNHA Board members, to ensure that all Board members are culturally-competent and fully familiar with their legal and fiduciary obligations;
 - d. Develop and implement a cost-effective plan, selection and evaluation process and role description for a male and female Elder Advisor for the Board of Directors of the FNHA (and FNHA);
 - e. Conduct and provide research to BC First Nations for further discussion, development, and strategic decision on a holistic First Nations health governance model, including: other examples of First Nations health governance models; Regional Health Authorities profiles; the concepts of an Ombudsperson and a Charter of Rights for First Nations Health; legal analysis of existing legislative changes to benefit BC First Nations, and of potential new legislation to create the holistic First Nations health governance structure; business and sustainability plans; and, an overall map of how the holistic First Nations health governance structure will work;
 - f. Begin planning the implementation of a holistic First Nations health governance structure model as described in the Consensus Paper 2012 that is built on a legislative foundation, and that ensures that any non-profit or corporate entities are ultimately accountable to BC First Nations, and are subject to the transparency and accountability standards established by BC First Nations;

- g. Prepare a Regional Offices implementation plan to describe a cost-effective approach to and timeframes for creating Regional (and Sub-Regional as appropriate) Offices;
 - h. Employ the Engagement & Approval Pathway to obtain First Nations feedback and direction on strategic-level decisions with respect to the First Nations health governance structures;
 - i. Develop an annual Community Engagement Plan that will define annual engagement and communications priorities and milestones, and establish a schedule of Regional Caucus and other meetings each year, including an annual iFNHA report including finances and activities to each Regional Caucus session; and,
 - j. Undertake an independent evaluation of the First Nations health governance structure, including financial management, as depicted in Figure 2 of the Consensus Paper 2012 and provide that to BC First Nations Chiefs prior to Gathering Wisdom for a Shared Journey VI.
3. That the Chiefs in Assembly at Gathering Wisdom for a Shared Journey V direct the First Nations Health Council to update and enhance the Resolution 2011-01 Workplan to include the action items set out in this Resolution and Consensus Paper 2012, and provide quarterly updates to BC First Nations on progress in implementing that Workplan.
 4. That the Chiefs in Assembly at Gathering Wisdom for a Shared Journey V direct the First Nations Health Council to, consistent with the Consensus Paper 2011 and the Consensus Paper 2012, continue to engage and share information with, and be accountable to, First Nations through a variety of mechanisms, including but not limited to: Regional Caucuses; Gathering Wisdom for a Shared Journey forums; presentations to other provincial First Nations leadership organizations; annual reports; communiqués; and, online and digital media.
 5. That the Chiefs in Assembly at Gathering Wisdom for a Shared Journey V direct the First Nations Health Council, consistent with the commitments described in the Tripartite Framework Agreement on First Nation Health Governance, to hold Gathering Wisdom for a Shared Journey VI in Fall 2013 to report on progress in the implementation of this resolution, and seek further direction and approvals of First Nations Chiefs in BC.

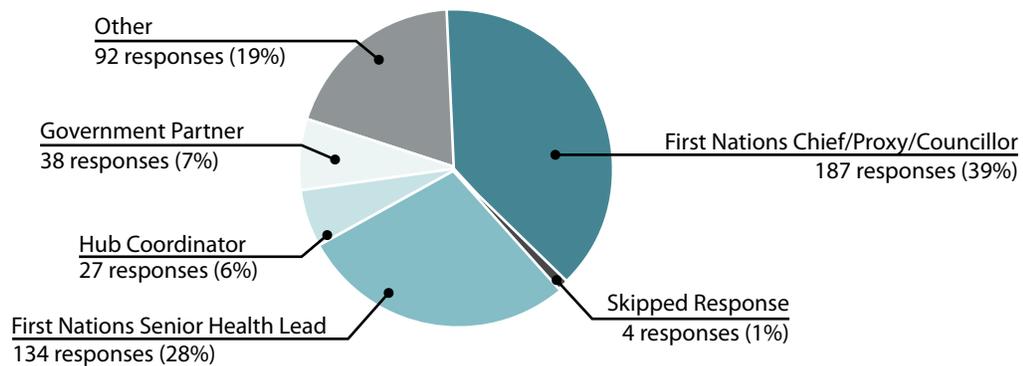
*For full resolution text please visit:
[http://www.fnhc.ca/pdf/FNHC_-_GW_V_Resolution_2012-01_\(SIGNED\).pdf](http://www.fnhc.ca/pdf/FNHC_-_GW_V_Resolution_2012-01_(SIGNED).pdf)

APPENDIX D: FORUM FEEDBACK

Total Registered Attendees: 748

Total Survey Responses: 482

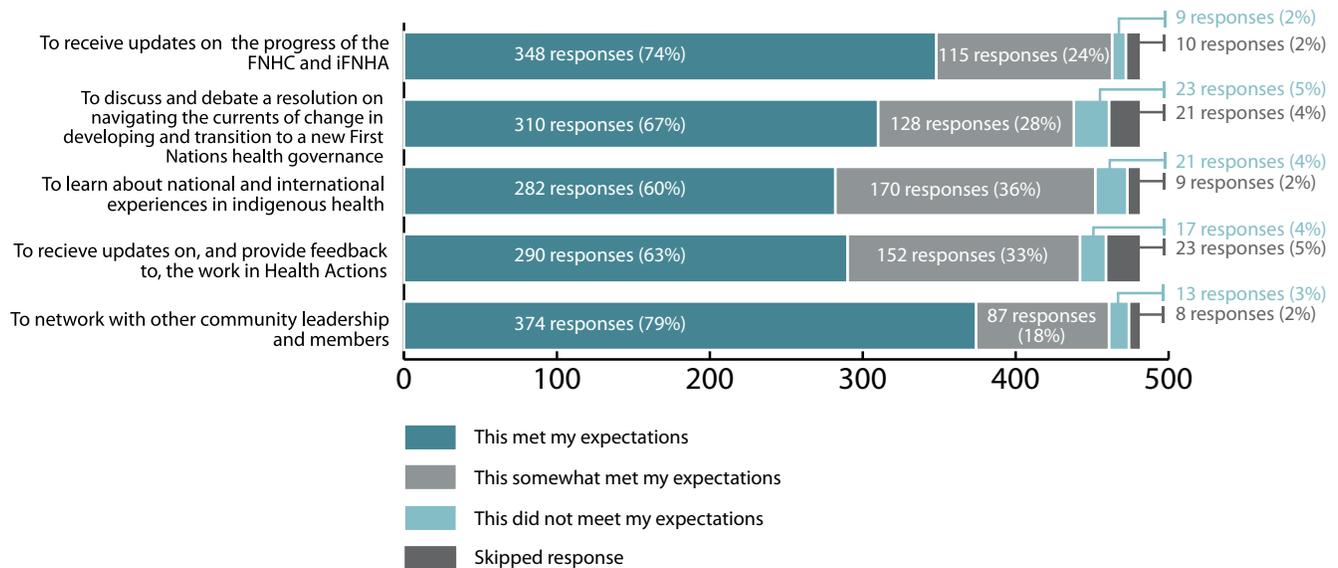
Figure 1. Please tell us a little about yourself (please check only one):



Snapshot of specified 'Other' attendees:

Elder, Board Member of Gitksan Child and Family Services, Community member, Community Healer, Community Health Manager, exhibitor, Volunteer, Licensed Practical Nurse (LPN), Youth Coordinator, observer, Aboriginal Education Worker/ Stelat'en First Nation, BC Women's Hospital, Esemkwu Aboriginal, UVIC - Self management Aboriginal Liaison, Consultant, Physician, LPN student, Treaty Coordinator, First Nations Dental Therapist, [Community Engagement] Hub Communications Assistant, Doctor.

Figure 2. Please rate your hopes and expectations for attending this forum:



Please tell us more on whether or not the forum met your key hopes and expectations:

- The forum was great I especially loved the health fair; health screening, fitness. And that it was held downtown Vancouver
- Health Actions should be first on the agenda especially the priority setting
- Would to the have the technicians have more time to focus on the work needed to be done and recommendations be given to F.N.
- Very well organized. My only disappointment was that the Resolution wasn't passed by consensus
- Forum went very well. The feedback from each Region was very clear and well planned
- Good networking and info on health issues for FN remote communities. We are on our road to looking after ourselves again
- I believe that more time is necessary for caucus groups to meet & discuss issues & thoroughly debate resolutions without being rushed
- What an honour to be amongst caring, hardworking informative First Nations & non-FN all with fun goal of unity Health prospects
- This forum demonstrated how to incorporate culture into health services delivery

Figure 3. Please let us know what you thought about the presentations and events that took place throughout the Forum:

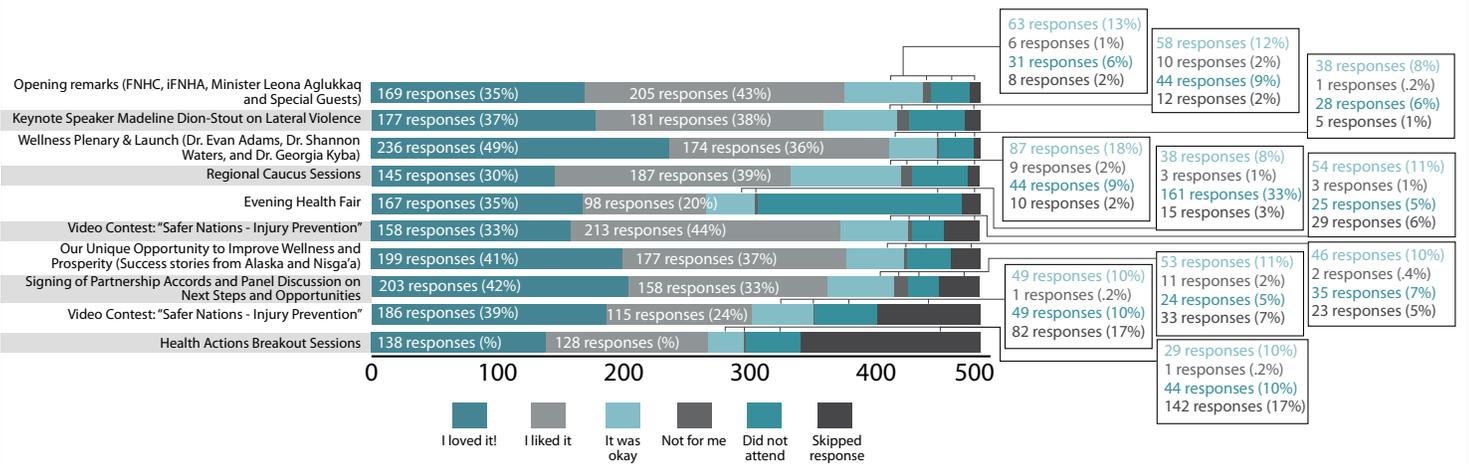
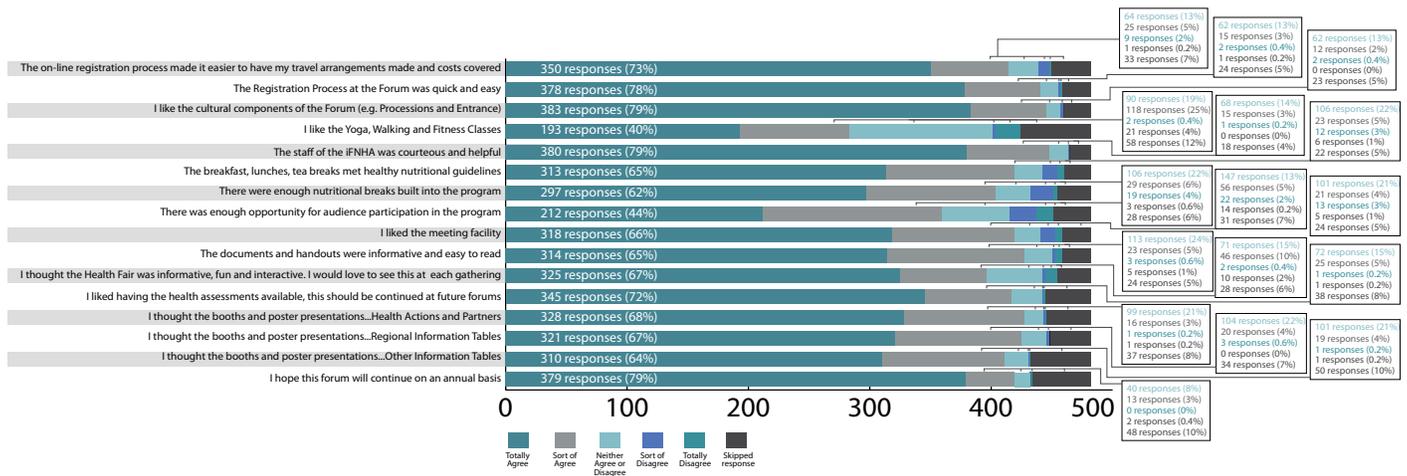


Figure 4. Please rate the following statements related to your experience at the Forum:



Please feel free to provide us with any other feedback and suggestions.

- The health fair/screening was awesome! Would love to see more break out workshops held. I would love to be able to have access to some of the presentations slide shows eg. Joe Gallagher: Nisga’a: Alaska: Great Job!!
- The Whole team working together, worked great together and were so helpful and always smile and nice. They worked very well together at the registration and did very wonderful together. I loved the place we stayed and enjoyed the whole meeting and everything that had gone on.
- It was great to see the Health Assessment as part of the forum & as leaders we need to be role models for our Community members
- Provided great opportunity to network with First Nations communities and provincial partners. Provided opportunity to share resources and work on FNHA resources
- The ceremonial opening processions are very important part of these meetings and can only encourage continuing with them.
- Excellent service from beginning to end. Klecco.
- Look forward to Gathering Wisdom VII!!
- Too much swag \$\$\$?? \$\$ needed at home! Footprint “Plastic”
- I really enjoyed and learned even more and met so many more 1st nations on same page/concerns, change, Health

- 2 fair nights 34th floor (Awesome) Great food - Daytime takes away from forum (to experience it)
- Thank you for your great efforts. This is a great undertaking
- Our leadership should pose questions for concerns in the regional caucus and not dominate @ the first signing
- Well Organized
- Financial resources are on-going concern. How much was spent on memorabilia? (Jackets, water bottles, pens, t-shirts for staff etc.)
- A great job as usual!!
- a lot of informative stuff & very little interactive
- The booths were exceptionally helpful & delivered their info well
- The forum is vital for communality and continuity also it allows the Chiefs greater input into the process
- Improvement every forum
- Would like Election process changed, standard process for nominations @ mtg. hear from the candidate forum to see if they are educated about health! This is our children, grand children's future lives at stake. Need to be accountable, open and transparent. Need to do it the right way, need good communication.
- I like being a part of growth in healthy way - we are going in the right direction
- I did not attend all booths and fitness classes; however I believe they are both very important to health and wellness. both for opportunity and access
- Full participation should be a requirement by all delegates, chiefs, etc.
- Activities were great! I loved the (illegible) breaks – humour is wonderful! I enjoyed the videos & the opportunity to interact. Although the information would be useful to take home its overwhelming took what I could and appreciate that it's there.
- Excellent! We all have to be aware that change take time. The speakers were very good and everyone very helpful. I liked traditional healers or health practitioners gave us a chance to de-stress, while away from our community work.
- I strongly feel Health Directors are being missed. They can only provide info to caucus & are not guaranteed to have their clear points put forth
- I loved all the traditional drumming. I felt inspired for next year
- I'm sore up but "well worth it"
- The event is perfect, don't change
- This is fantastic! Inspiring!! Strengthening and empowering!
- There should be more meeting in the communities. Come on (save money) a lot of distraction from business – should be separate
- This was a very informative session the fun parts sure helped. Dr Evan Adams Game. He livened everyone up

