Evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance

APPENDICES

First Nations Health Authority

Province of British Columbia

Indigenous Services Canada

December 2019

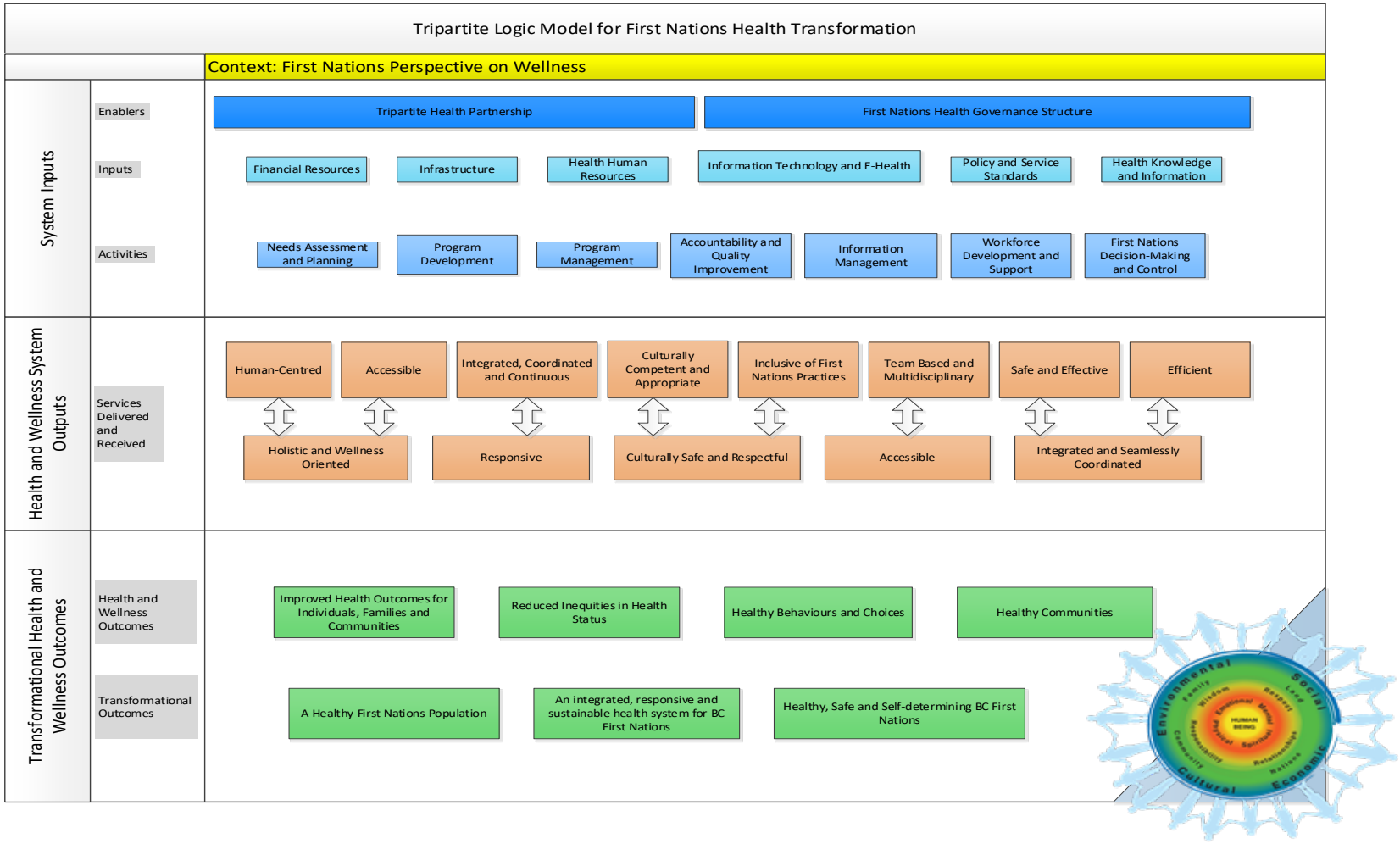
The work represented in this report is carried out on the unceded territories belonging to self-determining First Nations in what is now British Columbia. The Tripartite partners acknowledge and thank those who took the time to share their guidance and wisdom.

Appendix A: Logic Model

As a conceptual model, the Spiral Logic Model depicts the primary enablers, inputs, activities and outputs that correspond to the Tripartite Partners' shared vision for health system change and the causal relationships that exist between its core components. It defines the areas in which information, evidence and evaluation are required for planning, implementing and reporting on the performance of the Tripartite First Nations Health Plan. The use of the logic model as a basis for conceptual and operational planning lends important context for evaluation purposes and supports consistency across multiple assessments. A linear version of the Spiral Logic Model appears as Figure 2 below.

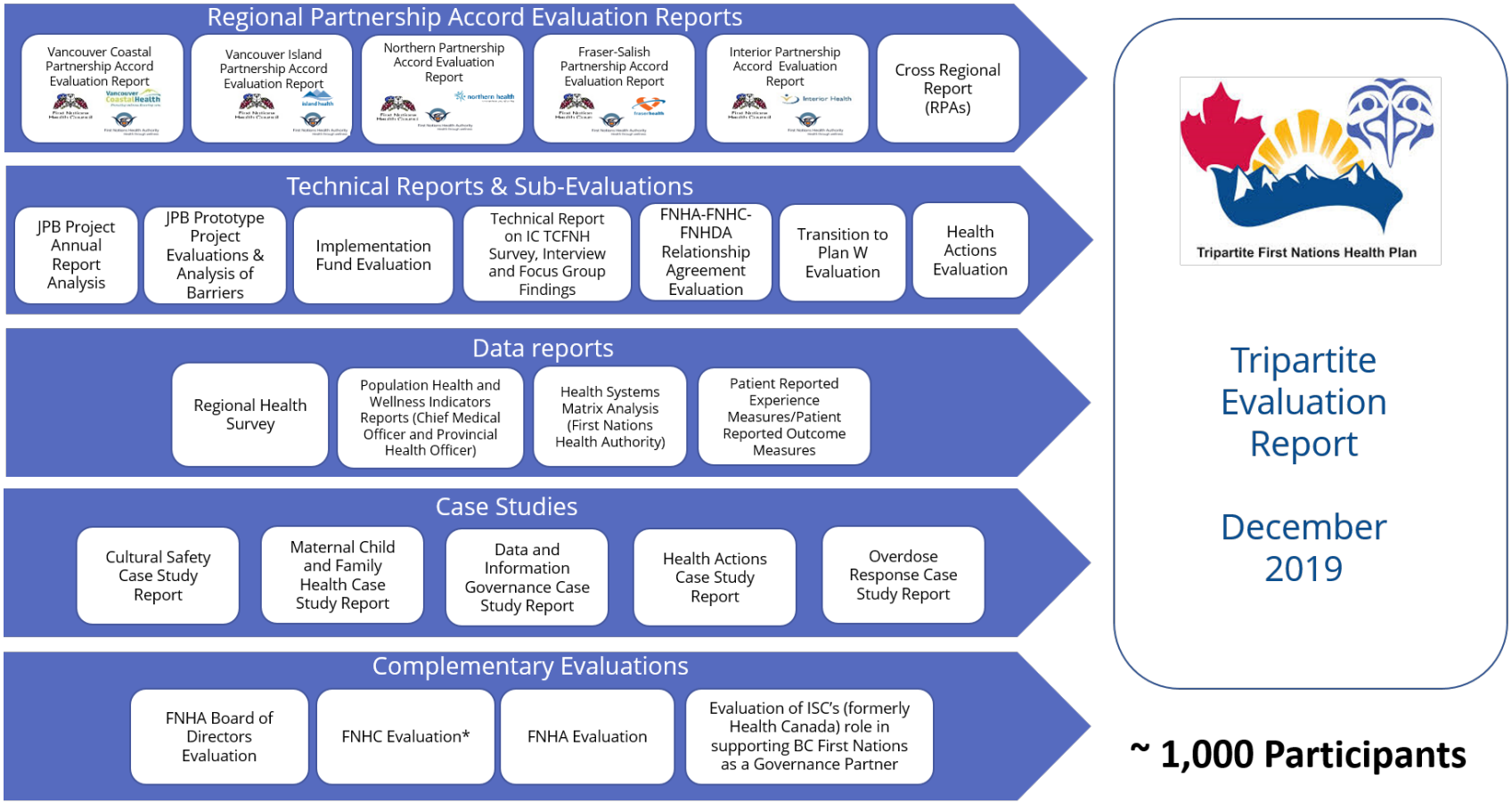
Figure 1: The Spiral Logic Model

Figure 2: Linear Logic Model



Appendix B: Tripartite Evaluation Reporting Products

Figure 3: Tripartite Evaluation Reporting Products



Appendix C: Quantitative Data Sources

Various sources of quantitative data are used to help inform this report namely the Health System Matrix (HSM), the Regional Health Survey and Patient Reported Experience Measures surveys (PREMs).

A common limitation of these data sources, with the exception of the 2018 Emergency Department Patient Reported Experience Measures survey, is the timeliness of the available data. At the time of writing this report, the most recent HSM data is from 2014/15, and the latest RHS is from 2015-2017. Effects of initiatives to improve health care access such as the Joint Project Board initiatives are unlikely to be reflected in these data sources findings, which were still early in project implementation in 2014/15. Even if fully implemented, the majority of Joint Ministry of Health – First Nations Health Authority Project Board (Joint Project Board) clinicians are salaried positions, and thus the impacts on access measures such as GP attachment through the HSM would be minimal (which rely on fee-for-service data). This limitation would not affect the ASCS or Emergency Department services measures.

Health System Matrix Data

The Health System Matrix is a provincial database that summarizes how people use provincial health services every year. The HSM divides the BC population into population groups according to their usage of available sources of health services data. These groups are aggregated into four health status groups (HSGs): Staying Healthy (non-users and low users), Getting Healthy (major users not included in another HSG), Living with Illness & Chronic Conditions (persons with low, medium and high chronic diseases, cancer and severe Mental Health & Substance Use) and Towards End of Life (frail and palliative individuals).

Table 1: Further Information about Health Systems Matrix

Most recently available data	**Sampling Framework**	**Method of identifying First Nation respondents**	**Limitations**
The most recent Health System Matrix (HSM) data is from 2014/15 and therefore does not cover most of the evaluation period (between October 2013 and December 2018).	HSM provides an overview of health service utilization of approximately seventy per cent of all provincial health expenditures for individuals who have chosen/been able to access health services. Excluded from the HSM are:	A deterministic linkage with the First Nation Client File identifies records of individuals who are highly likely to be Status First Nations. Does not capture individuals	Lacking utilization data for First Nation communities, salaried physicians, Nurse Practitioners and alternate payment plans may artificially attenuate measures of access to health services. First Nations are believed to be more likely to access health services through alternative payment plans.

	• service utilization from First Nation community health services, • Joint Project Board projects, • the ~ 30 per cent of provincial expenditures such as population health programs, community mental health programs • physician services provided via salaried positions. The HSM does contain a portion of salaried/alternate payment plan physicians who shadow bill (submit fee codes corresponding to the patient's visit). • Nurse Practitioners hired through the NP4BC initiative, • sessional employment and incentives encouraging physicians to practice in rural environment, • data from BC Cancer Agency, BC Renal Agency and the Ministry of Child and Family Development.	who are non-Status or Métis.	Shifts in utilization may indicate shifts in access and/or true shifts in underlying condition being measured.

Patient Reported Experience Measurement Surveys / Patient Report Outcome Measures Surveys

Since 2003, the Ministry of Health and Provincial Health authorities have implemented a program to measure the self-reported experience of patients in a range of health care sectors using *Patient-Reported Experience Measurement* surveys (PREMs) and, more recently, Patient-

Reported Outcome Measures surveys (PROMs). The surveys are conducted province-wide and in a number of health care sectors including Acute Inpatient hospitals, Emergency Departments, Outpatient Cancer Care services, Mental Health in-patients and Long-term care facility residents. All Patient Reported Experience Measures surveys include a First Nations self-identifier variable.

Table 2: Further Information about Patient Reporting Experience Measurement Surveys

Most recently available data	**Sampling Framework**	**Method of identifying First Nation respondents**	**Limitations**
The PREMs sector surveys are completed in various health sectors. The most recent surveys conducted were the Emergency Department survey (conducted between Jan-March, 2018 in 108 Emergency Department facilities across the province) and the Sept-December 2017 survey (conducted among 80 acute care hospitals)	Randomly selected sample of individuals who has been discharged from an ED/Acute inpatient facility	Individual self-identify as Aboriginal	As a voluntary sample survey utilizing voluntary self-identification of Aboriginal ethnicity, it is unknown to what extent the survey findings reflect the experiences of all First Nations accessing the health system in BC. The percentage of respondents identifying as Aboriginal varies between sector surveys. The 2018 Emergency Department survey, for example, 5.8 per cent of respondents self-identified as Aboriginal vs. the 2016/17 Acute Inpatient survey, in which only 3 per cent of respondents identified as Aboriginal[1].

The key drivers of patient experiences were reported in this evaluation. The 2018 Emergency Department PREMs questions included in each dimension are presented in the table below.

[1] According to the 2016 RHS, 5.9% of the BC population was Aboriginal. Source: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/details/page.cfm?Lang=E&Geo1=PR&Code1=59&Data=Count&SearchText=British%20Columbia&SearchType=Begins&B1=Aboriginal%20peoples&C1=All&SEX_ID=1&AGE_ID=1&RESGEO_ID=1

Table 3: 2018 Emergency Department PREMs Questions

Key Driver Dimension	Survey questions included
Getting timely care	• Reported waiting less than 5 minutes before someone talked to them about the reason they were there • Reported getting care within 30 minutes of getting to the Emergency Department
How well Emergency Department doctors and nurses communicate with patients	• Reported nurses treated them with courtesy and respect (ALWAYS) • Reported nurses listened carefully to them (ALWAYS) • Reported nurses explained things in a way they could understand (ALWAYS) • Reported doctors treated them with courtesy and respect (ALWAYS) • Reported doctors listened carefully to them (ALWAYS) • Reported doctors explained things in an understandable way (ALWAYS)
Receiving culturally responsive and compassionate care	• Felt their care providers were respectful of their culture and traditions (COMPLETELY) • Reported that they were treated with compassion (COMPLETELY)
How well continuity across transitions in care is managed:	• Reported that after they left the Emergency Department their doctors or other staff who usually provide their medical care seemed up-to-date about the care they received in the emergency department (COMPLETELY) • Reported that someone discussed with them whether they would need follow-up care (YES) • Reported that someone asked them whether they would be able to get follow-up care (YES)

Regional Health Survey

The Regional Health Survey (RHS) is a unique national survey that increases the decision-making and control of First Nations peoples to collect, control and share their own health information. In the past, on-reserve populations were excluded from major national health surveys. The RHS began as a way to fill this gap and it captures the self-reported health and wellness status of at-home First Nations peoples in BC. The RHS has been completed nationally three times: Phase 1 in 2002-03, Phase 2 in 2008-10 and Phase 3 in 2015-17.

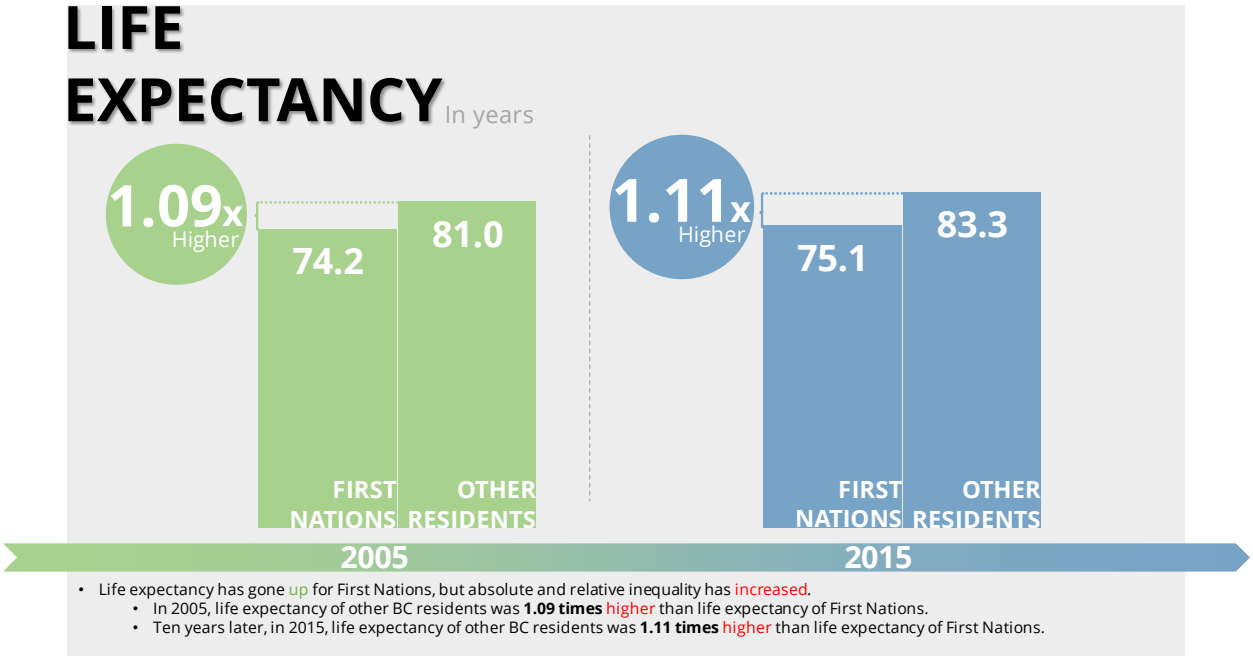
Source	Data available	Sampling Framework	Method of identifying First Nation respondents	Geography	Limitations
RHS	The most recent RHS was completed in 2015-2017	Randomly selected Status individuals on the Band list of a First Nation community who are living in that community at the time of the survey	Individuals are all First Nations	Selection of First Nations communities	Not complete coverage of all First Nations communities and not complete response rate. Only able to reflect experience of First Nation individuals living in community.

Appendix D: Transformative Change Accord: First Nations Health Plan Indicators

The following appendix provides an overview of trends in Transformative Change Accord: First Nations Health Plan (TCA: FNHP) indicators between 2005 and 2015, with a particular emphasis on the relative inequality and absolute inequality between Status First Nations and other residents.

As shown below, in 2005, the gap between Status First Nations and other residents was roughly 6.8 years. In 2015, even though the life expectancy had increased for Status First Nations by just under a year (from 74.2 to 75.1 years), the gap has increased to 8.2 years.

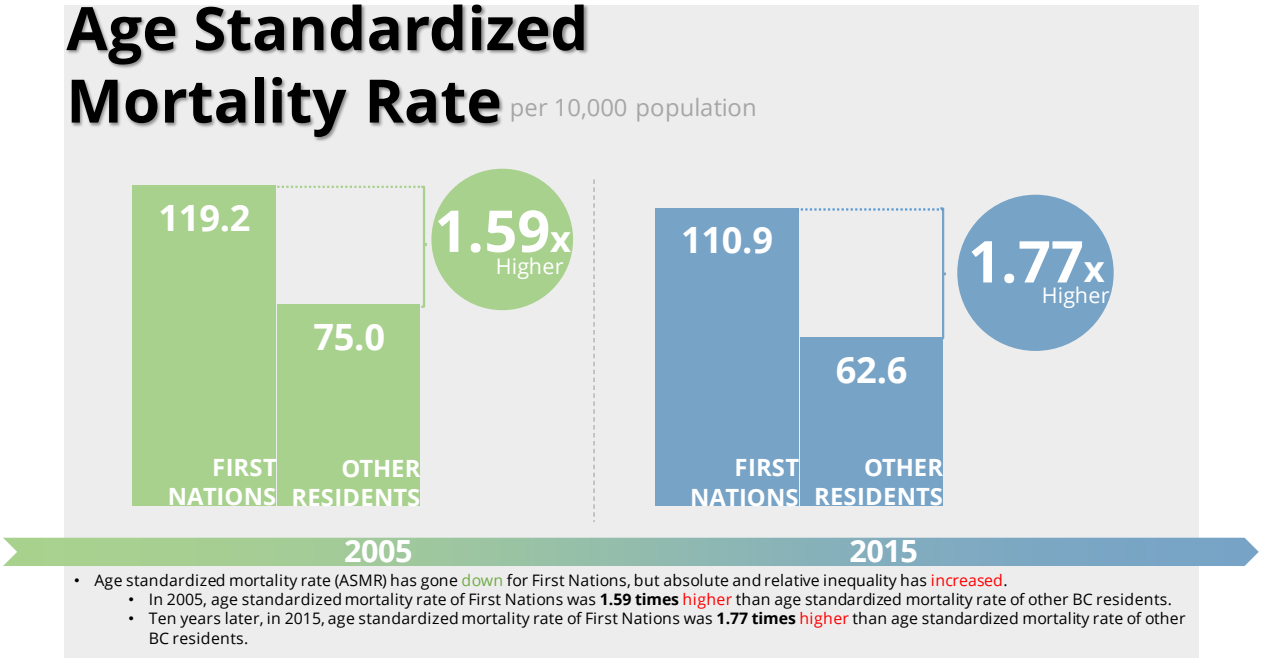
Figure 4: Shifts in life expectancy, absolute and relative inequality between Status First Nations and other residents from 2005 - 2015



Source: BC Vital Statistics Agency and First Nations Client File (Release v2015), data as of November 2017 as presented in PHO (2018). Indigenous Health and Well-being: Final Update. Available from: http://www.fnha.ca/Documents/FNHA-PHO-Indigenous-Health-and-Well-Being-Report.pdf

Age-standardized all-cause mortality rates have gone down between 2015 and 2005, but the difference between Status First Nations and other residents has increased in absolute and relative terms.

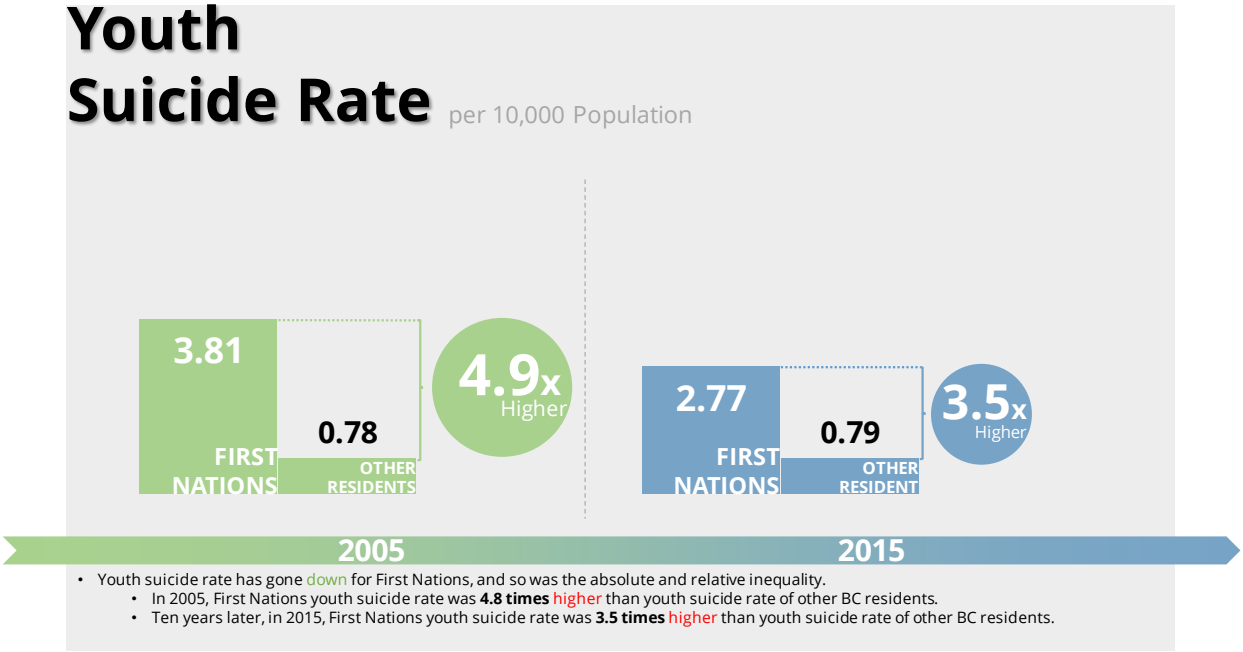
Figure 5: Shifts in All cause, age standardized mortality, absolute and relative inequality between Status First Nations and other residents from 2005 - 2015



Source: BC Vital Statistics Agency and First Nations Client File (Release v2015), data as of November 2017 as presented in PHO (2018). Indigenous Health and Well-being: Final Update. Available from: http://www.fnha.ca/Documents/FNHA-PHO-Indigenous-Health-and-Well-Being-Report.pdf. Note: Standardized to the Canada 2011 population

As displayed in Figure 6 below, the youth suicide rate has decreased between 2005 and 2015, and both the absolute and relative gap between Status First Nations and other residents has narrowed.

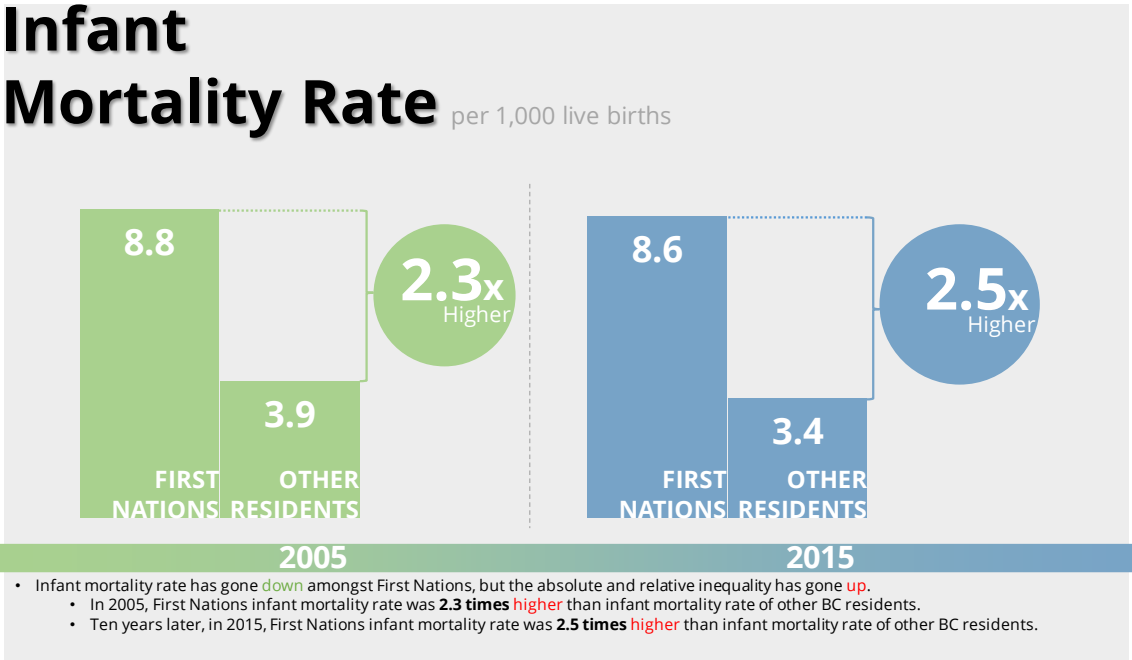
Figure 6: Shifts in youth suicide rate, absolute and relative inequality between Status First Nations and other residents from 2005 - 2015



Source: BC Vital Statistics Agency and First Nations Client File (Release v2015), data as of November 2017 as presented in PHO (2018). Indigenous Health and Well-being: Final Update. Available from: http://www.fnha.ca/Documents/FNHA-PHO-Indigenous-Health-and-Well-Being-Report.pdf.

As displayed in Figure 7, infant mortality rates have gone down among First Nations between 2005 and 2015, but both the absolute and relative gap between Status First Nations and other residents has increased.

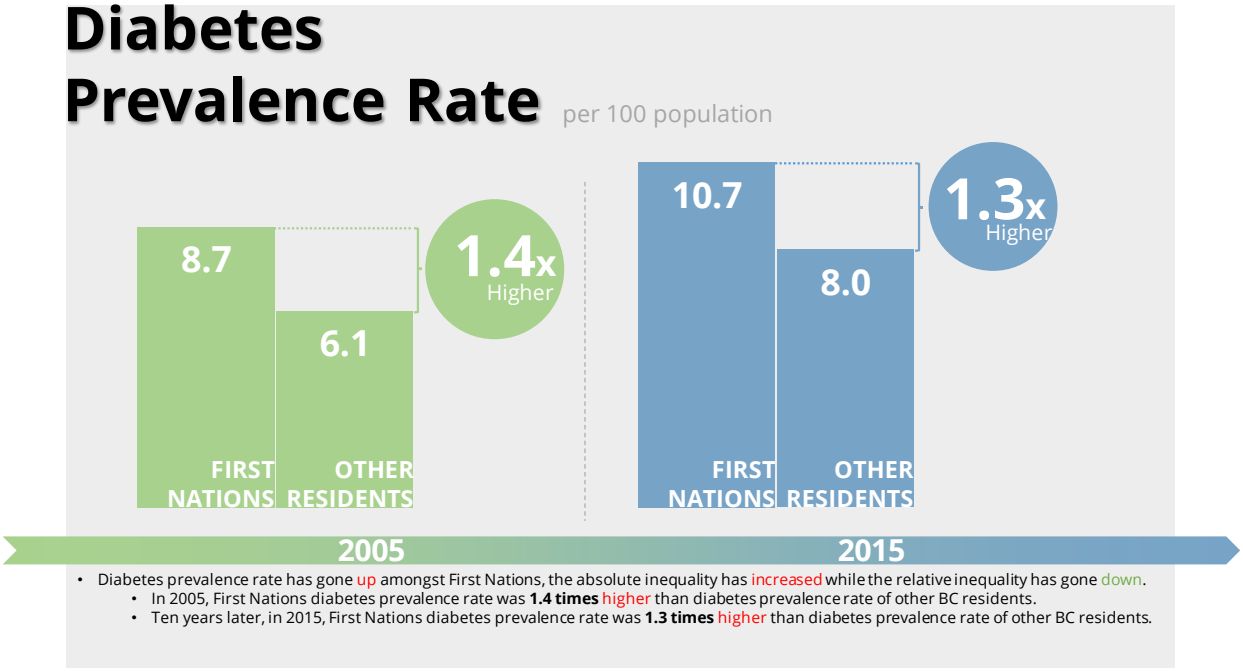
Figure 7: Shifts in infant mortality rate, absolute and relative inequality between Status First Nations and other residents from 2005 - 2015



Source: BC Vital Statistics Agency, data as of November 2017 and First Nations Client File (Release v2015) as presented in PHO (2018). Indigenous Health and Well-being: Final Update. Available from: http://www.fnha.ca/Documents/FNHA-PHO-Indigenous-Health-and-Well-Being-Report.pdf.

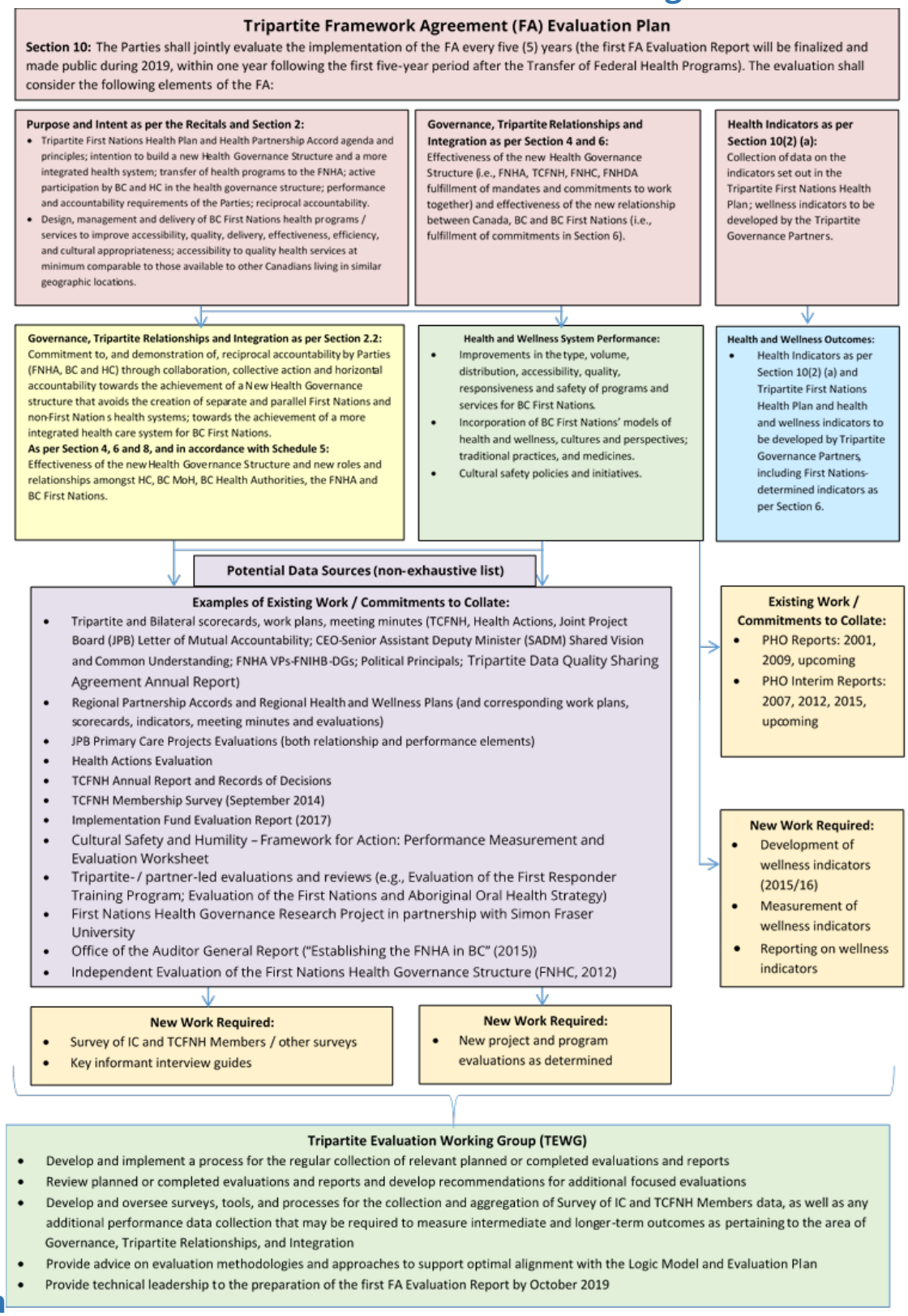
Figure 8 shows that diabetes prevalence rates have gone up among both Status First Nations and other residents. The absolute inequality has gone up slightly, but the relative inequality has narrowed slightly.

Figure 8: Shifts in diabetes prevalence, absolute and relative inequality between Status First Nations and other residents from 2005 – 2015



Source: BC Ministry of Health Chronic Disease Registries and First Nations Client File (Release v2015) as presented in PHO (2018). Indigenous Health and Well-being: Final Update. Available from: http://www.fnha.ca/Documents/FNHA-PHO-Indigenous-Health-and-Well-Being-Report.pdf

Appendix E Visual Overview of the Framework Agreement Evaluation Plan



Appendix F Commitment Table

1. The Parties shall jointly evaluate the implementation of this Agreement every five (5) years. This evaluation shall consider the purpose and intent of this Agreement as set out in the Recitals and section two and be carried out within the wider context of the health partnership with BC First Nations.

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2. The Parties shall, within eighteen (18) months of the signing of this Agreement, prepare an evaluation plan and begin collecting data and reports to track at least the following:

   2a. Health Indicators:

   i. Life expectancy at birth;
   ii. Mortality rates (deaths due to all causes);
   iii. Status Indian youth suicide rates;
   iv. Infant mortality rates;
   v. Diabetes rates;
   vi. Childhood obesity rates;
   vii. The number of practicing First Nations health care professionals who are registered or otherwise accepted members of recognized health professions under the BC *Health Professions Act*; and
   viii. Any other additional indicators, including wellness indicators supported by the governance stakeholders; namely the Tripartite Committee, the FNHC and the FNHDA.

   2b. Governance, Tripartite Relationships and Integration:

   i. The effectiveness of the new Health Governance Structure described in section 4; and
   ii. The effectiveness of the new federal, provincial and First Nation relationships set out in section 6.

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3. A tripartite evaluation report will be finalized within one year following the first five year period of the Transfer of Federal Health Programs. The report shall be made public.

BC Tripartite Framework Agreement Evaluation Status Map

Section 10 of the *BC Tripartite Framework Agreement on First Nations Health Governance* (FA) outlines the evaluation work to be undertaken by Tripartite Partners. Specifically, Section 10 states that:

The following scorecard presents the status of key commitments made by the Province of BC, the Government of Canada, and BC First Nations outlined in Section 10 of the Framework Agreement. For the purposes of this scorecard, the status of each commitment is colour-coded as:

- **COMPLETE** – refers to an activity that has been fulfilled and does not require further action.
- **ONGOING** – refers to an ongoing activity that requires sustained action.
- **WORK INITIATED** – refers to an activity that has been initiated but has not moved beyond early discussions.
- **WORK NOT STARTED** – refers to an activity that has been identified but is not underway.
- **UNKNOWN/NOT AVAILABLE** – refers to an activity that was not reviewed as part of the evaluation or is unknown at this time (e.g. 'upon request').

Note that activities may fit more than one category and have multiple colours assigned to them. Two further activities not covered under the evaluation have not started, including 9.1(1) and 9.1(2) regarding exploring federal and provincial legislation, recognizing that the partners have worked to incorporate First Nations perspectives into other legislative efforts.

It is also important to note, that as described in the main report above, in many ways the partners have undertaken efforts beyond what was initially envisioned in the Framework Agreement.

A Section	Activities	Status	FA Evaluation Section
Recitals			
Recitals A	Build on previous BC First Nations health plans with Canada and the Province of BC.		2.1
Recitals B	Use of established guiding principles in the Framework Agreement.		2.1
Recitals C	Develop a Health Partnership Accord for a more responsive and integrated health system for First Nations in BC.		2.1
FA Section	**Activities**	**Status**	**FA Evaluation Section**

A Section	Activities	Status	FA Evaluation Section
Recitals D	BC funds, administers and delivers health care services to all Status Indians.		6.4
Recitals E	Canada funds or provides community- based health programs and services and non-insured health benefits.		3.1
Recitals F	FNHC is mandated to act as an advocate for BC First Nations in health related matters.		2.2.1
Recitals G	FNHS is mandated to promote and advance health and health services issues and implement commitments of the TCA: FNHP (2006), FNHP MOU (2006), TFNHP (2007).		2.1
Recitals H	Full BC First Nation involvement in decision making regarding their health, service and program planning, design, management and delivery to serve their needs.		4.2, 4.5, 7.1.2
Recitals I	Parties work together to build a new Health Governance Structure for a more integrated health system.		4.5, 6.1, 6.2
Health Indicators			
10.2(a)	i. Life expectancy at birth; ii. Mortality rates (deaths due to all causes); iii. Status Indian youth suicide rates; iv. Infant mortality rates; v. Diabetes rates; vi. Childhood obesity rates; vii. The number of practicing First Nations health care professionals who are registered or otherwise accepted members of recognized health professions under the BC *Health Professions Act*; and viii. Any other additional indicators, including wellness indicators supported by the governance stakeholders; namely the Tripartite Committee, the FNHC and the FNHDA.		8.1.2

A Section	Activities	Status	FA Evaluation Section
New Health Governance Structure			
4.1 (1)	The new Health Governance Structure will be composed of the First Nations Health Council (FNHC), First Nations Health Authority (FNHA), First Nations Health Directors Association (FNHDA) and Tripartite Committee on First Nations Health (TCFNH).		4.1-4.4
4.2 (1)	The FNHS shall, as soon as possible after execution of this Agreement, take the necessary steps to establish the FNHA, a non-profit legal entity, representative of and accountable to BC First Nations that will reflect a structure to be developed by BC First Nations through a community engagement exercise. It shall be constituted with the good governance, accountability, transparency and openness standards which are set out in Schedule 4 or such other standards as are consistent with or exceed those standards.		4.3
4.2 (2)	The FNHA shall, among other things: (a) plan, design, manage, deliver and fund the delivery of FN Health Programs;		4.3
	(b) receive federal, provincial and other health funding for or to support the planning, design, management and delivery of FN Health Programs and to carry out other health and wellness related functions;		
	(c) collaborate with the BC Ministry of Health and BC Health Authorities to coordinate and integrate their respective health programs and services to achieve better health outcomes for First Nations in British Columbia;		
	(d) incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into the FN Health Programs, recognizing that these may be reflected differently in different regions of BC;		
	(e) establish standards for the First Nations Health Programs that meet or exceed generally accepted standards;		
	(f) collect and maintain clinical information and patient records and develop protocols with the BC Ministry of Health and the BC Health Authorities for sharing of patient records and patient information, consistent with law;		

A Section	Activities	Status	FA Evaluation Section
	(g) over time, modify and redesign health programs and services that replace Federal Health Programs through a collaborative and transparent process with BC First Nations to better meet health and wellness needs;		
	(h) design and implement mechanisms to engage BC First Nations with regard to community interests and health care needs;		
	(i) enhance collaboration among First Nations Health Providers and other health providers to address economies of scale service delivery issues to improve efficiencies and access to health care;		
	(j) carry out research and policy development in the area of First Nations health and wellness;		
	(k) maintain financial records and prepare financial statements in accordance with generally accepted accounting standards in the province of BC;		
	(l) be audited on an annual basis by an independent auditor recognized in the province of BC; and		
	(m) make its accounting records and audit reports available to its members, Canada and British Columbia and the Auditor General of Canada and the Auditor General of British Columbia upon request to conduct or cause to be conducted a financial or performance audit.		
4.2 (3)	The FNHA may undertake other functions, roles and responsibilities connected to health and wellness of First Nations and other Aboriginal people in BC.		6.3
4.2 (4)	The FNHS shall act as the interim FNHA provided that the FNHS meets the minimum criteria set out in subsections 4.2(1) and (2) prior to undertaking that role.		
4.2 (5)	Following community consultation the FNHC may conclude that the FNHS shall act as the FNHA on a permanent basis or that for operational reasons a different legal entity should be constituted as the FNHA. In this latter case, the Parties undertake to take all steps necessary to ensure a seamless successorship from the FNHS to the new entity. These steps shall include such new entity becoming a Party to this Agreement or otherwise taking legally binding steps to adopt the obligations that are set out for the FNHA in this Agreement and the consequent release of the FNHS from such obligations.		2.1
4.2 (6)	Successorship under subsection 4.2(5) is restricted to a successor legal entity that itself meets the minimum criteria established under subsections 4.2(1) and (2) and may include a statutory body.		

A Section	Activities	Status	FA Evaluation Section
4.3 (1)	A Tripartite Committee shall be established which will be co-chaired by the following: Deputy Minister of the BC Ministry of Health, the Assistant Deputy Minister of HC/FNIHB and the Chairperson of the board of the FNHA. The membership of the Tripartite Committee will also include the following persons or their delegates: (a) the President/ Chief Executive Officers of each of the BC Health Authorities; (b) the Provincial Health Officer under the BC Public Health Act and the Aboriginal Health Physician Advisor; (c) the Chairperson and Deputy Chairperson of the FNHC; (d) one representative from each of the 5 First Nations regional tables; (e) the Chief Executive Officer of the FNHA; (f) the President of the FNHDA; (g) the appropriate Associate Deputy Minister and Assistant Deputy Minister of the BC Ministry of Health; and, (h) any other non-voting, observer or full members as agreed to by the Tripartite Committee.		4.2
4.3 (2)	The Parties shall ensure that the Tripartite Committee performs the following functions: (a) meets at least twice per year;		4.2
	(b) coordinates and aligns planning, programming, and service delivery between the FNHA, BC Health Authorities and the BC Ministry of Health, including the review of their respective FNHA MYHP and BC Regional Health Authorities' Aboriginal Health Plans consistent with the purposes of this Agreement;		
	(c) facilitates discussions and coordinates planning and programming among BC First Nations, British Columbia and Canada on all matters relating to First Nations health and wellness;		
	(d) provides a forum for discussion on the progress and implementation of this Agreement and other health arrangements including the *Transformative Change Accord: First Nations Health Plan*		

A Section	Activities	Status	FA Evaluation Section
	(2006), the *First Nations Health Plan MOU* (2006), the *Tripartite First Nations Health Plan* (2007) and the Health Partnership Accord;		
	(e) prepares and makes public an annual progress report for the Minister of Health (BC), the Minister of Health (Canada) and the FNHC on the progress of the integration and the improvement of health services for First Nations in British Columbia; and		
	(f) undertakes such other functions as the Tripartite Committee members may from time to time agree, and which are consistent with the purposes and intent of this Agreement and its terms of reference.		
4.4 (1)	The FNHC is an unincorporated association composed of fifteen (15) members. It is a political and advocacy organization, representative of and accountable to BC First Nations, with a mandate to serve as the advocacy voice of BC First Nations in achieving their health priorities and objectives.		4.1
4.4 (2)	The FNHC undertakes the following support and advocacy functions for and on behalf of BC First Nations consistent with its mandate, including: (a) supporting and assisting BC First Nations in achieving their health priorities and objectives;		4.1
	(b) advocacy on health issues and health services for First Nations people in BC;		
	(c) providing a BC First Nations leadership perspective to research, policy and program planning processes related to First Nations health in BC; and		
	(d) providing continued leadership for the implementation of the *Transformative Change Accord: First Nations Health Plan* (2006), the *First Nations Health Plan MOU* (2006) and the *Tripartite First Nations Health Plan* (2007).		
4.4 (3)	The FNHC may, with the approval of BC First Nations, alter its structure and mandate without the consent of the Parties, provided that it continues to fulfill the roles and functions set out in subsections 4.4 (1) and (2).		4.1
4.5 (1)	The FNHDA is a society under the BC *Society Act* with members representing the Vancouver Coastal, Vancouver Island, Fraser, Interior and North regions of British Columbia.		4.4

A Section	Activities	Status	FA Evaluation Section
4.5 (2)	The FNHDA has a mandate, *inter alia*, to: (a) represent health directors and managers working in First Nation communities;		
	(b) support education, knowledge transfer, professional development and best practices for health directors and managers of First Nation Health Providers; and		
	(c) act as an advisory body to the FNHC and FNHA on research, policy, program planning and design related to administration and operation of health services in First Nation communities.		
New Roles and Relationships			
6.1 (1)	The FNHA shall: (a) establish working relationships with Health Canada, the BC Ministry of Health, BC Health Authorities and other health and health-related organizations as necessary;		2.3
	(b) support a regional structure which allows First Nations to collaborate amongst themselves, with BC Health Authorities and with the FNHA;		2.2.5
	(c) work collaboratively with the BC Ministry of Health and BC Health Authorities on the design and delivery of provincial health services available to First Nations in BC, to address gaps in health services and to better coordinate such services with FN Health Programs so as to improve efficiency and effectiveness of health care for First Nations in BC;		
	(d) work with the BC Health Authorities to examine and supplement health data collection, health status monitoring, and reporting systems used by the BC Health Authorities which include First Nations-determined indicators of health and wellness;		3.4
	(e) work with the BC Ministry of Health and BC Health Authorities to integrate First Nation models of wellness into the health care system, to improve health outcomes and wellness for First Nations in BC;		6.1, 8.1.1
	(f) develop clinical information and patient record systems and protocols with the BC Ministry of Health and BC Health Authorities for the sharing of patient records, consistent with the law, to better serve First Nations patients and to enable greater First Nations control over the use,		6.4, 8.1.2

A Section	Activities	Status	FA Evaluation Section
	collection and access to health data relevant for the improvement of health services and to better monitor and report on First Nations health in BC;		
	(g) provide First Nations health program and policy advice to Canada, the BC Ministry of Health, BC Health Authorities, service providers, and agencies and seek to enhance the BC First Nations' opportunities to work with relevant government departments and agencies to improve the health outcomes of First Nations in BC; and		5.1
	(h) enhance its ability to build multi-sectoral partnerships to better address the social determinants affecting the health status of First Nations.		6.1
6.2 (1)	British Columbia shall create and support the operations of the Tripartite Committee forthwith after execution of this Agreement in accordance with section 4.3 and will direct all BC Health Authorities to participate on this Committee.		4.2
6.2 (2)	British Columbia shall, as soon as practicable following creation of the FNHA: (a) consistent with the BC *Health Authorities Act*, direct BC Health Authorities to work collaboratively with BC First Nations in their respective regions to: (i) develop and review their respective Aboriginal Health Plans and First Nations Community Health and Wellness Plans with the goal of achieving better coordination in health planning. Such plans should identify needs that are unique or specific to each region; (ii) collaborate regarding the delivery of health care services for Aboriginal people; and (iii) discuss innovative arrangements for service delivery where appropriate, and, where appropriate, establish funding arrangements at a time mutually agreed upon. These arrangements shall be planned and determined at a local and regional level between the FNHA, regional tables, and BC Health Authorities;		2.2.5
	(b) direct BC Health Authorities to work with the BC Ministry of Health and the FNHA to explore options for entering into agreements with the FNHA on record and patient information sharing, in keeping with applicable privacy legislation;		5.1
	(c) work with the Provincial Health Officer to change the role of the Provincial Aboriginal Health Physician Advisor to that of a Deputy Provincial Health Officer so as to work with the FNHA to		6.3

A Section	Activities	Status	FA Evaluation Section
	improve, among other things, the quality of data being collected and the health indicators available for First Nations health and wellness; and		
	(d) enter into a funding agreement with the FNHA for the funding agreed to, on terms and conditions as outlined in Schedule 2.		6.3
6.3 (1)	Canada shall, under the Canada Funding Agreement, provide funding to the FNHA to support the Transfer of Federal Health Programs. The Transfer of Federal Health Programs shall occur in phases or blocks as the FNHA and Canada agree and shall be completed within two (2) years of the signing of this Agreement, or such later time as both Canada and the FNHA agree. In this Agreement, a "Transfer of Federal Health Programs" means: (a) with respect to the FNHA, the assumption of responsibility for: (i) the planning, design, management and delivery of one or more FN Health Programs to replace Federal Health Programs, subject to and in accordance with the terms of this Agreement, and the Canada Funding Agreement; and (ii) all administrative, policy and other support functions required to plan, design, manage and deliver or fund the delivery of FN Health Programs;		3.2
	(b) with reference to Canada, the cessation of: (i) the planning, design, management and delivery, or the funding of the delivery of Federal Health Programs replaced under paragraph (a); and (ii) all administrative, policy and other support functions required to plan, design, manage and deliver or fund the delivery of such Federal Health Programs; and		
	(c) the provision of funding by Canada under the Canada Funding Agreement in order to fund or assist in funding the FN Health Programs and related administrative, policy and other support functions.		
6.3 (2)	Canada shall negotiate and make best efforts to conclude the Canada Funding Agreement for any Transfer of Federal Health Programs, and to amend the Canada Funding Agreement as necessary for any subsequent Transfer or Transfers of Federal Health Programs, provided that: (a) the FNHA has been established and is operating in accordance with section 4.2 of this Agreement;		3.1.2

A Section	Activities	Status	FA Evaluation Section
	(b) the FNHA has developed a satisfactory Interim Health Plan or Multi-Year Health Plan, as the case may be, for its operations in accordance with sections 5.2 and 5.3;		
	(c) the implementation and transition steps in section 7 relevant to any Transfer of Federal Health Programs have been completed; and		
	(d) the Sub-Agreements required for any Transfer of Federal Health Programs have been completed, Canada agreeing that it will use best efforts to conclude such Sub-Agreements.		
6.3 (3)	Canada shall, during the period of time from the signing of this Agreement until the date or dates for the Transfer of Federal Health Programs to the FNHA, maintain the budget allocation to the HC/FNIH Regional Office for the First Nations and Inuit Health program at a level no less than that of the allocation in the fiscal year of the signing of this Agreement.		3.1.3
6.3 (4)	Canada shall establish the Interim Management Committee and undertake the functions set out for the HC/FNIH Regional Office as part of that committee in section 7.3.		3.1.1
6.3 (5)	Canada shall provide funding to the FNHA subject to and in accordance with sections CF 10, CF 11 and CF 12 of Schedule 1.		3.1.2