

URBAN ABORIGINAL HEALTH STRATEGY 2018

NORTH SHORE ✦ VANCOUVER ✦ RICHMOND

Vancouver
CoastalHealth



First Nations
Health Council



VANCOUVER COASTAL REGION
First Nations Health Authority

April 15, 2018

Welcome,

My name is Leah George-Wilson. My ancestral name is Sisi-ya-ama and I am a member of the Tsleil-Waututh Nation, located in North Vancouver. I have been a member of the First Nations Health Council (FNHC) since 2011 as one of three Vancouver Coastal Region Political Representatives.

In May, 2012, Vancouver Coastal Health (VCH) signed a *Partnership Accord* with the First Nations Health Authority (FNHA) and First Nations Health Council (FNHC) representatives for the region. One of the commitments in this Accord was the joint development of an *Urban Aboriginal Health Strategy* (UAHS). Developing the UAHS is also a priority outlined in the Regional Health and Wellness Plan for Vancouver Coastal Region, more recently refreshed in 2016.

Work on this strategy began with extensive engagement with the Aboriginal community on health-related issues over the last 20 years in the urban Vancouver area. Themes emerged and were engaged on through the discussion document: *Towards an Urban Vancouver Aboriginal Health Strategy* from 2015 to 2017. This discussion document synthesized all prior engagement feedback and input into a set of key observations and priorities to be addressed and validated by our community of partners, community representatives and other stakeholders. Their perspectives and feedback led to the following six strategies in this draft UAHS:

- Strategy 1. Strengthen relationships in the urban community;
- Strategy 2. Strengthen access to culturally appropriate primary health care;
- Strategy 3. Strengthen access to culturally appropriate mental wellness and substance use services;
- Strategy 4. Promote wellness and prevention of illness;
- Strategy 5. Information about, and access to, services; and
- Strategy 6. Improve data and information on Aboriginal health outcomes.

Following the review and validation of this draft UAHS, partners will define implementation approaches to these strategies. Our hope is the UAHS will contribute toward a more coordinated, integrated and culturally safe and relevant health care system for smooth patient journeys for the Urban Vancouver Aboriginal community. In our shared health system, we recognize this is the responsibility of all partners and service providers.

In my capacity as the FNHC VC Political Representative, I have worked to provide high-level direction to the development of this strategy, and assured First Nations engagement and leadership on the process.

In Wellness,

INSERT Leah's Signature

Leah George-Wilson

Vancouver Coastal Political Representative First Nations Health Council



DRAFT

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MUSQUEAM, TSLEIL-WAUTUTH AND SQUAMISH NATIONS ACKNOWLEDGMENT

The UAHS covers health services in the greater Vancouver area including the North Shore, Vancouver and Richmond. These municipalities are acknowledged to be residing in the unceded traditional territories of the Musqueam, Tsleil-Waututh and Squamish Nations. We raise our hands to and acknowledge these Nations for keeping their territories alive and well for those of us who live and work on these lands. These three host Nations are important leaders in urban Aboriginal¹ health and wellness and are also key leaders in health service delivery. We acknowledge these Nations as the hosts for all people who live and work in these Coast Salish territories. We give thanks for their leadership and support.

BACKGROUND

Where did this work come from?

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

In health, progress has been made through a series of political agreements between First Nations in BC and federal and provincial governments: The *Transformative Change Accord: First Nations Health Plan* (2006); *First Nations Health Plan Memorandum of Understanding* (2006); *Tripartite First Nations Health Plan* (2007); *Basis for a Framework Agreement on Health Governance* (2010); *Tripartite Framework Agreement on First Nations Health Governance* (2011); and *Health Partnership Accord* (2012). These agreements were led by BC First Nations with a unique, first-of-its-kind engagement pathway that supported consensus and direction setting on long-standing health and wellness challenges.

Collective efforts of BC First Nations are united and guided by a shared vision: “Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities.” To achieve this vision, we must move from a sickness system to a wellness system. The Shared Values of **Respect, Discipline,**

¹ Throughout BC and Canada, many First Nations and non-First Nations organizations as well as government agencies are transitioning their language to now use the term Indigenous rather than Aboriginal. Although the First Nations Health Authority is also discussing how we can best reflect the communities we serve through the language that we use, we have chosen to use the term Aboriginal throughout this strategy, as it reflects the language used in community engagements, by community members, that led to the development of this plan.

Relationships, Culture, Excellence and Fairness guide our work. First Nations in BC also agreed upon the following 7 Directives to describe the fundamental standards and instructions for the new BC First Nations health governance system. These 7 Directives guide the work of this strategy, and are:

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

In the Vancouver Coastal Region, a *Partnership Accord* was signed between the FNHC (Vancouver Coastal Region representatives), the FNHA and VCH in 2012. This Accord signalled the creation of a new path to improving health outcomes, programs and services for First Nations and Aboriginal people in the Vancouver Coastal Region. It resulted from many years of dedicated First Nations governance efforts in BC and the support of our federal and provincial partners.

The Accord sets the goal of attaining significant improvements in health outcomes by achieving a higher level of integration through joint planning and engagement, a focus on accountability and evaluation, and by providing culturally appropriate, safe and effective services. One of the deliverables of the Accord is the development of an **Urban Aboriginal Health Strategy** (UAHS) that has a goal of supporting and improving health services for Aboriginal people living in greater Vancouver.

The UAHS aligns with the Joint VCH and FNHA Regional Health and Wellness Plan (RHWP), 2016-2021, another Accord deliverable. The RHWP is grounded in BC First Nations Governance Directives, our Shared Values and the First Nations Perspective on Health and Wellness. The six main priorities of the RHWP are (see Appendix 3):

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

The RHWP was developed by the 14 First Nations communities in the Vancouver Coastal Region, and it guides the work of our shared health and wellness system transformation journey and plays a key role in informing strategy and action at the provincial level. One of the strategic goals of the RHWP is to: **Realize and Implement an Urban Aboriginal Health Strategy** (Goal 1.4). Objective 1.3.1 outlines the commitment to “*Ensure host First Nations have a governance role and voice in the governance process.*” Lastly, Objective 1.3.2 outlines the intention to “*Implement an engagement process to support the development and implementation of a strategy in the urban center.*”

All of this work is grounded in the principle of reciprocal accountability—a core principle of the new First Nations health governance structure. Reciprocal accountability acknowledges the shared responsibility of each of us as individuals and organizations to achieve our vision and goals—each of us is accountable to one another for the effective implementation of our commitments towards our shared outcomes. Everyone has a role: our actions affect others and contribute to the outcomes of our interdependent and interconnected system.

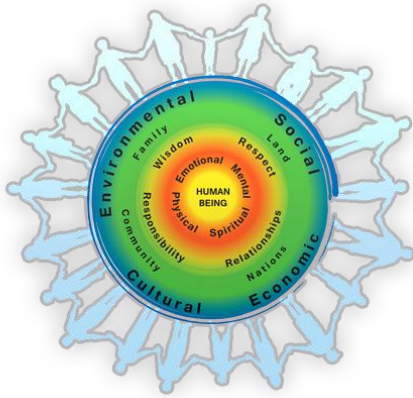
The principle of cultural humility and safety is at the heart of all work related to the strategy implementation. Cultural humility is a life-long process of self-reflection and self-critique to understand personal biases and to develop and maintain mutually respectful partnerships based on mutual trust. Cultural humility enables cultural safety, which supports an environment that is free of racism, biases, stereotypes and discrimination where people feel safe receiving health care. With our partners' commitment to cultural humility, cultural safety will be improved for First Nations and all British Columbians.

In addition, the importance of traditional wellness to the health and wellness of First Nations peoples across the region needs to be recognized. Cultural sharing and traditional approaches are instrumental to guide and inform our shared health and wellness system transformation journey. The ways in which traditional wellness is weaved into existing service provision are vast and should honour the unique cultural protocol and processes of each community. Furthermore, the BC First Nations Perspective on Health and Wellness is fundamental to this document and weaves through all six strategies.

The First Nations Perspective on Health and Wellness (see figure below) is a holistic health and wellness approach, and is intended to guide the health and wellness planning, program and service delivery to First Nations and Aboriginal peoples throughout BC. It builds on the idea that health and wellness are intimately connected, and that emotional, mental, spiritual and physical dimensions of well-being—as well as external factors such as our communities, Nations, territories, environments and society as a whole—all have an influence on our health and wellness.

A holistic and integrated approach is fundamental to the success of achieving improved health and wellness outcomes for First Nations peoples in the Vancouver Coastal Region. This perspective has guided, and will continue to guide, the development and implementation of regional plans and strategies, including the Urban Aboriginal Health Strategy.

BC First Nations Perspective on Health and Wellness



Who is this work for?

The BC population includes First Nations, Inuit and Métis peoples living on-reserve and off-reserve. In the 2005 *Transformative Change Accord: First Nations Health Plan*, the BC provincial government affirmed its responsibility and commitment to contributing to improvement in the health of BC First Nations community members and the Aboriginal population regardless of where they reside.

This strategy focuses on a strength-based approach to celebrate the diversity and Aboriginal community and population in the urban Vancouver area. The 2016 census revealed there was a significant increase in the Aboriginal population in Canada since 2006—it grew 42.5% to 1,673,785.² This is due to natural growth (increased life expectancy) and relatively high fertility rates as well as an increase in self-reported identification (an ongoing trend for some time). Urban Vancouver has the third largest Aboriginal population of any Canadian city at 61,460 (this figure does not include the North Shore and Richmond).³ This number includes First Nations (both BC and non-BC), Métis and Inuit peoples. This compares to Victoria at 17,245 and Prince George at 12,396.⁴

Since 2006, the increased population numbers reflect a 52.4% growth in the urban Aboriginal population with the 2006 census metropolitan areas of Vancouver reporting 40,310 Aboriginal people (consistently the largest population in any BC city).⁵ According to BC statistics, the Aboriginal population in the urban Vancouver area is likely to be higher in reality, as it is known that some Aboriginal people do not identify their ethnicity.⁶ Of the total urban Aboriginal population, over 4,500 people, or 26%, reside in the Downtown Eastside Local Health Area and 2,500 (15%) reside on the

² <http://www.statcan.gc.ca/daily-quotidien/171025/dq171025a-eng.htm>

³ Ibid

⁴ Ibid

*2016 Data is being updated.

⁵ <http://www.statcan.gc.ca/pub/89-638-x/2010004/article/11085-eng.htm>

⁶ www.aandc.gc.ca : Fact Sheet (Sept 2010) - Urban Aboriginal population in Canada – noting a trend over the years for Aboriginal people to complete the census when they had never done so before.

North Shore. Estimates are that around 2/3 of the urban Vancouver population are First Nations (BC and other provinces) and the remainder are Métis and Inuit*.

It should be noted that the proposed strategy is for greater Vancouver—*not* Metro Vancouver, which is an area that includes many municipalities in the Fraser Health Authority region (e.g., Surrey, Burnaby). However, it is also noted that some First Nations, Inuit and Métis populations traverse the boundaries between VCH and Fraser Health to seek out services or connect with family and friends while accessing health services. The Fraser Health Authority is working with FNHC and other partners to develop their own Urban Aboriginal Health Strategy for their region.

In order to achieve the shared Vision of “Healthy, self-determining and vibrant First Nations children, families and communities,” we have to consider the impacts the social determinants of health have on health outcomes experienced by First Nations people. The social determinants, which include social, economic, political and environmental factors, all influence our ability to be healthy. Healthy families and healthy communities are the foundation of a healthy environment.

When these social determinants of health are negatively impacted, they may result in higher rates of poverty, homelessness, food insecurity, alcohol and drug use, smoking and exposure to second-hand smoke; opioid overdose; teenage pregnancies; infectious diseases (including HIV/AIDs and TB); chronic diseases; major depression; suicide rates; infant mortality; and disabilities. Furthermore, intergenerational trauma and internalized racism continue to lead to other health outcome disparities for First Nations people, and can contribute to individuals engaging in substance use.

Recently, in 2016, the opioid emergency was declared a public health emergency by the BC Provincial Health Officer under the Public Health Act due to the unprecedented increase in overdoses and deaths in the province. The data has shown that First Nations people are five times more likely than non-First Nations people to experience an overdose event and three times more likely than non-First Nations people to die due to an overdose.⁷

Although substance use is common across BC, the opioid public health emergency has disproportionately affected First Nations people and communities due to the ongoing legacy of colonization.¹ It is vital that these gaps are addressed by transforming the current system to create a more effective, integrated, culturally competent, equitably distributed set of health care services across the greater Vancouver area. We also know from the research that First Nations people are tired of being measured by deficit indicators; it is imperative that resilience and wellness are celebrated through a strengths-based approach to health and wellness.

⁷ FNHA Overdose Data and First Nations in BC, Preliminary Findings (2016)

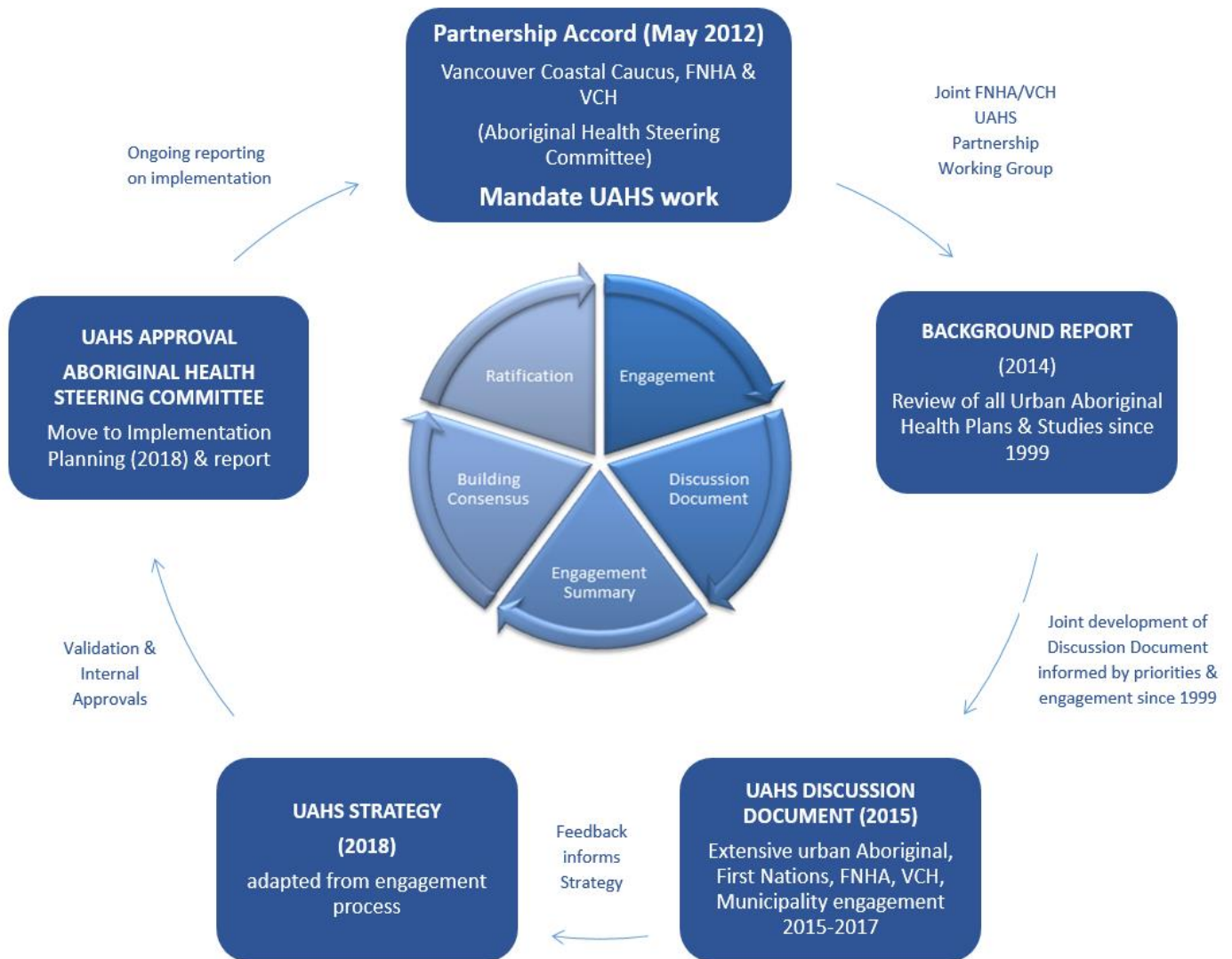
HOW DID THIS STRATEGY COME TO BE?

This strategy is grounded in the partners' commitment to develop key strategic focus areas in the direction of health transformation in order to improve health and wellness outcomes for the urban Vancouver Aboriginal population. The partners recognized that significant improvements can be made in health and wellness outcomes through improved service integration, understanding the patient journey as well as by increasing culturally appropriate person or family-centred care. By doing a meta-analysis of the last 20-25 years of urban Aboriginal literature, and research, along with collecting current and past data, such as service mapping, compounded with key input from partners, community members and stakeholders, key priority areas to be addressed were identified and validated.

A robust engagement and approval pathway was used to validate the priority areas by the urban First Nations and Aboriginal communities and service partners. Please refer to the summarized engagement pathway in the diagram below, with the full engagement pathway provided for reference in the appendices (this pathway is derived from the "Engagement and Approvals Pathway" process used by the First Nations Health Council to gather First Nations input and guidance and build consensus on key decisions, as adopted by resolution in 2011).

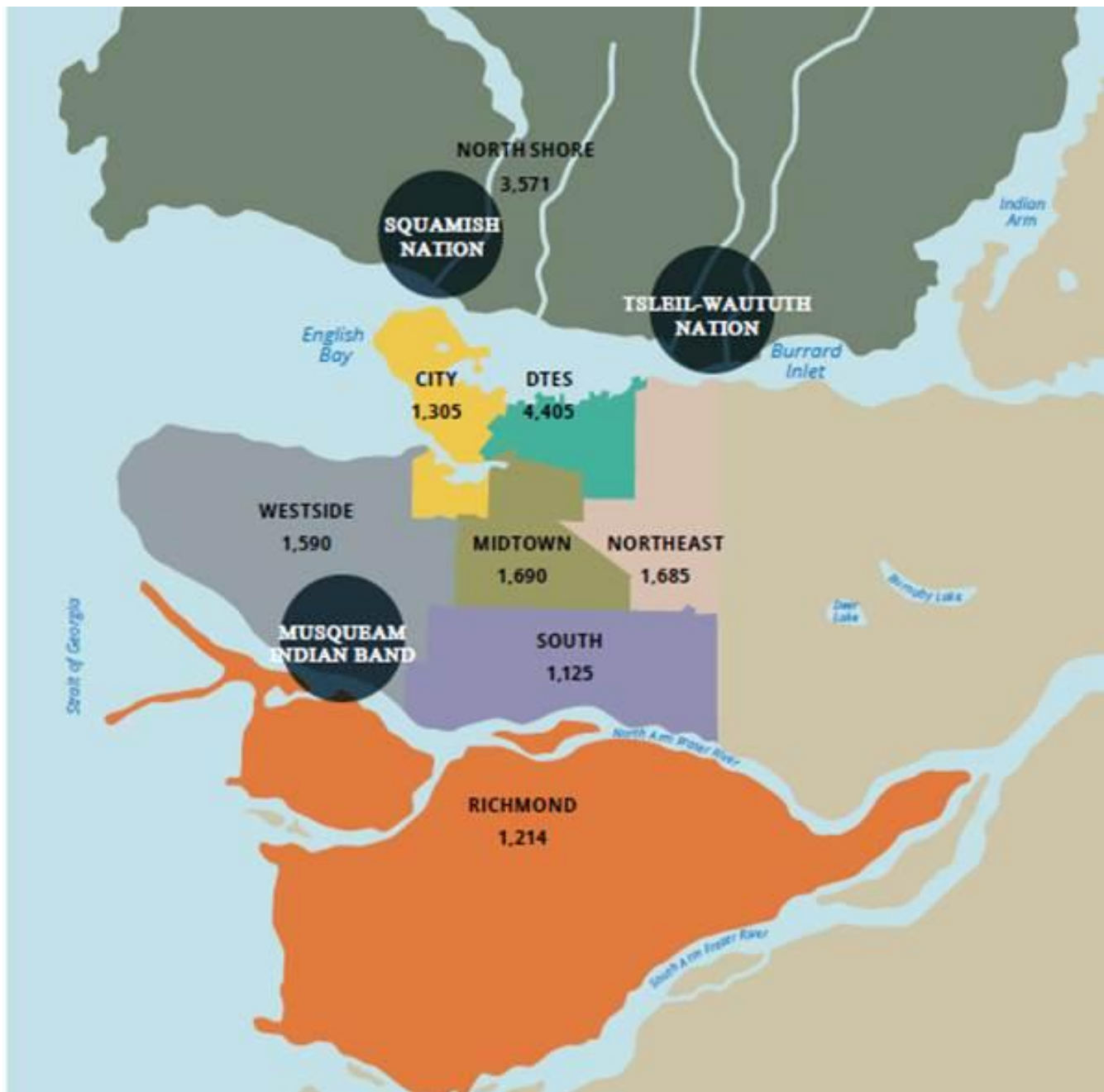
The six UAHS strategic areas of focus have been identified based on feedback provided on the priority areas.

ENGAGEMENT AND APPROVALS PATHWAY: URBAN ABORIGINAL HEALTH STRATEGY



WHAT AREA DOES THIS STRATEGY APPLY TO?

Local planning areas within the scope of the Urban Aboriginal Health Strategy are shown in the map below, along with estimated Aboriginal populations (Census 2006):



WHAT IS THE PURPOSE OF THIS STRATEGY? WHO WAS INVOLVED?

The purpose of this strategy is to guide and inform organizations involved in providing services related to improving urban Aboriginal health and wellness. All partners share the goal to significantly improve health and wellness outcomes through improved service integration, understanding of the patient journey as well as by increasing culturally appropriate person or family-centered care. Key stakeholders in the development of this strategy have included: the urban Aboriginal community residents, regional First Nations community leaders, the FNHA, VCH, City of Vancouver, City of North Vancouver as well as other organizations serving urban Aboriginal health and wellness interests, such as the Metro-Vancouver Aboriginal Executive Council. The goal of the strategy stakeholders is to

ultimately improve health and wellness service planning and delivery for the urban Aboriginal population. The strategy lays out the health priorities for the Aboriginal population that have been determined and validated from many years of research and engagement with the Aboriginal community.

These health priorities and needs led to the key strategies outlined in this document. Working with partners such as Aboriginal service organizations, Providence Health, Provincial Health Services Authority (PHSA), municipalities and the Divisions of Family Practice, the intent is that together we can make meaningful and sustainable improvements to the way we all approach our work that will benefit the Aboriginal population.

The strategy is intended to be a living document, and may be updated annually as the urban Aboriginal population and health and wellness priorities change and the population grows. The strategy should be re-evaluated or re-written every five to 10 years as appropriate.

WHAT IS THE SCOPE OF THIS STRATEGY?

The scope of the UAHS includes improvements to health services of the urban Aboriginal community in Vancouver, North Shore and Richmond areas funded or influenced by the First Nations Health Authority and VCH. However, it is hoped the strategic plan may support and provide guidance to other health service partners and providers who serve the urban Aboriginal population in health and wellness by supporting service transformation, and improving the integration and cultural appropriateness of programs and services.

Out of scope are broader services that may be categorized as “social determinants of health,” i.e., housing, employment and education. While the significance of social determinants on health outcomes is undeniably recognized, we are committed to starting with improvements to health services first in order to make the initiatives manageable within current capacity.

WHAT UAHS WORK HAS BEEN DONE ALREADY?

When the Partnership Accord partners began this work we started with a small Working Group in 2014. The Working Group included senior staff from the FNHA and VCH, along with the lower mainland First Nations Health Council representative. Everyone at the table recognized that much work had been done before, and that the urban Aboriginal community was tired of being researched with little to no tangible positive outcomes or benefits. We started by reviewing all of the published literature that we could on past projects, studies and reports since the mid-1990s that involved the Aboriginal community. We summarized this into a Literature Review and identified a number of consistent themes and issues that the Aboriginal community had raised over the years at a wide variety of engagements. In Nov. 2015, in partnership with FNHA, the joint FNHA-VCH UAHS Partnership Working Group was established to continue moving the work forward.

The partners also reviewed the activities that other key stakeholders were doing in parallel with this strategy work so that we did not repeat what they were doing and “over-engage” with the communities. Vancouver Coastal Health was already in the process of an extensive engagement process in the Downtown Eastside (DTES) for their DTES Second Generation project at the time. This engagement had a high level of Aboriginal input with over half of respondents to their consultation being Aboriginal.

The City of Vancouver was also finalizing their Local Area Plan for the DTES as well as their Healthy Cities Strategy and Mayor’s Taskforce on Mental Health and Addictions work. Those pieces of work had involved extensive engagement and participation from the Aboriginal community. We drew the key issues from those engagements that were being said by the Aboriginal participants.

The three host Nations—Squamish Nation, Tsleil-Waututh Nation and Musqueam Nation—were also in the process of developing a Regional Health and Wellness Plan with the FNHA and VCH, alongside the other 11 First Nations in the region. Key issues and aspirations by the Nations are incorporated into the regional plan. This was updated again in 2016 and the priorities have been reflected in this strategy.

The Metro-Vancouver Aboriginal Executive Council (MVAEC) was also leading work on the federally funded Off-Reserve Aboriginal Action Plan (ORAAP) initiative, which had included extensive engagement on their part with the Aboriginal community.

Vancouver Coastal Health also undertook its own Service Mapping process with 47 Aboriginal, VCH and non-government service providers to look at the range of primary health care services they provided (or didn’t provide) for the Aboriginal community to determine where access was reasonably good versus areas across greater Vancouver where access was not so good and where gaps existed. These service gaps also contribute to the strategy development.

It became evident very quickly that there had been, and was currently, extensive engagement with the Aboriginal community on health-related issues—engagement that has been ongoing for at least the last two decades. Well over 3,500 Aboriginal people had participated in many studies, projects, reviews and initiatives. The partners agreed that they did not want to engage again at this time. Instead, all of the work was synthesized into a Discussion Document in 2014/2015 which identified 13 Key Themes / Issues that had been consistently raised by the Aboriginal community in the prior engagement processes. There were also six focus areas proposed for moving forward, along with a vision for the UAHS (that was informed by a vision originally developed by the Aboriginal community in 1999 during the Healing Ways engagement process).

The partners took this Discussion Document out to a number of stakeholders for validation and asked:

- (1) Is the 1999 “Healing Ways” vision for the urban Aboriginal community still relevant?

- (2) Are the key issues we identified from all prior research, studies and engagements still valid / correct? Was anything missed?
- (3) Are the six identified focus areas valid for the strategy moving forward?

The engagement process on these questions was completed in spring of 2017. Stakeholders included First Nations health, political and technical representatives in the region; Aboriginal service providers contracted to VCH; municipalities; and divisions and community representatives at conferences and gatherings. We then made edits to the vision, key issues and proposed focus areas and these foundations have now formed the basis of this strategy.

It should also be acknowledged that during the period in which this strategy was being developed, work has continued on many fronts by many partner agencies involved in the greater Vancouver area. In order to ensure the work is relevant and aligned to current activity moving forward, a “current state” is identified for each priority area.

VALIDATED HEALTH CHALLENGES AND PRIORITIES FOR THE URBAN ABORIGINAL COMMUNITY

- 1) **RACISM AND DISCRIMINATION AS BARRIERS TO ACCESS:** In 15 years since a 1999 Service Review, this pattern does not appear to have been addressed, as it has been reinforced again as recently as the 2013 Second Generation Downtown Eastside project, which surveyed community members. Research continues to show that tacit and sometimes overt discriminatory practices and policies continue to marginalize many Aboriginal people in the mainstream health care system. Racism was a central element in the experience of urban, marginalized Aboriginal people trying to navigate the health care, justice and housing systems and that community infrastructure was not sufficiently robust.
- 2) **RECONCILIATION INITIATIVES AND HEALING ARE REQUIRED:** Related to the public knowledge and understanding the history and impact of Indian Residential Schools, reclamation of cultural identity is imperative, as a strong identity is foundational to well-being; basic needs must be met without struggle; and promoting, streamlining and expanding on existing services and supports is needed to better coordinate access to these for the urban Aboriginal community. The Truth and Reconciliation Commission (TRC), in its May 2015 report further supports the need for greater efforts to support reconciliation and healing. Specifically, the TRC recommended that governments acknowledge that the current state of Aboriginal health is a result of previous Canadian policies (including Indian Residential Schools) and that health care rights for Aboriginal people needed to be recognized and implemented (Rec. # 18).
- 3) **SPACES / PLACES ARE NEEDED FOR ABORIGINAL HEALING AND WELLNESS:** There have been many calls for culturally based healing centres / places / spaces in Vancouver that would offer both

traditional medicine and western medicine within the same structure. These should incorporate Aboriginal healing and wellness approaches alongside mainstream services and include: drop-in fellowship; a community resource centre; services of Elders and traditional healers; assistance for clients in gaining control of their lives, making responsible decisions, and taking responsibility for their actions; and referrals to these agencies where appropriate. The TRC (May 2015) also made a recommendation (# 21) that there be sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional and spiritual harms caused by Residential Schools.

- 4) STRONG SUPPORT FOR ABORIGINAL-SPECIFIC SERVICES:** Seven in ten community members use or rely on the city's Aboriginal services or organizations in Vancouver. Reported use is similar for First Nations peoples and Métis in Vancouver. Aboriginal peoples in Vancouver who are regular users of the city's Aboriginal services and organizations say they are motivated by the specific services offered and/or by the positive environments they find. Programs and social services, education and employment services, health supports, and services related to Aboriginal benefits or advocacy are the most typical resources they describe using. There is a strong consensus among Aboriginal people in Vancouver that it is important for Aboriginal services to exist in addition to non-Aboriginal ones.
- 5) LACK OF SUSTAINED FUNDING FOR ABORIGINAL SERVICE PROVIDERS:** Many Aboriginal service providers have been in existence for over 20–30 years, yet few have sustainable funding and relationships with their funders. Several identified in the 1999 Vancouver Richmond Health Board review are still operating today and expressing the same issues that they did then. There is a desire for sustainable services and not one-off, short-term funding so that Aboriginal organizations can build capacity and offer the long-term sustainability people want. Service providers agreed that competition for funding creates and reinforces existing divisions in the community. Often, funders demanded more burdensome reporting from an Aboriginal group compared to a similar mainstream group.
- 6) CONTRACTING AND FUNDING NEEDS TO INCORPORATE A HOLISTIC APPROACH:** An Aboriginal holistic approach to providing a service or support requires more flexibility than a funder often allows because they are not valuing the health contribution of Aboriginal approaches. Service providers wish to see more recognition of holistic approaches to health recognized and included in funding agreements (such as Talking Circles, healing journeys, culture camps, language and identity initiatives) so that these are recognized for their important contributions to health and well-being. The Truth and Reconciliation Commission (May 2015) Recommendation # 22 also called upon “those that can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.” Furthermore, holistic approaches mean removing competition between agencies and sponsoring collaborations where service providers can come together to deliver shared care models. They

would also like to see longer-term relational funding arrangements such as the Block Flexible agreements.

- 7) **LACK OF SERVICE INTEGRATION MAKING ACCESS DIFFICULT AND NAVIGATIONAL SUPPORT A NECESSITY:** There are multiple disconnected service providers making it difficult for clients and creating problems with referrals. There are several smaller specialized services (e.g., for youth, for Aboriginal women, for drug-users) but a lack of coordination between these and other services. There is a need for information about available services for Aboriginal community members so that they know what is available and for advocates to help people navigate into, between and through services. The wide range of and fragmented services make it difficult for community members to learn about what is available and then to physically access and move between those services. There is a need to improve transitions from hospitals to home to ensure services are in place for those returning back to their communities, especially those who are discharged on weekends. Additionally, barriers to access can be demoralizing and confusing and can lead to disengagement with care services and providers. Distrust in the system's lack of cultural safety and confidentiality is also a barrier to access.
- 8) **ABORIGINAL CLIENTS ARE HIGHLY MOBILE AND DEMAND FOR SERVICES COME FROM ACROSS GREATER VANCOUVER AND PARTS OF THE FRASER SALISH REGION:** People are moving from some local health areas into the DTES to get to Aboriginal services, e.g., from Richmond and South Vancouver to the DTES, or from the Fraser Salish Region to the DTES, because there are more Aboriginal services there. In fact, the 1999 Vancouver Richmond Health Board "Healing Ways" review recommended that the Board should direct new or enhanced services for Aboriginal people to locations outside of the city core to avoid DTES-centric services for Aboriginal people. There are limited Aboriginal funded services outside of the DTES, which impacts access to culturally appropriate services. There has been substantial Aboriginal housing development in the past decade and many Aboriginal families have moved from the downtown core to other suburbs across Vancouver, including to the North Shore, Richmond and to Surrey, Burnaby and the Tri-Cities in the Fraser Salish Region. This has not necessarily led to Aboriginal friendly services following them to these new housing areas.
- 9) **ABORIGINAL WOMEN, CHILDREN AND YOUTH ARE PRIORITY GROUPS:** Community members are highly concerned about children and youth, but they are firm in their belief that strategies for change must include the family and that they want to see a better future for their children and their children's economic and social life. Large majorities of Aboriginal people in Vancouver believe it is very important to also have Aboriginal child and family services, housing services, and child care or daycares. The BC Representative for Children and Youth (RCY) issued the report "Paige's Story: Abuse, Indifference and a Young Life Discarded" in May 2015. Key recommendations # 2 and # 5 call on Vancouver Coastal Health, the Ministry of Health, the FNHA and the City of Vancouver to review their current provision of services (including health care and substance use treatment) to vulnerable children in the DTES.

Services recommended to be reviewed include:

- Sexual and reproductive health and reproductive education (promoting contraception vs. terminations);
- After-care planning and follow-up services, including expansion of outreach;
- Follow-up GP appointments for female children after pregnancy terminations;
- Intensive drug and alcohol services with an Aboriginal trauma lens and a family-centred model that avoids further stigmatizing and traumatizing of these vulnerable populations;
- Aboriginal youth addiction services including secure short-term care, strong after-care and a focus on education and resilience.

Aboriginal women are a priority population group due to a greatly disproportionate level of violence against First Nations, Inuit and Métis women and girls. Furthermore, the Missing and Murdered Indigenous Women's Inquiry highlights that Aboriginal women are a group at risk and require additional supports and culturally appropriate approaches to health and wellness. The "Missing Women Commission of Inquiry" noted in 2012 that more than 60 missing and murdered women were taken from the DTES, 1/3 of these being Aboriginal.

- 10) **ELDERS ARE A PRIORITY:** Elders are important in the lives of First Nations and Aboriginal people as the knowledge keepers in the communities and those who provide wisdom and leadership for younger generations. Elder's needs for support to live independently in their homes and to remain at home and not away from families are vital to sustaining the culture and identity of First Nations and Aboriginal communities. The need for culturally appropriate home care, residential care (e.g., assisted living) and long-term care for Aboriginal Elders is a priority.
- 11) **TWO-SPIRIT AND THE LGBTQ2 ABORIGINAL COMMUNITY ARE PRIORITY GROUPS:** Aboriginal people who are Two-Spirit, lesbian, gay, bisexual or transgender are members of every community. They are diverse, come from all walks of life, and include people of all ages, all socioeconomic statuses, and from many different First Nations and Aboriginal communities. The perspectives and needs of Two-Spirit and LGBTQ people must be routinely considered in public health efforts to improve the overall health of every person and eliminate health disparities. There is a need for culturally safe medical care and prevention services that are specific to this population. Social inequality is often associated with poorer health statuses, and sexual orientation has been associated with multiple health threats. Members of the Two-Spirit and LGBTQ community are at increased risk for a number of health threats when compared to their heterosexual peers. Differences in sexual behaviour account for some of these disparities, but others are associated with social and structural inequities, such as the stigma and discrimination that the Two-Spirit and LGBTQ populations experience.
- 12) **KEY GAPS IN PRIMARY HEALTH CARE, DENTAL, VISION AND MENTAL WELLNESS AND ADDICTION SERVICES:** Insufficient primary health care services exist to meet demand in an equitable way. Geographically the area with the greatest general access to Primary Health Care is

the North Shore. The DTES has the presence of many primary health care services although it has insufficient capacity to meet needs due to the additional population (outside of DTES) accessing the services. There are major gaps in provision of culturally safe care across various VCH services (especially Community Health Centres, Mental Health and Addictions and home care), however there are many initiatives that have begun to address cultural safety. This is likely to have led to the issue that some VCH services are under-used by Aboriginal people while many Aboriginal services are over-used and struggling to meet demand. There is a need for more mental wellness and substance use services, especially treatment for crack cocaine users (including methadone), trauma counselling, social work support and services for people with concurrent chronic illness and mental health disorders.

13) GAPS IN PREVENTION AND WELLNESS PROGRAMS THAT TARGET THE ABORIGINAL

COMMUNITY IN A CULTURALLY APPROPRIATE WAY: There are known gaps in smoking cessation / prevention, suicide and injury prevention programs for the urban Aboriginal community. There is a need for investment in prevention programming, including for early childhood prevention programs for health and wellness; school-based / school-readiness; foster parenting; and youth mental health and addictions. This work requires collaboration and involvement of school districts, municipalities and park boards to support environments and initiatives that foster health and wellness, such as walking trails, parks, rivers and beaches, appropriate community events, programs and services. There is a need to strengthen Aboriginal input into all of these agencies to ensure program design and investment in communities includes the needs and voices of the Aboriginal community. There is also a need to continue strengthening communicable disease control efforts particularly in Sexually Transmitted Infections (STIs), HIV, Hepatitis and TB.

14) ABSENCE OF GOOD DATA ABOUT SERVICE USE (OR LACK OF): There are significant challenges in monitoring the health of urban Aboriginal people because there is no routine collection of Aboriginal identification in health services. Furthermore, a high number of independent organizations (non-VCH) do not have electronic records of any sort, including Aboriginal service providers. The lack of robust community-level data, shared client-information files, and case conferencing practices for health services have become a critical impediment to improving care for what is a diverse, complex and changing client population. This includes referrals and follow-ups for Aboriginal clients.

THE STRATEGY

The primary focus of this strategy is to identify and implement changes that will upgrade and improve the extent, quality and configuration of health services in greater urban Vancouver to improve access and outcomes for First Nations, Inuit, Métis people living in Urban Vancouver. The goal is to build an efficient, coordinated, integrated and culturally relevant health care system for the Aboriginal population of greater Vancouver.

VISION

In 1999, as part of the “Healing Ways” project, the Aboriginal community developed a vision for urban Aboriginal health and wellness. In 2012 this vision was re-validated and supported as a vision for the Urban Aboriginal Health Strategy (UAHS):

Urban Vancouver is a community where health services provide opportunity for Aboriginal community members to honour and practise their distinct cultures and traditions toward their own wellness. Culturally rich, open and clean neighborhoods are supported to be free of alcohol, drugs, crime and violence. Aboriginal people are confident in their strengths and skills and are continually learning and being empowered to take care of their own health and well-being. Aboriginal children are healthy, happy, trained and educated in both traditional and non-traditional ways in health and well-being supported by Elders whose important role in passing on traditional wisdom, beliefs and practices is promoted. Aboriginal people are aware that health and wellness comes from making wise lifestyle choices and when needed, personal choices for care include traditional healing ways and mainstream systems of care.



STRATEGY ONE: STRENGTHEN RELATIONSHIPS IN THE URBAN COMMUNITY

- (a) **RECOGNIZE THE TERRITORIES OF MUSQUEAM, SQUAMISH AND TSLEIL-WAUTUTH NATIONS IN URBAN VANCOUVER AND SUPPORT THEIR ROLE AS HOST NATIONS TO EMBRACE AND COLLABORATE WITH ABORIGINAL SERVICE PROVIDERS (E.G., CEREMONY, FORMALIZED NETWORK)**

CURRENT STATE TO BUILD ON:

- VCH Policy on Land Acknowledgement (Aboriginal Cultural Competency Policy CA_5200 – See Appendix 2)
- Protocol between the three host Nations (November 2014) created through ceremony and collaboration – see copy at Appendix 1
- FNHA Vancouver Coastal Regional Community Engagement Coordinators (CECs) working closely to build relationships with host Nations
- Advisory committee created for the Aboriginal Addictions Substance Use RFP design included the three host Nations working collaboratively to design and develop the First Nations Service Delivery model in Urban Vancouver

OBJECTIVES MOVING FORWARD:

- (1) Implement Task 5.3.1 of First Nations Regional Health and Wellness Plan to “identify and support Nation and sub-regional aspirations for provision of services to off-reserve and non-First Nations community members”
- (2) Subject to three host Nations protocol development and signing, honour and respect the protocol, including traditional wellness approaches, as foundational to ensure it is embedded throughout future strategies and documents

- (b) **CREATE AND FORMALIZE URBAN FIRST NATIONS / ABORIGINAL HEALTH NETWORK: THREE FIRST NATIONS AND DESIGNATED ABORIGINAL SERVICE PROVIDERS TO STRENGTHEN RELATIONSHIPS AND COLLABORATION IN HOLISTIC PRIMARY HEALTH CARE**

CURRENT STATE TO BUILD ON:

- “First Nations and Aboriginal Primary Care Network” initiated October 2016 by three host Nations health departments as well as Vancouver Native Health Society, Lu ‘ma Medical Centre and Urban Native Youth Association (UNYA). Aligns with the provincial Primary Care Home model

OBJECTIVES MOVING FORWARD

- (1) Network invitation to VCH stakeholders (Community Health Centre [CHC] Directors, Mental Wellness & Substance Use [MWSU] Directors, Home Care Directors), Divisions and municipalities to create models of shared care, referrals and holistic service development
- (2) Support Health Directors to participate in regional and sub-regional level discussions with health partners (3.3.2 Regional Health and Wellness Plan)
- (3) FNHA implementing VC Regional Traditional Wellness Coordinator to work collaboratively with VCH, Nations and health service partners to ensure traditional wellness is foundation in all regional and partnership work

(c) FIRST NATIONS / ABORIGINAL NETWORK MEETS REGULARLY WITH PARTNERS TO COORDINATE SHARED CARE, REFERRALS AND HOLISTIC SERVICE DEVELOPMENT: CHC AND MWSU DIRECTORS; DIVISIONS OF FAMILY PRACTICE; VCH, FNHA AND MUNICIPALITIES

CURRENT STATE TO BUILD ON:

- “First Nations and Aboriginal Primary Care Network” initiated October 2016 by three host Nations health departments as well as Vancouver Native Health Society , Lu’ ma Medical Centre and Urban Native Youth Association (UNYA). Three Host Nation clinics meet with Divisions and VCH already.

OBJECTIVES MOVING FORWARD:

- (1) Network invitation to VCH stakeholders (CHC Directors, MWSU Directors, Home Care Directors), Divisions and municipalities to create models of shared care, referrals and holistic service development

d) CAPACITY BUILDING – INVEST IN TRAINING AND WORKFORCE DEVELOPMENT

Invest in training and workforce development, Aboriginal recruitment and retention into the health workforce and promote cultural safety training for VCH, Providence Health Care and FNHA staff. The TRC also recommended (# 23) in its May 2015 Calls to Action that the number of Aboriginal professionals working in health care be increased; that Aboriginal health care providers in Aboriginal communities be retained; and that cultural safety training be provided for Aboriginal professionals.

CURRENT STATE TO BUILD ON:

- First Nations Regional Health and Wellness Plan (Appendix 4) prioritizes Health Human Resource activities (e.g., FNHA’s commitment to being more trauma-informed as an organization with development of trauma-informed training initiatives)

- VCH Indigenous Cultural Safety curriculum developed and being implemented across different teams, departments and sites in VCH
- VCH-FNHA Indigenous Cultural Safety (ICS) Partnership Working Group is focusing on jointly finalizing and implementing the VCH First Nations and Aboriginal Culturally Competent and Responsive Strategic Framework Plan including the development of an Aboriginal HR Strategy and establishment of culturally safe pilot sites
- VCH Elders Guideline developed
- FNHA Region moving to expand on Family of Traditional Wellness Practitioners (primary and community care integration) and Traditional Knowledge Keepers network
- FNHA Indigenous Wellness Team leading Harm Reduction initiatives across Region (e.g., “Decolonizing Addiction” Train the Trainer Workshops to build capacity in communities and organizations)
- VCH Human Resources Recruitment and Retention Strategy in development (as of March 2017)

OBJECTIVES MOVING FORWARD:

- (1) Implement tasks from First Nations Regional Health and Wellness Plan (Appendix 4)
- (2) Continue with VCH Indigenous Cultural Safety curriculum being implemented across different teams, departments and sites in VCH and track progress
- (3) Improve the mental wellness workforce development and capacity, including cultural humility for culturally safe services. Implement an MWSU workforce development capacity strategy to promote MWSU careers among youth. (3.1.3 and 4.2.1 Regional Health and Wellness Plan)
- (4) FNHA to collaborate with VCH to support health career promotional activities for First Nations and Aboriginal individuals (4.1.1 Regional Health and Wellness Plan)
- (5) Implement and report on VCH Elders Guideline
- (6) Complete and implement VCH HR Recruitment and Retention Strategy



STRATEGY TWO: STRENGTHEN ACCESS TO CULTURALLY APPROPRIATE PRIMARY HEALTH CARE

a) FIRST NATIONS / ABORIGINAL URBAN PRIMARY CARE NETWORK TO STRENGTHEN REFERRALS AND INFORMATION SHARING, AND TO PREVENT PEOPLE FROM “FALLING THROUGH GAPS”

CURRENT STATE TO BUILD ON:

- “First Nations and Aboriginal Primary Care Network” initiated in October 2016 by three host Nations health departments as well as Vancouver Native Health Society, Lu’ma Medical Centre and Urban Native Youth Association (UNYA). It aligns with the provincial Primary Care Home model. Referrals and information sharing is on the network’s agenda and there is potential for an on-call network in the future

OBJECTIVES MOVING FORWARD:

- (1) VCH and FNHA continue to meet with the network to identify ways of strengthening referrals and information sharing to enable Aboriginal people and their families to access quality primary care
- (2) Review on-call opportunities with the network and the resource implications of an on-call approach
- (3) Development of a shared FNHA VCH joint Crisis Response Protocol to support and strengthen patient primary care, (including safe discharge planning in partnership with the KUU-US initiative to ensure people in crisis are supported)

b) DEVELOP RESPECTFUL AND SUSTAINABLE CONTRACTS WITH KEY FIRST NATIONS AND ABORIGINAL SERVICE PROVIDERS IN PRIMARY HEALTH CARE

CURRENT STATE TO BUILD ON:

- Three First Nations on minimal Alternative Payment Plan arrangement through their Joint Project Board (JPB) agreements (1 day per week Musqueam, ½ day per week Tsleil-Waututh and 1.5 days per week Squamish Nation)
- Vancouver Native Health Society on annual sessional agreement for multiple physicians (large client panel)
- Lu’ma Medical Centre on Fee-For-Service arrangement (Aboriginal physicians)—growing the panel of Aboriginal physicians
- Urban Native Youth Association has limited Nurse Practitioner-led primary care service (Nurse Practitioner employed by Providence Health Care)

OBJECTIVES MOVING FORWARD:

- (1) VCH (Aboriginal Health and Primary Care) and FNHA (working with JPB) review overall funding arrangements for all six First Nations and Aboriginal Primary Care providers; develop options for achieving equity and sustainability; and work with the network members to develop a consistent and equitable model of sustainable funding that stabilizes all six clinics. Implement agreed model in agreed timeline
- (2) Recognize and embed traditional, cultural and spiritual practices into funding agreements

c) INTEGRATE CULTURE INTO PRIMARY HEALTH SERVICES (E.G., VCH COMMUNITY HEALTH CENTRES) USING BEST AVAILABLE EVIDENCE AND EXPERT ADVICE ON CULTURALLY SAFE APPROACHES

CURRENT STATE TO BUILD ON:

- Provincial Declaration of Commitment (July 16, 2015) to Cultural Safety and Humility
- VCH Aboriginal Cultural Competency Policy (July 3, 2015)
- VCH ICS training program
- Successful Aboriginal Women's Health Day 2016
- Community Feast to discuss the opioid crisis, February 2017
- Elder/Healer services at Lu'ma Medical

OBJECTIVES MOVING FORWARD:

- (1) Work with VCH Home Care Managers, specifically front-line staff, and First Nations Home Care teams to align and improve the delivery of home care services for First Nations and Aboriginal people in a culturally appropriate and consistent manner (especially for Aboriginal Elders)
- (2) Implement Elders-in-Residence programs at VCH Community Health Centres, including Sheway, Downtown Community Health Centre
- (3) Improve primary health care services for Aboriginal women by ensuring women-specific clinics are available across the FN/AB Primary Health Care network and VCH Community Health Centers in DTES
- (4) Continue to implement DTES Women's Intensive Case Management initiative (DTES 2nd Gen) and track Aboriginal women's use of this service to ensure there are no barriers to access

- (5) Develop and implement Aboriginal Women Strategy (VCH Aboriginal Health lead) in partnership with VCH's overall Women's Strategy and building on the successful Aboriginal Women's Wellness Day in 2016
- (6) Collaborate with and support physicians, nurses, maternal and child health workers, and JPB teams to deliver holistic, culturally safe services with cultural humility (3.2.4 Regional Health and Wellness Plan)
- (7) Support the Coastal Family Residency program operated by North Shore Division of Family Practice and placement of physicians in First Nations communities (4.3.1 Regional Health and Wellness Plan)
- (8) Work with Trans Care BC and Health Equity EQT2 group to align efforts for improving primary health care services that are accessible for the Two-Spirit and LGBTQ Aboriginal community
- (9) Service providers to evaluate patient and client perceptions on cultural appropriateness of care
- (10) Emphasize value of research to establish proof of efficacy and effectiveness of culturally based interventions

d) CONSIDER A SHARED URBAN MOBILE DENTAL AND OPTOMETRY SERVICE ACROSS VANCOUVER BETWEEN THE THREE HOST NATIONS, URBAN ABORIGINAL SERVICE ORGANIZATIONS, FNHA AND VCH

CURRENT STATE TO BUILD ON:

- Vancouver Native Health Society dental service currently offered
- Individual eligible First Nations claimants and dental / vision / pharmacy practices already claiming dental, vision and pharmacy benefits (data availability to determine high need locations for services)
- FNHA Oral Health Strategy in place (March 2014)
- VCH Population Health outreach preventive dental services to Musqueam, Sheway, RayCam, Phil Bouvier, Aboriginal Mother Centre, Head Start programs

OBJECTIVES MOVING FORWARD:

- (1) Work with Vancouver Native Health Society to review dental service model and identify lessons and opportunities for expansion

- (2) Develop and implement Task 5.3.2 of Regional Health and Wellness Plan to “work with First Nations to operate and own dental, physician, vision, pharmacy and other health practices that may generate income while providing more accessible services for their community and sub-regional communities”
- (3) Review First Nations Health Benefits high expenditure locations for dental, vision and pharmacy in the urban Vancouver coverage area to identify opportunities for service locations to support Task (1) above
- (4) Utilize partnerships and innovative opportunities across communities and with others to support sustainable, high-quality facilities in alignment with new service models (5.2.2 Regional Health and Wellness Plan)
- (5) Review dental policies and procedures around tooth extraction



STRATEGY THREE: STRENGTHEN ACCESS TO CULTURALLY APPROPRIATE MENTAL HEALTH AND WELLNESS SERVICES

a) DEVELOP RESPECTFUL AND SUSTAINABLE CONTRACTS WITH KEY FIRST NATIONS AND ABORIGINAL SERVICE PROVIDERS IN MENTAL WELLNESS AND SUBSTANCE USE (MWSU)

CURRENT STATE TO BUILD ON:

- Draft MWSU Framework developed (Appendix 5) in July 2016 identifying current targeted First Nations and Aboriginal MWSU services delivered by:
 - Native Court Workers and Counselling Association of BC
 - Urban Native Youth Association (counsellors and residential)
 - Vancouver Native Health Society
- Joint Project Board MWSU Flagship project Redesign and delivery
- Metro Vancouver Aboriginal Executive Council Opioid Task Force
- Partnerships with Culture Saves Lives, Western Aboriginal Harm Reduction Society (WAHRS) around harm reduction

OBJECTIVES MOVING FORWARD:

- (1) Convene meeting of Aboriginal Wellness Program, Vancouver Native Health Society, Urban Native Youth Association and Native Court Worker & Counselling Association of BC to review current state of MWSU services in urban Vancouver against the MWSU Framework (Appendix 5) and discuss new model of respectful and sustainable contracts for MWSU services that meet targeted needs identified through engagement of “Pathway – 10 Year Mental Wellness and Substance Use Plan.” Implement agreed upon changes and improvements
- (2) Review scope, remuneration and competencies of key positions where First Nations, FNHA and VCH deliver similar services (e.g., MWSU workers, nursing, mental health, traditional knowledge keepers)
- (3) Implement the MWSU Flagship project to address health service priorities and gaps identified in the VC region (3.1.1 of Regional Health and Wellness Plan)
- (4) Recognize and embed traditional, cultural and spiritual practices into funding agreements, including investing in traditional knowledge keepers

(5) Partner with urban Aboriginal organizations in the DTES to develop and deliver cultural activities and increase access to Aboriginal harm reduction services, including KUU-US Crisis Line

b) FACILITATE LINKAGE OF VCH MENTAL HEALTH AND ADDICTION SERVICES FOR FIRST NATIONS AND ABORIGINAL PRIMARY HEALTH CARE AND MWSU SERVICES TO DELIVER PLACE-BASED, COMMUNITY AND OUTREACH SERVICES

CURRENT STATE TO BUILD ON:

- Draft MWSU Framework developed (Appendix 5) in July 2016 to identify current targets
- Hope, Help, and Healing Suicide Prevention, Intervention, and Post-vention Toolkit and funds distributed to First Nations communities
- Partnership with City of Vancouver—TORO project
- Jointly partnered on VC Opioid response to include First Nations Perspective on Health and Wellness, culturally safe campaigns and educational resources to support the safety of all First Nations, at-home and away-from-home who are impacted by the opioid crisis
- VCH Aboriginal Mental Health Liaison outreach work in the community to help Aboriginal people living with mental illness and addictions

OBJECTIVES MOVING FORWARD:

- (1) Create opportunities for outreach to Nations through relationship and partnership opportunities. Work with VCH MWSU Managers and First Nations MWSU staff / teams to align and improve the delivery of MWSU services for First Nations and Aboriginal people in a culturally appropriate and consistent manner
- (2) Roster VCH mental health and addictions clinicians to First Nations and Aboriginal Primary Care clinics in urban Vancouver
- (3) Develop and implement joint FNHA and VCH Crisis Response Protocol supports (including VCH partnerships with KUU-US for discharge safety planning). Support suicide prevention, intervention and post-vention regionally and sub-regionally (3.1.2 of Regional Health and Wellness Plan)

c) SUPPORT CULTURAL INTEGRATION INTO VCH AND PROVIDENCE MWSU SERVICES USING BEST AVAILABLE EVIDENCE AND EXPERT ADVICE ON SUCCESSFUL CULTURALLY COMPETENT APPROACHES

CURRENT STATE TO BUILD ON:

- Provincial Declaration of Commitment to Cultural Humility (July 16, 2015)
- VCH Aboriginal Cultural Competency Policy (July 3, 2015)
- VCH Indigenous Cultural Safety (ICS) training program
- Successful Aboriginal Women's Health Day 2016
- VCH Aboriginal Wellness Program (AWP) Aboriginal counsellors
- FNHA newly created Traditional Wellness Coordination role
- FNHA BC Governance Structure Provincial Health and Wellness

OBJECTIVES MOVING FORWARD:

- (1) VCH (Aboriginal Health) continue to provide ICS training to all MWSU teams at all sites
- (2) Implement Elders in Residence programs in VCH MHSU teams, including Hope Centre
- (3) Work with Trans Care BC and Health Equity EQT2 group to align efforts for improving MWSU services that are accessible for the Two-Spirit and LGBTQ Aboriginal community
- (4) Create a network of First Nations and Aboriginal Traditional Wellness workers
- (5) Promote traditional wellness integration into all services



STRATEGY FOUR: PROMOTE WELLNESS AND PREVENTION OF ILLNESS

- a) INVEST IN WELLNESS PROGRAM GAPS ACROSS VANCOUVER (SMOKING CESSATION, INJURY PREVENTION AND ALCOHOL/DRUG USE) PARTICULARLY WITH EARLY CHILDHOOD AND SCHOOLS AND STRENGTHENING ROLE OF PUBLIC HEALTH.

CURRENT STATE TO BUILD ON:

- FNHA Opioid Framework for Action developed with four action areas
- FNHA Indigenous Wellness Team supporting harm reduction initiatives across the Vancouver Coastal Region (e.g., Decolonizing Addiction Train the Trainer Workshops)
- FNHA Harm Reduction Grants: total of 10 grants allocated (awarded to six First Nations communities and four urban agencies)
- BC Quit Now program in place providing nicotine replacement therapy and other quit resources and aids. First Nations Health Benefits provide nicotine replacement therapy.
- FNHA expanding Mental Wellness team to include Traditional Wellness Coordinator
- VCH Population Health:
 - Harm Reduction/overdose Prevention
 - Injury Prevention
 - Early Childhood (wellness)
 - Tobacco Control
- FNHA Respecting Tobacco campaign and Tobacco Timeout campaign
- School Health Services funded and provided by VCH
- FNHA funds three host Nations for Chronic Disease and Injury Prevention as well as Communicable Disease (HIV, Hepatitis, TB), Maternal Child Health and Early Childhood (Aboriginal Headstart on Reserve) programs
- VCH implementing Hope to Health HIV Strategy with First Nations (with dedicated First Nations Nurse Educator position) and FNHA has dedicated Communicable Disease nursing leads
- Opioid Response Partnership Working Group (joint initiative between VCH and FNHA) work underway, as well as FNHA's "Indigenous Approaches to Harm Reduction" and "Decolonizing Addiction" initiatives. This work is being done jointly between the VCH and FNHA Indigenous Wellness Team/Health Protection Team (and their engagements with our Nations at sub-regional).

FNHA Opioid Regional Response to include peer-led models (linked to urban/Aboriginal agencies to promote access) in order to increase peer participation in the objectives of moving forward as a part of the Opioid Response Framework.

OBJECTIVES MOVING FORWARD:

- (1) Work with Quit BC to determine First Nations and Aboriginal access to the program and improvements that can be made to ensure this program is accessible to the Aboriginal community
- (2) Identify schools with high Aboriginal populations (with Aboriginal Enhancement Agreements) and ensure School Health Services in these schools are supported to provide culturally safe services for Aboriginal children and youth
- (3) Convene a joint Prevention and Wellness table of VCH Population Health team and associated FNHA program leads in smoking cessation, injury prevention and alcohol and drug prevention; avoid duplication; prioritize program development, resource and health education development; and school health services and early childhood services to review and align prevention programming. Review injury prevention programs and services for First Nations communities with Health Directors and develop a transformation plan (3.2.2 Regional Health and Wellness Plan)
- (4) Support leadership wellness, including through screenings at regional and sub-regional events and wellness and lateral kindness initiatives (3.2.3 Regional Health and Wellness Plan)
- (5) Work with Trans Care BC and Health Equity EQT2 group to align efforts for improving public / population health care services that are accessible for the Two-Spirit and LGBTQ Aboriginal community
- (6) Develop crisis intervention/support for family and friends impacted by traumatic overdose
- (7) Increase access to low-barrier traditional, spiritual, cultural health and healing supports in Vancouver's DTES

b) WORK WITH MUNICIPALITIES AND PARK BOARDS TO STRENGTHEN CONNECTION WITH HOST FIRST NATIONS HEALTH AND WELL-BEING PROGRAMS AND INITIATIVES SO THIS IS REFLECTED IN OFFICIAL COMMUNITY PLANS AND HEALTHY CITIES STRATEGIES

CURRENT STATE TO BUILD ON:

- Vancouver Healthy City Strategy and local health authority plans completed (e.g., DTES)
- Municipality Official Community Plans completed (Richmond, North Shore)
- Vancouver Parks Board plan
- Partnership with City of Vancouver

OBJECTIVES MOVING FORWARD:

- (1) Review Official Community Plans (OCP) and Healthy City Plans to determine First Nations input and role in these and align efforts with First Nations priorities
- (2) Develop partnerships with other municipalities in the VC region to engage with First Nations to seek their direction and input to their input to their OCP and Health City Plans

c) IDENTIFY OPPORTUNITIES FOR HOST NATIONS AND ABORIGINAL SERVICE PROVIDERS TO DELIVER HEALTH PROMOTION AND PREVENTION PROGRAMS OFF-RESERVE

Current state to build on:

- FNHA funds three host Nations for Chronic Disease and Injury Prevention
- VCH funds HIV prevention at Vancouver Native Health Society
- VCH funds healing circles at WAHRS

Objectives Moving Forward:

- (1) Support Health Directors and staff to integrate holistic models of prevention and wellness and traditional healing into programming including new regional and sub-regional service models (3.2.1 Regional Health and Wellness Plan)
- (2) Identify and support Nation and sub-regional aspirations for provision of services to off-reserve and non-First Nations community members (5.2.1 Regional Health and Wellness Plan)
- (3) Recognize traditional and spiritual practises through new and existing services, program plans, and funding agreements, including investments in traditional knowledge keepers

d) SUPPORT RECONCILIATION INITIATIVES THAT ENABLE WIDER COMMUNITY TO UNDERSTAND ABORIGINAL HISTORY OF COLONIZATION, RESIDENTIAL SCHOOLS AND CHILD WELFARE IMPACTS

Current state to build on:

- FNHA #ItStartsWithMe cultural safety and humility campaign: Creating a Climate for Change
- FNHA Cultural Safety Pledges
- FNHA Cultural Safety Webinars
- Vancouver “City of Reconciliation” declaration in place
- Reconciliation joint event VCH and City of Vancouver 2016 held
- VCH ICS curriculum being delivered at VCH sites
- VCH “Cultural Safety Starts with Me” poster campaign

Objectives Moving Forward:

- (1) Continue delivering ICS curriculum at all VCH sites
- (2) Metro Vancouver Aboriginal Executive Council role in delivering an urban ICS curriculum
- (3) Work with other municipalities to strengthen their commitment as cities of reconciliation (similar to City of Vancouver City of Reconciliation declaration)
- (4) Encourage VCH staff to participate in Walk for Reconciliation (Sep. 2017)

e) DEVELOP AN ADVOCACY STRATEGY IN ORDER TO PROMOTE WELLNESS DETERMINANTS. THIS WOULD INCLUDE ADVOCACY FOR IMPROVED EMPLOYMENT, HOUSING, EDUCATION AND SOCIAL SUPPORT OPTIONS AND SUPPORTING EFFORTS TO ADDRESS HOMELESSNESS

CURRENT STATE TO BUILD ON:

- Memorandum of Understanding (MOU) signed by the First Nations Health Council and the Minister for Aboriginal Relations and Reconciliation (MARR) on March 3, 2016. The MOU with the Government of BC represents and reaffirms a shared commitment to work from a holistic perspective. It is an acknowledgement that coordinated and concerted action is required to address the related and underlying circumstances that determine individual and collective well-being. This encompasses the dimensions of physical and mental well-being, family income and food security, early learning and education, child safety, and connectedness to family, community, culture and language. The social determinants of health are complex and require dialogue to set strategic direction.

OBJECTIVES MOVING FORWARD:

- (1) Work with Aboriginal Success programs in school districts to support Aboriginal students
- (2) Support First Nations communities to manage and transform their medical transportation programs and to reinvest savings into community and/or sub-regional health services (3.3.5 Regional Health and Wellness Plan)
- (3) FNHA to work with VCH and Aboriginal service partners on Wellness Indicators (under development) that encompass cultural determinants of health
- (4) Support and promote Aboriginal service organizations and partners who work in these areas of social determinants to align efforts with health service organizations

f) SUPPORT AND STRENGTHEN EFFORTS TO IMPROVE HEALTH LITERACY OF THE ABORIGINAL POPULATION INCLUDING INFORMATION AND HEALTH EDUCATION RESOURCES

CURRENT STATE TO BUILD ON:

- FNHA Spirit Magazine is one tool for improving health literacy
- Health literacy guides / literature available
- VCH complaints booklet

OBJECTIVES MOVING FORWARD:

- (1) VCH and FNHA Communications leads develop and implements a Health Literacy Framework and guide for VCH services targeted to First Nations and Aboriginal populations.



STRATEGY FIVE: INFORMATION ABOUT, AND ACCESS TO, SERVICES

- a) EXPAND VCH ABORIGINAL PATIENT NAVIGATOR (APN) PROGRAM TO PROVIDE MORE SUPPORT IN ACUTE FACILITIES ACROSS VCH TO HELP “STEER” INAPPROPRIATE PRIMARY HEALTH CARE ADMISSIONS INTO FIRST NATIONS AND ABORIGINAL PRIMARY HEALTH CARE NETWORK

CURRENT STATE TO BUILD ON:

- APN program restructured in 2016 to shift navigators from primarily “one-on-one” patient navigation to supporting existing VCH staff (admissions, social workers, discharge staff) with learning the art of Aboriginal patient support navigation in acute sites in Vancouver, including Lions Gate Hospital (LGH) and Vancouver General Hospital (VGH)—spreading the knowledge, skills and experience of APNs to VCH staff at each site
- Alternative Payment Plan (APP) and other funding sources to increase capacity of urban PRIMARY HEALTH CARE clinics
- Primary Care Network members available to patients who are using Emergency Rooms (ER) inappropriately.

OBJECTIVES MOVING FORWARD:

- (1) Create promotional materials for ERs targeted to Aboriginal patients to access services either in First Nations communities or off-reserve in urban settings:
- a. Vancouver Native Health Society (would need to enhance capacity as not currently accepting new patients)
 - b. Urban Native Youth Association (for Aboriginal youth)
 - c. Lu’ma (accepting patients for Nurse Practitioners)
 - d. Three First Nations (targeting on-reserve community members) – Squamish, Musqueam and Tsleil-Waututh Nations

- b) CONVENE “NAVIGATORS” FORUM TO DEVELOP A MEANS OF COORDINATING THE VARIETY OF NAVIGATIONAL RESOURCES (PEOPLE, INFORMATION, DATABASES) ACROSS GREATER VANCOUVER (NAVIGATE THE NAVIGATORS)

CURRENT STATE TO BUILD ON:

- Many navigational and information sources exist but are un-coordinated and not easily accessible for the Aboriginal community

- 8-1-1 Health Line to access Registered Nurses
- BC Health Link service offered by province
- PHSA's BC Women's and Children's Hospitals have existing patient navigators
- Various Aboriginal service organizations (e.g., Lu'ma) and mainstream service organizations have "navigators"
- Lu'ma has produced an Aboriginal services resource directory that is available and could be turned into an electronic search directory
- City of Vancouver operates a database of available services in Vancouver and a call centre (BC211 service) to help community members find out about what is available

OBJECTIVES MOVING FORWARD:

- (1) VCH and FNHA call meeting of all "navigators" in urban Vancouver (whether in person or operating help-lines) including municipalities to discuss ways of improving and coordinating this for the Aboriginal community.
- (2) Look to streamline access and make it more identifiable for the Aboriginal community (arising from navigational discussion above), particularly for Mental Wellness and Substance Use services
- (3) Support Aboriginal Patient Navigators to improve the quality of services available to First Nations / Aboriginal clients (3.3.3 Regional Health and Wellness Plan)
- (4) Work with Trans Care BC and Health Equity EQT2 group to align efforts for improving access to appropriate health care services that are accessible for the Two-Spirit and LGBTQ Aboriginal community



STRATEGY SIX: IMPROVE DATA AND INFORMATION ON ABORIGINAL HEALTH OUTCOMES

a) IMPROVE MONITORING AND REPORTING ON ABORIGINAL HEALTH OUTCOMES THROUGH ROUTINE COLLECTION OF THE ABORIGINAL IDENTIFIER AT ALL VCH COMMUNITY-BASED AND ACUTE SITES

CURRENT STATE TO BUILD ON:

- The Clinical & Systems Transformation project is designed to improve the quality and consistency of patient care across VCH, PHSA and Providence Health Care. The project's clinical goals are to improve safety, reduce unnecessary work, increase consistency, provide more accurate information, and improve information system reliability and sustainability. The project is overseeing the implementation of Cerner. A clinical information system is a computer system designed for collecting, storing, amending and retrieving information relevant to health care delivery. Soon, VCH, PHSA and Providence Health Care will begin implementing a shared clinical information system based on software developed by Cerner. The new system will consolidate patient data from over 50 current systems into one electronic health record.
- VCH Public Health Surveillance leading My Health My Community (MHMC) Urban Aboriginal Health profiles: looking at Aboriginal-specific health indicators. FNHA in partnership with VCH and Fraser Health Population Health to examine Aboriginal-specific data from the MHMC survey and create a profile of the urban Aboriginal population of Metro Vancouver.
- FNHA Health Systems Matrix (HSM) key findings compiled. These findings ~~and~~ report on First Nations Client File ~~across~~ by region and provincially to examine health service utilization

OBJECTIVES MOVING FORWARD:

- (1) VCH through Aboriginal Health Leads maintains presence on the Clinical & Systems Transformation project to ensure the Aboriginal identifier is included in the clinical systems design, Cerner transformation and training. This will ensure Aboriginal patient data will be available to monitor service utilization, and contribute to monitoring health outcomes
- (2) Service providers (e.g., VCH, FNHA, First Nations communities, etc.) to work towards ensuring records can be transferable across clinics and between service providers and

health authorities using the same electronic medical records systems with centralized records accessible by all partners

b) IMPROVE REPORTING AND SHARING OF SUCCESSFUL SERVICES OR INITIATIVES THAT CAN BE USED AS BEST PRACTICES FOR OTHERS TO LEARN FROM

CURRENT STATE TO BUILD ON:

- Many best practices to be documented (e.g., Case Study HIV at Tla'amin Health)
- Promising practices included in Village of Wellness toolkit
- Promising practices included in "Hope, Help, and Healing Toolkit"

OBJECTIVES MOVING FORWARD:

- (1) VCH Aboriginal Health (Communications) identify and document best practice successes across VCH and across urban Vancouver organizations (e.g., best practices from Native Court Workers, UNYA, Vancouver Native Health Society)
- (2) Celebration / honouring Vancouver Native Health Society
- (3) FNHA VC Region (Communications) identify and document best practice successes and promising practices across host First Nations communities (e.g., best practices related to NNADAP, Home Care, Primary Care)
- (4) VCH support the First Nations and Aboriginal Primary Care Network member clinics with optimizing use of their (non-identifiable) patient data for monitoring population health trends and directing collective efforts to address priority health issues

c) WORK WITH THE DIVISIONS OF FAMILY PRACTICE TO ENCOURAGE AND ADVOCATE FOR COLLECTION AND REPORTING OF ABORIGINAL PATIENT IDENTIFICATION (AND ATTACHMENT) TO MEMBER MEDICAL PRACTICES

CURRENT STATE TO BUILD ON:

- Province and Divisions have worked with medical practices and physicians across the province to transition practitioners to Electronic Medical Records (EMR)
- Physicians and practices currently report MSP data to MSP through tele-plan electronically. There may be potential to do a data match with the First Nations Client File to assess access, utilization and main diagnoses.

OBJECTIVES MOVING FORWARD:

- (1) Work with top five EMR vendors to promote inclusion of Aboriginal identifier in their products now and in future versions
- (2) Work with the Doctors of BC; Richmond, Vancouver and North Shore Divisions of Family Practice; and the Practice Support Program to develop strategies for promoting Aboriginal data collection among member physicians and practices (including provision of toolkit and education)
- (3) FNHA and VCH work with Province of BC and MSP (tele-plan) to capture MSP billings from practices and report out of First Nations and Aboriginal primary health care utilization and ICD-9 codes

d) **REPORT ON ABORIGINAL SERVICE UTILIZATION, ADMISSIONS (ESPECIALLY EMERGENCY) AND DISCHARGES FOR EACH KEY SPECIALTY IN ORDER TO MONITOR OVER- OR UNDER-USE OF DESIGNATED SERVICES AND ANY BARRIERS TO IMPROVING OUTCOMES**

CURRENT STATE TO BUILD ON:

- CareConnect operated by VCH captures hospitalization data for Vancouver Coastal acute facilities / hospitals and is accessed by VCH practitioners currently
- Clinical & Systems Transformation project will be able to report data with Aboriginal identifier for hospital admissions and discharges once implemented
- Transformative Change Accord: First Nations Health Plan (TCA: FNHP) between First Nations, the provincial and federal governments outlines key indicators for measurement
- Surveillance workshop with US EpiCentres
- Regional Health Survey data
- FNHA Health Systems Matrix (HSM) key findings compiled. These findings and report on First Nations Client File ~~across~~ by region and provincially to examine health service utilization
- FNHA research project on strengths-based indicators

OBJECTIVES MOVING FORWARD:

- (1) Review with CareConnect the potential for a First Nations data match with the First Nations Client File to provide a current baseline of First Nations hospitalizations / discharges

(2) VCH through Aboriginal Health Leads maintains presence on the Clinical & Systems Transformation project to ensure Aboriginal identification is included in the clinical systems design, Cerner transformation and training. This will ensure Aboriginal patient data will be available to monitor service utilization, and contribute to monitoring health outcomes

e) **ALIGN ABORIGINAL HEALTH OUTCOME MEASUREMENT WITH THOSE RECOMMENDED BY THE TRUTH AND RECONCILIATION COMMISSION (TRC) - RECOMMENDATION # 19 (May 2015)**

CURRENT STATE TO BUILD ON:

- TRC Calls to Action (Recommendation # 19) recommends several indicators to measure progress
- Health Data Collaborative is an inclusive partnership of international agencies, governments, philanthropies, donors and academics, with the common goal of improving health data. The Health Data Collaborative is a joint effort by multiple global health partners to work alongside countries to improve the availability, quality and use of data for local decision-making and track progress toward the health-related United Nations Sustainable Development Goals (SDGs). The SDGs are an ambitious set of targets adopted by world leaders in 2015 that envision a world with zero poverty, shared prosperity and security, and where no one is left behind. The Health Data Collaborative exists to empower countries to achieve the targets set out in the health-related goals, especially but not exclusively those in Goal 3: ensuring healthy lives and promoting well-being for all at all ages. Achieving these goals will require accurate and timely data in order to understand how much work needs to be done, to stay on track, and to keep leaders accountable. The Collaborative recommends a number of goals in four key areas: Health status; Risk Factors; Service Coverage; and Health Systems (see Appendix 6)

OBJECTIVES MOVING FORWARD:

- (1) Work with the host First Nations, FNHA and VCH Health Surveillance teams to develop, implement and report on a set of comprehensive and specific measures / indicators for reporting health status of the urban Aboriginal population that align with the Transformative Change Accord: First Nations Health Plan (TCA); the (TRC) call to action # 19; and the United Nations Sustainable Development Goals (SDG) and include:
 - Infant mortality (TCA, TRC, SDG)
 - Maternal health (TRC, SDG)
 - Suicide (TCA, TRC, SDG)

- Mental health (TRC, SDG)
 - Addictions (TRC)
 - Life expectancy (TCA, TRC, SDG)
 - Birth rates (TRC, SDG)
 - Infant and child health issues (TCA – childhood obesity, SDG)
 - Chronic diseases (TCA – diabetes prevalence rates, TRC, SDG)
 - Illness and injury incidence (TRC, SDG)
 - Availability of appropriate health services (TRC, SDG)
 - Age-standardized mortality rate (TCA, SDG)
 - Number of practising, certified First Nations health care professionals in BC (TCA)
- FNHA Wellness Indicators developed



APPENDICES

APPENDIX 1: HEALTH PARTNERSHIP PROTOCOL – NOVEMBER 2014



tə ʔniməʔ sʔəqʷiʔtəl / Ta Nímalh Sʔekw'íʔtel

A Health Partnership Between Squamish, Tsleil-Waututh, and Musqueam

THIS HEALTH PROTOCOL AGREEMENT made effective as of *November 20, 2014*.

BETWEEN: **YÚUSTWAY HEALTH SERVICES DEPARTMENT** representing the Squamish Nation
AND: **TSLEIL-WAUTUTH HEALTH DEPARTMENT** representing the Tsleil-Waututh Nation
AND: **MUSQUEAM INDIAN BAND HEALTH DEPARTMENT** representing the Musqueam Indian Band

(Collectively, the "Parties")

WHEREAS:

- A. This Health Protocol Agreement is designed to establish a positive working relationship based on common local interests.
- B. Over recent years the Parties have come together to form a Community Engagement Hub ("CeH") to facilitate greater collaboration, improve communications, and establish a solid foundation for future planning that will lead to improved health outcomes for members of each nation.
- C. The Parties recognize there is value in all Parties working together (including but not limited to the CeH) on a number of practical items in each community.
- D. This Health Protocol Agreement builds on the Protocol Agreement signed between Squamish Nation, Tsleil-Waututh Nation and Musqueam Indian Band in March 2014.

1.0 GOVERNING PRINCIPLES

- 1.1 The Health Protocol Agreement represents that the Parties shall work together with mutual respect and recognition;
- 1.2 The Parties agree to open and frank communications with each other on areas of mutual interest;
- 1.3 The Parties acknowledge, and are inclusive of, the diverse skills, knowledge and perspectives each party brings;



- 1.4 The interface between the parties is necessarily characterized by regular two-way communication including -
- a. requests for information;
 - b. attendance at meetings; and
 - c. formal and informal discussions regarding related health issues.

2.0 TERM AND TERMINATION

- 2.1 The Parties agree this Health Protocol Agreement shall take effect upon the signing of this Agreement by each respective Party
- 2.2 This Health Protocol Agreement will remain in effect until replaced by the Parties with a successor agreement or is terminated by one of the Parties pursuant to section 2.3;
- 2.3 This Protocol may be terminated by any Party on one month's prior written notice to the other Parties.

3.0 JOINT MANAGEMENT GROUP

- 3.1 The Parties agree to establish a Joint Management Group (the "Management Group") comprised of:
- Yúustway Health Services Department, Department Head
 - Yúustway Health Services Department, Manager, Health Benefits Advocacy and Promotion
 - Tsleil-Waututh Health Department, Director of Community Development
 - Tsleil-Waututh Health Department, Health Manager
 - Musqueam Indian Band, Health Program Manager
 - Musqueam Indian Band, Administrative Assistant
 - CeH Coordinator/Coordination Team (based on approval of resources from First Nations Health Authority)
- 3.2 The Management Group will meet on an ongoing basis, at least monthly [or more frequently as desired] to discuss issues of common concern and interest and monitor the progress of the CeH against agreed deliverables.
- 3.3 The Management Group will be responsible for:
- Setting the strategic direction to guide and direct relevant activities;
 - Ensuring the effective management of resources and the collaborative activities of the Parties;
 - Discussing, exploring and developing opportunities of mutual interest; and
 - Monitoring activities to ensure it is in keeping with the founding principles, objects and values.



- 3.4 The venue for the Management Group meetings will be rotated between Squamish, Tsleil-Waututh and Musqueam to ensure fairness and equality.
- 3.5 The Management Group may, if the Parties agree, seek technical assistance on any issue.
- 3.6 The Management Group will identify a spokesperson, for each of the Parties, on an issue by issue basis to deal with media and community information sharing regarding any of the collaborative activities of the Parties. The Parties will issue joint statements and press releases where relevant and mutually agreed.

4.0 MUTUAL CONFIDENTIALITY

- 4.1 Each Party will take all prudent measures to ensure that any information, including traditional knowledge, documents, reports or other material (hereinafter called 'information') provided by it to the other Party pursuant to or in connection with the CeH and/or this Health Protocol Agreement is treated as confidential and is not disclosed to any person except as otherwise consented to in advance by the other Party.
- 4.2 Without limiting the generality of Section 4.1, each party agrees that to ensure the foregoing confidentiality obligation is met, it will, from time to time, either in writing or verbally, expressly identify information as confidential or non-confidential to assist the other Parties in fulfilling their confidentiality obligation.

5.0 RESOURCING

- 5.1 The Parties will dedicate the resources necessary to engage effectively in the collaborative process and will work together to ensure that the parties give a full understanding of each other's capacities, traditional roles, responsibilities, and current projects.
- 5.2 The Parties will make best efforts to ensure staff resources are available to implement the activities jointly agreed to by the Parties.
- 5.3 The Parties agree to make every effort to ensure that any costs for undertaking the collaborative work are borne equally between the Parties.

6.0 COMMUNICATION

- 6.1 The Parties acknowledge and agree that all communication regarding any collaborative activities undertaken by the Parties (including but not limited to the CeH) and this Health Protocol Agreement and the matters set out herein will be jointly agreed upon prior to any public releases, subject to each Party's respective legal rights.



- 6.2 With specific reference to the CeH, the Parties agree that where the Hub Coordinator receives an inquiry, request or information from the First Nations Health Authority or other stakeholder, the Hub Coordinator will immediately inform the Joint Management Group or managers as appropriate. The Joint Management Group will consult each other to determine how the inquiry, request or information will be handled.
- 6.3 With specific reference to the CeH, the Hub Coordinator will seek approval of any proposed responses on matters before providing a response, statements or letters to the sender. Comment and input will be sought from the Joint Management Group and other team managers as appropriate in a timeframe that enables the Hub Coordinator to meet the expected deadlines.

7.0 AMENDMENTS

- 7.1 This Health Protocol Agreement may be amended from time to time by written agreement by all Parties to reflect changes in the relationship between the Parties.

8.0 DISPUTE RESOLUTION

- 8.1 When a dispute arises between the Parties in relation to this Protocol Agreement, the Parties agree to engage in communication in an attempt to resolve specific issues.
- 8.2 Where a dispute between the Parties has not been resolved by the communications outlined in article 8.1, a Party may, upon reasonable notice, call a special meeting of the Parties and may include reference to a body of Elders (as appointed by the Parties) or mediation to discuss a resolution to the dispute.
- 8.3 Nothing in this Health Protocol Agreement will prevent the Parties from dealing with other implementation matters under this Agreement while an issue is being addressed in the dispute resolution process.
- 8.4 Nothing in this Health Protocol Agreement is intended to limit legal remedies available to a Party.

9.0 GENERAL TERMS

- 9.1 This Health Protocol Agreement does not affect any aboriginal right, title or interest of either Party.
- 9.2 This Health Protocol Agreement does not prejudice or affect each of the Parties' respective rights, powers, duties or obligations in the exercise of their respective functions.



9.3 This Health Protocol Agreement is in addition to any other agreements that already exist between the Parties and is not intended to replace any such agreement. It is intended to indicate the Parties' intention to work co-operatively together to progress matters relating to health and wellness and any such issues of mutual concern.

9.4 The Parties agree that it is not intended to be a legally binding agreement. Neither Party shall have the ability to bind the other Parties as agents or otherwise.

10.0 NOTICE

10.1 Any notice, direction, payment or any or all material that any Party may be required or desire to give or deliver to the other Parties shall be in writing and shall be given by personal delivery, by facsimile, by mailing or by courier, in each case addressed to the intended recipient as follows:

a. To Yúustway Health Services Department:

Manager, Health Benefits, Advocacy and Promotion
Squamish Nation
Unit 9a, 380 Welch Street
West Vancouver, BC, V7P0A7
Phone: (604) 982 0332
Facsimile: (604) 982 0372

b. To Tsleil-Waututh Health Department:

Health Manager, Health Department
Tsleil-Waututh Nation
3075 Takaya Drive
North Vancouver, BC, V7H3A8
Phone: (604) 924 4160

c. To Musqueam Indian Band Health Department:

Health Manager, Health Department
Musqueam Indian Band
6735 Salish Drive
Vancouver, BC V6N 4C4
Phone: 604-263-3261
Phone: (604) 263-3261

Or such other address or addressees as a Party may, from time to time, designate in writing.



IN WITNESS HEREOF the Parties have signed the Health Protocol Agreement effective as of the 20
day of November, 2014.

By: [Signature]
Signature: [Signature]
Print Name: Kim C. Brooks
Title/Position: Department Head, Livingston Health Services

By: [Signature]
Signature: [Signature]
Print Name: Michelle George
Title/Position: Health Manager Tsleil-Waututh Nation

By: [Signature]
Signature: [Signature]
Print Name: COREEN PAUL
Title/Position: HEALTH DIRECTOR. MUSQUEAM INDIAN BAND

Witnessed by: [Signature]
Signature: [Signature]
Print name: Shane Pointe
Title/Position: Musqueam Band Member & Speaker.



Aboriginal Cultural Competency Policy

1. Introduction

Policy Purpose

Vancouver Coastal Health (VCH) is committed to partnering with the First Nations Health Authority and the Vancouver Coastal Caucus to decrease health inequities in the First Nations and Aboriginal populations.

A key strategy for decreasing health inequities for Aboriginal peoples is by providing culturally competent, safe and responsive services. Culturally competent services can reduce access barriers, increase the quality and safety of services, positively impact patterns of service utilization, improve clinical outcomes, and decrease disparities in health status.

The purpose of this policy is to provide direction to VCH regarding the organization's approach to Aboriginal Cultural Competency by outlining some key components that will enhance Aboriginal patient/client/resident experience, strengthen Aboriginal patients/clients/residents as partners in their own care, and improve service delivery and health outcomes.

Scope

This policy applies to all VCH staff and all VCH sites, facilities, departments, units and programs.

Principles

- First Nations and Aboriginal culturally competent and responsive health care practices are embedded in leadership and staff's daily practices.
- First Nations and Aboriginal communities are central in the identification, development, delivery and evaluation of health services to First Nations and Aboriginal people.
- First Nations and Aboriginal health practices are included in culturally competent health care delivery for First Nations and Aboriginal people.
- First Nations and Aboriginal people have the right to access traditional ceremonies, health practices, Aboriginal Elders, Traditional Practitioners, and/or Traditional Medicines as part of their patient care plan.
- First Nations and Aboriginal peoples' spiritual connections to First Nations Traditional Territories are recognized as an important component to their health, well-being, and care.

2. Policy

Policy Statement

This policy aims to guide VCH to become a more Aboriginal culturally competent organization by strengthening Aboriginal leadership in health care; ensuring welcoming, inclusive, and respectful environments; and facilitating the inclusion of traditional practices, practitioners, and medicines into patient care.

The policy aligns with VCH's True North Goals and will assist VCH to:

- Reduce barriers to and improve quality of services for First Nations and Aboriginal people.
- Improve First Nations and Aboriginal people's experiences within VCH's systems of care.
- Provide consistency in building VCH's capacity and competency to meet the needs of First Nations and Aboriginal people.

Specifically, the policy identifies the following three areas for implementation of VCH's commitment to Aboriginal Cultural Competency and to transform care and improve health outcomes for First Nations and Aboriginal people:

2.1. Aboriginal Leadership in Health Care

Establish Aboriginal leadership in all areas of health service delivery where an Aboriginal context enhances health practice, particularly in the areas of knowledge transmission and program service delivery. In particular, this will be reflected in community and client engagement, staff education, workforce recruitment, and health service delivery.

2.2. Acknowledgement of First Nations Traditional Territory

Recognize and incorporate Aboriginal culture and heritage as part of official protocol and events, particularly centered around the Welcoming to Traditional Territory and the Acknowledgement of Traditional Territory.

2.3. Cultural and Ceremonial Use of Tobacco and Smudging Medicines

Facilitate the inclusion of the ceremonial use of tobacco and smudging in health services for Aboriginal clients as part of providing culturally competent health care and promoting the healing of body, mind, and spirit.

For details on specific procedures for the above, see [Appendices](#).

Procedures

See [Appendices](#) for specific procedures for:

- Aboriginal Leadership in Healthcare

- Acknowledgement of First Nations Traditional Territory
- Ceremonial Use of Tobacco or Smudging Medicines

3. References

References

- Aboriginal Cultural Guide*. CSC Pacific Region Aboriginal Initiatives. Correctional Service Canada, 2007.
- All Nations Healing Room Cultural/Ceremonial Use of Tobacco or Traditional Medicine*. VIHA, 2011.
- Battiste, M. and J. (Sakéj) Youngblood Henderson. "Protecting Indigenous Knowledge and Heritage: A Global Challenge" in M. Battiste (ed.) *Reclaiming Indigenous Voice and Vision*. UBC Press. Vancouver, 2000.
- Castellano, M.B. "Ethics of Aboriginal research". *Journal of Aboriginal Health*, 1(1). 2004: 98-114.
- CIHR guidelines for health research involving Aboriginal people*. CIHR, 2007.
- Correctional Service Canada Commissioner's Directive 702*, 2008.
- Cultural Ceremonial Use of Tobacco Special Consideration Guidelines. Traditional Medicines in Contemporary Contexts*. Northern Health, 2007.
- Culturally Responsive Education*. Keynote address. Trent University, 2010.
- Meyer, M. A. *Remembering Our Future: Higher Education Quality Assurance and Indigenous Epistemology*. University of Hawaii. Hilo, 2005.
- OCAP Ownership, Control, Access and Possession*. Sanctioned by the First Nations Information Governance Committee, 2007.
- Royal Commission on Aboriginal Peoples. 1996.
- Spiritual /Cultural Ceremony involving a Burning Substance*. Interior Health, 2011.
- VCH Aboriginal Health and Wellness Plan 2008-2011*.
- VCH Working in Partnership with Aboriginal Elders CPD*. Aboriginal Health Practice Council, 2010.

Related Policies

- [Cultural Competency and Responsiveness Policy](#)
- [Respectful Workplace and Human Rights Policy](#)
- [Smoke-Free Premises Policy](#)

Definitions

“Aboriginal Health Care” refers to health care services that are led and informed by Aboriginal leaders, knowledge keepers and traditional practitioners.

“Aboriginal Health Care Practitioners” are Aboriginal people engaged in the delivery of health services. This can include VCH staff such as (but not limited to) Aboriginal Patient Navigators, Aboriginal support workers, counsellors, psychologists and outreach workers.

“Aboriginal Knowledge Keepers” are Aboriginal people with specific cultural knowledge.

“Aboriginal People” includes all indigenous people of Canada. The Canadian Constitution recognizes three groups of Aboriginal people: Indians (status and non-status), Métis and Inuit. These three separate groups have their own unique heritages, languages, cultural practices and spiritual beliefs.

“Aboriginal Traditional Medicines” are plants used by Aboriginal peoples throughout North and South America for healing of mind, body, emotion and spirit.

“Aboriginal Traditional Practitioners” are Aboriginal peoples who conduct traditional indigenous practices, including ceremonies for spiritual, mental, emotional and physical wellness.

“Cultural Competency” refers to developing cultural knowledge, skills in understanding cross-cultural interactions, and an awareness and acceptance of the dynamic variety of people and populations that VCH works with as all crucial components of cultural competency. Cultural competence is not a discrete end point but rather a commitment to and an active engagement in a lifelong process. Organizational cultural competence requires multi-level interventions and supports to foster a culture of openness and respect.

“Cultural Responsiveness” involves improving both the competency of the practitioner and the system in which the practitioner operates. Involves building the capacity of the system or institution to be culturally competent, improving professional attitudes, knowledge, behaviours and practices (the “people” component), as well as strategies, plans, policies, procedures, standards, performance management, and remuneration mechanisms (the “institutional” component) in order for the whole to be responsive.

“Cultural Safety” is an outcome of cultural competency, defined and experienced by those who receive the service – they feel safe. Cultural safety is based on understanding the power differentials and potential discriminations inherent in the health service delivery system.

“First Nation” refers to the Indian people of Canada, both status and non-status, who were the original people to inhabit Canada or “First Nations.”

“Inuit” are people of Aboriginal descent in Northern Canada who generally reside in the Northwest Territories, Nunavut, Northern Quebec and Labrador.

“**Métis**” is a person of Aboriginal ancestry whose history dates back to the days of the fur trade when First Nations people partnered with French, Irish, Scottish or others of European descent. The blending of European and First Nations cultures gave rise to a distinct language, culture and identity known today as the Métis Nation. Unlike status First Nations, the federal government does not presently acknowledge a fiduciary responsibility for Métis people.

“**Non-Status Indian**” is a person of First Nations ancestry who is not registered under the Indian Act.

“**Public**”: refers to all people and may include patients, clients, residents as well as VCH staff while not performing work related duties.

“**Public Event**” is any VCH-hosted gathering where the public is invited to attend or participate.

“**Smudging and Cleansing Ceremony**” is a ceremonial burning of traditional plants and medicines that is considered a holistic health practice used for prayers, offerings, cleansing and healing of mind, body, emotion, and spirit. Can also include the brushing of people with sacred medicines or items.

“**Status Indian**” is an Indian under the Indian Act and is usually a member of a First Nation or Band. Prior to the mid-1960s, most status Indians lived on reserve. In recent years, a steady migration to the urban centres has seen almost 50% choosing to live off-reserve.

“**Traditional Territory**” is land occupied and used historically, passed down through families and Nations for generations.

Questions

Contact: Aboriginal Health Strategic Initiatives: aboriginalhealthservices@vch.ca

Website: <http://aboriginalhealth.vch.ca/working-together/cultural-competency>

Issued by:		
Name: <u>Dr. Patricia Daly</u>	Title: <u>Vice-President, Public Health and Chief Medical Health Officer</u>	Date: <u>May 15, 2015</u>
Signature of issuing official		

APPENDICES

Appendix A: Aboriginal Leadership in Health Care – Procedures

Procedures for key components to implement Aboriginal Leadership in Health Care:

1. Leadership

Follow the Aboriginal Health Leadership Framework ([VCH Aboriginal Health and Wellness Plan](#)). This plan was developed in collaboration with First Nations and Aboriginal communities and was approved by senior leadership in VCH.

2. Recruitment

- Management recruits Aboriginal health care practitioners to increase employment and career opportunities for Aboriginal people at all levels of the organization.
- For positions that require experience with Aboriginal communities and culture, management will seek out candidates of Aboriginal ancestry.
- VCH will include Aboriginal knowledge keepers and traditional health practitioners in the delivery of health care to Aboriginal clients.

3. Engagement

- VCH programs that provide services to a large number of Aboriginal clients consult with Aboriginal people in the development of education and services regarding Aboriginal health.
- VCH staff create opportunities for Aboriginal knowledge keepers and traditional practitioners to share their expertise on health matters for Aboriginal peoples.

4. Education

- VCH provides ongoing education and training opportunities to staff on topics relevant to Aboriginal health.
- VCH Aboriginal health care staff and Aboriginal knowledge keepers and care providers (e.g. Elders, spiritual leaders, and traditional practitioners) are encouraged to identify, develop, and deliver education and training to VCH staff to build culturally competent practices.
- Staff education and awareness specific to Aboriginal health perspectives and practices will be provided by Aboriginal people and can be co-facilitated with other VCH staff.
- VCH management promotes and disseminates information on culturally competent education and training.
- VCH management creates opportunities for staff to participate in educational forums and training on culturally competent practice relevant to Aboriginal Health, including the [Provincial Health Services Authority's Indigenous Cultural Competency online training course](#).

5. Practice

- Aboriginal patients have a way to identify health options for their care (e.g. questions included in assessments and interviews that identify culturally specific care options).
- VCH staff consult with Aboriginal clients and/or extended family members about specific times when cultural services/interpreters/liaisons are relevant and, when possible, help to facilitate the inclusion of cultural support.
- Care coordination for Aboriginal clients includes, when possible, appropriate or requested indigenous care providers in addition to mainstream services.
- Aboriginal traditional or cultural practices provided within VCH health care services are led by Aboriginal people.
- Aboriginal health care practitioners (e.g. VCH Aboriginal staff) may act as consultants, liaisons, and interpreters when requested by Aboriginal clients, extended family members, or designate in regards to the patient's care. Aboriginal health care practitioners may also be called in as consultants or liaisons by VCH staff.
- VCH staff may access the VCH Aboriginal Regional Director, Aboriginal Wellness Program staff, or Aboriginal Patient Navigators for consultation and/or to arrange for access to liaisons, interpreters, and/or traditional practitioners.

6. Documentation of Cultural Practices

- Documentation of Aboriginal health care services provided to Aboriginal clients is included in the client's care plan.
- Documentation includes all cultural, liaison or interpretive services accessed by the client.
- Documentation of cultural services includes the traditional practitioner's name and type of service or ceremony (e.g. birthing ceremony) but does not include specific details of the service or ceremony.

- Acknowledgements should also be done for VCH events held in First Nations, Métis and/or Inuit communities.

4. Honorarium

- When a Welcoming and/or Acknowledgement is provided by a non-VCH staff person, an honorarium is provided.

5. Placement of a Welcoming or Acknowledgement in an Agenda

- The Welcoming is the first item on the agenda and appears on the agenda as “Welcoming to Traditional Territory”.
- In some cases, depending on the protocols of the First Nations involved, it may be appropriate to have a Welcoming at the beginning and a Closing at the end of the event. If having a Closing, the agenda would state “Cultural Closing”.
- When providing an Acknowledgement without a Welcoming, the Acknowledgement is the first thing on the program and should appear on the agenda as “Acknowledgement of Traditional Territory.”

6. Guidelines for VCH Staff Making an Acknowledgement

The Acknowledgement is simple:

- Acknowledge the Territory on which the event is occurring.
- Name the First Nations people on whose Territory the event is occurring on.
- Thank the First Nations for access to and use of their land.
- Example: “Good morning. I would like to open with an acknowledgement of the traditional territory we are gathering on today. I acknowledge and thank the local First Nations [insert local First Nations] (e.g. Squamish, Musqueam and Tsleil-Waututh) for keeping their territory alive and healthy and for ability to live and work on these lands.”
- Refer to the [First Nations and Aboriginal Communities within VCH Region](#) for a map of the communities served by VCH.

Appendix B: Acknowledgement of First Nations Traditional Territory – Procedures

Procedures for key components to implement Acknowledgement of First Nations Traditional Territory:

1. Welcoming to Traditional Territory

- VCH staff follows the guidelines in the VCH Aboriginal Health Services brochure, [Working in Respectful Partnership with Aboriginal Elders](#), for procedures on how to invite an Elder to provide a Welcoming.
- VCH invites the local First Nations to provide a Welcoming when VCH hosts large public events such as Open Board meetings or conferences on First Nations Traditional Territory.
- When hosting an event within a First Nations community, VCH asks the local First Nations to provide the appropriate welcoming or opening, as protocols vary between First Nations.
- In the case of very formal events hosted by VCH, a hereditary chief of the local First Nations should be asked to provide the Welcoming. VCH staff should consult with the Regional Director of [Aboriginal Health Strategic Initiatives](#) or the local First Nations Band Administrative Office as to who would be the most appropriate person to do the Welcoming.
- For smaller, less formal events, if there is an Aboriginal person at the meeting who is from the Territory, it would be appropriate to ask that person if they are willing to do the Welcoming.

2. Acknowledgement of Traditional Territory

- At public events, acknowledgement will be provided by and from VCH of the traditional First Nations Territory on which VCH is holding the event. This acknowledgement can be done by the Emcee, speakers, or VCH staff.
- Even if the territory is acknowledged by the local First Nations who do the opening or welcoming for the event, VCH itself still needs to acknowledge the Traditional Territory.
- Each keynote speaker or presenter may also say a simple acknowledgement of the Territory as part of their presentation, though this is optional.

3. Applicability

The appropriateness and applicability of having a Welcoming or offering an Acknowledgement varies according to the size and nature of the event:

- For large public events such as forums or conferences held by VCH, both a Welcoming and an Acknowledgement of the Territory is appropriate.
- For less formal events such as meetings, professional development and gatherings, an Acknowledgement is sufficient.

Appendix C: Ceremonial Use of Tobacco or Smudging Medicine – Procedures

Procedures for key components to implement Ceremonial Use of Tobacco or Smudging Medicine:

1. Rights to Ceremonial Use of Tobacco and Smudging Medicines

- Aboriginal clients and extended family members may have access to the ceremonial use of traditional medicines such as tobacco, sage, cedar, or sweetgrass while within VCH facilities or programs for use of ceremony or gifting. All other use of tobacco products will comply with the VCH Smoke-Free Policy.
- Aboriginal clients and extended family members may request a smudge or cleansing ceremony while receiving services within a VCH facility.
- The Aboriginal client can participate in a smudging or cleansing ceremony even if unable to physically respond. This can be determined between the client, the family, the VCH health care practitioner, and, if appropriate, the Aboriginal person leading the ceremony.

2. Health Care Service Delivery

- VCH recognizes an Aboriginal smudging or cleansing ceremony as a holistic cultural health practice used in prayers, offerings, cleansing and healing of mind, body, emotion, and spirit.
- The Aboriginal client, family member, extended family or designated Aboriginal person, or a VCH Aboriginal staff person may lead a smudging or cleansing ceremony dependent on the wishes of the client first, then family or extended family, if appropriate.
- VCH staff works with the client or family members in determining the time for the ceremony to take place. All efforts will be made by VCH staff to accommodate the request in a timely manner within one to three hours.
- If the Aboriginal client, family member, or extended family member requests a smudge or cleansing ceremony but do not know of an Aboriginal traditional practitioner who can provide the ceremony, VCH staff may consult with the Aboriginal Health and Strategic Initiatives team, the Aboriginal Wellness Program staff, the Aboriginal Patient Navigators, or the local First Nations Band office for recommendation of practitioners.

3. Medicines and Supplies

- VCH staff are to refrain from touching any of the sacred items and medicines without first having permission from the Aboriginal people involved in the ceremony.
- Smudging medicines and tobacco, along with any sacred items, if held by VCH, will be stored in a safe and accessible place for use by Aboriginal clients. Management ensures that there is a procedural work flow in place to facilitate access to these medicines and tobacco for Aboriginal clients.
- Generally, the Aboriginal client, family, extended family or Aboriginal healing practitioner provides the supplies required for a smudging and cleansing ceremony. VCH

may, at the discretion of the manager or director involved, provide supplies for the ceremony.

4. Facility Space and Sacred Space

- Cleansing ceremonies are held in designated ceremonial spaces. If there is no designated space for ceremonies or if it is undesirable to transport the Aboriginal client to such a space, the following steps are taken:
 - Make ceremonial space available within the Aboriginal client's room.
 - Make ceremonial space available within the clinical setting.
 - Create ceremonial space outdoors.
- Facilities management develops procedures relevant to each site.

5. Preparing the Space for the Ceremony

- VCH staff speaks to the Aboriginal person conducting the ceremony or the client and or family members to ensure that burning substances are kept away from medical equipment.
- VCH staff notifies other occupants in shared spaces (staff and clients) of the upcoming ceremony.
- VCH are familiar with the site's fire response procedures and know the location of pull stations and fire extinguishers in the immediate area.
- VCH staff ensures that all free flowing oxygen bagging units in the room are turned off during the ceremony.
- VCH staff contacts maintenance to ensure adherence to building protocols and proper ventilation. Staff notifies maintenance services of the planned ceremony well in advance of the commencement of the ceremony – a minimum of one hour in advance, preferably two to three hours in advance. Longer notification times may be necessary at specific sites.
- Maintenance staff determines the smoke detector device number, room number, and disables the devices. Once the devices have been disabled, maintenance notifies VCH staff.

6. During the Ceremony

- VCH staff monitors hospital and other medical equipment during the ceremony.
- VCH staff, if participating in the ceremony, respects and follows the ceremonial protocols established by the Aboriginal person conducting the ceremony.

7. After the Ceremony

- Upon completion of the ceremony, VCH staff notifies maintenance services who are then responsible for reactivating smoke detectors.

- VCH staff ensures that the door of the room used for the ceremony stays closed for the appropriate length of time before the room is reopened for general patient, client, resident, or family use. The air in the room must be cleaned for approximately half an hour after the ceremony or until the scent is cleared.
- VCH staff may turn on room fans to assist in the air cleaning of the room.
- There may be a rare occurrence when VCH staff is asked to provide safe and culturally respectful removal of the remains of the cleansing. This is done in accordance with the protocols outlined by the Aboriginal person conducting the ceremony. In most cases, the remains of the ceremony will be taken care of by the Aboriginal person conducting the ceremony.

8. Documentation

- VCH staff will document requests and actions taken to access a smudging ceremony or cultural practice.
- Documentation of the smudging or cleansing ceremony is included as part of the Aboriginal client's care plan. Documentation does not include the particulars of specific cultural practices but provides a statement that a ceremony or practice occurred and the name of the Traditional Practitioner, if applicable, who provided the ceremony.

OVERVIEW: URBAN VANCOUVER ABORIGINAL HEALTH STRATEGY (UVAHS):

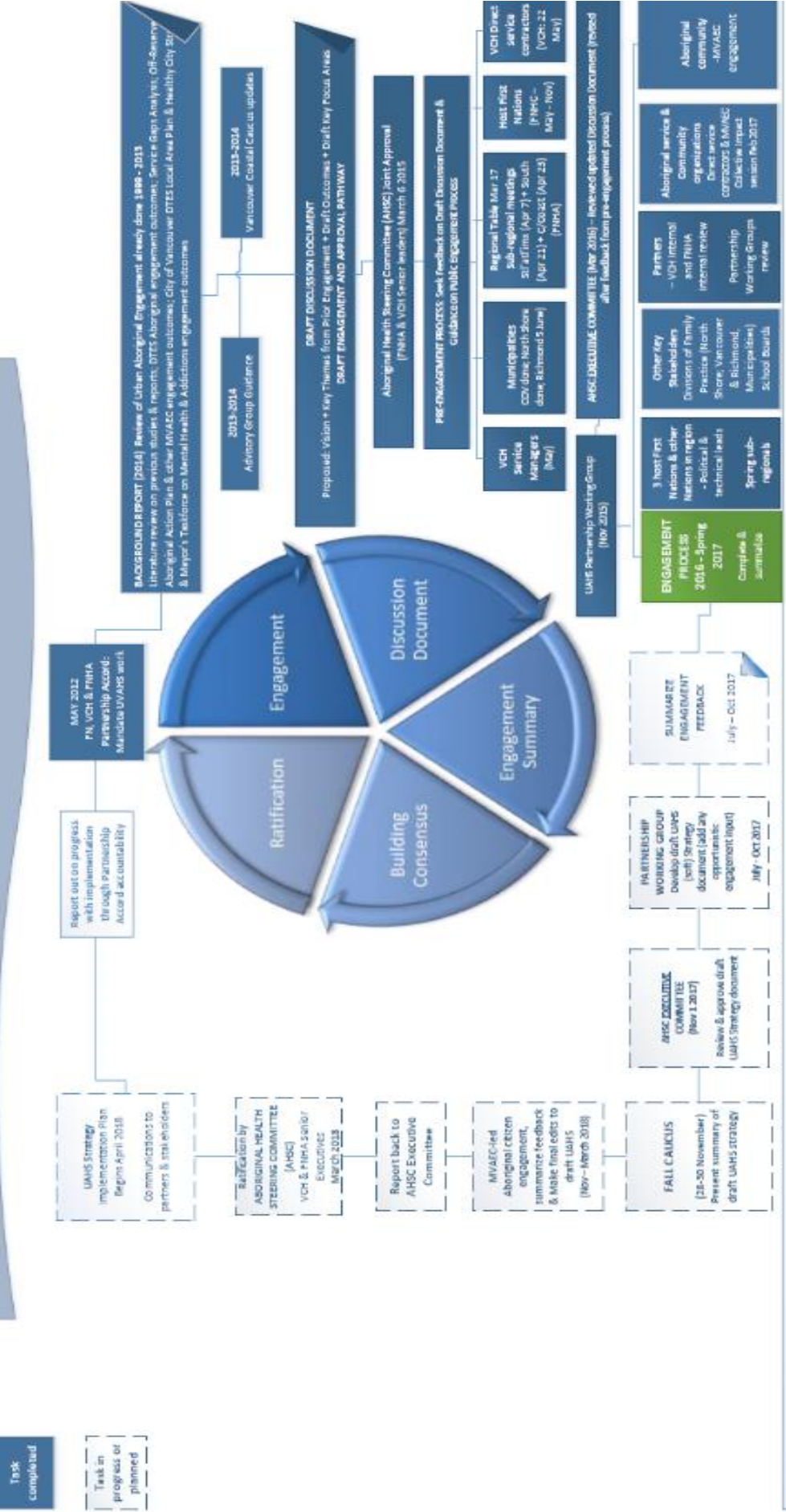
RICHMOND, VANCOUVER AND NORTH SHORE

A project arising from the VCH – FNHA Partnership Accord, May 2012 (Update as at Sept 6 2017)



First Nations Health Authority
Health through wellness

ENGAGEMENT AND APPROVAL PATHWAY FOR THE URBAN VANCOUVER ABORIGINAL HEALTH STRATEGY (UVAHS)



Vancouver Coastal Region

Regional First Nations Health and Wellness Plan 2016-2021



3. Priority: Holistic Wellness and Health Service Delivery

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

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

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

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

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

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

Goal 3.3: Address barriers to health care access.

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

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

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

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

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

4. Priority: Health Human Resources

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

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

Goal 4.1: Increase the number of Aboriginal health professionals delivering health care services.

- | | |
|------------|---|
| Objectives | 4.1.1: Collaborate with VCH to support health career promotional activities for First Nations and Aboriginal individuals. |
| | 4.1.2: Support regional, subregional, and community First Nations and Aboriginal health career promotional activities. |

Goal 4.2: Encourage First Nations and subregional service delivery providers partnerships to attract, retain and develop a high quality workforce.

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

Goal 4.3: Support partners to work with/in First Nations and sub-regional service delivery models.

- | | |
|------------|---|
| Objectives | 4.3.1: Support the Coastal Family residency program and placement of physicians in First Nations communities (operated by North Shore Division of Family Practice). |
| | 4.3.2: Work with post-secondary institutions to encourage students (especially Aboriginal students) to undertake practicum opportunities with First Nations. |

5. Priority: Operational Excellence

The partners of this RHWP aim to:

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

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

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

4.1.2: Support Nations who choose to be accredited.

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

Objectives 5.2.1: Support overall transformation of the FNHA capital program.

5.2.2: Utilize partnerships and innovative opportunities across communities and with others to support sustainable, high quality facilities in alignment with new service models.

5.2.3: Continue to support safety and quality of existing health facilities.

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

Objectives 5.2.1: Identify and support Nation and subregional aspirations for provision of services to off-reserve and non-First Nation community members.

5.2.2: Work with First Nations to operate and own dental, physician, vision, pharmacy and other health practices that may generate income while providing more accessible services for their community and subregional communities.

APPENDIX 4: PROVINCIAL DECLARATION OF COMMITMENT TO CULTURAL SAFETY & HUMILITY – JULY 2015

DECLARATION OF COMMITMENT - JULY 16 2015

CULTURAL SAFETY AND HUMILITY IN HEALTH SERVICES DELIVERY FOR FIRST NATIONS AND ABORIGINAL PEOPLE IN BRITISH COLUMBIA

Our Declaration of Commitment is an important step toward embedding cultural safety and humility within health services for First Nations and Aboriginal people in British Columbia. This commitment reflects the high priority we, as the designated BC First Nations and Aboriginal health system leaders, place on cultural safety and humility as essential dimensions of quality and safety within the First Nations and Aboriginal health services for which we are responsible.

This Declaration of Commitment is based on the following guiding principles of cultural safety and humility:

- Cultural humility builds mutual trust and respect and enables cultural safety.
- Cultural safety is defined by each individual client's health service experience. As such, approaches to cultural safety must be client-centred.
- Cultural safety must be understood, embraced and practiced at all levels of the health system including governance, health organizations and within individual professional practices.
- All stakeholders, including First Nations and Aboriginal individuals, elders, families, communities, and nations must be involved in co-development of action strategies and in the decision-making process, with a commitment to reciprocal accountability.

Strong leadership on concrete actions is essential to achieving our vision of a culturally safe health system for First Nations and Aboriginal people in our province. We, the members of the Leadership Council, will:

CREATE A CLIMATE FOR CHANGE BY:

- Articulating the pressing need to ensure cultural safety within First Nations and Aboriginal health services in BC.
- Opening an honest and convincing dialogue with all stakeholders to show that change is necessary.
- Forming a coalition of influential leaders and role models who are committed to the priority of embedding cultural humility and safety in BC health services.
- Leading the creation of the vision for a culturally safe health system and developing a strategy to achieve the vision.
- Supporting the development of workplans and implement through available resources.

ENGAGE AND ENABLE STAKEHOLDERS BY:

- Communicating the vision of culturally safe health system for First Nations and Aboriginal people in BC and the absolute need for commitment and understanding on behalf of all stakeholders, partners and clients.
- Openly and honestly addressing concerns and leading by example.
- Identifying and removing barriers to progress.
- Tracking, evaluating and visibly celebrating accomplishments.


IMPLEMENT AND SUSTAIN CHANGE BY:


- Empowering health organizations and individuals to innovate, develop cultural humility and foster a culture of cultural safety.
- Allowing organizations and individuals to raise and address problems without fear of reprisal.
- Leading and enabling successive waves of actions until cultural humility and safety are embedded within all levels of the health system.


Our signatures demonstrate our long term commitment to providing culturally safe health services for First Nations and Aboriginal people in British Columbia and to championing the process required to achieve this vision.


This Declaration of Commitment is endorsed by the BC Tripartite Committee on First Nations Health and signed by the members of the Leadership Council.

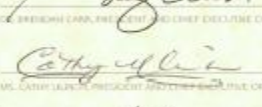
SIGNED on this date: July 16, 2015



 MR. STEPHEN DEWAR, DEPUTY MINISTER, MINISTRY OF HEALTH



 MR. J.C. GALAMBOS, CHIEF EXECUTIVE OFFICER, FIRST NATIONS HEALTH AUTHORITY



 MR. CARL ROW, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PROVINCIAL HEALTH SERVICES AUTHORITY


 MR. MICHAEL ANICHINI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PRINCE GEORGE HEALTH


 DR. ROBERT HULTINE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, INTERIM HEALTH


 DR. BRENDA LAMB, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ISLAND HEALTH

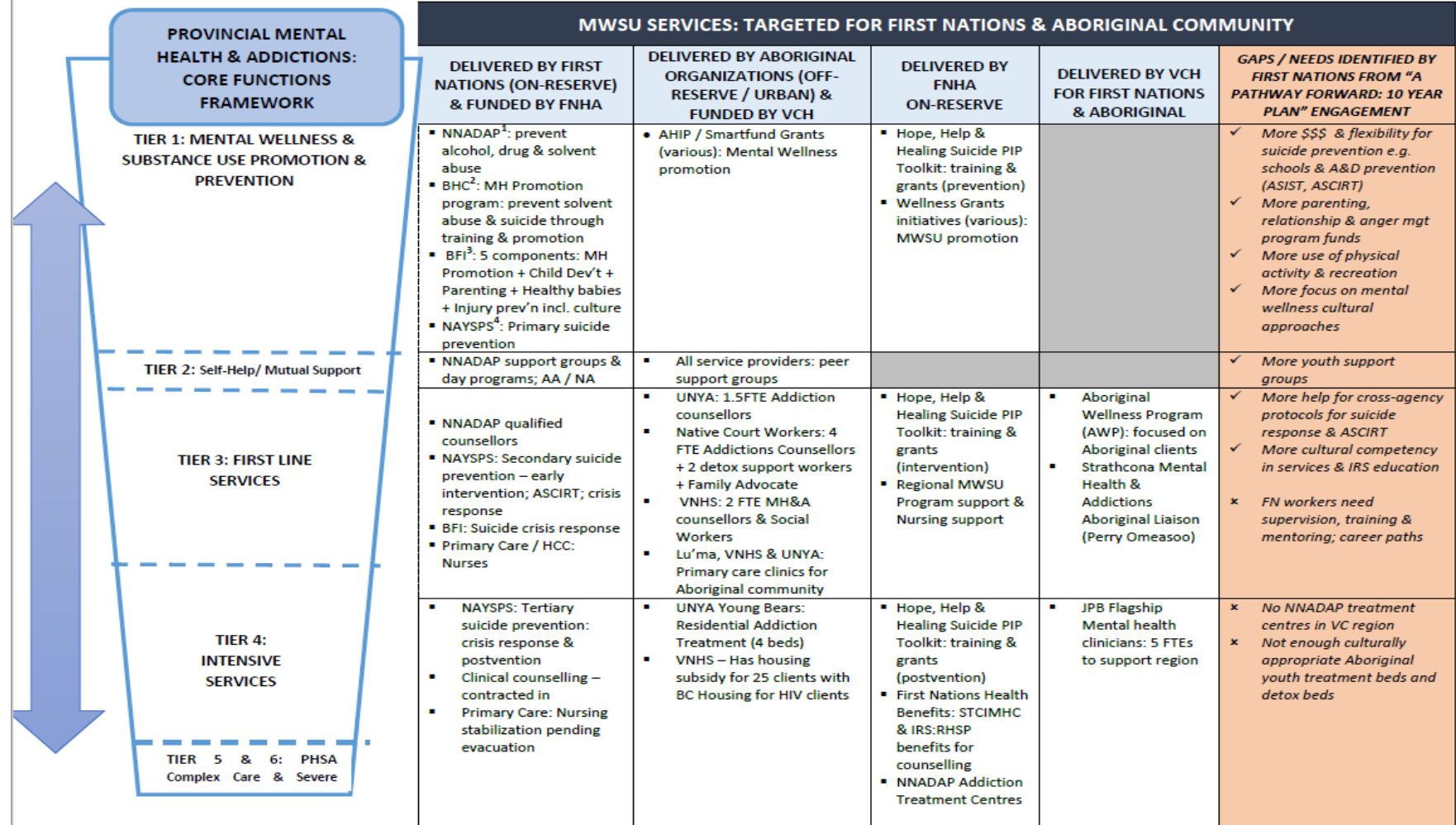

 MS. CATY LEWIS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NORTHERN HEALTH


 MS. MARY ACKEMA, PRESIDENT AND CHIEF EXECUTIVE OFFICER, WICACOMR (COASTAL HEALTH)



APPENDIX 5: MENTAL WELLNESS AND SUBSTANCE USE FRAMEWORK – VANCOUVER COASTAL REGION – JULY 2016

VCH ABORIGINAL HEALTH: July 20th 2016: DRAFT MENTAL WELLNESS & SUBSTANCE USE FRAMEWORK



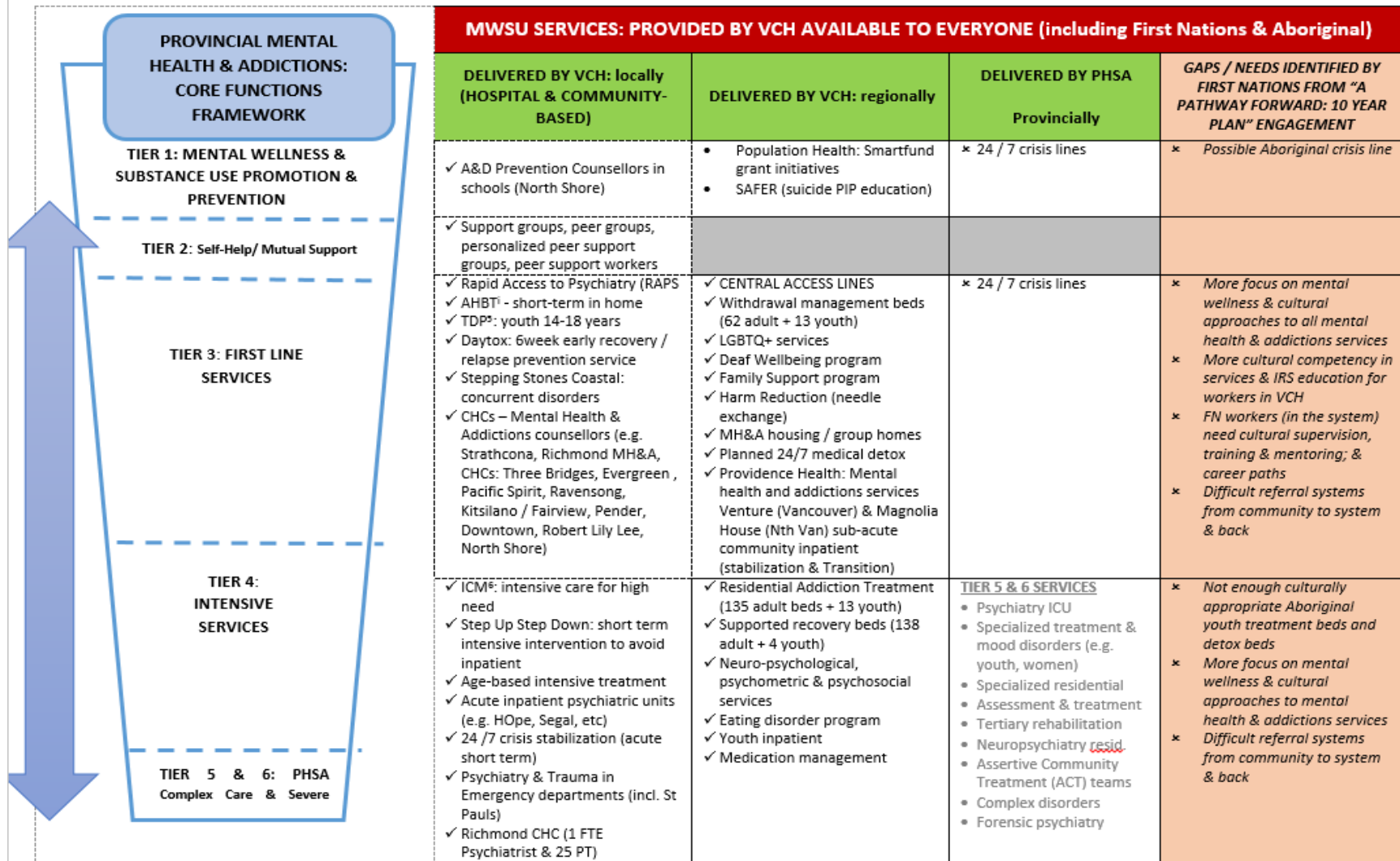
¹ National Native Alcohol & Drug Addiction Program

² Building Healthy Communities

³ Brighter Futures Initiative

⁴ National Aboriginal Youth Suicide Prevention Strategy

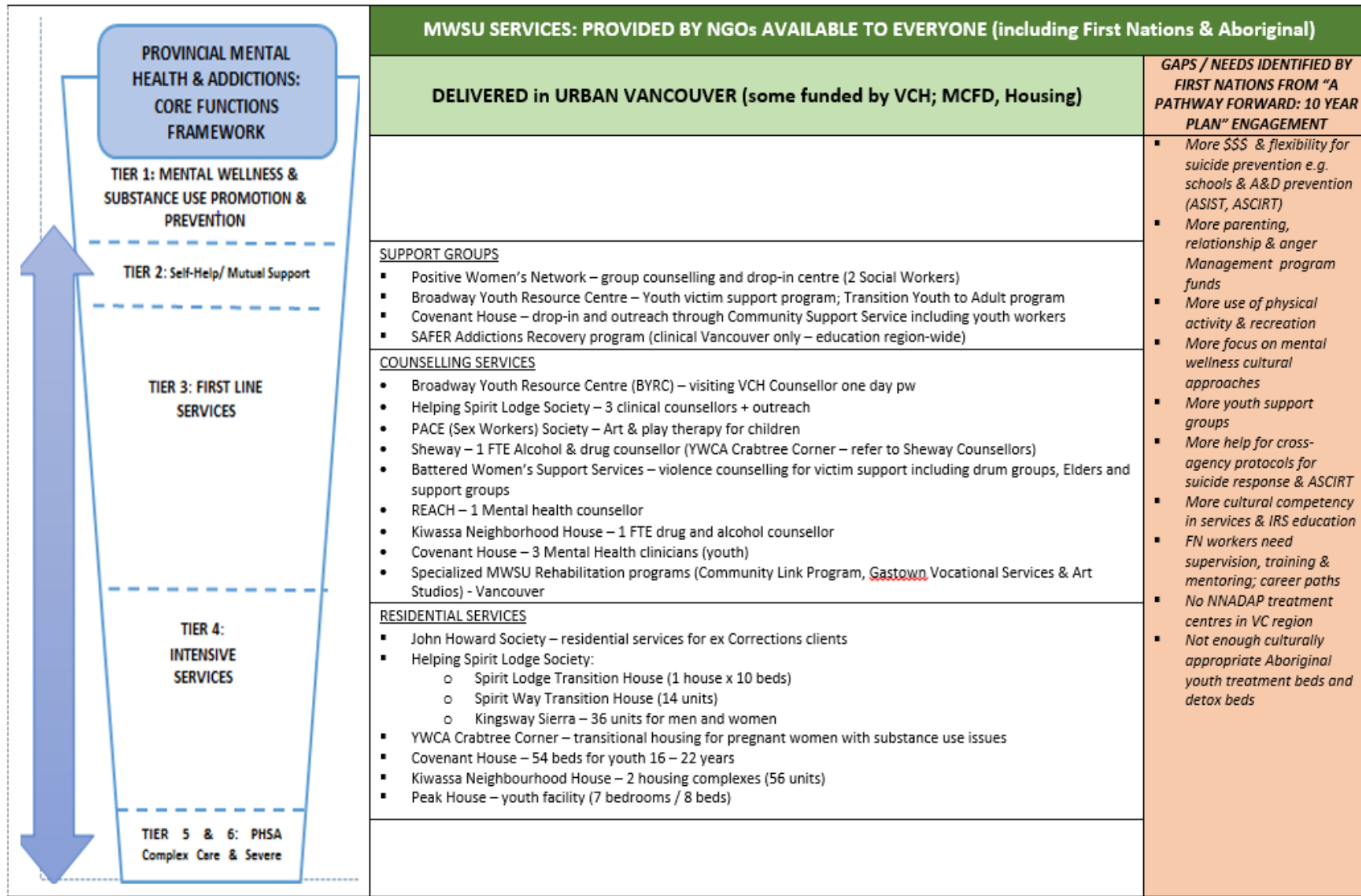
VCH ABORIGINAL HEALTH: July 20th 2016: MENTAL WELLNESS & SUBSTANCE USE FRAMEWORK



² TDP: Therapeutic Day Program

³ ICM: Intensive Case Management

⁴ AHBT – Acute Home Based Treatment



APPENDIX 6: RECOMMENDED HEALTH SYSTEM MEASURES: UNITED NATIONS SUSTAINABLE DEVELOPMENT GOALS

The Health Data Collaborative is an inclusive partnership of international agencies, governments, philanthropies, donors and academics, with the common aim of improving health data, supported by donors, academics, UN agencies and civil society organizations.

The Health Data Collaborative is not a formal partnership. They operate with a light, nimble governance structure, based on a shared vision that by working together to strengthen country information systems, they can contribute meaningfully to better decision-making and better health. The Health Data Collaborative is not a fund. It is not directly responsible for financing health information systems, but for bringing countries, donors and other partners together to make sure investments are made in the most efficient and effective way.

The Health Data Collaborative is a joint effort by multiple global health partners to work alongside countries to improve the availability, quality and use of data for local decision-making and tracking progress toward the health-related United Nations Sustainable Development Goals (SDGs).

The SDGs are an ambitious set of targets adopted by world leaders in 2015 that envision a world with zero poverty, shared prosperity and security, and where no one is left behind. The Health Data Collaborative exists to empower countries to achieve the targets set out in the health-related goals, especially but not exclusively those in Goal 3: ensuring healthy lives and promoting wellbeing for all at all ages. Achieving these goals will require accurate and timely data in order to understand how much work needs to be done, to staying on track, and to keeping leaders accountable.

The following are suggested indicators (with detailed explanations of each) suggested by the Health Data Collaborative.



Mortality by age and sex

- [Life expectancy at birth \(39 kB\)](#)
- [Adult mortality rate between 15 and 60 years of age \(39 kB\)](#)
- [Under-five mortality rate \(47 kB\)](#)
- [Infant mortality rate \(40 kB\)](#)
- [Neonatal mortality rate \(47 kB\)](#)
- [Stillbirth rate \(39 kB\)](#)

Mortality by cause

- [Maternal mortality ratio \(42 kB\)](#)
- [TB mortality rate \(39 kB\)](#)
- [AIDS-related mortality rate \(36 kB\)](#)
- [Malaria mortality rate \(47 kB\)](#)
- [Mortality between 30 and 70 years of age from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases \(41 kB\)](#)
- [Suicide rate \(37 kB\)](#)
- [Mortality rate from road traffic injuries \(39 kB\)](#)

Fertility

- [Adolescent fertility rate \(41 kB\)](#)
- [Total fertility rate \(43 kB\)](#)





Morbidity

- [New cases of vaccine-preventable diseases \(39 kB\)](#)
- [New cases of IHR-notifiable diseases and other notifiable diseases \(39 kB\)](#)
- [HIV incidence rate \(39 kB\)](#)
- [HIV prevalence rate \(43 kB\)](#)
- [Hepatitis B surface antigen prevalence \(37 kB\)](#)
- [Sexually transmitted infections \(STIs\) incidence rate \(34 kB\)](#)
- [TB incidence rate \(46 kB\)](#)
- [TB notification rate \(46 kB\)](#)
- [TB prevalence rate \(46 kB\)](#)
- [Malaria parasite prevalence among children aged 6–59 months \(39 kB\)](#)
- [Malaria incidence rate \(40 kB\)](#)
- [Cancer incidence, by type of cancer \(36 kB\)](#)


RISK FACTORS







Nutrition

-  Exclusive breastfeeding rate 0–5 months of age (40 kB)
-  Early initiation of breastfeeding (34 kB)
-  Incidence of low birth weight among newborns (36 kB)
-  Children under 5 years who are stunted (40 kB)
-  Children under 5 years who are wasted (39 kB)
-  Anaemia prevalence in children (42 kB)
-  Anaemia prevalence in women of reproductive age (42 kB)

Infections

-  Condom use at last sex with high-risk partner (34 kB)

Environmental risk factors

-  Population using safely managed drinking-water services (41 kB)
-  Population using safely managed sanitation services (41 kB)
-  Population using modern fuels for cooking/heating/lighting (43 kB)
-  Air pollution level in cities (36 kB)

Noncommunicable diseases

-  Total alcohol per capita (age 15+ years) consumption (38 kB)
-  Tobacco use among persons aged 18+ years (35 kB)
-  Children aged under 5 years who are overweight (40 kB)
-  Overweight and obesity in adults (Also: adolescents) (43 kB)
-  Raised blood pressure among adults (35 kB)
-  Raised blood glucose/diabetes among adults (35 kB)
-  Salt intake (35 kB)
-  Insufficient physical activity in adults (Also: adolescents) (50 kB)

Injuries

-  Intimate partner violence prevalence (36 kB)

SERVICE COVERAGE



Reproductive, maternal, newborn, child and adolescent

- Demand for family planning satisfied with modern methods (38 kB)
- Contraceptive prevalence rate (39 kB)
- Antenatal care coverage (42 kB)
- Births attended by skilled health personnel (45 kB)
- Postpartum care coverage (37 kB)
- Care-seeking for symptoms of pneumonia (42 kB)
- Children with diarrhoea receiving oral rehydration solution (ORS) (41 kB)
- Vitamin A supplementation coverage (37 kB)

Immunization

- Immunization coverage rate by vaccine for each vaccine in the national schedule (36 kB)

HIV

- People living with HIV who have been diagnosed (36 kB)
- Prevention of mother-to-child transmission (38 kB)
- HIV care coverage (42 kB)
- Antiretroviral therapy (ART) coverage (46 kB)
- HIV viral load suppression (43 kB)

HIV/TB

- TB preventive therapy for HIV-positive people newly enrolled in HIV care (36 kB)
- HIV test results for registered new and relapse TB patients (37 kB)
- HIV-positive new and relapse TB patients on ART during TB treatment (36 kB)

Tuberculosis

- TB patients with results for drug susceptibility testing (35 kB)
- TB case detection rate (41 kB)
- Second-line treatment coverage among multidrug-resistant tuberculosis (MDR-TB) cases (36 kB)

Malaria

- Intermittent preventive therapy for malaria during pregnancy (IPTp) (36 kB)
- Use of insecticide treated nets (ITNs) (36 kB)
- Treatment of confirmed malaria cases (36 kB)
- Indoor residual spraying (IRS) coverage (36 kB)

Neglected tropical diseases

- Coverage of preventive chemotherapy for selected neglected tropical diseases (38 kB)

Screening and preventive care

- Cervical cancer screening (35 kB)

Mental health

- Coverage of services for severe mental health disorders (33 kB)



Quality and safety of care

- [Perioperative mortality rate \(31 kB\)](#)
- [Obstetric and gynaecological admissions owing to abortion \(34 kB\)](#)
- [Institutional maternal mortality ratio \(38 kB\)](#)
- [Maternal death reviews \(34 kB\)](#)
- [ART retention rate \(37 kB\)](#)
- [TB treatment success rate \(35 kB\)](#)
- [Service-specific availability and readiness \(42 kB\)](#)

Access

- [Service utilization \(31 kB\)](#)
- [Health service access \(35 kB\)](#)
- [Hospital bed density \(26 kB\)](#)
- [Availability of essential medicines and commodities \(38 kB\)](#)

Health workforce

- [Health worker density and distribution \(28 kB\)](#)
- [Output training institutions \(40 kB\)](#)

Health information

- [Birth registration coverage \(34 kB\)](#)
- [Death registration coverage \(39 kB\)](#)
- [Completeness of reporting by facilities \(26 kB\)](#)

Health financing

- [Total current expenditure on health \(% of gross domestic product\) \(34 kB\)](#)
- [Current expenditure on health by general government and compulsory schemes \(% of current expenditure on health\) \(35 kB\)](#)
- [Out-of-pocket payment for health \(% of current expenditure on health\) \(34 kB\)](#)
- [Externally sourced funding \(% of current expenditure on health\) \(34 kB\)](#)
- [Total capital expenditure on health \(% current + capital expenditure on health\) \(34 kB\)](#)
- [Headcount ratio of catastrophic health expenditure \(37 kB\)](#)
- [Headcount ratio of impoverishing health expenditure \(37 kB\)](#)

Health security

- [International Health Regulations \(IHR\) core capacity index \(34 kB\)](#)