



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

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



First Nations Health Authority
Province of British Columbia
Indigenous Services Canada

December 2019

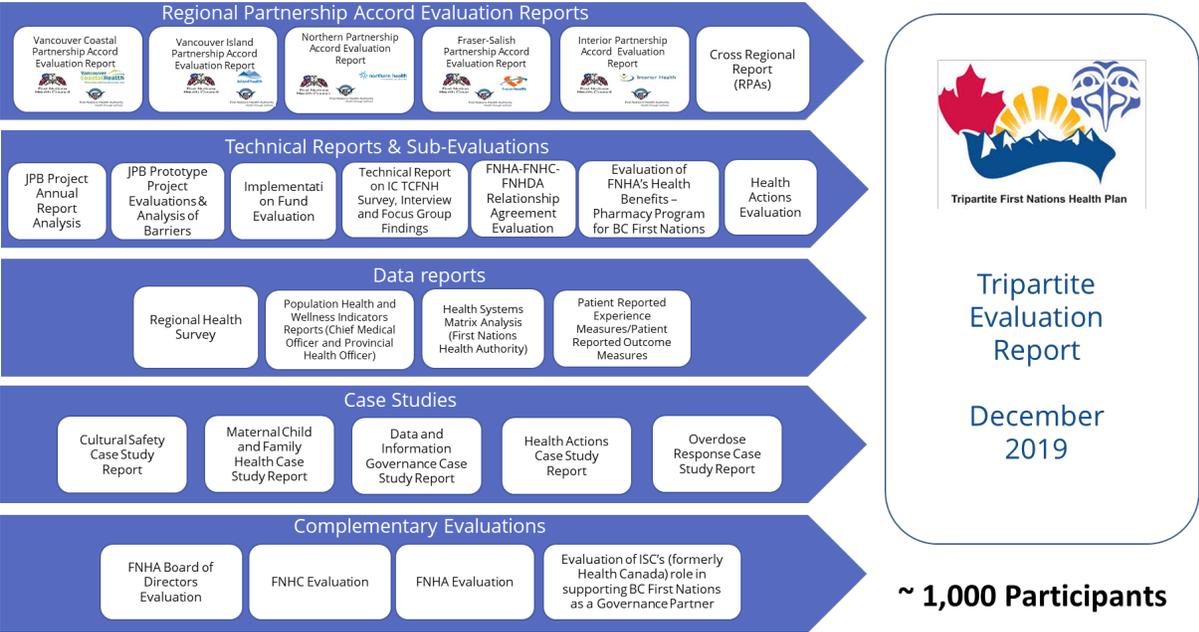
The work represented in this report is carried out on the unceded territories belonging to self-determining First Nations in what is now British Columbia. The Tripartite partners acknowledge and thank those who took the time to share their guidance and wisdom.

Emotional Trigger Warning: This report discusses culturally unsafe experiences in health care, traumatic experiences and health and wellness topics that may trigger memories of personal experiences or the experiences of friends and family. While the report's intent is to create knowledge to begin addressing these negative experiences, the content may trigger difficult feelings or thoughts. First Nations and other Indigenous peoples who require emotional support can contact the 24-hour KUU-US Crisis Line at 1-800-588-8717.

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Nature of this Report

The evaluation of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* has been a comprehensive process that has included many sub-evaluations, case studies, and data reports carried out over a number of years. Each of these reports has its own integrity as a product, including its own set of recommendations and key findings. This evaluation synthesizes relevant aspects of those individual studies into a single narrative report, as per the provisions of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* and the Tripartite Evaluation Strategy developed in 2013.



Many partners have contributed to this journey and the evaluation. Too numerous to list here, these partners work together each day to weave together reciprocally accountable relationships. In five short years, significant progress has been made to become more inclusive of First Nations decision-making and to integrate the First Nations Perspective on Health and Wellness into health care systems and services. This has established the groundwork for further change in health system performance and health and wellness outcomes.

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Acronyms

ACSC	Ambulatory Care Sensitive Conditions
FNHA	First Nations Health Authority
FNHC	First Nations Health Council
FNHDA	First Nations Health Directors Association
FNIHB	First Nations and Inuit Health Branch
FNLC	First Nations Leadership Council
FNHS	First Nations Health Society – a precursor to the FNHA
Framework Agreement	British Columbia Tripartite Framework Agreement on First Nation Health Governance
HPA	Health Partnership Accord
HSM	Health System Matrix
IC	Implementation Committee
IM/IT	Information Management and Information Technology
ISC	Indigenous Services Canada
Joint Project Board (JPB)	Joint Ministry of Health – First Nations Health Authority Project Board
KI	Key Informant (participants in the evaluation processes)
MMHA	Ministry of Mental Health and Addictions
MOH	Ministry of Health
MOU	Memorandum of Understanding
OCAP®	Ownership, Control, Access and Possession
PHO	Provincial Health Officer – BC Ministry of Health
PHSA	Provincial Health Services Authority
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
RHS	Regional Health Survey
TCA: FNHP	Transformative Change Accord: First Nations Health Plan
TCFNH	Tripartite Committee on First Nations Health
TDQSA	Tripartite Data Quality and Sharing Agreement
TEWG	Tripartite Evaluation Working Group
TFNHP	Tripartite First Nations Health Plan

Terminology

The Canadian *Constitution Act* specifies that the Aboriginal peoples of Canada include the Indian (First Nations), Inuit and Métis peoples of Canada.¹ Increasingly, the term Indigenous is being used in place of the term Aboriginal, with an analogous meaning. In this report, the terms Indigenous and Aboriginal are used as they are in the source documentation cited.

The term First Nations is used frequently within this report. This term includes individuals with and without Status under the Indian Act.²

This report utilizes a range of data sources, some of which rely on self-identification of ethnicity to identify Indigenous sub-populations, others which are based on deterministic data linkages using the First Nations Client File. As per the protocol utilized in reporting by the Office of the Provincial Health Officer (PHO) and the First Nations Health Authority (FNHA) Chief Medical Office, the term “Status First Nation” will be used in place of “Status Indian” in sections of this report that utilize the First Nations Client File, recognizing that the legal connotation of the term ‘Indian’ originates from a colonial framework.³

The terms “at-home” and “community-based” are used to refer to geographically-based First Nations communities, whether they qualify as “reserves” under the Indian Act, or whether the First Nation has signed a modern treaty or holds title to the land. The term “away from home” signifies First Nations individuals that live away from their First Nation communities.

The references to the Government of Canada’s participation in this report is sometimes referred to as “Health Canada” and sometimes as “Indigenous Services Canada.” This reflects that the work originated while the First Nations and Inuit Health Branch was within Health Canada, and was then transferred in December 2017 to a newly created federal department called Indigenous Services Canada.

¹ Government of Canada. (n.d.). *Constitution Acts 1867 to 1982*. Retrieved from: <https://laws-lois.justice.gc.ca/eng/Const/page-16.html?txthl=inuit#inc>.

² An Act to amend and consolidate the laws respecting Indians, S.C. 1876, c. 18.

³ Office of the Provincial Health Officer. (2018). *Indigenous health and well-being: Final update*. Retrieved from <http://www.fnha.ca/Documents/FNHA-PHO-Indigenous-Health-and-Well-Being-Report.pdf>.

Summary of Key Findings and Conclusions

This section outlines a set of strategic-level key findings and conclusions that have been synthesized and summarized from the many individual sub-evaluations, case studies, and data reports produced as part of the Tripartite Evaluation process. These conclusions are also embedded in appropriate chapters throughout the body of this report. For more detailed findings, we encourage engaging with the individual sub-evaluations, case studies and data reports.

Recommendations have purposefully not been included in this report. The key findings and conclusions that follow, paired with the recommendations and findings of each of the case studies and sub-evaluations will be used as a basis for further engagement with First Nations and amongst partners at various levels of the system to co-create action plans for the next step in this shared journey.

The Parties achieved successful completion of transfer of responsibility for all activities formerly performed by the FNIHB – BC Region, including headquarters functions, to the FNHA, with many lessons learned to inform others across the country. The significant complexities and challenges of the transition period were addressed through the commitment and openness of partners, disciplined negotiations processes, established tripartite success factors, dedicated funding and robust briefing/communications/engagement processes.

Strong relationships between the FNHA and federal and provincial governments, underpinned by a partnership philosophy and commitment to learning, enabled the transition. Transition is a continuing process for the FNHA in areas such as Information Management/Information Technology systems, labour relations, and evolution of organizational design such as regionalization.

The First Nations health governance structure, along with partnerships between BC First Nations and federal and provincial governments, has demonstrated reciprocal accountability and facilitated collaboration.

Strong and consistent leadership has fostered trust and relationships that are leading to innovative service models and enhanced investments. The Tripartite Partners have established tables and processes for federal and provincial governments and First Nations to come together at different levels (local, regional, provincial). These have proven effective in building relationships, establishing priorities, and addressing issues. Regional Partnership Accords have been successful in providing opportunities to come together,

strengthen relationships, discuss issues and shared priorities and collaborate on solutions. There is increased awareness across the system of the importance and need for the health system to engage with First Nations and support First Nations decision-making.

With that said, the increasing demand on the FNHA and First Nations to participate in a broad range of processes and tables at local, regional and provincial levels, runs the risk of the FNHA and First Nations being spread too thin. The relationship and alignment between all of the various components of the First Nations health governance structure can be improved by drawing clear linkages between the various components of the governance structure, particularly in terms of how issues, barriers and priorities can be resolved from local, regional, and provincial levels. There is a need to clarify roles and responsibilities, and define the right table and level to address issues, with a focus on distinguishing between political advocacy and operational tables and decisions.

The strength of partnerships, the establishment of Regional Partnership Accords, and a commitment by all partners towards cultural safety and humility has led to hardwiring the First Nations Perspective on Health and Wellness into the BC health system. The First Nations Perspective on Health and Wellness is permeating throughout the system.

As a result of work to support health systems integration and navigation and newly funded services, access to the health system and health services for First Nations in BC may be beginning to improve. However higher rates of avoidable hospitalizations among First Nations residents further suggest that access to primary care among First Nations residents is less than optimal. Momentum has been created in cultural safety and humility amongst health system partners. This is leading to action but efforts are in early stages and more work needs to be done to have it “trickle down” to improve client experience of care.

Racism in the system persists and partners need to move beyond training and education into initiatives that achieve systemic change. While there have been improvements, barriers to accessing health services persist, such as jurisdictional issues regarding service delivery in-community and away from home and Nations straddling multiple health authority boundaries.

The First Nations health governance structure is generating value through new investment.

There is new access to both federal and provincial funding that would not have been secured without the existence of the First Nations health governance structure. The existence of the FNHA at a province-wide level provides the ability to generate and release

data in a safe and ethical way, which is now driving health system planning and investment at local, regional and provincial levels.

However, some funding and resources are short-term and temporary, which creates challenges with sustainability of programming and services. There is a need to plan for and balance both organizational growth and investments at the provincial, regional and local/community levels to ensure long-term sustainability.

Flexible funding streams have been created and are complementary to existing funding sources. Existing funding allocation mechanisms primarily support at-home clients, with fewer investments supporting clients living away from home.

New service models are emerging that are improving health system access and the quality of services, through approaches such as the Joint Ministry of Health/First Nations Health Authority Project Board (Joint Project Board), Tripartite Mental Health and Wellness Memorandum of Understanding (MOU), and First Nations-led primary health care projects.

There are early signals on improvement of health outcomes; however, more progress is needed.

The First Nations health data governance has shifted the paradigm to health and wellness indicators. Reports to date reveal modest improvements in several *Transformative Change Accord: First Nations Health Plan* indicators; however, inequality between the First Nations population and other residents of BC has increased on four of the five indicators. The indicators that are showing modest improvements include: life expectancy, age standardized mortality, infant mortality and youth suicide. Improvements have not been made on diabetes rates; however, diabetes rates are going up for other residents of BC as well.

Five years is an insufficient amount of time for observable shifts in health outcomes at the population level. Transformation of health outcomes will take time and be fueled by the progress seen in governance partnerships and health system performance. Accelerating progress will require greater effort across governments and First Nations organizations on issues at the root of wellness/determinants of health.

Chapter 1 Overview of this Report

This chapter discusses the purpose, scope and methodology of this inaugural evaluation of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (Framework Agreement).

This Framework Agreement evaluation considers the effectiveness of the First Nations health governance structure and the roles and partnerships between First Nations, Canada and BC. The intention behind the Framework Agreement is shown in Box 1.

Box 1: Recital I of the Framework Agreement

The Parties wish to work together to build:

- (1) a new Health Governance Structure that avoids the creation of separate and parallel First Nation and non-First Nation health systems and in which First Nations will plan, design, manage and deliver certain health programs and services in British Columbia and undertake other health and wellness-related functions;
- (2) a more integrated health system:
 - with stronger linkages among the FNHA, First Nation Health Providers, Health Canada, the BC Ministry of Health and BC Health authorities, to better coordinate the planning, design, management and delivery of FN Health Programs so as to improve the quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs and services for First Nations;
 - that reflects the cultures and perspectives of BC First Nations and incorporates First Nations' models of wellness;
 - that embraces knowledge and facilitates discussions in respect of determinants of health in order to contribute to the design of First Nation health programs and services, and
 - in which First Nations in all regions of British Columbia will have access to quality health services at a minimum comparable to those available to other Canadians living in similar geographic locations.

The evaluation scope and methodology are presented in the remainder of this chapter.

1.1 Purpose of the Framework Agreement Evaluation

Section 10 (1) of the Framework Agreement requires that the Parties jointly evaluate the implementation of the Framework Agreement every five years. The evaluations are meant

to consider the purpose and intent of the Framework Agreement and be carried out within the wider context of the health partnership with First Nations in BC.

Section 10 (2) stipulates that an evaluation plan would be prepared within 18 months of the signing of the Framework Agreement, and sets out the data to be collected and tracked in two main categories: health indicators (including life expectancy from birth, mortality rates, information about practicing First Nations health care professionals, and any other wellness indicators to be developed); and, governance, tripartite relationships and integration (to include the effectiveness of the First Nations health governance structure, and the effectiveness of tripartite relationships).

1.2 Scope

"If people can tell stories about what success looks like and what it's been [...] if you can have a conversation about where it has happened, what it looked like, what it felt like, and the story that's wrapped around that, then you can celebrate that and also learn from that and try to incorporate it into areas where maybe it isn't happening as much." – Northern Health Authority Key Informant (KI)

The core focus of this evaluation is to assess progress against the commitments to establish a new BC First Nations health governance structure, including anticipated outcomes. The new First Nations health governance structure is meant to enable the transformation of the health system in a manner that is innovative, embodies best practice and aligns with First Nations values and ways of doing business.

A set of legal and political agreements and jointly prepared evaluation strategies and plans adopted by the Implementation Committee (IC) shaped and defined the purpose, scope, focus and design of this evaluation. These included types of information and indicators to identify, analyze and report on the IC (described further in section 3.3). The evaluation focuses on activities occurring between October 2013 and December 2018.⁴

As per the evaluation strategies and plans approved by the IC, this evaluation is organized around three themes (see Figure 1):

1. **Governance, Tripartite Relationships and Integration** - relevance, efficiency and effectiveness of the First Nations in BC health governance structure and Tripartite

⁴ To ensure this evaluation is as up to date as possible, some data were collected in the first half of 2019.

Health Partnership as set out in Framework Agreement Sections 2.2, 4, 6 and 8, and consistent with Schedule 5.

2. **Health and Wellness System Performance** - improvements in the type, volume, distribution, accessibility, quality, responsiveness and safety of programs and services for First Nations across the province.
3. **Health and Wellness Outcomes** - data and reporting on the health and wellness indicators set out in Section 10(2)(a) of the Framework Agreement and Tripartite First Nations Health Plan, as well as the newly developed Population Health and Wellness Indicators, which take a more strengths-based and wholistic perspective.

The current evaluation establishes a baseline against which future Framework Agreement evaluations can compare.

Figure 1: Main Areas of Focus for the 2019 Evaluation of the Framework Agreement

Tripartite Evaluation Report		
<p>Governance, Tripartite Relationships and Integration</p> <ul style="list-style-type: none"> ▪ Effectiveness of Tripartite Relationships ▪ Effectiveness of Governance Structure ▪ Reciprocal Accountability ▪ Meeting requirements of Sections 2.2, 4, 6 and 8 of the Framework Agreement 	<p>Health and Wellness System Performance</p> <p>Progress/improvements in:</p> <ul style="list-style-type: none"> ▪ Type ▪ Volume ▪ Distribution ▪ Accessibility ▪ Quality ▪ Responsiveness and ▪ Safety of services 	<p>Health and Wellness Outcomes</p> <ul style="list-style-type: none"> ▪ Tripartite First Nations Health Plan Indicators (7 total) ▪ Wellness Indicators (15 total) ▪ RHS Outcome Data
Immediate Outcomes	Intermediate Outcomes	Transformational Outcomes
Focus of the First Evaluation Report (2013-2018)		

Additional details, such as outcome statements, indicators, data sources and measures are laid out in the Framework Agreement Evaluation Matrix found in Appendix A⁵. The matrix was used to guide all evaluation work described in this report.

⁵ Available at <https://www.fnha.ca/about/governance-and-accountability/audits-and-evaluations>

1.3 Methodology

Oversight

The IC was created as per the provisions of the Framework Agreement and is composed of senior leadership from the FNHA, First Nations Health Council (FNHC), Ministry of Health (MOH) and ISC. The IC was responsible to oversee this evaluation, which included approving the Evaluation Strategy, reviewing the Evaluation Plan (including methodology and evaluation questions), and confirming the release process. It created a Tripartite Evaluation Working Group (TEWG) to carry out the work on a day-to-day basis.

The TEWG, comprised of representatives from the FNHA, the Province of BC and Canada (FNIHB, ISC), conducted the Framework Agreement evaluation with independent consultant support from Ference & Company, Marcia Nickerson, Praxis Management Ltd., Goss Gilroy Inc., MNP, Malatest & Associates Ltd. and Ian W. Potter Consulting.

To strengthen and validate the findings and reliability of the data, this report underwent iterative reviews by the TEWG and IC, and key findings were presented at the fall 2019 First Nations Regional Health Governance Caucuses.

Approach

The Framework Agreement evaluation followed a participatory (collaborative) approach, meaning IC and other key stakeholders – particularly for the Regional Partnership Accord evaluations – participated in the design (e.g. evaluation frameworks, matrices and data collection instruments), implementation (e.g. preferences for data gathering and coordination) and reporting (e.g. interpretation of findings and the development of conclusions and recommendations). Data collected and used in this evaluation included interviews, focus groups, a key informant survey, case studies and evaluations, and quantitative data sources.

Data Sources

Interviews, focus group and surveys

The IC/Tripartite Committee on First Nations Health (TCFNH) survey and key informant interview guides were co-developed by Ference & Company and the TEWG. Guides were tailored to key informants based on level of involvement in the committees as well as by organization (FNHA, MOH, FNIHB). Interview guides were piloted with IC/TCFNH members prior to dissemination. Interviews were conducted by Ference & Company and supported by Ian Potter Consulting. All interviews and focus groups were digitally recorded and professionally transcribed by external consultants. Each respondent was invited to validate

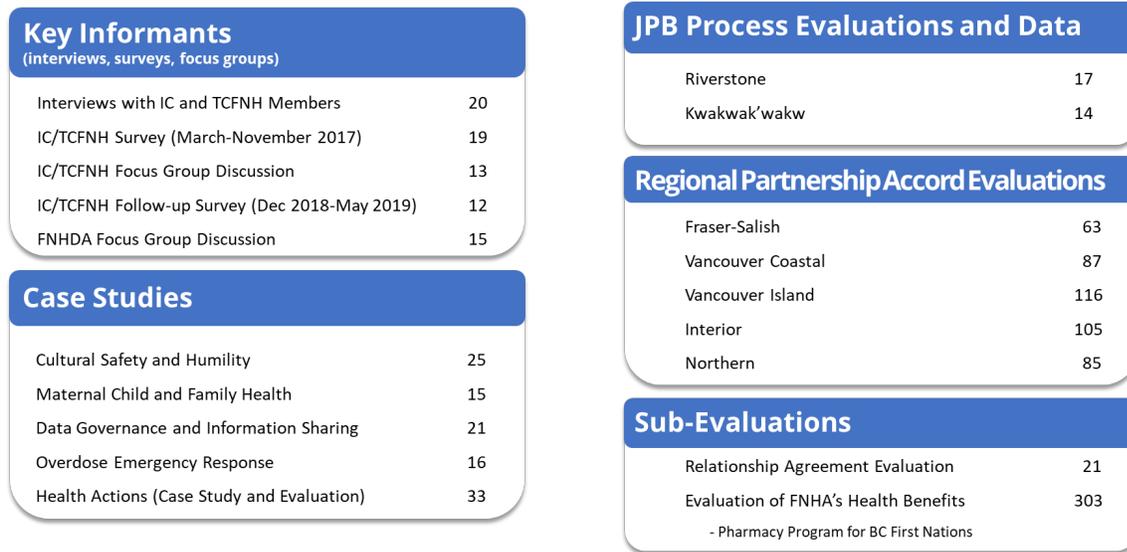
the transcript of their interview or focus group. Ference & Company analyzed the results, which were compiled into a final report and presented to the TEWG. This technical report as well as the case studies, Regional Partnership Accord evaluation reports and Joint Project Board project evaluation reports were entered into NVivo, qualitative data analysis software designed to give evaluators insights from qualitative and mixed-methods data. The software allows users to connect and thematically analyze different sources of data.

As shown in Figure 2, approximately 1,000 people participated in data collection for this report.⁶ Ference & Company and Ian Potter Consulting jointly conducted the initial survey and key informant interviews with IC/TCFNH members in 2017. The TEWG conducted a follow-up survey in 2019. Ference & Company provided further support on the Regional Partnership Accord evaluations and a Cross-Regional Technical Report and case studies that feed directly into this report.

The initial survey was administered between March and November 2017, with 19 of 35 invitees (54%) completing the survey. The follow-up survey administered between December 2018 and May 2019 had 29 invitees and 12 responses (41%) and focused on changes within the IC/TCFNH during the intervening year. Participants included representatives from the FNHC, the FNHA, the First Nations Health Directors Association (FNHDA), BC regional health authorities, MOH and the FNIHB. Follow-up focus group discussions and key informant interviews were arranged once the survey was completed, or were offered as an alternative to the survey.

⁶ The figure is approximate due to some individuals participating in more than one of the data collection methods.

Figure 2: Framework Agreement Evaluation Participants by Data Source

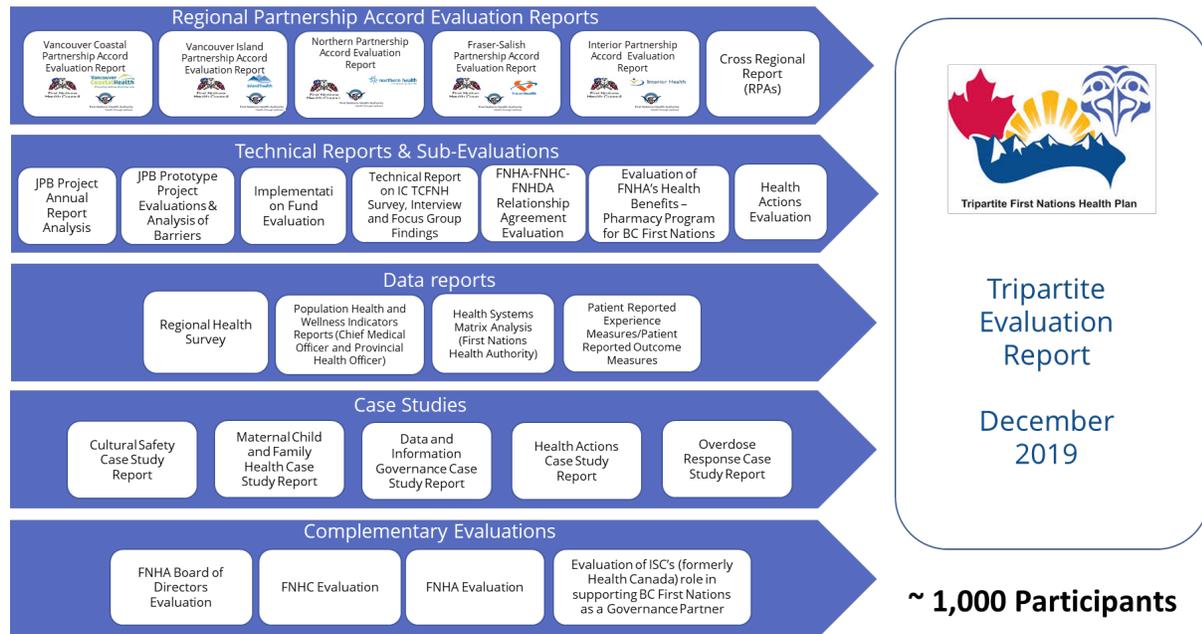


Approximately 1,000 Participants

Reporting Products

A number of reporting products were used to inform all parts of the evaluation, summarized below.

Figure 3: Tripartite Evaluation Reporting Products



Regional Partnership Accord Evaluations

The evaluation of each of the Regional Partnership Accords was led by a regional evaluation working group. Members included the relevant regional health authority, the FNHA regional team and the FNHA evaluation team, which reported to their respective regional tables depending on the regional structure. Ference & Company supported the conduct of interviews with partnership table members. All five evaluations engaged regional table representatives, FNHA/regional health authority staff, community representatives and working group members through a combination of surveys, focus groups, and interviews. Some common questions were asked across all Regional Partnership Accord evaluations; however, the approach was guided and tailored by each regional working group. Ference & Company also produced a Cross-Regional Technical Report that informed this evaluation. The total number of regional participants is included in Figure 2. Malatest and Associates completed transcriptions for all of the Partnership Accord evaluation interviews.

Evaluation of Joint Project Board Activities and Projects

Findings relating to the Joint Project Board project evaluations came from three main sources:

- 1) summary findings from Joint Project Board projects' annual reports for 2016-17 and 2017-18;
- 2) initial findings from two process evaluations of prototype projects (Riverstone Home/Mobile Detox/Daytox Program in Fraser Region and Kwakwaka'wakw Primary Maternal, Child and Family Health Collaborative Team in Vancouver Island Region); and,
- 3) a focused analysis of common barriers encountered by prototype projects.

FNHC-FNHA-FNHDA Relationship Agreement Evaluation

An FNHC-FNHA-FNHDA Steering Committee led the *FNHC-FHNA-FNHDA Relationship Agreement Evaluation*, which considers the quality and effectiveness of the relationship and its shared functions such as planning, engagement, communications, governance processes and supports. Marcia Nickerson completed this report.

Evaluation of FNHA's Health Benefits – Pharmacy Program for BC First Nations

This evaluation focuses on the FNHA's Pharmacy Program for BC First Nations with a primary focus on the transfer of drug benefits to PharmaCare Plan W in 2017. The evaluation addresses a range of topics related to effectiveness, efficiency, governance structure, risk management and controls, and implementation of Plan W. More specifically, the evaluation reviewed the planning for and implementation of Plan W, the results of the transition, opportunities for improvement, and lessons learned that should be considered

in planning for changes to other health benefits. The evaluation addresses requests from BC First Nations leadership and community for an independent evaluation of the transition to Plan W.

Case Studies

External contractors completed four of the five case studies identified by Tripartite Partners as key areas of shared work to showcase for the Framework Agreement evaluation. Contractors include Marcia Nickerson (Cultural Safety and Humility and Maternal Child Health case studies), Ference & Company (Overdose Response case study) and Praxis Consulting (Data and Information Governance case study). The internal evaluation team of the FNHA conducted the Health Actions case study, including an evaluation of Health Actions in 2014 that was conducted by MNP.

Document Review

A review of 318 documents informed the evaluation of the Framework Agreement. This included 2007-2018 meeting materials from a range of relevant committee processes, FNHA annual reports, and other pertinent documentation such as previous evaluations and data reports.

Complementary Evaluations

To date, three evaluations have been completed on topics related to the evaluation of the Framework Agreement, as well as an evaluation of the FNHA. They include:

Evaluation of the First Nations BC Tripartite Contribution Agreements 2007-08 to 2011-12

This 2013 evaluation examines Health Canada's role in the BC Tripartite Initiative in advance of the transfer of FNIHB activities to the FNHA.⁷ The two contribution agreements entered into by Health Canada and the First Nations Health Society (FNHS, a precursor to the FNHA) in this pre-transfer period totalled \$56 million. They are found to have enabled the FNHA's ability to participate in the BC Tripartite Initiative as the representative organization for all First Nations in BC and to develop capacity and evolve operations to assist in the transition towards designing, managing and delivering First Nations health programming in the province. The evaluation concludes that "consistent partnership, commitment and shared Vision of all players were instrumental to the progress made to

⁷ Health Canada & the Public Health Agency of Canada. (2013). *Evaluation of the First Nations BC Tripartite contribution agreements 2007-08 to 2011-12*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/ahc-asc/alt_formats/pdf/performance/eval/2012/bc-tripartite-evaluation-cb-eng.pdf

date.” The Government of Canada’s internal evaluation department conducted this evaluation.

Evaluation of Health Canada’s Role in Supporting the First Nations Health Authority as a Governance Partner

This 2017 evaluation focuses on the role Health Canada took as governance partner in supporting the FNHA during the period after the transfer of responsibilities from the FNIHB to the FNHA in October 2013.⁸ The evaluation concluded that Health Canada’s role was to “facilitate access to, and relationships with, other federal departments and agencies” and to continue to administer the Non-Insured Health Benefits Program until the transition to BC Pharmacare Plan W on October 1, 2017. The evaluation revealed “a high level of satisfaction with [Health Canada] in supporting the FNHA,” and that Health Canada had adhered to the concept of reciprocal accountability that is woven into the Framework Agreement. Health Canada actively participated in governance discussions and facilitated new relationships between the Tripartite Partners and other federal departments and stakeholders. Health Canada’s participation was increasingly through informal channels as relationships strengthened over time. The Government of Canada’s internal evaluation department conducted this evaluation.

The FNHA Implementation Fund Evaluation

The FNHA commissioned an independent evaluation of the Implementation Fund to examine the one-time \$17 million in funding extended to the FNHA for costs associated with the transfer and transition of the FNIHB to the FNHA. The evaluation found that the fund was critical in supporting key costs pre-transfer, but did not meet all transition costs and requirements, primarily in the areas of Information Management and Information Technology (IM/IT) (\$11.6 million of the fund was dedicated to IM/IT, far in excess of the \$4.5 initially projected). The flexibility of the fund was vital in allowing the FNHA to reallocate resources toward IM/IT needs; this was also facilitated by the Canada Funding Agreement coming into effect, which provided base funding that enabled the FNHA to absorb other transition-related costs (for example, communications). The evaluation found staff dedication a critical and “uncosted” factor leading into transfer. The timeline of the fund was challenging, and although the full-allocated expenditure timeline was used, there

⁸ Public Health Agency of Canada. (2017). *Evaluation of Health Canada's role in supporting BC First Nations Health Authority as a governance partner*. Retrieved from <https://www.canada.ca/en/public-health/corporate/transparency/corporate-management-reporting/evaluation/health-canada-role-supporting-british-columbia-first-nations-health-authority-governance-partner.html>.

was insufficient time for such a young organization to identify the most appropriate systems solutions. Marcia Nickerson conducted this evaluation.

The First Nations Health Authority Evaluation

The Framework Agreement [Schedule 1 (CF 8)] commits to five-year evaluations of the FNHA, the first of which has been conducted concurrently with the Tripartite Evaluation. The FNHA Evaluation reviews the FNHA's plans and programs, organizational structure and organizational effectiveness, the management of First Nation health provider relationships and health benefit provider relationships. Goss Gilroy Ltd. conducted this evaluation.

Quantitative Data

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

Evaluation Strengths and Limitations

Two particular strengths of this evaluation are the use of multiple lines of evidence to triangulate findings and increase data reliability, and the co-creation of data collection tools.

Potential for bias from informants still exists despite multiple lines of evidence. Sampling for focus groups and interviews was purposive, and not all those invited to participate did so. As such, results may not represent all views of all IC/TCFNH members, FNIHB, MOH or FNHA, FNHC or FNHDA members, First Nations communities or individuals. In addition, retrospective bias may be present given that participants were asked to look back in time and discuss certain events and circumstances based on their recollections. Bias may exist wherein the perspectives of individuals no longer involved in this work vary from those who were available to participate in evaluation activities. This was minimized by attempting to reach out to some individuals involved in the work regardless of whether they were presently involved.

The large scope and complexity of the evaluation in and of itself represents a limitation. Data collection, analysis and writing were conducted by a team of FNHA evaluation staff and external contractors in partnership with the TEWG. Each analyst's experiences and perspectives can contribute to bias in qualitative research. Because no single individual was involved in all sub-projects feeding into this report, some trends and gaps may be missing. Validation with the TEWG and review by analysts and Steering Committee members consistently involved in the work attempted to minimize this bias.

1.4 Report Structure

Considering this is the first evaluation of the Framework Agreement (future evaluations will occur every five years), **Chapter 2** “Arriving at the Framework Agreement”, describes the sequence of events that took place to: establish a new health partnership; establish a series of key political and legal agreements (including the Framework Agreement); and, build consensus among BC First Nations to create a new First Nations health governance structure.

The Framework Agreement committed the Parties to transfer from the FNIHB to the FNHA responsibility for all activities formerly performed by the FNIHB BC Region, as well as headquarters functions such as policy development and strategic planning and services. **Chapter 3** describes the implementation process culminating in a two-phased transfer in 2013.

The four component entities of the First Nations health governance structure – the FNHC, the FNHA, FNHDA and TCFNH – were envisaged as supporting greater involvement of First Nations in the planning, design, management and delivery of health services to First Nations in BC while maintaining appropriate distinction between roles and functions. **Chapter 4** presents evaluation findings around how each entity has fulfilled its mandate, and considers the effectiveness and maturation of the First Nations health governance structure as a whole.

Chapter 5 considers how both the First Nations Perspective on Health and Wellness and the FNHA itself have been embedded throughout the provincial health system, including examining the partnerships formed with entities and organizations beyond those initially envisioned in the Framework Agreement. **Chapter 6** explores how the creation of the new governance structure and its “hardwiring” into the provincial health system has improved the performance of the health system in areas such as cultural safety, responsiveness, accessibility and experiences of care for First Nations.

Chapter 7 presents information about the health and wellness outcomes called for under Section 10 (2) of the Framework Agreement. It explores the currently available performance indicators and data relating to health and wellness outcomes, as well as the newly developed Population Health and Wellness Agenda that includes indicators that take a more strengths-based and wholistic perspective.

Finally, **Chapter 8** provides a short conclusion and a summary of the key findings of the evaluation in the three categories of the Tripartite Evaluation Plan: Governance, Tripartite Relationships and Integration; Health and Wellness System Performance; and, Health and

Wellness Outcomes. The **Appendices**⁹ include a spiral and linear logic model that depicts the primary enablers, inputs, activities and outputs that correspond to the Tripartite Partners' shared Vision for health system change. Appendices also provide detailed information regarding the Framework Agreement evaluation, including the formal evaluation commitments, evaluation matrix, plan, data collection tools, data sources and reporting products.

⁹ See <https://www.fnha.ca/about/governance-and-accountability/audits-and-evaluations>

Chapter 2 Arriving at the Framework Agreement

This chapter provides the broad context for First Nations health transformation in British Columbia, including an overview of the shared perspective of health and wellness amongst BC First Nations, the intentional disruption of this perspective through the policies and processes of colonialism, and the resulting issues and inequities that spurred the movement to create a new tripartite health partnership and First Nations health governance structure in BC. The chapter also describes the sequence of events that took place to establish a new health partnership between BC First Nations and federal and provincial governments, establish a series of key political and legal agreements (including the Framework Agreement), and build consensus among BC First Nations to create a new First Nations health governance structure.

2.1 Background

First Nations in BC are exceptionally diverse, with Nations and residents spread across a vast geographic area, holding different languages, histories, cultural expressions and traditions. Despite this diversity, these Nations share a common health and wellness worldview that is wholistic and focuses on achieving a balance between key dimensions of health and wellness, including the spirit, mind, body and relationship with land, community and all creation.^{10,11,12} Connections to ancestors, future generations and to all living beings underpin this wholistic perspective.

"We are connected to everything around us as a principle, whether that connectedness is through the four-legged, the winged ones, the water, all of those things that non-First Nations people see as inanimate. We see as alive and full of spirit. That's why we're here. If we die today, all the two-legged on this part of the world, those things would thrive actually. They can live without us, but we can't live without them. So those kinds of principles are really important when we begin to talk about, as we move forward in this issue of our health because

¹⁰ Hill, L.P. (2008). Understanding Indigenous Canadian traditional health and healing. *Theses and Dissertations (Comprehensive)*. Retrieved from <http://scholars.wlu.ca/etd/1050>

¹¹ First Nations Health Council. (2017). *Social determinants of health discussion guide*. Retrieved from <http://fnhc.ca/wp-content/uploads/FNHC-Discussion-Paper-Ten-Year-Determinants-of-Health-Strategy.pdf>

¹² First Nations Health Authority. (2014). *Traditional wellness strategic framework*. Retrieved from <https://www.fnha.ca/what-we-do/traditional-healing/traditional-wellness-strategic-framework>

our health is not just the physical health, it's the mental, emotional and spiritual.”¹³

Honouring wisdom, respect, responsibility and relationship in connection with the land are vital components to achieving optimal health and wellness. First Nations have enjoyed time-honoured traditions for relating with one another based on culture and ceremony.^{14,15} Cultural teachings and the use of traditional languages, foods, art, land-based activities and medicines are the basis of healing and wellness practices that strengthen body, spirit, community and cultural connections.¹⁶

The First Nations Perspective on Health and Wellness (Figure 4) portrays an interconnected and relational worldview of wellness.¹⁷ The image was developed by the FNHA, based on engagement with First Nations leaders, Elders, and cultural healers in BC, and informed by research into other models of health and wellness and participation from federal and provincial partners. It depicts the interconnection between individual human beings, their internal and external teachings and contexts, and the broader social, economic, cultural and environmental determinants of health and wellness.

¹³ O'Neil, J., Gallagher, J., Wylie, L., Bingham, B., Lavoie, J., Alcock, D., & Johnson, H. (2016). Transforming First Nations health governance in British Columbia. *International Journal of Health Governance*, 21(4), 229-244. Retrieved from <https://www.emerald.com/insight/content/doi/10.1108/IJHG-08-2016-0042/full/html>

¹⁴ First Nations Health Authority. (2013). *Our story: The made-in-BC Tripartite health transformation journey*. Retrieved from <https://www.fnha.ca/about/news-and-events/news/our-story-the-made-in-bc-tripartite-health-transformation-journey>

¹⁵ First Nations Health Council. (2011). *Implementing the vision: BC First Nations health governance*. Retrieved from http://www.fnha.ca/Documents/FNHC_Health_Governance_Book.pdf

¹⁶ First Nations Health Authority. (2019). *Traditional healing*. Retrieved from <http://www.fnha.ca/what-we-do/traditional-healing>

¹⁷ First Nations Health Authority. (2019). *First Nations Perspective on Health and Wellness*. Retrieved from <https://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/first-nations-perspective-on-wellness>

Figure 4: BC First Nations Perspective on Health and Wellness



Health outcome inequities between First Nations people in BC and other residents are rooted in the forcible interruption of the well-being of First Nations people through colonial policy measures designed to “get rid of the Indian problem,”¹⁸ including prohibiting First Nations’ personal and collective self-determination, dispossessing First Nations from the environments that enabled them to flourish, and disrupting cultural, community, and familial connections that supported First Nations’ mental, emotional, physical and spiritual security.¹⁹

For many decades, BC First Nations leadership has fought for change through direct action, court cases, and negotiations to acknowledge their title and rights. This created an opportunity to develop a new relationship between BC First Nations, federal and provincial governments, including a new tripartite health partnership, marked by a series of health plans and agreements including the Framework Agreement.

¹⁸ Stated by Duncan Campbell Scott, who in his civil servant role as deputy superintendent of the Department of Indian Affairs and one of several commissioners for Treaty 9, supported the complete assimilation of Indigenous peoples into non-Indigenous society by way of the residential school system.

¹⁹ First Nations Health Authority. (2017). *2017/2018 FNHA summary service plan*. Retrieved from <http://www.fnha.ca/Documents/FNHA-Summary-Service-Plan-2017-2018.pdf>

2.2 Origins of the Tripartite Relationship

This section describes the efforts, key events and agreements, and important decisions that led to the Framework Agreement and subsequent transfer of responsibility from the FNIHB BC Region and associated headquarters functions to the FNHA in 2013.

The Health and Well-being of Aboriginal People in British Columbia, the 2001 report of the Provincial Health Officer (PHO), highlighted the significant gaps in health outcomes and access for Aboriginal people compared to the rest of the BC population. It also reported a lack of integration of health programs and services stemming from the constitutional division of powers related to health and to First Nations. The report recognized the importance of including First Nations as full partners in the design and delivery of health programs and services.

The 2004 Supreme Court of Canada decisions on *Haida Nation v. British Columbia* and *Taku River Tlingit First Nation v. British Columbia*, clarified the roles, responsibilities and duty of the Crown to consult and accommodate First Nations when government decisions may infringe upon their title and rights. BC First Nations recognized that these decisions provided an important opportunity for progress on First Nations title and rights issues, best achieved through unity among themselves.²⁰ The Province of BC also recognized the need for a new relationship with BC First Nations.

The three First Nations political organizations – the First Nations Summit, the Union of BC Indian Chiefs and the BC Assembly of First Nations – provided leadership for the unity movement, formalized in the joint signing of the *First Nations Leadership Accord*²¹ in **March 2005**. The Accord committed the Parties to “a cooperative working relationship...to politically represent the interests of First Nations in British Columbia and develop strategies and actions to bring about significant and substantive changes to government policy that benefit all First Nations.” The three political organizations agreed to work together through a First Nations Leadership Council (FNLC) made up of their respective executives, to implement the Accord’s agenda.

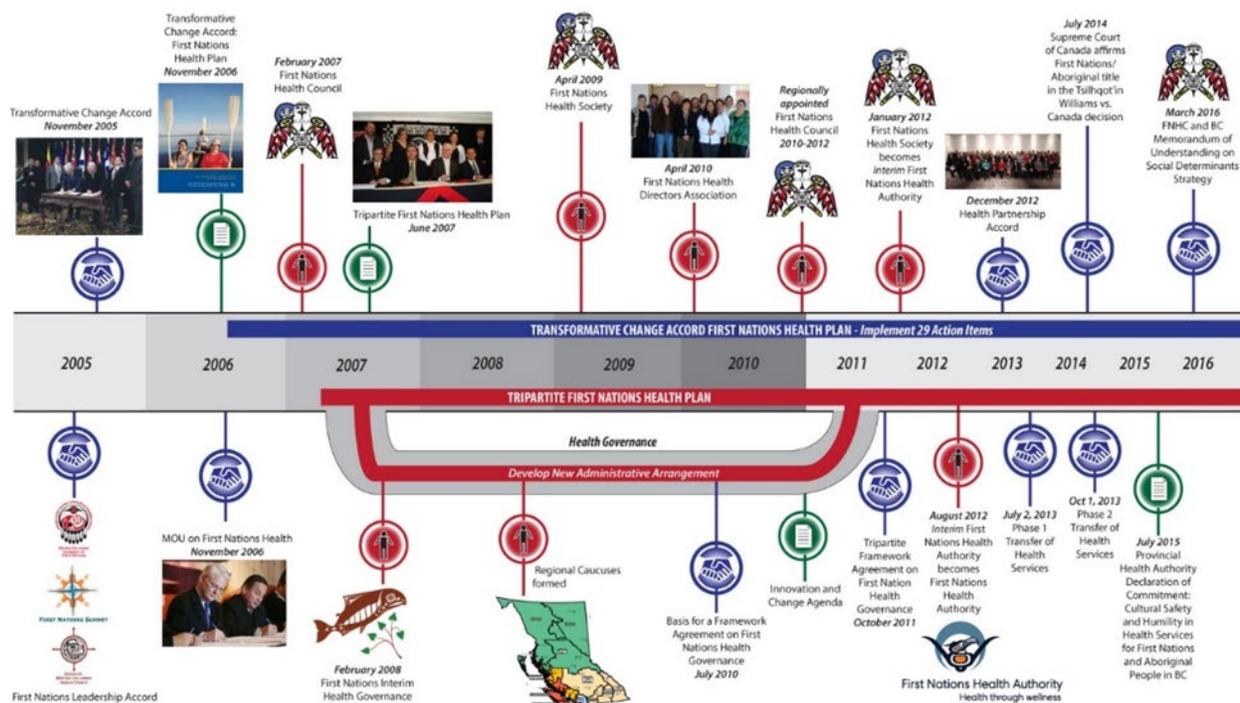
The FNLC and the provincial government jointly developed the New Relationship document, released in **May 2005**. The New Relationship outlined a government-to-

²⁰ First Nations Health Authority. (2013). *Our story: The made-in-BC Tripartite health transformation journey*. Retrieved from <https://www.fnha.ca/about/news-and-events/news/our-story-the-made-in-bc-tripartite-health-transformation-journey>

²¹ Assembly of First Nations BC Region, First Nations Summit, & Union of British Columbia Indian Chiefs. (2005). *Leadership Accord*. Retrieved from <https://bcafn.ca/leadership-council/leadership-accord/>

government relationship based on respect, recognition and accommodation of Aboriginal title and rights.²² It committed to action plans to establish processes and institutions for shared decision-making about lands and resources, revenue and benefit sharing, and achieving strong governments, social justice and economic self-sufficiency for First Nations.²³ The FNLC and the *First Nations Leadership Accord* represented the first steps in the journey toward the full realization of First Nations health governance in BC, as shown in Figure 5.

Figure 5: First Nations Health Governance Journey in BC



Simultaneously, efforts were taking place across the country to prepare for a First Ministers Meeting on Aboriginal Affairs. To prepare for this historic meeting, with detailed input from BC First Nations,²⁴ the FNLC finalized the *First Nations Health Blueprint for British Columbia* (not appearing in Figure 5) in **July 2005**. Finding a serious lack of access to existing health

²² Government of British Columbia. (2005). *The New Relationship Accord*. Retrieved from: https://www2.gov.bc.ca/assets/gov/environment/natural-resource-stewardship/consulting-with-first-nations/agreements/other-docs/new_relationship_accord.pdf

²³ First Nations Health Authority. (2013). *Our story: The made-in-BC Tripartite health transformation journey*. Retrieved from <https://www.fnha.ca/about/news-and-events/news/our-story-the-made-in-bc-tripartite-health-transformation-journey>

²⁴ First Nations Health Authority. (2013). *Our story: The made-in-BC Tripartite health transformation journey*. Retrieved from <https://www.fnha.ca/about/news-and-events/news/our-story-the-made-in-bc-tripartite-health-transformation-journey>

services, particularly in rural and remote areas, the Blueprint identified a new Vision and approach for health service delivery and access to contribute towards improvement of the overall health and well-being of First Nations in BC, “chart[ing] a path towards the reduction of disparities with other Canadians, through defining and strengthening the First Nations health sector and the concepts of self-determination, partnership, and cultural values and practices.”²⁵

The First Ministers Meeting on Aboriginal Affairs in **November 2005** between Prime Minister Paul Martin, Aboriginal Leaders and premiers from across Canada was a significant political event, with a public commitment to strengthen relationships between government and Indigenous people in Canada, and to reduce disparities. The resulting *Kelowna Accord* set out a number of measures as well as an agreement to work together;²⁶ however, the agreement was ultimately not supported following the **2006** federal election.²⁷ During this 2005 First Ministers Meeting, the Government of BC, the Government of Canada and the FNLC negotiated and signed a made-in-BC *Transformative Change Accord* (TCA), committing the Parties to develop 10-year action plans in five key areas (relationships, education, housing and infrastructure, health, and economic opportunities) to address and close social and economic gaps between First Nations and other BC residents.²⁸

“We all agreed that the status quo wasn’t working, that it was creating a parallel system that operated in silos, and there were gaps [...] by working and supporting one another, we’ve been able to overcome these things. Mostly with the First Nations, of course, in the lead on this work; and establishing a Vision that moves us from a traditional, historical, ‘we’re stuck in the past’, to something where we’re seeing First Nations in BC actually manage and deliver their health services.” – FNIHB Key Informant (KI)

²⁵ BC First Nations Leadership Council. (2015). *First Nations health blueprint for British Columbia*. Retrieved from <http://www.fnha.ca/Documents/HBprintBC150705.pdf>

²⁶ First Ministers and National Aboriginal Leaders. (2005). *First Ministers and National Aboriginal Leaders: Strengthening relationships and closing the gap*. Retrieved from <http://caid.ca/Kelowna2005.pdf>

²⁷ First Nations Health Authority. (2013). *Our story: The made-in-BC Tripartite health transformation journey*. Retrieved from <https://www.fnha.ca/about/news-and-events/news/our-story-the-made-in-bc-tripartite-health-transformation-journey>

²⁸ Government of British Columbia, Government of Canada, & The Leadership Council. (2005). *Transformative change accord*. Retrieved from https://www.fnha.ca/Documents/transformative_change_accord.pdf

During the period surrounding the 2006 federal election, the FNLC and the Province of BC advanced their TCA commitments on a bilateral basis, selecting health as the first area in which to develop a 10-year action plan. The *Transformative Change Accord: First Nations Health Plan* (TCA: FNHP) was released **November 26, 2006** by the FNLC and the Province.²⁹ This set out 29 “health actions” intended to close gaps in health status between First Nations people and other British Columbians, organized around four health areas: governance, relationships and accountability; health promotion / disease and injury prevention; health services; and performance tracking.³⁰

At the same time, the federal government confirmed an interest to follow-through on its TCA commitments. Therefore, on **November 27, 2006**, the FNLC, Province of BC and Governments of BC and Canada signed a *First Nations Health Plan Memorandum of Understanding* (MOU), which committed the signatories to develop and implement “a Tripartite ten-year First Nations health plan” using the TCA: FNHP as its framework.³¹

In **February 2007**, as per the commitments in the TCA: FNHP, the FNLC established the FNHC as a provincial-level political leadership and advocacy organization representative of, and accountable to, First Nations in BC, to implement the TCA: FNHP and the 2006 MOU. FNHC representatives were appointed by the FNLC member organizations to mirror the composition of the FNLC: First Nations Summit (three appointees), the Union of BC Indian Chiefs (three appointees) and the BC Assembly of First Nations (one appointee). The first Gathering Wisdom for a Shared Journey – a provincial health conference hosted by the FNHC – was held in **2007** to solicit guidance from First Nations on the implementation of the health agreements.

As committed in the MOU, the FNLC, Government of Canada and Government of British Columbia built upon the TCA: FNHP in releasing the ten-year *Tripartite First Nations Health Plan* (TFNHP) in **June 2007**.³² This plan charted a broad tripartite Vision of an interconnected and integrated health system for First Nations, founded in First Nations

²⁹ First Nations Health Council, Government of Canada, & Government of British Columbia. (2010). *British Columbia Tripartite First Nations health: Basis for a framework agreement on health governance*. Retrieved from http://publications.gc.ca/collections/collection_2013/sc-hc/H34-266-2010-eng.pdf

³⁰ BC Assembly of First Nations, First Nations Summit, Union of British Columbia Indian Chiefs, & Province of British Columbia. (2006). *The transformative change accord: First Nations health plan - supporting the health and wellness of First Nations in British Columbia*. Retrieved from https://www.health.gov.bc.ca/library/publications/year/2006/first_nations_health_implementation_plan.pdf

³¹ First Nations Leadership Council, Government of Canada, & Government of British Columbia. (2006). *First Nations health plan: Memorandum of Understanding*. Retrieved from http://www.fnha.ca/Documents/TFNHP_MOU.pdf

³² First Nations Health Council, Government of Canada, & Government of British Columbia. (2010). *British Columbia Tripartite First Nations health: Basis for a framework agreement on health governance*. Retrieved from http://publications.gc.ca/collections/collection_2013/sc-hc/H34-266-2010-eng.pdf

participation in decision-making. The TFNHP endorsed all of the actions committed to in the TCA: FNHP and introduced a new set of work on First Nations health governance. This included the establishment of entities such as a professional association for Health Directors, affirming the role of the FNHC, creating a First Nations health advisory committee inclusive of health system decision-makers, and a commitment to develop a plan to transfer the design, management and delivery of federal health services for First Nations in BC to a First Nations health governing body.

To advance this new governance stream of work in the TFNHP, the FNHC and FNLC created the First Nations Interim Health Governance Committee in **February 2008** to “provide leadership in Governance, Relationships and Accountability within the TFNHP [...] to lead work on behalf of the FNHC and First Nation communities in the province [...] and] participate in a Tripartite committee process to develop a new structure for the governance of First Nations health services.”³³ The committee was comprised of one FNHC representative, one representative from each political organization making up the FNLC, one political member from each BC health region (Northern, Interior, Vancouver Coastal, Fraser and Vancouver Island), with senior managers working on social determinants of health and senior technical advice and support as required.³⁴ The First Nations Interim Health Governance Committee Terms of Reference were set forth on **September 22, 2008** to guide this work. Five Regional Health Governance Caucuses (for each of the health regions) were convened in **2008** to provide a forum for dialogue and mandate setting amongst First Nations leadership for health governance reform.

In **April 2009** the First Nations Health Society (a non-profit society and predecessor to the FNHA)^{35,36} was created to serve as the operational arm of the FNHC. The FNHC served as members of this new non-profit Society and through this role appointed a Board of Directors to oversee operations, financial and staffing matters.

As part of the set of commitments outlined in the TFNHP, the First Nations Health Directors Association (FNHDA) was registered as a legal entity in **April 2010**, accomplishing a long-held goal of many First Nations Health Directors in BC of building a better health system

³³ First Nations Health Council. (2008). *First Nations interim health governance committee: Terms of reference*. Retrieved from http://www.fnhc.ca/pdf/Terms_of_Reference_FNIHGC.pdf

³⁴ First Nations Health Council. (2008). *First Nations interim health governance committee: Terms of reference*. Retrieved from http://www.fnhc.ca/pdf/Terms_of_Reference_FNIHGC.pdf

³⁵ A society under the BC Society Act, R.S.B.C. 1996, c. 433. Retrieved from http://www.bclaws.ca/civix/document/id/consol17/consol17/00_96433_01

³⁶ First Nations Health Directors Association & First Nations Health Authority. (2012). *Memorandum of Understanding*. Retrieved from <http://fnhda.ca/wp-content/uploads/2016/04/MOU-signed-FNHDA-FNHA-Nov-2012.pdf>

from the ground up.³⁷ The FNHDA was designed to support Health Directors and managers working in First Nations in BC through education, knowledge transfer, professional development and best practices; and to act as a technical advisory body to the FNHC and the FNHA on research, policy, program planning and design, as well as health plan implementation.

“Before this initiative, having First Nations and the Province and the federal government sitting around the same table to discuss First Nations health issues in this way, would have never happened. And that in itself is a really, really huge success. I think the level of commitment and the type of collaboration that has happened in BC, it’s really unprecedented.” – FNIHB KI

On **July 26, 2010**, the *Basis for a Framework Agreement on First Nations Health Governance* (or Basis Agreement) was signed by the FNHC, Government of Canada and Government of BC.³⁸ This was informed by the work of the First Nations Interim Health Governance Committee and extensive engagement through Regional Caucuses, as well as processes of mandating what federal and provincial governments did within their own systems. The Basis Agreement provided “the basic commitments and processes necessary to develop a new administrative arrangement for the delivery of existing federal health services that uniquely reflects the cultures and Indigenous perspectives of BC First Nations and that is founded on a First Nations definition of health and wellness.”³⁹ It confirmed that the Parties would “continue to be engaged in tripartite negotiations to further develop, identify, and outline the commitments, and processes necessary for the creation of a new FNHA, and the other three components of the new First Nations health governance structure, consistent with the vision, principles, and objectives identified in the TFNHP.”⁴⁰ This detailed, non-binding political agreement outlined the agenda for negotiation of a legal agreement to enable a new FNHA to take over programs, services, functions, and activities of the FNIHB as well as any other functions.⁴¹

³⁷ First Nations Health Directors Association. (2018). *Our history*. Retrieved at <http://fnhda.ca/about/our-history/>

³⁸ Reached as a “Political Agreement” during February 2010. First Nations Health Council. (2011). *Implementing the vision: BC First Nations Health Council*. Retrieved from http://www.fnha.ca/Documents/FNHC_Health_Governance_Book.pdf

³⁹ First Nations Health Council, Minister of Health, Minister of Health Services, & Minister of Healthy Living and Sport. (2010). *British Columbia Tripartite First Nations health: Basis for a framework agreement on health governance*. Retrieved from http://publications.gc.ca/collections/collection_2013/sc-hc/H34-266-2010-eng.pdf

⁴⁰ First Nations Health Council, Minister of Health, Minister of Health Services, & Minister of Healthy Living and Sport. (2010). *British Columbia Tripartite First Nations health: Basis for a framework agreement on health governance*. Retrieved from http://publications.gc.ca/collections/collection_2013/sc-hc/H34-266-2010-eng.pdf

⁴¹ First Nations Health Council. (n.d). *Basis for a framework agreement presentation*. Retrieved from http://www.fnhc.ca/pdf/TAB_5- Communiqué-Health_Directors- Learning_Circles.pdf

The Basis Agreement then served as the platform to negotiate the legally binding *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (Framework Agreement). This involved extensive processes of negotiations amongst the Parties, with each Party undertaking its own internal mandating, briefing, and approval processes. The Parties also assisted one another with those approval processes, with FNHC and FNHS representatives briefing senior officials in Ottawa and Victoria, and federal and provincial officials making themselves available to support First Nations engagement.

The process of mandating and approval amongst First Nations for the Framework Agreement was extensive and unprecedented. Within what is now BC, there are 26 cultural groups, 34 languages and over 200 First Nations. The ability of First Nations in BC to unify and collaborate in light of linguistic, geographical and historical diversity is recognized as vital to the development of the Framework Agreement and the establishment of a new BC First Nations health governance structure. The consensus-building process depicted in the Engagement and Approval Pathway (Figure 6) served to inform the Framework Agreement negotiation efforts underway and ensured that the mandate for negotiation of the Framework Agreement and sub-agreements was driven by First Nations. The consensus-building process spanned several years.⁴² The “wisdom, direction, innovation, thoughts and perspectives”⁴³ of First Nations helped to inform the envisioned health governance arrangement.

⁴² First Nations Health Authority. (2013). *2013 Guidebook: Building blocks for transformation*. Retrieved from http://www.fnha.ca/Documents/2013_Guidebook.pdf

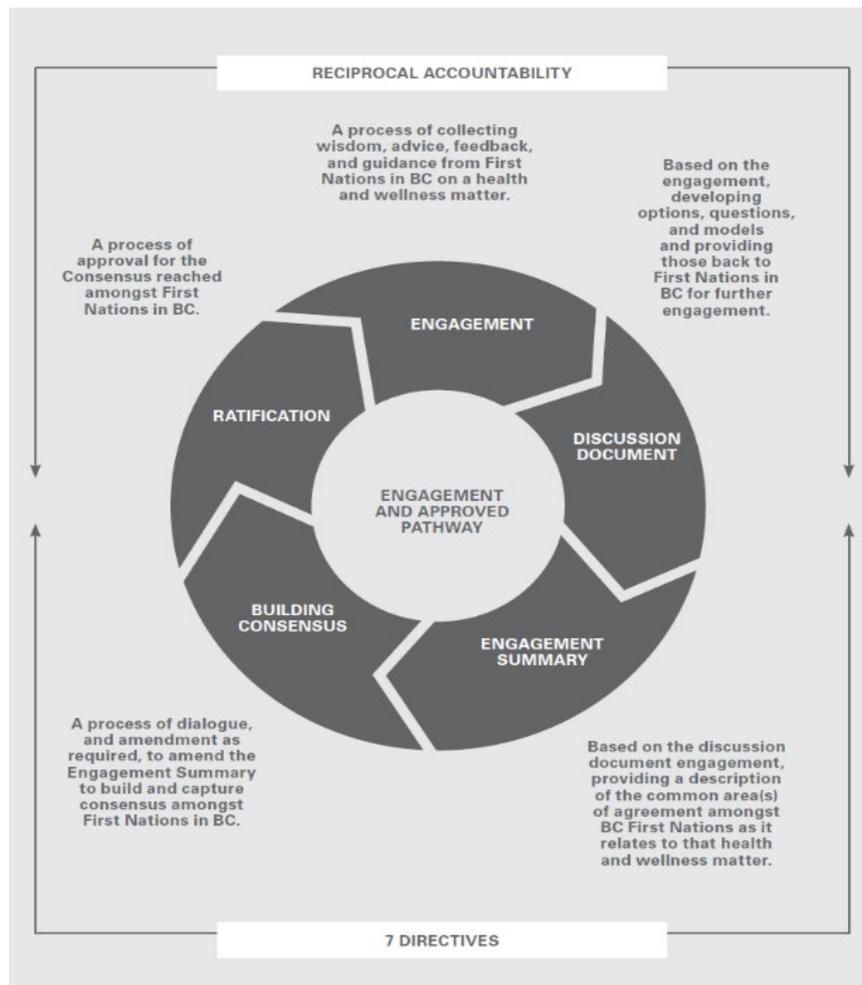
⁴³ Interim First Nations Health Authority. (2012). *Navigating the currents of change: Transitioning to a new First Nations health governance structure*. Retrieved from http://www.fnha.ca/Documents/iFNHA_Consensus_Paper_2012.pdf

Figure 6: BC First Nations Engagement and Approvals Pathway

Engagement and Approvals Pathway

As part of the *Resolution 2011-01* at Gathering Wisdom IV, an “Engagement and Approvals Pathway” was adopted by First Nations in BC, formalizing the existing process followed to date by the FNHC to facilitate consensus-building amongst BC First Nations leadership on key governance decisions. The pathway is guided by the FNHA-FNHDA-FNHC 7 Directives and the principle of Reciprocal Accountability, and has five steps. Engagement (collecting wisdom, advice, feedback and guidance) leads to the creation of a discussion document that includes options, questions and models for further engagement. The Engagement Summary is based on the discussion document, and describes common areas of agreement. Further dialogue and amendment of the Engagement Summary takes place during consensus-building, with Ratification referring to the process of approval.

The Engagement and Approvals Pathway has been used in hundreds of regional, sub-regional, provincial and community meetings, as well as digitally-based participation providing direction and feedback for important governance-level decisions. It provides space for the voice of each First Nation to be heard.



For more than three years, the FNHC – as directed by First Nations in BC – engaged in discussions and negotiations with federal and provincial governments and facilitated more

than 120 regional and sub-regional discussions and negotiations to build consensus. Feedback solicited throughout the consensus-building process was documented over time and systematized into regional-level reporting for review by corresponding First Nations. Region-specific feedback was then sorted and captured at a province-wide level in the 2011 Consensus Paper. This Consensus Paper provided a mandate to enter into the Framework Agreement, established the component entities of the First Nations health governance structure and expectations about accountability back to leadership, and articulated the 7 Directives – a set of fundamental standards to guide First Nations health governance at all levels.⁴⁴

Uniquely and amazingly, in BC, there was the Leadership Council that could put forward a more unified, collaborative point of view for all of the First Nations in BC. There were still huge differences in opinion and directions. One of the big parts of this process was actually creating some kind of a structure for governance capacity, where most First Nations in British Columbia felt comfortable in the way in which things were structured.” – FNIHB KI

“When people hear the story about the creation of a consensus by BC Chiefs to move ahead with the development, construction and building of the FNHA, they marvel at that.” – FNHC KI

This Consensus Paper was circulated amongst First Nations leadership for review. Additionally, the draft Framework Agreement was also circulated and reviewed at a series of Regional Caucuses. An independent legal opinion was procured to further satisfy First Nations’ leadership that the Framework Agreement did not impinge upon their rights or the fiduciary Duty of the Crown. Special sessions were held with a group of political leaders with specific interests in the work, to ensure they had additional opportunity to address issues and pose questions.

This work culminated at Gathering Wisdom for a Shared Journey IV (**May 24-26, 2011**). At this provincial conference, First Nations leaders were asked to consider, debate and reaffirm their commitment to the First Nations’ vision of a new health governance structure.⁴⁵ At this forum, the Chiefs endorsed a resolution (“*Resolution 2011-01*”) on

⁴⁴ First Nations Health Council. (2011). *Consensus Paper: British Columbia First Nations perspective on a new health governance arrangement*. Retrieved from http://www.fnha.ca/Documents/FNHC_Consensus_Paper.pdf

⁴⁵ First Nations Health Council. (2011). *Gathering Wisdom IV resolution debate* [Video file]. Retrieved from <https://www.youtube.com/playlist?list=PLCB2E74DBC5E385CC>

Consensus Paper 2011: British Columbia First Nations Perspectives on a New Health Governance Arrangement,⁴⁶ and the Framework Agreement. This resolution adopted both the Consensus Paper and Framework Agreement, and provided the mandate for the FNHS to be changed into an interim First Nations Health Authority, the first step in formalizing BC First Nations health governance structure and establishing the FNHA as the First Nations governing body originally envisaged in the ten-year TFNHP.

“Following approval of this Consensus Paper and the signing of the Framework Agreement, the FNHC will direct the First Nations Health Society to take steps to amend its bylaws to become the interim FNHA and begin the early steps in implementing the new health governance arrangement.”⁴⁷

A total of 146 Nations voted in favour of the resolution.

“It was a powerful moment when they all agreed that we could sign it, and the signing ceremony was very traditional, in terms of process and powerful commitment.” — North, FNHA KI

“What I think makes this work isn’t the fact that we’re transforming health services, it’s the fact that we’re doing that to a health governance structure where First Nations governance matters. Because you could throw any subject matter in there and it still would be the importance of the governance that makes a difference to how that works — the whole notion of nothing for us, without us [...] I describe it as the largest self-determination decision ever made in this country by First Nations.” — FNHA KI

Throughout 2012, another consensus-building process was undertaken to more fully articulate the composition and mandate of the FNHA and the change management approach for the upcoming transfer of the FNIHB to the FNHA. At the Gathering Wisdom for a Shared Journey V forum (**May 15-17, 2012**) the *Consensus Paper 2012: Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure* was

⁴⁶ First Nations Health Council. (2011). *Consensus Paper: British Columbia First Nations perspective on a new health governance arrangement*. Retrieved from http://www.fnha.ca/Documents/FNHC_Consensus_Paper.pdf

⁴⁷ First Nations Health Council. (2011). *Consensus Paper: British Columbia First Nations perspective on a new health governance arrangement*. Retrieved from http://www.fnha.ca/Documents/FNHC_Consensus_Paper.pdf

adopted by Resolution of BC First Nations leaders. Of the 158 Chiefs that participated in the vote, 148 voted in favor.⁴⁸

This Consensus Paper described the Transition and Transformation phases of work and facilitated the transition of the interim FNHA into the FNHA.^{49,50} The evolution of the mandate of the FNHS and interim FNHA (formerly the “operational arm” of the FNHC) into the FNHA envisioned in **Section 4.2 (5)** of the Framework Agreement was designed to uphold an appropriate and arms-length relationship between business and politics. It described the structure of the FNHA Board of Directors, the nomination and appointment process for that Board, and the required competencies of Board members.

“Following community consultation the FNHC may conclude that the FNHS shall act as the FNHA on a permanent basis or that for operational reasons a different legal entity should be constituted as the FNHA. In this latter case, the Parties undertake to take all steps necessary to ensure a seamless successorship from the FNHS to the new entity. These steps shall include such new entity becoming a Party to this Agreement or otherwise taking legally binding steps to adopt the obligations that are set out for the FNHA in this Agreement and the consequent release of the FNHS from such obligation.”⁵¹

The Framework Agreement (Recital C) included a commitment to establish a companion non-legal agreement reflecting the broad and enduring Vision of the Parties for this new health governance structure and health partnership. On **December 17, 2012**, the *Health Partnership Accord* (HPA) was released by the FNHC, Government of BC and Government of Canada with support from the FNHA as “a central component of [a...] new way of doing business for First Nations health in British Columbia.” The HPA serves as a purposeful companion to the Framework Agreement, capturing aspects of the partnership that do not lend themselves to a legal agreement, such as the broader commitment of the partners, a set of principles, a shared Vision, and a set of future possibilities. It provides the context

⁴⁸ Interim First Nations Health Authority. (2012). *Navigating the currents of change: Transitioning to a new First Nations health governance structure*. Retrieved from http://www.fnha.ca/Documents/iFNHA_Consensus_Paper_2012.pdf

⁴⁹ First Nations Health Authority. (2013). *Our story: The made-in-BC Tripartite health transformation journey*. Retrieved from <https://www.fnha.ca/about/news-and-events/news/our-story-the-made-in-bc-tripartite-health-transformation-journey>

⁵⁰ First Nations Health Council & First Nations Health Authority. (2012). *Transition update, October 2012*. Retrieved from <http://www.fnha.ca/Documents/TransitionUpdate-FNHCandFNHA.pdf>

⁵¹ Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

and intentions through which the Framework Agreement should be interpreted and implemented.

“The Partners have a shared vision; this vision represents the place to which we are travelling on this shared journey. The vision is a future where BC First Nations people and communities are among the healthiest in the world. We envision healthy and vibrant BC First Nations children, families, and communities playing an active role in decision-making regarding their personal and collective wellness. We see healthy First Nations people living in healthy communities, drawing upon the richness of their traditions of health and well-being. In this vision, First Nations people and communities have access to high quality health services that are responsive to their needs, and address their realities. These services are part of a broader wellness system – a system that does not treat illness in isolation. These services are delivered in a manner that respects the diversity, cultures, languages, and contributions of BC First Nations.”⁵²

With respect to the HPA, key informants identified the document as critical in providing the Vision and principles for the work, particularly as turnover brings new individuals. Key informants indicate that the document remains relevant and it would be beneficial to update the HPA to include new goals and outcomes, more detailed information on the commitments and accountabilities of the partners. It would also be useful to include a community lens or framework such that individual Nations can easily understand the commitments made in the HPA from their perspectives.

Another critical development at this time was the signing of Regional Partnership Accords between regional health authorities and their respective First Nation Regional Caucuses **(2011-2012)**. These Accords ensure a strong regional basis for health planning and prioritization, with formal partnership processes established to advance common agendas

⁵² Canada, Province of British Columbia, & First Nations Health Council. (2012). *Health Partnership Accord*. Retrieved from [https://www.fnha.ca/Documents/Health Partnership Accord Publication.pdf](https://www.fnha.ca/Documents/Health_Partnership_Accord_Publication.pdf)

at local and regional levels.^{53,54,55,56} The Accords help generate priorities for action, learning, or resolution at the province-wide level. Each Accord sets out the creation of a partnership table comprised of regional political representatives and health authority executives unique to each region. Over time, regional structures have grown to include joint working groups and operational committees. These regional relationships allow for the alignment of health care priorities and for the development of Regional Health and Wellness Plans, as well as improved coordination and integration of programs and services. This collaboration and partnership between First Nations and regional health authorities represents the hardwiring of First Nations decision-making throughout multiple levels of the provincial health system, beyond what was initially outlined in the Framework Agreement (see Chapter 4).

In **October 2013**, transfer was successfully completed and the FNHA became responsible for functions performed by the FNIHB BC Region and associated headquarters supports (see Chapter 3). Throughout the period from 2011-2013, Regional Caucus and other engagement sessions continued, with a goal of ensuring transparency and dialogue on all of the sub-agreements and supporting change management and preparation for transfer in areas that significantly and directly impacted communities, such as novation. As noted by Joe Gallagher, former FNHA Chief Executive Officer, “[...] in the work towards building the FNHA, there were many pieces that were happening simultaneously in order to achieve a successful transfer.”

2.3 The Parties and the BC First Nations Health Governance Structure

Through the tripartite health partnership, First Nations, federal and provincial governments, and other key partners⁵⁷ are working together to achieve the shared Vision for health system transformation described in the HPA and the Framework Agreement. The parties involved in the tripartite health partnership hold unique roles and responsibilities deployed towards common goals, in the spirit of reciprocal accountability, as outlined in Figure 7.

⁵³ First Nations Health Council, Interior Region Nation Executive, & Interior Health Authority. (2012). *Partnership Accord*. Retrieved from http://www.fnhc.ca/pdf/Interior_Partnership_Accord_FINAL_COPY.pdf

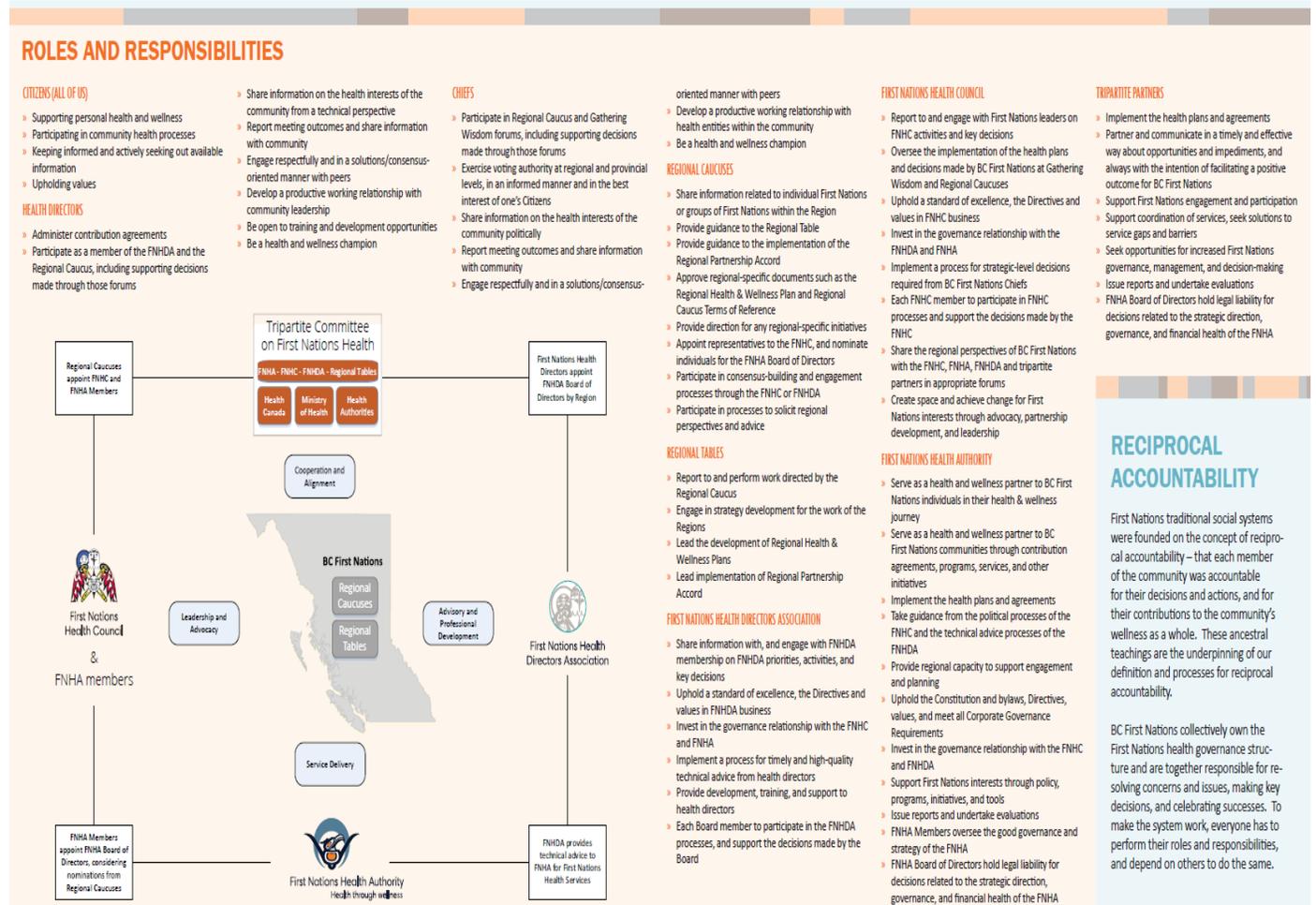
⁵⁴ First Nations Health Council, Fraser Salish Regional Caucus, & Fraser Health Authority. (2011). *Fraser Partnership Accord*. Retrieved from http://www.fnha.ca/Documents/Fraser_Partnership_Accord.pdf

⁵⁵ Vancouver Coastal Caucus, Interim First Nations Health Authority & Vancouver Coastal Health. (2012). *Vancouver Coastal Partnership Accord*. Retrieved from http://www.fnha.ca/Documents/Vancouver_Coastal_Partnership_Accord.pdf

⁵⁶ First Nations Health Council. Northern Regional Health Caucus, Northern Health Authority & Interim First Nations Health Authority. (2012). *Northern Partnership Accord*. Retrieved from http://www.fnhc.ca/pdf/Northern_Partnership_Accord_May_11%2C_2012.pdf

⁵⁷ Indigenous Services Canada, BC Ministry of Health, Regional and Provincial Health Authorities, BC Provincial Health Officer, First Nations Health Council, & First Nations Health Directors Association

Figure 7: Health Governance Roles in BC



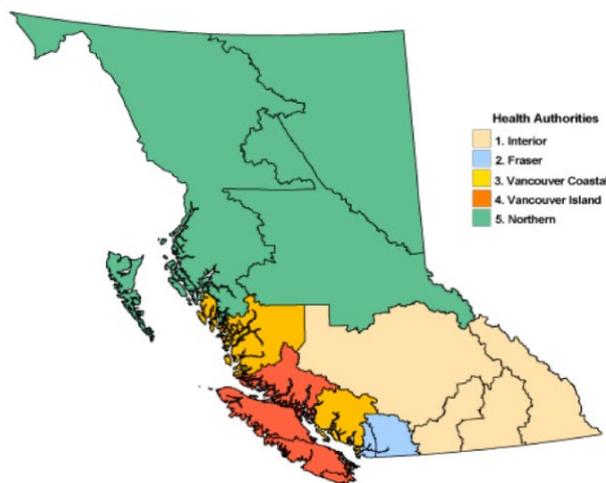
BC Ministry of Health

The BC Ministry of Health (MOH) plays a pivotal role in directing health care by setting out province-wide policy, standards and performance agreements for health care delivery by regional and provincial health authorities. As laid out in Section 6.2.2 of the Framework Agreement, MOH ensures collaboration between health authorities and the FNHA with respect to developing plans, service delivery and data sharing.⁵⁸

⁵⁸ Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

BC Regional Health Authorities

Figure 8: Regional Health Authorities



Five regional health authorities were established in 2002 to govern, plan and deliver a full spectrum of health care services within geographic areas that reflect distinct physical boundaries and patient and physician referral arrangements. These are Interior Health Authority, Fraser Health Authority, Vancouver Coastal Health Authority, Island Health Authority and Northern Health Authority. The regional health authorities are responsible for identifying population health needs, planning appropriate programs and services, ensuring programs and services are properly funded and managing and meeting mandated performance objectives.

Provincial Health Services Authority

The Provincial Health Services Authority (PHSA) was established in 2002 and is responsible for managing the quality, coordination and accessibility of specific province-wide programs and agencies through partnering organizations, including the BC Centre for Disease Control, BC Injury Prevention Unit, Chronic Disease Prevention Group, Centre of Excellence in HIV/AIDS, and BC Cancer.⁵⁹ Specific PHSA accountabilities include working with regional health authorities to plan and co-ordinate the delivery of provincial programs and specialized services, as well as governing and managing the organizations that provide specialized province-wide health services.

⁵⁹ The Institute of Public Administration of Canada, MNP & Fasken Martineau. (2013). *Healthcare Governance models in Canada: A provincial perspective*. Retrieved from http://neltoolkit.rnao.ca/sites/default/files/Healthcare%20Governance%20Models%20in%20Canada_A%20Provincial%20Perspective_Pre-Summit%20Discussion%20Paper%20March%202013.pdf

Government of Canada (Canada)

Canada, represented by the FNIHB (previously at Health Canada and now under ISC since 2017), plays an important health system governance role through active participation in key discussions to share knowledge and discuss plans, priorities and policies related to the Framework Agreement, and to review the Framework Agreement's implementation and contribute to its strategic direction. (For more on FNIHB's mandate prior to transfer, see the Evaluation of the FNHA). Crucially, Canada helps facilitate new relationships between the Tripartite Partners and other federal departments and stakeholders. As noted in the 2017 *Evaluation of Health Canada's Role in Supporting BC First Nations Health Authority as a Governance Partner* report, Canada promotes the "implementation and smooth functioning of legal and funding agreements and health plans as funder and governance partner to the FNHA and BC First Nations."⁶⁰

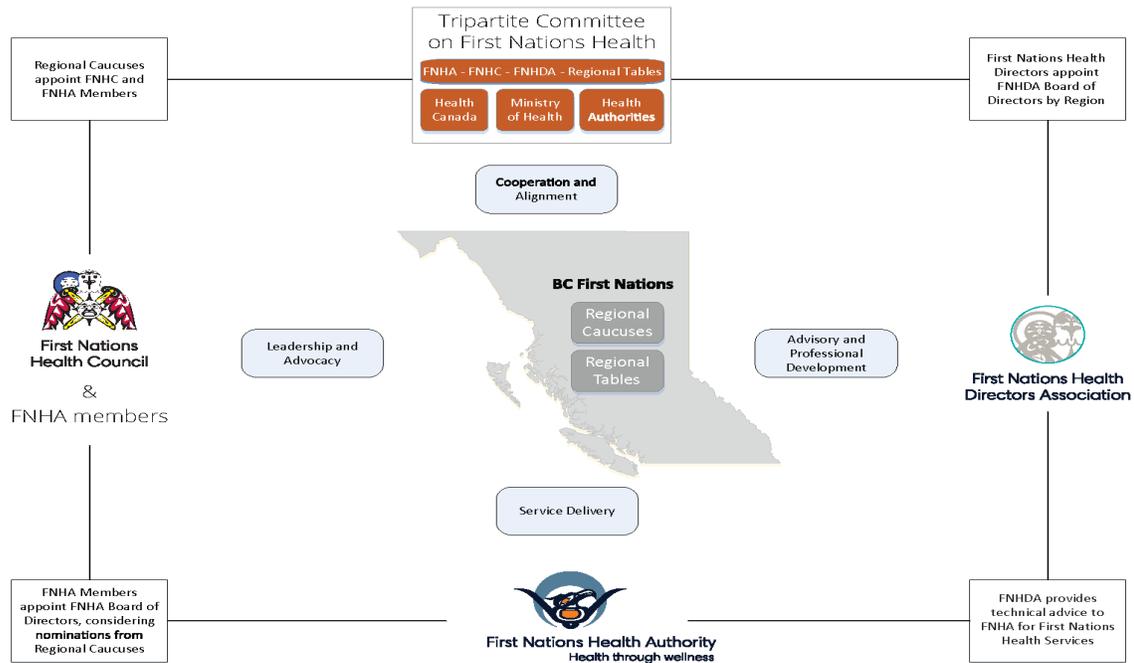
Tripartite Committee on First Nations Health



The TCFNH is a forum in which the FNHA, FNHDA, PHO, health authorities, MOH, Ministry of Mental Health and Addictions (MMHA) and FNIHB participate. The TCFNH is comprised of senior leaders from federal and provincial governments and First Nations. Committee members collaborate in pursuing the improvement of health and wellness outcomes for First Nations in British Columbia. The TCFNH meets twice a year to co-ordinate and align planning, programming and service delivery. The Committee collaboratively establishes current priorities and deliverables, and identifies health care and service delivery barriers that the partners wish to address. Although the TCFNH originally included political representatives, as relationships have strengthened, the composition of the forum has evolved to a senior executive operational forum to ensure alignment and advancement of the health plans, accountable to political leadership. The membership has also grown to include other representatives as the composition of provincial Ministries has evolved; for example, the MMHA.

⁶⁰ Office of Audit and Evaluation, Health Canada, & The Public Health Agency of Canada. (2017). *Evaluation of Health Canada's role in supporting BC First Nations Health Authority as a governance partner*. Retrieved from <https://www.canada.ca/en/public-health/corporate/transparency/corporate-management-reporting/evaluation/health-canada-role-supporting-british-columbia-first-nations-health-authority-governance-partner.html>

Figure 9: BC First Nations Health Governance Structure



First Nations Health Authority



The FNHA is the first province-wide health authority of its kind in Canada. In 2013, the FNHA assumed the programs, services, and responsibilities formerly handled by FNIHB – including both BC Region operations and the associated headquarters functions. Within the context of the BC health system, the FNHA is responsible for performing a number of strategic functions, including planning, management, service delivery and funding of health programs previously provided by FNIHB in partnership with federal and provincial partners and First Nations communities (see Figure 9). Guided by the Vision of embedding cultural safety and humility into health service delivery, the FNHA is working to transform health policy, programs and services accessed by First Nations through direct service delivery, provincial partnership collaboration, and health systems innovation at a province-wide and population-wide level. The FNHA works closely with government and other partners to achieve this Vision and a suite of health transformation goals (for more on the evolution and role of the FNHA since transfer, see the Evaluation of the FNHA).

First Nations Health Council



In 2006, BC and First Nations entered into the TCA: FNHP that included the creation of the FNHC. Initially the FNHC was composed of representatives appointed by each of the three FNLC organizations (three each appointed by the First Nations Summit and Union of BC Indian Chiefs, and one appointed by the BC Assembly of First Nations); this changed in 2010 to be a 15 member Council with three representatives appointed by First Nations in each region.⁶¹ The FNHC provides political leadership for implementation of the health plans and agreements. As a political advocate for the health of First Nations in BC, the FNHC aims to build “a new relationship based on mutual respect and recognition, and to close the social and economic gaps between First Nations and other British Columbians in several areas of health.”⁶² Major roles and responsibilities of the FNHC include the implementation of health plans and decisions made by First Nations in BC at Gathering Wisdom for a Shared Journey.^{63,64}

First Nations Health Directors Association



The FNHDA is comprised of Health Directors and technical health lead representatives, with membership open to all BC First Nations communities and mandated health service organizations. The FNHDA Board is comprised of 15 members, three elected by the FNHDA membership from each of the five health regions. The FNHDA supports education, knowledge transfer, professional development and best practices for Health Directors and managers. The FNHDA provides technical advice on research, policy, program planning and design, and the implementation of the health plans and agreements.

Regional Structures

The new First Nations health governance structure is guided and informed by the priorities of established regional and sub-regional tables and bodies. These include tables for collaboration between First Nations and regional health authorities. The structures vary to reflect the practices and governance structures of First Nations in each region. A comprehensive description of each region’s structure and tables can be found in the

⁶¹ In the Fraser-Salish region, there are FNHC reps from Sto:lo Nation, Sto:lo Tribal Council, and Independents, rather than geographic sub-regions.

⁶² First Nations Health Council. (2019). *Our story*. Retrieved from <http://fnhc.ca/about-us/our-story/>

⁶³ This unique forum is the largest First Nations health and wellness forum in BC and the only one of its kind in Canada. Since its inception, the Gathering Wisdom for a Shared Journey forums have set the stage for BC First Nations to design a more accessible and culturally appropriate system of health care in BC.

⁶⁴ First Nations Health Council. (2018). *Gathering Wisdom for a Shared Journey IX FAQ*. Retrieved from <http://fnhc.ca/2018/02/gathering-wisdom-for-a-shared-journey-ix-faq/>

respective Regional Partnership Accord Evaluation reports. There are some similarities across these regional structures, identified in Figure 10 below.

Figure 10: Regional Structure Bodies

		Interior	Fraser	Vancouver Coastal	Vancouver Island	Northern
		Regional Caucus				
First Nations Structures	Regional Table	Interior Region Nation Executive	Fraser-Salish Regional Table	Vancouver Coastal Regional Table	Vancouver Island Regional Table	Northern Regional Table
	Sub-Regions or Nations	Interior Nation Health Assemblies (7)	Stó:lō Tribal Council, Stó:lō Nation Chiefs Council, Independent Nations	Central Coast, Southern St'at'imx and South	Coast Salish, Nuu-Chah-nulth and Kwakwaka'wakw	Northwest, North Central, North East
	Regional Partnership Accord Table	Partnership Accord Leadership Table	Aboriginal Health Steering Committee	Aboriginal Health Steering Committee	Partnership Accord Steering Committee	Northern First Nations Health Partnership Committee
Joint First Nation - Regional Health Authority Structures	Joint Operational Table	Interior Region Aboriginal Wellness Committee	Aboriginal Health Operations Committee		Partnership Accord Executive Committee	Northern First Nations Health Operations Table
	Joint Working Groups		Primary Health; Public Health; Mental Wellness and Substance Use; Cultural Safety and Humility	Cultural Safety and Humility; Primary Care; Maternal and Child Health; Public Health; Mental Wellness and Substance Use; and Indigenous Overdose Response		Primary Care; Mental Wellness and Substance Use; Maternal and Child Health; Cultural Safety; Population and Public Health
	Nation or Local Structures	Letter of Understanding Tables	Aboriginal Wellness Advisory Committees		Cultural Safety Committees; Wellness Committees	Indigenous Health Improvement Committees

Regional Caucuses

Regional Caucuses were established in 2008 by formal resolutions at the BC Assembly of First Nations, Union of BC Indian Chiefs and First Nations Summit.⁶⁵ For the most part, the Caucuses align with regional health authority boundaries, and their purpose is to engage in dialogues on health governance with all First Nations communities in BC. Regional Caucuses have become a central aspect of the regional governance structure, with

⁶⁵ First Nations Health Authority. (2013). Our story: *The made-in-BC Tripartite health transformation journey*. Retrieved from <https://www.fnha.ca/about/news-and-events/news/our-story-the-made-in-bc-tripartite-health-transformation-journey>

decisions and engagement at Caucus meetings informing the work of all governance partners, and increasingly serving as a forum for engagement with First Nations by other federal and provincial departments, outside of the health system.

Representatives from all First Nations communities in each region are invited to attend twice-yearly Regional Caucus meetings. Each Regional Caucus appoints three members to the FNHC, with each region determining their own appointment process. Each Regional Caucus has a number of sub-structures, described further below.

Sub-Regional Gatherings

The Sub-Regional Caucus is a forum for community representatives to share regional perspectives and information, discuss community-level health concerns, and build dialogues leading into full Regional Caucus. Each region organizes their sub-regions according to cultural families or geographic distinctions. For example, the Northern Region is geographically divided into Northwest, North Central or North East compared to Vancouver Island, which is culturally organized as Coast Salish, Nuu-Chah-nulth and Kwakwaka'wakw families. The Interior Region does not have sub-regions, but has organized themselves based on their seven Nations.

Regional Tables

Regional Tables serve as strategic working groups for each Caucus to advance the leadership work between Caucus sessions. The membership and responsibilities vary widely by region, with some interfacing with other tables as independent bodies (Interior) and others acting as an open forum (Fraser). In Vancouver Coastal, Island and Northern, these tables are directly responsible for the Regional First Nations Health and Wellness Plan.

Partnership Accord Tables

Each region has a partnership accord table that oversees the implementation of the Regional Partnership Accord and acts as a forum for collaboration and decision-making between First Nations and regional health authority partners. The tables also identify priorities and issues for province-wide consideration or policy attention of the TCFNH and other provincial bodies. Membership varies, but consistently includes the CEO of the regional health authority, FNHC representatives and senior officials of the FNHA. Interior and Fraser meet four times per year, Northern meets three times per year, and Vancouver Island and Vancouver Coastal have biannual meetings.

Operational Tables

With the exception of the Vancouver Coastal Region, all regions have established an operational table to carry out the technical aspects of the work set out at the partnership accord table. Composition varies by region, and is a combination of community technical representatives, regional health authority and FNHA staff.

Working Groups

Topic-specific working groups in each region perform work between the governance and technical table meetings. They are composed of a combination of regional health authority, MOH, FNHA, and community technical leadership. Regional working groups address topics such as Cultural Safety and Humility, Primary Care, Mental Wellness and Substance Use.

Community Working Groups

Local committee, working group, and other collaboration structures have also been developed amongst First Nations and jointly between First Nations, the FNHA and health authorities.

2.4. Key Findings

A climate of political change in the province - related to the New Relationship, FNHC and First Ministers Meeting on Aboriginal Issues - created an environment to begin the complex process towards health governance transformation. This transformation was made possible through unity and consensus building among First Nations, underpinned by flexible resources for engagement and the building of relationships and partnerships with federal and provincial governments. The development of the Framework Agreement was also facilitated by disciplined and transparent processes amongst First Nations, Canada and BC.

Political unity among the leaders of the BC Assembly of First Nations, First Nations Summit and Union of BC Indian Chiefs was critical in setting the tone for collaboration and providing First Nations with a common voice to engage provincial and federal partners in health and many other areas. There was a strong commitment towards the need for change by all partners, which created an open environment to envision a new future.

Robust consensus-building processes among First Nations contributed to increased trust and support for transfer; however, it was challenging to develop a robust and transparent process while simultaneously building consensus. This process would not have been

possible without federal and provincial governments' willingness to provide flexible resources dedicated to engagement.

The Parties agreed to some fundamental understandings that created a strong policy foundation to facilitate more detailed negotiations:

- 1) a focus on service delivery and administration rather than jurisdiction;
- 2) the Province acknowledged responsibility to provide health services for First Nations both at-home and away from home; and
- 3) the Parties fostered trust through an openness to proactively learn together and the consistency of key lead negotiators in the process.

Chapter 3 Achieving the Transfer

The Framework Agreement committed the Parties to transfer from FNIHB to the FNHA responsibility for all activities formerly performed by FNIHB BC Region, as well as headquarters functions such as policy development and strategic planning and services. This chapter describes the process of implementation of the transfer provisions of the Framework Agreement leading up to the two-stage transfer from Canada to First Nations in BC in July and October 2013.

Transfer refers to the transfer of FNIHB BC Region responsibilities and health services, programs, employees, resources and assets to the FNHA. This was the first time Canada had transferred responsibilities on this scale. A staged transfer approach was followed as agreed by Canada and the FNHA:

- On **July 2, 2013**, the FNHA assumed responsibility for FNIHB headquarter responsibilities, services and functions. These included responsibilities for Health Plans and Agreements; policy and planning, and Non-Insured Health Benefits headquarters functions.
- Transfer of FNIHB BC regional functions to the FNHA occurred on **October 1, 2013**.⁶⁶ This included regional staff, assets, funding agreements, and programs and services.

This transfer was successfully achieved through the leadership of an Implementation Committee (IC) and associated working group and committee structure, as well as the negotiation of a series of Sub-Agreements and funding agreements, which included “buy-back” arrangements to allow for a longer transition in more complex areas of transfer.

3.1 Implementation Committee

The IC was established in **2011** as per Section 7.1 of the Framework Agreement. The IC holds responsibility for overseeing the implementation of the Framework Agreement, accountable to the Political Principals (the FNHC, provincial Minister of Health and Minister of Indigenous Services Canada). During 2011-2013, the IC provided strategic direction and issue resolution and established a range of sub-committees to facilitate transfer. The IC also oversaw the negotiation and approval of Sub-Agreements and Funding Agreements between the Parties, which provided the legal and financial framework for a successful phased transfer.

⁶⁶ First Nations Health Authority. (2019). *Transition and transformation*. Retrieved from <http://www.fnha.ca/about/transition-and-transformation>

3.2 Sub-Agreements

Schedule 5 of the Framework Agreement lists seven Sub-Agreements, including a set of terms for each that were to be negotiated between Canada and the FNHA. These Sub-Agreements outlined the mechanics of physically and legally transferring all headquarters and regional functions of FNIHB responsibilities in BC to the FNHA including office space, assets, employees, funding, information, records and programs. This would provide the basis for the FNHA to work with First Nations to evolve and transform programs, services and functions on an ongoing basis post-transfer.

To advance the negotiation of these Sub-Agreements, the IC established a joint Sub-Agreement Sub-Committee (SASC). SASC included representatives from the interim FNHA, FNHC, Canada and BC. In order to support an appropriate pace, depth of analysis and quality of work, the negotiations of the Sub-Agreements were phased, with initial concentration on agreements requiring federal approval (Human Resources and Health Benefits, as well as the Health Partnership Accord and the Canada Funding Agreement). Assets and Software Sub-Agreements were also given priority, considering their vital nature in allowing business continuity for First Nations Health Directors and individuals. Processes for concluding Sub-Agreements involved extensive analysis, joint workshopping and legal drafting. This involved a spirit and processes of shared learning between the Parties, recognizing that this had never been done before and the issues at hand were complex.

As the Sub-Agreements were concluded by SASC, they were reviewed by the full FNHC from a governance-level perspective. This was intended to ensure that each respected the 7 Directives and the Vision and principles of the Framework Agreement and would cause no disruption and minimal adjustment to First Nations communities and individuals for continuation of their health services or health benefits, alongside minimal disruption or minimal added work burden for First Nations program providers. Meanwhile, the FNHA reviewed each Sub-Agreement from an operational-level perspective to ensure that implementation was successful and sustainable at both a practical and business level, and the Sub-Agreements would be collectively and individually workable. Over time, the Sub-Agreements were individually initialed to signify that the Parties were generally satisfied, and upon the conclusion of all agreements, they were all to be considered together to ensure that all linkages and dependencies were taken into account. Once finalized, Sub-Agreements served as the “detailed roadmap” for the transfer process.⁶⁷ Table 1 gives details of each of the seven Sub-Agreements listed in the Framework Agreement and the date that each was signed.

⁶⁷ First Nations Health Council & First Nations Health Authority. (2012). *Transition update, December 2012*. Retrieved from <http://www.fnha.ca/Documents/TransitionUpdateDecember.pdf>

Table 1: Signing of the Sub-Agreements, 2013

Sub-Agreement	Description	Signing
Accommodations (office space) #5	Outlines conditions and obligations of each party relating to transfer of office space from FNIHB to the FNHA.	May 2013
Assets and Software #4	Outlines conditions and obligations relating to transfer of assets and software from FNIHB to the FNHA.	May 2013
Capital Planning (health facilities) #6	Outlines details for transfer of FNIHB BC Region's capital planning programming and funding for First Nations health facilities to the FNHA.	May 2013
Health Benefits #2	The FNHA shall accept responsibility for design, planning, management, delivery and funding of the delivery of health benefits to First Nations individuals in BC. Canada to provide elements of program on behalf of the FNHA for the buy-back period. Also sets out a phased approach to transfer, whereby the FNHA would purchase certain services from Canada as described in a Health Benefits Service Agreement (see next).	June 2013
Health Benefits Service Agreement	Sets out the services to be provided by Canada to the FNHA consisting of the administration and delivery of the Specified Health Benefits (pharmacy, dental and medical supplies and equipment), including terms and conditions under which Canada would conduct this work on behalf of the FNHA.	June 2013
Human Resources #1	To facilitate the transfer of eligible Health Canada regional employees. The FNHA to provide Reasonable Job Offers to eligible employees, BC Labour Relations Code provisions regarding successorship rights apply.	May 2013
Information Sharing*	Describes roles and responsibilities of Canada and the FNHA for collection, use, disclosure, retention, disposal and protection of Personal Information.	May 2013
Novation (Contributions) #7	Novation means substitution of a new contract for an old one. Outlines conditions and obligations of each party relating to transfer of funding contribution agreements from FNIHB to the FNHA. Novation ends the Canada contribution agreements and replaces them with new contribution agreements between recipients and the FNHA.	May 2 2013
Records transfer #3	To outline terms, conditions, roles and responsibilities for transferring records from Canada to the FNHA	May 2013

Note: *Included within Records Transfer, Information Management and Information Sharing Sub-Agreement (#3) set out in Schedule 5, Framework Agreement.⁶⁸

⁶⁸ First Nations Health Council. (n.d.). *Tripartite Framework Agreement on First Nation Health Governance Sub-agreement Summary*. Retrieved from http://www.fnhc.ca/pdf/APP_C_Summaries-FIN.pdf

3.3 Canada Funding Agreement

Consistent with the funding parameters outlined in the Framework Agreement, the 10-year Canada Funding Agreement (CFA) was signed on **May 3, 2013** by the FNHA and Canada. The CFA outlines the federal resources to be provided to the FNHA to support the commitments and legal obligations associated with transfer of FNIHB BC Region responsibilities and health services, programs, employees, resources and assets.⁶⁹ It also outlines the flexibilities, parameters, and accountabilities associated with this funding. It included an escalator for the first five years of the agreement, and provisions to renegotiate the escalator for the second five years of the agreement.

3.4 Transfer and Transition

The signing of the Framework Agreement signified a commitment to implement a complex transfer and transition within two years. The IC agreed to a simple set of success factors to guide this transfer:

- ensuring no disruption and minimal adjustment required by individual First Nations people and communities to the continuation of their health services or health benefits;
- ensuring minimal disruption and minimal added work burden on First Nations program providers who deliver community programs;
- respecting the 7 Directives; and,
- respecting the Vision and principles of the Framework Agreement and creating a solid foundation for its continuing implementation.⁷⁰

With the transfer initiated on July 2, 2013 and completed on October 1, 2013, these success factors were achieved. Achievements include meeting agreed-upon timelines, smoothly transitioning programs, services and operations with minimal service or program disruptions, and establishing new systems to undertake internal functions. The strong health partnership, an established and disciplined committee and planning/project management process, and the provisions of Sub-Agreements all helped mitigate a number of challenges which are elaborated upon below. The transfer was celebrated during a Transfer Commemoration Ceremony held during Gathering Wisdom for a Shared Journey

⁶⁹ While CFA funding was an important way through which to support transition, at the time of this report, the FNHA was still considered to be in transition.

⁷⁰ First Nations Health Authority. (2013). Our story: *The made-in-BC Tripartite health transformation journey*. Retrieved from <https://www.fnha.ca/about/news-and-events/news/our-story-the-made-in-bc-tripartite-health-transformation-journey>

VI on October 22, 2013. During the Ceremony, Kukpi7 Wayne Christian observed that “We are not transforming into something new but instead transforming back to the ways of our people.”⁷¹

A number of key issues and challenges were addressed, and lessons learned, throughout the period leading into, and following, transfer in 2013. One key informant summed up the challenges that were met and overcome during implementation in the following way:

“You are going to have to innovate and change and adapt in the future, I think we learned that, as we implemented this, things rarely were rolled out in the way in which they were envisioned, Things jump out in the way, things happen, change takes place, but as long as we were clear about what we wanted, and what were the pre-requisites to getting there, then you can work together in collaboration.” – FNIHB KI

Health Planning

The Framework Agreement and Canada Funding Agreement require the FNHA to create and submit comprehensive strategic plans that describe the planned use of federal and provincial funding. It was recognized that the first three years post-transfer will be a period of significant transition; therefore, each year the FNHA would submit an Interim Health Plan, eventually maturing to create five-year Multi-Year Health Plans. The FNHA’s first Interim Health Plan in 2013 covered a partial year, given that transfer began in July, and was accepted by federal and provincial governments. The FNHA successfully had three Interim Health Plans before transitioning to its first Multi-Year Health Plan in 2016/2017.

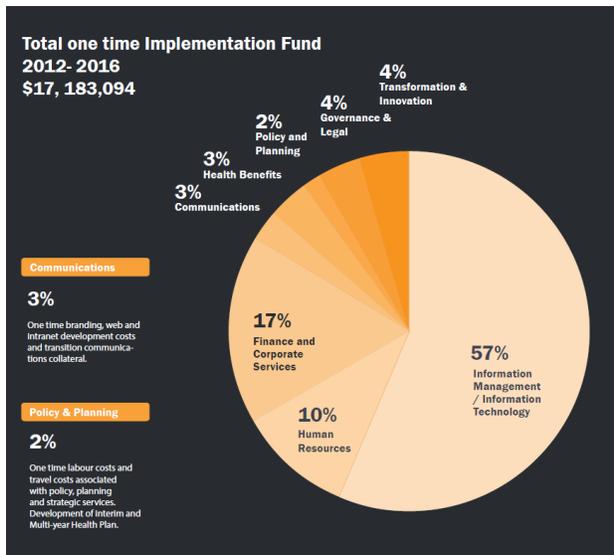
Implementation Fund

In addition to the Canada Funding Agreement, the Framework Agreement committed a one-time fund to support the implementation and transition costs needed to establish the FNHA and related operations over a five-year period (between 2012 and 2016).⁷² A one-time Implementation Fund of \$17 million was provided by Canada to support the costs to establish the FNHA and its operations, transition programs, services and functions to its management, and support information management and technology needs.

⁷¹ First Nations Health Council & First Nations Health Authority. (2013). The last transition update. *A Joint First Nations Health Council and First Nations Health Authority Newsletter, Vol. 01(05)*. Retrieved from http://www.fnha.ca/Documents/FNHA_Transition_Update_December_2013.pdf

⁷² First Nations Health Council & First Nations Health Authority. (2012). *Transition update, October 2012*. Retrieved August 19, 2019 from <http://www.fnha.ca/Documents/TransitionUpdate-FNHCandFNHA.pdf>

Figure 11: Total One-Time Implementation Fund



Source: First Nations Health Council & First Nations Health Authority. (2012). *Transition update*, October 2012.

The 2017 evaluation of the Implementation Fund found that the existence of specific funding dedicated to transfer was essential in facilitating a successful transfer, as was the flexible nature of that funding. Namely, original expenditure plans evolved to address the information management and technology requirements, which were much higher than initially anticipated. In the period following transfer, the FNHA was able to absorb a range of transfer and transition-related costs (e.g. staff time) from its operating budget, allowing the remainder of the Fund to be dedicated to information management and technology costs.

A key success was the migration – ahead of schedule and under-budget – of the FNHA from the service continuity arrangement concluded with Canada for various technology platforms. At the same time, the evaluation notes that the Implementation Fund’s five-year timeframe could have been extended, recognizing that decisions on technology systems are best made when the entity (in this case, the FNHA) has had sufficient time to fully understand the inherited business and identify any new business requirements for transformation.

Similarly, the evaluation noted that there was insufficient time prior to transfer to conduct a full inventory of Health Canada web content, publications and program descriptions methodically to determine which components to keep, which to let go and which ones to modify to reflect the FNHA brand. This made it difficult to establish the FNHA in people’s minds as distinct from the federal bureaucracy/ies it replaced.

Human Resources and Labour Relations

As per the Human Resources Sub-Agreement, which respected a set of legal parameters that the federal government needed to follow, FNIHB regional staff would receive reasonable job offers to commence work at the FNHA on October 1, 2013. Active engagement strategies were implemented to introduce federal and FNHS (later FNHA) staff to each other and to share information about transition. FNIHB and the FNHA, with the support of Elder Qut-Same Leonard George [səlilwətaʔ (Tseil-Waututh) Nation],⁷³ began the process of welcoming FNIHB regional staff through “Coffee and Conversations” and “Better Together” gatherings that were rooted in First Nations cultures and teachings. FNIHB also hosted town hall sessions to share information and respond to questions. The federal Minister of Health also visited the region to share a Vision for the future of the partnership. These efforts, as well as extensive negotiations with unions, as detailed below, resulted in the transfer of 134 permanent and 73 term federal positions from FNIHB to the FNHA.

The associated four federal unions and six collective agreements also transitioned to the FNHA. Complexities associated with this transition included: the need for the unions to become certified to operate within BC; the need for relationship-building between the unions and the FNHA; and work to consolidate some of the collective agreements given that, with the transition, the number of staff operating under some of the collective agreements was very small. Ultimately, this resulted in the FNHA successfully negotiating collective agreements with two federal unions. Currently, the FNHA maintains relationships with these same unions.

There were also challenges associated with building a new FNHA leadership team. First Nations leadership supported a phased creation of the FNHA, requiring the FNHS to transition to an interim FNHA prior to affirming the transition to the permanent FNHA. While the organization was seeking to enhance and stabilize staffing in preparation to receive the transfer, it proved difficult to recruit experienced senior-level executives and permanent staff to an “interim” organization.

Novation

Novation refers to the process where contribution agreements between FNIHB, First Nations, and their mandated health service organizations were transferred to the FNHA.

⁷³ Elder Qut-Same Leonard George adopted all FNHA staff as honorary members of the Tak’aya Wolf Clan. Being part of a clan system means becoming family and provides an identity for the FNHA, one that is rooted in the protocols and teachings of the Coast Salish peoples.

Contribution agreements provide funding for First Nations to resource, design, and deliver community-based health services (accounting for approximately 40% of the FNHA annual health budget). Transfer was taking place mid-way through a fiscal year, requiring a three-way novation agreement to be signed between the FNHA, FNIHB, and each contribution agreement holder. A series of regional engagement sessions were held to describe the process, significant communications products were prepared and disseminated, and a disciplined structure was put into place to monitor progress in the conclusion of these agreements. This was a significant and detailed process resulting in the signing of 99% of the novation agreements between May and September of 2013, and the remaining shortly thereafter.

Health Benefits

Due to the complexity of the commitment to transfer health benefits and the short timelines established for transfer, the Parties agreed to enter into a service provider arrangement via the *Health Benefits Service Agreement* (HBSA), whereby Canada would continue to administer certain elements of the FNHA's Health Benefits Program. This saw portions of the Health Benefits Program immediately transferred to the FNHA in 2013 (medical transportation and vision care), with Canada continuing to administer the larger and more complex benefit areas of the federal Non-Insured Health Benefits Program (pharmacy, dental, and medical supplies and equipment). This gave the FNHA time to build capacity and implement a plan for the full administrative transition of all program elements. The HBSA was in place for six years until, in October 2019, through partnerships with BC PharmaCare and Pacific Blue Cross, the FNHA completed the final phase of full administrative transfer of their Health Benefits Program. (For more on planning and transition of health benefits to the FNHA, see the *Evaluation of FNHA's Health Benefits – Pharmacy Program for BC First Nations*).

Information Management and Information Technology Service Continuity

Transfer required the FNHA to migrate off a broad range of Canada's systems and technology. The two-year timeline for transfer, paired with Canada's internal work to create Shared Services Canada, meant that there was insufficient time to fully transfer off of Canada's systems. Therefore the Parties negotiated a Service Continuity Agreement to give the FNHA continued access to those systems while it implemented replacements.

A disciplined and partnered approach was taken to migrate from the Service Continuity Agreement. Following transfer, the FNHA migrated, replaced or decommissioned 61 of the original 71 systems that were used in BC. This project included reconciling the remaining Health Canada systems in addition to migrating 321,000 network file shares and replacing more than 165 users' desktop devices. The massive two-year project was completed six

months ahead of schedule. On March 26, 2015, the FNHA officially unplugged from the federal network, marking independence from Health Canada's information technology infrastructure, with the exception of certain elements of the Health Benefits Program where Canada continued to act as a service provider in the administration of pharmacy, dental, and medical supplies and equipment benefits until September 2019.

Early Audits

In 2015/2016, the FNHA participated in a *Special Study of the Office of the Auditor General* (OAG) intended to explore how BC First Nations were working to overcome a number of structural impediments that had been previously identified by the OAG as severely limiting the delivery of services to First Nations communities and hindering improvements in living conditions. The OAG report identified a number of success factors, including the sustained commitment and collaboration by the Partners, that enabled the establishment of the FNHA. Covering a period from 2005 to 2013, as well as the early implementation period from 2013 to 2015, the OAG noted many strengths and positive aspects of the work and a number of areas for improvement; these were followed by action plans and management responses co-developed and monitored by the FNHA and FNIHB in a partnership approach.

3.5 Key Findings

The Parties achieved successful completion of transfer with many lessons learned to inform others across the country.

The Parties succeeded in accomplishing the major transfer activities outlined in the Framework Agreement, including the creation of a new Health Authority by and for First Nations, and the smooth transition of identified FNIHB functions to its mandate. The success factors identified by the Parties were met, and a genuine commitment to learning, partnership and change facilitated the effort.

The IC provided effective oversight and support in the implementation of the transfer and early transition period; a key lesson learned is that the IC has needed to extend its mandate as an ongoing forum for coordination amongst the Parties in implementation of the Framework Agreement.

The significant complexities and challenges of the transition period were addressed through the commitment and openness of partners, disciplined negotiations processes, established Tripartite success factors, dedicated funding, and robust briefing/communications/engagement processes. Transition is a continuing process today.

There was significant complexity inherent to the negotiations process, including:

- negotiating the creation of an unprecedented transfer and First Nations health governance structure, which required significant depth of policy and legal analysis and shared learning;
- First Nations developing a robust and transparent First Nations consensus-building process while simultaneously building consensus;
- simultaneously mandating processes amongst First Nations, Canada and BC;
- a political requirement for an interim FNHA prior to a permanent FNHA created challenges in recruiting experienced senior-level executives and permanent staff to an interim organization;
- a mid-year transfer which then required a process of novation of contribution agreements; and,
- an insufficient time period to fully address more complex aspects of the transfer, including the “people side of change”, a rebranding and analysis of all FNIHB communications products and policies, IM/IT service continuity and Health Benefits transition.

Time and effort was required to engage with all partners (First Nations, federal and provincial governments, unions, and others) to generate buy-in and trust across the system while trying to achieve change within a clear two-year window (2011-2013).

Transition highlighted the importance of the relationships with federal and provincial governments, underpinned by a partnership philosophy and commitment to learning. Complexity was also well navigated through a disciplined meeting structure and shared Tripartite Secretariat to provide dedicated capacity and process clarity. The Implementation Fund supported a range of key costs associated with the transfer.

A key lesson learned is that transition is a longer process than initially envisioned by the Parties and continues today in many forms, particularly as the FNHA works to implement new IM/IT systems, mature labour relations and evolve its organizational structure.

Chapter 4 BC First Nations Health Governance Structure

As outlined in Chapter 2, the four entities of the BC First Nations health governance structure – the FNHC, the FNHA, FNHDA and TCFNH – were envisaged as supporting greater involvement of First Nations in the planning, design, management and delivery of health services to First Nations in BC, while maintaining appropriate distinction between roles and functions. This chapter presents evaluation findings around how each entity has fulfilled its mandate, and considers the effectiveness and maturation of the First Nations health governance structure as a whole.

4.1 First Nations Health Council

The FNHC, in collaboration with the FNHA Board of Directors and management team, played a vital role in the design of the Framework Agreement and First Nations health governance structure. The FNHC, in its role as political leadership, led community engagement to develop understanding of the new arrangement and generate consensus among BC First Nations.

The FNHC represents, and is accountable to, First Nations in BC, and therefore plays an important role in the First Nations health governance structure as a political and advocacy organization. Findings from evaluation reports, key informant interviews and documentation emphasize the vital role the FNHC played in making the Framework Agreement a reality, and in building partnership and consensus among First Nations, and with federal and provincial governments. Key informants ranging from First Nations health governance partners, Tripartite Parties and other health partners noted the success of the FNHC in ensuring that the health governance structure was understood, and its principles and values were incorporated into new ways of working within and between organizations. The relatively low turnover of FNHC leadership in the early years of the work leading into the conclusion of the Framework Agreement and implementation of transfer was attributed as a key facilitator of this success.

In recent years, the FNHC has shifted its political focus towards addressing social determinants of health. The FNHC and the Province of BC signed a *Memorandum of Understanding (MOU) on the Social Determinants of Health* in 2016. The MOU defines an engagement framework for the work on the social determinants of health, establishes

bilateral structures to engage in a process of planning and priority setting, and articulates the commitment to develop a ten-year social determinants of health strategy.⁷⁴

“The First Nations Health Council ... don’t have to pound their fists on the table anymore [...] and it’s time for the people who run the health system to go and run the health system effectively in partnership and they can now turn their attention to what appears to be their new projects around the social determinants of health, where they need a political focus to get where that piece of work needs to get to.” – MOH KI

4.2 First Nations Health Directors Association

With membership made up of managers who oversee the delivery of community-based health services, the FNHDA brings a unique perspective to Tripartite efforts.

The role of the FNHDA includes providing technical advice and strategic feedback to the other component entities of the First Nations health governance structure; creating a system for networking and information sharing across the health governance structure; and providing opportunities for First Nations Health Directors to access professional development, training and support. The FNHDA also plays a key networking and quality improvement role by providing information and training to health providers working in First Nations communities.

The FNHDA has supported and built the capacity of Health Directors by inventorying health resources and opportunities and providing training opportunities. It continues work on developing a certification program and annual training work plans. The FNHDA also acts as an important advisor to the FNHA on quality improvements, and a change ambassador amongst First Nations in BC. Two clear examples are the technical advice and communications support provided for the Community Health and Wellness Planning Toolkit and the transition from Non-Insured Health Benefits.

An important part of the FNHDA’s work has been championing the movement on “lateral kindness” that led to the signing of the Declaration of Lateral Kindness with the FNHA and FNHC in January 2017, and ongoing training to ensure that lateral kindness is an integral part of Health Directors’ work.

⁷⁴ First Nations Health Council. (2016). *Memorandum of understanding on the social determinants of health*. Retrieved from <http://fnhc.ca/2016/03/memorandum-understanding-social-determinants-health/>

Some key informants noted that in the early years, there was a lack of awareness around the role of the FNHDA within Tripartite discussions, coupled with the perception of its role as more community-focused and operational. Over time, however, increased understanding of the FNHDA's role, coupled with clearer processes of inclusion and technical advice, resulted in increased recognition of the key role of the FNHDA as a technical advisor. The FNHDA continues to clarify its role and responsibilities within the First Nations health governance structure.

4.3 First Nations Health Authority

The FNHA is the first province-wide health authority of its kind in Canada. In 2013, the FNHA assumed the programs, services and responsibilities formerly handled by Canada's First Nations Inuit Health Branch (FNIHB) – including both regional operations and the associated headquarters functions. BC First Nations also established a mandate for the FNHA that went beyond the space previously occupied by FNIHB, as outlined in foundational governance documents such as the Framework Agreement and the Health Plans and Agreements. The broader mandate includes:

- upholding the 7 Directives,⁷⁵ and implementing mechanisms to support engagement and decision-making processes among BC First Nations to guide the work;
- responding in ways that are culturally appropriate and incorporating and promoting First Nations knowledge, beliefs, values, practices, medicines and models of health and healing;
- supporting the interests of all BC First Nations people, regardless of their residence, within the health care system, working with them on their health and wellness journeys as a health and wellness partner;
- collaborating with the provincial government to coordinate and integrate their respective health programs and services to achieve better health outcomes for First Nations people in BC;
- modifying and redesigning existing programs or creating new health programs and services through a collaborative and transparent process with BC First Nations to better meet health and wellness needs – implementing a two-way accountability model of reciprocal accountability between the FNHA and funding arrangement holders;

⁷⁵ The 7 Directives, established through hundreds of regional and sub-regional Caucus meetings and Health Partnership Workbooks, were developed by First Nations in BC, and describe the fundamental standards and instructions for the health governance relationship. See: <https://www.fnha.ca/about/fnha-overview/directives>

- providing population and public health leadership, undertaking First Nations specific research, health status monitoring, gathering knowledge and collecting and maintaining clinical information and patient records; and,
- prioritizing disease and injury prevention and a wellness approach in health and building multi-sectoral partnerships to better address the social determinants affecting the health status of First Nations.^{76,77}

Key informants noted that over time the FNHA has become more trusted by First Nations communities across the province, enabling the organization to evolve and better meet their needs. It was stated that First Nations in BC have directly experienced the benefits of the organization's distribution of funds to complement and improve existing health services and health delivery in a way that addresses key priorities identified by First Nations while not creating a parallel health system.

As elaborated upon in other sections of this report, the existence of the FNHA has increased capacity and opportunity for First Nations to engage with the FNHA and the provincial health system. FNHA staff such as Community Engagement Coordinators, who support engagement, collaboration and information sharing between health system partners and communities, have served to increase capacity. With this in mind, respondents noted that the establishment of the FNHA does create a risk that partners may view engagement with the FNHA as equivalent to engaging directly with communities. There is also a risk that engagement is viewed as evidence of shared decision-making, which is sometimes, but not always, the case.

For more on the FNHA mandate and its added value to the BC health system, see the Evaluation of the FNHA.

4.4 BC Ministry of Health

The Framework Agreement formally commits the FNHA to establish working relationships with MOH and work collaboratively on design and delivery of provincial health services available to First Nations in BC. The years spent developing the precursor agreements, and eventual signing of the Framework Agreement, demonstrate the provincial government's commitment to be a responsive and supportive partner for change.

⁷⁶ First Nations Health Council. (2011). *Consensus Paper: British Columbia First Nations perspective on a new health governance arrangement*. Retrieved from http://www.fnha.ca/Documents/FNHC_Consensus_Paper.pdf

⁷⁷ Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

The provincial government's commitment and declaration of responsibility for health services for all BC residents, including First Nations people living in-community,⁷⁸ established a critical precedent for bridging jurisdictional divides between levels of government that were previously seen as a hindrance to coordinated service efforts for First Nations.

"The number one lesson for us from my perspective is, without a strong relationship with the province or with the Ministry, I think it would have been very difficult for us to have any success in moving forward. I think one of the greatest advantages that we have here is that we've been fortunate, I believe, to have a very responsive Ministry and Ministry partners who are [...] very eager to help." – FNHA KI

The relationship between the FNHA, MOH and BC health authorities has also matured since the signing of the Framework Agreement. In the early days of transition, much time and work was spent working in partnership with Health Canada. As time progressed, an increased emphasis was placed on "hardwiring" (or embedding) the FNHA into the provincial system and, as a result, BC First Nations are now highly active in decision-making at multiple levels. This hardwiring is one of the primary successes of the Framework Agreement and therefore Chapter 5 has been dedicated to exploring this further.

4.5 Government of Canada (Canada)

Canada's role has evolved considerably, from being "a designer and deliverer of First Nations health services to that of funder and governance partner."⁷⁹ Survey responses from key informants underscore Canada's leadership and support as key factors for the successful implementation of the Framework Agreement.

Mechanisms to support strong connections between Canada and the FNHA developed as Canada's involvement shifted to one of funder and governance partner. Beginning in 2014, the FNHA and Canada developed an annual agreement – the *Shared Vision and Common Understanding* document – establishing joint priorities and deliverables between the FNHA and Canada. Implementation of this document is guided by regular meetings between the

⁷⁸ BC Assembly of First Nations, First Nations Summit, Union of BC Indian Chiefs & Province of British Columbia. (2006). *The Transformative Change Accord: First Nations health plan*. Retrieved from http://fnhc.ca/pdf/TCA_FNHP.pdf

⁷⁹ Health Canada. (2009). *Tripartite First Nations health plan in British Columbia: Health Canada residual role*.

FNHA Chief Executive Officer and FNIHB Senior Assistant Deputy Minister, an FNHA Vice-Presidents and FNIHB Directors General Committee, and a strong working partnership between the intergovernmental staff at the FNHA and the BC Tripartite Team at FNIHB. Minutes from bilateral meetings between the FNHA and FNIHB demonstrate that these forums are being successfully used to identify and develop solutions to challenges as they arise. Annual meetings between the FNHA Board of Directors and FNIHB Senior Assistant Deputy Minister are the primary mechanism to discuss the accountabilities of the FNHA to the FNIHB.

The FNHA and Canada have also established a suite of joint policy papers to provide for ongoing working protocols on issues of mutual connection and reciprocal accountabilities, such as the Multi-Year Health Plan, information sharing, new funding allocations for the FNHA for new federal programs and services, and FNHA corporate governance requirements.⁸⁰ Many of these collaborative processes are over and above the compliance-based partnership requirements within the Framework Agreement and/or provide greater interpretation and clarity to the operationalization of Framework Agreement commitments.

“The Framework Agreement was actually quite descriptive in laying out the governance structure. But there has been an ability for us, because of good relationships and trust [...] to actually evolve it, and so we hope that it’ll be even more effective going forward.” - KI

Canada has also served as a facilitator between the FNHA and other federal partners as needed to address a range of arising issues. For example, following a diesel spill off the north coast of BC in 2014, some responding agencies questioned the FNHA’s presence. The FNIHB was able to foster a helpful conversation and ensure that the FNHA had a place on the response team. This facilitator role has been incorporated into work plans among partners, whereby the FNIHB coordinates with other federal departments to support the FNHA and MOH and foster integration, partnership and positive working relationships at the federal level.⁸¹

⁸⁰ Shared Vision and Common Understanding: An Executive Agenda between Health Canada’s FNIHB & the First Nations Health Authority.

⁸¹ First Nations Health Authority. (2016). *Together in wellness: Tripartite Committee on First Nations Health annual report, October 2015-2016*. Retrieved from <http://www.fnha.ca/Documents/2015-2016-Together-In-Wellness.pdf>

4.6 Tripartite Committee on First Nations Health

The TCFNH is an important part of the First Nations health governance structure, serving as the forum for coordinating and aligning planning, programming and service delivery in support of First Nations health and wellness and allowing for improved coordination and collaboration between partners.

Strong and consistent TCFNH leadership has fostered trust and relationships that are based on respect, reciprocal accountability, collaboration and innovation that are conducive to the pursuit of improved health and wellness for and with First Nations in BC. The requirement for two annual meetings ensures that leaders in the health system focus on commitments to First Nations health on a regular basis.

The inclusion of all of the key players in the health system supports collective and system-wide approaches to shared priorities in a manner that involves First Nations decision-making. Key informants who participated in this evaluation agree that the work that the TCFNH undertakes is facilitated in part by its composition. For example, the inclusion of Health Authority CEOs enables alignment of priorities across the health authorities, and provides an opportunity to exchange ideas and wise practices. Indeed, one key informant suggested that the presence of all the health authorities at the TCFNH creates additional benefits to health and wellness for First Nations in BC:

“What I find is that the Tripartite Committee motivates people to action. There is a fair amount of competition between the health authorities on how they do this, which is great. One of them can say, ‘well we’ve been doing this and it’s wonderful,’ and the others go, ‘well, why aren’t we doing that?’” – FNHA Board Member KI

The TCFNH is an evolving and maturing forum. Key informants suggested that in the early days, it was difficult to have meaningful conversations; however, over time, the TCFNH has become receptive to discussing difficult topics that can be successfully worked through. Prior to transfer, partnerships were new, unprecedented and untested. At the outset, an entirely new way of working, combined with a newly formed, unproven organization and a focus on negotiation-style talks, was not conducive to establishing trust between Partners. As it has matured, trust and understanding have improved among its members.

This trust and receptiveness enhanced as TCFNH membership evolved, and the composition of the TCFNH outlined in the Framework Agreement has shifted in two key

ways. One is the inclusion of other provincial representatives, particularly the Ministry of Mental Health and Addictions (MMHA), which was created in 2017 and works across the provincial government (including but not limited to MOH) to support mental health for British Columbians. It was seen as important to include MMHA given the importance of mental health and wellness as a priority for BC First Nations. Key informants noted the possible opportunity to further expand the scope of discussions at the TCFNH, in light of recent developments to consolidate Indigenous services through the creation of ISC. While it may be unnecessary to formally include additional members, some key informants suggested that other representatives could be invited to TCFNH meetings where there is a particular and substantive focus relevant to their mandates. Key informants agree that the membership of the Committee has been well considered.

“Even as we sit with the Tripartite Committee now, I've got two provincial ministries that relates to health [...] one health and one mental health and addictions. And I have two Federal Departments that somehow have an interest in the work, both on governance and services division, and a third – Health Canada - who I don't want to totally be disconnected from, because they are the Health Department at the federal government [...] Five different ministers, where we only thought we needed two.” – FNHA KI

The second key change in the composition of the TCFNH is the evolution from a quasi-political forum to a senior executive one. In response to findings of a survey commissioned as part of this evaluation, changes to TCFNH membership were made in 2018. The survey found concerns among members that with a great portion of the meeting time being allocated to political and governance discussions and reporting out on progress, agendas were too dense for meaningful discussions to occur on how to operationalize commitments. In other words, the TCFNH was becoming less effective at addressing operational and strategic issues, resulting in a lack of advancement on core priorities. As a result, the membership of the TCFNH was changed, with the FNHC and political regional table representatives delegating their seats to the FNHA. Key informants reported that the changes allowed the discussions to become more streamlined and to focus on strategic operational issues such as primary care transformation and cultural safety and humility change leadership. This agility in form has proven vital to ensuring the entity is responsive to evolving priorities of First Nations and federal and provincial governments and is able to evolve as the health partnership matures.

"I think it's always a work in progress, for all four areas or four pillars. These things are always changing and maturing. We didn't know then what we know now and I think it's a learning for everybody...You're always working at it, it will never be static." - KI

*"An important success of the governance arrangement has been its responsiveness and flexibility to current realities." - **FNHA KI***

The trust developed between members is particularly well illustrated by the way that work both within and outside the TCFNH has increased beyond what was initially envisaged. For example, CEO-to-CEO meetings have emerged between the FNHA and health authorities, creating further trust, as well as the opportunity to address a range of specific issues at this bilateral level, rather than through the TCFNH, or alternatively to bring those issues forward to the TCFNH if they are systemic in nature. This has also supported the evolution of the TCFNH to address cross-system issues and priorities.

*"If you look at what happened at [...] the Tripartite Committee that we sit at, it's gone from being suspicious and very guarded, to a very positive, mutually respectful, trusting relationship." - **KI***

*"There is more openness to talk frankly about policy barriers, operational issues and funding as a health system." - **IC/TCFNH follow-up survey***

The TCFNH has also taken measures to ensure that Committee agendas and discussions are calibrated for maximum effectiveness. Key informants noted that TCFNH reporting was overly focused on successes, inhibiting the Committee's opportunity to gain insight into, and build solutions to, systemic barriers. One key informant summed up these concerns:

*"I think this Committee probably needs a bit of a revisit...it doesn't seem to be serving the purpose for all of the members...A lot of the focus of the meeting is really on reporting out, as opposed to talking about some of the more high-level and strategic issues at a province-wide level that they could be tackling as a table." - **FNIHB KI***

As a result, the TCFNH simplified reporting processes: health authorities, in collaboration with the FNHA, now submit written assessments of progress in addressing barriers and recommended joint solutions in order to avoid time-consuming verbal updates during meetings. Briefing notes are proactively sought to identify and make recommendations regarding systemic barriers. These are then directly integrated into the TCFNH accountability register. It was suggested that meetings could be further improved by aligning agendas with identified areas of maximum potential impact, and by ensuring greater “lead time” in the circulation of barrier report cards prior to meetings.

Box 2: Addressing Barriers at the TCFNH

In Fall 2016 as part of a progress report to the TCFNH, the Interior Region Partnership Accord Leadership Table submitted a briefing note elevating concerns regarding the inequitable and limited access to community-based palliative care services and benefits.

The crux of the barrier lay in how Status First Nations individuals diagnosed with an advancing life limiting illness access BC Palliative Care Benefits (BCPCB). These benefits cover certain drugs, medical supplies, and equipment that are used in palliative care. As both BCPCB and the FNHA had policies stating they are not first payer, and that they will only pay in the event that coverage is refused by an alternate agency, Status First Nations individuals were ineligible to receive provincial BC Palliative Care Benefits (BCPCB) without first applying for Benefits coverage (through the FNHA). This process of applying for coverage from one provider, in order to be denied, prior to receiving coverage from another created delays. Ultimately, this posed a barrier to First Nations individuals being able to die at-home, as they would wish to, and as other British Columbians could.

As decision-makers from MOH, FNIHB, the FNHA, and BC health authorities all attend the TCFNH, the TCFNH was able to take the necessary steps to address the issue, including creating short-term working group to resolve the issue in the interim before a longer-term solution came into effect. In the interim, the TCFNH adopted a “Jordan’s Principle” approach whereby members agreed that each would pay first and would identify the payer after care had been provided, resolving the immediate issue. The eventual transition of First Nations pharmacy benefits to BC PharmaCare, which provides BCPCB, offered a long-term solution by ending the requirement for written confirmation from the FNHA that a drug is not covered before providing coverage. Work on the more complex issue of medical supplies and equipment benefits continues for the FNHA and regional health authorities.

Increased availability of relevant data and information has also enhanced the effectiveness of the TCFNH. Key informants identified information provided through linkages conducted between the First Nations Client File and other administrative data repositories as essential for informing policy and programming decisions among TCFNH members. Some examples of the data sets that have initiated action include cancer, overdose and health system utilization. There is also regular reporting on outcome indicators identified in the TCA: FNHP, which has enabled the Committee to focus on key areas where more work is needed (see Chapter 7 Health and Wellness Outcomes). This data has also been taken from the TCFNH level to inform health service planning at the regional levels, providing impetus for new targeted funding and service allocations. Key informants stressed the importance of

continuing to leverage data to support more informed TCFNH discussions on priorities and approaches.

4.7 Effectiveness of the First Nations Governance Structure

Tripartite Relationship

Through the Framework Agreement, the Parties commit “to establishing a new and enduring relationship, based on respect, reciprocal accountability, collaboration and innovation that is conducive to the pursuit of improved health and wellness for First Nations in BC. Within this new relationship, the Parties have distinct but interrelated roles.”⁸²

“Partners change, governments change...people move and people change and people forget and so it’s always good to have a document to remind people that this is the basis or the beginning of why all of this work has started, and I think it’s a good reminder.” – FNHA KI

The IC and TCFNH are the primary formal forums for the Tripartite relationship; key informants describe the ongoing value of these forums. As a result of the commitments and partnership philosophy framed within the Framework Agreement and HPA, key informants indicate that the Parties have demonstrated new and unprecedented ways of working together. Partnerships have matured beyond the letter of the Framework Agreement and beyond the Tripartite Partners to include a broader network of formal and informal relationships, tables and processes for First Nations, federal and provincial governments, and others coming together at different levels (local, regional, provincial) to effectively build relationships, establish priorities and address issues. (Chapter 5 outlines details on the way in which the FNHA-MOH partnership has grown beyond Framework Agreement commitments to integrate the FNHA as a governance partner into multiple aspects of the provincial health system.)

Key informants acknowledge that consistency and strength of senior leadership facilitates the work of the governance structure, moving beyond the negotiating phase of the work and fostering trust that leads to new and evolving opportunities.

⁸² Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

“The whole idea of building trust with each other and building relationship...communication is really key for the partnership. Certainly in the early years of the negotiation phases, that wasn't always easy but I think that the willingness and the commitment of the Partners to get through that was very important in that we did have that shared vision.” – MOH KI

“I think the relationships between the Parties started off very challenging. During the period of negotiation and implementation of transfer, there was a sense of a new type of partnership, a new sense of people working together for the interest for all.” – FNIHB KI

“Finding the right people that have a sincere commitment to the work I think is a big deal. You've got to bring people to the table that think we can actually get something done and that decolonizing aspect of partnering in an authentic way that's a challenge with Indigenous people. That was a big lesson: unless we really do partner in an authentic way, it becomes inauthentic, and that's much less effective.” – FNHA KI

Evaluation findings indicate that the relationship and alignment between all of the various formalized and/or evolving components of the governance structure could be improved. Clearer linkages could be drawn between various bilateral and Tripartite tables, particularly in terms of how issues, barriers and priorities are resolved from local, regional and provincial levels. Creating greater flow and clarity would ensure that issues are resolved in a timely way; for example, not necessarily waiting for TCFNH meetings, but using the CEO to Deputy Minister and CEO-to-CEO forums to discuss issues.

“I see significant change and conversation that aligns to the Principles released by the Government of Canada, and subsequently by the Province, in that there seems to be greater appetite to learn and recognize opportunities for integration of Indigenous perspectives in policy design, development and implementation. This is great positive momentum, and an opportunity to really leverage the Tripartite supports in advancing Indigenous health.” – IC/TCFNH follow-up survey

Reciprocal Accountability

First Nations traditional social systems were founded on the concept of reciprocal accountability: that each member of the community was accountable for their decisions and actions and for their contributions to the community's wellness as a whole. These ancestral teachings underpin the BC First Nations health governance structure and are embedded in the Framework Agreement itself. Reciprocal accountability is defined as a shared responsibility among First Nations, and between First Nations and federal and provincial government partners, with each deploying their part of the system towards the achievement of common goals. The principle of reciprocal accountability supports the partners to hold responsibility for a common agenda even as their capacities and assets are very different from each other.

A Reciprocal Accountability Framework was adopted by the TCFNH in the fall of 2015. The intention was to create dialogue and facilitate innovation and adaptation rather than prescriptively govern outcomes. It is inspired by the HPA principles regarding leading with culture, honouring those that paved the way, maintaining unity and discipline, creating strong relationships, engaging at the appropriate level and respecting each other's process.

Box 3: The Reciprocal Accountability Framework

The Reciprocal Accountability Framework describes how Partners will support each other to achieve common goals and desired outcomes and “serves as a shared commitment of the Partners to be responsive, transparent, collaborative and diligent in advancing common priorities and striving for creative problem-solving as a means to overcome barriers.” The document is evergreen and is intended to support and guide ongoing efforts.

The Reciprocal Accountability Framework describes the ways in which the Partners will translate reciprocal accountability into their practice at five health system levels:

Tripartite Political Activities: Demonstrated by ongoing engagement between the FNHC, provincial Minister of Health and Minister of Indigenous Services Canada (formerly Health Canada).

Tripartite Governance Activities: Demonstrated by Tripartite Partners monitoring implementation of key commitments, working to identify and resolve issues and aligning planning and programming at the provincial level. This can be demonstrated through work of the TCFNH and the IC.

Regional and Provincial Governance Activities: First Nations in BC, regional health authorities and the Provincial Health Services Authority will demonstrate reciprocal accountability by working together to develop strategies and plans to address and advance health and wellness goals of First Nations provincially, regionally and locally. This is demonstrated by the work of Regional Partnership Accord Tables and associated Regional Health and Wellness Plans.

Executive and Senior Operational Activities: Executive leadership from respective organizations demonstrates reciprocal accountability by working collaboratively to develop strategies, priorities, policies, service standards, funding arrangement and regulations with respective mandates. This is demonstrated through partnerships at executive levels of organizations.

Operational and Health Service Delivery Activities: regional health authorities, the Provincial Health Services Authority and its subsidiaries, the FNHA and First Nations communities and service

providers demonstrate reciprocal accountability by strengthening collaborative partnerships for the coordination of service planning, design, management and delivery of health services for First Nations.

There is agreement that the integration of reciprocal accountability has been vital to the Framework Agreement's success and is a cornerstone to building trust and informing a new way of working together in partnership. Partners at various levels of the health system are developing mutually-supportive understandings of respective organizational roles and responsibilities in pursuit of common goals.

“Reciprocal accountability is to not just do what we’re supposed to do, but to help our partner to do what they committed to do well. That was real, they bought into it, that was really positive.” - FNIHB KI

There is increasing evidence of reciprocal accountability underpinning the way Partners work together. The evaluation shows that the TCFNH forum allows the TCFNH as a whole to maximize outcomes by capitalizing on the strengths and resources of each member organization, demonstrating reciprocal accountability as a function of working together. Examples of reciprocal accountability in practice amongst the partners, and at various levels of the health system, include: cultural safety and humility, the transition of pharmacy benefits from Non-Insured Health Benefits to BC PharmaCare and the response to the overdose public health emergency.

I've often said that the BC Tripartite partnership, inclusive of this notion of reciprocal accountability, was really the precursor to the broader kind of federal direction of reconciliation, and this kind of desire to create this renewed partnership with the First Nations.” - FNIHB KI

Whereas consistency of leadership has been deemed a component of success, key informants identified staff turnover as interrupting the flow of work and contributing to differing understandings of Framework Agreement roles and responsibilities. While all Partners are committed to the concept of reciprocal accountability, the evaluation suggests that the understanding of the concept, and the way it is put into practice, can be inconsistent. This is attributable in part to the turnover within partner organizations.

Key informants proposed several ways in which reciprocal accountability could be better understood by Partners. For example, there are regular election cycles within the FNHC

and FNHDA, a high level of turnover of Chiefs and Health Directors, as well as consistent changes within MOH and Health Authority representation at the TCFNH. While the Partners have their own onboarding/orientation processes, there is an opportunity to design and deliver an onboarding package and orientation sessions for new FNHC, FNHA, and FNHDA members and TCFNH representatives to facilitate collective understanding of the Framework Agreement, the First Nations health governance structure, and the concept of reciprocal accountability.

Enhanced First Nations Decision-Making

A primary purpose of the Framework Agreement is to ensure that BC First Nations are fully involved in health program and service delivery and decision-making regarding the health of their people.⁸³ The First Nations health governance structure is designed to facilitate First Nations decision-making in the transformation of health and wellness. (Chapter 5 outlines some of the collaborative efforts between First Nations and the provincial health system in more detail.)

“Another success of the health governance structure has been the inclusion of every BC First Nation, which allows for the advancement of health care that is suitably tailored to local-level need rather than reinventing the wheel/starting from scratch.” – KI

The engagement network operated by the FNHA consists of both dedicated staff and a set of formalized meeting processes. Staff include Community Engagement Coordinators and leaders embedded within regional teams who are supported by a centralized engagement and communications function. Formal meeting processes include Sub-Regional Caucuses, Regional Health Governance Caucuses and Gathering Wisdom for a Shared Journey. Key informants identify the engagement structure as an effective mechanism for gathering perspectives from First Nations in BC at local, regional and provincial levels and facilitating participation in key decisions affecting their health. This network is increasingly utilized to engage First Nations on issues related to health and wellness, but led by other parts of government, such as emergency management.

The creation of the FNHA, establishment of Regional Partnership Accords and regional engagement processes, as well as FNHC advocacy and the technical voices of the FNHDA

⁸³ Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

were underscored by respondents as key mechanisms for increasing First Nations presence, voice and influence at decision-making tables. Key informants from across the province indicate an increase in First Nations involvement in decision-making with respect to the planning, design and management of health services.

Expectations and awareness of the importance and need for the health system to engage with First Nations in local and regional service planning and design have also increased, leading to a series of agreements and committee structures between health authorities and First Nations. Key informants cite a greater frequency and willingness to engage First Nations about their needs and priorities; however, this is coupled with the need to ensure early engagement on decisions that have implications for communities – particularly as there are now established agreements and pathways for this to occur.

A set of challenges arose with the increase in shared decision-making and engagement opportunities. One of these relates to the definitions and expectations of shared decision-making and engagement; some respondents noted that the establishment of the FNHA creates a risk that partners may view engagement with the FNHA as equivalent to engaging directly with First Nations communities. There is also a risk of viewing engagement as evidence of shared decision-making which is sometimes, but not always, the case. In some cases, FNHA staff and First Nations community representatives feel their decision-making involvement is a “check box” exercise. Examples were shared of insufficient time being allocated for meaningful engagement, delayed engagement, poor integration of community-level feedback into final products or outcomes, and variability in the inclusion of First Nations in decision-making across the regional health authority geographic areas.

“The word ‘engagement’ sometimes is subjective and people have a different understanding of what engagement means and what the level of engagement means [...] it ranges from full on, right in my office and making decisions right beside me to advising and consultation. That’s sort of the spectrum and we have people that are all within that spectrum [...]. There are people that want to be hand-in-hand with my operational decision-making and there are some people that [...] want to be heard and want to see their work or their comments within the work but I think overall it’s been [...] successful; [we’re] still trying to find that sweet spot; what is that proper level of engagement, because it’s a wide spectrum.” – FNHA KI

Respondents expressed interest in having a better understanding of when and how policy and programming decisions take place and greater clarity on where First Nations can best

participate in these processes. There is often a lack of clarity on who are the points of contact in First Nation communities and health authorities for specific areas of work. There are also varying degrees of familiarity with the key commitments of the Regional Partnership Accord within health authorities, due in part to staff turnover.

Another challenge of shared decision-making is that each community and Nation has different health priorities; thus, suitably representing all First Nations communities as a single voice at decision-making tables is challenging. The FNHA has been diligent in its efforts to achieve an acceptable balance between the “Community-Driven, Nation-Based” principle and region or system-wide priorities. Maintaining a shared Vision and priorities across organizations requires effort, and at times a “political balancing act”, as described by one key informant. While key informants acknowledge that enabling First Nations to speak with a unified voice and make decisions regarding their health and wellness is a key success of the Framework Agreement, varying priorities between regions and communities are an important reality. Key informants are interested in having priorities more clearly or transparently drawn from local to regional and provincial levels so that all participants understand how priorities are generated and how they benefit First Nations individuals.

“The idea about being community-driven and having a regional viewpoint; those two things are in tension and that’s something we deal with all the time – and [the Health Authority] is trying to be standardized across a really large region and a little bit tailored for community context. I think that is a tension that lives on even in our world” – Northern Region KI

Finally, key informants frequently note the realities of time and capacity constraints to engage in shared decision-making. In most instances, partners are aware and respectful of the time and effort that is required for meaningful engagement to occur with First Nations. However, there are often pressing deadlines in areas such as service planning that do not facilitate the development of meaningful relationships and trust, particularly at a local level. Community representatives have many competing priorities and each community varies in its capacity to engage and participate in decision-making. Furthermore, there is often a lack of dedicated funding for engagement activities and communities may be expected to provide their time in-kind for engagement with regional health authorities and other provincial representatives. There is also the pressure of how much to invest in engagement relative to investing in service delivery priorities.

The FNHA shares the perpetual challenge of a lack of capacity in comparison to other provincial health authorities. Initially this was by design, with the intention of emphasizing

the development of partnerships with regional health authorities and other health system partners at a strategic decision-making level – ideally to the point where partners are aware of and considerate of First Nations interests even when the FNHA is not present at the table. However, at the moment, there is significant demand for the FNHA and First Nations to participate in a broad range of processes and tables at local, regional and provincial levels. Both the FNHA and First Nations run the risk of being spread too thin by participating in all opportunities. Key informants acknowledge that, due to its relatively small size within the health system, the FNHA will always be constrained in the number of tables in which it can fully participate, underscoring the importance of FNHA representation on strategic tables rather than all tables, and a health system primed to reflexively consider and integrate First Nations perspectives.

FNHC-FNHDA-FNHA Relationship

The work of the FNHC, FNHDA and FNHA leadership is guided by six shared values collaboratively developed in 2012: respect, discipline, relationships, culture, excellence and fairness.⁸⁴ The separate but complementary roles of the FNHC, the FNHA and the FNHDA are designed to facilitate reciprocal accountability for First Nations health and wellness priorities while also maintaining an appropriate separation of roles and functions. Key informants within an *FNHC-FNHDA-FNHA Relationship Agreement Evaluation* shared that mutual trust and reciprocal accountability between members has enabled each to become more effective in its own right.⁸⁵

“At the beginning, everyone was in a canoe, paddling together side-by-side, while now everyone is in the same canoe and has to learn how to row together.”⁸⁶

Formal Relationship Agreements, signed in 2012 and updated in 2018, aim to support the FNHC, the FNHA and the FNHDA to work together as effectively as possible.⁸⁷ These Agreements laid the foundation for joint planning meetings, which key informants cite as important means of facilitating dialogue on issues to be addressed, effectively building relationships, agreeing on shared priorities and allowing for information exchanges. The addition of four Elder Advisors to the group, as well as ceremony and a series of informal

⁸⁴ First Nations Health Authority. (2019). *Shared Values*. Retrieved from <http://www.fnha.ca/Documents/FNHA-Shared-Values.pdf>

⁸⁵ First Nations Health Authority. (2019). *FNHA-FNHC-FNHDA Relationship Agreement Evaluation*.

⁸⁶ First Nations Health Authority. (2019). *FNHA-FNHC-FNHDA Relationship Agreement Evaluation*.

⁸⁷ First Nations Health Authority. (2019). *FNHA-FNHC-FNHDA Relationship Agreement Evaluation*.

gatherings, is credited with allowing inter-personal and inter-organizational relationships to grow.

Key informants indicate a number of improvements in the partner relationships, attributing these to leadership, shared commitments to lateral kindness and improved outcomes, and establishment of a shared secretariat. Despite the advances in the relationships across organizations, the *FNHC-FNHA-FNHDA Relationship Agreement Evaluation* suggests areas for improvement. Key informants suggest that there are still a number of relationship challenges, including: a lack of clarity around roles and responsibilities (including how political advocacy is carried out and by whom), varied processes and levels of engagement of the FNHC and FNHDA at a regional level, and differing levels of trust between the FNHDA, the FNHC and the FNHA. The Relationship Agreement Evaluation recommends resolving these issues by: increasing clarity and discipline around joint processes, clearly defining the roles of each party through a matrix system, establishing a dispute resolution mechanism, and articulating the separation of business and advocacy roles for each body.

4.8 Key Findings

The Tripartite Committee on First Nations Health (TCFNH) ensures a whole-system approach to implementation of the Health Plans and Agreements and other commitments to First Nations health and wellness – in the spirit of reciprocal accountability. An important feature has been its ability to evolve through time, particularly as there has been success in “hardwiring” the FNHA and First Nations decision-making in the routine leadership processes of the health system, and maturing partnerships at regional and local levels.

Findings indicate increased trust and strengthened relationships built on reciprocal accountability. As efforts have shifted from transfer to health system improvement, partnerships have matured beyond the letter of the Framework Agreement to encompass a broader network of formal and informal tables. This has supported the TCFNH to evolve to become more effective at addressing system-wide issues requiring senior executive leadership. Relative consistency of senior leaders has facilitated the work of the governance structure.

However, member turnover (e.g. retirement, elections) can interrupt the flow of work and contribute to differing understandings of the Framework Agreement and intended roles and responsibilities, resulting in some inconsistencies in understanding of the concept of reciprocal accountability and the way it is operationalized.

The BC First Nations health governance structure is seen as an increasingly effective mechanism for facilitating First Nations participation in key decisions affecting their health, though roles and responsibilities could be more clearly articulated, risks related to turnover could be mitigated by onboarding opportunities, and time and capacity constraints could be managed.

The BC First Nations health governance structure, formalized by the Framework Agreement, is characterized by a shared commitment to the transformation of health and wellness for First Nations in BC and facilitated by its flexibility and mutual trust between entities.

Factors such as time, an increasing familiarity with the structure, consistency of key personnel, a common Vision and a genuine openness to change have facilitated the maturation of the relationship. Informal relationships between the Partners are now commonplace and complement the formal governance mechanisms outlined in the Framework Agreement. Success is also attributed to the engagement capacity and meeting processes that serve as vital components to the overall governance structure. With the strong increase in inclusion of First Nations in decision-making comes a set of challenges: finding a common understanding of what constitutes engagement and shared decision-making, tensions between local priorities and system-wide priorities, determining the right level of investment in engagement relative to service delivery pressures, and managing shared decision-making interests with the realities of time pressures and capacity constraints (particularly on the part of First Nations communities and the FNHA).

Chapter 5: Hardwiring First Nations and the First Nations Health Authority into the Provincial System

The Framework Agreement describes a commitment that the FNHA shall “work collaboratively with the BC Ministry of Health and BC health authorities on the design and delivery of provincial health services available to First Nations in BC” and “...integrate First Nation models of wellness into the health care system, to improve health outcomes and wellness for First Nations in BC. Over time, these relationships have evolved into the “hardwiring” of First Nations priorities into the provincial health system.

Hardwiring refers to embedding First Nations priorities and perspectives into decision-making processes across the provincial health system, recognizing that it is the system providing the vast majority of health policy, funding, programs and services accessed by First Nations people in BC, whether they live at home or away from home. The ability to work alongside provincial partners in policy development, planning, service design and delivery is fundamental to ensuring that First Nations perspectives become fully integrated into health services, and to improving the health and well-being of all First Nations individuals, families and communities in BC.⁸⁸

This evaluation noted numerous forums and mechanisms supporting and/or exemplifying hardwiring, including the introduction of the FNHA’s Quality Agenda,⁸⁹ the inclusion of the FNHA in the review of regional health authority and PHSA Mandate Letters,⁹⁰ the establishment of regional governance structures and processes, First Nations representation on health authority boards and joint planning and decision-making in emergency situations and community crises.

“Through this agreement First Nations are designing, delivering health services, and they’re more culturally appropriate; they’re based on what the communities need. They’re regionally and provincially relevant because they’re working more collaboratively with the provincial health system and the Health Authority.

⁸⁸ First Nations Health Authority. (2018). *Annual report 2017-2018*. Retrieved from <https://www.fnha.ca/Documents/FNHA-Annual-Report-2017-2018.pdf>

⁸⁹ First Nations Health Authority. (2018). *2018/2019 FNHA summary service plan*. Retrieved from <http://www.fnha.ca/Documents/FNHA-Summary-Service-Plan-2018-2019.pdf>

⁹⁰ Minister of Health. (2018). *Fraser Health Authority Mandate Letter*. Retrieved from https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/About-Us/Accountability/Taxpayer/201810_Mandate_Letter.pdf

*Through this agreement the First Nations have become a real player in the provincial health system.” – **FNHKB KI***

5.1 FNHA-MOH Health Governance Partnership

*“The Province has a very large set of policy agendas including primary care and mental health, those kinds of areas, and we’re able to influence those now and start hearing the provincial senior executives representing the work using some of our language and our ideologies. So it’s really interesting to see how it’s becoming embedded in their work.” – **FNHA KI***

*“FNHA is now seen as part of the provincial health system, participates in all important system governance and service committees, including the health system Leadership Council, and is the go-to organization for the important First Nations perspective when developing new health system strategies and policies, such as primary care redesign and MMHA’s new provincial mental health and addictions strategy.” – **MOH KI***

Since 2016, annual Letters of Mutual Accountability outlining the working relationship and annual priorities between the FNHA and MOH have been signed by the MOH Minister and Deputy Minister, the FNHA Board Chair and the FNHA CEO. These letters differ from the Mandate Letters issued by MOH to the other health authorities, in that the Letter of Mutual Accountability is framed as part of a governance partnership founded upon the principle of reciprocal accountability, and is co-created by the partners.

These successive Letters of Mutual Accountability were cited as examples of hardwiring the FNHA within strategic health system decision-making. As government systems are designed to be responsive to directives emanating from the highest levels, Key informants identified the annual Letter of Mutual Accountability as important in driving systemic change. For example, the 2016/2017 Letter of Mutual Accountability stated “the Ministry commits to align and “hardwire” the FNHA and First Nations health governance structure within the provincial health system and provincial priorities.” The annual Letter establishes a set of expectations for partnership, engagement and priorities for action, supported by a regular process of meetings between the MOH Deputy Minister and the FNHA CEO to oversee progress.

The partnership between the FNHA and MOH has matured by way of the FNHA sitting on all strategic health sector committees. In 2013, the FNHA was invited as a guest to the BC Health Leadership Council, whose membership is comprised of the Health Authority CEOs and the Deputy Minister of Health. Empowered through the authority of the MOH Deputy Minister, the BC Health Leadership Council “provides strategies, philosophies and principles that govern decision-making on a wide range of major provincial needs and issues and across all aspects of BC’s regionalized health care system.”⁹¹ In 2017, the FNHA became a full formalized member of the BC Health Leadership Council. Respondents to a follow-up survey conducted during winter and spring 2019 consistently cited the FNHA’s participation on the BC Health Leadership Council as both a facilitator and an example of the FNHA being hardwired into the provincial system. Key informants credited this process with supporting the development of relationships between the FNHA CEO and the CEOs of the other health authorities, particularly given the frequency of its meetings (monthly). In addition to the Leadership Council, the FNHA appoints members to all other provincial health Standing Committees.

Recognizing the unique role of the FNHA and MOH as governance partners, MOH has involved the FNHA in the mandating and planning processes of the other health authorities. MOH and the FNHA align Health Authority Mandate Letters and Health Authority service plans with the Letter of Mutual Accountability. MOH mandate letters to the health authorities include a provision to work jointly with the FNHA to further integrate First Nations perspectives into decision-making regarding health services and delivery.

“The [FNHA] CEO is on Leadership Council, so he’s got full voice and presence [...] and I actually I think [the FNHA is] beginning now to influence the agenda [...] from a formal structural point of view [the FNHA is on] equal footing as everyone else, and I think that actually that’s beginning to benefit all of us, in part [because] you build the relationships with people you see all the time.” – MOH KI

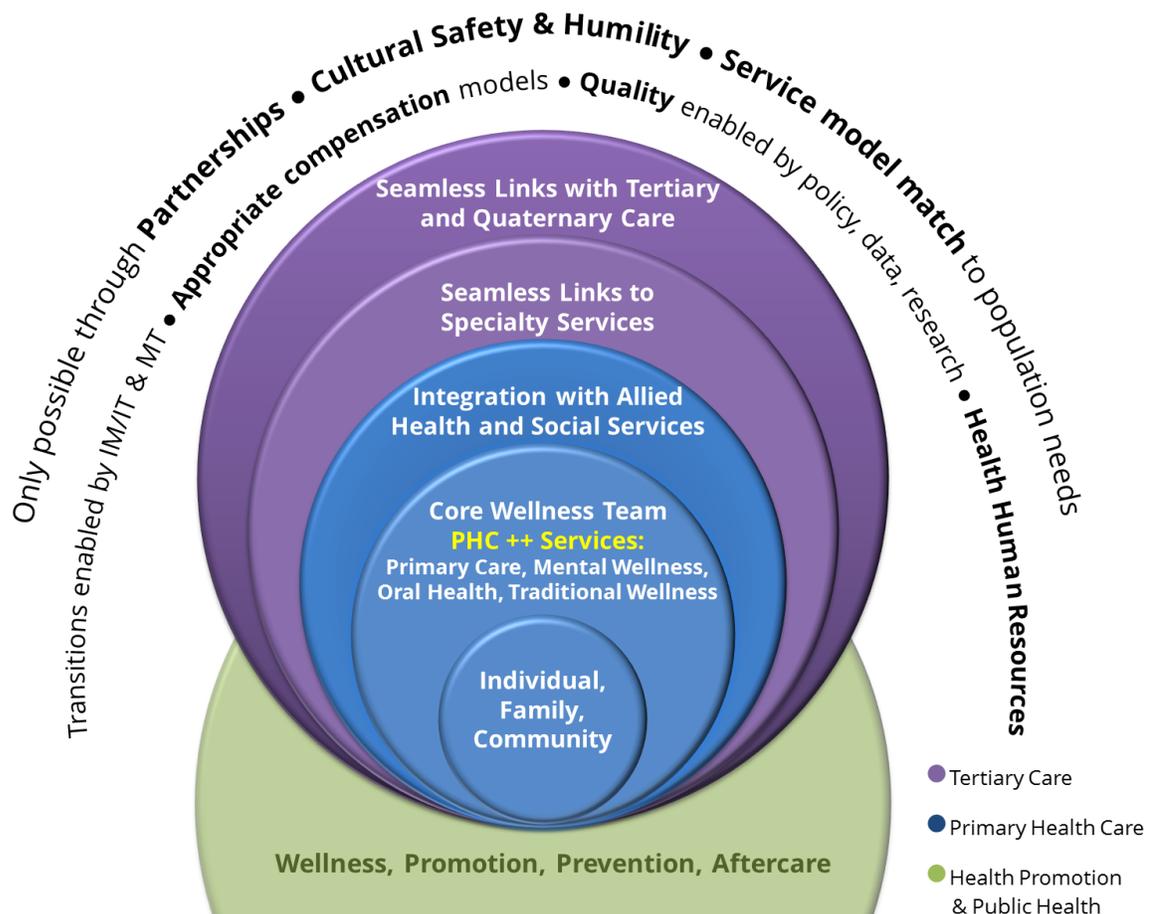
Primary Care

Primary care has been a key topic of focus of the FNHA-MOH governance partnership, with policy approaches supporting First Nations’ access to quality and culturally safe primary health care in alignment with the FNHA’s Primary Health Care ++ Approach. This approach

⁹¹ Information Management and Information Technology Executive Council. (2015). *Terms of reference*. Retrieved from https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/ehealth/bc_health_imit_executive_council_v11.pdf

places the individual, family and community at the centre, supported by interdisciplinary team-based care and wrap-around services provided at primary, secondary and tertiary levels with seamless integration. The “++” represents unique perspectives on health and wellness for BC First Nations, including the importance of cultural safety and humility as well as trauma-informed care, the provision of traditional wellness, oral health and mental health and wellness at the primary health care level, and strong integration with upstream community public health, allied health and wellness services.

Figure 12: The Primary Health Care++ Approach



Source: First Nations Health Authority (2018). *PHC++ Approach Backgrounder*.

The FNHA, MOH and other health system partners, such as the General Practice Services Committee, have undertaken work to ensure First Nations interests and perspectives are incorporated into all provincial primary care transformation initiatives. For example, in May 2018, the Government of BC launched a new provincial primary health care strategy focused on integrated, team-based care. One key initiative of the strategy was the establishment of primary care networks, which are clinical networks of primary care service providers situated in a geographical area serving the primary health care needs of a local

community, inclusive of First Nations communities. The FNHA, MOH and other health system partners worked to develop cultural safety and humility as a key attribute in the policy and ensure that the delivery of culturally safe care for First Nations in BC is a core priority of every network. The partners are actively working at the provincial and local levels to advance models of care that reflect First Nations needs.

In addition to the inclusion of First Nations perspectives and priorities in the primary care policy, the FNHA also worked with provincial partners to inform the development of a Primary Care Network Performance Monitoring and Evaluation Framework, wherein the FNHA supported the development and inclusion of indicators related to cultural safety. Likewise, as part of a major initiative to develop a province-wide measurement system for physician quality improvement, co-led by MOH and Doctors of BC, the FNHA has participated in a working group tasked with developing provincial quality measures for primary care. Finally, findings show that MOH and the FNHA worked in partnership to ensure the incorporation of First Nations perspectives into Physician Master Agreement policy re-opener and re-negotiation discussions. These examples attest to both the growing influence and hardwiring of the FNHA into the provincial system and the transformative work of making services more responsive to First Nations in BC.

These efforts are also leading to new service delivery opportunities, the status and impacts of which will be assessed in the next five-year evaluation. Through the governance partnership, the FNHA and MOH have partnered to provide funding for a range of First Nations-led Primary Health Care initiatives which will include hiring health and wellness practitioners, including traditional healers. This is expected to allow the FNHA and communities to provide primary care that is reflective of the First Nations Perspective on Health and Wellness and the Primary Health Care++ Approach.

“When First Nations are able to own and influence the decisions about our health and other services that impact our families and communities, the outcomes and successes will be positive.”⁹²

⁹² BC Ministry of Health, Fraser Health, & First Nations Health Authority. (2019). Improving primary care for Surrey’s Indigenous population. *BC Gov News*. Retrieved from <https://news.gov.bc.ca/releases/2019HLTH0042-000385>

Joint Ministry of Health – First Nations Health Authority Project Board (Joint Project Board)

Pursuant to the *Agreement In Lieu of Medical Services Plan (MSP) Premiums* negotiated by the FNHA and MOH in 2012, approximately \$15 million annually was earmarked to support new, improved primary care and mental health and wellness access and services across BC.

A Joint Project Board between the FNHA and MOH senior executive teams was established to oversee distribution of this new funding envelope. Criteria for this funding required alignment to Regional Health and Wellness Plans, partnership between First Nations and provincial health authorities, and incorporation of First Nations models of health and healing. This resulted in 27 new projects in areas of key importance for First Nations across BC, including primary care, mental health and substance use, and maternal child health.⁹³

Joint Project Board projects were continuously cited by key informants as emblematic of both shared decision-making and integration of the First Nations Perspective on Health and Wellness into service models. Joint Project Board projects have reported that building relationships between project staff/providers and staff/providers from other local health facilities and organizations and strengthening partnerships with health authority staff helped to strengthen coordination. See Chapter 6 for a summary of the impacts of these projects.

5.2 Regional Partnerships

Regional Partnership Accords, Regional Health and Wellness Plans and an increase in First Nations representation on most regional health authority boards have served to increase integration of First Nations perspectives into different parts of the health care system at a regional level. Evaluation findings cite Regional Health and Wellness Plans in particular as good examples of First Nations decision-making regarding region-specific health service planning and delivery, driven by First Nations priorities, needs, principles and values.

Relationship development among regional health authorities, First Nations leaders, technical health staff and community members is fundamental in developing a shared understanding of needs, building trust and establishing communication channels. Yet it is also challenging, given the historical relationship and mistrust of health institutions by First Nations people, as well as geographical distance, budget and time constraints. The Regional Partnership Accords have created a foundation for a relationship between

⁹³ Government of British Columbia & First Nations Health Authority. (2015). *Joint Project Board: Year in Review 2014-15*. Retrieved from <http://www.fnha.ca/Documents/2014-15-JPB-Year-In-Review.pdf>

regional health authorities and local First Nations. According to key informants, these Accords are strengthening relationships and collaboration, and demonstrate evidence of First Nations decision-making. Relationship building and the commitment demonstrated by partners have helped facilitate the success of the Regional Partnership Accords; as a result, many of the commitments described in the Accords are being operationalized.

Structures established through the Regional Partnership Accords provide an opportunity for the partners in each region to come to the table to build relationships, discuss issues, identify shared priorities and collaborate on solutions. Each Regional Partnership Accord has a unique structure that supports carrying out the work. A description of each regional structure is found in Section 2.3. Key informants noted that having the right representatives at the regional partnership accord tables is key to making progress and taking action (e.g. senior executives/CEO with decision-making capabilities, Chiefs and Health Directors). In all regions, separating governance and operational conversations was an identified need/challenge. Most regions (four out of five) have evolved to have operational tables that address more technical issues.

Regional Partnership Accord Evaluations found that a key facilitator to Health Authority-wide shifts in awareness, commitment and progress on the shared goals was the extent to which Health Authority CEOs championed and provided leadership to the commitments made in the Partnership Accords. Key informants regularly pointed to examples of Health Authority CEOs that made both personal and organizational-wide efforts to create accountability to the commitments in the Regional Partnership Accords.

Another key outcome identified in the Regional Partnership Accord evaluations is an increased awareness and understanding of each partner's roles and responsibilities in advancing the key goals of the agreement. For example, partners described an increased understanding of the locus of control on particular decisions, such as funding, program changes, timelines, and how decisions are made, engaged on and agreed upon. As a result of this increased understanding, partners reported an increased ability to focus on areas they could easily work together on and identified areas that would be better addressed and advanced through more systemic changes at more senior-level forums.

Turnover of leadership was cited in some cases as hindering momentum. The lack of funding and resources to support more relationship-strengthening opportunities (for example, dedicating time and money to in-person gatherings) and variations in organization size, flexibility, capacity, resources and policies to support Regional Partnership Accord work between the FNHA, First Nations communities and regional health authorities were also identified as a challenge. The provincial health system, inclusive of

regional health authorities, is large and complex, requiring prioritization and strategic focus to ensure work is sustainably advanced.

The Regional Partnership Accord evaluations indicated that, as a result of the Accord, there is enhanced openness, more awareness of First Nations customs, traditions and perspectives on wellness, and formal integration of the First Nations Perspective on Health and Wellness into facilities and activities (human resource supports, traditional wellness protocols, familiar spaces). The Regional Partnership Accord evaluations revealed fewer examples of shared decision-making at the local level with notable exceptions such as Joint Project Board projects and committees/working groups focusing on specific initiatives within a particular geography/care facility, such as cultural safety committees and Indigenous Health Improvement Committees. In addition, Regional Partnership Accord evaluations found that challenges still persist to ensure services are available and coordinated for BC First Nations individuals at home and away from home, and for Nations straddling multiple health authority boundaries.

A common suggestion among Regional Partnership Accord evaluation participants is to engage in more strategic planning discussions in order to identify partner capacities, better coordinate and guide partnership work and leverage resources in a coordinated way. In addition, there may be an opportunity in some regions to better integrate the goals of regional partnerships into the strategic plans and priorities of the regional health authorities.

“[The FNHA is] really looking to embed an Indigenous worldview to health and wellness services and our decision-making that matters around it [...] When we’re not in the conversation, people go back to their comfort zones, and that doesn’t include us [...] We’re still building those new relationships and trying to open people’s minds to how they think about health and wellness as it relates to our people.” – FNHA KI

5.3 Integrating the First Nations Perspective on Health and Wellness

“Our people [...] we can make decisions that matter to us, so I think that’s really one of the greatest achievements; that the Framework Agreement is creating a space [...] to put forward First Nations Perspective of Health and Wellness and that our [...] view of who we are and our health is becoming something that’s part of the mainstream conversation of health in this province.” – FNHA KI

The *Transformative Change Accord: First Nations Health Plan* and *Tripartite First Nations Health Plan* define health for First Nations as encompassing the physical, spiritual, mental, economic, emotional, environmental, social and cultural wellness of the individual, family and community. The Framework Agreement supports a governance structure that “reflects the cultures and perspectives of BC First Nations and incorporates First Nations models of wellness.”⁹⁴ The HPA defines a “wellness system” as “the incorporation of [I]ndigenous models of wellness into the health system and a shift in focus from sickness to wellness.”⁹⁵ Under Directive #3 of the FNHA, FNHC and FNHDA’s Shared 7 Directives – Improve Services - one of the strategic approaches is to “protect, incorporate and promote First Nations wholistic models of health and wellness into health services.” The First Nations Perspective on Health and Wellness (illustrated in Figure 4) continues to be a fundamental pillar of the work and is permeating throughout the system at multiple levels, from policy to service delivery.

At a provincial policy level, MOH and MMHA work with the FNHA to integrate the First Nations Perspective on Health and Wellness into multiple system-wide policies and strategies, including population and public health initiatives, the Strategic Mental Health and Addictions Roadmap,⁹⁶ and the planning and delivery of primary care networks. Similarly, the FNHA created a number of policy documents to support the integration of the First Nations Perspective on Health and Wellness, as well as cultural and traditional healing; for example, the 2014 *Traditional Wellness Strategic Framework*, developed through extensive consultation with traditional healers and First Nations, describes strategies and recommendations to promote and strengthen the role of traditional medicines and practices in the wholistic wellness of First Nations peoples in BC.

⁹⁴ Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

⁹⁵ First Nations Health Council, British Columbia Ministry of Health & Health Canada. (2012). *Health Partnership Accord*. Retrieved from <https://www.health.gov.bc.ca/library/publications/year/2012/health-partnership-accord.pdf>

⁹⁶ Government of British Columbia. (2019). *A Pathway to hope: A roadmap for making mental health and addictions care better for people in British Columbia*. Retrieved from https://www2.gov.bc.ca/assets/gov/british-cubians-our-governments/initiatives-plans-strategies/mental-health-and-addictions-strategy/bcmentalhealthroadmap_2019web-5.pdf

“We are seeing the [First Nations Perspective on Health and Wellness] consistently being championed and promoted in FNHA approaches with provincial partners and now the province has awareness and are including it as an element in provincial policy and programming.” – IC/TCFNHC follow-up survey

At a regional level, the First Nations Perspective on Health and Wellness is guiding service planning and delivery and the development of new initiatives and projects. The 2006 *Transformative Change Accord: First Nations Health Plan* established 19 Health Actions, which the Province of British Columbia committed to fund through the FNHA. In total, there have been 556 Health Actions initiatives funded, amounting to approximately \$32.8 million dollars. A review of Health Actions projects between 2014 and 2019 (see Health Actions Case Study) demonstrated that almost every mental health and wellness-related project was guided by the First Nations Perspective on Health and Wellness and almost half had a specific focus on traditional wellness revitalization.⁹⁷ Funding provided opportunities for community-driven, innovative approaches and projects to advance local and traditional values, thereby strengthening community resilience.

There is further evidence that models of care are shifting emphasis to wholistic, person-centered and family-centered care, supported by integrated care teams and partnerships and communications with other health providers and organizations. For example, Maternal Child Health Case Study key informants shared that there have been increased opportunities to learn, ask questions and bring reconciliation into their work, leading to the incorporation of First Nations cultural practices, such as baby welcoming ceremonies, and more wholistic approaches into maternal and child health care. The Fraser Health Authority pilot project on acute care wards identifies spiritual and cultural preferences, while providing an opportunity to include the social determinants of health as part of patients' care plans. Another pilot within Island Health Authority has incorporated First Nations perspectives on death and dying into the design of palliative care spaces.

Key informants suggested that these efforts are all integral to transforming the health care system in BC; however, there are ingrained policies, practices, and beliefs discounting Indigenous ways of knowing, constraining the development of a more wellness-oriented health system for First Nations. Maintaining a focus on wellness is a challenge in a sickness-

⁹⁷ The Mental Wellness and Substance Use category includes projects that pursued community solutions to mental wellness and substance use issues.

focused system wherein resource allocation is prioritized towards the most acute issues. Finally, while the concept is increasingly visible in strategies and policies, key informants indicate that some senior health staff may still only have a superficial awareness wellness, and that many frontline clinical staff and policy-makers remain unaware or do not understand how to integrate the First Nations Perspective on Health and Wellness into their work.

As a result, key informants proposed a number of suggestions for further influencing and embedding the First Nations Perspective on Health and Wellness into the health system:

- increasing opportunities to understand the concept through continued implementation of First Nations-led initiatives demonstrating the First Nations perspective and through awareness building activities (e.g. shared public health learning events and embedding champions within health authorities);
- developing a policy makers toolkit or instructional aid for applying the First Nations Perspective on Health and Wellness as a core lens of policy development (e.g. recent development of Indigenous Engagement and Cultural Safety Guidebook);⁹⁸
- collaborating with systems partners regulatory bodies and educational institutions,
- continuing expansion of team-based care;
- developing or continuing to support a cross-sectoral approach to addressing social determinants; and
- identifying resources to better integrate the First Nations Perspective on Health and Wellness into services and facilities (e.g. limited capital funding to make facilities more welcoming for Indigenous people).

“BC First Nations are re-writing the way their health care is delivered and traditional healing will play a vital role in this new system.”⁹⁹

In terms of traditional medicine specifically, the 2015-2017 Regional Health Survey study found that 43 per cent of study participants (First Nations adults in-community in BC) have used traditional medicines in the past year, showing that traditional medicines continue to be an integral part of the health and wellness journeys for many First Nations people in BC. That said, a significantly greater percentage of adults reported barriers to accessing

⁹⁸ BC Ministry of Health and First Nations Health Authority Cultural Safety Attribute Working Group. (2019). *Indigenous engagement and cultural safety guidebook: A resource for primary care networks*. Retrieved from https://www.pcnbc.ca/media/pcn/PCN_Guidebook-Indigenous_Engagement_and_Cultural_Safety_v1.0.pdf

⁹⁹ First Nations Health Authority. (2014). *Traditional wellness strategic framework*. Retrieved from https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA_TraditionalWellnessStrategicFramework

traditional medicines such as not knowing where to get them and not knowing enough about them. There is not similar data available for those living away-from-home.

“We continue to practice and plan in a Westernized way of describing health due to payment models, educational systems and regulatory body definitions.” – IC/TCFNH follow-up survey

“Integrating the First Nations Perspective on Health and Wellness into the health system requires a critical first step which is the mass recognition that Indigenous ways of knowing and being exist and are valuable and valid. Without that cultural shift at a structural/ideological level, the system will forever be challenged to create meaningful space for the First Nations Perspective on Health and Wellness.” – IC/TCFNH follow-up survey

BC Quality Matrix

The BC Patient Safety and Quality Council provides system-wide leadership efforts designed to improve the quality of health care in BC. In 2009, a BC Health Quality Matrix was adopted by the Health Quality Network,¹⁰⁰ comprised of 40 health system stakeholders in the province that is convened by the Quality Council. The Matrix aims to provide a common language, attributes, and understanding about health care quality across the entire provincial healthcare system. The collaboration between the FNHA and Quality Council created an awareness that the BC Health Quality Matrix definitions did not meet the needs of Indigenous clients, thus requiring the incorporation of new learning and a wholistic understanding of quality which is patient-centered. This work also advances the “best of both worlds” approach to uniting Indigenous and non-Indigenous worldviews. The update to the Matrix allowed for the First Nations Perspective on Health and Wellness to be hardwired within the provincially established Quality Matrix to be used by health care delivery organizations, leaders and practitioners.

Additionally, the FNHA participates as part of the steering committee for the annual BC Patient Safety and Quality Council Quality Forum and, through this process, First Nations health has been hardwired throughout the Forum’s proceedings.

¹⁰⁰ BC Patient Safety and Quality Council. (2019). *BC health quality matrix handbook*. Retrieved from <https://bcpsqc.ca/wp-content/uploads/2018/02/BCPSQC-Health-Quality-Matrix-February2017.pdf>

The Patient Voices Network,¹⁰¹ which is hosted by the BC Patient Safety and Quality Council, is another forum for inclusion of the First Nations Perspective on Health and Wellness. The Network is comprised of patients, families and caregivers who work with health care partners to improve BC's health care system. It aims to connect patient partners with health care providers to engage patient voices in an effort to improve quality care. For the development of a Cultural Safety and Humility Standard (see Cultural Safety and Humility Case Study for more information), the FNHA and Health Standards Organization partnered to convene a Cultural Safety and Humility Technical Committee. As part of this, three patients were recruited to sit on the committee through the Patient Voices Network, to bring the patient and family voices of First Nations to the development of the standard.

5.4 Integration of Cultural Safety and Humility

Possibly the most emblematic examples of hardwiring First Nations perspectives into the health system are the Declarations of Commitment related to cultural safety and humility. The first was signed by the senior executive leadership of MOH and all health authorities (including PHSA and the FNHA) in BC. Subsequent Declarations of Commitment have been signed by all 23 health regulatory bodies, the Ministry of Mental Health and Addictions, the Doctors of BC, the BC Coroners Service, Providence Health Care, Pacific Blue Cross, Emergency Management BC, BC College of Family Physicians and BC Patient Safety and Quality Council. The movement has also recently spread to federal organizations, including Health Canada, Indigenous Services Canada, and the Public Health Agency of Canada. The Declarations commit signatories to facilitate the creation of culturally safe environments and experiences for Indigenous people within the BC health care system, such as through building a workforce that reflects cultural humility in its work.

The hardwiring of cultural safety and humility throughout the provincial system is attributable to the formation of an executive working group by the TCFNH in 2015, made up of the FNHA CEO, the Provincial Health Services Authority CEO and MOH Deputy Minister. This group produced the first Declaration of Commitment, and an accompanying tool titled, *Guiding Framework for Action on Cultural Safety and Humility for First Nations and Aboriginal Health Services in BC*. The first policy statement publically released by the FNHA was its statement on cultural safety and humility in 2016.¹⁰²

Evaluation reports attest to the meaningfulness of the Declarations. Key informants describe a greater awareness and acknowledgement of the concept of cultural safety and

¹⁰¹ BC Patient Safety and Quality Council. (2019). *Patient Voices Network*. Retrieved <https://bcpsqc.ca/advance-the-patient-voice/patient-voices-network/>

¹⁰² First Nations Health Authority. (2016). *FNHA's policy statement on cultural safety and humility*. Retrieved from <https://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf>

humility within the provincial health care system. Many identified that one of the most effective means of celebrating successes in advancing cultural safety and humility is ceremony and public witnessing, building awareness and emotional memory of key accomplishments.

Building on commitments, a number of health authorities and organizations have produced their own frameworks and policies dedicated to creating culturally safe health care, and are reviewing their policies and services from a cultural safety and humility lens. Cultural safety and humility is an expectation in all mandate letters, and as a result, is now part of work plans and discussions of all Regional Partnership Accord tables. In addition, cultural safety and humility is embedded in Provincial Health Services Authority, Providence Health Care and BC Coroners Service work plans. There is evidence that territorial acknowledgements and cultural protocols are now routinely being carried out at local, regional, provincial and tripartite meetings.

Regional-level policy changes ensure that health facilities throughout the regions are becoming more welcoming for First Nations patients and their families. For instance, there has been an increase in displays of Indigenous art in facilities across the regions, increased availability of traditional foods in some hospital menus, drummer and dancer events, and the creation of Gathering Rooms, some of which include access to gardens growing traditional medicinal plants. Other facilities have created large birthing rooms to permit a larger number of family members to attend births. There is widespread policy change to allow for cultural practices such as smudging.

Additionally, several regional health authorities have introduced or expanded their Elders-in-Residence programs to support Indigenous clients, visits and facility staff. The Elders-in-Residence programs are considered to be particularly innovative and well-received by First Nations clients, who have appreciated the mentorship, personal consultation and perspective brought forward to ensure that they are supported in decisions about their health and wellness in an environment that is culturally safe.

According to the Cultural Safety and Humility Case Study, tripartite work has been undertaken to translate the momentum and awareness surrounding cultural safety into action. In March 2018, TCFNH approved a proposal to develop a Change Leadership Strategy on cultural safety and humility to consolidate, coordinate and systematically embed cultural safety and humility across the health system. The strategy focuses on supporting best practices, education and development, structural and personal aspects of change, reporting and measurement. Work is also underway to develop a measurement framework and accreditation standard, revisit the BC Quality Matrix and strengthen provincial cultural safety and humility knowledge development.

Key informants point to increased requests for the FNHA to participate in committees advising health care organizations on how to make programs and services culturally safe and review policies and processes. The increased interest in improving cultural safety and humility throughout the health system has led to a heavier burden on the FNHA relative to its resources and those of its partners, as well as heavy reliance on Aboriginal/Indigenous Health teams and Indigenous staff within health authorities to carry out cultural safety and humility responsibilities for organizations. The Change Leadership Strategy intends to generate dedicated capacity to manage this workload.

Many key informants indicate that while there is extensive and genuine leadership commitment towards cultural safety and humility, the work thus far has primarily focused on education and training, which may have limited impact on the complex problem of racism. More efforts are needed to move beyond training into interventions that support organizational culture change that will improve the client experience at the point of care.

It takes time for culture change to work its way through a complex system with many parts, ranging from provincial ministries to health authorities, from corporate leadership to frontline care providers, from doctors to intake nurses, from exempt to unionized personnel, and from provincial head office to regional teams. It will also take time to undo hundreds of years of colonialism, which has worked to dismantle Indigenous cultures, societies and governments over many generations. – FNHA KI

5.5 Data Governance and Availability

There is more data available now regarding the health status and health utilization of First Nations people in British Columbia than ever before. The signing of the *BC Tripartite Data Quality and Sharing Agreement* (TDQSA) in 2010 led to the creation of the First Nations Client File and the establishment of First Nations health information governance principles¹⁰³ in alignment with First Nations Ownership, Control, Access and Possession (OCAP®) principles.¹⁰⁴

¹⁰³ FNHA. (2019). *Health information governance*. Retrieved from <https://www.fnha.ca/what-we-do/research-knowledge-exchange-and-evaluation/health-information-governance>

¹⁰⁴ *Ibid.* This directly speaks to FNHA, FNHC and FNHDA Shared Directive #2: Increase First Nations Decision-Making and Control, specifically, implementation of the OCAP principle.

It is the existence of a province-wide institution such as the FNHA that creates the scope and resources required to develop the required partnerships, analytical expertise, and technological capacity to support the provision of data at provincial, regional, and local levels that otherwise would not be feasible.¹⁰⁵ Efforts have led to an increased respect for First Nations health information governance and OCAP® in key partner organizations such as MOH, PHO, and the Canadian Institute for Health Information – including First Nations control over First Nations data, inclusion of story and qualitative data, First Nations leading their own reporting, and the development of wellness-based indicators. For example, through the Population Health and Wellness Agenda, the FNHA has been consulting with Elders, Knowledge Keepers and youth across BC to explore the development of a First Nations-led ecological indicator that captures the First Nations connections to land, water and territory.

The existence of data sources such as the Health System Matrix (HSM) have been critical in identifying access and service levels for First Nations in each region of the province and is considered a key resource that First Nations can utilize to advocate for more targeted funding. Provincial and regional resource allocation decisions are influenced by data linkages that have been made between health utilization data and the First Nations Client File across all health regions. Both the HSM data and examples of its use to support service planning and investment are described further in Chapter 6.

There are still challenges with respect to the timeliness of data provisioning, and the full scope of data access by the FNHA due to legislative barriers.¹⁰⁶ A recent review of the TDQSA is leading to a focused work plan to address these issues.

5.6 Relationship between the FNHA Chief Medical Officer and BC's Provincial Health Officer

The Framework Agreement set the stage for improved collaboration between partners in provincial public health discussions. In fulfillment of Framework Agreement commitments, the role of a provincial Aboriginal (now Indigenous) Health Physician Advisor transformed into a Deputy Provincial Health Officer, expanding the authority of the role to include those enumerated under the *Public Health Act*. The Deputy Provincial Health Officer serves as the primary liaison between the Offices of the PHO and the Chief Medical Officer (CMO) at the FNHA. The CMO position is a unique function of the FNHA that did not previously exist within Health Canada.

¹⁰⁵ Praxis Management. (2019). *Data and information governance case study*. Retrieved from <https://www.fnha.ca/about/governance-and-accountability/audits-and-evaluations>

¹⁰⁶ *Ibid.*

The relationship between the FNHA CMO and the PHO was formalized through the signing of a Memorandum of Understanding (MOU) in October 2014. The MOU built on Framework Agreement commitments for the parties to work together through coordination and collaboration on strategies, reporting and responses to population and public health issues facing First Nations in BC. It further identified that the parties will support the designated Deputy Provincial Health Officer to work closely with the FNHA, and to support the effective functioning of the Office of the CMO. The FNHA CMO and PHO will sign a refreshed MOU in 2020.

Collaborative CMO and PHO work to develop and report on a suite of 15 new wellness indicators illustrates how new venues for collaboration have enabled the hardwiring of First Nations perspectives into BC public health approaches. First Nations identified the focus on deficits in existing Indigenous population health indicators; in response, the partners set out to develop new indicators reflecting both the First Nations Perspective on Health and Wellness and a strengths-based approach to health measurement. The new indicators were launched at Gathering Wisdom for a Shared Journey IX in 2018,¹⁰⁷ representing a transformed, strength-based approach to measuring Indigenous well-being in BC. The CMO and PMO will track these indicators over the next ten years (see Chapter 7 for further detail).

The partnership continues to expand and evolve, providing ongoing opportunities for the FNHA to influence provincial public health discussions and initiatives. For example, the CMO and PMO continue to work collaboratively on initiatives of interest for First Nations in BC, such as the overdose public health emergency, the development of a baseline measure for childhood obesity and a mechanism for data collection regarding the number of practicing certified First Nations health care providers.

The partners are also collaborating on the development of a comprehensive report examining the progress and challenges related to closing the gaps between the health status of Indigenous women and other women in BC using a wellness, social determinants and equity-based perspective. This report is expected to discuss success stories and areas where there may be room for improvement, innovative indicators connected to land and self-determination, as well as recommendations for the creation of specifically targeted programs to support better health.

¹⁰⁷ FNHC. (2018). Gathering Wisdom for a Shared Journey IX Recap. Retrieved from: <http://fnhc.ca/2018/06/>

5.7 Other Key Partnerships

In addition to becoming hardwired into the provincial health system at MOH and the provincial and regional health authority level, the FNHA has developed relationships with other health partners in alignment with Framework Agreement Section 6.1(1) (a) to “establish working relationships with...other health and health related organizations as necessary.” A number of these partnerships are outlined below.

- In 2014, the FNHA strengthened partnerships with the College of Physicians and Surgeons, the College of Dental Surgeons of BC and the College of Pharmacists. The FNHA works with professional associations such as Doctors of BC (formerly the BC Medical Association).¹⁰⁸
- The FNHA and Canadian Red Cross have built partnerships with other emergency service organizations, such as First Nations Emergency Services, BC Ambulance, Royal Canadian Mounted Police and ISC to ensure First Responder services and community infrastructure are integrated and aligned with provincial and federal health and emergency programs.¹⁰⁹
- In January 2016, contributions of \$1.3 million from Simon Fraser University and St. Paul’s Hospital Foundation (in addition to the FNHA’s \$600,000) helped establish Dr. Jeff Reading, a leading national and international expert in Indigenous health, as the inaugural FNHA Chair in Heart Health and Wellness at St. Paul’s Hospital, the first of its kind in Western Canada.¹¹⁰
- From 2016-2017, the FNHA, BC Cancer, the BC Association of Aboriginal Friendship Centres (BCAAFC) and Métis Nation BC partnered on a number of initiatives related to cancer – leading to the development of the Indigenous Cancer Strategy, *Improving Indigenous Cancer Journeys: A Road Map*, which was released in December 2017.¹¹¹
- The FNHA is a member of the Joint Steering Committee on BC’s Overdose Response, led by the BC Provincial Health Officer and all provincial task groups in direct partnerships with regional health authorities and the BC Centre for Disease Control.¹¹²

¹⁰⁸ First Nations Health Authority. (2014). *Annual report 2013-2014*. Retrieved from http://www.fnha.ca/Documents/FNHA_Annual_Report_2013-14.pdf

¹⁰⁹ First Nations Health Authority. (2015). *Annual report 2014-2015*. Retrieved from <https://www.fnha.ca/Documents/FNHA-Annual-Report-2014-2015.pdf>

¹¹⁰ First Nations Health Authority. (2016). *Annual report 2015-2016*. Retrieved from <https://www.fnha.ca/Documents/FNHA-Annual-Report-2015-2016.pdf>

¹¹¹ First Nations Health Authority. (2017). *Annual report 2016-2017*. Retrieved from <https://www.fnha.ca/Documents/FNHA-Annual-Report-2016-2017.pdf>

¹¹² First Nations Health Authority. (2017). *Annual report 2016-2017*. Retrieved from <https://www.fnha.ca/Documents/FNHA-Annual-Report-2016-2017.pdf>

- The FNHA has funding partnerships in place with many Indigenous organizations, such as the First Nations Education Steering Committee; Indigenous Sport, Physical Activity and Recreation Council; New Relationship Trust; BC Aboriginal Child Care Society; and the BCAAFC. These are further elaborated upon in the Health Actions Case Study.

Box 4: Relationship between BC Coroners Services and the FNHA

Relationship between BC Coroners Services and the FNHA

The relationship between the BC Coroners Service and the FNHA has evolved significantly throughout the years. The partnership and subsequent relationship-building activities were initiated following the death of Makara Gallagher, a seven week old Tla'amin infant (see [Makara's story](#)) in 2012. Since then, the BC Coroners Service has successfully worked with pathologists who conduct autopsies to make their practice more culturally appropriate for the families and communities of deceased children. Previously, standard practices dictated that pathologists retain the brainstem of infants for two weeks or more following a death. This practice is counter to the Tla'amin belief that the body be whole within a week following physical death so it can properly carry out its role in the Spirit World. Discussions were held between the FNHA and MOH on the coroner's practice, resulting in a coroners' review that found no added investigative value to retaining the brainstem once legal requirements were satisfied. As a result, the BC Coroners Service changed its practice to post mortem investigation of infant deaths to ensure the use of minimally invasive means wherever possible. As of 2016, the vast majority (over 90%) of families – including both First Nations and non-First Nations families – had their children's remains returned intact and have more of a voice in determining how their children's remains will be treated.

Building on these discussions, the FNHA and the BC Coroners Service signed a Memorandum of Understanding in 2014 and developed a joint work plan focusing on [common priority areas](#) related to data surveillance and the building of First Nations relationships and culturally safe services. These priorities have set the stage for collaboration between FNHA Regional Directors and Regional Coroners to support each other to improve the public safety and prevention of deaths for First Nations, develop regional death and dying protocols and ensure that FNHA staff are included in the event of complicated deaths.

A 2017 joint FNHA and BC Coroners Service death review panel demonstrates how the evolving partnership continues to hardwire Indigenous considerations into service changes. The report assessed the circumstances of injury-related deaths of 95 First Nations youth and young adults between 2010 and 2015. The review showed that the mortality rate for First Nations youth and young adults is twice that of non-Indigenous youth and young people. As a result of the report, the partners have developed an action plan to address injuries or the untimely death of First Nations youth and young adults.

5.7 Key Findings

The First Nations Perspective on Health and Wellness and the FNHA itself are “hardwired” into the provincial health system due to strengthening partnerships, the establishment of Regional Partnership Accords and an FNHA-led movement towards cultural safety and humility.

The First Nations Perspective on Health and Wellness, including related concepts such as Primary Health Care++, is becoming increasingly embedded in the policies, strategies and practices of the provincial health system. This level of hardwiring is attributed to strong executive partnership with MOH; the establishment of Regional Partnership Accords and associated capacity and committee structures; and the inclusion of the FNHA in various health system decision-making processes.

This influence has expanded with strong partnerships established with health organizations beyond those specifically named in the Framework Agreement, including other provincial Ministries, universities and key health care provider groups. This has served to advance strategic priorities and service improvements, and more broadly integrate First Nations perspectives into the health system and beyond.

Declarations of Commitment to Cultural Safety and Humility have created momentum in the system. A range of initiatives are now underway across many organizations to address racism and enhance cultural safety through cultural humility.

While broad leadership commitment and strong partnerships exist, some of the specific jurisdictional issues remain and require specific intervention (for example, related to data, to ensure services are available at home and away from home and to address Nations straddling multiple health authority boundaries). Similarly, the complex problem of racism is pervasive and will require systemic and focused efforts to influence change that improves the experience of care for First Nations and Indigenous peoples.

Regional Partnership Accords have been a key success in strengthened relationships and collaboration, identifying challenges and collaborating on solutions, and identifying shared priorities. The Accords have increased awareness of the importance and need for the health system to engage with First Nations and support First Nations decision-making.

The Accords have created systematic structures and processes for collaboration that have allowed for formal and informal relationships to flourish, particularly at leadership levels. Having the right representatives at the Regional Partnership Accord tables is key – and

must involve senior executives from the FNHA and the regional health authorities as well as representatives from the region. At the same time, there is a need to create greater distinction between governance and operational conversations.

As a result of the Partnership Accords, there is increased awareness of the need for First Nations engagement. At the same time, there is now a significant engagement “burden” with insufficient capacity on the part of the FNHA and First Nations in the region to participate in all of the requests. In larger health authority systems, there is also variable knowledge of the Partnership Accord commitments, particularly at the local level.

There are some early signals that the Regional Partnership Accord commitments are resulting in improved awareness and integration of the First Nations Perspective on Health and Wellness into service delivery, and emerging service delivery projects (e.g. Joint Project Board), thereby enhancing the quality of services.

Baseline data has been established for the first time and is being analyzed and released in a manner consistent with First Nations health data governance. Data are being leveraged to improve health service planning at regional and provincial levels, providing the impetus for new targeted funding and service allocations.

The establishment of the FNHA has created the opportunity for First Nations to lead the reporting of the health of their own population through their own institution. This is also resulting in increased appreciation and incorporation of First Nations health data governance not only in the work of the FNHA but its partner institutions. The availability of new data is generating new investments in First Nations health. The demand for data is not currently being met in a timely manner, and focused work is needed to support more effective data provisioning for local, regional, and provincial planning and investment.

Chapter 6 Improving Health and Wellness System Performance

The logic model for this evaluation posits that health and wellness system performance will increase for First Nations people as First Nations are more involved in governance and decision-making and as relationships between First Nations and the health system improve. The earlier chapters focus on progress made in governance, relationships, and integration. This chapter considers any early shifts in health and wellness system performance, with particular reference to service integration and coordination, cultural safety and humility, access and service utilization and experiences of care.

First Nations people in Canada historically had access to separate, sub-optimal health programs and services compared to other residents. The effects of systemic racism, in conjunction with the broader effects of colonial policies, have denied First Nations access to safe and quality health care.¹¹³ Jurisdictional disputes between provincial and federal governments regarding responsibilities for service delivery have also resulted in service gaps and barriers that are unique to First Nations. In response to such disparities, the Parties have continued to seek ways to “improve the quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs and services for First Nations.”¹¹⁴

Acknowledging it is still early days, IC/TCFNH survey participants indicate progress has been made with respect to improved health and wellness services for First Nations.

Illustrative examples that were provided by participants include:

- signing Declarations of Cultural Safety and Humility and the implementation of the *Framework for Action for Cultural Safety and Humility* (2016);
- 27 Joint Project Board-funded projects that address primary health care and other priority needs;
- *A Path Forward: BC First Nations and Aboriginal Peoples Ten Year Mental Wellness and Substance Use Plan*, released in April 2013;¹¹⁵

¹¹³ Allan, B., & Smylie, J. (2015). *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada*. Toronto, ON: the Wellesley Institute.

¹¹⁴ Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

¹¹⁵ Tripartite Committee on First Nations Health. (2014). *A report on the third year of BC Tripartite Framework Agreement on First Nation health governance implementation*. Retrieved from <http://www.fnha.ca/Documents/Together-In-Wellness-2013-14-Annual-Report.pdf>

- as discussed elsewhere in this report, commitments and actions to address jurisdictional barriers related to service provision in-community and for individuals away from home; and,
- responding to the BC overdose public health emergency, which has disproportionately impacted First Nations.

6.1 New Investments

The strength of the health partnership and inclusion of the FNHA at strategic levels of the health system have facilitated new federal and provincial investments in First Nations health. There are many examples of access to both federal and provincial funding that would not have been secured without the existence of the BC First Nations health governance structure.

In primary care, the Province of BC and the FNHA partnered through the Nurse Practitioner for BC (NP4BC) Initiative to fund 82 Nurse Practitioner positions to support First Nations communities and increase access to primary care, particularly in rural and remote areas. In recent years, regional health authorities and the FNHA have also made a number of joint investments in primary care delivery. The Lu'ma Medical Clinic, for example, is a new primary care home for urban Indigenous people in Vancouver which opened in April 2016 with funding from Vancouver Coastal Health Authority and the FNHA.¹¹⁶ In March 2019, the FNHA and Fraser Health Authority opened a jointly funded Indigenous Primary Health and Wellness Home in Surrey, providing a range of services to address physical, mental and social needs through their diverse staff, including a physician, primary care nurses and a registered psychiatric nurse.

In February 2018, the FNHA and British Columbia announced \$20 million in funding over three years to support Indigenous-specific responses to the overdose public health emergency, including \$2.4 million in harm reduction grants, which were distributed across 55 community-driven projects. The funding came in response to a review of preliminary data showing the overrepresentation of First Nations peoples in the overdose public health emergency. As per the Overdose Response Case Study, with this funding, the FNHA and partners developed and expanded harm reduction and mental health and substance use services. This included bringing culturally safe and relevant harm reduction training and services into community, such as “Not Just Naloxone” train-the-trainer workshops, and funding new First Nations-specific roles within the health system, such as Addictions Specialists and Peer Coordinators. The case study found that efforts to remove barriers

¹¹⁶ First Nations Health Authority. (2016). *Together in wellness: Tripartite Committee on First Nations Health annual report, October 2015-2016*. Retrieved from <http://www.fnha.ca/Documents/2015-2016-Together-In-Wellness.pdf>

around opioid agonist treatment (OAT) are working particularly well – including covering clinic fees, accepting people on OAT into treatment centres, and supporting Health Canada regulation changes so nurses and other allied health professionals can maintain people on OAT, among others. Other aspects of the overdose response that appear to be working well include “Indigenizing” overdose recognition and response training (i.e. naloxone training) as a way to initiating culturally safe and relevant discussions about substance use and harm reduction in First Nations communities, as well as covering both naloxone formulations (i.e. intranasal and intramuscular) as an insured health benefit.

At a regional health authority level, there are numerous examples of innovative and new funding approaches and commitments. For example, in October 2017 Interior Health approved \$2 million – the equivalent of 30 residential care beds – for nursing enhancement (see Box 5: Health System Matrix). Northern Health Authority and the FNHA have also partnered in delivering community-based wellness funding projects, with \$160,000 being allocated to 34 projects in 2015/16.¹¹⁷

Additional examples include the Joint Project Board funding envelope, Mental Health and Wellness planning funding, wildfire response support and funding for the Aboriginal Head Start On-Reserve program. These investments are emblematic of the shift that has been achieved in addressing jurisdictional wrangling, and the strength of the FNHA’s inclusion in decision-making processes at the provincial level. Key informants indicated that some funding and resources are short-term and temporary, which creates challenges with sustainability of programming and services.

Box 5: Data in Decision-Making

The FNHA and MOH have increasingly leveraged the First Nations Client File to improve health service planning at regional and provincial levels, furthering the integration and coordination of services, as discussed in the examples below.

Health System Matrix

The FNHA and MOH enabled a data linkage between the First Nations Client File and the provincial health system matrix to identify opportunities for enhanced effectiveness in provincial health services accessed by First Nations. Initially the project started with Interior Region and was expanded province-wide. In Interior Region alone, this data match led to enhanced investments in nursing, mental health and designated substance use recovery beds. The project identified “that in comparison to other residents in 2013/14, First Nations Elders were less likely to visit physicians, had higher prevalence rates for many chronic conditions, and were more likely to visit

¹¹⁷ First Nations Health Authority. (2016). *Together in wellness: Tripartite Committee on First Nations Health annual report, October 2015-2016*. Retrieved from <http://www.fnha.ca/Documents/2015-2016-Together-In-Wellness.pdf>

the emergency department.”¹¹⁸ These informed Interior Health’s decision to invest \$2 million (the equivalent of 30 residential care beds) on an ongoing basis for nursing enhancements for Elders and those living with chronic conditions, set to begin in 2019/20. The FNHA contributed an additional \$1 million beginning in 2018/19 to this initiative to support community preparedness.¹¹⁹ The data set led to the Interior Region leveraging 15 of the 73 substance use treatment beds to be designated for First Nations within the Interior Region among existing Aboriginal service providers as part of the Province’s commitment to add 500 additional substance use spaces throughout British Columbia by 2017.^{120,121}

Overdose Response

In August 2017, the FNHA and provincial partners released *Overdose Data and First Nations in BC: Preliminary Findings*, employing the First Nations Client File linked to data from the BC Coroners Service, Drug and Poison Information Centre, BC Emergency Health Services/Ambulance Service and emergency department visits at hospitals across BC.¹²² The linkage showed “First Nations peoples are disproportionately affected by overdose events and overdose deaths.”¹²³ The report found that, relative to other residents, First Nations people are five times more likely to experience an overdose event, and are 3 times more likely to die due to an overdose.¹²⁴ Subsequent data shows that the death rate from overdose events rose by 21 per cent between 2017 and 2018, with First Nations people 4.2 times more likely than other residents to die due to an overdose.¹²⁵ Since the release of *Overdose Data and First Nations in BC*, MOH, in partnership with the MMHA, has committed \$20 million to support First Nations communities and Indigenous peoples to respond to the overdose crisis.

¹¹⁸ First Nations Health Authority, & Interior Health. (2017). *\$3 million dollar joint investment brings enhanced Elder care to Interior Nations*. Retrieved from [https://www.fnha.ca/about/news-and-events/news/\\$3-million-dollar-joint-investment-brings-enhanced-elder-care-to-interior-nations](https://www.fnha.ca/about/news-and-events/news/$3-million-dollar-joint-investment-brings-enhanced-elder-care-to-interior-nations).

¹¹⁹ First Nations Health Authority., Interior Health. (2017). *\$3 million dollar joint investment brings enhanced Elder care to Interior Nations*. Retrieved from [https://www.fnha.ca/about/news-and-events/news/\\$3-million-dollar-joint-investment-brings-enhanced-elder-care-to-interior-nations](https://www.fnha.ca/about/news-and-events/news/$3-million-dollar-joint-investment-brings-enhanced-elder-care-to-interior-nations).

¹²⁰ Interior Health. (2016). *Initial contracts awarded for support recovery beds*. Retrieved from <https://www.interiorhealth.ca/AboutUs/MediaCentre/NewsReleases/Documents/Initial%20contracts%20awarded%20for%20support%20recovery%20beds.pdf>

¹²¹ First Nations Health Authority. (2017). *Aboriginal supportive recovery beds planned for newly opened wellness centre*. Retrieved from <https://www.fnha.ca/about/news-and-events/news/aboriginal-supportive-recovery-beds-planned-for-newly-opened-wellness-centre>

¹²² First Nations Health Authority. (2017). *Overdose data and First Nations in BC*. Retrieved from https://www.fnha.ca/AboutSite/NewsAndEventsSite/NewsSite/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb_July2017.pdf.

¹²³ First Nations Health Authority. (2017). *Overdose data and First Nations in BC*. Retrieved from https://www.fnha.ca/AboutSite/NewsAndEventsSite/NewsSite/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb_July2017.pdf.

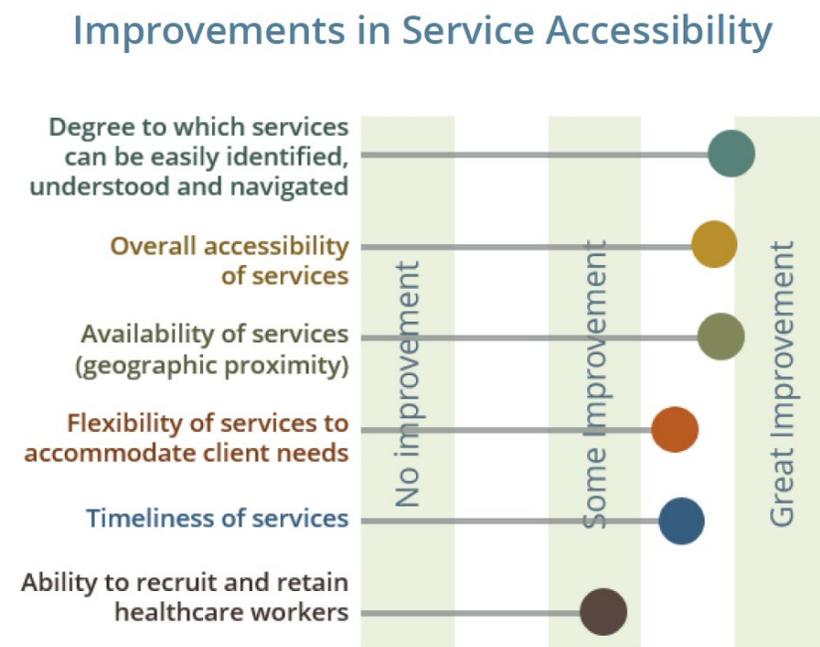
¹²⁴ First Nations Health Authority. (2017). *Overdose data and First Nations in BC*. Retrieved from https://www.fnha.ca/AboutSite/NewsAndEventsSite/NewsSite/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb_July2017.pdf

¹²⁵ FNHA. (2019). *The impact of the opioid crisis on First Nations in BC*. Retrieved from: <https://www.fnha.ca/AboutSite/NewsAndEventsSite/NewsSite/Documents/FNHA-Impact-of-the-Opioid-Crisis-on-First-Nations-in-BC-Infographic.pdf>

Joint Project Board Projects

As noted in the previous chapter, there are currently 27 Joint Project Board projects across the province. They focus largely on primary care and/or mental health and substance use (71 per cent of projects), as well as service navigation, chronic disease, home care and maternal child health. In 2017/18, 52 per cent of projects were fully operational (all clinicians hired and seeing clients) across the province, and the majority of funded health care provider positions have been filled. Joint Project Board projects across the province were cited as supporting increased access to health services across multiple dimensions (see Figure 13), including the degree to which services can be identified and navigated, the increased availability of services closer to home, and the timeliness of access to services. Projects reported increases in outreach and service uptake through participating in community events, engaging with Health Directors, utilization of text and email notifications regarding services, and ensuring flexibility of services that accommodate the schedules of patients.

Figure 13: Rating of Accessibility Improvements from Joint Project Board Projects

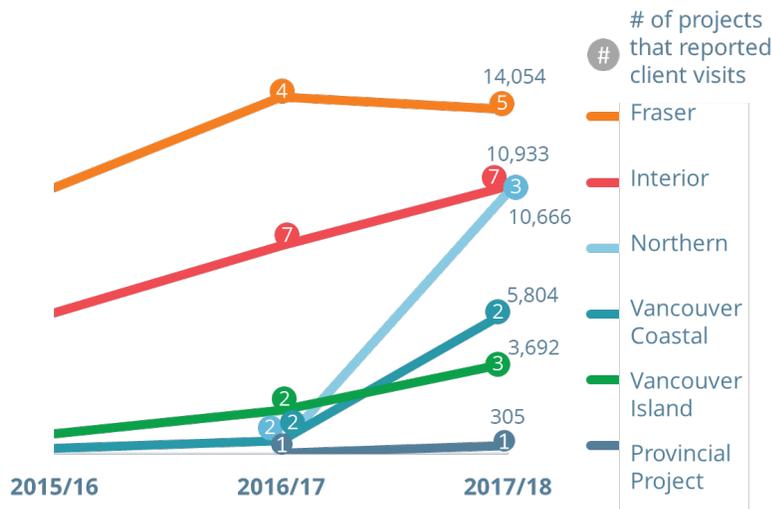


Source: First Nations Health Authority. (2019) JPB 2017/18 Annual Narrative Report submissions

Projects described a strong emphasis on providing wraparound care, characterized by wholistic, person-centred and family-centred care. As of 2017/18, 92 per cent of Joint Project Board projects reported that wellness is being integrated into care delivery, primarily through the inclusion of social and environmental factors (e.g. housing and food

security) into wellness assessments and discussions with clients, introduction of navigators and coordinators, and building partnerships with other organizations outside of the health sector. Ninety six per cent of Joint Project Board projects reported that, as a result of the project, cultural safety and humility has been improved.

Figure 14: Provincial Analysis Report



Source: First Nations Health Authority. (2019). JPB Projects 2017/18 Provincial Analysis Report

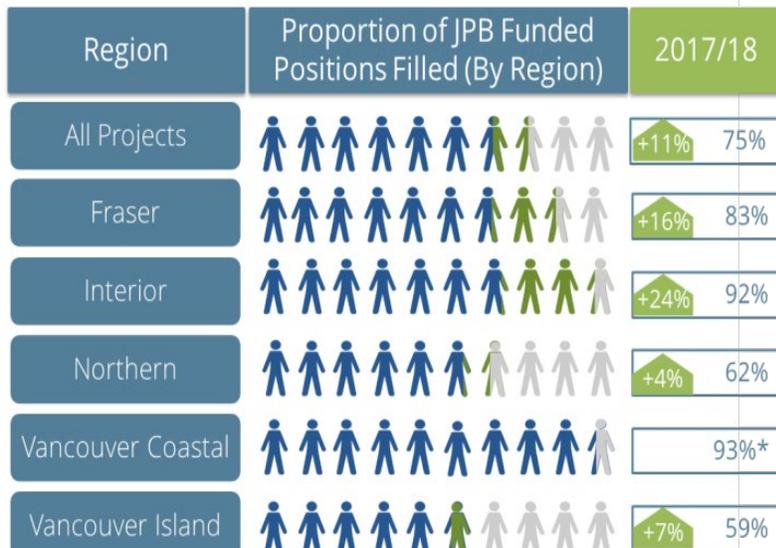
Project impact on improving accessibility and availability of services, combined with steady implementation progress, is reflected in increased utilization of project services in all regions over the past three years. Total client visits of all Joint Project Board projects increased by 77% (from 25,682 to 45,454 visits) from 2016/17 to 2017/18 (see Figure 14).

The top service utilization-related barriers reported within Joint Project Board projects were “client being unaware of services” and “restricted provider hours/availability”, reported by 50 per cent of projects. Other service utilization barriers reported included “clients don’t trust/know the providers yet,” reported by 39 per cent of projects, and “location of services difficult for clients to get to,” reported by 29 per cent of projects. The proportion of projects reporting these service utilization barriers remained roughly the same from 2016/17 to 2018/19, except for “location of services difficult for clients to get to,” which increased from 19 per cent in 2016/17 to 29 per cent of projects in 2017/18.

Some common challenges have arisen across the operationalization of these projects. Recruitment and retention challenges were among the top barriers reported by projects in both 2016/17 and 2017/18. However, the proportion of filled Joint Project Board funded positions has increased or been maintained in every region and across every health care professional group indicating improved recruitment and retention strategies (see Figure

15Figure 3). The percentage of JPB funded positions increased by 11 per cent between 2016/17 and 2017/18, with 75 per cent of positions filled.

Figure 15: Joint Project Board Funded Positions by Region



Source: First Nations Health Authority (2019). JPB Projects 2017/18 Provincial Analysis Report

As shown in Figure 16, the top three most commonly reported implementation barriers in 2017/18 included: “lack of trained candidates in the area,” “information and technology (IT) issues,” and “barriers related to funding conditions.” Key informants noted that as the FNHA and partners embark on additional primary care projects and initiatives, these will likely face similar barriers.

Figure 16: Top Three Most Commonly Reported Implementation Barriers, JPB Project, 2017/18

Recruitment & Retention	Infrastructure	Funding Conditions
Lack of trained candidates in the area (54%)	IT issues (e.g. Bandwidth, EMR) (50%)	Barriers related to funding conditions (42%)
Lack of short-term housing/accommodation (38%)	Lack of physical office space (42%)	Lack of clarity on funding usage, eligible activities, and available resources
Unable to attract local qualified candidates (33%)	Lack of confidential clinical space (42%)	
Length of time to hire (e.g. developing job description, posting job, signing contract, setting up workspace) (25%)	Lack of spaces where clients feel comfortable and safe accessing care	
Finding candidates who are an appropriate fit and culturally safe and humble		

Source: First Nations Health Authority (2019). JPB Projects 2017/18 Provincial Analysis Report

Two examples of JPB projects being delivered across the province include the Kwakwaka’wakw Primary Maternal, Child and Family Health Collaborative Team on Vancouver Island and the Riverstone Mobile Detox/Daytox Program in the Fraser Salish region. These projects are described in further detail below.

The Kwakwaka’wakw Primary Maternal, Child and Family Health Collaborative Team, for example, is a Joint Project Board project that began in 2015 on North Vancouver Island. It aims to provide Indigenous women who are pregnant with a coordinated maternal, child and family health program that is closer to home, culturally safe, trauma-informed and women-and-family-centred. An evaluation of the program found that women felt supported by the services offered, and that the check-ins and practical supports offered by staff (e.g. helping to arrange or providing transportation, facilitating access to food or other health, wellness or cultural supports, attending medical or other appointments and providing moral and emotional supports) helped reduce stress for families. The project has also identified a marked reduction of newborn children removed from families and placed into the system. This is attributed in part to increased access to regular prenatal care, improved collaboration with the Ministry of Children and Family Development and other agencies to develop a plan before babies arrive, increased collaboration between various

programs supporting families, and the provision of relational, trauma-informed and woman-centred midwife services (it was also noted that rates of newborns removed from families in hospital may have been decreasing generally on the North Island during this period of time).

The Riverstone Mobile Detox/Daytox Program, a Fraser Health Authority project which began in 2010 and expanded through Joint Project Board funding in 2015 to include the creation of a First Nations Outreach Team, is another example of a program that directly supports needed services in First Nations communities. The aim of the Riverstone program is to provide short-term support to clients and their families through the provision of mobile, home and outpatient detox services using a culturally-safe wraparound model. Since the Outreach Team started visiting communities, some of the most significant changes observed include an increase in self-referrals among community members in some communities, coupled with a stronger willingness to go through the detox process. Naloxone kits are also widely seen as being more available and used in community as a result of Riverstone. In one powerful example, a community member who was hesitant to pick up a naloxone kit for himself picked up three kits when a Riverstone staff member encouraged him to take some for his friends. A week later, the person returned, proudly stated that he had “saved three lives that week.” And while First Nations Health Directors acknowledged that substance use disorders are a chronic relapsing condition and that many patients do not benefit from detoxification services immediately, a few have observed that clients of the Riverstone program have benefitted substantially (e.g. ceased to consume alcohol and other drugs as well as improved diet and exercising).

6.2 Integration and Coordination of Services

The Framework Agreement envisioned a more integrated health system for First Nations, one in which stronger linkages exist between the Parties to “better coordinate the planning, design, management and delivery” of programs and services (Recitals, S I.2) and an intention to “avoid the creation of separate and parallel First Nation and non-First Nation health systems.”¹²⁶ This Vision is particularly important due to the long-standing jurisdictional gap between provincial and federal governments over health services for First Nations. Jurisdictional disputes originate from the constitutional division of powers, wherein health care is the primary jurisdiction of the provinces while “Indians and land

¹²⁶ Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

reserved for Indians” are a federal responsibility.¹²⁷ The acknowledgement by the Province of BC in the TCA: FNHP of its responsibility to provide “all aspects of health services to all residents of British Columbia, including Status [First Nations] living on and off-reserve,”¹²⁸ was a bold and critical step in eliminating this jurisdictional gap.

Findings from evaluations of the Regional Partnership Accords suggest there is greater willingness and understanding of the need to integrate and coordinate with partners to support successful design and implementation of services. In some regions there is also greater willingness and understanding of the need to collaborate directly with First Nations communities. In addition, there is a sense that transfer, together with intentional efforts to better understand the distribution of services available to First Nations, enables an enhanced awareness of service fragmentation and gaps, which is instrumental for service transformation moving forward (see Box 6: Addressing barriers at the TCFNH).

“I think we can see changes [...] there's not that divide. Before, you'd want to get service for a First Nations person, they'd say: “nope, that's not our responsibility, that's a federal responsibility.” [...] I had a couple clients phone and say, you know: ‘I can't get this service’ but [then if] you phone the Health Authority and they [...] said: ‘oh! Well, yeah, we can do that,’ and they helped resolve those issues.” - MOH KI

Key informants cited the partners’ response to the provincial wildfire emergencies in 2017 and 2018 as an example of how the new governance arrangement, and the relationships borne of it, enables the partners to overcome jurisdictional divisions to mount a more timely, coordinated emergency response than previously possible. While there was still a lack of certainty surrounding the roles of partners’ respective responsibilities in responding to the wildfires, key informants noted a greater willingness of the partners to respond in a timely way rather than debate the respective roles that each partner were legally mandated to fulfill. Relationships forged between executives through the TCFNH and between the FNHA and regional health authorities were cited as facilitators allowing the partners to navigate through the challenge of coordinating roles and activities of various agencies involved. At the regional health authority level, there were efforts to ensure the FNHA was included in multi-agency and internal meetings, kept apprised of developments

¹²⁷ British North America Act, 1867, 30-31 Vict., c. 3 (U.K.) Retrieved from <https://www.justice.gc.ca/eng/rp-pr/csjsj/constitution/lawreg-loireg/p1t11.html>

¹²⁸ BC Assembly of First Nations, First Nations Summit, Union of British Columbia Indian Chiefs, & Province of British Columbia. (2006). *The Transformative Change Accord: First Nations health plan - supporting the health and wellness of First Nations in British Columbia*. Retrieved from https://www.health.gov.bc.ca/library/publications/year/2006/first_nations_health_implementation_plan.pdf

and identified in opportunities for coordination and support throughout the response. MOH and the FNHA also worked closely with multiple health system partners to develop and release BC's Mental Health and Wellness Disaster Recovery Guide in 2019.

In addition, the FNHA transition to BC PharmaCare in 2017 was identified as a step towards greater integration with provincial services, as FNHA clients are now part of the provincial drug benefits insurance program. While the transition process to PharmaCare saw some challenges, over the long term, the transfer is anticipated to support increased access to benefits and services, simplified approvals processes that reduce the number of steps needed for prescription approvals, reduced need to navigate parallel systems (i.e. federal and provincial) and increased opportunities for partnership with provincial stakeholders. For more on planning and transition of health benefits to the FNHA, see the Evaluation of FNHA's Health Benefits – Pharmacy Program for BC First Nations.¹²⁹

Regional Partnership Accord evaluation reports also attest to efforts being made to improve health system coordination for First Nations clients and their families through Aboriginal Patient Liaisons or Aboriginal Patient Navigators. These positions support patients and their families to better navigate the health care system, including discharge planning, accessing community and spiritual services and other supports. Joint Project Board funding also supports a range of navigation positions. Finally, Northern Health Authority has evaluated the dissemination of a range of booklets created to support Indigenous access and navigation of the health system developed in response to the needs identified by Indigenous community members, leaders and health care providers.

While there are a range of initiatives to address fragmentation in services for First Nations and to align priorities and plans, there is a sense that improving integration and coordination of services remains a work in progress. In some regions, while there are examples of coordinated service delivery initiatives, findings suggest improved coordination of services has not always extended beyond the confines of partnership projects, or beyond the executive and leadership levels into other and/or more local levels of the Health Authority systems. One region cited the continuing challenges in providing regional health authority services in-community, which resulted in specific gaps in services (e.g. home care services). Regional health authority union and human resources policies (e.g. working alone policies, restrictive travel policies limiting travel on forest roads) are perceived to constrain the expansion of regional health authority delivery of services in community, particularly for rural and remote communities.

¹²⁹ Goss Gilroy Inc. (2019). Evaluation of FNHA's Health Benefits – Pharmacy Program for BC First Nations. Retrieved from <https://www.fnha.ca/Documents/Evaluation-of-FNHAs-Health-Benefits-Pharmacy-Program-for-BC-First-Nations.pdf>

Additionally, jurisdictional and geographical realities, such as First Nations whose territories cover more than one regional health authority catchment area, create potential barriers to health services due to confusion by First Nations communities on where to receive services and health service providers or Health Authority jurisdictional confusion/divisions. A lack of alignment between regional health authority geographic regions or sub-regions, and the existing territorial boundaries of Nations, is seen as a challenge to coordination of service. Some Nations' territories straddle multiple geographic health authorities, compounding confusion regarding responsibilities for services and doubling or even tripling the amount of communication received by First Nations.

Findings also suggest that a lack of clarity regarding roles and responsibilities with respect to service delivery among regional health authorities, the FNHA and other agencies, hinders improvements. The Regional Partnership Accord evaluations indicate a lack of clarity regarding the services that each agency is providing, or is responsible for delivering, to First Nations. Community respondents in Regional Partnership Accord evaluations identified a lack of awareness around which services are or should be available in community and in some cases noted a lack of consistency of available services between communities. Some key informants noted that as the FNHA assumes a greater service delivery role, the risk of duplication of services also increases in the absence of coordinated planning. Fear of duplicating services, in the absence of clearly assigned responsibilities for specific services, was perceived to have a demobilizing effect, slowing efforts to address areas where there are gaps or pressing needs.

Finally, the Framework Agreement commits to the development of clinical/patient information protocols and systems between the FNHA and BC to support better integration and coordination of care. The sharing of clinical information at the frontline service delivery level emerged across regions and Joint Project Board projects as a barrier to coordination and continuity of care. This includes a lack of community access to regional health authority electronic medical record (EMR) systems and lack of integration of multiple EMR systems, reluctance to share information between providers due to perceived privacy concerns, and misperceptions regarding circumstances in which information can be appropriately shared within the circle of care. Without formalized processes enabling the sharing of clinical information, there is a reliance on actions of individual clinicians and ad hoc relationship-based measures, which are cited as insufficient to ensure the consistent flow of clinical information.

The ongoing barriers reported in this area signal that there has been limited system-wide progress on these Framework Agreement commitments, and that greater attention is

needed by the Partners in the development of new policies, systems, and other formalized measures.

6.3 Cultural Safety and Humility

Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. Successful integration of cultural safety is expected to result in a health care environment that is free of racism and discrimination, where people feel safe when receiving health care. This includes experiences of care at both the patient-provider and system levels that may be described as appropriate, competent, sensitive, and respectful, and that considers the physical, mental, social, spiritual and cultural components of patients and their environment.

Cultural humility is a process of self-reflection and self-interrogation that seeks to understand and remove personal, non-objective biases and develop and maintain respectful partnerships based on mutual trust. This approach seeks to remove the historically pervasive perception of power imbalance between the patient and care providers by training and encouraging providers to instead partner with patients in their health care journey.¹³⁰

As described in Chapter 5, the cultural safety and humility movement is now being embedded in health policy and planning across the province. The FNHA and health authorities have introduced a range of different projects aiming to improve BC First Nations' experiences of, and access to, culturally safe care. While increased awareness of cultural safety and humility has been coupled with significant organizational activities, sustained efforts are required to determine whether improvements are being felt by First Nations accessing health services. Most efforts are in early stages and more work needs to be done to have it "trickle down" to front line service delivery. For example, the Overdose Response case study suggested that while cultural safety and humility is clearly embedded at a policy level, there is a need for more work with system partners to meaningfully embed cultural safety and humility across a range of the interventions underway, including harm reduction and treatment services, overdose prevention services, drug checking, and support for individuals in corrections facilities, among others.

¹³⁰ Tripartite Committee on First Nations Health. (2016). *Together in wellness: A report on the progress of the integration and improvement of health services for First Nations in British Columbia October 2015 - October 2016*. Retrieved from <http://www.fnha.ca/Documents/2015-2016-Together-In-Wellness.pdf>

Creating a Culturally Aware Workforce

A key component of improving cultural safety and humility across the health system in BC is ensuring that every individual in the health system workforce has the necessary training and awareness to better meet the needs of caring for First Nations patients and their families. To increase awareness, a campaign and range of resources for health care professionals and administrators was created in 2016. This included a *Creating a Climate for Change* resource booklet, a 12-part cultural safety and humility webinar action series,¹³¹ and a “#itstartswithme” pledge and Twitter campaign (see Figure 17).

Figure 17: The It Starts With Me Cultural Safety and Humility Campaign Pledge



In terms of training, PHSA created the San'yas Indigenous Cultural Safety Training Program¹³² as part of its commitment to the TCA: FNHP. Over time, the modules have evolved and post-training modules have been introduced in the areas of anti-racist training, mental health and wellness and unpacking the colonial relationship. One measure of its success is that over 48,000 health staff in BC have completed the training as of February 2018. To this end, key respondents recognize that demand currently exceeds supply, due in part to the program not having sufficient core funding. All regional health authorities, MOH, MMHA and other partners have designated numbers of seats for staff every year to complete the course, which does not always meet the needs of interested staff, resulting in long waitlists.

Findings from the Cultural Safety and Humility Case Study identified opportunities to build on existing training programs moving forward. While the training provides a foundational awareness of key concepts, there is an opportunity for future content to cultivate a deeper

¹³¹ First Nations Health Authority. (2017). *Cultural safety and cultural humility webinars*. Retrieved from <https://www.fnha.ca/wellness/cultural-humility/webinars>

¹³² Provincial Health Services Authority. (n.d.). *San'yas Indigenous cultural safety training*. Retrieved from <http://www.sanyas.ca/>

understanding of historical relationships and power dynamics that affect today's healing journeys of First Nations in BC, and to incorporate region or Nation-specific content.

As cultural humility is considered a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust, evaluation findings stressed the importance of ongoing organizational commitment to support learning and reinforcement. Respondents also noted that training is self-driven and self-determined; therefore, its effectiveness in changing individual-level behaviour will vary. Supporting multiple training modalities and successive training opportunities may be beneficial to reinforce learning. In fact, evaluation reports and key informant interviews show that a number of health authorities have already developed their own cultural safety and humility training resources and curricula, including in-person workshops, "lunch and learns", learning circles, communities of practice, self-learning resources and newsletters, as well as funding for backfilling and overtime while senior and other staff engage in training. Interior Health has created three Cultural Safety and Humility Educator positions, as well as a Knowledge Coordinator to advance cultural safety and humility of staff. Three regional health authorities have developed their own guidelines that are disseminated widely throughout their organizations and seek to enable staff to work in a culturally safe way, and include information on cultural practices and beliefs.

As part of the initial set of commitments in the TCA: FNHP, there is a longstanding commitment to increase the number of First Nations health professionals as a means to enhance cultural safety and humility. Health authorities have demonstrated a commitment to increasing the number and proportion of First Nations staff by hosting career workshops, attending career fairs, offering one-on-one support from Aboriginal Career Coaches for those who have an interest in applying for positions, and creating specific plans to increase First Nations staff. For example, Interior Health rejuvenated its Aboriginal Human Resource Plan in 2018, and Fraser Health Authority completed an Aboriginal staff-experience survey in 2019 that is expected to inform human resource and staff retention strategies.¹³³

Partnership work resulted in medical, nursing, pharmacy, dental and other professional bodies including a cultural safety and humility question to their annual license renewal processes, allowing for more reliable baseline data. The FNHA continues upstream work to ensure that cultural safety and humility is part of the post-secondary education health services curricula, to reduce the burden on the health system to undertake responsibility for the full scope of training.

¹³³ Tripartite Committee on First Nations Health. (2019). *Tripartite Committee on First Nations Health consolidated progress report – October 2018 to April 2019*.

Performance Measurement

Methods to evaluate the success of cultural safety and humility initiatives are under development in a range of settings. For example, Northern Health Authority developed a framework to measure the impact of its cultural safety and humility interventions. Interior Health Authority developed an evaluation model that aims to measure cultural safety and humility across each of six organizational domains. Additionally, the Provincial Health Services Authority has built on the Interior Health Authority model and is piloting an assessment tool to articulate what cultural safety could look like throughout the organization and across multiple levels.¹³⁴ The FNHA and the Health Standards Organization are leading the development of a new provincial standard for cultural health and safety, guided by a cross-system Technical Committee, and anticipate releasing the standard in the fall of 2020. Finally, a working group to develop a system-wide cultural safety and humility measurement framework has been established, which reports through the provincial Standing Committee on Performance Measurement, Analytics and Evaluation.

The true measure of whether cultural safety and humility is successfully embedded in a health care system can only be confirmed by those accessing and interacting with the health care system, rather than by the health care provider or system itself. This idea is articulated in the following statement borrowed from the FNHA's Policy Statement on Cultural Safety and Humility: "We have achieved cultural safety when First Nations tell us we have."¹³⁵ Ultimately, although cultural safety and humility has been hardwired into the health system at the policy level, it will take time for change to happen and become embedded at the client level. Key informants hope that leadership continues to prioritize cultural safety and humility to create culturally safe health care for First Nations in BC.

Complaints Processes

Regional health authorities are beginning to embed cultural safety and humility into the complaints process, given the perception that the complaint process itself is culturally unsafe and intimidating. Northern Health Authority, Fraser Health Authority and Vancouver Coastal Health Authority have each produced and widely disseminated booklets to support Indigenous people's understanding and navigation of the complaints process. Other approaches include allowing third parties to bring complaints forward with the consent of a client or their family in an effort to make complainants feel safer in sharing their concerns

¹³⁴ Provincial Health Services Authority. (2016). *Cultural safety framework: An organizational assessment tool*.

¹³⁵ First Nations Health Authority. (2019). *FNHA's policy statement on cultural safety and humility*. Retrieved from <http://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf>

and experiences. Interior Health Authority is exploring ways to address issues outside the formal provincial complaints process, resulting in one hospital having its own Declaration of Commitment to Cultural Safety and Humility and exploring a restorative justice approach through use of healing circles to address incidents.

The Interior Regional Partnership Accord evaluation found a restorative process in response to a complaint filed regarding the treatment of an Elder in a hospital impactful. Nations from the surrounding area were invited to attend a ceremony to voice concerns regarding services. Aboriginal participants shared personal stories concerning their health care system experiences with Interior Health staff. The process supported increased awareness among regional health authority boards regarding systemic racism, directed focus to areas requiring immediate attention within the Region and underscored the need for enhanced efforts targeting improvements among frontline staff. The FNHA also tracks and works with various complaints processes and quality offices about FNHA-delivered and FNHA-funded services, and offers a route for people to submit complaints about the quality of care in the provincial health system.

Patient complaint processes are perceived to be underutilized by First Nations patients, with no clear mechanism to consistently identify patient complaints submitted through health authority processes. There is no formal way of quantifying, within the system as a whole or at the Health Authority level, the number of complaints made by First Nations or Indigenous people relative to the rest of the population, whether that number is increasing or decreasing and what factors might be affecting those numbers. An emerging partnership, the First Nations, Métis, and Inuit Cultural Safety and Humility in the Patient Care Quality Program, is currently in early development. It is led by MOH and informed by a Project Collective that includes all regional health authorities, PHSA, the BCAAFC and Metis Nation British Columbia. The aim is for the patient care quality complaints process to be culturally safe and accessible to First Nations, Métis and Inuit peoples, contributing to respectful, patient-centered care improvements across the health system.

6.4 Health System Utilization

Health system utilization summarizes how people use provincial health services and provides a window from which to view health disparities and gauge whether the health system is performing effectively for First Nations. This report uses health service utilization data from the Health System Matrix (HSM), Patient Reported Experience and Outcomes Measures (PREMs/PROMs) survey data from the 2018 Emergency Department survey and the 2016/17 Acute In-patient hospitalizations stays across the province and the 2008-2010

and 2015-2017 Regional Health Surveys (RHS).¹³⁶ For full data reports reference the Health Systems Matrix Analysis and the PREMs/PROMs data reports.

A common limitation, with the exception of the 2018 Emergency Department PREMs survey, is the timeliness of the available data. At the time of writing this report, the most recent HSM data are from 2014/15 and the latest RHS is from 2015-2017. Impacts of initiatives to improve health care access, such as Joint Project Board initiatives, are unlikely to be reflected in these data sources findings, which were still early in project implementation in 2014/15.

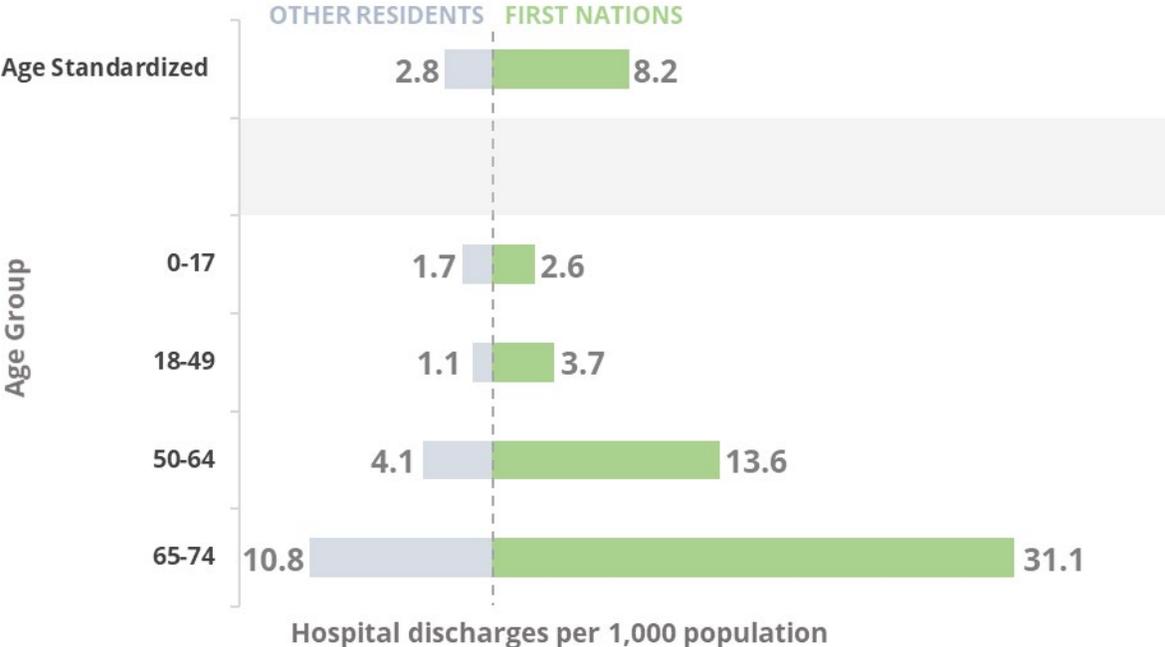
Primary care should be the first point of contact within the health system for most clients. The evaluation reveals evidence of poorer access to overall primary care services. HSM findings show that First Nations are less likely to be attached¹³⁷ to a general practitioner (GP) (74.4 per cent versus 77.2 per cent respectively) and that there has been a downward trend in attachment between 2008/09 to 2014/15 among First Nations people of all age groups. Of concern are the higher acuity health status groups that have no attachment to a physician (approximately 20 per cent of First Nations aged 0-49 years living with chronic conditions or towards the end of life in 2014/15 were not attached to a GP. These individuals may be under the care of a Nurse Practitioner or a physician reimbursed through an alternative payment plan (which is not captured in the HSM); even so, these groups had the highest rates of Emergency Department usage.

Higher rates of avoidable hospitalizations among First Nations residents further suggest that access to primary care among First Nations residents is less than optimal. Avoidable hospitalizations, or Ambulatory Care Sensitive Conditions (ACSCs), are a proxy measure for primary care access due to the fact that these conditions (e.g. asthma, diabetes, hypertension, and angina among others) – if treated appropriately in a primary care setting – should not lead to hospitalization. Trends were stable over time between 2008/9 and 2014/15; however, age-standardized hospitalization rates for ACSCs among First Nations was nearly three times higher than among other residents in 2014/15. The gap was largest among 18-49 year olds (3.4 times higher), but the rates of ACSC hospitalization were highest among First Nations age 65-74 (see Figure 18).

¹³⁶ Each data source differs in terms of the sample population, methods for identifying First Nations respondents, and subject area.

¹³⁷ MOH considers an individual to be attached if at least 50% of their visits are with GPs in a single practice. If less than five visits are found in a fiscal year, then up to ten previous years are included to find at least five visits. This definition is based on physician visits, and excludes other health care professionals who may be the first primary contact with the health system, such as nurse practitioners. It also excludes most physician services paid through an alternate payment plan.

Figure 18: Age-Specific and Age-Standardized Ambulatory Care Sensitive Condition Hospitalization Rates, among First Nations and Other Residents, 2014/15, Health System Matrix

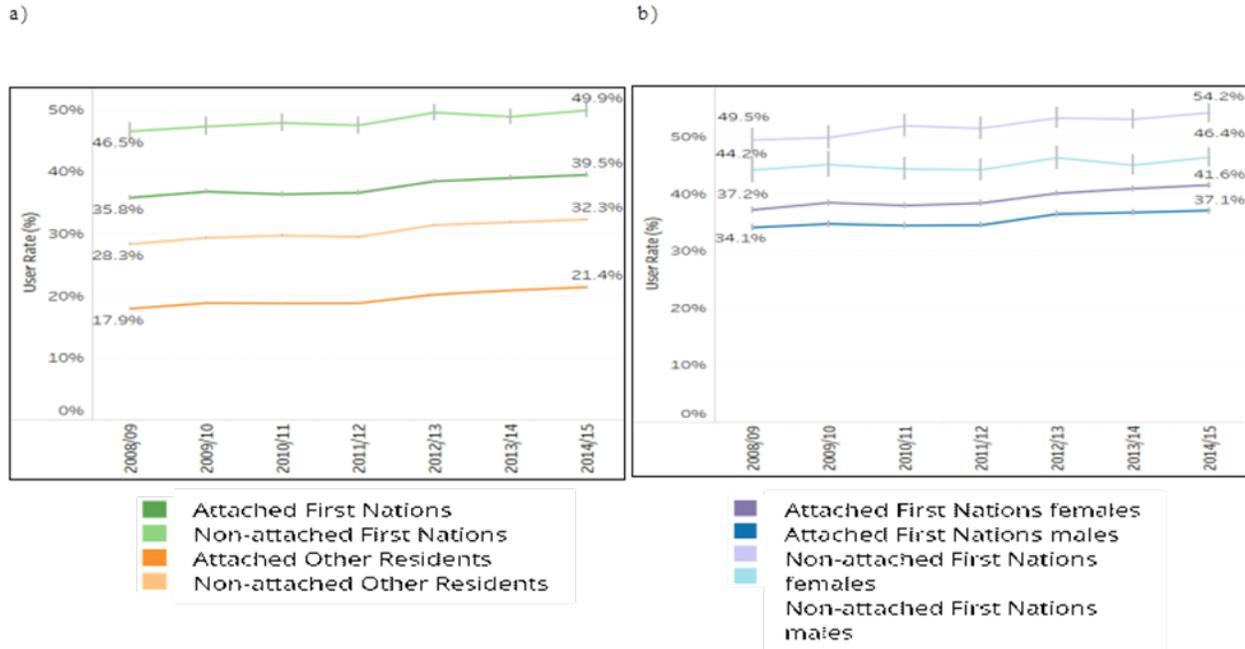


Source: 2008/09 – 2014/15 Health System Matrix for the Tripartite Evaluation report

The HSM also revealed a higher rate of Emergency Department utilization among First Nations compared to other residents, regardless of age and GP attachment status, including a part of the population (the “Staying Healthy” health status group) that should be relatively healthy. Among First Nations who were attached to a primary care provider regardless of their health status group, Emergency Department utilization was lower (39.5 per cent versus 49.9 per cent respectively) (see Figure 19), but still higher than for other residents. First Nations were also less likely than other residents to visit physicians outside of hospitals. This lower utilization of physicians outside of hospitals is a possible contributor to First Nations being hospitalized to a greater extent (rates of inpatient stays among First Nations were higher among all age groups except for ages 0-17). First Nations men were also less likely to access primary care physician services for mental health, but more likely to use hospital services compared to other resident men. It should be noted, however, that First Nations female hospitalization rates for mental health services were also elevated compared to the other resident population, despite this population also having higher utilization of physician services for mental health, indicating that there may be multiple drivers leading to increased hospitalizations.

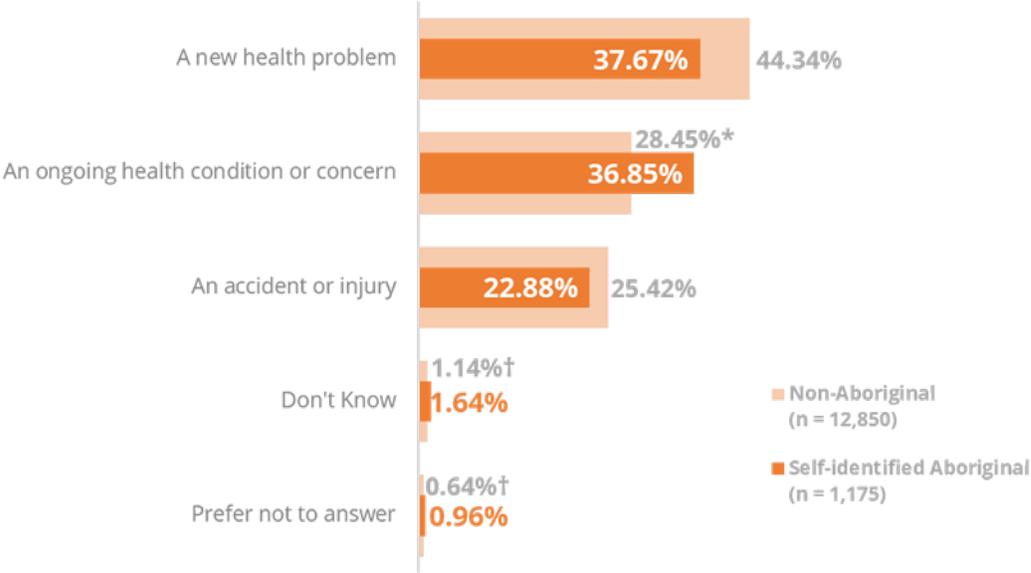
Figure 19: Trends in Age Standardized Emergency Department User Rates by Sex and Attachment Status, 2008/9-2014/15

Figure 4.6: Trends in a/s ED user rates a) overall (First Nations and Other Residents) and b) by sex (First Nations), by attachment status, BC, 2008/09-2014/15



Analysis of the 2018 Emergency Department PREMs survey suggests that self-identified Aboriginal residents rely on the Emergency Department for management of ongoing health conditions. The 2018 Emergency Department PREMs survey found that 36.9 per cent of self-identified Aboriginal patients presented to the Emergency Department for an ongoing health condition or concern compared to 28.5 per cent of non-Aboriginal patients (see Figure 20).

Figure 20: Main Reason for Emergency Department Visits among Self-Identified Aboriginal and Non-Aboriginal, 2018



Source: 2018 Emergency Department Patient Reported Experience Measures Survey (n = 13,710 British Columbians, 1,246 of which self-identified as “First Nation”, “Inuit”, “Métis”, or “Indigenous / Aboriginal (not included elsewhere)”). Weighted percentage of Aboriginal respondents is 5.8%,

Note: Provincial scores are weighted.

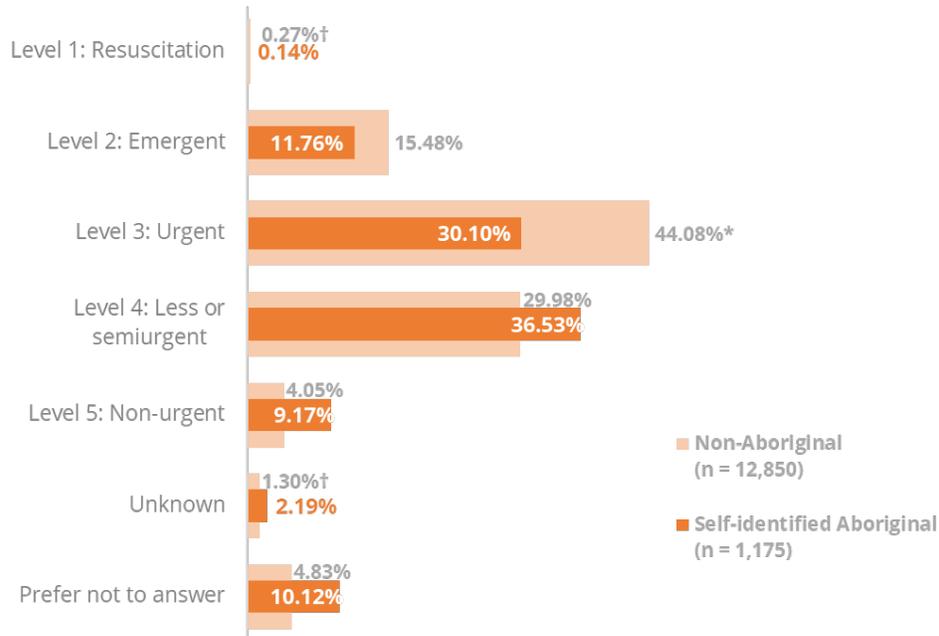
* Statistically significant ($\alpha = 0.05$) differences between self-identified Aboriginal patients and non-Aboriginal patients indicated with “*”.

† Denotes at 0.05 significant level, the confidence interval contains zero.

Likewise, as shown in Figure 21, findings reveal that 4.1 per cent of non-Aboriginal patients and 9.2 per cent of self-identified Aboriginal patients were visiting the Emergency Department for non-urgent conditions,¹³⁸ suggesting access issues to lower levels of care. The 2018 Emergency Department PREMs survey found that a greater proportion of self-identified Aboriginal respondents noted that they did not have a doctor’s office, clinic or other place to go, other than the Emergency Department, for check-ups/medical advice or when sick or hurt (8.8 per cent versus 5.0 per cent among all survey respondents). These findings are echoed by qualitative data collected as part of the Regional Partnership Accord evaluations indicating perceived gaps in services across regions, including primary care, home care, mental wellness and rehabilitative services.

¹³⁸ The urgency of an individual’s condition during an Emergency Department visit is based on the Canadian Triage & Acuity Scale (CTAS) distribution. The CTAS score is assigned to each patient when presenting to the Emergency Department and is based on the type and severity of the presenting signs and symptoms.

Figure 21: Level of Acuity Distribution among Self-Identified Aboriginal and Non-Aboriginal from the 2018 Emergency Department Patient Reported Experience Measure Survey



Source: 2018 Emergency Department Patient Reported Experience Measures Survey (n = 13,710 British Columbians, 1,246 of which self-identified as “First Nation”, “Inuit”, “Métis”, or “Indigenous / Aboriginal (not included elsewhere)”. Weighted percentage of Aboriginal respondents is 5.8%,

Note: Provincial scores are weighted.

* Statistically significant ($\alpha = 0.05$) differences between self-identified Aboriginal patients and non-Aboriginal patients indicated with “*”.

† Denotes at 0.05 significant level, the confidence interval contains zero.

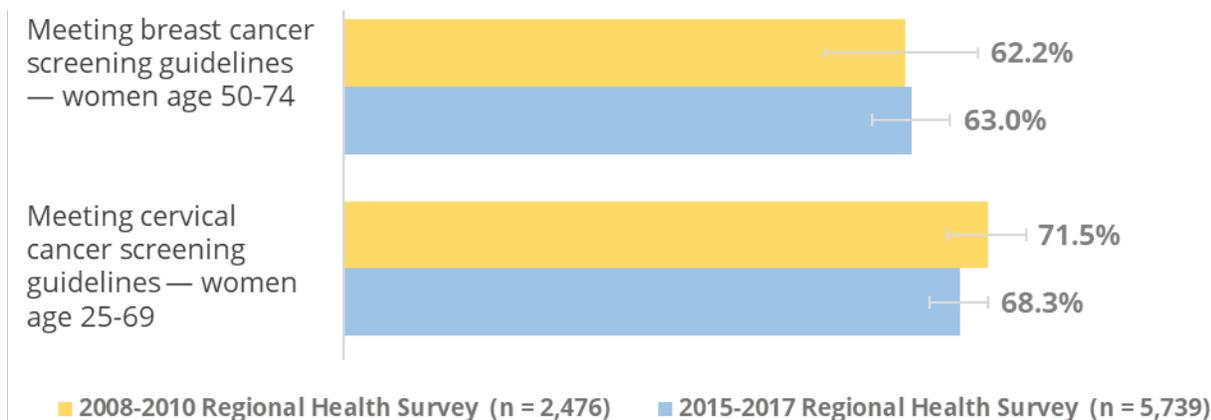
HSM analysis findings reveal significantly higher rates of hospitalizations for dental caries among First Nations children (over 5.5 times higher than other resident children), among other service lines. This disparity may point to a lack of access to prevention services, potentially due to a lack of dental services in First Nations communities, lack of fluoridated water, dental hygiene practices, diet, social determinants and historical trauma from dental treatment.¹³⁹ The FNHA Community Oral Health Initiative is a prevention program that seeks to promote oral wellness as well as prevent community members from having to travel for appointments and reduce the need for specialist referrals; however, these programs are available only to residents in-community.¹⁴⁰

¹³⁹ First Nations Health Council. (2018). *My dad's unbelievable story, untold by him* [Video file]. Retrieved from <https://www.youtube.com/watch?v=LSfwDEIQVjM>

¹⁴⁰ First Nations Health Authority. (n.d). *Community “tooth fairies” bring oral health to BC First Nations through the children’s oral health initiative (COHI)*. Retrieved from [https://www.fnha.ca/wellness/sharing-our-stories/community-tooth-fairies-bring-oral-health-to-bc-first-nations-through-the-children-s-oral-health-initiative-\(cohi\)](https://www.fnha.ca/wellness/sharing-our-stories/community-tooth-fairies-bring-oral-health-to-bc-first-nations-through-the-children-s-oral-health-initiative-(cohi))

Data also suggests there is a lesser degree of access to some cancer and cardiovascular disease-related preventive services among Indigenous residents. A comparison of RHS data between 2008-2010 and 2015-17 found that there have been no significant shifts in trends in cervical cancer screening¹⁴¹ or breast cancer screening over time (see Figure 22):^{142, 143} Higher rates of cervical cancer among First Nations women compared to other residents^{144, 145} underscore the need to increase geographically available and culturally safe cervical screening.

Figure 22: Percentage of First Nations Women Living In-Community Reporting Meeting Breast and Cervical Cancer Screening Guidelines, 2008-10 and 2015-17 Regional Health Survey



Source: 2008-2010 Regional Health Survey report and 2015-2017 Regional Health Survey report.

Note: No statistically significant difference between the 2008-10 and 2015-17 RHS for breast and cervical cancer screening guidelines were observed.

¹⁴¹ Current guidelines for cervical cancer screening are every three years for women aged 25-69 who are, or have been, sexually active.

¹⁴² Current guidelines for breast cancer screening emphasize shared decision-making and are conditional on the relative value a woman places on the benefits and risks for screening (some women may place a higher value on avoiding harms from screening such as unnecessary treatment of cancer and physical and psychological consequence from false positive as compared to a modest absolute reduction in breast cancer mortality). For women aged 40-49 who are not at increased risk no screening is recommended. For women aged 50-69 and 70-74, screening every 2-3 years is recommended. These recommendations do not apply to women with a personal or family history of breast cancer, women who are carriers of gene mutations such as BRCA1 or BRCA2, or have a first degree relative with these gene mutations and women who had chest radiation therapy before 30 years of age or within the past year.

¹⁴³ Klarenbach, S., Sims-Jones, N., Lewin, G., Singh, H., Theriault, G., Tonelli, M., Doull, M., Courage, S., Garcia, A.J., & Thombs, B.D., for the Canadian Task Force on Preventive Health Care. (2018). Recommendations on screening for breast cancer in women aged 40-74 years who are not at risk for breast cancer. *Canadian Medical Association Journal*, 190(49), 1441-1451. doi: <https://doi.org/10.1503/cmaj.180463>

¹⁴⁴ Health System Matrix Data

¹⁴⁵ McGahan, C.E., Linn, K., Johnson, H., Coldman, A.J., Spinelli, J.J., & Caron, N.R. (2017). Cancer in First Nations people living in British Columbia, Canada: An analysis of incidence and survival from 1993 to 2010. *Cancer Causes Control*, 26(10), 1105-1116. doi: 10.1007/s10552-017-0950-7

Despite higher prevalence rates of cardiovascular disease, both First Nations women and men had negligible or even lower rates of hypertension than other residents, respectively, suggesting that this important precursor to cardiovascular disease is being missed through lack of screening and diagnosis. First Nations rates of cardiovascular disease were 1.2 to 2.2 times higher than other residents (i.e. heart failure, acute myocardial infarction, stroke and angina); however, rates of cardiovascular interventions such as angioplasty and coronary artery bypass graphs were not elevated, suggesting that there are access issues to these interventions, differing acuity of disease, or higher mortality between these two populations.

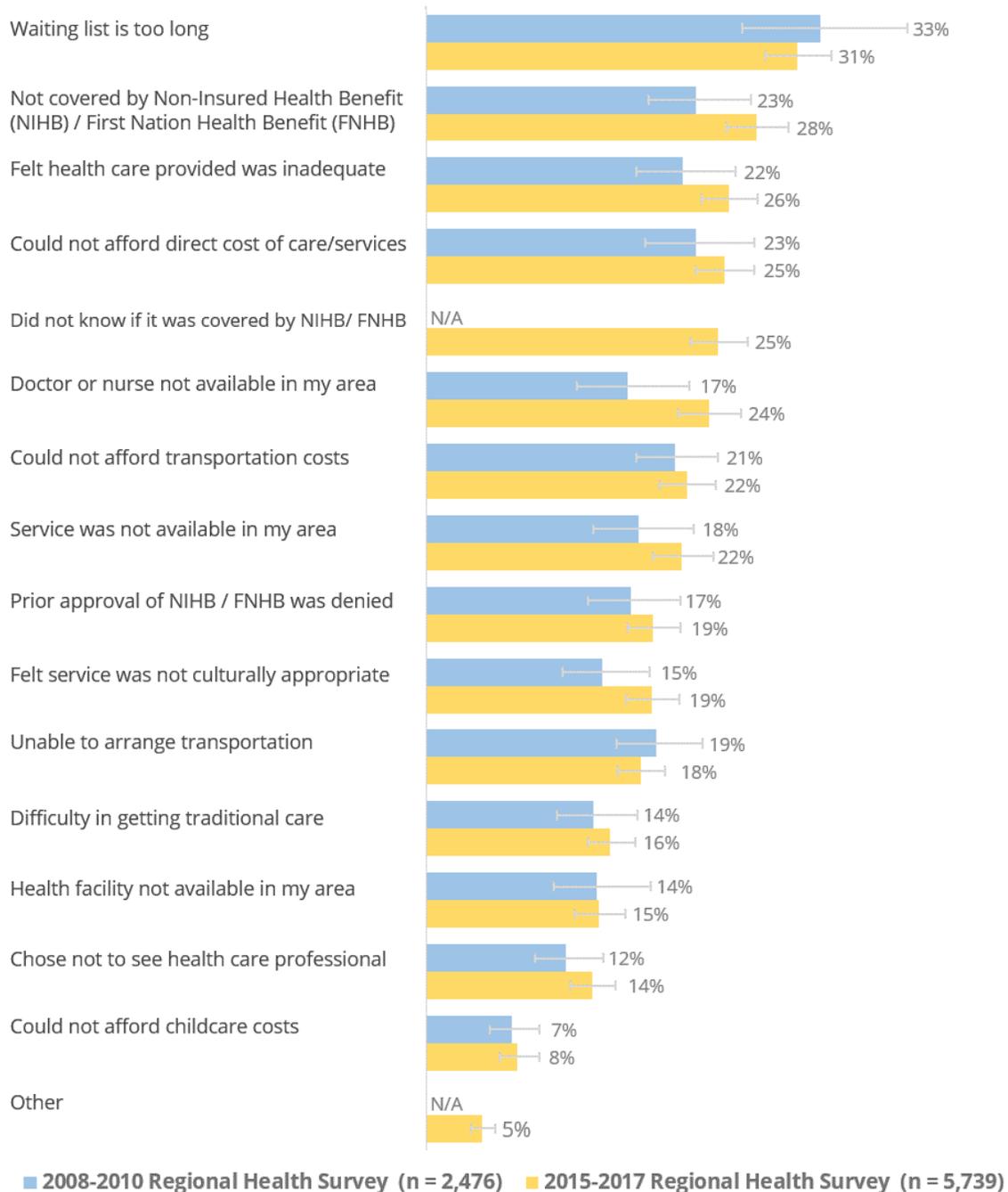
The 2015-17 RHS sheds light on the importance of a number of barriers to health services confronting First Nations resident in-community who have reported the need for health care services within the past year. As illustrated in Figure 23, the top five barriers to health services were:

1. wait lists were too long (32 per cent);
2. health services were not covered by under Non-Insured Health Benefits (NIHB)¹⁴⁶ (28 per cent);
3. feeling that health care provided was inadequate (26 per cent);
4. not being able to afford the direct cost of care/services (25 per cent), and
5. not knowing if the services were covered by NIHB/First Nations Health Benefits (FNHB) (25 per cent).

Importantly, no statistical significant differences were observed in reported barriers to health services between the 2008-10 and 2015-17 RHS.

¹⁴⁶ At the time of the 2008-10 Regional Health Survey, the health benefit program available to First Nations in BC was the Non-Insured Health Benefit Program. By 2015, when the 2015-17 Regional Health Survey was conducted, the program name had been changed to the First Nations Health Benefit Program.

Figure 23: Barriers to Receiving Health Care Reported by First Nations Adults who Reported Needed Health Care from a Doctor, Nurse or Other Professional in the Past Year, 2015-17 and 2008-10 Regional Health Survey



Source: 2008-2010 Regional Health Survey Report and 2015-2017 Regional Health Survey Report.

Note: No statistically significant differences were noted between 2008-10 and 2015-17 RHS

When considered in their totality, HSM, PREMs, RHS survey results and qualitative data from Regional Partnership Accord evaluations support a finding of a lower degree of

utilization and possibly access to primary care among First Nations. This, in conjunction with the higher rates of many chronic conditions (as explored in this chapter), make barriers to health services an even greater concern. That said, there is also good news from the data around access. ACSC rates have remained steady, Acute Inpatient day rates have decreased, rates of cardiovascular disease have been stable and rates of cardiovascular interventions have been going up (suggesting increased survival of original cardiovascular event and/or increased access).

6.5 Experiences of Care

Since 2003, MOH, regional health authorities and PHSA have implemented a program to measure the self-reported experience of patients in a range of health care sectors using PREMs^{147,148} and, in the most recent survey, PROMs. The surveys are conducted province-wide in health care sectors deemed to be priorities by MOH and the health authorities, including Acute Inpatient care, emergency department care, outpatient cancer care, short-stay mental health and substance use care and long-term residential care.¹⁴⁹ All PREMs surveys have included an Aboriginal self-identifier ethnicity variable.¹⁵⁰

Results of the Acute Inpatient and Emergency Department sector surveys include gauging patients' overall satisfaction with their care experiences through "global rating" measures. Analysis of these measures suggests that self-identified Aboriginal patients' experiences of care differ from those of other residents and vary across health sectors (see Figure 24). Self-identified Aboriginal patients scored their overall experiences of care lower in the Emergency Department than in Acute Inpatient settings, and all global ratings of overall patient experience were significantly lower among self-identified Aboriginal respondents in the 2018 Emergency Department survey than non-Aboriginal patients.¹⁵¹ This finding is in line with ethnographic research that shows that the experiences of Aboriginal patients in the Emergency Department are different than non-Aboriginal patients and that

¹⁴⁷ All provincial PREMs reports available: <https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/patient-experience-survey-results>

¹⁴⁸ Government of British Columbia. (n.d.). Patient Experience Survey Results. Retrieved from <https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/patient-experience-survey-results>

¹⁴⁹ Government of British Columbia. (n.d.). Patient Experience Survey Results. Retrieved from <https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/patient-experience-survey-results>

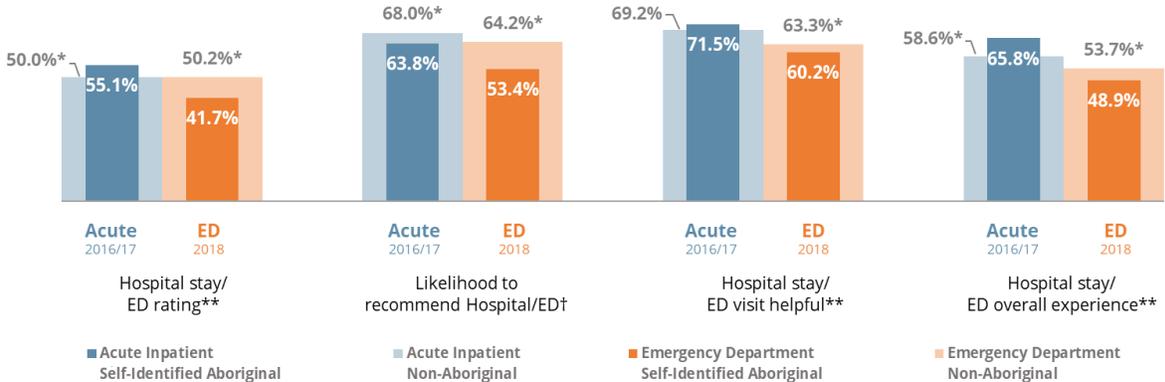
¹⁵⁰ The survey question asked whether the respondents considered themselves to be First Nation, Inuit, Métis, or Other Indigenous / Aboriginal. For the 2016/17 Acute Inpatient provincial report only patients who self-identified as one of these four categories and not another ethnicity were included in the self-identified Aboriginal population.

¹⁵¹ No significance testing is available.

experiences can be challenging, with interactions affected by the individual's wider social, economic and historical contexts.¹⁵² The cultural safety of patient experiences within the Emergency Department has been the impetus behind much of the health system's work related to cultural safety and humility (see Chapters 5 and 6).

In the 2016/17 Acute In-patient survey three of the four measures were higher among self-identified Aboriginal patients and the differences were statistically significant compared to non-Aboriginal patients for two measures (rating of the hospital (55.1 per cent vs. 50.0 per cent) and overall experience of the hospital stay (65.8 per cent vs. 58.6 per cent). The percentage of self-identified Aboriginal patients in the 2016/17 Acute In-patient sector survey was lower than expected given the Aboriginal population in BC (3.8 per cent of the survey respondents self-identified as Aboriginal, whereas 5.9 per cent of the BC population is Aboriginal, according to the 2016 Census).¹⁵³ Non-response bias could affect the results.¹⁵⁴

Figure 24: Global Ratings of Overall Patient Experience among Self-Identified Aboriginal Patients vs Non-Aboriginal Patients, 2016/17 Acute Inpatient Patient Reported Experience Measures Survey and 2018 Emergency Department Patient Reported Experience Measures Survey



¹⁵² Browne, A.J., Smye, V.L., Rodney, P., Tang, S.Y., Mussell, B., & O’Neil, J. (2010). Access to primary care from the perspective of Aboriginal patients at an urban emergency department. *Qualitative Health Research*, 21(3), 333-348. doi: [10.1177/1049732310385824](https://doi.org/10.1177/1049732310385824)

¹⁵³ Statistics Canada. (2018). Aboriginal Population Profile, 2016 Census. Retrieved February 22, 2019 from: <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/index.cfm?Lang=E>

¹⁵⁴ Non-response bias could affect results if self-identified Aboriginal respondents differed (in demographics, socio-economic status or other factors affecting their experiences of care) from those who (i) were not selected (due to exclusion/inclusion criteria); (ii) chose not to participate; or (iii) chose not to self-identify their ethnicity.

Source: 2018 Emergency gave ratings of “Definitely”. Department Patient Reported Experience Measures Survey (n = 13,710 British Columbians, 1,246 of which self-identified as “First Nation”, “Inuit”, “Métis”, or “Indigenous / Aboriginal (not included elsewhere)”. Weighted percentage of Aboriginal respondents is 5.8%, 2016/17 Acute Inpatient Patient Reported Experience Measures Survey (n = 24,279 British Columbians, 865 of which self-identified as “First Nation”, “Inuit”, “Métis”, or “Indigenous / Aboriginal (not included elsewhere)”. Weighted percentage of Aboriginal respondents is 3.9%.

Note: Provincial scores are weighted.

Note: Percentage of patients who gave ratings of 9 or 10 on a 0-10 point scale.

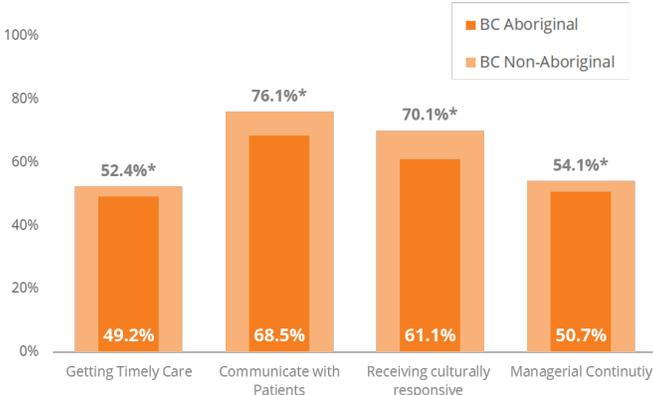
* Statistically significant ($\alpha = 0.05$) differences between self-identified Aboriginal patients and non-Aboriginal patients indicated with “*”.

An analysis of the 2018 Emergency Department survey was conducted to better understand the “key drivers” of higher patient experience scores. These four areas are 1) receiving timely care, 2) how well Emergency Department doctors and nurses communicated, 3) culturally responsive and compassionate care, and 4) how well continuity across transitions in care post discharge were managed (see Appendix C¹⁵⁵ for the specific questions included in these four areas). As displayed in

¹⁵⁵ Available at <https://www.fnha.ca/about/governance-and-accountability/audits-and-evaluations>

Figure 25 below, these drivers of overall patient experience were significantly lower among self-identified Aboriginal patients than among other respondents for each of the four areas.

Figure 25: Key Drivers of Overall Patient Experience among Self-Identified Aboriginal Patients vs Non-Aboriginal Patients, 2018 Emergency Department Patient Reported Experience Measures Survey



Source: 2018 Emergency Department Patient Reported Experience Measures Survey (n = 13,710 British Columbians, 1,246 of which self-identified as “First Nation”, “Inuit”, “Métis”, or “Indigenous / Aboriginal (not included elsewhere)”. Weighted percentage of Aboriginal respondents is 5.8%,
 Note: Provincial scores are weighted.

These Key Driver consist of four high-level questions on:

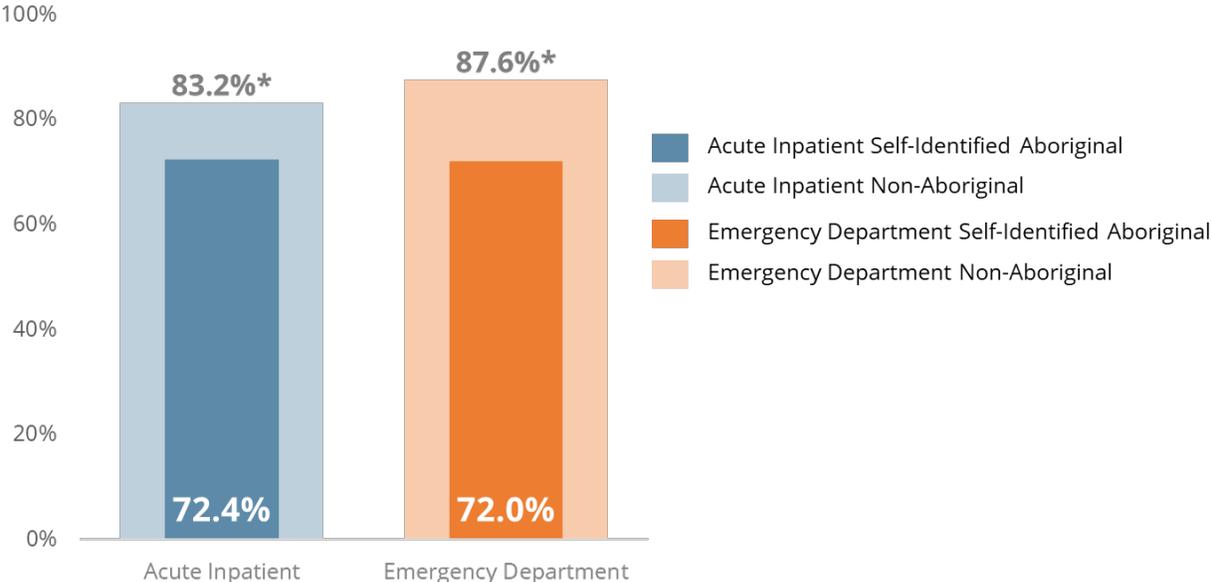
- 1) Getting timely care
- 2) How well Emergency Department doctors and nurses communicate with patient
- 3) Receiving culturally responsive and compassionate care
- 4) How well continuity across transitions in care in managed

Note: Statistically significant ($\alpha = 0.05$) differences between self-identified Aboriginal patients and non-Aboriginal patients indicated with “*”.

Self-identified Aboriginal patients were less likely to report that their care providers were completely respectful of their cultures and traditions in both the 2016/17 Acute Inpatient and 2018 EMERGENCY DEPARTMENT surveys, as displayed in

Figure 26 below. These findings echo results from interviews from individuals that work with patient complaints data. These informants indicate that many patient complaints from Aboriginal patients relate to instances of racism, stereotyping assumptions, lack of respect or being made to feel like one was less worthy of care.

Figure 26: Providers Completely Respectful of Cultures and Traditions, Self-Identified Aboriginal Patients vs Non-Aboriginal Patients, 2016/17 Acute Inpatient Patient Reported Experience Measures Survey, 2018 Emergency Department Patient Reported Experience Measures Survey



Source: 2018 Emergency Department Patient Reported Experience Measures Survey (n = 13,710 British Columbians, 1,246 of which self-identified as “First Nation”, “Inuit”, “Métis”, or “Indigenous / Aboriginal (not included elsewhere)”. Weighted percentage of Aboriginal respondents is 5.8%, 2016/17 Acute Inpatient Patient Reported Experience Measures Survey (n = 24,279 British Columbians, 865 of which self-identified as “First Nation”, “Inuit”, “Métis”, or “Indigenous / Aboriginal (not included elsewhere)”. Weighted percentage of Aboriginal respondents is 3.9%.

Note: The indicated data shows the proportional of patient felt their care providers were respectful of their culture and traditions [COMPLETELY].

Note: Provincial scores are weighted.

* Statistically significant ($\alpha = 0.05$) differences between self-identified Aboriginal patients and non-Aboriginal patients indicated with “*”.

6.5 Key Findings

Partners are taking steps to ensure a more integrated and coordinated landscape of health services for First Nations in BC.

The work in BC to address jurisdictional barriers and enhance integration of services for First Nations is unprecedented within Canada. Still, ongoing jurisdictional divisions with respect to health service delivery, inadequate mechanisms for sharing clinical information between partners and a lack of alignment between First Nations territories and service delivery catchments are barriers to achieving greater coordination of services. Participants from multiple regions underscored the need to clarify service roles and responsibilities and undertake more strategic service planning to better coordinate service delivery in First

Nations communities, avoid gaps and the duplication of effort, and maximize successful outcomes.

Partners are implementing a range of initiatives to improve cultural safety across all levels of the health system in BC. While evidence shows enhanced awareness of cultural safety, sustained efforts are required to determine whether improvements are being felt by First Nations accessing health services.

Initial efforts at awareness-raising and creating an enabling environment through Declarations of Commitment and subsequent awareness-raising efforts are now taking deeper root through a broad and meaningful range of organizational efforts that focus on training and education, recruitment and retention of Indigenous staff, creating welcoming spaces, and reviewing policies from a cultural safety lens. Furthermore, there are now cross-system activities underway, such as: development of a measurement framework and accreditation standard; revision of the BC Quality Matrix; a focus on emergency departments, and the co-funding of a “backbone” team to work across the system to support systemic cultural safety and humility initiatives and knowledge exchange.

Racism in the system remains and needs to be addressed by the Partners. Efforts to date are particularly strong around developing senior level commitments and training at the provincial and regional levels. At this point, there is a need to move beyond training and education into initiatives that leverage systemic change.

Access to the health system and health services for First Nations in BC may be beginning to improve. Baseline data about the ongoing challenges associated with health system access for First Nations in BC is now available and points to the need to address avoidable hospitalizations (ambulatory care sensitive conditions) and lower rates of general practitioner attachment for First Nations.

At provincial, regional and local levels, there are efforts to make the health system more welcoming for First Nations through increasing cultural safety and humility. There is also work to support health systems integration and navigation. Finally, there have been new services funded (particularly through the Joint Project Board) that are reporting increased access for First Nations.

However ongoing challenges in accessing the health system remain. These include being unaware of services and uncertainty around which services are covered, social determinants of health issues (e.g. costs, transportation and travel), the existence of racism and gaps in services in certain geographic areas. These result in a range of health access disparities that show that the system is not performing optimally for First Nations.

It should be noted that much of the baseline data included here is from 2013/14, so it predates most of the efforts described within this report. Now that baseline data have been established, it will be easier to measure improvements at the next five year evaluation.

Although work is being undertaken to fundamentally change the way First Nations in BC experience health care in the province, analyses of BC patient experience measures reported by Aboriginal patients suggest there is room for improvement, in particular within Emergency Department service areas.

There remains room for improvement in changing the experience of care for First Nations in BC, particularly within Emergency Departments where nine out of ten key drivers of overall patient experience were lower among self-identified Aboriginal patients in 2018.

Chapter 7 Health and Wellness Outcomes

The preceding sections of this report outline progress relating to governance, partnerships and health system performance since the transfer of FNIHB responsibilities to the FNHA in 2013. The aim of this work is to improve the health and well-being of First Nations people in BC.¹⁵⁶ This chapter explores the currently available performance indicators and data relating to health and wellness outcomes.

Many precursors to wellness or illness are years in the making.¹⁵⁷ While attempts have been made to attribute higher-level macro policy shifts to shifts in health outcomes,¹⁵⁸ the present evaluation does not attempt to assess causality at this time. One of the challenges of causal inference is that other events and changes in the socio-economic political contexts of Indigenous peoples at a national, provincial, regional and community level over the past five years have also influenced individual and community-level contexts and determinants of health in complex and interacting ways, independent of the Framework Agreement. For example, both the Government of Canada and Government of British Columbia have committed to adopting and implementing the [United Nations Declaration on the Rights of Indigenous People](#) (UNDRIP) and the 94 [Calls to Action](#) from Canada's Truth and Reconciliation Commission. Both governments have also developed approaches to enact these commitments: the [Principles respecting the Government of Canada's relationship with Indigenous peoples](#) and the [Draft Principles that Guide the Province of BC's Relationship with Indigenous Peoples](#). In November 2019, British Columbia became the first province in Canada to enshrine the human rights of Indigenous peoples in law, with the passing of the Declaration on the Rights of Indigenous Peoples Act. These, and

¹⁵⁶ Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

¹⁵⁷ The Building on Values Report (Romanow, 2002, p. 16) indicates that a shift in one-year of life expectancy can take five years to transpire. Source: Romanow, R. J. (2002). *Building on values: the future of health care in Canada*. Retrieved from <http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>

¹⁵⁸ McAllister, A., Fritzell, S., Almroth, M., Harber-Aschan, L., Larsson, S., & Burstrom, B. (2018). How do macro-level structural determinants affect inequalities in mental health? – a systematic review of the literature. *International Journal for Equity in Health*, 17(180). Retrieved from <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-018-0879-9>

other shifts at provincial^{159,160} and federal¹⁶¹ levels, may together have complex, interacting and cumulative impacts on health and wellness outcomes for Indigenous Peoples now and into the future.

7.1 Transformative Change Accord: First Nations Health Plan Indicators

The 2005 *Transformative Change Accord* between the Government of BC, Government of Canada and the the First Nations Leadership Council focused on closing the gap in the areas of education, health, housing and economic opportunities. The Accord laid out actions to close the gap in each of these areas as well as possible indicators to measure changes over time. The indicators for closing the gap in health included disease/deficit-based indicators relating to mortality, chronic disease and suicide (including all-cause mortality, youth suicide, diabetes prevalence, life expectancy and infant mortality). These indicators were reported on by the office of the Provincial Health Officer in a series of reports produced between 2007 and 2018.¹⁶²

The trends between 2005 and 2015 for five of the TCA: FNHP indicators are presented in Figure 27.

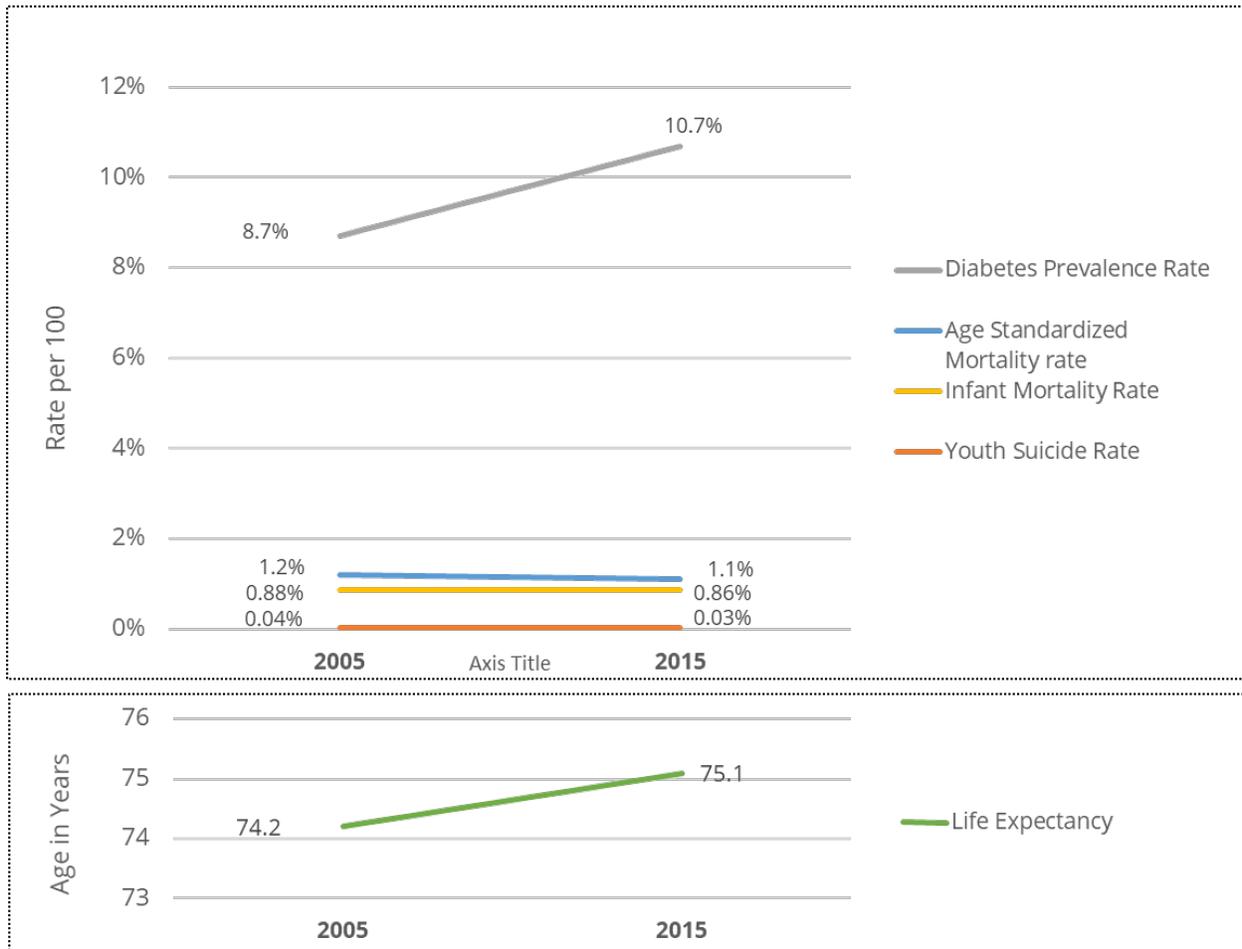
¹⁵⁹ The provincial government expanded free post-secondary tuition for former foster children in BC in 2017. Source: Office of the Premier. (2017). Premier Horgan expands tuition waiver for former youth in care. *BC Gov News*. Retrieved from <https://news.gov.bc.ca/releases/2017PREM0076-001509>

¹⁶⁰ *Tsilhqot'in Nation v. British Columbia*, 2014 SCC 44 (CanLII), [2014] 2 SCR 257. Retrieved from <http://canlii.ca/t/g7mt9>

¹⁶¹ New Fiscal Relationship between First Nations and Canada to address disparities in socio-economic conditions. Source: Assembly of First Nations and Indigenous Services Canada. (2017). *A new approach: Co-development of a new fiscal relationship between Canada and First Nations*. Retrieved from <https://www.afn.ca/wp-content/uploads/2018/03/A-New-Approach-Co-development-of-a-New-Fiscal-Relationship.pdf>

¹⁶² All reports available from the following source: Government of British Columbia. (n.d.). Special reports. *Office of the Provincial Health Officer: Reports & Publications*. Retrieved from <https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports>

Figure 27: Trends in Indicators in the Transformative Change Accord: First Nation Health Plan, Status First Nations, 2005-2015



Source: PHO (2018). Indigenous Health and Well-being: Final Update. Available from:

<http://www.fnha.ca/Documents/FNHA-PHO-Indigenous-Health-and-Well-Being-Report.pdf>

Note: Life expectancy and youth suicide rates are based on five year rolling average (from 2001-2005 to 2011-2015) rather than single years (e.g. 2005 or 2015).

There have been **modest improvements** in three of the five TCA indicators for First Nations in BC:

Life expectancy	From 74.2 years in 2005 to 75.1 years in 2015
Age standardized mortality	From 119.2 deaths per 10,000 population to 110.9 deaths per 10,000 population
Youth suicide	From 3.81 youth suicides per 10,000 population in 2001-2005 to 2.77 youth suicides per 10,000 population in 2011-2015.

- **Diabetes rates are going up** in both populations. There is still a higher rate for First Nations (10.7 per 100 population) compared to other residents (8.0 per 100 population).
- There has been **little progress in improving Infant mortality rates**. In 2001-2005 there were 8.8 infant deaths per 1,000 live births and in 2011-2015 there were 8.6 infant deaths per 1,000 live births.
- **Inequality has increased** between the First Nations population and other residents of BC for life expectancy, infant mortality and mortality rates.

Measuring gaps in health outcomes among different groups of people (whether by age, gender, ethnicity or where people live) helps bring to light inequities that might otherwise go unnoticed, however, comparing the health outcomes of First Nations and other residents and reporting solely on deficits and disparities alone can undermine the inherent strengths and resilience of First Nations.

"First Nations have often been defined by deficit, by what's wrong with our populations. And very rarely has it reflected the voice of the Nations and how resilient the Nations are."¹⁶³

The Framework Agreement left open the opportunity for growth in how health and wellness are measured.¹⁶⁴ A recent initiative to redefine how health and wellness are measured, the "Population Health and Wellness Agenda", has developed 15 new health and wellness indicators that span a large scope of economic, social and environmental indicators.¹⁶⁵

¹⁶³ First Nations Health Authority. (2018). *Island families gather at fall Caucus to improve health programs and services*. Retrieved from <http://www.fnha.ca/about/news-and-events/news/island-families-gather-at-fall-caucus-to-improve-health-programs-and-services>

¹⁶⁴ The Framework Agreement lays out the desire to work together to build a more integrated health system that reflects the cultures and perspectives of BC First Nations; incorporates First Nations' models of wellness; and that embraces knowledge and facilitates discussions in respect of determinants of health in order to contribute to the design of First Nation health programs and services. Source: Canada, Province of British Columbia, & First Nations Health Society. (2011). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

¹⁶⁵ First Nations Health Authority & Office of the Provincial Health Officer. (2016). *First Nations health & wellness indicators presentation to Gathering Wisdom*. Retrieved from <http://fnhc.ca/2016/12/summary-and-presentations-from-gathering-wisdom-for-a-shared-journey-viii/>

7.2 Population Health and Wellness Agenda

A person's overall health and well-being involves a complex interplay of social, economic, environmental, cultural and political factors that interact in unique, cumulative and complex ways, relating with individual circumstances to affect physical biological pathways, psychological responses, healthy and unhealthy coping behaviours and health outcomes.^{166,167}

The past and ongoing impacts of colonialism are part of this complex interaction of factors impacting health across multiple levels. Government policies and programs have systematically denied First Nations people access to the resources and conditions necessary to optimize socioeconomic and health status, and suppressed traditional systems of self-governance and self-determination.^{168,169,170} Over generations, these barriers produced social and material inequalities with compounding effects on well-being that communities continue to experience.^{171,172,173}

Although a number of frameworks have been developed to illustrate the social and structural determinants of health,^{174,175} measuring the health of populations has typically focused on downstream factors, such as health behaviours and health outcomes, rather than structural determinants such as governmental policy and societal structures of power

¹⁶⁶ Beckfield, J., & Krieger, N. (2009). Epi+demos+cracy: Linking political systems and priorities to the magnitude of health inequalities – evidence, gaps and a research agenda. *Epidemiology Reviews*, 31, 152-177.

¹⁶⁷ Mikkonen, J., & Raphael, D. (2010). Social determinants of health: The Canadian facts. Retrieved from http://thecanadianfacts.org/the_canadian_facts.pdf.

¹⁶⁸ Reading, J., & Halseth, R. (2013). *Pathways to improving well-being for Indigenous peoples: How living conditions decide health*. Prince George, Canada: National Collaborating Centre for Aboriginal Health.

¹⁶⁹ Reading, C., & Wien F. (2009). *Health inequalities and social determinants of Aboriginal peoples' health*. Prince George, Canada: National Collaborating Centre for Aboriginal Health.

¹⁷⁰ Reading, C. (2018). Structural determinants of Aboriginal peoples' health. In Greenwood. M., De Leeuw, S., & Lindsay, N.M, (Eds.), *Determinants of Indigenous peoples' health: Beyond the social*. Toronto, Canada: Canadian Scholars.

¹⁷¹ Reading, C., & Wien F. (2009). *Health inequalities and social determinants of Aboriginal peoples' health*. Prince George, Canada: National Collaborating Centre for Aboriginal Health.

¹⁷² Reading, C. (2018). Structural determinants of Aboriginal peoples' health. In Greenwood. M., De Leeuw, S., & Lindsay, N.M, (Eds.), *Determinants of Indigenous peoples' health: Beyond the social*. Toronto, Canada: Canadian Scholars.

¹⁷³ Czyzewski, K. (2011). Colonialism as a broader social determinant of health. *The Indigenous Policy Journal*, 2(1). Retrieved from <https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1016&context=iipj>

¹⁷⁴ Canadian Council on Social Determinants of Health. (2015). *A review of frameworks on the determinants of health*. Retrieved from: http://ccsdh.ca/images/uploads/Frameworks_Report_English.pdf

¹⁷⁵ Solar, O., & Irwin, A. (2010). *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva; World Health Organization. Retrieved from https://www.who.int/social_determinants/corner/SDHDP2.pdf

and influence, or the “roots of wellness” for First Nations, such as self-determination. First Nations concepts of health and well-being are interconnected, complex and multi-dimensional. Western concepts of health, in contrast, focus on sickness and disease, and tend to focus on quantifiable, physical aspects of health. A 2009 survey of Canadians revealed that there is limited understanding of the many factors that impact health, with the majority of individuals attributing health to more individual-level risk factors and behaviours such as smoking and physical activity than structural or societal factors such as laws and policies, work and living conditions, cultural histories, level of power and self-determination, early childhood experiences or access to social supports.^{176,177}

The FNHA, in partnership with the PHO and the TCFNH, has been on a journey of redefining what is measured and collected in order to expand upon western measures of health by focusing on factors that impact First Nations health, well-being and self-determination in BC. Through the development of new strengths-based measures, partners are working to redefine how health and wellness are conceptualized and measured in terms of health outcomes, healthy behaviours, and the social determinants of health.

One of the biggest things I look forward to is understanding how we look as vibrant people.”¹⁷⁸

“We want every Nation to define what a healthy, vibrant youth is. So we want to start counting things that are positive.”¹⁷⁹

The 2020-2027 First Nations Population Health and Wellness Agenda establishes a long-term outlook and system of measurement and reporting and will be measured over the coming ten years. This includes expanding beyond the seven deficit-based indicators in the TCA: FNHP, to embody the commitment in the Framework Agreement to develop wellness indicators. The 15 new health and wellness indicators were developed by the FNHA and the PHO through an extensive process of consultation with experts, collaboration between

¹⁷⁶ Canadian Institute for Health Information. (2005). *Select highlights on public views of the social determinants of health*. Retrieved from https://secure.cihi.ca/free_products/CPHI_Public_Views_FINAL_e.pdf

¹⁷⁷ Born, D. (2017). The intersection between traditional healing and western medicine in Canada [Web log post]. Retrieved from <http://blogs.ubc.ca/dawsonborn/files/2017/03/The-Intersection-Between-Traditional-Healing-and-Western-Medicine-In-Canada.pdf>

¹⁷⁸ First Nations Health Council. (2019). *Living well: Transforming First Nations health in BC* [Video file]. Retrieved from <https://www.youtube.com/watch?v=BDzw73W5OCQ&t=42s>

¹⁷⁹ First Nations Health Council. (2019). *Living well: Transforming First Nations health in BC* [Video file]. Retrieved from <https://www.youtube.com/watch?v=BDzw73W5OCQ&t=42s>

project teams and investigation into available data sources. Over 400 First Nations people were engaged in these discussions.

"Our people have survived over time and developed ways of care-giving and health-giving to our families and Nations that are often not reflected in government statistics. So this agenda and set of indicators were making a deliberate shift away from that narrative and towards an approach that promotes and builds on strengths and acknowledges the structures and environments that support us and help us to grow."¹⁸⁰

The resulting 22 indicators (see Table 2 below) include the original seven Transformative Change Accord: First Nation Health Plan indicators as well as an additional 15 new indicators that span five areas of health and wellness, inspired by a strength-based approach and the First Nations Perspective on Health and Wellness.

Table 2: First Nations Population Health and Wellness Indicators

HEALTHY, SELF-DETERMINING NATIONS AND COMMUNITIES: LAND, FAMILY, COMMUNITY, NATIONS
Self-Determination – <i>forthcoming indicator</i>
Connection to Land – <i>indicator in progress</i>
Cultural Wellness – Knowledge of a First Nations language, participation in cultural activities, importance of traditional spirituality, use of traditional medicine, consuming traditional food
SUPPORTIVE SYSTEMS: ENVIRONMENT, SOCIETY, CULTURE, ECONOMY, AND HEALTH SYSTEMS
Food Insecurity – Proportion of households who could not afford to eat a balanced meal
Acceptable Housing – Proportion of households with acceptable (adequate, suitable, affordable) housing
Education – Proportion of students who complete high school within 8 years
Avoidable Hospitalizations – Rate per 10,000 population
Cultural Safety and Humility – Experience in health care <i>Acute care</i> <i>Emergency department</i>
Certified, Practicing First Nations Health Care Providers – Number of registered First Nations physicians in BC

¹⁸⁰ First Nations Health Authority. (2018). *Island families gather at fall Caucus to improve health programs and services*. Retrieved from <http://www.fnha.ca/about/news-and-events/news/island-families-gather-at-fall-caucus-to-improve-health-programs-and-services>

HEALTHY, VIBRANT CHILDREN AND FAMILIES – PHYSICAL, MENTAL, SPIRITUAL, AND EMOTIONAL WELLNESS

Healthy Birth Weights – Percentage of babies born at a healthy birth weight for sex and gestational age
Infant Mortality Rate – Rate per 1,000 live births
Children’s Oral Health – Percentage of kindergarten children who are cavity free
Healthy Childhood Weights – Percentage of children age 2-11 with a healthy/ moderate body mass index
Youth/Young Adult (Age 15-24) Suicide – Rate per 10,000 population
Mental and Emotional Well-being – Percentage who feel balanced physically, emotionally, mentally, and spiritually.
Physical Activity – Percentage meeting the recommended physical activity guidelines. <i>Adults</i> <i>Children & Youth</i>
Diabetes Incidence – Rate per 1,000 population
Smoking – Percentage who smoke commercial tobacco <i>Adults</i> <i>Youth</i>
Serious Injuries – Rate of serious injuries requiring hospitalization per 10,000 population
Life Expectancy – At birth
Mortality Rate – Rate of deaths due to all causes per 10,000 population
Alcohol-attributable Mortality – Rate per 10,000 population

The Population Health and Wellness Agenda helps create accountability across multiple organizations and levels of the system towards commonly-desired health and wellness outcomes. It unites previously disparate data sources in service of improved health outcomes and includes “Calls to Action” to First Nations organizations, federal and provincial governments, and other partners to collaborate in a range of ways to achieve meaningful change against these indicators and associated targets.

Figure 28: Actions to Nourish First Nations Roots of Wellness



Source: FNHA and Office of the Provincial Health Officer. (2020). First Nations Population Health and Wellness Agenda. Summary of Findings.

This is just the beginning of the story, with much work to do to shift the paradigm from sickness-based to a wellness-based measurement of health and wellness, rooted in the self-determination of First Nations peoples to tell their own health and wellness stories. As expressed by key informants, the emphasis on wellness, so intrinsic to Indigenous ways of being, is “both timely and reflective of the aspirations of both Aboriginal and non-Aboriginal populations.”

7.3 Key Findings

There are early signals in improvement of health outcomes; however, there has been an insufficient amount of time for observable shifts in health outcomes at the population level. Efforts must continue to focus on improvement of health and wellness outcomes.

Reports to date reveal modest improvements in several *Transformative Change Accord: First Nations Health Plan* indicators including: life expectancy, age standardized mortality and youth suicide. Improvements have not been made in infant mortality rates or diabetes rates, which are on the rise for other residents of BC as well. Inequalities between the First Nations population and other residents of BC has increased on three of the five indicators.

Through the development of new strength-based measures, partners are working to redefine how health and wellness are conceptualized and measured.

The Population Health and Wellness Agenda helps shift the paradigm from a sickness-based to a wellness-based model of care, and holds the possibility to enhance reciprocal accountability for First Nations health and wellness across multiple organizations and systems.

There is an opportunity to revisit the tripartite planning and accountability approach in the context of the new Population Health and Wellness Agenda indicators, involving other organizations and agencies with contributions to make to the “roots of wellness”.

Chapter 8 Conclusion and Summary of Key Findings

Given the extensive level of engagement, the multiple lines of inquiry and numerous evaluation products, this report provides a high-level summary of the complexity of this evaluation. Each evaluation, case study and report referenced has its own integrity and set of findings and recommendations that can drive improvements in specific areas. As per the evaluation methodology (see Figure 1), the highest-level findings from all of these efforts are outlined below in three categories:

1. **Governance, Tripartite Relationships and Integration** - relevance, efficiency and effectiveness of the First Nations in BC Health Governance Structure and Tripartite Health Partnership.
2. **Health and Wellness System Performance** - improvements in the type, volume, distribution, accessibility, quality, responsiveness and safety of programs and services for First Nations across the province.
3. **Health and Wellness Outcomes** - data and reporting on the health and wellness indicators.

Governance, Tripartite Relationships and Integration

The First Nations health governance structure and partnerships with federal and provincial governments demonstrate reciprocal accountability and have facilitated historic changes. The First Nations health governance structure is seen as an increasingly effective mechanism for facilitating First Nations participation in key decisions affecting their health, though roles and responsibilities could be more clearly articulated. Additional onboarding resources could mitigate risks related to turnover. The First Nations Perspective on Health and Wellness, and the FNHA itself, are becoming embedded in the BC health system due to strengthened partnerships, the establishment of Regional Partnership Accords and a commitment by all partners toward cultural safety and humility.

The TCFNH ensures a whole-system approach to implementation of the Health Plans and Agreements and other commitments to First Nations health and wellness. An important feature has been its ability to evolve through time, particularly as there has been success in “hardwiring” the FNHA and First Nations decision-making in the routine leadership processes of the health system, and maturing partnerships at regional and local levels.

The strength of partnerships, the establishment of Regional Partnership Accords, and a commitment by all partners towards cultural safety and humility has led to hardwiring the First Nations Perspective on Health and Wellness into the BC health system. Regional

Partnership Accords have been a key success in strengthened relationships and collaboration, serving as an opportunity to come together, strengthen relationships, discuss issues and shared priorities, and collaborate on solutions. The Accords have increased awareness of the importance and need for the health system to engage with First Nations and support First Nations decision-making.

Improved relationships and hardwiring of First Nations decision-making has led to increased health system improvement initiatives. Across the health system, cultural safety and humility are cornerstones of the work undertaken by Tripartite Parties and partners. This hardwiring of the First Nations health governance structure is generating value through new investments, as is the availability of data. Baseline data has been established for the first time and is being leveraged to improve health service planning at regional and provincial levels, providing the impetus for new targeted funding and service allocations.

Health and Wellness System Performance

Partners are taking steps to ensure a more integrated and coordinated landscape of health services for First Nations in BC.

Partners are implementing a range of initiatives to improve cultural safety and humility across all levels of the health system in BC. While evidence shows enhanced awareness of cultural safety and humility, sustained efforts are required to determine whether improvements are being felt by First Nations accessing health services.

Access to the health system and health services for First Nations in BC is beginning to improve due to dedicated funding streams (e.g. the Joint Project Board), and increased partnerships on key priorities (e.g. Mental Health and Wellness Mobile Support Teams, the overdose public health emergency response and Jordan's Principle).

Ongoing challenges associated with health system access for First Nations in BC are exemplified, for instance, by higher rates of avoidable hospitalizations (i.e. ambulatory care sensitive conditions) and lower rates of general practitioner attachment.

Although work is being undertaken to fundamentally change the way First Nations in BC experience health care in the province, analyses of BC patient experience measures reported by self-identified Aboriginal patients suggest there is room for improvement, in particular within Emergency Department service areas.

While this report uses older data in many areas, the next evaluation will provide more insight on impacts on health system performance.

Health and Wellness Outcomes

First Nations health information governance has shifted the paradigm to health and wellness indicators. Reports to date reveal modest improvements in several *Transformative Change Accord: First Nations Health Plan* indicators; however, inequality between the First Nations population and other residents of BC has increased on four of the five indicators.

Indicators showing modest improvements include life expectancy, age standardized mortality, infant mortality and youth suicide. Improvements have not been made on diabetes rates, however, diabetes rates are going up for other residents of BC as well.

Tripartite Partners, led by the FNHA, have worked to drive a paradigm shift from a sickness-based to a wellness-based model of care. First Nations have increasing data and analytical capacity to tell their own health and wellness stories, however, challenges to accessing timely and geographically-granular data persist.

The 2020-2027 Population Health and Wellness Agenda helps create accountability across multiple organizations and levels of the system towards commonly-desired health and wellness outcomes.



For more information, please visit:

First Nations Health Authority:
www.fnha.ca

Province of British Columbia:
www.gov.bc.ca/hls

Government of Canada:
www.canada.ca/en/indigenous-services-canada.html