

Decision-making matrix to co-design evidence-based care solutions with First Nations Peoples

The Health System	Person-focused care		Population-based care	
	Interpersonal continuity	Informational continuity	Longitudinal continuity	Management continuity
	1 Care adapted to patients' behavioural, personal, cultural beliefs, and family influence	4 Positive patient-provider communication; patients are informed of what and why their care is changing	5 Care navigator or community connector	6 Proactive, regular monitoring of long-term conditions
	2 Continued relationships and trust among providers, patients, and caregivers	14 Information shared among providers and settings to ensure "collective memory."	8 Links and referral strategies for care professionals	7 Case-finding and detection of high-risk individuals
	3 Flexible, consistent, adaptable care along the continuum	16 Shared, synchronised care records	9 Care and follow-up by a professional or team in all settings or care levels	11 Case management across sectors
	18 Care by the same central providers for all care needs	17 Standardised, common clinical protocols in all care settings	10 Support by informal carer or social network	12 Care planning with the perspectives and recommendations of multiple providers
			13 Discharge planning from admission	15 Shared collaborative care by an interdisciplinary team
Micro and Meso levels			Meso and Macro levels	

The most important enablers and strategies for achieving continuity of care and its integration for First Nations Peoples living with chronic conditions are illustrated in Table 3, as per the synthesis of 103 publications. Table 3 situates the reader on the order of importance of needed strategies (nature, levels, and types) around enabling care for First Nations Peoples.[23, 40, 65, 67-71] These enablers are ranked in order of importance from 1-18 as per frequency of themes identification within the qualitative review process.