Vancouver Coastal Region

Regional First Nations Health and Wellness Plan 2016-2021

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Executive Summary

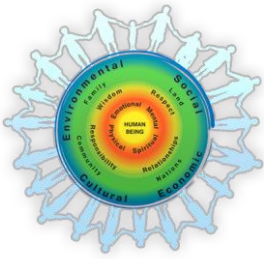
First Nations in the Vancouver Coastal region are a unique family. We are journeying together to navigate new waters with one heart, one mind. Each of our fourteen communities and four sub-regions are unique in their culture, traditions, and geography. This is reflected in our diverse strengths, needs and challenges. Central Coastal communities, for example, are accessible only by plane or boat. Whereas Southern Stl'atl'imx communities face challenges through long drives and poor road conditions.

Our Vancouver Coastal Southern sub-regional cousins are diverse communities that include rural and urban environments. Each has their own access to health and service delivery constraints that require different approaches and supports. We work in inclusive and collaborative ways to take full advantage of the exciting opportunities in health and wellness that lie ahead on behalf of our people.

The First Nations health governance structure established by First Nations, for First Nations, supports and enables decision-making and influence in the health system. First Nations are in a position to transform health care in BC. This Vancouver Coastal Regional First Nations Health and Wellness Plan (RHWP) will guide the work of the Vancouver Coastal region as we contribute to this system transformation journey.

The work is grounded in our Directives, our shared values, perspective on health and wellness, and guiding principles. These shape how we will advance the following priorities outlined in this RHWP:

1. Priority: Health Governance
2. Priority: Planning, Engagement and Communications
3. Priority: Holistic Wellness and Health Service Delivery
4. Priority: Health Human Resources
5. Priority: Operational Excellence
6. Priority: Data and Research



Regional Health and Wellness Planning is a critical connection to all levels of planning: community, subregional, regional and provincial. It helps coordinate and align the work of all partners in our region — the 14 First Nation communities, Vancouver Coastal Health, the First Nations Health Authority and others.

Introduction

PURPOSE OF THE REGIONAL HEALTH AND WELLNESS PLAN (RHWP)

The Regional Health and Wellness Plan (RHWP) defines strategic priorities, goals, and objectives for the Vancouver Coastal region over a five year period from 2016-2021. This plan is endorsed by the Vancouver Coastal Caucus. The RHWP is intended to support annual regional work plans and be aligned with more detailed sub-regional plans and activities, reflecting the unique needs of First Nations communities within Vancouver Coastal. The RHWP will guide approaches, strategies, partnerships, and investments at the regional and/or sub-regional levels. The RHWP serves as a common voice for the region and plays a key role in informing strategy and action at the provincial level.

The plan aims to answer three key questions:

1. ***Who is involved?*** Nations and their health partners
2. ***Who does what?*** Roles and mandates
3. ***What are we planning for together?*** Priorities, Goals and Objectives

BACKGROUND

Since 2005, First Nations in British Columbia (BC), and federal and provincial governments have been committed to a shared agenda to improve the quality of life of First Nations people. This shared agenda, described in the *Transformative Change Accord*, includes five key areas of focus: relationships; education; health; housing and infrastructure; and economic opportunities.

In health, progress has been made through a series of political agreements between First Nations in BC and federal and provincial governments: the *Transformative Change Accord: First Nations Health Plan* (2006); *First Nations Health Plan Memorandum of Understanding* (2006); *Tripartite First Nations Health Plan* (2007); *Basis for a Framework Agreement on Health Governance* (2010); *Tripartite Framework Agreement on First Nations Health Governance* (2011); and the *Health Partnership Accord* (2012).

The *Tripartite Framework Agreement on First Nation Health Governance* (the "Framework Agreement") provides for the legal commitments of the parties to create a new First Nations health governance structure that consists of:

First Nations Health Authority (FNHA): responsible to design, manage, and deliver health and wellness services to BC First Nations, and work to improve the services accessed by BC First Nations from the broader provincial health system. This is the organization through which operational and business implementation of the health plans and agreements occurs.

First Nations Health Council (FNHC): provides political leadership and oversight for the First Nations health governance process in BC, including responsibility to uphold the governance structure established by BC First Nations. This is the process through which BC First Nations Chiefs speak with a common governance voice on health matters, and resolve governance matters.

First Nations Health Directors Association (FNHDA): composed of health directors and managers working in First Nations communities. Acts as a technical advisory body to the FNHC and the FNHA on research, policy, program planning and design, and the implementation of the Health Plans. The FNHDA is the process through which Health Directors speak with one voice, and the process through which Health Directors access support, training, and professional development.

Tripartite Committee on First Nations Health (TCFNH): the forum for coordinating and aligning programming and planning efforts between the FNHA, BC Regional and Provincial Health Authorities, the BC Ministry of Health, and Health Canada Partners.

This is the First Nations health governance structure that operates at a province-wide level; it is rooted in and guided by the governance and partnership processes and structures in place in each of the five regions in BC (described for Vancouver Coastal region in "Vancouver Coastal Region" section below).

BC FIRST NATIONS SHARED VISION, VALUES, AND GUIDING PRINCIPLES

Collective efforts of BC First Nations are united and guided by a shared vision of "Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities." In support of the overall vision, the following shared values are in place: Respect, Discipline, Relationships, Culture, Excellence, and Fairness. First Nations in BC also agreed upon the following Seven Directives within the new health governance relationship:

Directive #1: Community-Driven, Nation-Based
Directive #2: Increase First Nations Decision-Making and Control
Directive #3: Improve Services
Directive #4: Foster Meaningful Collaboration and Partnership
Directive #5: Develop Human and Economic Capacity
Directive #6: Be Without Prejudice to First Nations Interests
Directive #7: Function at a High Operational Standard

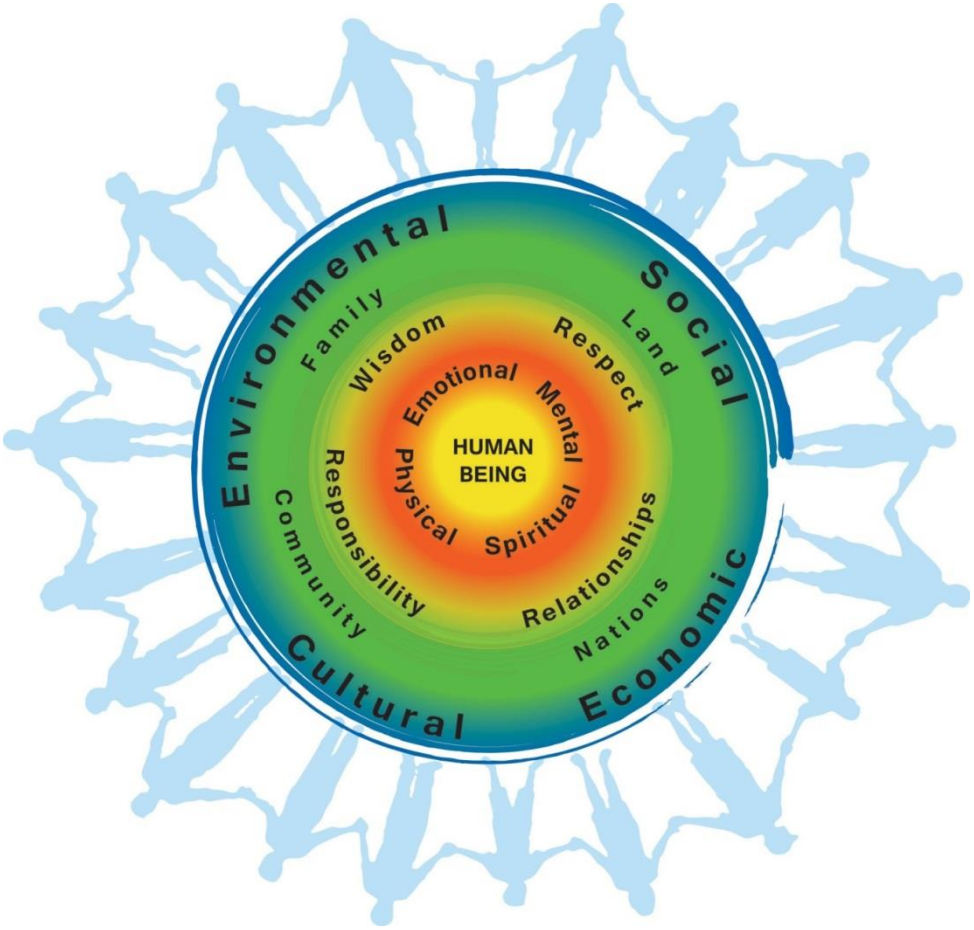
Reciprocal accountability is a core principle of the new First Nations health governance structure. Reciprocal accountability is a shared responsibility that each of us as individuals and organizations has to achieve our vision and goals - each of us being accountable to one another for the effective implementation of our commitments towards our shared outcomes. Everyone has a role and our actions affect others, and contribute to the outcomes of our interdependent and interconnected system.

Also important is the principle of *Cultural Humility*: a life-long process of self-reflection and self-critique to understand personal biases and to develop and maintain mutually respectful partnerships based on mutual trust. *Cultural safety* is to create an environment free of racism and discrimination where people feel safe receiving health care. Cultural humility enables cultural safety; and with the commitment of partners to cultural humility, cultural safety will be improved for all British Columbians.

BC FIRST NATIONS PERSPECTIVE ON HEALTH AND WELLNESS

The First Nations Perspective on Health and Wellness (see Figure 1 below) is a holistic health and wellness approach that provides a guide for health and wellness planning, program and service delivery to First Nations and Aboriginal peoples throughout BC. It builds on the idea that health and wellness are intimately connected, and that emotional, mental, spiritual and physical dimensions of well-being, as well as external factors such as our communities, Nations, territories, environments, and society as a whole all have an influence on our health and wellness. A holistic and integrated approach is fundamental to the success of achieving improved health and wellness outcomes for First Nations peoples in the Vancouver Coastal region. This perspective has guided, and will continue to guide, the development and implementation of this RHWP.

Figure 1: First Nations Perspective on Health and Wellness



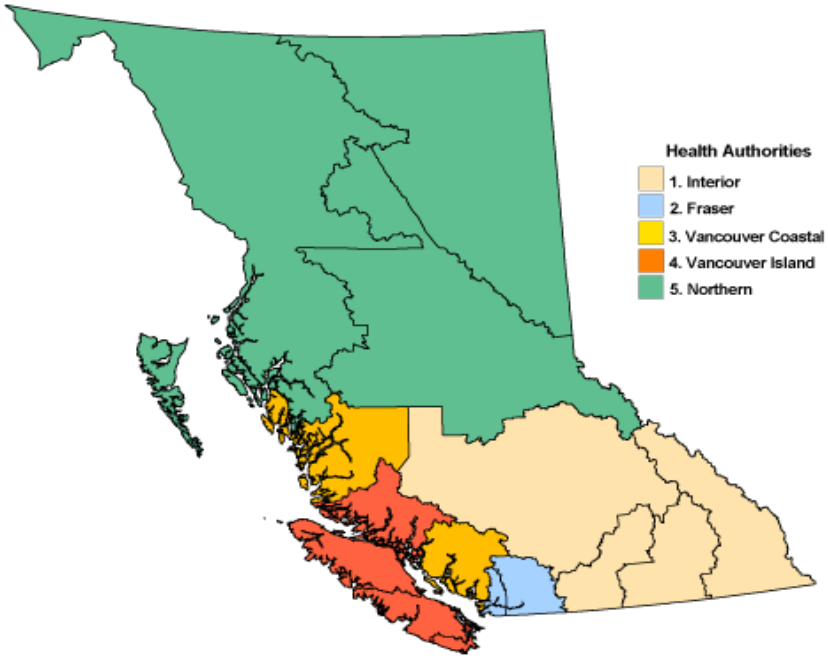
Vancouver Coastal Region

This section provides a regional profile, describes the governance structure and subregions, the Partnership Accord and ends with a description of the partners.

REGIONAL PROFILE

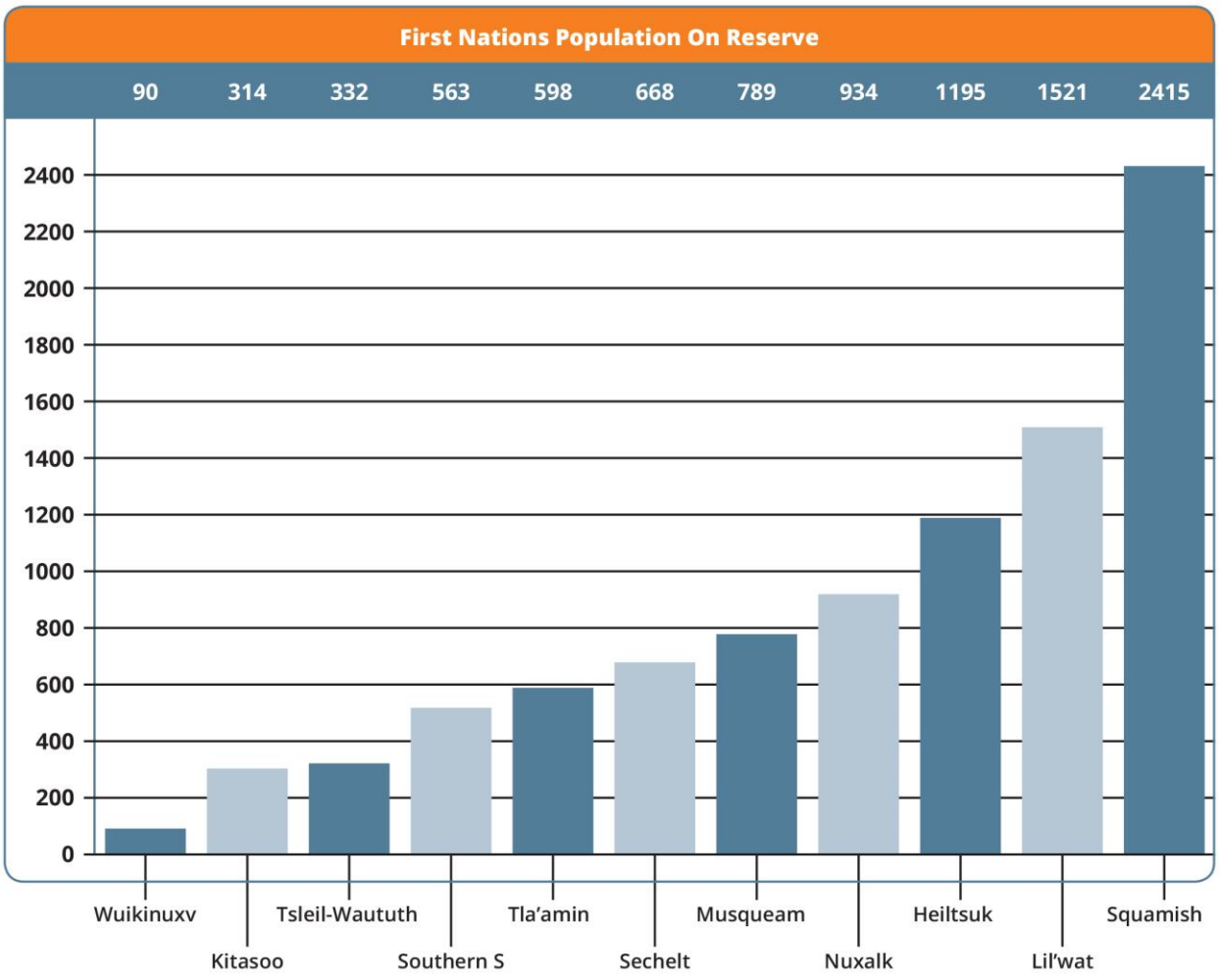
Vancouver Coastal region is outlined in the map below:

Figure 2. Vancouver Coastal Region



According to Indigenous and Northern Affairs Canada (INAC), there is an estimated 9419 First Nations people residing at-home/on-Reserve (2015) across 14 communities in the VC region, representing 11.9% of the total Aboriginal population in BC (approximately 17,,000). The communities are served by 11 First Nations health organizations.

Figure 3: Population on Reserve (INAC 2015)



*Southern Stl'atl'imx includes the Nations of: N'Quatqua, Samahquam, Skatin, and Xa'xtsa

There are 4 clusters of community sizes represented in Figure 2:

- Population less than **100** — 1 community
- Population between **101 – 500** — 6 communities
- Population between **501 - 699** — 2 communities
- Populations between **700 – 1,760** — 5 communities

REGIONAL GOVERNANCE STRUCTURE

Caucus

The Vancouver Coastal Caucus (VCC) is comprised of the First Nation communities within the Vancouver Coastal Region. Each Vancouver Coastal First Nation designates one political representative and one technical (health service delivery lead) representative, for a total of 28 representatives. Each

First Nation Band or Tribal Council selects its own political and technical representatives using its own processes. The VCC meets approximately twice per year usually in the spring and the fall.

The Caucus is the main regional forum for communications, collaboration, and accountability - it is where the FNHC, FNHDA, and FNHA engage directly with leadership about their work regionally and provincially, and where the Regional Table is provided with guidance as to its work on behalf of the Caucus.

Regional Table

The Vancouver Coastal Regional Table is comprised of three FNHC governance representatives from each of the subregions (for three year terms), as well as three technical leads from each of the subregions (for two year terms). The regional table purpose is to carry out the direction of the Vancouver Coastal Caucus. The representatives will be responsive to regional issues and will interface with regional health leads, senior staff and board members of VCH, and community health and technical leads in the implementation of the Vancouver Coastal Partnership Accord.

The table works with the goal of improvements in service delivery through more collaboration between VCH, First Nations communities they serve, the FNHC, FNHA, and the region's First Nations Health Centers. The regional table supports the Partnership Accord vision to increase the influence of First Nations regarding health services in the Vancouver Coastal region with the goal of attaining shared decision-making.

Subregions

Vancouver Coastal Region is comprised of 3 subregions: South, Southern Stl'atl'imx, and Central Coast. Subregional areas are defined based on geographical proximity to one another, where long standing relationships between communities have existed. Subregional gatherings occur several times annually, where political and technical leadership have an opportunity to come together purposefully to plan, communicate, and collaborate on shared health priorities.

Supporting one another subregionally, communities work in partnership and collaborate with other service delivery organizations such as Vancouver Coastal Health. These collaborations provide partnership and collaborations to leverage new opportunities in a way that is innovative, i.e. Joint Project Board projects. Subregional gatherings further strengthen political engagement and participation in caucus decision-making processes. As described above, each subregion also makes an appointment to the FNHC.

A brief description of each subregion is outlined below along with community descriptions.

Figure 4: Vancouver Coastal Caucus Sub-Regions

SOUTH (population = 8,576*)		SOUTHERN STL'ATL'IMX (population= 3,633*)		CENTRAL COAST (population = 4,889*)	
Nation	**Location**	**Nation**	**Location**	**Nation**	**Location**
Squamish	West Vancouver and Squamish	Lil'wat	Mount Currie	Heiltsuk	Bella Bella
Tsleil-Waututh	North Vancouver	N'Quatqua	D'Arcy	Nuxalk	Bella Coola
Musqueam	Vancouver	Skátin	Skookum chuck Hot Springs	Kitasoo/Xai'xais	Klemtu
Sechelt	Sechelt	Samahquam	Lillooet River	Wuikinuxv	Rivers Inlet
Tla'amin	Powell River	Xa'xtsa (Douglas)	Port Douglas		

* INAC 2015 Data

Central Coast Subregion. This subregion is comprised of the the Heiltsuk, Xai'Xais, Nuxalk, and Wuikinuxv First Nation peoples.

HEILTSUK NATION (BELLA BELLA)

The Heiltsuk Nation is a First Nations government in the Central Coast region of British Columbia, centered on Campbell Island, in the community of Waglisla (Bella Bella). The Heiltsuk people speak the Heiltsuk language. The Heiltsuk language is a dialect of the North Wakashan (Kwakiutlan) language Heiltsuk- Oowekyala. According to 2015 INAC Band Affiliation data, there were 1,195 community members living at-home/on-reserve, and 1.191 members living away from home/off-reserve. The Hailika'as Heiltsuk Health Center (with its own health board) located on-reserve, provides a variety of health services to the community.

KITASOO/XAI'XAIS (KLEMTU)

The town of Klemtu is home to the Kitasoo/Xai'xais people. Two distinct tribal organizations live here: the Kitasoo (Tsimshian) who were originally from Kitasu Bay and the Xai'xais of Kynoc Inlet. The Kitasoo/Xaixais people are the only permanent residents within the traditional territories of this First Nation, and they are members of the Oweekeno-Kitasoo-Nuxalk Tribal Council. According to 2015 INAC Band Affiliation data, there were 314

community members living at-home/on-reserve, and 199 members living away from home/off-reserve.

NUXALK (BELLA COOLA)

The Nuxalk Nation is located in and around what is known as Bella Coola, British Columbia. Current INAC population estimates indicate a total Nuxalk population of 1,701 with 934 members living on the Nuxalk reserve in Bella Coola. However, according to traditional Nuxalk government, the true Nuxalk population is closer to 3,000. This number includes people of Nuxalk ancestry who are not registered or may be registered to another First Nations Band. Nuxalk Nation is a member of the Oweekeno-Kitasoo-Nuxalk Tribal Council. The Nuxalk Health and Wellness Center is part of the Nation's structure.

WUIKINUXV – OWEKEENO (RIVERS INLET)

The traditional Wuikinuxv territory lies 300 miles northwest of Vancouver, and is only accessible by boat and float plane. The community is located on the banks of the Waanukv River, which connects Owikeno Lake to the head of Rivers Inlet. The nearest town is Port Hardy across the Queen Charlotte Strait. The Wuikinuxv Nation is a member of the Oweekeno-Kitasoo-Nuxalk Tribal Council. There is no direct transport between Wuikinuxv and Bella Bella or Bella Coola. There are an estimated 90 members living on-reserve and 197 members living off-reserve.

Stl'atl'imx Subregion. This subregion is comprised of the Lil'wat, N'Quatqua, Samahquam, Skatin, and Xa'xtsa First Nation peoples.

LIL'WAT (MOUNT CURRIE)

The Lil'wat Nation (Mount Currie) is a First Nations government located about 8km east of Pemberton, in the southern Coast Mountains. Lil'wat Nation is a member of the Lower Stl'atl'imx Tribal Council. The first language of the Lil'wat, and other Interior Salish people, is Ucwalmicwts. The 2015 INAC Band Affiliation data lists 1,521 members living at-home/on-reserve, and 659 members away from home/off-Reserve. The Pqusnalhcw Health Center, located at-home/on-reserve in the Lil'wat Nation, provides a variety of health services to the community.

N'QUATQUA, SAMAHQUAM, SKATIN, AND XA'XTSA (DOUGLAS)

These four communities are located north and southeast of Pemberton and are members of the Lower Stl'atl'imx Tribal Council (LSTC) along with Lil'wat Nation.

The INAC 2015 population data identified the following:

- **N'Quatqua** - 205 members at-home/on-reserve and 151 away from home/ off-reserve;
- **Samahquam** – 113 at-home/on-Reserve and 254 away from home/off-reserve;
- **Skatin** - 138 at-home/on-reserve and 276 away from home/off-reserve; and
- **Xa'xtsa** – 107 at-home/on-reserve and 207 away from home/off-reserve.

The Southern Stl'atl'imx Health Society (SSHS) provides some health services to the four communities to complement the services that each community provides itself.

South Subregion. This subregion is comprised of the Sechelt, Tla'Amin, Tsleil-Waututh, Musqueam, and Squamish First Nation peoples.

SECHELT

The Sechelt (Shíshálh) First Nation is located on the scenic Sunshine Coast. In 1986 the Shíshálh Nation became an independent self-governing body, a unique third order of the government of Canada. The Sechelt Indian Government District holds jurisdiction over its lands and exercises the authority to provide services and education for its residents.

The 2015 INAC Band Affiliation data lists 668 members living at-home/on-reserve, and 708 members away from home/off-reserve. Independent and self-governing, Sechelt chooses to participate in and is welcomed into FNHA governing structures.

TLA'AMIN (SLIAMMON) – POWELL RIVER

The Tla'amin Nation (Sliammon) is part of the Coast Salish Indigenous peoples inhabiting the western coast of BC, located north of Powell River. Traditional Tla'amin territory was along the northern part of the Sunshine Coast, extending along both sides of the Strait of Georgia. Current INAC population estimates indicate a total Tla'amin population of 1,074 with 598 members living at-home/ on-reserve.

TSLEIL-WAUTUTH NATION

The Tsleil-Waututh Nation is located on the north shore of Burrard Inlet, and is surrounded by the city of North Vancouver. The INAC 2015 population data for Tsleil-Waututh lists 332 members at-home/on-reserve and 247 away from home/off-reserve. Community members access services from its health team located on reserve, North Shore physicians, VCH's Lions Gate Hospital (LGH) and community services.

MUSQUEAM

The Musqueam traditional territory occupies what is now Vancouver and surrounding areas. The Musqueam Indian Reserve is located south of Marine Drive, near the mouth of the Fraser River, and this reserve represents a very small portion of their traditional territory. The most recent INAC population estimates indicate a total Musqueam population of 1,381 members, with 789 members living at-home/on-reserve.

SQUAMISH NATION

Skwxú7mesh Úxwumixw (Squamish Nation) community members are the descendants of the Coast Salish Aboriginal peoples who lived in the present day Greater Vancouver area, Gibson's landing and Squamish River watershed. Currently there are approximately 2,415 members living at-home/on-reserve, and 1,750 living away from home/off-reserve.

Yúustway Health Services provides service to Squamish Nation. As per the traditional name Yúustway (meaning "taking care of each other"), this department strives to improve the health and wellness of Squamish Nation membership through the provision of community health services and the promotion and support for access to all health services.

Partnership Accord

The Framework Agreement establishes a broad vision for high functioning partnerships between First Nations and Health Authorities at a regional level. The Vancouver Coastal Partnership Accord was signed in May 2012 by the FNHC regional representatives on behalf of the Vancouver Coastal Caucus (political members), the FNHA and VCH.

The Partnership Accord calls for improvements in service delivery through more collaboration between VCH, First Nations communities they serve, the FNHC, FNHA, and the region's First Nations Health Centers. The Accord also directs cooperative work with community health leaders to develop more culturally appropriate health strategies. It sets out a vision to increase the influence of First Nations regarding health services in the Vancouver Coastal region with the goal of attaining shared decision-making.

The current Partnership Accord outlines seven key commitments of the partners:

1. Regional Health and Wellness Plan (this document)
2. Joint Community Engagement Strategy (completed and approved by Aboriginal Health Steering Committee, January 2013; in process of being updated at the time of refreshing this plan)
3. Urban Aboriginal Health and Wellness Strategy Advisory Framework (in progress)
4. First Nations and Aboriginal Culturally Competent and Responsive Strategic Framework (in progress)
5. Cultural Competency training (ongoing Indigenous Cultural Competency training and cultural days on-reserve)
6. Annual Progress Report and Review of Performance Indicators (to be developed)
7. Communications, Collaboration, and Engagement (ongoing and subject to continual process improvements)

As described above, the Regional Table supports this Partnership Accord processes and deliverables. The **Aboriginal Health Steering Committee (AHSC)** oversees the implementation of the Vancouver Coastal Partnership Accord and serves as a senior and influential forum for partnership, collaboration, and joint efforts on First Nations and Aboriginal health priorities, policies, budgets, programs and services in the Vancouver Coastal region. The AHSC membership includes:

- VCC: the three representatives appointed to the FNHC;
- FNHA: the Chief Executive Officer (CEO) or designate, Board Chair, and Chief Operating Officer (COO);
- VCH: the CEO, Board Chair, Vice President of Public Health, and COO of Coastal Community of Care;
- And any ex-officio members as jointly appointed by the parties.

As per the AHSC Terms of Reference, the **Aboriginal Health Steering Committee Executive Committee** identifies strategic priorities, and ensures execution of FNHA and VCH partnered strategic initiatives, plans for AHSC meetings and communicates accordingly. The scope of the Executive Committee encompasses all strategic and operational decision-making resulting from the VCH/FNHA/FNHC Partnership Accord. The Executive Committee is comprised of:

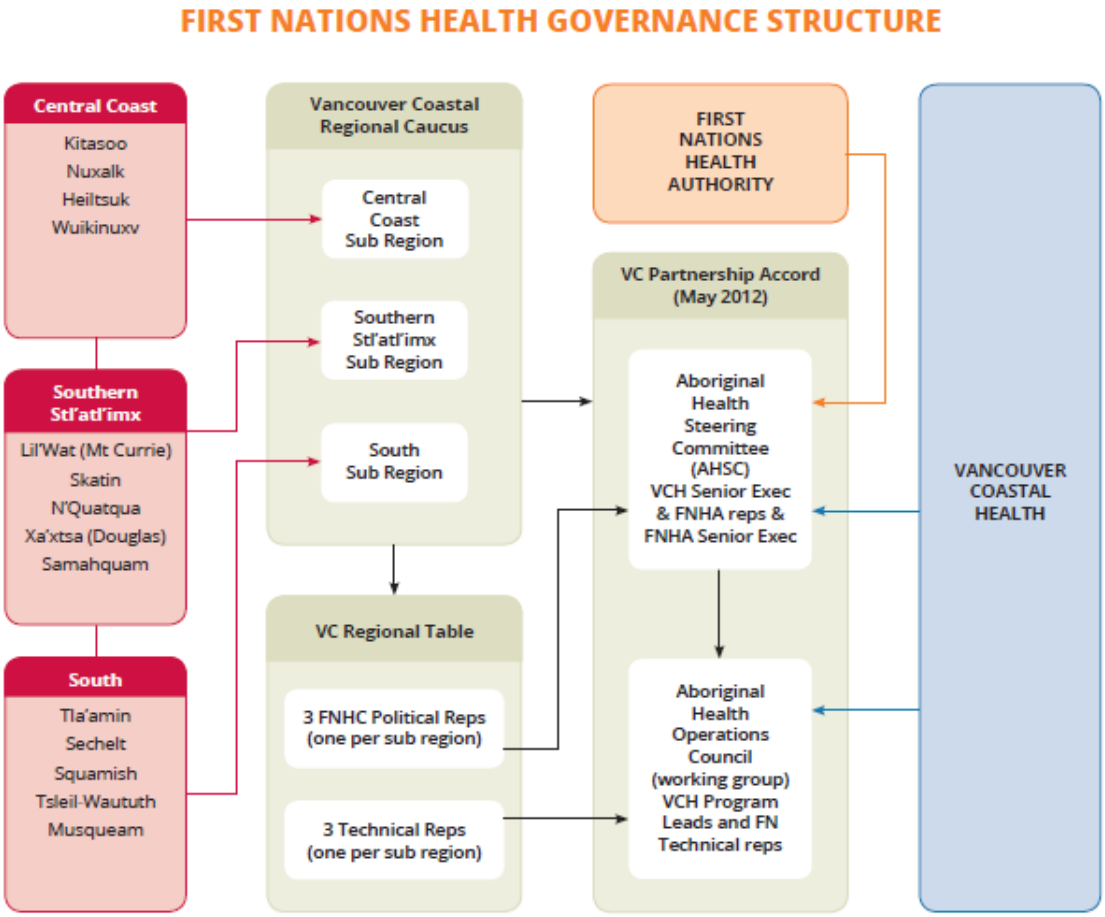
- Vice President (VP) of Public Health & Chief Medical Health Officer , VCH – Co-Chair
- COO, FNHA – Co-Chair
- First Nations Health Council (FNHC) Representative
- Executive Lead of Aboriginal Health – VCH, and
- Vancouver Coastal Regional Director, FNHA

A working group structure will be created to build a stronger working relationship at an operational level. The working groups will focus on primary care, mental wellness and substance use, as well as other priorities outlined in this RHWP

The 14 First Nations in the region, Regional Table, AHSC, AHSC Executive Committee and related working group structures work within many feedback loops. The FNHA provides operational capacity in support of this work alongside that of VCH to support the partnership accord and region overall. The Vancouver Coastal Caucus is the annual main forum where all come together for dialogue and exchange. Regional First Nation priorities ultimately guide all of the work.

The following diagram summarizes the overall regional First Nations health governance structure described above:

Figure 5: Vancouver Coastal First Nations health governance structure



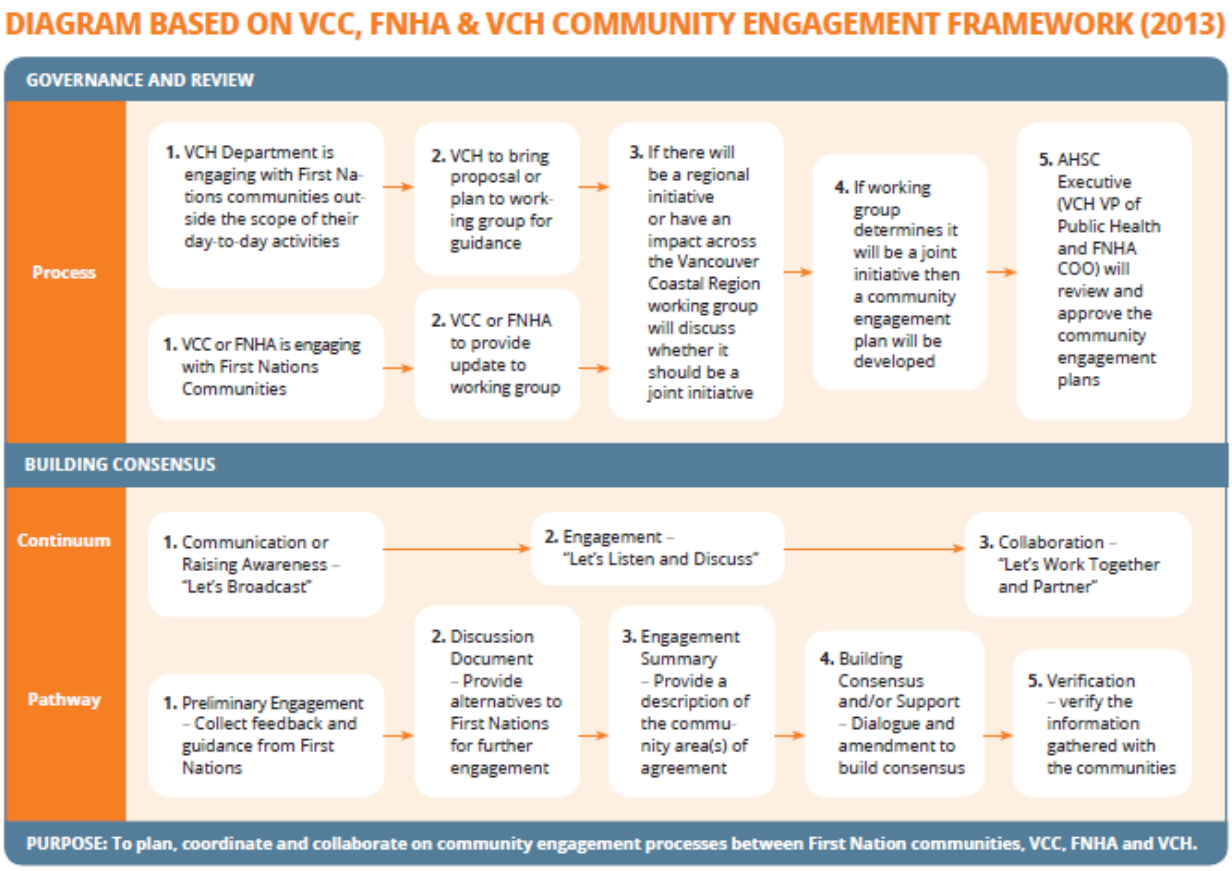
Community Engagement

Completed on January 17, 2013, the Joint Community Engagement Strategy was developed by VCC, FNHA, and VCH. Committed to continuous improvement, it also requires refreshing to reflect lessons learned and to be effective. In it, the partners agreed to adapt their processes, tools or goals to provide a common understanding in conducting joint community engagement with First Nations communities.

They also agreed that community engagement and development has a direct benefit to the health care system. It enables the system to design programs more closely tailored to the needs of First Nations and Aboriginal community members. The partners recognize and acknowledge that each partner consults or engages with First Nations and Aboriginal communities and want to coordinate efforts in order to not overburden First Nations and Aboriginal communities.

The figure below provides a visual depiction of Vancouver Coastal regional engagement process and flow.

Figure 6. VCC, FNHA, and VCH Community Engagement Framework (2013)



Partners

The diagram on the following page (Figure 6) identifies key partners who are involved in the delivery of our RHWP. Together we can use resources wisely to provide health care in a way that the community decides is best for them.

Figure 7: Partners in the Regional Health and Wellness Plan

Vancouver Coastal Health (VCH): One of the six health authorities in BC guided by policy and directions from the BC Ministry of Health. The geographic area covered by VCH includes 12 municipalities and four regional districts in the coastal mountain communities, Vancouver, North Vancouver, West Vancouver, Richmond and 14 First Nations communities. VCH serves more than one million residents and also has responsibility for services for First Nations people living away from home/off-Reserve (whether from BC or not), and Aboriginal peoples living in urban areas of the region.

Provincial Health Services Authority (PHSA)

Ensures that BC residents have access to a coordinated network of high-quality specialized health care services. This includes selected services provided in facilities governed by other health authorities, as well as those programs and services provided through the following provincial agencies:

- BC Cancer Agency
- BC Center for Disease Control
- BC Children's Hospital (and Sunny Hill Health Center for Children)
- BC Mental Health & Substance Use Services
- BC Renal Agency
- BC Transplant
- BC Women's Hospital & Health Center
- Cardiac Services BC
- Perinatal Services BC

Divisions of Family Practice and Physicians

Community-based groups of family physicians working together to achieve common health care goals. Not all family physicians belong to Divisions. In the Vancouver Coastal region there are five Divisions of Family Practice:

1. Richmond Division of Family Practice
2. Vancouver Division of Family Practice
3. North Shore Division of Family Practice
4. Sea-to-Sky & Sunshine Coast Division of Family Practice
5. Powell River Division of Family Practice

Other service providers and partners

There are many other service providers who deliver all forms of health care for First Nation community members. Some are under contract arrangements with the Nations themselves, and some independently in towns and cities that community members access. These service providers include: dentists, pharmacists, optometrists, chiropractors, physiotherapists, and occupational therapists. There are also non-profit agencies that provide some services for the First Nations communities.

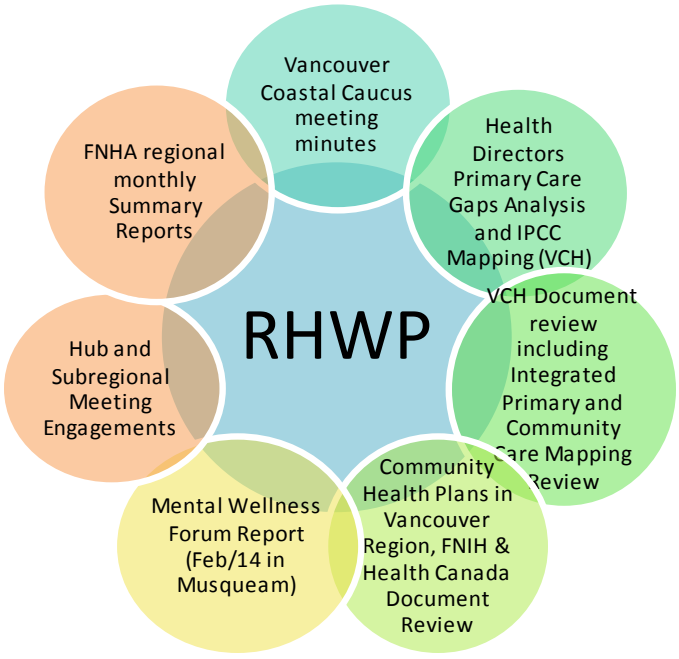
Methodology and Process

The inaugural, *interim* Vancouver Coastal Regional Health and Wellness Plan was drafted and engaged upon during 2013 and 2014. Attention to process and engagement was paramount in ensuring community wisdom, advice, feedback and guidance informed the RHWP priorities. The process started at 'Gathering Wisdom for a Shared Journey IV' (2011), where BC First Nations provided direction for each of the five health regions (Northern, Interior, Vancouver Island, Fraser Salish, and Vancouver Coastal) to develop an interim Regional Health and Wellness Plan (*i*RHWP).

The Vancouver Coastal Caucus endorsed the initial interim draft VC RHWP, subject to greater First Nation engagement at the subregional level. In the following 6 months (May to October, 2014) , regional First Nations did a considerable amount of work to identify and validate priorities and to recommend ways to improve services. This work happened in partnership and collaboration with one another, the FNHA, and with Vancouver Coastal Health at subregional and regional level engagement gatherings. The resulting priorities are reflected in the goals and objectives outlined in this plan. The first Vancouver Coastal RHWP was endorsed at the VCC on October 23, 2014 as the full RHWP as a result.

Priorities, goals and objectives are grounded in the following:

Figure 8. Key Engagement and Information Sources for the RHWP



The RHWP serves as the common voice of the region and supports further planning and implementation sub-regionally.

Regional Priorities, Goals, and Objectives

The six key priority areas of Vancouver Coastal First Nations are identified below:

1. Priority: Health Governance
2. Priority: Planning, Engagement and Communications
3. Priority: Holistic Wellness and Health Service Delivery
4. Priority: Health Human Resources
5. Priority: Operational Excellence
6. Priority: Data and Research

The figure below illustrates how these six priorities align with the Seven Directives as a foundation for this RHWP.

Figure 10: Vancouver Coastal Regional Priorities Alignment with the Seven Directives

	Directive #						
Priority	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Health Governance	✓	✓	✓	✓	✓	✓	✓
Planning, Engagement and Communications	✓	✓	✓	✓	✓		✓
Holistic Wellness and Health Service Delivery	✓	✓	✓	✓			✓
Health Human Resources	✓		✓	✓	✓		✓
Operational Excellence	✓		✓		✓	✓	✓
Data and Research	✓	✓	✓	✓	✓	✓	✓

Directive #1: Community-Driven, Nation-Based
Directive #2: Increase First Nations Decision-Making and Control
Directive #3: Improve Services
Directive #4: Foster Meaningful Collaboration and Partnership
Directive #5: Develop Human and Economic Capacity
Directive #6: Be Without Prejudice to First Nations Interests
Directive #7: Function at a High Operational Standard

1. Priority: Health Governance

It is a continued priority to enhance and strengthen the regional health governance structure in Vancouver Coastal described above. This renewed RHWP marks another step in our journey of transformation and will support the next steps in Partnership Accord implementation and sub-regional planning.

Goal 1.1: Acknowledge, respect and support First Nations decision-making in health service design and delivery.

Objectives	1.1.1: Refresh and implement the Partnership Accord and support associated governance structure to enhance integrated and effective service delivery in alignment with First Nations perspectives and needs.
	1.1.2: Support effective regional participation at the Tripartite Committee on First Nations Health (TCFNH).
	1.1.3: Implement and evolve regional and sub-regional governance structures and processes to effectively engage health and political leadership in health service design and delivery.
	1.1.4: Expand engagement with other agencies whose mandates impact the determinations of health.
	1.1.5: Support communities and subregions to actively participate in governance structures.

Goal 1.2: Support region, sub-regions and communities to maximize flexible funding opportunities, including the regional envelope.

Objectives	1.2.1: All partners collaborate to improve and leverage funding arrangements.
	1.2.2: Strategically dedicate financial and human resources, such as the regional envelope, focused on achieving RHWP priorities.

Goal 1.3: Support reciprocal accountability throughout the VC region health governance structure.

Objectives	1.3.1: Support communities and subregions to actively participate in the governance structure.
	1.3.2: Support the regional table to report back to communities at Caucus. Seek community and subregional guidance in implementing Caucus decisions.
	1.3.3: Support the FNHC and FNHDA representatives, FNHA teams to report back and get guidance at Caucus as per the Partnership Accord commitment, including sharing Annual Report(s).
	1.3.4: Support the development of a reporting framework against the RHWP with success indicators and provide annual progress reports at Caucus

Goal 1.4:	Realize and implement an Urban Vancouver Aboriginal Health Strategy (UVAHS)
Objectives	1.3.1: Ensure host First Nations (Tsleil'Waututh, Musqueaum, and Squamish) have a governance role and voice in the governance process.
	1.3.2: Implement an engagement process to support the development and implementation of a strategy or the urban center.
	1.3.3: Implement an engagement process for regional areas outside of Vancouver.

2. Priority: Planning, Engagement and Communication

From the beginning, community engagement has existed on a spectrum from communication, collaboration, and engagement to planning. This RHWP carries that foundational work forward. The success of the work to date has been because of a commitment to community engagement which is carried forward in the development and implementation of this RHWP. Engagement and communications are critical to our collective success. First Nations will create opportunities through working collaboratively with federal, provincial, and regional partners.

The diagram below depicts the planning approach within the new First Nations health governance structure. Community Health and Wellness Plans will inform Regional Health and Wellness Plans, which in turn inform the FNHA MYHP and operational plans as well governance partner plans.

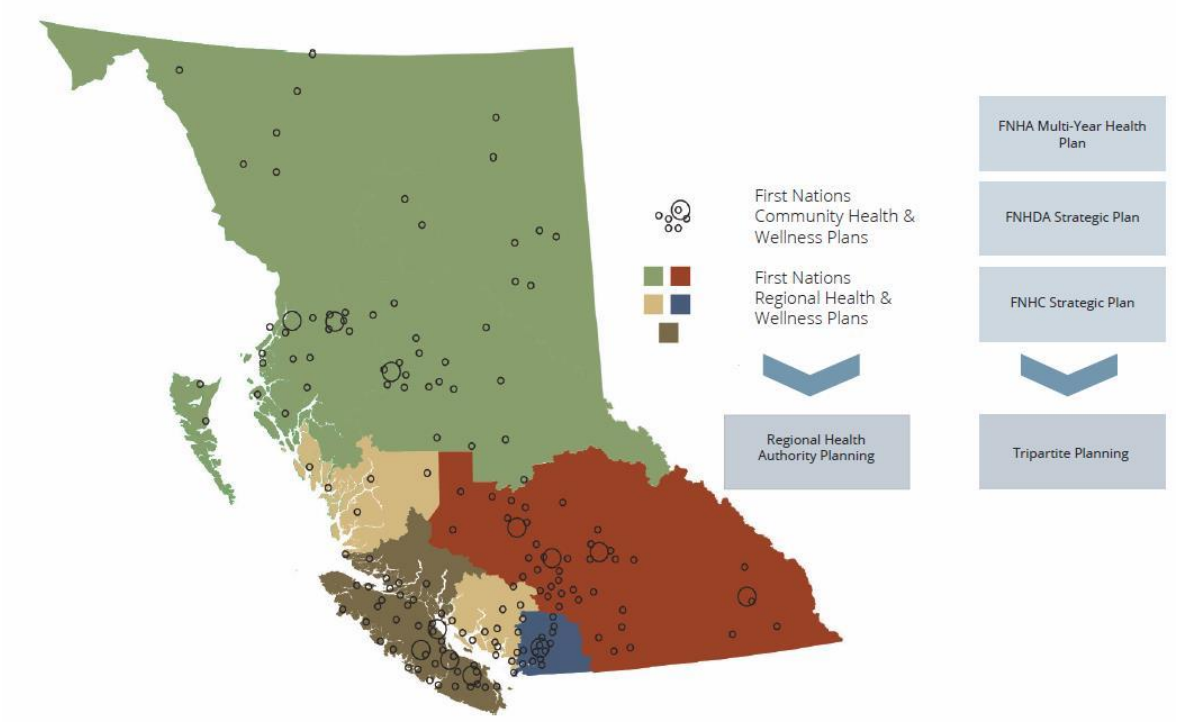


Figure 11: First Nations Planning Approach

Goal 2.1: Support effective planning at multiple levels within the region.

Objectives	2.1.1: Support communities to develop Community Health and Wellness Plans.
	2.1.2: Support subregions to develop and implement subregional workplans.
	2.1.3: Review community and sub-regional health and wellness plans and priorities to inform RHWP development and implementation.

Goal 2.2: Strengthen consistent and coordinated community engagement and communications efforts across FNHA Regional Team, FNHA, VCH and VC First Nations.

Objectives	2.2.1: Continue to uphold commitments to regional and subregional engagement structures.
	2.2.2: Collaborate efficiently with engagement partners through a joint FNHA/VCH Community Engagement Plan to ensure best use of time and resources.
	2.2.3: Maintain current information, such as on the website, in newsletters and Annual Reports, for use by communities and subregions in an accessible and useable medium.

3. Priority: Holistic Wellness and Health Service Delivery

This RWHP is grounded in the BC First Nations Perspective on Health and Wellness, which articulates a holistic, balanced, and interconnected view of health and well-being. The wisdom of this perspective guides our regional work and partnerships. All dimensions of health and wellness are important – mental, emotional, physical and spiritual.

The 14 First Nations in the Vancouver Coastal region access health services through different means, including First Nations Health Centers, VCH, FNHA, specialists, and other local and large urban center providers (see Appendix A for a list of service delivery providers and their services). Even though services may be available from providers – community members may have difficulty accessing them. This can be for a number of reasons – lack of or absence of services to meet all the community's needs; distance / transport challenges; cost; or cultural appropriateness of services.

Goal 3.1: Advance improvements in Mental Wellness and Substance use (MWSU) in VC Region.

Objectives	3.1.1: Implement the MWSU Flagship Project to address health service priorities and gaps identified by VC region.
	3.1.2: Support suicide prevention, intervention, and postvention regionally and sub-regionally.
	3.1.3: Improve mental wellness workforce development and capacity, including cultural humility for culturally safe services.

Goal 3.2: Promote holistic and innovative models of prevention and health promotion within partnerships and collaborations across the health system.

Objectives	3.2.1: Support Health Directors and staff to integrate holistic models of prevention and wellness and traditional healing into programming, including new regional and subregional service models.
	3.2.2: Review injury prevention programs and services for First Nations communities with Health Directors and develop a transformation plan.
	3.2.3: Support leadership wellness, including through screenings at regional and subregional events and wellness and lateral kindness initiatives.
	3.2.3: Collaborate with and support Physicians, nurses, maternal and child health workers and Joint Project Board teams to deliver holistic, culturally safe services with cultural humility.

Goal 3.3: Address barriers to health care access.

Objectives	3.3.1: Prioritize and implement innovative, subregional Joint Project Board initiatives.
	3.3.2: Support Health Directors to participate in regional and subregional level discussions with health partners.
	3.3.3: Support Aboriginal Patient Navigators to improve the quality of services available to First Nations/Aboriginal clients.
	3.3.4: Utilize tele-health to reduce barriers and enhance access to a variety of health services.
	3.3.5: Support First Nations communities to manage and transform their medical transportation programs and to reinvest savings into community and/or subregional health services.

Goal 3.4: Formalize service delivery arrangements for First Nations communities to support seamless service delivery.

Objectives	3.4.1: Formalize transfer of services between Vancouver Island Health/other and VCH or vice versa, where communities request support to do so.
	3.4.2: Support First Nations to formalize health agreements with health authorities where needed.

Goal 3.5: Advance the cultural humility of practitioners delivering to and the culturally safety of health services delivered for First Nations and Aboriginal peoples.

Objectives	3.5.1: Increase VCH First Nations and Aboriginal cultural competency and humility through Indigenous Cultural Competency (ICC) training, cultural days and site visits within communities.
	3.5.2: Finalize and implement the VCH First Nations and Aboriginal Culturally Competent and Responsive Strategic Framework Plan including the development of an Aboriginal HR Strategy and establishment of culturally safe pilot sites.

	3.5.3: Support the Declaration on Cultural Safety and Humility and associated TCFNH efforts.

4. Priority: Health Human Resources

Health Human Resources is a critical enabler of delivering culturally safe services and will be addressed as part of the work done in the Region by First Nations to plan and design changes to health policy and service delivery. There is a joint desire by FNHA and VCH to support communities to grow their own workforce and to generate more health workers and health professionals from First Nations in the VC region. Many communities still rely on agency nurses and contracted health professionals as they cannot recruit their own First Nations qualified staff.

A vision of more First Nations and Aboriginal physicians, dentists, pharmacists and optometrists also exists. Addressing these broader issues for more Aboriginal health professionals is a key strategy for partners at all levels, particularly the provincial level.

Goal 4.1: Increase the number of Aboriginal health professionals delivering health care services.	
Objectives	4.1.1: Collaborate with VCH to support health career promotional activities for First Nations and Aboriginal individuals.
	4.1.2: Support regional, subregional, and community First Nations and Aboriginal health career promotional activities.

Goal 4.2: Encourage First Nations and subregional service delivery providers partnerships to attract, retain and develop a high quality workforce.	
Objectives	4.2.1: Implement a MWSU workforce development capacity strategy to promote MWSU careers among youth.
	4.2.2: Encourage First Nation health centers and subregional service delivery providers to have qualified staff and to support staff to gain qualifications.
	4.2.3: Review scope, remuneration and competencies of key positions where First Nations, FNHA and VCH deliver similar services (e.g. MWSU workers, nursing, mental health, home care).
	4.2.4: Work with the FNHDA to develop and implement training and learning opportunities for the community health workforce.
	4.2.5: Work with the FNHDA to create a competency and qualifications framework for CHRs.
	4.2.6: Work with the FNHDA to create a competency and qualifications framework for CHRs.

Goal 4.3: Support partners to work with/in First Nations and sub-regional service delivery models.	
Objectives	4.3.1: Support the Coastal Family residency program and placement of physicians in First Nations communities (operated by North Shore Division of Family Practice).
	4.3.2: Work with post-secondary institutions to encourage students (especially Aboriginal students) to undertake practicum opportunities with First Nations.

5. Priority: Operational Excellence

The partners of this RHWP aim to:

- Be accountable, including through clear, regular and transparent reporting
- Make best and prudent use of available resources
- Implement appropriate competencies for key roles and responsibilities at all levels, and
- Operate with clear governance documents, policies, and procedures, including for conflict of interest and dispute resolution.

Goal 5.1: Support the development and documentation of operational Policies and Procedures for First Nations Health Centers and subregional service delivery providers.

Objectives	5.1.1: Support First Nations Health Centers and subregional service delivery providers to regularly review and update documented Policies and Procedures.
	4.1.2: Support Nations who choose to be accredited.

Goal 5.2: Promote access to sound, safe and accessible health facilities for programs and health services and subregional service delivery practitioners.

Objectives	5.2.1: Support overall transformation of the FNHA capital program.
	5.2.2: Utilize partnerships and innovative opportunities across communities and with others to support sustainable, high quality facilities in alignment with new service models.
	5.2.3: Continue to support safety and quality of existing health facilities.

Goal 5.3: Work with First Nations to develop economic and business opportunities in health care at community, subregional, and regional levels.

Objectives	5.2.1: Identify and support Nation and subregional aspirations for provision of services to off-reserve and non-First Nation community members.
	5.2.2: Work with First Nations to operate and own dental, physician, vision, pharmacy and other health practices that may generate income while providing more accessible services for their community and subregional communities.

6. Priority: Data and Research

Our success in implementing this RHWP and addressing the priorities identified above is dependent on timely access to good quality data. We prioritize data, data governance, evaluation and research as enablers of health system integration, innovation and transformation.

Goal 6.1: Support VC First Nations to participate in FNHA data, research and evaluation initiatives.

Objectives	6.1.1: Identify measurable successful indicators for the Partnership Accord commitments aligned with tripartite evaluation initiatives.
	6.1.2: Participate in the Regional Health Survey and utilize the data to support planning and investment.
	6.1.2: Support the development of wellness indicators.
	6.1.3: Ensure that collection of the "Aboriginal Identifier" is included in the planning and implementation of the new CST project comprehensive electronic health record at VCH.
	6.1.4 Implement standardization EMR in all 14 First Nations communities.

Goal 6.2: Support VC First Nations to identify their research priorities and to conduct or participate in identified research projects.

Objectives	6.2.1: Confirm BC First Nation research priorities that support RHWP implementation at community, subregional, and/or regional level.
	6.2.2: Develop research grants and partnerships ensuring community involvement in research projects.

Goal 6.3: Support for regional knowledge exchange opportunities to enhance and strengthen regional capacity in First Nations data governance.

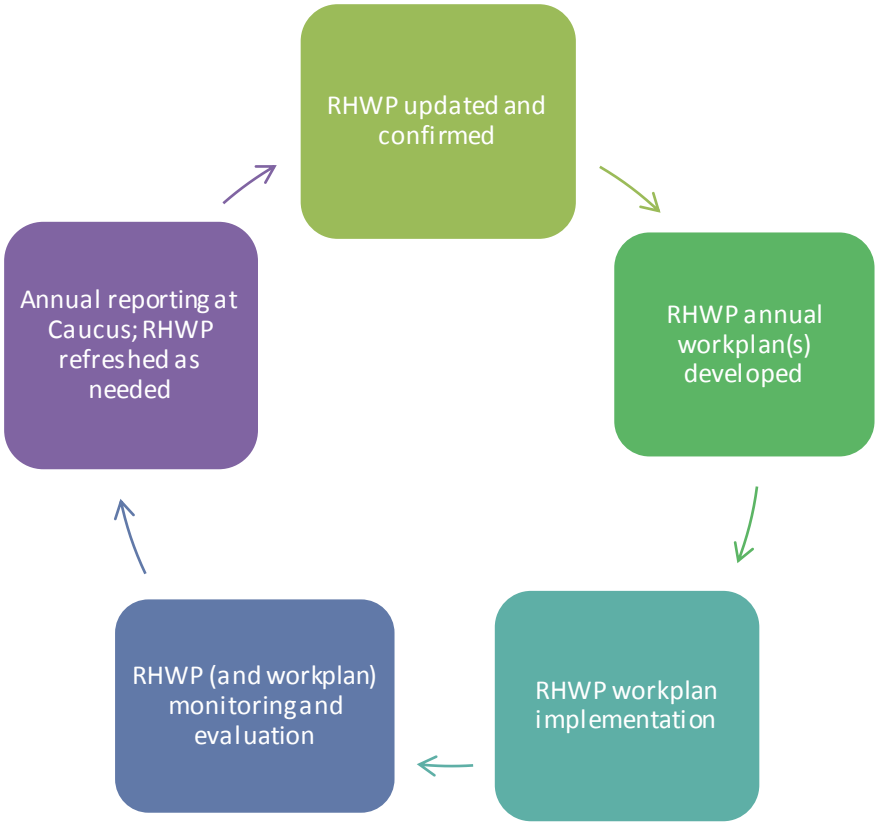
Objectives	6.2.1: Report on health status and outcomes are provided annually at Caucus to inform planning and investment.
	6.2.2: Support for knowledge exchange opportunities on research projects to support communities to learn from one another and best practices overall.

Next Steps

PLANNING, IMPLEMENTATION AND EVALUATION

Planning, implementation and evaluation of this RHWP exists in an iteratively evolving cycle. The planning cycle below attempts to show how the cycle of regional health and wellness planning works. Following the completion of this refreshed version, workplan(s) will be developed with identified actions, leads, support, and timeframes. Following or concurrent with the workplan(s) implementation monitoring and evaluation of RHWP progress will occur, with annual reporting to Caucus on RHWP progress. With caucus direction the RHWP may be refreshed regularly.

Figure 12. Vancouver Coastal RHWP Planning Cycle



Appendix A: Health Service Delivery Context and Priorities

The 14 First Nations in the Vancouver Coastal region access health services through different means:

First Nation	The Nation itself provides some programs to the community with funding from the FNHA. If they have a Flexible Contribution Agreement they are managing and delivering the programs according to their own perspectives although some elements must be mandatorily provided and cannot be ceased or changed by the Nation (e.g. communicable disease prevention). Programs delivered may include maternal / child health programs; alcohol and drug programs; some home and community care.
FNHA	Some communities (Kitasoo and Nuxalk) have not assumed full transfer of functions from the FNHA so the FNHA employed staff continue to provide some services on-Reserve through Nurses and Environmental Health Officers. Find out the full scope of FNHA services at: www.fnha.ca/what-we-do.
VCH	VCH provides some services on-Reserve but most are provided in the general community (e.g. at a local health center) or in a hospital. These may include acute / surgical care; primary care; home health; mental health and addictions (e.g. psychiatric units, detox, and addiction beds); public health programs; specialist services.
Health Practitioners	Physicians provide a range of medical and clinical services for community members. Often these are accessed by community members in the nearest township but some physicians do travel to communities to provide care in clinics and homes (e.g. fly-in Doctor for Southern Stl'atl'imx communities from Pemberton or boat-in Doctor to Kitasoo from Bella Bella). Community members are covered by MSP to access these services. More communities now have Nurse Practitioners who operate in the First Nations health centers even though they are formally VCH employees (e.g. Tla'Amin). Members also access dentists, optometrists, pharmacy and other practitioners for their health needs, and sometimes these costs are supported by the FNHA First Nations Health Benefits program.
Birthing	Some communities in the VC region do not have local birthing / maternity services (e.g. central coast) so community members are required to be flown to Vancouver or elsewhere to have their babies. Most times there is a need to support this with Patient Travel funding from the First Nations Health Benefits program which may either be managed by the Nation or by the FNHA.
Specialists	Most specialty care is available in hospitals and often community members have to travel to specialist appointments or for surgery or to see specialists for dental, eye problems, kidney and liver problems, cancer / oncology etc. Some of these specialized services are delivered by PHSA rather than VCH.

CURRENT ACCESS TO SERVICES

Even though the services may be available from the above providers – community members may have difficulty accessing them. This can be for a number of reasons – lack of or absence of services to meet all the community's needs; distance / transport challenges; cost; or cultural appropriateness of services.

Figure 1 below displays the geographic location of the fourteen communities. The circles represent health service delivery areas where Nations share health service providers or have access to health care in neighbouring communities. There are nine service delivery areas in the Vancouver Coastal region.

Each service delivery area is centered on where First Nations community members access local physicians and hospital services, or secondary care services, as well as other community-based services from the provincial system. It is important to identify these service delivery areas because they determine where service improvements need to occur.

- Heiltsuk members access services from the Hailika'as Heiltsuk Health Center, and from three physicians and various hospital and community services from Waglisla (including R. W. Large Hospital at Waglisla) operated by Vancouver Coastal Health (VCH)[1].

- Kitasoo's nearest access to physicians, hospital, and community services is in Bella Bella, approximately 80km away by ferry.

- Wuikinuxv community members access services along Pacific Coastal flight routes, which include the Port Hardy and Port McNeil hospitals, in the Island Health authority region. The visiting physician is also based at Port McNeil.

- Tla'Amin accesses services from Powell River Township including VCH's hospital and community services, and local physician care from several practices in Powell River, some members travel by ferry to Comox for health services, since this is a regular BC Ferries route and because there are historical and cultural familial relationships.

- The Squamish Nation community in the upper Squamish Valley accesses physicians from 3 main practices in Squamish Township; from VCH's Sea to Sky community services, and from Squamish General Hospital (SGH). The Squamish Nation community on the North Shore of Burrard Inlet accesses health services from the Yúustway Health Services department on-Reserve, and from North Shore physicians, VCH's Lions Gate Hospital (LGH), and community services.

- Lil'wat community members also access services from VCH's Pemberton Health Center; physicians at Pemberton and from VCH's Squamish General Hospital (SGH) and Sea to Sky community services which cover the Sea to Sky corridor.

- Musqueam community members access services from VCH's Pacific Spirit physicians and community services, as well as other South Vancouver physician practices and from Vancouver-based hospitals operated by VCH and Providence Health.

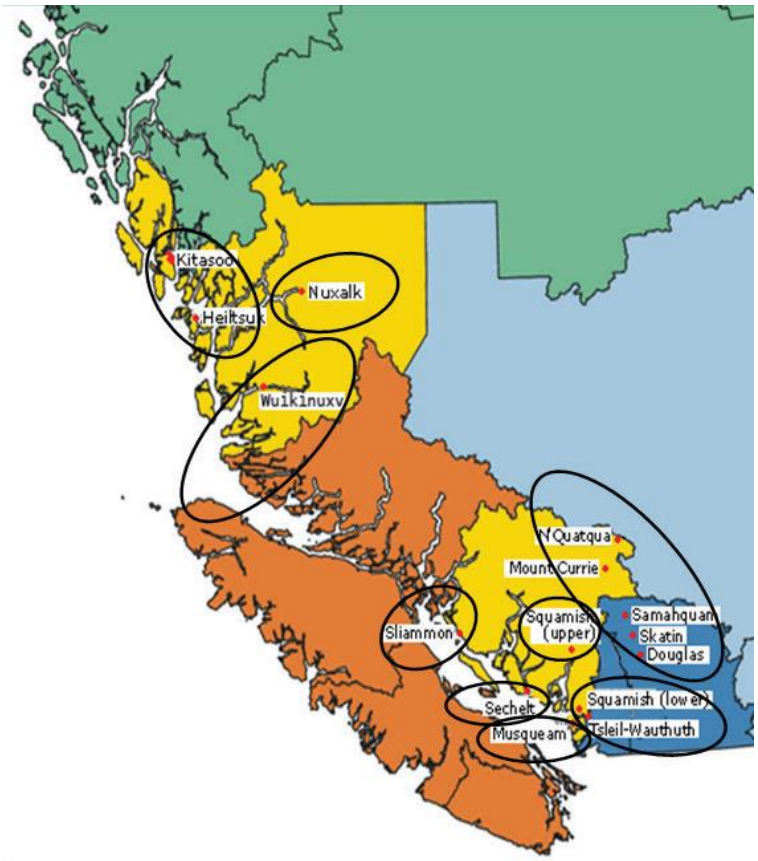
[1] VCH assumed management of these services on April 1st, 2014 from United Church Services

- Sechelt community members access services from Sechelt Township, including VCH's St. Mary's Hospital and community services, and from six physician practices including sixteen physicians in the community.

- Nuxalk members access services from Bella Coola Hospital (including community services) operated by VCH. There are also three physicians who operate from this hospital. There is no regular transport route between Bella Coola and Bella Bella.

- SSHS Community members also access services from VCH's Pemberton Health Center; physicians at Pemberton and from VCH's Squamish General Hospital (SGH) and Sea to Sky community services which cover the Sea to Sky corridor.

Figure 1: First Nations and service delivery areas in the Vancouver Coastal Region



ACCESS TO COMMUNITY-BASED SERVICES

In 2013 VCH worked with all 14 First Nations Health Directors and staff to map out the state of access to Primary Health Care services for on-Reserve communities[3] which reviewed access to:

- Mental Wellness and Substance Use services;
- Home & Community Care; Health Practitioners (physicians, nurses, pharmacy, optometry etc.);
- Health and wellness / prevention programs; and
- Family health services.

According to the findings of this review, the Health Directors identified that communities had good access to around 2/3 (68%) of the services that should be available. The most accessible services were Family Health Services (child health, women's health etc.) followed by Home and Community Care and Health Practitioners.

Health Directors identified services that were available but would benefit from aspects of quality improvement (average of 19%). The areas needing most quality improvement were in the availability of Traditional, Cultural and Spiritual Wellness supports (e.g. elders, healers, language, cultural activities) and Mental Wellness and Substance Use services. The majority of quality improvements identified include for example:

- Improving communication between service providers about patient care
- Improving referral and intake processes
- Improving the cultural competency of service delivery
- Making off-Reserve services more routinely available on Reserve through various means (mobile services coming, tele-health, visiting health professionals, reducing travel cost burden on communities)
- Ensuring after hours and weekend cover for some services not delivered by the Nation

ACCESS TO SPECIALIST / HOSPITAL SERVICES

There are concerns regarding patient discharge from hospitals and a breakdown in referral of community members back to the on-reserve health center. An area of concern was the lack of communication between physicians, hospitals, specialists and the First Nations health centers when multiple providers were treating the same person concurrently. Other areas of concern included:

- First Nations Health Benefits arose as a key issue for many Nations in the region. The former Non-Insured Health Benefit process was considered a huge barrier to community members accessing services.
- Cultural competency of VCH services also arose as a key issue for many communities. There were concerns about institutional racism and discrimination existing in some areas – and community members feeling very uncomfortable accessing and using health care services.

IDENTIFIED FIRST NATION PRIORITIES

The Feb 28, 2014 Mental Wellness and Substance Use (MWSU) Forum in Musqueaum identified top MWSU priorities to be:

a) Suicide prevention, intervention and postvention (PIP)
b) Cultural competency of MWSU services and programs (in community and in VCH)
c) Workforce development and capacity

Other priority issues related to Elder care, access to primary health care, mobile services, and integration of traditional models of wellness were all reinforced in this work. Finally the views and perspectives of First Nations to incorporate traditional models and concepts of wellness including acknowledgement of the land, family, community, and Nation (also discussed in the FNHA health and wellness model) are also a high priority.

Further, through the 2013 Primary Health Care review process (lead by VCH), Health Directors also agreed on regional priorities they wanted to address together:

- Improving and expanding mental wellness and substance use services – including counselling and support for Indian Residential School survivors and their family members;
- Injury prevention including suicide prevention and injury surveillance; and
- Smoking cessation and prevention.

Appendix B: Regional SWOC Analysis and Process Timeline

Strengths	Opportunities

• Strengthened capacity of VCH and FNHA
  ○ New VCH Director Leads
  ○ New AHSC Executive working group
  ○ VCH HR Strategy development/ implementation
• Regionalization (Regional team, regional investment strategy, refreshed Team Charter commitments)
• Access to services
• First Nations governing/management
• Guiding Elements: Shared Vision, Values, First Nations Perspective on Wellness, customer-owner philosophy
• Partner Investments: JPB projects; Mental Wellness flagship project; joint investment with VCH to implement Hope, Help and Healing Toolkit
• VCH commitment to realign AHIP/SMART funding
• RHS roll-out
• Strengthened relationships between Health Leads in communities at the sub-regional level, i.e. MOUs development underway re: working together and sharing services
	• VCH-FNHA telehealth partnership to service all communities (e.g. JPB implementation layer)
	• VCH –FNHA Consistent joint messaging
	• Wellness determinants woven throughout sub-regional plans and implementation
	• FNHA policy/program transformation is a 20 year journey
	• Sub-regional level service delivery partnership enhancement and community-level implementation/operation planning
	• Expanded services for revenue generation/subsidized service delivery for community members
	• Urban Strategy joint development
	• Engagement and partnership opportunities; development of engagement framework based on RHWP priorities
	• Cultural competency with VCH; application of Cultural Humility Framework
	• Development of FNHA-VCH MOU/protocol for crisis response
	• Tripartite commitments

Weaknesses	**Challenges**
• Timely access to good data • Data governance/evaluation measurements • Inconsistent messaging within and across FNHA and VCH • eMR process and selection • Weakened participation from Chiefs • FNHA Policy Framework – early in the transformation; managing expectations • Competition from non-First Nations for scarce services in community • Community disengagement/VCH-FNHA responsiveness to concerns/priorities	• Community spread – service access and delivery into communities; geographic factors • Broad range of community capacity • Communications and connectivity • Consistent messaging across VCH, FNHA and communities • eMR not in all communities • Consultant over-promise on behalf of VCH-FNHA • VCH-FNHA-community shared understanding of governance structure and processes/competing agendas and priorities • Communities overburdened with new process • Insufficient funding for community services • Not enough MWSU services • Jurisdictional issues for youth MWSU; involvement of MCFD

Appendix C: Glossary

AHIP: Aboriginal Health Initiative Program (a VCH health grants program)

AHOC: Aboriginal Health Operations Council

AHSC: Aboriginal Health Steering Committee

AIDS: Acquired Immuno-Deficiency Syndrome

ASCIRT: Aboriginal Suicide and Critical Incident Response Team

AWP: Aboriginal Wellness Program

CCRF: Culturally Competent and Responsive Framework

CHR: Community Health Representative

CST: Clinical and Systems Transformation

EHO: Environmental Health Officer

EMR: Electronic Medical Records

FNHA: First Nations Health Authority

FNHC: First Nations Health Council

FNHDA: First Nations Health Directors Association

FNIH/FNIHB: First Nations and Inuit Health Branch (Health Canada)

FTE: Full-Time Equivalent

GP: General Practitioner (doctor)

HC: Health Canada

HCC: Home and Community Care

HIV: Human Immuno-deficiency Virus

INAC: Indigenous and Northern Affairs Canada (formerly Indian and Northern Affairs Canada)

ICC: Indigenous Cultural Competency

IHP: Interim Health Plan

IPCC: Integrated Primary and Community Care

LPN: Licensed Practical Nurse

MCFD: Ministry of Family and Children Development (Province of BC)

MCH: Maternal and Child Health

MOA: Medical Office Assistant

MWSU: Mental Wellness and Substance Use

NP4BC: Nurse Practitioner for BC program

OCAP: Ownership, Control, Access, and Possession

PHC: Primary Health Care

PHSA: Provincial Health Services Authority

PIP: Prevention, Intervention, and Post-vention

RKEE: Research, Knowledge, Exchange, and Evaluation

RHWP: Regional Health and Wellness Plan

RN: Registered Nurse

STI: Sexually-Transmitted Infections

TFNHP: Tripartite First Nations Health Plan

VC: Vancouver Coastal

VCC: Vancouver Coastal Caucus

VCH: Vancouver Coastal Health

VIHA: Vancouver Island Health Authority

UVAHS: Urban Vancouver Aboriginal Health Strategy

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