



First Nations Health Authority  
Health through wellness

# Joint Project Board Projects Annual Report for Fiscal Year 2019/2020

- October 2021

# Acknowledgements

We acknowledge the traditional territories upon which the Joint Project Board projects are being delivered, as well as the many staff, clinicians and partners involved in establishing and implementing the vision of these initiatives.



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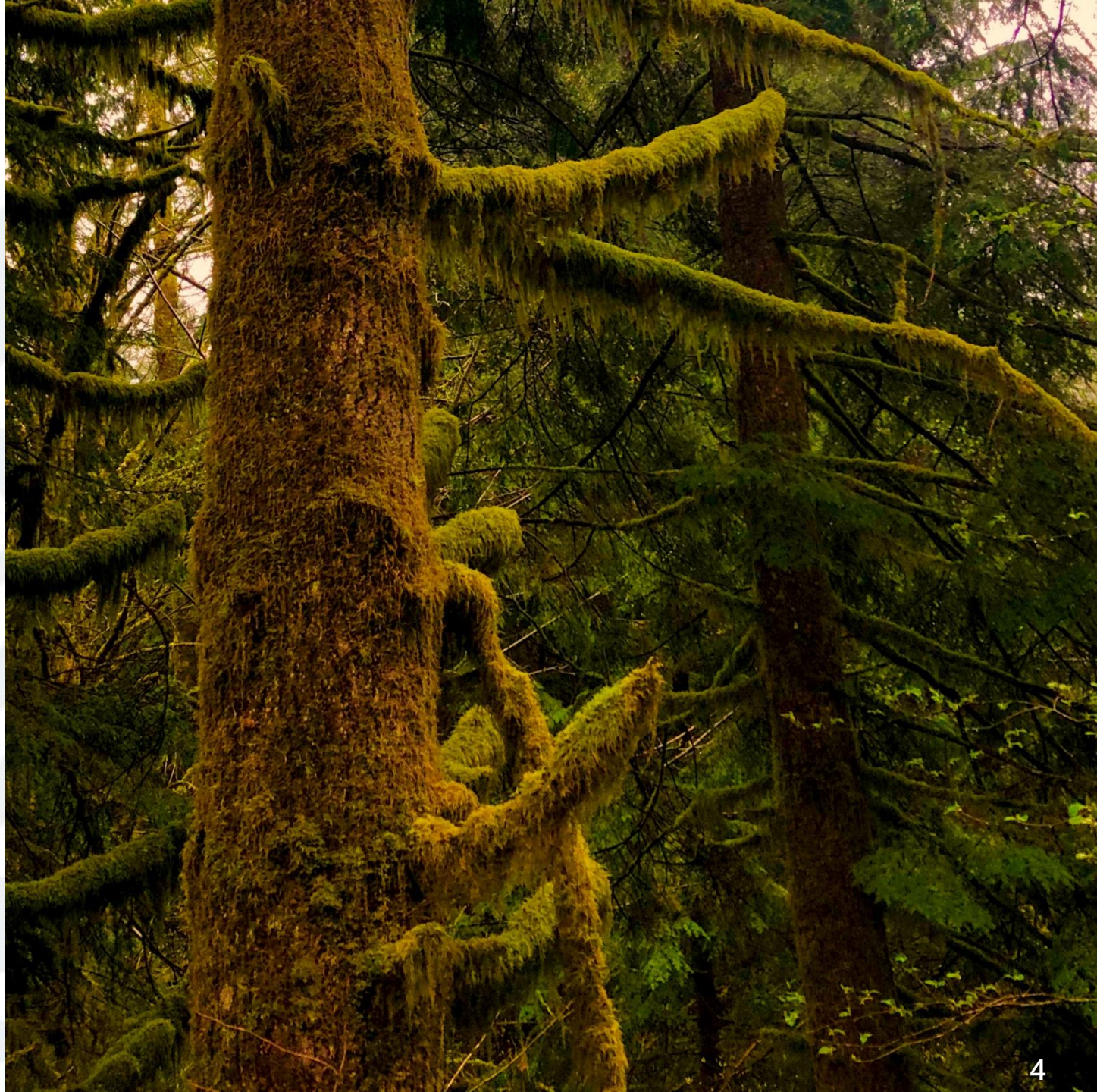
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# Introduction

- Program Profile
- Executive Summary
- Methodology
- Narrative Report Submission





## Joint Project Board

The Joint Project Board (JPB) was established in 2012 and is a [senior bilateral forum](#) between the assistant deputy ministers of the [BC Ministry of Health](#) and the chief operating officer and vice presidents of the [First Nations Health Authority](#) (FNHA).

Effective July 2, 2013, Health Canada transferred the funds it had historically used to pay Medical Services Plan (MSP) premiums on behalf of First Nations residents in BC to the FNHA. Through the Agreement in Lieu of MSP, a portion of these funds was set aside by the FNHA to support JPB projects and initiatives related to MSP services. Although the Government of British Columbia eliminated MSP premiums for British Columbians effective January 1, 2020, the FNHA continues to receive annual funding from the Ministry of Health to support these projects based on the commitment in the original agreement.

## JPB-Funded Projects

A [total of 27 JPB funded projects](#) have been approved, with 26 spread across the five regions, and one project that is provincial in scope and implemented by the Provincial Health Services Authority.

Each of the projects is different in scope and complexity; they are based on the realities and priorities of each region, on different care models and are at different stages of development and implementation. [A total of \\$15,008,590 annualized JPB funding](#) in fiscal year (FY) 2019/2020 was approved as well as \$3,182,459 of startup funding.

## Services

JPB projects provide services to [Status First Nations](#), as well as other [Indigenous Peoples \(Métis, Inuit and non-Status First Nations\)](#) and [non-Indigenous residents](#). Service locations are primarily on-reserve, but include services for off-reserve and away-from-home populations.

JPB projects focus on [direct service delivery](#) in the following priority areas:

- Primary Care
- Mental Wellness and Substance Use
- Maternal and Child Health

[Various service models](#) are used by the projects to best meet the needs of individual communities. These include convenient clinic locations, visiting health professionals, mobile teams, navigators and a combination of delivery models. The services are [wholistic, culturally safe](#) and often include referrals and navigation of health and social services.





# Executive Summary

## Operation

59%

of projects were fully operational and 41% were partially operational. Three additional projects became fully operational since the previous fiscal year.

75,510

service sessions were delivered and reported.

Despite COVID-19's impact on operation and services, projects quickly adapted to implement health protocols and use virtual care.

After the pandemic, projects will likely continue to provide virtual care to enhance patient access.

## Financial

\$21.13M

in total project funding (budget accounted for 69% and carry forward accounted for 31%) was available to the 27 JPB projects in FY 2019/2020. 22 projects received annual project funding of \$1 million (M) or less.

\$10.28M

in total expenditures were reported in FY 2019/2020, suggesting a gradual increase in operational level. 81% of expenditures were in direct service delivery. Top categories included nursing, mental health and wellness, allied health sessions and general practitioner sessions.

\$8.52M was the total unused amount, driven by recruitment and retention challenges.

\$2.33M was associated with pending financial reports.

## Staffing

76%

of the 165 ongoing direct service delivery positions were filled. Significant regional variations in staffing levels were reported, with the Northern region reporting the greatest difficulties (only 42% of positions filled).

The professional groups with the lowest reported staffing levels were miscellaneous health professional (74% of positions filled), registered nurses (RNs)/Licensed Practical Nurses (LPNs)/Midwives (73%) and social workers (58%).

First Nations health organizations were more effective in recruitment (81% of positions filled) than the FNHA (68%) and health authorities (68%). There is an opportunity to provide projects with more recruitment and retention support, and additional research and analysis is being undertaken on this topic.

## Service Delivery

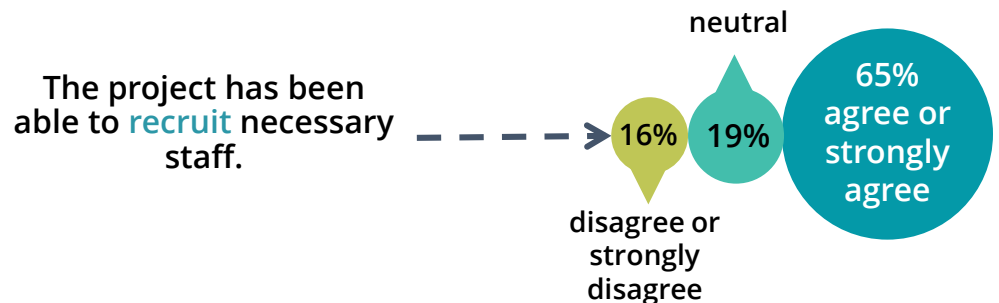
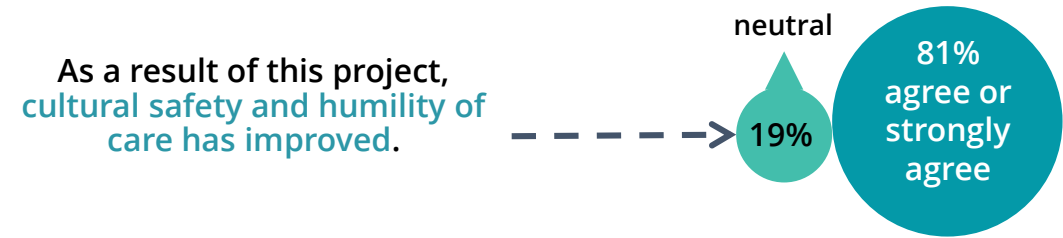
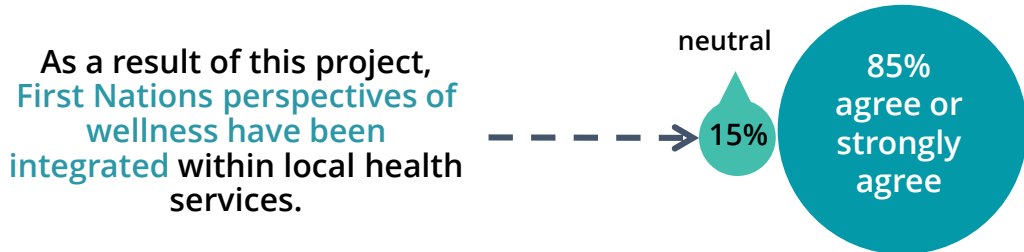
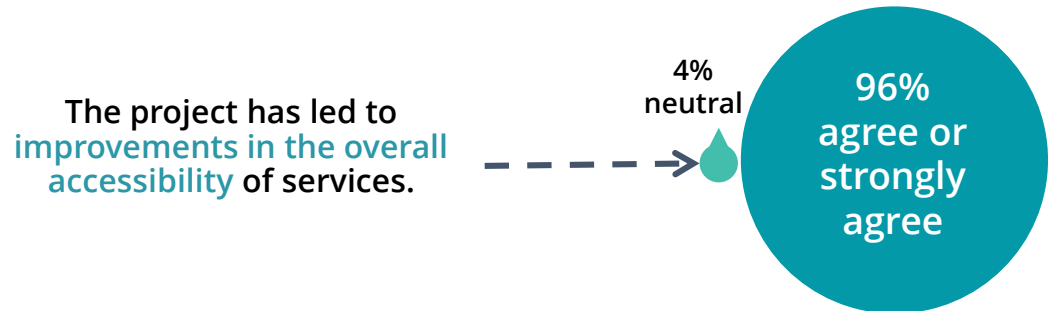
JPB projects used a variety of service models to best meet the needs of individual communities. These included convenient clinic locations, visiting health professionals, mobile teams, navigators and a combination of delivery models. The services provided were wholistic, culturally safe and often included referrals and navigation of health and social services.

Project ratings on many aspects of service delivery are illustrated on the next page.

# Executive Summary, Continued



Narrative reports indicate that Health Directors, project managers/staff and other key stakeholders believe a large majority of JPB projects have contributed to improvements in service accessibility, cultural safety and humility, and the integration of First Nations perspectives of wellness. The vast majority of projects reported on are considered flexible and responsive to the needs of communities and individuals. Staff recruitment and retention continue to be the primary challenge for JPB projects, impeding implementation.



Source: JPB Project Narrative Reports FY 2019/2020. Percentage reflects the proportion of all JPB projects that submitted narrative reports with reported agreement for closed-ended Likert scale questions. Ratings were provided by key stakeholders, including Health Directors, project managers and staff.



The annual report analysis is based on a project's self-reports and administrative and financial data.



## Project File Review

Project narrative reports are the main source of information. The analysis includes project narrative reports submitted on and before [April 14, 2021](#) (the reports were due in September 2020). JPB Standing Briefing, Funding Arrangement Tracking Documents and other project documents are reviewed to triangulate emergent findings.



## Data Analysis

Summative statistical analyses are performed on [quantitative questions in project narrative reports](#). Analyses include staffing, project implementation, service delivery and others.



## Financial Review

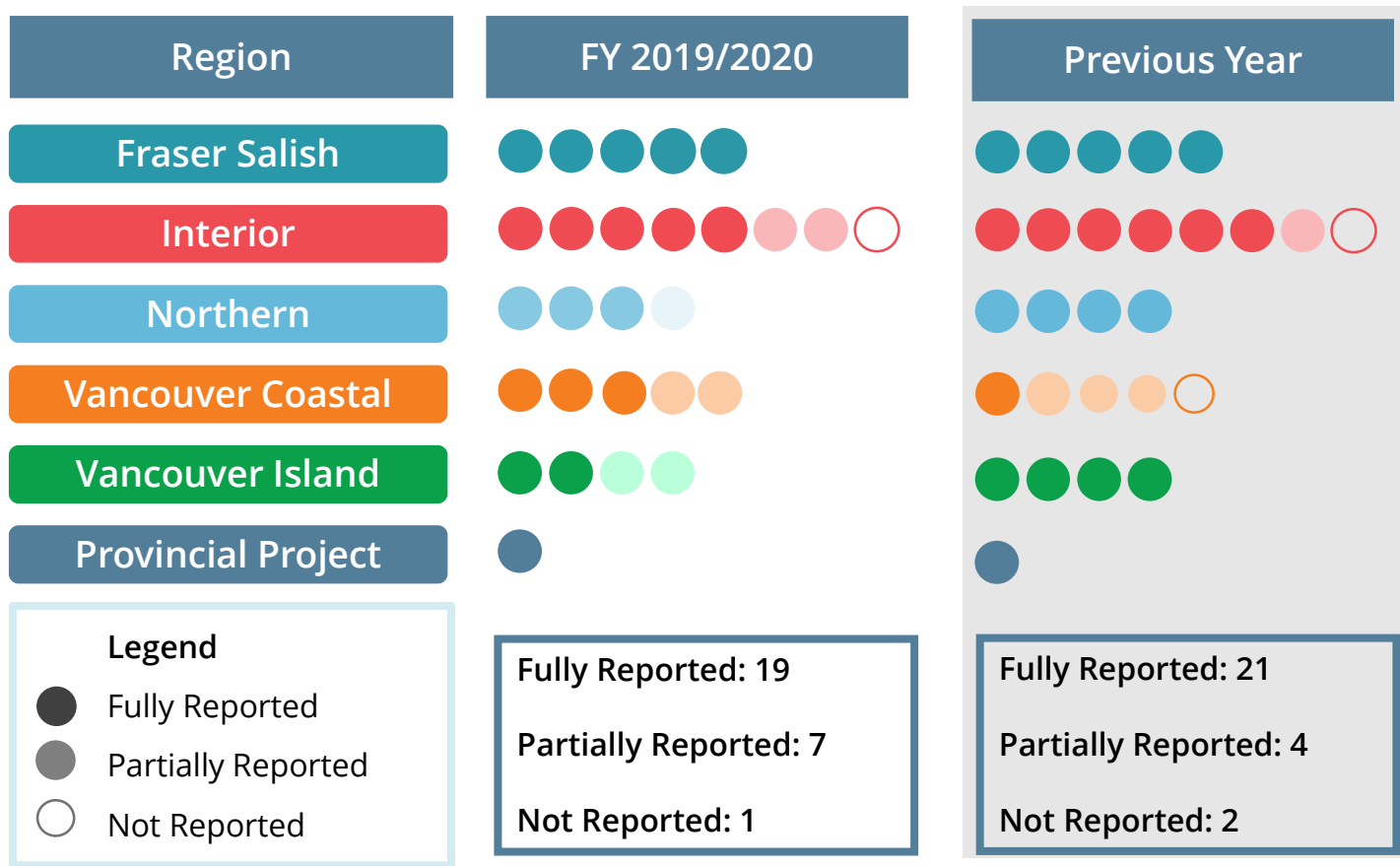
JPB financial data, which is based on project financial reports, was received from the FNHA finance department on [May 13, 2021](#). As of May 13, 2021, 87% of financial reports (66/76) were received. Further analyses were conducted to review the JPB funding level, spending and financial flow. Financial review is used in triangulation with data analysis based on narrative reports to enhance analysis strength.







As of April 14, 2021, 26 of 27 projects provided narrative reports for FY 2019/2020. These reports reflect the perspectives of Health Directors and regional staff.



JPB project narrative reports are the main source of information for annual report analysis.

Some JPB projects include multiple funding recipients; one unique report can be submitted by each recipient. For FY 2019/2020, 58 unique reports were received out of a possible 76 (a completion rate of 76%). As of April 14, 2021, 26 of 27 projects provided narrative reports, with 19 fully reported and 7 partially reported, meaning only some of the recipients submitted narrative reports.

Narrative reports submitted by First Nations health organization funding recipients were most commonly completed by Health Directors and/or project managers, and in some cases, service providers. Reports submitted by health authority and FNHA recipients were most commonly completed by regional staff.

COVID-19 severely impacted JPB funding recipients during the reporting period, including their ability to submit narrative reports.



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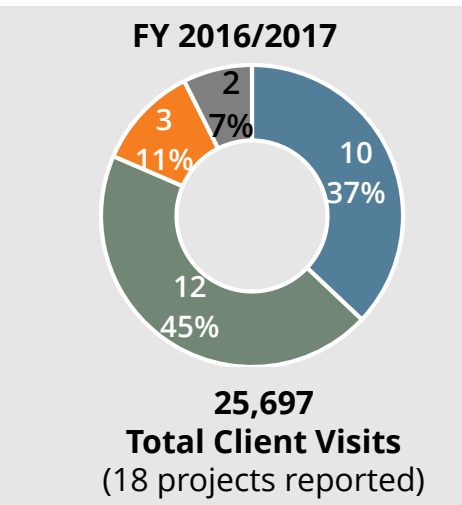
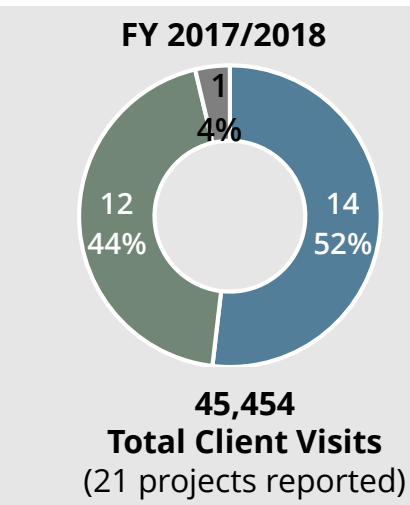
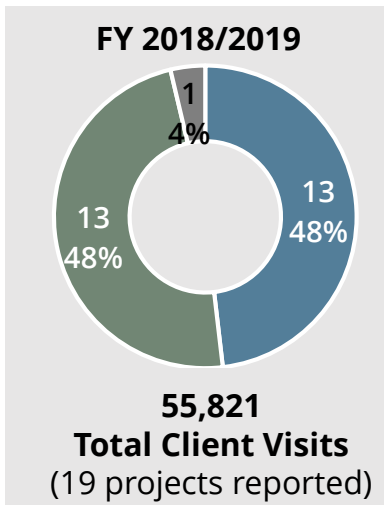
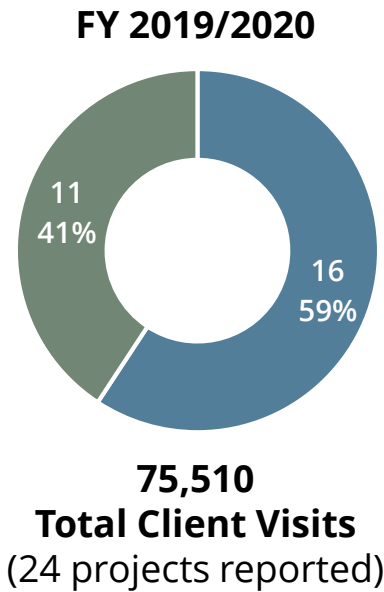
# Operation

- Implementation Progress
- Pandemic Adaptation
- Operation Ratings





The operational level of JPB projects has been gradually increasing. In FY 2019/2020, all 27 projects were operational, with 16 (or 59%) fully operational. There were 75,510 reported client visits.



- **Fully Operational:** All clinicians on the team hired and seeing clients
- **Partially Operational:** Some clinicians on the team hired and seeing clients
- **Not Operational:** No clinicians on the team hired/no clients being seen
- **Unknown:** Not enough information to determine implementation status

As illustrated, the operational level of JPB projects and the number of reported client visits have been gradually increasing over the years. In FY 2019/2020, all 27 projects were operational, with 16 (or 59%) fully operational and 11 (or 41%) partially operational. There were 75,510 reported client visits.

For comparison, in FY 2018/2019, 26 projects were operational, with 13 (or 48%) fully operational and 13 (or 48%) partially operational. One project was unknown. There were 55,821 reported client visits. In FY 2017/2018, 26 projects were operational, with 14 (or 52%) fully operational and 12 (or 44%) partially operational. One project was unknown. There were 45,454 reported client visits. In FY 2016/2017, 22 projects were operational, with 10 (or 37%) fully operational and 12 (or 45%) partially operational. Three projects were not operational and two were unknown. There were 25,697 reported client visits.

Note on client visit data:  
Without a uniform data collection approach, projects report data differently. For example, some projects provided the number of times clinicians visited the community, some reports were based on records while others were estimates, and some included services not funded by JPB. Reported data covers a different number of projects each fiscal year, which can make year-over-year comparisons unreliable. Conservative inference was used to calculate client visits in the slide.



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# Operation

- Implementation Progress
- Pandemic Adaptation
- Operation Ratings





Despite COVID-19's impact on operation and services, projects quickly adapted to implement health protocols and use virtual care.

## Impact of COVID-19 on Operation and Services

Social and travel restrictions required as part of the public health response to COVID-19 impacted the service levels of many JPB projects. [Scheduled travel to communities was cancelled](#) during the months of travel restrictions. [Some communities opted to isolate](#) and hence were [not reached by in-person services](#). Services that required close contact (e.g., physiotherapy) were heavily impacted.

## Health Protocols During COVID-19

Following provincial guidelines, COVID-19 safety [protocols were implemented to enable modified in-person services](#). Safety plans included mandatory masking, appropriate Personal Protective Equipment, social distance rules and markers, designated outdoor waiting areas, disinfecting office surfaces between patients and more.

## Use of Virtual Care (Phone, Zoom, etc.)

In response to COVID-19, [virtual care was widely adopted or scaled up across JPB projects](#). Zoom and phone appointments were widely used when in-person visits were not possible or advisable. Some projects noted that the [FNHA Medical Zoom license was helpful](#). The use of telephone and virtual health options [allowed patient access to continue](#) in some areas during the pandemic.

In many instances, a [hybrid virtual care model](#) was implemented (i.e., virtual services and limited in-person operating capacity at the physical clinic).





After the pandemic, projects will likely continue to provide virtual care to enhance patient access.

## Lasting Benefits of Virtual Care

Virtual care positively contributed to patient access. Many respondents observed that the flexibility of virtual care allowed people living in remote locations and away-from-home members to reach services easily. The convenient nature of virtual care (i.e., no need to take time off or travel), could have encouraged patients to seek services sooner. The privacy and ease of access of virtual care could also have increased the likelihood that people would seek mental health support.

Providing virtual care before in-office visits was highlighted by some as a sustainable change. In virtual care, practitioners are often able to assess, diagnose, educate and treat patients, and then refer them to book in-person visits when necessary. This reduces the number of people in the office, thus decreasing the transmission of infectious diseases like flus and colds. It also allows for quicker intervention as people do not need to wait until their in-person appointment to be treated. Urgent/emergent care needs can be identified through virtual care and then prioritized for treatment.

Furthermore, online collaboration enhances the participation of clinical staff in service planning.

Many projects think virtual care will continue in some capacity following the pandemic.

## Varying Receptivity of Virtual Care

Despite the successes, there are limitations to virtual visits. Certain services cannot be provided virtually and some therapeutic counselling techniques do not work well in virtual care. Moreover, in-person human interaction remains the best way to build relationships and work with families.

## Limiting Factors

Information technology (IT) infrastructure was identified as a major challenge for implementing and using virtual care. Some rural areas lack the necessary digital devices or IT infrastructure (e.g., a stable Internet connection). Some patients lack a private space to receive care.

Moreover, many projects commented that their office space was not set up to provide virtual care at a large scale. Additional investment was often required to purchase and sustain appropriate devices, licences and software.



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# Operation

- Implementation Progress
- Pandemic Adaptation
- Operation Ratings





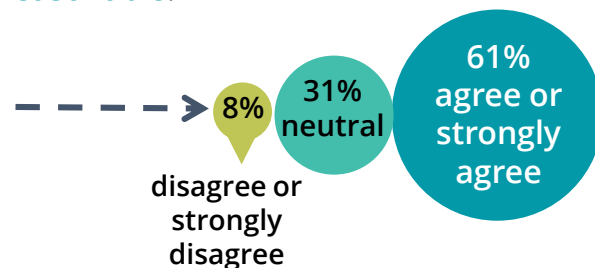
## Operation

# Operation Ratings: Governance and Partnership

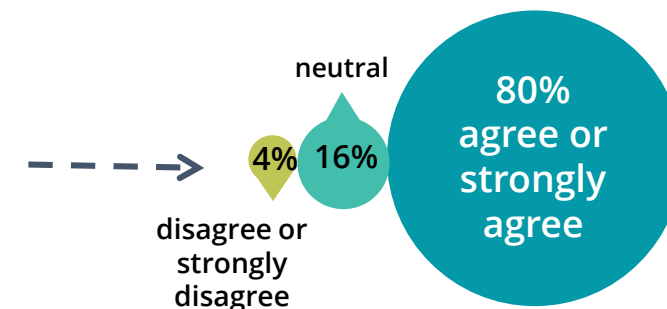
According to self-assessed narrative reports, nearly two-thirds of reported projects (61%) agree or strongly agree that **management support was sufficient**. Over half of projects (54%) agree or strongly agree that **sufficient centralized administrative supports were in place**. The majority of projects (69%) agree or strongly agree that **policies and procedures had been developed to support effective care co-ordination** (e.g., referral forms, program discharge policies). However, many respondents noted that improvements could be or are being made on the mechanisms of external collaborations.

Over three-quarters of reported projects agree or strongly agree (80%) that **accountability pathways to First Nations communities served have been developed** (e.g., reporting pathways, steering committees). Over two-thirds of projects (73%) agree or strongly agree that **partners demonstrate reciprocal accountability**. Over three-quarters of projects (77%) agree or strongly agree that **administration requirements for JPB funding are reasonable**.

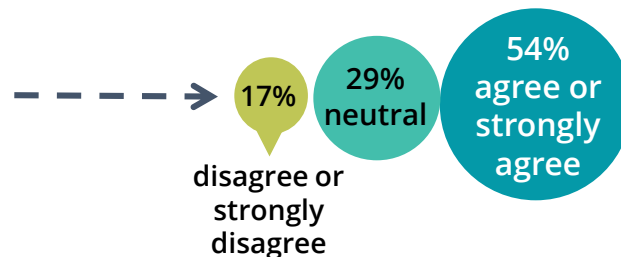
Management support is sufficient.



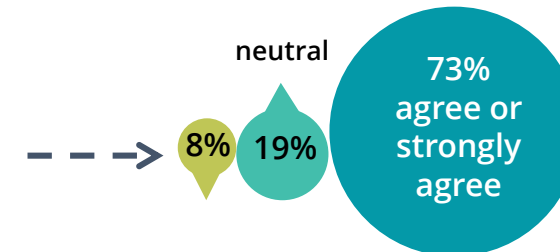
Accountability pathways to First Nations communities served have been developed (e.g. reporting pathways, steering committees).



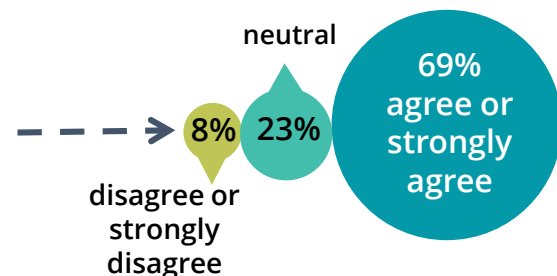
Sufficient centralized administrative supports are in place.



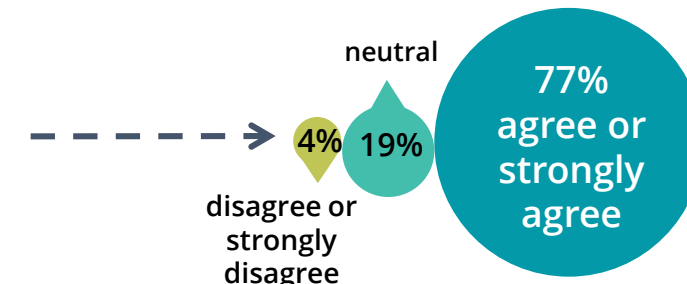
Partners demonstrate reciprocal accountability.



Policies and procedures have been developed to support effective care co-ordination (e.g., referral forms, program discharge policies).



Administration requirements for JPB funding are reasonable.



Source: JPB Project Narrative Reports FY 2019/2020. Percentage reflects the proportion of all JPB projects that submitted narrative reports with reported agreement for closed-ended Likert scale questions. Ratings were provided by key stakeholders including Health Directors, project managers and staff.





The lack of physical clinical space and the optimization of electronic tools continue to be challenges for JPB project operation.

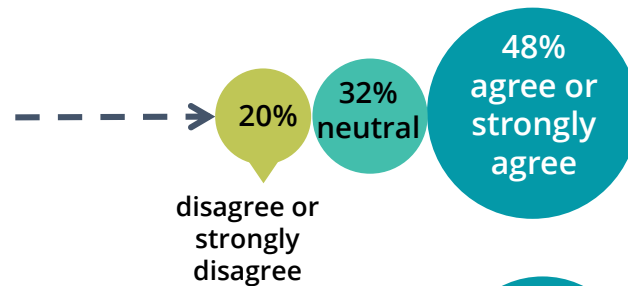
Project self-assessment in narrative reports indicates that **only 48% of projects agree or strongly agree that adequate physical space is available** to conduct clinical services (adequately equipped and confidential examination rooms). Many projects identify the lack of physical space and clinical space as one of their main challenges. Space has been a limiting factor to the growth of services.

**Only 39% of projects agree or strongly agree that adequate provider accommodations are available for overnight stays.** Given that **travel is an essential component** of many projects' service models, the lack of provider accommodations limits service reach and efficiency.

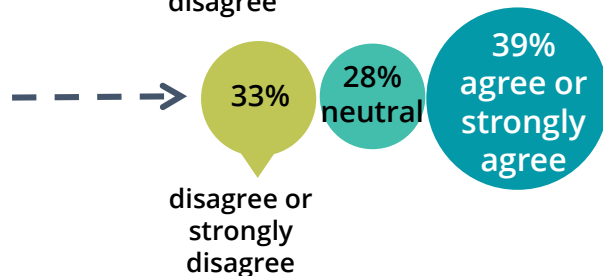
**81% of projects agree or strongly agree that circle of care privacy policies and procedures are in place** that allow for the effective flow of appropriate and timely clinical information.

**Only 30% of projects agree or strongly agree that electronic tools support effective care co-ordination with external partners.** Electronic medical records (EMR) systems are not consolidated, EMR access is sporadic and thus the care co-ordination potential of EMR is not fully realized.

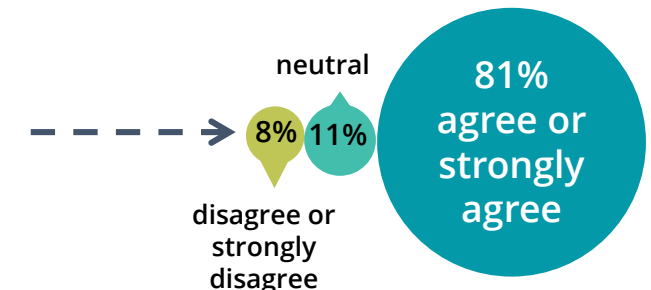
**Adequate physical space is available to conduct clinical services (adequately equipped and confidential examination rooms).**



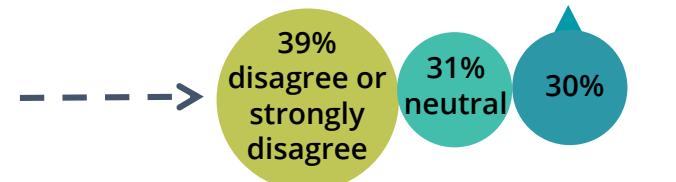
**Adequate provider accommodations are available for overnight stays.**



**Circle of care privacy policies and procedures are in place that allow for the effective flow of appropriate and timely clinical information.**



**Electronic tools (electronic medical records) support effective care co-ordination with external partners.**



Source: JPB Project Narrative Reports FY 2019/2020. Percentage reflects the proportion of all JPB projects that submitted narrative reports with reported agreement for closed-ended Likert scale questions. Ratings were provided by key stakeholders including Health Directors, project managers and staff.



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# Financial

- Financial Flow
- Funding Distribution
- Regional Financials
- Recipient Type Financials
- Expenditure
- Unused and Pending Funds

\* Financial data in the analysis was received on May 13, 2021.

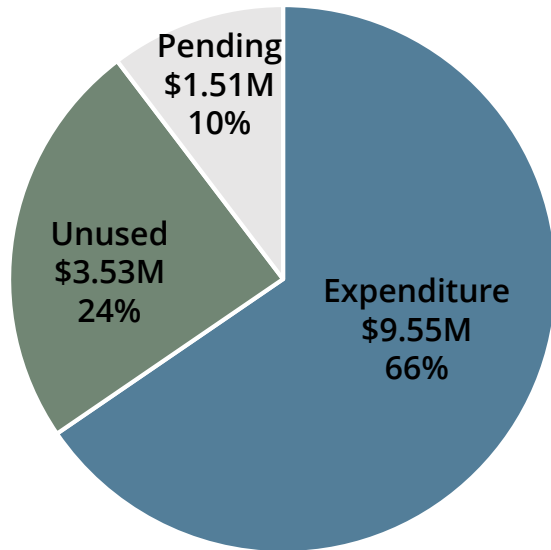
\* Financial figures are rounded to the closest decimal points. Hence in some cases, the sum of parts is slightly different from the total.





The JPB program has access to committed financial resources. Total expenditures suggest a gradual increase in operational level. The unused amount is driven by recruitment and retention challenges.

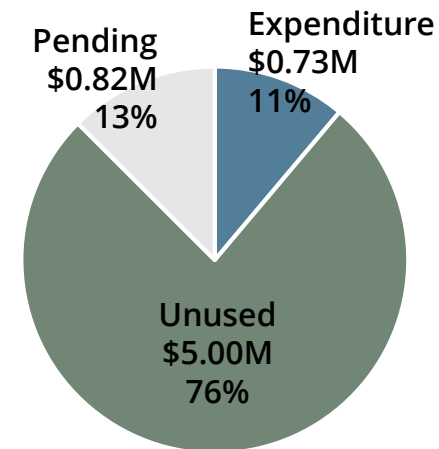
**FY 2019/2020  
Annual Budget  
\$14.58M**



The JPB program had access to up to **\$15,008,590 in annualized funding** in FY 2019/2020, as well as \$3,182,459 of startup funding, which represented the total approved project budget. The FNHA administered the resources according to JPB policies and guidelines.

The **annual budget** fluctuates each year due to project status changes, re-profiling and the fact that FNHA-led projects' annual budgets are based on the forecast. In FY 2019/2020, the annual budget was \$14.58M, of which JPB projects spent \$9.55M (or 66%). A total of \$3.53M or 24% was unused and \$1.51M (or 10%) was pending.

**FY 2019/2020  
Prior Years' Carry Forward  
\$6.55M**



JPB projects can submit **carry-forward requests for unused funds**. If approved, the amount can be carried forward to the next fiscal year in accordance with JPB policies and guidelines. Approval of unspent funds beyond the next fiscal year is considered on a case-by-case basis.

In FY 2019/2020, the approved **carry-forward amount from prior years was \$6.55M**, of which JPB projects spent \$0.73M (or 11%), \$5.00M (or 76%) was unused and \$0.82M (or 13%) was pending.

**Total expenditure (combining annual budget and carry forward)** is an indication of operational level. Total expenditure has been increasing over the years as shown below:

FY 2015/2016: \$3.90M

FY 2016/2017: \$8.44M

FY 2017/2018: \$8.50M

FY 2018/2019: \$10.24M

FY 2019/2020: \$10.28M

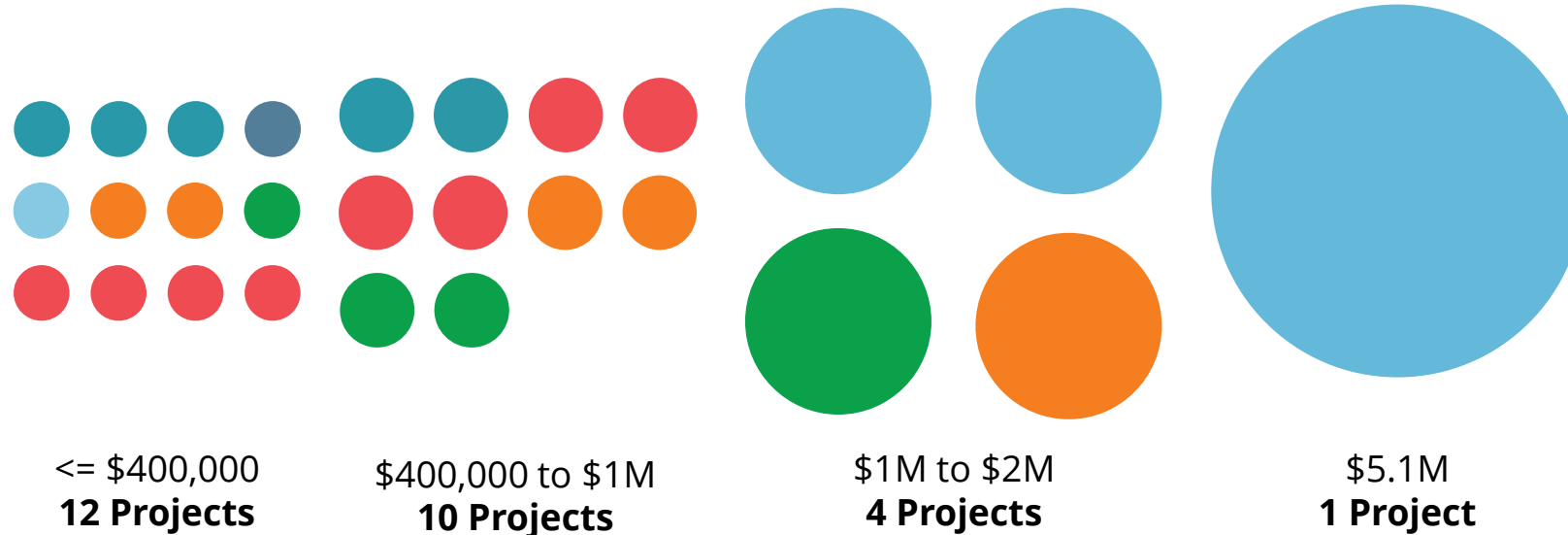
Pending amount is due to **pending financial reports**. As of May 13, 2021, 87% of financial reports (66/76) were received. The total amount in pending reports is \$2.33M, with \$1.51M in annual budget and \$0.82M in carry forward.

The reasons for unused amounts include recruitment and retention challenges and the inability to spend position-associated budgets (e.g., travel).

# Funding Distribution



In FY 2019/2020, there was \$21.13M (annual budget and carry forward combined) in total project funding for 27 JPB projects. 22 projects received annual funding of \$1M or less.



### Legend

- Northern
- Vancouver Island
- Interior
- Vancouver Coastal
- Fraser Salish
- Provincial

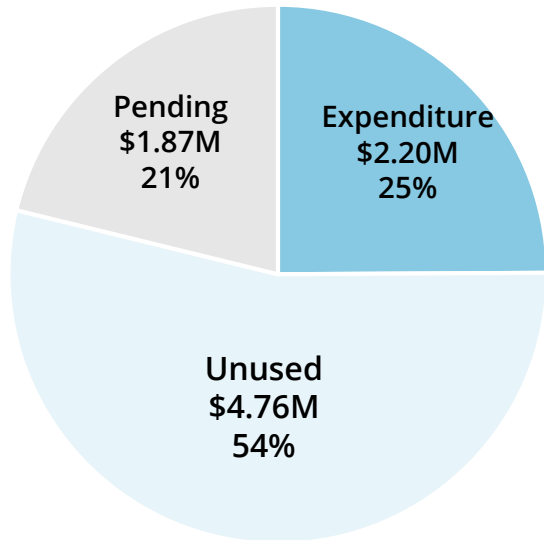
Most JPB projects receive annual project funding of less than \$1.0M. 12 projects have annual funding of less than or equal to \$0.4M, of which 3 are in Fraser Salish, 1 is in Provincial, 1 is in Northern, 2 are in Vancouver Coastal, 1 is in Vancouver Island and 4 are in the Interior. 10 projects have annual funding of between \$0.4M and \$1.0M, of which 2 are in Fraser Salish, 4 are in Interior, 2 are in Vancouver Coastal and 2 are in Vancouver Island.

4 projects have annual project funding between \$1.0M and \$2.0M, of which 2 are in Northern, 1 is in Vancouver Island and 1 is in Vancouver Coastal.

The one \$5.1M project is in the Northern region.



The Northern region has the biggest share of funding, \$8.83M, and has been able to use \$2.20M (or 25%) of that amount. The unused portion is driven by recruitment and retention challenges.

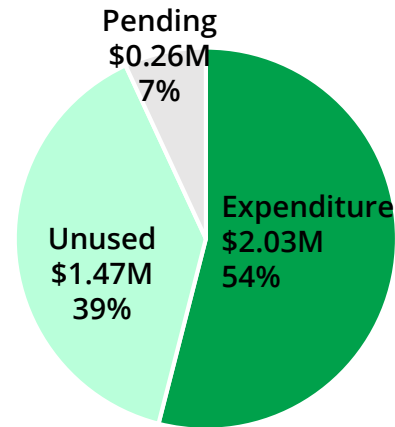


**Northern**  
\$8.83M Annual Total

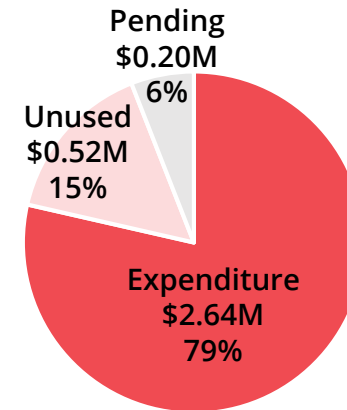
As illustrated, the Northern region received \$8.83M in FY 2019/2020 annual funding, Vancouver Island received \$3.76M, Interior received \$3.36M, Vancouver Coastal received \$3.03M, Fraser Salish received \$1.77M and the provincial project received \$0.38M.

**Expenditures:** The provincial project spent 89% of received funding, the Interior spent 79%, Fraser Salish spent 75%, Vancouver Coastal spent 58%, Vancouver Island spent 54% and Northern spent 25%.

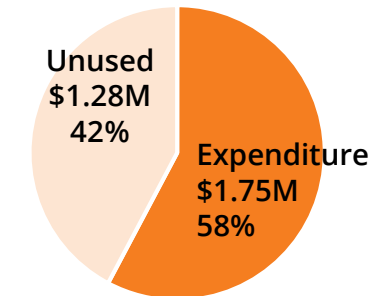
**Unused Funding:** Northern did not spend \$4.76M, Vancouver Island did not spend \$1.47M, Vancouver Coastal did not spend \$1.28M, Interior did not spend \$0.52M, Fraser Salish did not spend \$0.45M and the provincial project did not spend \$0.04M.



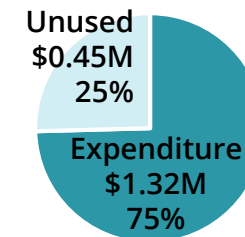
**Vancouver Island**  
\$3.76M Annual Total



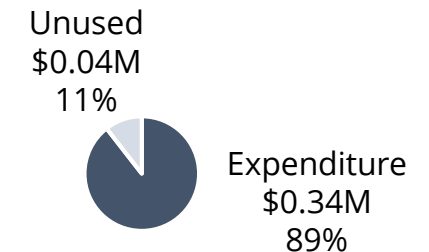
**Interior**  
\$3.36M Annual Total



**Vancouver Coastal**  
\$3.03M Annual Total



**Fraser Salish**  
\$1.77M Annual Total



**Provincial**  
\$0.38M Annual Total

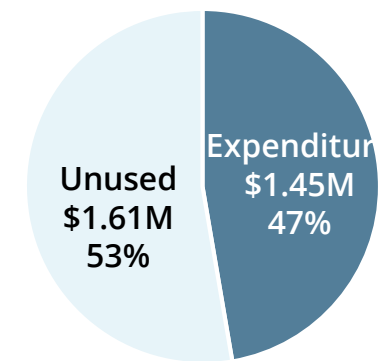
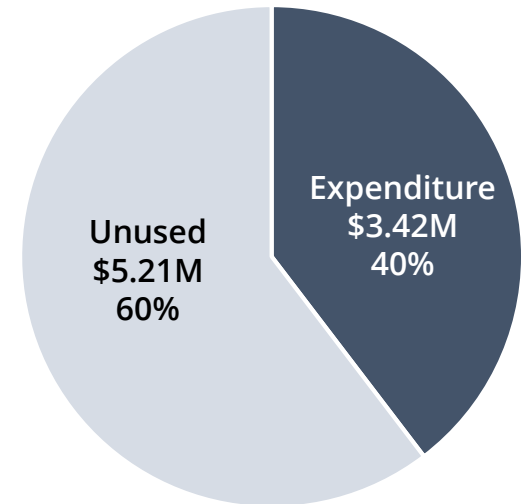
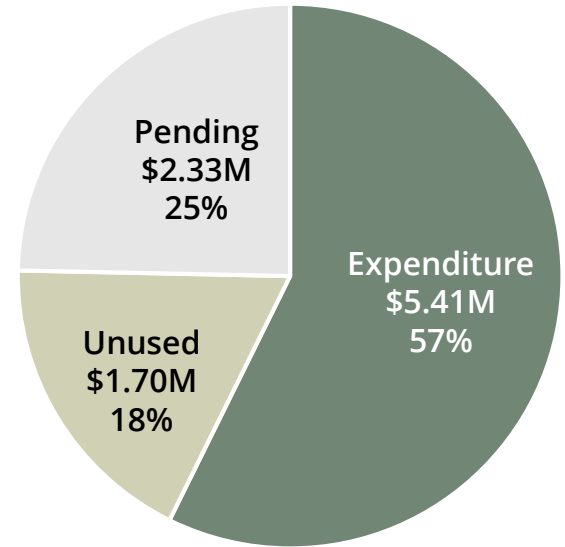
# Recipient Type Financials (Annual Budget and Carry Forward)

Financial



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First Nations health organizations used the highest percentage of allocated funding, spending 57%, compared to 40% for health authorities and 47% for the FNHA.



First Nations Health Organizations  
\$9.44M Annual Total

Health Authorities  
\$8.63M Annual Total

FNHA  
\$3.06M Annual Total

As illustrated above, in FY 2019/2020, First Nations health organizations had \$9.44M in funding, with \$5.41M (or 57%) in expenditure, \$1.70M (or 18%) in unused and \$2.33M (or 25%) in pending. Health authorities had \$8.63M in funding, with \$3.42M (or 40%) in expenditure and \$5.21M (or 60%) in unused. The FNHA had \$3.06M in funding, with \$1.45M (or 47%) in expenditure and \$1.61M (or 53%) in unused.

First Nations health organizations used the highest percentage of allocated funding, spending 57%, compared to 40% for health authorities and 47% for the FNHA. The higher funding utilization rate is an indication of a **higher operational level**. Staffing analysis (described in more detail below) shows First Nations health organizations were able to fill 81% of their ongoing direct service delivery positions, compared to 68% for health authorities and the FNHA.

# Expenditure: Category Breakdown (Annual Budget and Carry Forward)

Financial



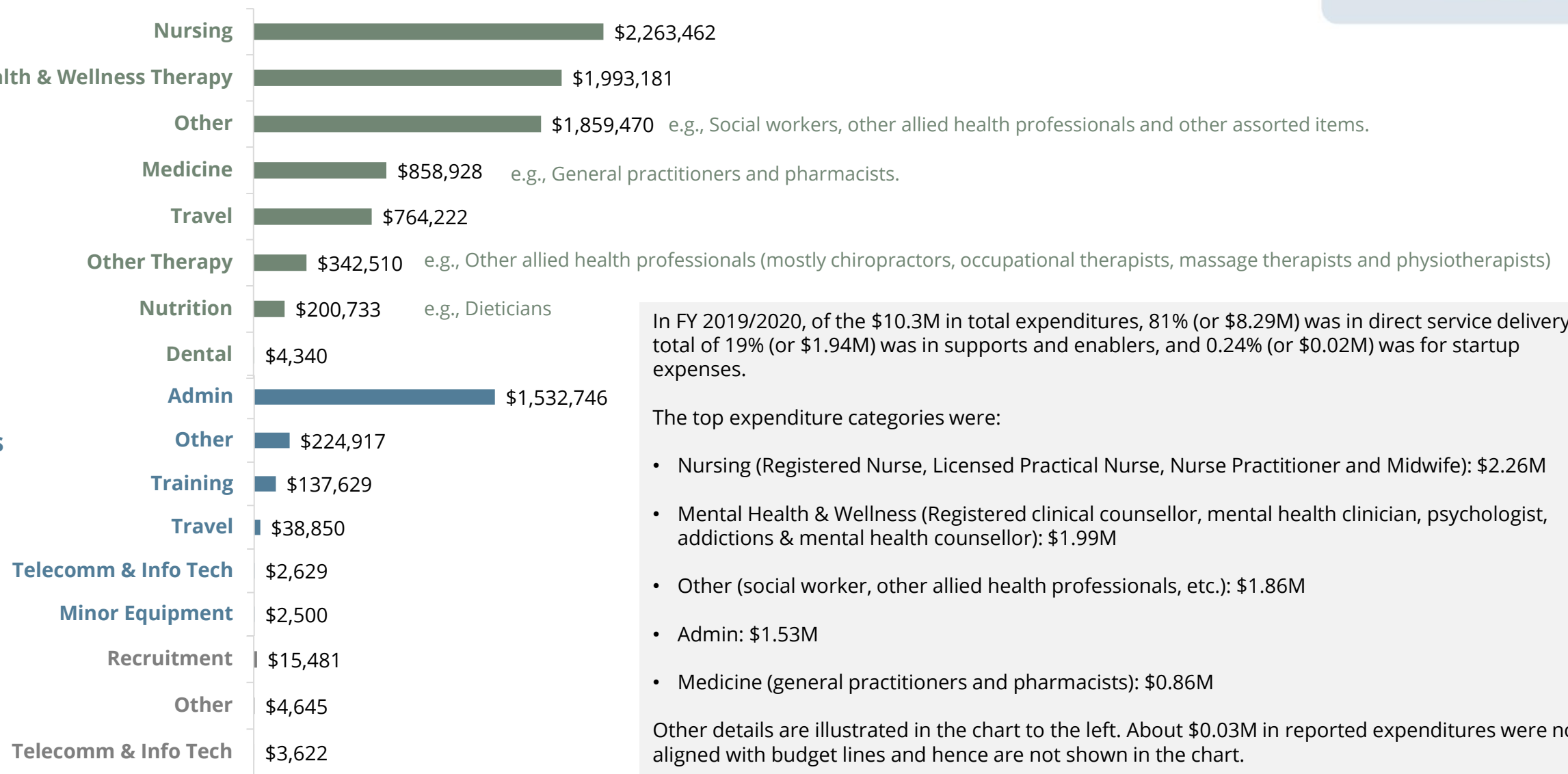
First Nations Health Authority  
Health through wellness

In FY 2019/2020, of the \$10.28M in total expenditures, 81% (or \$8.29M) was in direct service delivery. The categories with the highest expenditures include nursing, mental health and wellness, allied health sessions and general practitioner sessions.

**81%  
Direct  
Service  
Delivery  
\$8.29M**

**19%  
Supports  
and  
Enablers  
\$1.94M**

**0.24%  
Startup  
\$0.02M**



In FY 2019/2020, of the \$10.3M in total expenditures, 81% (or \$8.29M) was in direct service delivery. A total of 19% (or \$1.94M) was in supports and enablers, and 0.24% (or \$0.02M) was for startup expenses.

The top expenditure categories were:

- Nursing (Registered Nurse, Licensed Practical Nurse, Nurse Practitioner and Midwife): \$2.26M
- Mental Health & Wellness (Registered clinical counsellor, mental health clinician, psychologist, addictions & mental health counsellor): \$1.99M
- Other (social worker, other allied health professionals, etc.): \$1.86M
- Admin: \$1.53M
- Medicine (general practitioners and pharmacists): \$0.86M

Other details are illustrated in the chart to the left. About \$0.03M in reported expenditures were not aligned with budget lines and hence are not shown in the chart.

# Unused and Pending Funds: Category Breakdown

Financial



First Nations Health Authority  
Health through wellness

In FY 2019/2020, of the \$10.85M in total unused and pending funds, 69% (or \$7.45M) was in direct service delivery. The primary driver was the challenge of recruitment and retention.

	Annual Budget	Prior Years' Carry Forward	Total Unused and Pending
Other	\$924,319	\$2,150,650	\$3.07M
Travel	\$804,630	\$1,236,007	\$2.04M
Nursing	\$1,286,876	\$700,573	\$1.99M
Mental Health Therapy	\$1,105,080	\$347,990	\$1.45M
Admin	\$434,968	\$158,437	\$0.59M
Medicine	\$318,848	\$245,897	\$0.57M
Capital		\$452,417	\$0.45M
Recruitment		\$269,215	\$0.27M
Training	\$151,404	\$27,200	\$0.18M
Minor Equipment		\$94,946	\$0.09M
Other Therapy	(\$3,331)	\$87,622	\$0.08M
Telecomm & Info Tech	\$20,678	\$18,202	\$0.04M
Project Management		\$13,379	\$0.01M
Dental		\$13,160	\$0.01M
Nutrition	\$12,567		\$0.01M
Additional Info Required	(\$19,838)		(\$0.02M) deficit

**Direct Service Delivery**  
\$7.45 Million (69%)

**Supports and Enablers (except Travel)**  
\$1.36 Million (12%)

**Travel**  
\$2.04 Million (19%)

The top categories for the unused and pending funds were all position-related, suggesting that the **challenge of recruitment and retention was the key driver.**

The total of pending funds was \$2.33M, with \$1.51M in annual budget and \$0.82M in carry forward.

Carry-forward funding approved by the JPB is intended to be used in the following fiscal year. Use of unspent funds beyond the next fiscal year is considered on a case-by-case basis.





First Nations Health Authority  
Health through wellness

# Staffing

- Direct Service Delivery Positions
- Recruitment and Retention





Staffing analysis covers only ongoing direct service delivery positions funded by the JPB. The analysis is based on available narrative reports and program data.

### Key Findings

- As of March 31, 2020, 76% (125 out of 165) of direct service delivery positions were filled.
- There were significant regional variations in staffing levels. The Northern region was most impacted, with only 42% of positions filled.
- The lowest staffing levels among professional groups were reported by miscellaneous health professionals (74% of positions filled), RNs/LPNs/Midwives (73%) and social workers (58%).
- First Nations health organizations were more effective in recruitment (81% of positions filled) than the FNHA (68%) and health authorities (68%).
- Opportunities exist to provide JPB projects with additional recruitment and retention support.

### Staffing Analysis Methodology

- The data comes from FY 2019/2020 narrative reports submitted by projects. For the 44 positions (out of 165) where 2019/2020 narrative report data is not available, analysis relied on existing program data from 2018/2019.
- The analysis covered all 27 JPB projects' 165 ongoing direct service delivery positions.
- The analysis did NOT cover:
  - Carry-forward positions
  - Admin support positions (e.g., medical office assistants)
  - Non-JPB funded positions
- Be cautious when comparing FY 2019/2020 with the previous year:
  - The FY 2018/2019 analysis only covered 142 positions from 25 reported projects
  - Carry-forward positions, which often have significant recruiting challenges, were included in FY 2018/2019
  - As of March 31, 2019, 65% of direct service delivery positions were filled

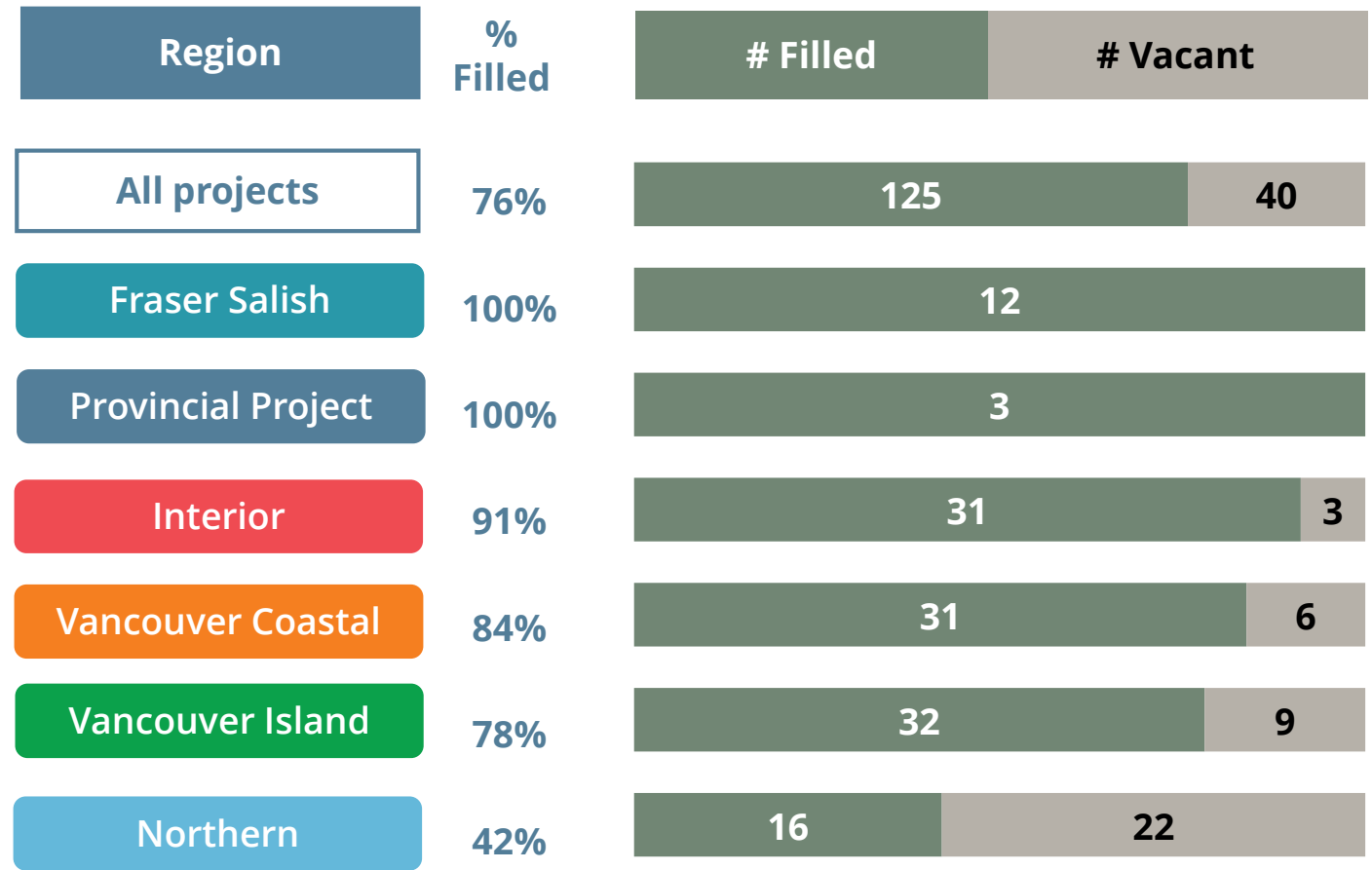
# Direct Service Delivery Positions by Region

Staffing



First Nations Health Authority  
Health through wellness

As of March 31, 2020, 76% (125 of 165) of direct service delivery positions were filled. Regional variations were significant, with position-filled rates ranging from 42% (Northern) to 100% (Fraser Salish and the provincial project).



As illustrated, there were 165 ongoing direct service delivery positions, of which 125 (or 76%) were filled and 40 were vacant.

Regional variations in the staffing level of direct service delivery positions were significant: Fraser (100% filled), Provincial (100% filled), Interior (91% filled), Vancouver Coastal (84% filled), Vancouver Island (78% filled) and Northern (42% filled).

The Fraser Salish region had 12 positions, all of which were filled. The provincial project had 3 positions, all of which were filled. The Interior region had 34 positions, of which 31 (or 91%) were filled and 3 were vacant. The Vancouver Coastal region had 37 positions, of which 31 (or 84%) were filled and 6 were vacant. The Vancouver Island region had 41 positions, of which 32 (or 78%) were filled and 9 were vacant. The Northern region had 38 positions, of which 16 (or 42%) were filled and 22 were vacant.



Professions with the lowest staffing levels were social workers (58% filled), RNs/LPNs/Midwives (73% filled) and miscellaneous health professionals (74% filled).

Profession	% Filled	# Filled	# Vacant
Allied Health Professional	89%	24	3
General Practitioner	80%	8	2
Mental Health & Wellness Staff	80%	35	9
Nurse Practitioner	77%	10	3
Miscellaneous Health Professional	74%	14	5
RN/LPN/Midwife	73%	19	7
Social Worker	58%	15	11

As illustrated, in FY 2019/2020, of the 27 allied health professional positions, 24 (or 89%) were filled and 3 were vacant. Of 10 general practitioner positions, 8 (or 80%) were filled and 2 were vacant. Of 44 mental health & wellness staff, 35 (or 80%) were filled and 9 were vacant. Of 13 nurse practitioner positions, 10 (or 77%) were filled and 3 were vacant. Of 19 miscellaneous health professional positions, 14 (or 74%) were filled and 5 were vacant. Of 26 RN/LPN/midwife positions, 19 (or 73%) were filled and 7 were vacant. Of 26 social worker positions, 15 (or 58%) were filled and 11 were vacant.

Among professional groups, miscellaneous health professional (74% of positions filled), RNs/LPNs/midwives (73%) and social workers (58%) had the lowest staffing levels.

Glossary:

- Allied health professional positions include dietitians, naturopathic doctors, traditional Chinese medical practitioners, occupational therapists, physical therapists, podiatrists and pharmacists.
- Mental health & wellness staff positions include registered clinical counsellors, mental health clinicians, psychologists and addictions & mental health counsellors.
- RN refers to registered nurse and LPN refers to licensed practical nurse.
- Miscellaneous health professional positions include project leads, program managers/supervisors, primary care co-ordinators and wellness system navigators.



First Nations health organizations were more effective in recruitment (81% of positions filled) than the FNHA (68%) and health authorities (68%).

Funding Recipient	% Filled	# Filled	# Vacant
First Nations Health Organization(s)	81%	81	19
FNHA	68%	17	8
Health Authorities	68%	27	13

Illustrated is a breakdown of the 165 ongoing direct service delivery positions by funding recipient type.

Of the 100 positions associated with First Nations health organizations, 81 (or 81%) were filled and 19 were vacant. Of the 25 positions associated with the FNHA, 17 (or 68%) were filled and 8 were vacant. Of the 40 positions associated with regional and provincial health authorities, 27 (or 68%) were filled and 13 were vacant.





First Nations Health Authority  
Health through wellness

# Staffing

- Direct Service Delivery Positions
- Recruitment and Retention



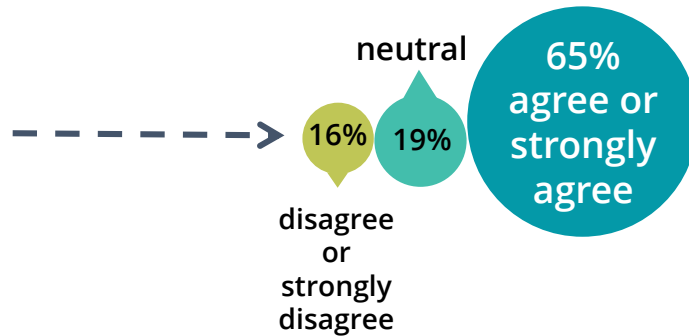


Recruitment and retention continue to be the primary challenge, impeding implementation of JPB projects. The lack of back-up/casual support is a critical issue for many projects.

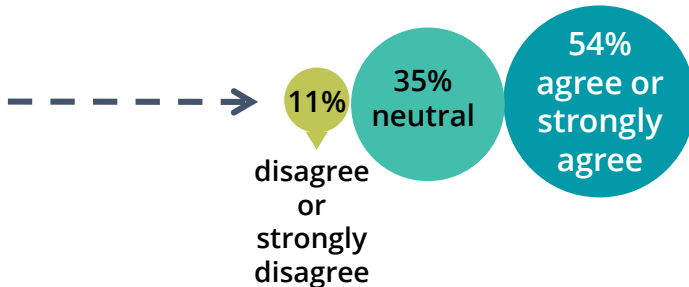
As illustrated, project self-assessment in narrative reporting indicates that 65% of reported projects agree or strongly agree the project has been able to recruit necessary staff. 54% of all projects agree or strongly agree the project has been able to retain necessary staff.

Back-up/casual support is largely unavailable due to limited funding and a lack of qualified candidates. Coverage is provided internally or not provided at all. 84% of reported projects agree or strongly agree that clinical staff are working to the greatest extent of their clinical practice/scope. 61% of reported projects agree or strongly agree that compensation levels for staff are competitive.

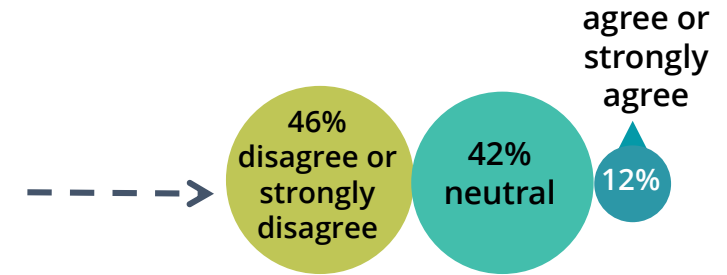
The project has been able to recruit necessary staff.



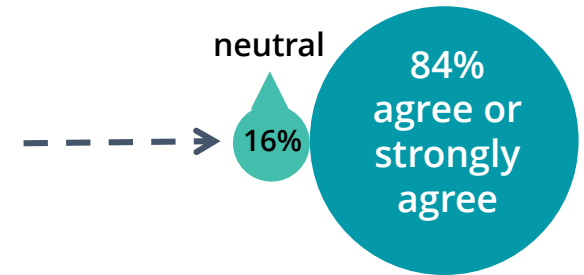
The project has been able to retain necessary staff.



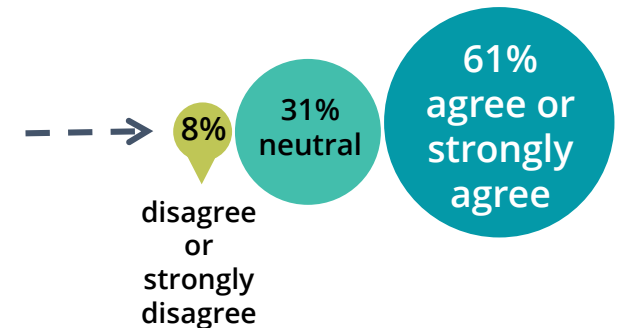
Back-up/casual support is available to cover holidays and leaves.



Clinical staff are working to the greatest extent of their clinical practice/scope.



Compensation levels for staff are competitive



Source: JPB Project Narrative Reports FY 2019/2020. Percentage reflects the proportion of all JPB projects that submitted narrative reports with reported agreement for closed-ended Likert scale questions. Ratings were provided by key stakeholders including Health Directors, project managers and staff.



Project narrative reporting reflected significant regional variations in the ability to recruit and retain staff. The Northern region experienced the most acute staffing challenges in FY 2019/2020.

	Overall	North	Fraser	Interior	Vancouver Coastal	Vancouver Island
The project has been <b>able to recruit</b> necessary staff.	65% (Strongly) Agree	25%	60%	71%	60%	100%
The project has been <b>able to retain</b> necessary staff.	54%	25%	60%	71%	40%	75%
Clinical staff are working to <b>the greatest extent of their clinical practice/scope</b> .	84%	50%	75%	100%	80%	100%
<b>Back-up/casual support is available</b> to cover holidays and leaves.	12%	25%	25%	14%	0%	0%
<b>Compensation levels for staff are competitive</b> .	61%	25%	80%	57%	60%	75% (Strongly) Agree

The visual to the left maps the percentage of reported project agreement to questions on each row. The overall column (circled) represents the all-project percentage; other columns represent regional percentages. A high level of agreement is indicated by green while a low level is indicated by red.

The Northern region experienced the most acute challenges. Only 25% of Northern projects agreed or strongly agreed that the project was able to **recruit** and **retain** necessary staff.

Regions have **different perspectives** regarding the competitiveness of **compensation levels** for staff. Northern respondents cited **occupational demands (e.g., long travel times)** as one reason why compensation is not competitive.

*“Compensation for health care professionals do not reflect northern realities. Many of the clinical positions on these teams require travel over large distances, in marginal conditions, on resource extraction roads, and overnight stays in over-burdened and limited accommodation. These types of occupational demands frequently limit the available pool of candidates (e.g., many of these are not very family-friendly positions with large travel and overnight requirements).”*

-- JPB Northern Project





There are opportunities to provide JPB projects with more recruitment and retention supports. A systematic review of HR-related issues would be beneficial.

In FY 2018/2019 narrative reports, projects highlighted the following **specific challenges**:

- Lack of trained candidates in **specialized areas of practice** [48% of reported projects experienced this challenge]
- **Lack of trained candidates locally** [44%]
- Lack of **short-term housing and residence** [44%]
- **Length of time to hire** candidates (e.g., HR process and onboarding) [32%]
- **Provider burnout** [28%]
- **Lack of interest** by local qualified candidates (e.g., salary, benefit, level of seniority) [28%]

The HR challenges and issues on this page are based on self-reports from projects. The extent to which the challenges are universal is difficult to assess. What is evident is that recruitment and retention is a continuing challenge for JPB projects. A systematic review of HR-related issues would be beneficial.

In the past two years, reported projects have noted the following HR-related issues:

- **Inability to offer extended benefits**, undermining the competitiveness of the compensation package.
- Difficulty finding service providers that are cultural fits.
- **High occupational demands** (e.g., frequent travel) for positions serving rural and remote communities.
- **Compensation levels do not match** occupational demands.
- **Complexity in hiring medical office assistants**: Providing medical office assistants for service providers might blur the line of contractor versus an employee.
- Requirement to **recruit within BC is a hindrance**. Suggest creating the opportunity to transition qualified health staff to BC.
- **More flexible full-time equivalent (FTE) arrangements could help with recruitment**: Some communities want to divide funding into small FTEs between communities to recruit locally, reduce travel and have additional time for service provision. Some note that small FTEs (0.25/0.5) impede recruitment, as people prefer full-time positions.



First Nations Health Authority  
Health through wellness

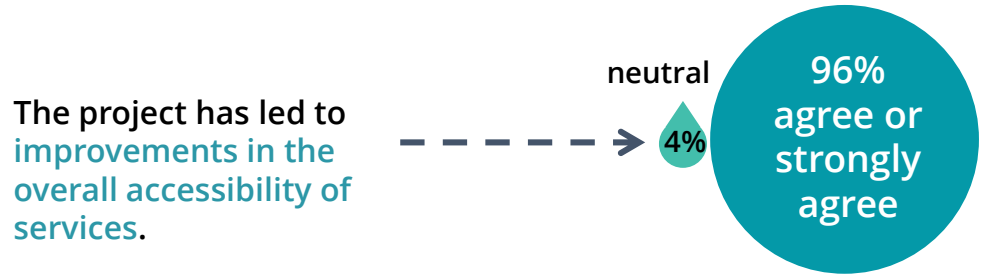
# Service Delivery

- Accessibility and Responsiveness
- Service Models
- Cultural Safety

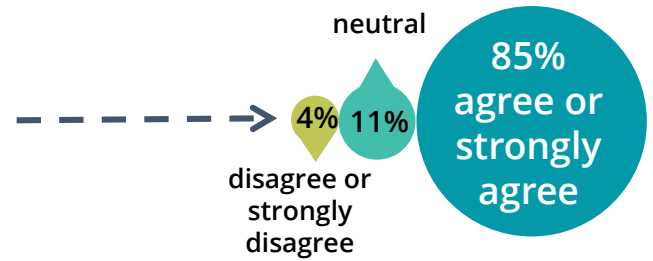




Project stakeholders believe JPB projects have contributed to improvements in service accessibility through increased flexibility, increased timeliness and increased understanding and navigation of services.



The project has led to increased flexibility of services to accommodate the needs of clients (e.g., appointment times outside of normal hours, alternate modes of delivery).

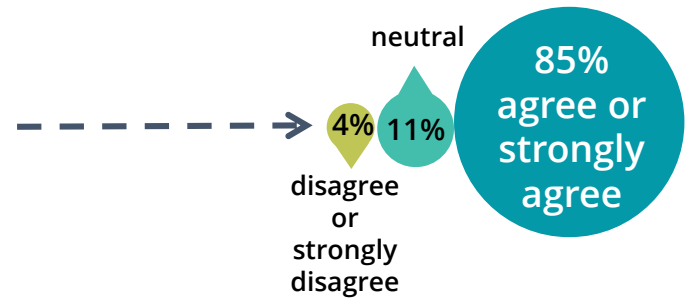


As illustrated, project self-assessment in narrative reporting indicates 96% of reported projects agree or strongly agree that the project led to improvements in the overall accessibility of services.

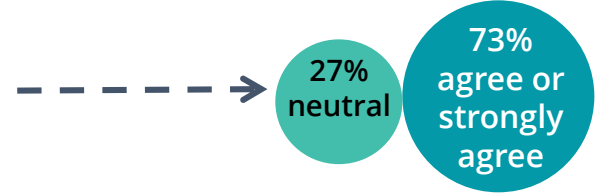
85% of projects agree or strongly agree that the project led to the increased flexibility of services to accommodate the needs of clients (e.g., appointment times outside of normal hours and alternate modes of delivery). 85% of projects agree or strongly agree that the project led to increased timeliness of services (services can be accessed when they're needed). 73% of projects agree or strongly agree that the project led to improvements in the degree to which services can be easily identified, understood and navigated.

Ratings were provided by key stakeholders, including Health Directors, project managers and staff.

The project has led to increased timeliness of services (services can be accessed when they're needed).



The project has led to improvements in the degree to which services can be easily identified, understood and navigated.



Source: JPB Project Narrative Reports FY 2019/2020. Percentage reflects the proportion of all JPB projects that submitted narrative reports with reported agreement for closed-ended Likert scale questions. Ratings were provided by key stakeholders including Health Directors, project managers and staff.



JPB projects are making services more accessible and enhancing clients' ability to access services. The following strategies are employed by at least 65% of reported projects.

## Making Health Services More Accessible

### Approachable

Creating an *open, comfortable and accessible atmosphere* for service delivery (88% of projects)

Services are accessible through *informal referrals* (88%)

### Acceptable and Culturally Appropriate

Hiring *staff from local community, Indigenous backgrounds or with significant experience working with Indigenous peoples* (73%)

Fostering *exchanges/interchanges* with regional health authority staff/sites (81%)

### Timely

*Walk-in appointments/services* are available (73%\*)

*Same-day/next-day appointments/services* are available (73%\*)

### Available and Accommodating

*Flexibility in terms of location of service delivery* (e.g., home visits) (92%)

Services/appointments by phone (96%)

Services via *virtual health* (e.g., Zoom) (81%)

Clinicians provide *longer appointment times* (92%)

## Enhancing Clients' Ability to Access Services

### Able to Perceive

Efforts have been made to *build trust with individuals* engaging in services (96%)

*Outreach to community members* (85%)

Engagements with communities to *develop relationships, trust and awareness of services* (81%)

### Able to Seek

*Assisting with health care paperwork/forms* (92%)

Helping *arrange transportation* (non-First Nations Health Benefit Medical Transportation related) (65%\*)

### Able to Reach and Pay

*Sending appointment reminders* (73%)

*Attending medical appointments for advocacy/health literacy/support* (77%)

Helping arrange First Nations *Health Benefit Medical Transportation benefits* (69%\*)

\*Some projects did not select these strategies as they are not applicable to mobile team or visiting professionals service models.

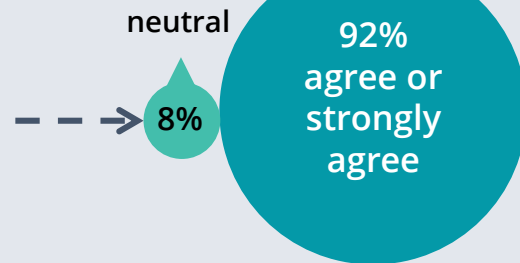
**Data Source:** JPB Project Narrative Reports FY 2019/2020. Percentage reflects the proportion of all reported JPB projects that adopted a certain strategy. Narrative Reports are filled out by key stakeholders including Health Directors, project managers and staff.

**Conceptual Model Source:** Levesque, J., Harris, M., Russell, G. (2013). "Patient-centred access to health care: conceptualising access at the interface of health systems and populations." *International Journal for Equity in Health*. 12:18.



The vast majority of reported projects are considered responsive to the needs of communities and individuals and well integrated with other services.

The project adapts programming based on the assessed needs of the community/individuals served.

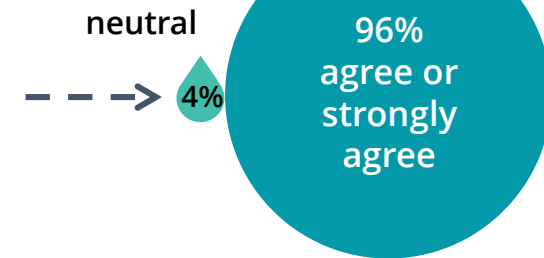


As illustrated, project self-assessment in narrative reporting indicates that 92% of reported projects agree or strongly agree that the project adapted its programming based on the assessed needs of the community/individuals served.

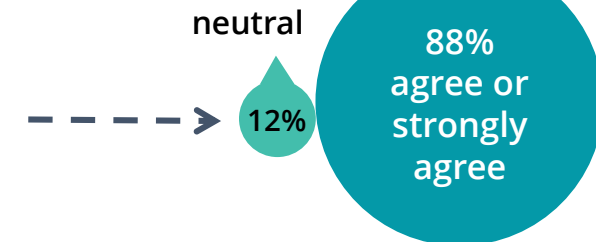
96% of projects agree or strongly agree that project services were well integrated with First Nations health organizations and services. 88% of projects agree or strongly agree that project services were well integrated with other local/regional/provincial health services. 73% of projects agree or strongly agree that clinical staff in place meet community needs.

Ratings were provided by key stakeholders, including Health Directors, project managers and staff.

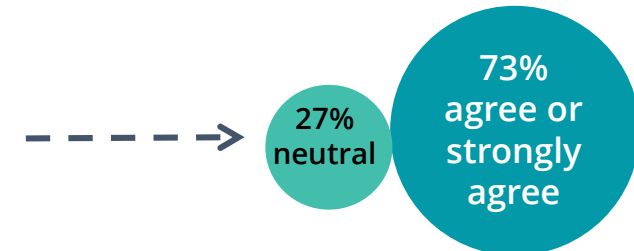
Project services are well-integrated with First Nations health organizations and services.



Project services are well integrated with other local/regional/provincial health services.



Clinical staff in place meet community needs.



Source: JPB Project Narrative Reports FY 2019/2020. Percentage reflects the proportion of all JPB projects that submitted narrative reports with reported agreement for closed-ended Likert scale questions. Ratings were provided by key stakeholders including Health Directors, project managers and staff.



First Nations Health Authority  
Health through wellness

# Service Delivery

- Accessibility and Responsiveness
- Service Models
- Cultural Safety





Regardless of the main service model, JPB projects provide wholistic team-based care that meets the needs of communities.

## Serving Multiple Communities with Flexibility

JPB projects typically serve multiple First Nations communities. Project service models are **uniquely designed for the communities' distinct needs**.

Many service **providers travel into communities** to provide care either on-demand or by schedule.

Proactive **in-community outreach activities** improve the overall accessibility of services.

**Transportation support** is sometimes provided when clients must receive care at the clinic but have no other transportation options.

**Home care** is provided to clients with mobility challenges.

## Navigation of Health and Social Services

Many projects help clients **navigate the health and social services** available to them. They have **strong linkages** to local services, health authority services and urban centre services.

JPB clinicians **refer clients to appropriate services** and advocate for clients' cultural interests when dealing with other providers.

## Addressing Social Determinants of Health

Many projects provide supports that touch upon issues of **travel, housing, food** and **income** security, applying for **official documents**, and legal and **child welfare** concerns.

## Health Literacy and Advocacy

Some JPB projects **enhance health literacy** by:

- Helping clients connect to, navigate and access services
- **Educating clients** on primary care, acute care, residential services, mental health, home health and public health services

Navigators and JPB clinicians **advocate for clients' cultural interests** when clients are referred to other providers.

## Wholistic Culturally Safe Care (details follow in the next section)

JPB projects embody **wholistic wellness-based care** by considering the social and cultural aspects of health.

Providing culturally appropriate and safe care is a priority for JPB projects.



A clinic with visiting professionals is the main service model of most JPB projects. This model offers the flexibility to meet the needs of most geographical areas.

## Clinic with visiting professionals

- Operating model of the majority of JPB projects.
- A physical clinic is located in a mutually convenient location for communities served by the project.
- Service providers travel into communities to provide care either on-demand or by schedule.

Service providers travel on-demand or by schedule (home/community visits or working out of a satellite office)



### Clinic with Visiting Professionals

Clinicians work in a physical location but some/all will also do outreach work (physically or with telehealth)



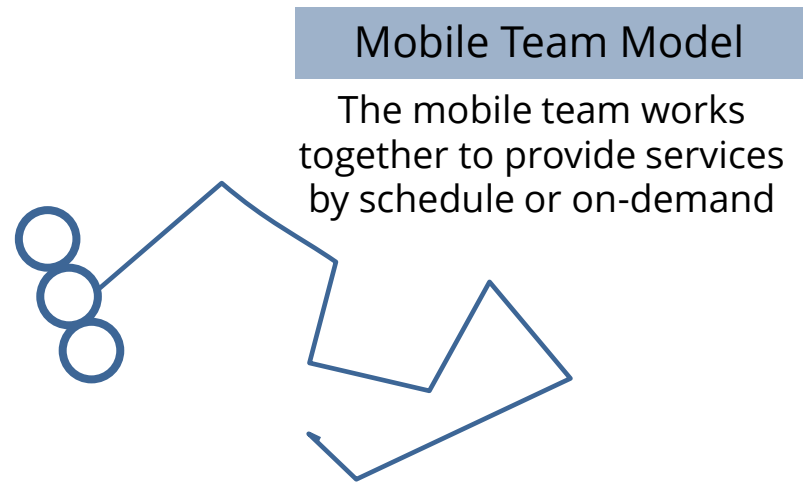




Seven JPB projects operate using a mobile team model. This model is especially effective in improving service accessibility in a geographical area with spread-out and remote communities.

## Mobile Team Model

- This is the operating model of 7 JPB projects. Without a central clinic location, teams of care providers travel to communities and work together to provide care either by schedule or on-demand.
- The model is designed to serve a geographical area with spread-out and remote communities, which often have limited in-community health services and where the cost and time of travel is a significant limiting factor for the accessibility of services.



## Strength

All mobile team projects reported that the model has been effective in improving the overall accessibility of services and increasing the flexibility of services to accommodate the needs of clients.

## Challenges

- **Information Technology:** Only 20% of mobile team projects reported sufficient information technology support. Only 17% of projects agreed that their electronic tools support effective care co-ordination among project team members. All projects stated that they did not have the tools to co-ordinate support with external partners.
- **Internal Team Management and Administration:** Only 33% of mobile team projects reported that they have sufficient central administrative support. Management support, quality improvement and care co-ordination are also challenges.

## EMR Deficiency is a Hindrance to the Circle of Care

*"Each community has [electronic medical records - EMR] but it is only community-based and there is no access to providers outside the community. If you are a health care provider and you travel between communities you don't have access to the records when not in the community. The family doctors and others don't have access to the information."*

-- Narrative Report Respondent



Four projects operate with the navigator or network model, providing navigation of health and social services, complex case management, and client advocacy and referrals.

## Navigator or Network Model

Four projects operate with this model. They themselves provide no or limited clinical service.

### Services include:

- Navigation of health and social services
- **Complex case management:** projects co-ordinate care plans with a multidisciplinary team
- Client advocacy and referrals

### Strength:

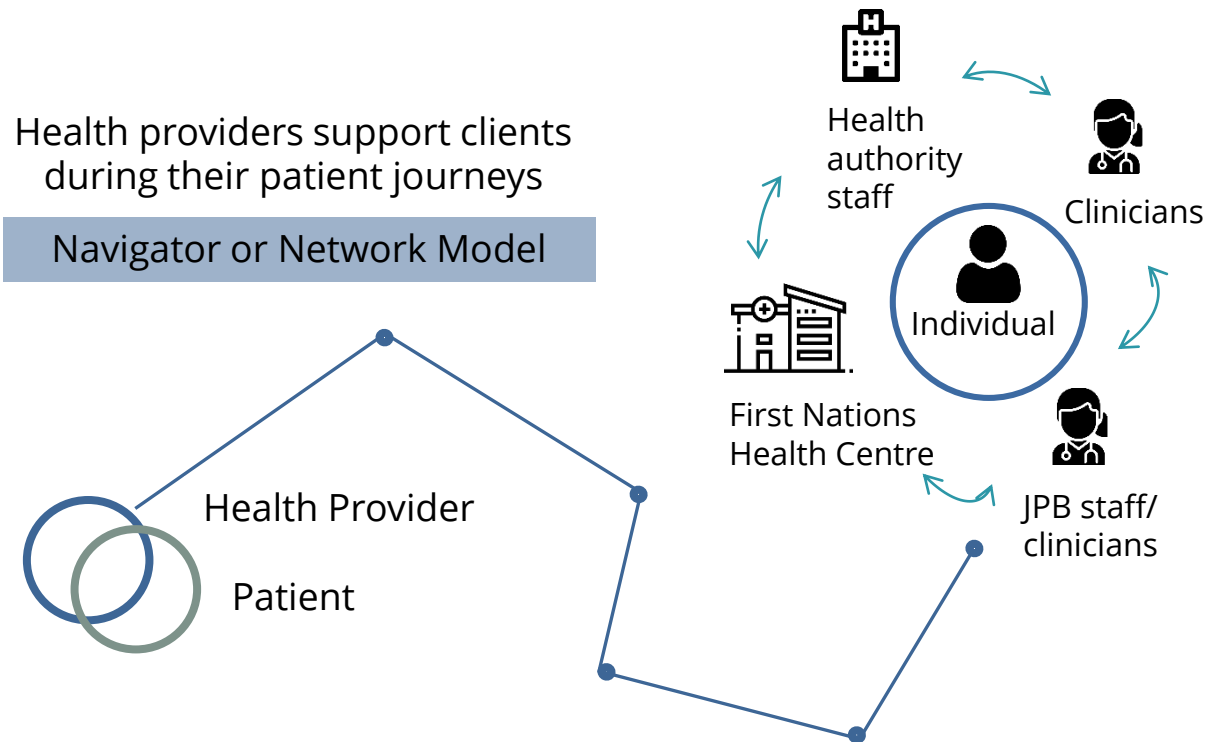
Compared to baselines, navigator/network projects report better satisfaction in internal team management and administration and physical infrastructure.

### Challenge:

However, **governance and external partnerships** are identified as challenges. For example, only 2 (out of 4) projects agreed that there is an effective framework to raise and resolve issues with external partners; and only 1 project agreed that partners demonstrate reciprocal accountability.

Health providers support clients during their patient journeys

### Navigator or Network Model





First Nations Health Authority  
Health through wellness

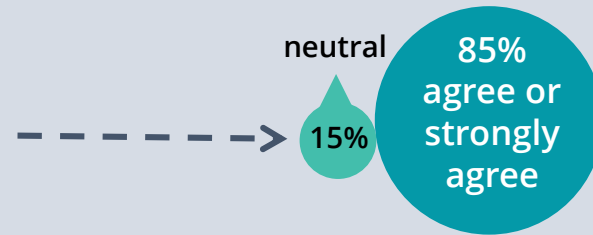
# Service Delivery

- Accessibility and Responsiveness
- Service Models
- Cultural Safety

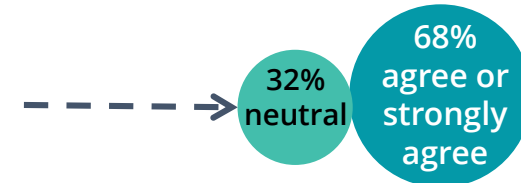




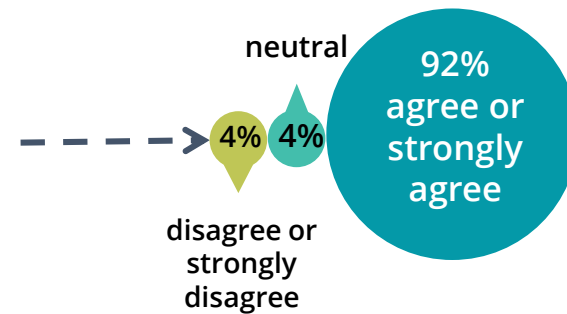
As a result of this project, First Nations perspectives of wellness have been integrated within local health services.



Local cultural and traditional wellness methods, medicines and/or teachings are integrated into project services.



Project services address physical, emotional, mental and spiritual wellness.



Source: JPB Project Narrative Reports FY 2019/2020. Percentage reflects the proportion of all JPB projects that submitted narrative reports with reported agreement for closed-ended Likert scale questions. Ratings were provided by key stakeholders including Health Directors, project managers and staff.





*“Community member and role model offered psychoeducation groups, from a **post-colonial perspective** ... a strength-based approach that recognizes that ‘symptoms’ are manifestations of deeper-rooted colonial wounds.”*

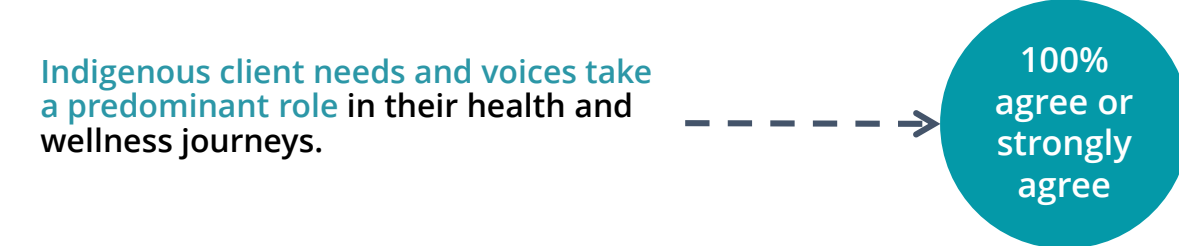
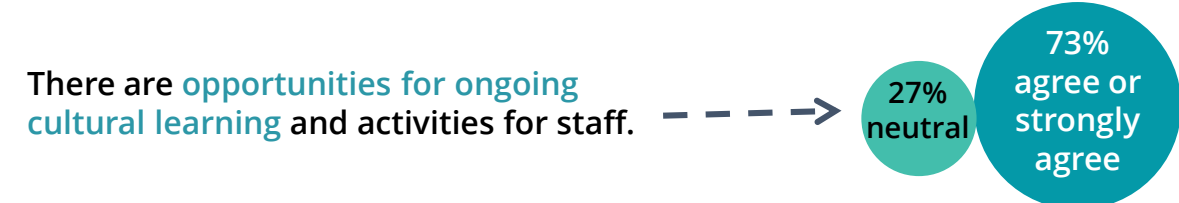
*“Providers receive **cultural competency training** developed by [the recipient]. We also encourage and provide **land-based learning** for providers and students. **Evaluation of cultural safety** is completed on an ongoing basis. A holistic approach to wellness is provided through integrated care teams and a focus on lifecycle and interconnection of health.”*

*“Individual and culturally unique system supports provided to **meet the client or community where they are** within their individual circumstance. Ensuring the **client’s voice** is loudly and clearly heard, valued and respected. Direct and unique **client advocacy** to enhance safety and respect to improve client/community health outcomes.”*

*“Services were delivered in the community, which assists in improving cultural safety by supporting clients where they are at. This also provides opportunities for the providers to create **positive working relationships** with communities, members and families. Services are co-ordinated with community-based staff that are working to provide referrals and an introduction to the services. This helps ensure that **services are safe and respectful to client needs.**”*

*“Our **services are based in the community** and we have worked hard with community leadership to ensure that the space available is one where community members feel safe to access. Our staff are **trained in cultural safety and humility** and provide where possible services that are linked with traditional and cultural practices and come from a **decolonized perspective** ... The clinician is well **integrated within the Indigenous-led staff team** and we’re constantly seeking new ways to provide services in a manner that’s culturally based and rooted in traditional wellness.”*





Source: JPB Project Narrative Reports FY 2019/2020. Percentage reflects the proportion of all JPB projects that submitted narrative reports with reported agreement for closed-ended Likert scale questions. Ratings were provided by key stakeholders including Health Directors, project managers and staff.



*"JPB clinician empowers youth to take control of their healing journey by providing empathy, building relationships and trust. Interventions are designed to reflect the youths' cultural and lived experience."*

*"Culturally variable primary care is provided to patients upon request. A variety of Indigenous treatment modalities are employed, including experiential exercises, storytelling, ceremonial processes and land-based healing techniques. Indigenous Focusing-Oriented & Complex Trauma honors core values of each community and respects local traditions."*

*"Many [Nurse Practitioners] .. have been providing services in First Nation communities ... [and] engaged with community for many years. This brings increased levels of trust, respect and engagement between practitioner and client, as well as the broader community ... These long-standing relationships also provide an effective model for addressing any concerns, and an effective forum for clients to voice concerns and successes in regards to the safety of care provided."*

*"Our clinic is part of a large First Nations Health services organization where cultural safety and humility are grounding stones. Orientation includes specific teachings around cultural safety and critical reflection. Our staff [are] First Nations. We are extending this work to include trauma-informed care. A workshop is under development."*

*"Having midwifery care has been extremely helpful for improving the cultural safety of the services provided. The midwife is available for after-hours support and has more time to spend with families. Now that a second midwife has started (August 2020), it is anticipated that there will be more benefits to offering this type of care to the communities, as there will be increased ability to support care provider education, local birth, and ensure a more sustainable model of care."*



# The End

We would like to thank the many staff, clinicians and partners involved in establishing and implementing the vision of these initiatives.

