



Vancouver Coastal Region

Interim Regional First Nations Health and Wellness Plan 2014

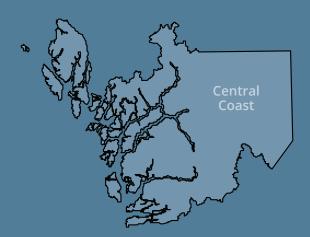






Table of Contents

EXECUTIVE SUMMARY	4
PURPOSE OF THE IRHWP	4
IRHWP REPORTING	5
INTRODUCTION AND BACKGROUND	6
IRHWP PROCESS	7
BC FIRST NATIONS SHARED VISION, VALUES AND DIRECTIVES	8
BC FIRST NATIONS PERSPECTIVE ON WELLNESS	9
PARTNERS IN OUR REGIONAL HEALTH AND WELLNESS PLAN	9
PARTNER OVERVIEW	9
FIRST NATIONS COMMUNITIES IN THE VANCOUVER COASTAL REGION	10
FIRST NATIONS HEALTH AUTHORITY	14
FIRST NATIONS HEALTH COUNCIL (FNHC)	14
FIRST NATIONS HEALTH DIRECTORS ASSOCIATION (FNHDA)	15
VANCOUVER COASTAL HEALTH (VCH)	15
PROVINCIAL HEALTH SERVICES AUTHORITY (PHSA)	16
DIVISIONS OF FAMILY PRACTICE AND PHYSICIANS	16
OTHER SERVICE PROVIDERS AND PARTNERS	17
FIRST NATIONS HEALTH GOVERNANCE STRUCTURES	18
FIRST NATIONS PARTNERSHIP WITH FNHA AND VANCOUVER COASTAL HEALTH	20
FIRST NATIONS RELATIONSHIPS WITH LOCAL PARTNERS	24
REGIONAL PRIORITIES, GOALS, AND ACTIONS	26
SWOT ANALYSIS – STARTING POINT FOR OUR PLAN	26
LONG TERM GOALS FOR VC REGION FIRST NATIONS HEALTH	27
DIRECTIVE 1: COMMUNITY-DRIVEN NATION-BASED	28
DIRECTIVE 2: INCREASE FIRST NATIONS DECISION-MAKING AND CONTROL	30
DIRECTIVE 3: IMPROVE SERVICES	34
DIRECTIVE 4: FOSTER MEANINGFUL COLLABORATION AND PARTNERSHIP	43
DIRECTIVE 5: DEVELOP HUMAN AND ECONOMIC CAPACITY	46
DIRECTIVE 6: BE WITHOUT PREJUDICE TO FIRST NATIONS INTERESTS	50
DIRECTIVE 7: FUNCTION AT A HIGH OPERATIONAL STANDARD	52
REPORTING AND ACCOUNTABILITY	57
REPORTING ON THE REGIONAL HEALTH AND WELLNESS PLAN	57
EVALUATION OF THE PARTNERSHIP ACCORD	57
RESOURCING THE REGIONAL HEALTH AND WELLNESS PLAN	58

RESOURCES FROM VCH	60
REFERENCES	61
APPENDICES	62
APPENDIX A: GAPS IDENTIFIED IN COMMUNITY-BASED SERVICES (JUNE 2013)	64
APPENDIX B: DESCRIPTION OF HEALTH TRANSFER CONTRIBUTION AGREEMENTS	67
APPENDIX C: PRIORITIES FROM PREVIOUS ENGAGEMENT WITH VC REGION FIRST NATIONS	68
APPENDIX D: SUMMARY OF GOALS RHWP	76
APPENDIX E: BRIEFING NOTE VC MWSU REGIONAL FORUM REPORT AND ACTION PLAN	78
APPENDIX F: DASHBOARD SUMMARY OF VC REGION PRIMARY HEALTH CARE ACCESS	83
APPENDIX G: WORKFORCE GAPS IDENTIFIED BY HEALTH DIRECTORS	85
APPENDIX H: GLOSSARY	86
Table of Figures	
Table of Figures	
Figure 1: Timelines of Health Plans and Agreements	6
Figure 2: Reciprocal Accountability Framework	7
Figure 3: Coordinated Health Planning Approach	8
Figure 4: First Nations Perspective on Wellness	9
Figure 5: Partners in the Regional Health and Wellness Plan	9
Figure 6: Population on Reserve (AANDC March 2013)	10
Figure 7: First Nations health governance structure(s)	18
Figure 8: Vancouver Coastal Caucus Sub-Regions	19
Figure 9: Aboriginal Health Operations Council (AHOC) Approval & Implementation Process	21
Figure 10: Vancouver Coastal PARTNERSHIP ACCORDPartnership Accord Relationship	22
Figure 11: Communications & Engagement Pathway	31
Figure 12: Health Service Delivery for First Nations communities	35
Figure 13: First Nations and service delivery areas in the Vancouver Coastal Region	37
Figure 14: A General Annual Timeline for "Living the Partnerships"	44
Figure 15: Health Workforce on-Reserve in First Nations communities (June 2013)	46
Figure 16: Vancouver Coastal region Region the fiscal year 2015/15 regional envelope	
(fiscal year 2015/16)	59
Figure 17: Engagement and Development Process on the iRHWP	61

RESOURCES FROM THE FNHA

58

Executive Summary

The First Nations health governance model supports and enables decision-making and influence in the health system. First Nations are in a position to transform health care in British Columbia (BC) since the formal transfer of Health Canada to the First Nations Health Authority (FNHA) on October 1st, 2013. This is the first Vancouver Coastal interim Regional Health and Wellness Plan (iRHWP) within this new system. Many lessons have been learned along this journey. Throughout the process, it has become clear that a larger planning cycle is required to truly reflect our regional and community health priorities. In keeping with the Seven Directives, regional planning efforts must start with:

- · Community health planning, followed by;
- Sub regional planning, followed by;
- · Regional planning.

This is necessary to reflect the unique sub regional health goals, actions, and geographical realities. This more robust pathway will take time to achieve—as will a larger systems transformation in First Nations health governance. It is recognized that this is an interim plan until we can achieve the above community-driven health-planning cycle in our region. Communities, the FNHA and Vancouver Coastal Health (VCH) all share responsibility to move planning forward using the regional structures that have been established to support their work.

First Nations in the Vancouver Coastal region are a unique family. We are journeying together to navigate these new waters with one heart, one mind. We work in inclusive and collaborative ways to take full advantage of the exciting opportunities and new learnings that lie ahead. Each of our 14 communities and sub-regions are unique in their culture, traditions, geography and context. This is reflected in their diverse needs and challenges. Central Coastal communities, for example, are accessible only by plane or boat. Whereas Southern Stl'atl'imx communities face challenges through long drives and poor road conditions. Our Vancouver Coastal Southern sub-regional cousins are diverse communities which include rural and urban environments. Each has their own access to health constraints that require different approaches and supports. This plan recognizes the hard work that Vancouver Coastal regional First Nations have done for many years in the area of health and wellness. Their work has been incorporated into this plan in order to honour its foundational importance. First Nations communities and their health partners are coming together in a way never done before. Together we will redesign and improve the First Nations health and wellness landscape. There are numerous organizations, committees and tables that exist to bring these different organizations together. We work according to the following values: respect, discipline, relationships, culture, excellence and fairness. In the spirit of reciprocal accountability, the responsibility ultimately sits with each one of us, in each of our communities, and respective organizations, to continue to work with unwavering dedication towards this unprecedented work. Together we will achieve our shared vision: healthy, self-determining and vibrant BC First Nations children, families and communities.

¹Appendix H - Glossary for a complete list of acronyms

PURPOSE OF THE IRHWP

The iRHWP defines priority goals and actions at the regional level and to inform the work of the FNHA and VCH as health partners to First Nations in the region (as per the Partnership Accord – see appendix). This is a living document. It will be updated and changed regularly through sub-regional engagement. It will help to inform and guide investments at the regional level through the FNHA regional envelope as well as VCH discretionary funding. In addition, the iRHWP will inform and foster systems transformation in First Nations health governance.

Finally the FNHA, FNHC and FNHDA will use the iRHWP at the provincial level as they work with the BC Ministry of Health, Health Authorities and Health Canada at a more strategic and/or political level. The plan aims to answer three key questions:

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

IRHWP REPORTING

The iRHWP will be updated regularly at caucus sessions semi-annually and will be reported on at each caucus as well to the 14 First Nations.

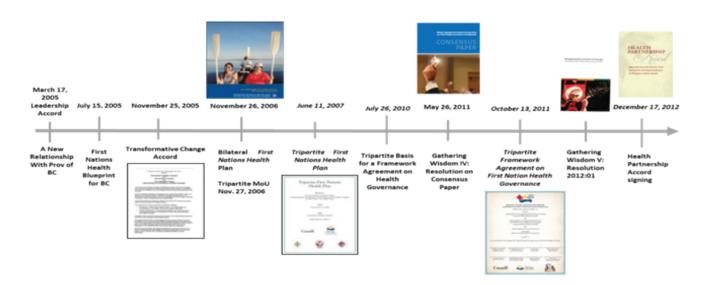
Introduction and Background

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

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

The Tripartite Framework Agreement on First Nation Health Governance (the "Framework Agreement") provides for the legal commitments of the parties to create a new First Nations health governance structure. This includes the establishment of the FNHA and the transfer the federal programs and operations to First Nations control. The Health Partnership Accord describes the parties' common vision for the partnership in the current state of its evolution. This includes the scope of possibilities for health innovation, enabled by a committed, resourced and supportive relationship. It sets the context for implementing the Framework Agreement and all of the commitments set out in previous political agreements regarding First Nations health. In May 2012, the FNHA and First Nations Health Council (FNHC), represented by its Vancouver Coastal members and VCH signed a Partnership Accord, which outlines agreements for regional progress on First Nations health (see Figure 1 for timeline of events).

Figure 1: Timelines of Health Plans and Agreements



IRHWP PROCESS

Reciprocal accountability is a core principle of the new First Nations governance structure. It is reflected in key agreements including: the Framework Agreement (2011), the Relationship Agreement amongst the FNHC-FNHA-FNHDA (2012), the *Health Partnership Accord* (2012), and the *Vancouver Coastal Partnership Accord* (2012). Reciprocal accountability is a shared responsibility that each of us as individuals and organizations has to achieve our vision and goals. Everyone has a role and our actions affect others, and contribute to the outcomes of our interdependent and interconnected system. The iRHWP upholds the principle of Reciprocal Accountability (Figure 2), in that First Nations communities, the FNHA, the Vancouver Coastal Regional Caucus and VCH commit to working together to achieve the goals and outcomes outlined in this plan

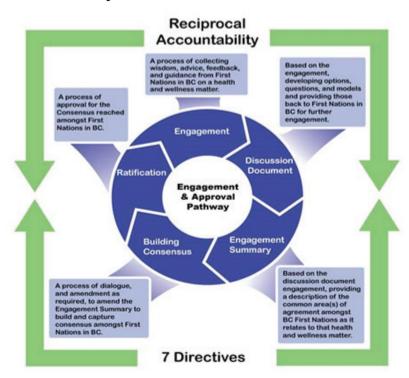


Figure 2: Reciprocal Accountability Framework

This core principle guides the development of the iRHWP by including a process of collecting wisdom, advice, feedback and guidance starting at 'Gathering Wisdom for a Shared Journey IV' (2011). First Nations leadership of BC provided direction for each of the five health regions (Northern, Interior, Vancouver Island, Fraser-Salish, and Vancouver Coastal) to develop a Regional Health and Wellness Plan (RHWP). RHWPs are a key part of the overall health and wellness planning approach by BC First Nations (see Figure 3). By Fall 2013, each region had prepared an iRHWP. Emerging regional priorities identified by the engagement teams and Regional Tables were included.

Based on the engagement, the first draft of the iRHWP was brought to the Vancouver Coastal Regional Caucus in May 2014 for discussion. In June 2014 a second draft with updates, that was more reflective of sub-regional priorities, was created and distributed to the First Nations Health Directors, the Regional Table and Vancouver Coastal Caucus. As a means to build consensus and in order to ensure there was a process in place for ongoing dialogue, a working group was formed. The working group created space for everyone give input and identify community needs. The purpose of the iRHWP is to establish a common voice in each region.

Once completed, each iRHWP will help to prioritize and implement the region's work and its partnership with the FNHA (including establishment of regional supports). It will support the delivery and transformation of high-quality, culturally appropriate health and wellness programs and services for First Nations and Aboriginal peoples in BC. The future RHWP will also inform the work and planning processes of the FNHC, FNHDA and FNHA, including strategic plans, Interim Health Plans (IHPs) and Multi-Year-Health Plans (MYHPs). In turn, the iRHWP is informed by existing and future community health and wellness needs, priorities and plans. The purpose of the iRHWP is to enhance the health and wellness of all First Nations people living in the region regardless of status or location within the province.

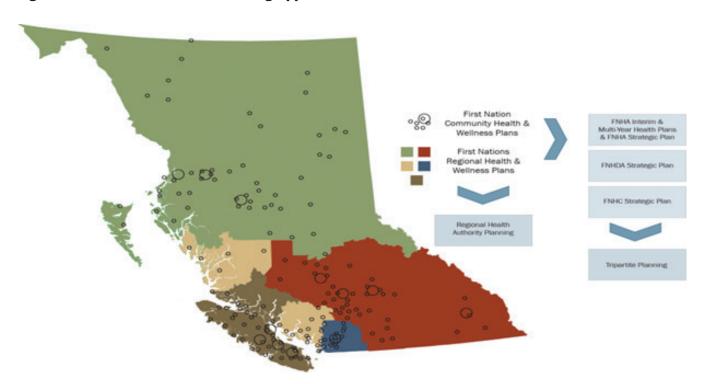


Figure 3: Coordinated Health Planning Approach

BC FIRST NATIONS SHARED VISION, VALUES AND DIRECTIVES

Collective efforts of BC First Nations are united and guided by a vision of "Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities." In working to achieve the overall vision, efforts are conducted with one another in accordance with the following shared values: Respect, Discipline, Relationships, Culture, Excellence, and Fairness. First Nations of BC also agreed-upon the following Seven Directives:

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

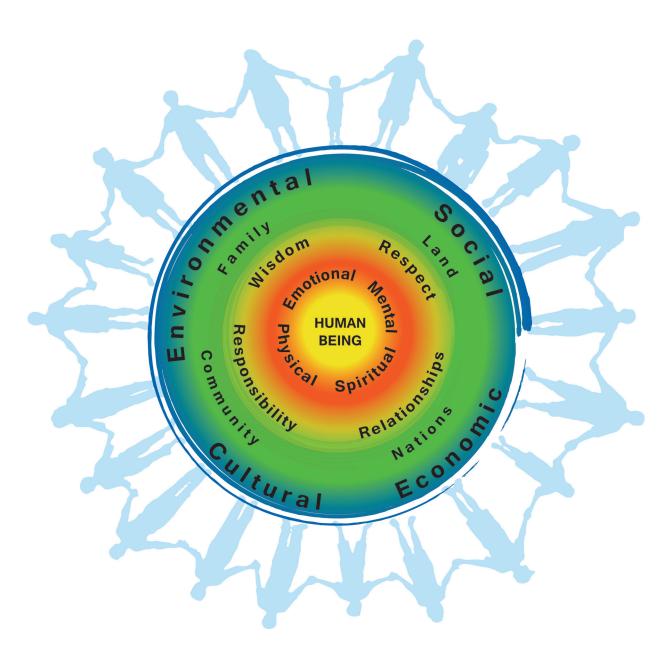
Directive #6: Be Without Prejudice to First Nations Interests

Directive #7: Function at a High Operational Standard

BC FIRST NATIONS PERSPECTIVE ON WELLNESS

The First Nations Perspective on Wellness (see Figure 4) is a holistic health and wellness approach that provides a guide for health and wellness planning, program and service delivery to First Nations and Aboriginal peoples throughout BC. It builds on the idea that health and wellness are intimately connected, and that they encompass emotional, mental, spiritual and physical health and well-being. All of these elements are essential and need to be balanced in order to achieve wellness. A holistic and integrated approach is fundamental to the success of achieving improved health and wellness outcomes for First Nations and Aboriginal peoples in the Vancouver Coastal region and will be upheld by the FNHA, Vancouver Coastal Regional Caucus. This will guide the development of this iRHWP and future Regional Health and Wellness Plans.

Figure 4: First Nations Perspective on Wellness

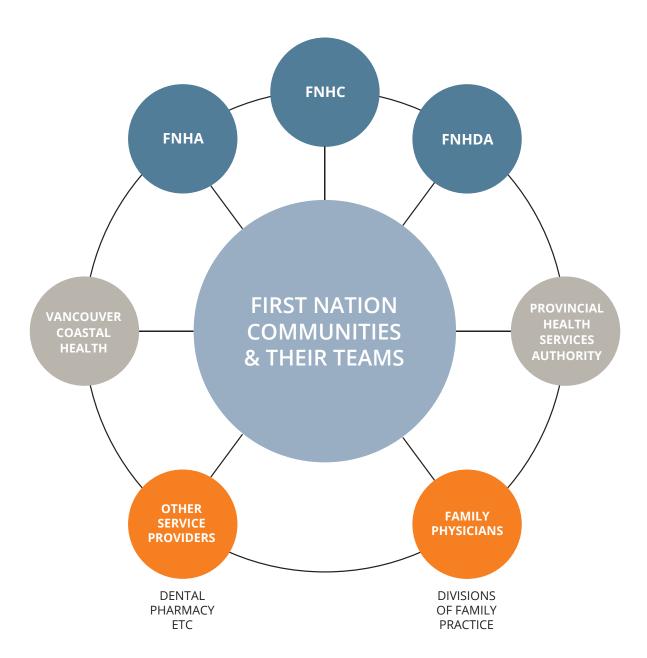


Partners in our Regional Health and Wellness Plan

PARTNER OVERVIEW

The following diagram identifies the key partners who are involved in the delivery of our iRHWP. Together we can use resources wisely to provide health care in a way that the community decides is best for them. This section provides a description of each of the key health partners:

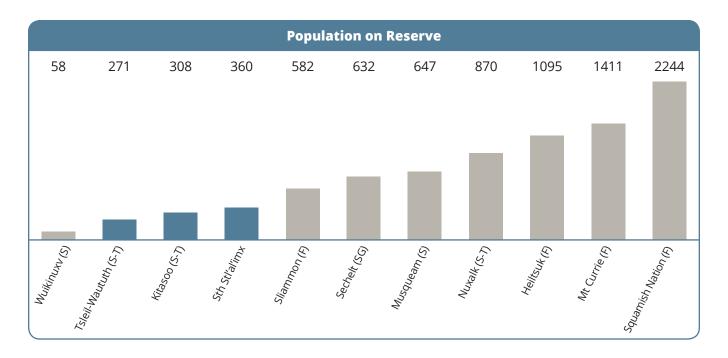
Figure 5: Partners in the Regional Health and Wellness Plan



FIRST NATIONS COMMUNITIES IN THE VANCOUVER COASTAL REGION

According to Aboriginal Affairs and Northern Development Canada (AANDC), there are a total of 8,478 First Nations people residing at-home/on-Reserve (2013) across 14 communities in the VC region, representing 34% of the total Aboriginal population (approximately 25,000). The communities are served by 11 First Nations health centres (please see pg. 37 for a map of Vancouver Coastal Region and location of First Nation communities).

Figure 6: Population on Reserve (AANDC March 2013)



There are 4 clusters of community size represented in Figure 5 (colour-coded in the graph):

• Population less than 100

1 community

• Population between 101 – 500

3 communities

• Population between 501 - 699

3 communities

• Populations between 700 – 2,244

4 communities



HEILTSUK NATION (BELLA BELLA)

The Heiltsuk Nation is a First Nations government in the Central Coast region of British Columbia, centered on Campbell Island, in the community of Waglisla (Bella Bella). The Heiltsuk people speak the Heiltsuk language. The Heiltsuk language is a dialect of the North Wakashan (Kwakiutlan) language Heiltsuk-Oowekyala. According to 2011 AANDC Band Affiliation data, there were 1,171 community members living at-home/on-reserve, and 1,119 members living away from home/off-reserve.

The Hailika'as Heiltsuk Health Centre (with its own health board) located onreserve, provides a variety of health services to the community, and is primarily funded through a Flexible Transfer Agreement with the FNHA (see Appendix B for description of contribution agreement types).



KITASOO/XAI'XAIS (KLEMTU)

The town of Klemtu is home to the Kitasoo/Xai'xais people. Two distinct tribal organizations live here: the Kitasoo (Tsimshian) who were originally from Kitasu Bay and the Xai'xais of Kynoc Inlet. The Kitasoo/Xaixais people are the only permanent residents within the traditional territories of this First Nation, and they are members of the Oweekeno-Kitasoo-Nuxalk Tribal Council. According to 2011 AANDC Band Affiliation data, there were 320 community members living at-home/on-reserve, and 192 members living away from home/off-reserve.

The Xai'xais Kitasoo Health Centre operates under a combined Set-Transitional Agreement with the FNHA and receives some services directly from FNHA Nursing and Environmental Health staff.



NUXALK (BELLA COOLA)

The Nuxalk Nation is located in and around what is known as Bella Coola, British Columbia. Current AANDC population estimates indicate a total Nuxalk population of 1,592 with 896 members living on the Nuxalk reserve in Bella Coola. However, according to traditional Nuxalk government, the true Nuxalk population is closer to 3,000. This number includes people of Nuxalk ancestry who are not registered or may be registered to another First Nations Band. Nuxalk Nation is a member of the Oweekeno-Kitasoo-Nuxalk Tribal Council.

The Nuxalk Health and Wellness Centre is part of the Nation's structure and currently in a Transitional Contribution Agreement with the FNHA although is in the process of moving towards a Flexible agreement.



WUIKINUXV - OWEKEENO (RIVERS INLET)

The traditional Wuikinuxy territory lies 300 miles northwest of Vancouver, and is only accessible by boat and float plane. The community is located on the banks of the Waanuky River, which connects Owikeno Lake to the head of Rivers Inlet. The nearest town is Port Hardy across the Queen Charlotte Strait. The Wuikinuxy Nation is a member of the Oweekeno-Kitasoo-Nuxalk Tribal Council. The Wuikinuxy Health Centre receives funding from Health Canada through a Set Contribution Agreement. There is no direct transport between Wuikinuxv and Bella Bella or Bella Coola



LIL'WAT (MOUNT CURRIE)

The Lil'wat Nation (Mount Currie) is a First Nations government located about 8km east of Pemberton, in the southern Coast Mountains region. Lil'wat Nation is a member of the Lower Stl'atl'imx Tribal Council. The first language of the Lil'wat, and other Interior Salish people, is Ucwalmicwts. The 2011 AANDC Band Affiliation data lists 1485 members living at-home/on-reserve, and 600 members away from home/off-Reserve.

The Pgusnalhcw Health Centre, located at-home/on-reserve in the Lil'wat Nation, provides a variety of health services to the community, and is funded through a Flexible Transfer Agreement with the FNHA.



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

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

The AANDC 2011 population data identified the following:

- N'Quatqua 107 members at-home/on-reserve and 107 away from home/ off-reserve;
- Samahquam 113 at-home/on-Reserve and 221 away from home/off-reserve;
- Skatin 132 at-home/on-reserve and 258 away from home/off-reserve; and
- Xa'xtsa 90 at-home/on-reserve and 161 away from home/off-reserve.

The Southern Stl'atl'imx Health Society (SSHS) provides some health services to the four communities to complement the services that each community provides itself. The Southern Stl'atl'imx Health Society currently receives FNHA funding through a Flexible Transfer Agreement.



SECHELT

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

The 2011 AANDC Band Affiliation data lists 658 members living at-home/onreserve, and 624 members away from home/off-reserve. The Sechelt Nation is in a self-governance arrangement, and does not receive Health Transfer funding from the FNHA since health resources come through their Self-Governance Agreement.



TLA'AMIN (SLIAMMON) - POWELL RIVER

The Tla'Amin Nation (Sliammon) is part of the Coast Salish Indigenous peoples inhabiting the western coast of BC, located north of Powell River. Traditional Tla'amin territory was along the northern part of the Sunshine Coast, extending along both sides of the Strait of Georgia. Current AANDC population estimates indicate a total Tla'Amin population of 990 with 584 members living at-home/ on-reserve. The Tla'Amin Community Health Centre currently receives funding from FNHA through a Flexible Contribution Agreement.



TSLEIL-WAUTUTH NATION

The Tsleil-Waututh Nation is located on the north shore of Burrard Inlet, and is surrounded by the city of North Vancouver. The AANDC 2011 population data for Tsleil-Waututh lists 287 members at-home/on-reserve and 210 away from home/off-reserve. Community members accesses services from North Shore physicians and VCH's Lions Gate Hospital (LGH) and community services.

The Tsleil-Waututh Community Health Centre is currently in the process of moving from a Set to a Transitional Transfer Agreement with the FNHA.



MUSQUEAM

The Musqueam traditional territory occupies what is now Vancouver and surrounding areas. The Musqueam Indian Reserve is located south of Marine Drive, near the mouth of the Fraser River, and this reserve represents a very small portion of their traditional territory. The most recent AANDC population estimates indicate a total Musqueam population of 1,270 members, with 756 members living at-home/on-reserve.

The Musqueam Community Health Centre receives funding from the FNHA through a Set Contribution Agreement and is currently moving towards a Flexible Transfer agreement.



SQUAMISH NATION

Skwxú7mesh Úxwumixw (Squamish Nation) community members are the descendants of the Coast Salish Aboriginal peoples who lived in the present day Greater Vancouver area, Gibson's landing and Squamish River watershed. Currently there are approximately 2,420 community members living at-home/ on-reserve, and 1,660 living away from home/off-reserve.

Yúustway Health Services provides service to Squamish Nation. As per the traditional name Yúustway (meaning "taking care of each other), this department strives to improve the health and wellness of Squamish Nation membership through the provision of community health services and the promotion and support for access to all health services. This is made possible through the Flexible Transfer Contribution Agreement with the FNHA and partnerships with Vancouver Coastal Health among others.

FIRST NATIONS HEALTH AUTHORITY

As part of the Tripartite Agreement, the FNHA plans, designs, manages, and funds the delivery of First Nations health programs and services in BC. These community-based services are largely focused on health promotion and disease prevention - such as:

- Primary Care Services
- Children, Youth and Maternal Health
- Mental Health and Addictions Programming
- Health and Wellness Planning
- Health Infrastructure and Human Resources
- · Environmental Health and Research
- First Nations Health Benefits
- eHealth Technology

Their work does not replace the role or services of the Ministry of Health and Regional Health Authorities. The FNHA collaborates, coordinates, and integrates respective health programs and services to achieve better health outcomes for BC First Nations.

FIRST NATIONS HEALTH COUNCIL (FNHC)

The 15 member FNHC provides political leadership for implementation of Tripartite commitments and supports health priorities for BC First Nations. According to the FNHC Terms of Reference 2010-2012:

- Serve as the advocacy voice of BC First Nations on health related matters;
- Support BC First Nations in achieving their health priorities, objectives and initiatives;
- Participate in Federal and Provincial government health policy and program planning process;
- Provide leadership in the implementation of the Transformative Change Accord: First Nations Health Plan, the First Nations Health Plan Memorandum of Understanding, and the Tripartite First Nations Health Plan (TFNHP); and,
- Provide direction and oversight for the health governance negotiations process pursuant to the British Columbia Tripartite First Nations Health Plan: Basis for a Framework Agreement on Health Governance;

The FNHC was established in 2007 by the First Nations Summit, Union of BC Indian Chiefs and Assembly of First Nations. Between 2008 and 2010 BC First Nations developed five Regional Health Caucuses, made up of leadership and health technicians from each of BC's 203 First Nations. The development of Caucuses and the call for a more direct community appointment process to led the FNHC to transition to regional representation in 2010. Today, each of the five Regional Health Caucuses appoints three representatives to the FNHC, through their own regionally determined process.

FIRST NATIONS HEALTH DIRECTORS ASSOCIATION (FNHDA)

The FNHDA was registered as a legal entity in April 2010. The FNHDA is a pillar in the new First Nations health governance arrangement. It acts as technical advisor to its partners, the Federal and Provincial governments (including the regional health authorities), the FNHC and the FNHA. They have a unique vantage point as managers responsible for delivering front-line health services for First Nations community members. The Board is made up of regional representatives from the five health authority regions in BC elected by registered members.

Strategic Priorities of the FNHDA are:

- Support First Nations Health Directors and mandated health organizations
- Provide technical input and advocacy to transform government systems
- Provide technical input and advocacy to government policy and legislation
- Work collaboratively with other First Nations Health Governance partners
- Operate a high functioning Association for members.

VANCOUVER COASTAL HEALTH (VCH)

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

VCH: ABORIGINAL HEALTH INITIATIVE PROGRAM

The Aboriginal Health Initiative Program (AHIP) is a grants program that supports health promotion projects with Aboriginal non-profit organizations and First Nations communities in the VCH region. AHIP provides capacity building and health promotion training opportunities. It provides funds to First Nation, Aboriginal, and Métis communities and organizations to support locally responsive health promotion and capacity building projects that fit within one of the five broad funding streams:

- 1. Chronic or infectious disease prevention
- 2. Early childhood development
- 3. Food security
- 4. Injury Prevention
- 5. Mental Wellness & Self-Esteem

VCH: ABORIGINAL PATIENT NAVIGATOR PROGRAM

The Aboriginal Patient Navigator program helps Aboriginal people access health services at VCH. Patient navigators provide referral, advocacy and support to patients to ensure access to appropriate health care and community services. Navigators provide a high level of support for Aboriginal and First Nations people being transferred from out-of-region to Vancouver-based hospitals including people from the northern and interior regions as well as those from rural and remote areas of the Vancouver Coastal region.

VCH: ABORIGINAL WELLNESS PROGRAM

The Aboriginal Wellness Program delivers culturally safe mental wellness & substance use programs for First Nations and Aboriginal peoples residing within the Lower Mainland. Their work is based on nine values commonly used across many First Nations and Aboriginal cultures - Vision/Wholeness; Spirit Centered; Respect/ Harmony; Kindness; Honesty/Integrity; Sharing; Strength; Bravery/Courage; Wisdom; and Respect/Humility. Services of the Aboriginal Wellness Program include: Adult counselling, outreach services, group cultural activities and cultural support and teachings.

PROVINCIAL HEALTH SERVICES AUTHORITY (PHSA)

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

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

The PHSA's Aboriginal Health team currently develops, manages and delivers the provincial "On-Line Indigenous Cultural Competency" (ICC) training (see www.culturalcompetency.ca) that aims to provide learning and knowledge development for health professionals and health workers across BC to improve the way in which they provide care for First Nations and Aboriginal peoples. The team also helps to coordinate support for the Aboriginal Patient Navigators in BC that work for each Health Authority.

DIVISIONS OF FAMILY PRACTICE AND PHYSICIANS

Divisions of Family Practice are community-based groups of family physicians working together to achieve common health care goals. Not all family physicians belong to Divisions. There are currently 33 Divisions of Family Practice in BC that encompass 129 communities. In the Vancouver Coastal region there are five Divisions of Family Practice:

- 1) Richmond Division of Family Practice (has 128 members)
- 2) Vancouver Division of Family Practice (has 750 physician members) and is building its relationship with Musqueam Indian Band
- 3) North Shore Division of Family Practice (has 170 members) and has an ongoing relationship with Squamish Nation and Tsleil-Waututh Nation

- 4) Sea-to-Sky & Sunshine Coast Division of Family Practice (has 48 members) and has ongoing relationships with Lil'Wat Nation, Southern Stl'atl'imx Nations, Squamish Nation and Sechelt Indian Band
- 5) Powell River Division of Family Practice (has 30 members) and has an ongoing relationship with Tla'Amin Health at Sliammon First Nation

A joint province-wide initiative between the Divisions, Government of BC and Doctors of BC is the roll out of "A GP for Me" (or GP4ME). The goal is to strengthen the health care system by supporting the relationship between patients and family doctors and enable people who want a family doctor to find one. Some of the Nations within the region are working with their local Division on the GP4ME initiative to help ensure all community members have a regular physician.

OTHER SERVICE PROVIDERS AND PARTNERS

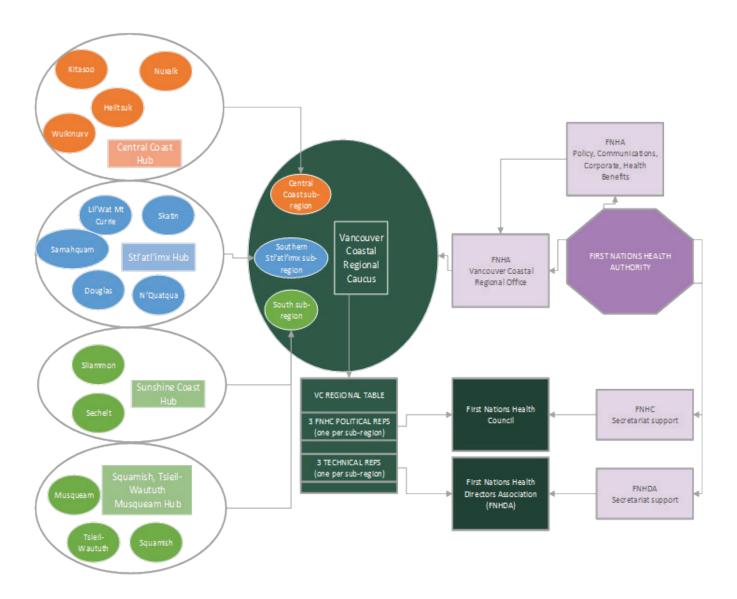
There are many other service providers who deliver all forms of health care for First Nation community members. Some are under contract arrangements with the Nations themselves, and some independently in towns and cities that community members access. These service providers include: dentists, pharmacists,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

There are also non-profit agencies that provide some services for the First Nations communities such as the BC Lung Association (smoking cessation); BC Cancer Society; BC Heart and Stroke Foundation; and BC Transport Safety Authority. They are key partners who offer support to community members where the current availability of services is limited.

FIRST NATIONS HEALTH GOVERNANCE STRUCTURES

The following diagram aims to describe the First Nations health governance structure that exists in the region:

Figure 7: First Nations health governance structure(s)



This diagram highlights the 14 Nations and the 4 engagement team collaborations that they operate within and how the Nations are organized into the three sub-regions of the VC region. Members of the three subregions each appoint a political lead to sit on the 15-member First Nations Health Council. Health Directors who are members of the FNHDA elect their representatives to sit on the 15-member FNHDA Board. The FNHA Regional Office for the Vancouver Coastal region provides technical support advice for the hubs, Caucus and Regional Table, with the support of other departments within the FNHA as shown on the diagram. The FNHA also hosts the Secretariat offices for the FNHC and the FNHDA.

LOCAL COMMUNITY COLLABORATION

Following the formation of FNHA Regional offices in 2013, and agreement to make community engagement more cost-effective, it was determined by some Nations that Community Engagement Hub's would no longer be funded through communities. Instead the FNHA Regional Office employed Community Engagement Coordinators (CECs) to support communities to communicate, collaborate and plan, unless a Nation decided to retain their own coordinator. There are currently three sub-regions in the Vancouver Coastal Region:

- 1. Central Coast Sub-Region: Heiltsuk, Nuxalk, Wuikinuxw [Oweekeno], and Kitasoo. The central coast aligns its' work with the Central Coast Health and Wellness Charter and Health and Wellness Plan.
- 2. Southern Sub-Region: Tsleil-Waututh Nation, Squamish Nation, Musqueam (retaining their own Community Engagement Coordinator as at the time of publishing this plan) and the Sunshine Coast communities Tla'amin, and Sechelt
- 3. Lower Stl'Atl'Imx Sub-Region: Xa'Xtsa, N'Quatqua, Samahquam, Skatin, Lil'wat/Mt. Currie

Whether coordination is conducted by the FNHA Regional Office or by the sub-region itself, communication, collaboration and planning will remain an important part of the role. It is through collaboration that the FNHA and the Regional Office will facilitate its engagement with communities on plans and priorities.

Please Note: Ulkatcho at Anahim Lake is officially in the VC region but receives the majority of its services from the Interior region. Ulkatcho has been included in the Interior Region Health and Wellness Plan.

VANCOUVER COASTAL CAUCUS

The Vancouver Coastal Caucus (VCC) is represented by the First Nation communities within the Vancouver Coastal Region. The region is divided into three sub-regions, including the 14 Nations: South, Southern Stl'atl'imx, and Central Coast.

Figure 8: Vancouver Coastal Caucus Sub-Regions

SOL	SOUTH		SOUTHERN STL'ATL'IMX		CENTRAL COAST	
Nation	Location	Nation	Location	Nation	Location	
Squamish	West Vancouver and Squamish	Lil'wat	Mount Currie	Heiltsuk	Bella Bella	
Tsleil-Waututh	North Vancouver	N'Quatqua	D'Arcy	Nuxalk	Bella Coola	
Musqueam	Vancouver	Skátin	Skookumchuck Hot Springs	Kitasoo/Xai'xais	Klemtu	
Sechelt	Sechelt	Samahquam	Lillooet River	Wuikinuxv	Rivers Inlet	
Tla'amin	Powell River	Xaʻxtsa (Douglas)	Port Douglas	Ulkatcho at Anahim Lake is officially in the VC region but receives the majority of its services from the Interior region. Ulkatcho has been included in the Inte- rior region Health and Wellness Plan.		

The VCC has created space for every Vancouver Coastal First Nation to appoint one political representative and one technical representative, for a total of 28 representatives. Each First Nation Band or Tribal Council selects its own political and technical representatives using its own processes. The VCC meets approximately twice per year usually in the spring and the fall. Three VCC representatives are appointed to the First Nations Health Council by their respective sub-regions to sit with the 3 representatives from each of the other 4 health regions.

VANCOUVER COASTAL REGIONAL TABLE

To engage in relationship-building with VCH, the Caucus established the Vancouver Coastal Regional Table. Comprised of six representatives - three regional FNHC Representatives and three technical representatives (Health Directors), the Regional Table carries out the directions of the VCC, including developing and implementing agreements and arrangements with VCH.

The members of the Regional Table may still require further engagement with the communities as they carry out the Caucus directives, and they report at each Caucus on progress made on directives from the previous Caucus meeting.

FIRST NATIONS PARTNERSHIP WITH FNHA AND VANCOUVER COASTAL HEALTH

The Vancouver Coastal Partnership Accord was signed in May 2012 by the FNHC VCC (political members), the FNHA and VCH. The Partnership Accord calls for improvements in service delivery through more collaboration between VCH, First Nations communities they serve, the FNHC, FNHA, and the region's First Nations Health Centres. The Accord also directs cooperative work with community health leaders to develop more culturally appropriate health strategies.

It sets out a vision to increase the influence of First Nations regarding health services in the Vancouver Coastal region with the goal of attaining shared decision-making. The Partnership Accord provides for the establishment of two key committees:

- Aboriginal Health Steering Committee (AHSC) and
- Aboriginal Health Operations Council (AHOC).

ABORIGINAL HEALTH STEERING COMMITTEE (AHSC)

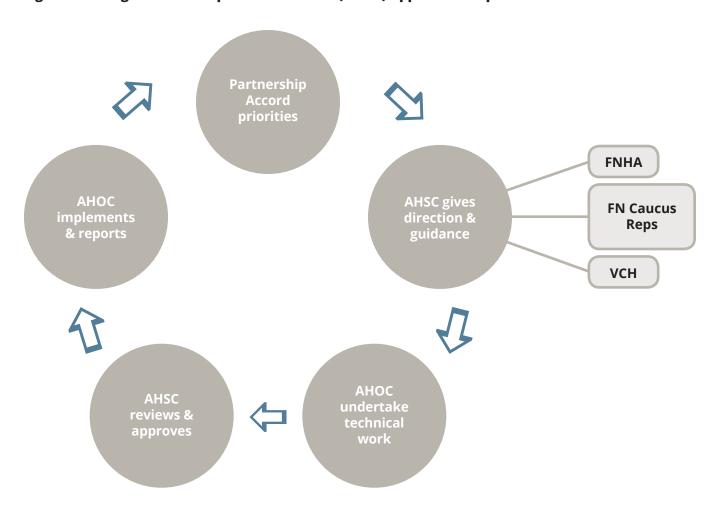
The AHSC oversees the implementation of this Partnership Accord and serves as a senior and influential forum for partnership, collaboration, as well as joint efforts on First Nations and Aboriginal health priorities, policies, budgets, programs and services in the Vancouver Coastal region. The AHSC membership includes:

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

ABORIGINAL HEALTH OPERATIONS COUNCIL (AHOC)

The AHOC includes a variety of VCH Service / Program Managers as well as three Health Directors (technical leads) and FNHA Regional Office representatives. The Council meets quarterly to undertake the technical work directed by the Partnership Accord and the VCC, and to preview and endorse initiatives that go to the Aboriginal Health Steering Committee for approval. Once the AHSC approves any AHOC recommendations, then AHOC can begin implementation within VCH and FNHA and with communities (Figure 9).

Figure 9: Aboriginal Health Operations Council (AHOC) Approval & Implementation Process



The current **Partnership Accord** outlines seven key priorities for the partners

- 1. Regional Aboriginal Health and Wellness Plan (this document)
- 2. Joint Community Engagement Strategy (completed and approved by AHSC January 2013)
- 3. Urban Aboriginal Health and Wellness Strategy Advisory Framework (in progress)
- 4. First Nations and Aboriginal Culturally Competent and Responsive Stategic Framework (in progress)
- 5. Cultural Competency training (ongoing ICC training and cultural days on-reserve)
- 6. Annual Progress Report and Review of Performance Indicators (to be developed)
- 7. Communications, Collaboration, and Engagement.

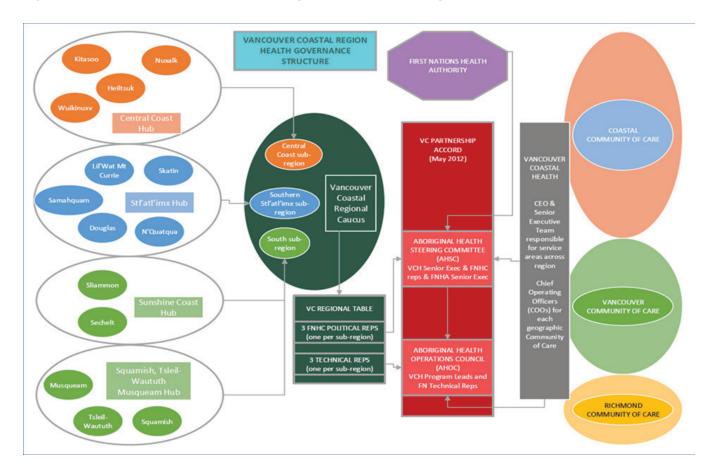


Figure 10: Vancouver Coastal Partnership Accord Relationship

JOINT COMMUNITY ENGAGEMENT STRATEGY

Completed on January 17, 2013, the Joint Community Engagement Strategy was developed by VCC, FNHA, and VCH. The partners agreed to adapt their processes, tools or goals to provide a common understanding in conducting joint community engagement with First Nations communities. The partners agreed that community engagement and development has a direct benefit to the health care system. It enables the system to design programs more closely tailored to the needs of First Nations and Aboriginal community members. The partners recognized and acknowledged that each partner consults or engages with First Nations and Aboriginal communities and wanted to coordinate efforts in order to not overburden First Nations and Aboriginal communities.

URBAN ABORIGINAL HEALTH STRATEGY ADVISORY FRAMEWORK

In December 2012, representatives from the FNHC, FNHA and VCH organized a meeting with urban First Nations and Aboriginal Health stakeholders to begin work on a strategy for urban health services in the region. Since that time a review of primary health care services for urban First Nations and Aboriginal people in the greater Vancouver area (including North Shore and Richmond) and a literature review on health status and access to care has taken place.

In order to move forward with the strategy, a working group comprised of FNHA and VCH representatives is taking the lead, however the project will be overseen by an Advisory Committee made up of key stakeholders in urban First Nations and Aboriginal health in Vancouver. The working group has drafted a project charter for the development of an urban strategy and is pulling together an Advisory Committee of urban stakeholders in order to guide the engagement process.

FIRST NATIONS AND ABORIGINAL CULTURALLY COMPETENT AND RESPONSIVE FRAMEWORK (CCRF)

As part of the Transformative Change Accord (2006), and a continuation of the work accomplished by VCH Aboriginal Health and Strategic Initiatives, the VCC, FNHA and VCH committed to develop, implement and evaluate First Nations and Aboriginal cultural competency training to VCH executive, board, staff and contractors and to jointly develop a First Nations and VCH Aboriginal Cultural Responsiveness Strategy. The overarching focus of this strategic framework is to increase cultural competency of all VCH staff and organizational structures and processes while building avenues to incorporate First Nations and Aboriginal perspectives of health.

In March 2013, A Cultural Competency and Responsive Framework (CCRF) Working Group was struck, which includes FNHA and VCH staff members from a wide cross-section of the organizations. This working group has now developed a draft set of indicators and goals which the implementation of the CCRF is aimed at achieving. This includes measures for governance and management, service delivery and quality improvement. In 2014 and beyond the working group will finalize the Indicator Framework with stakeholders and seek approval to the final indicators. These will provide a valuable input to the Implementation Plan for implementing changes and improvements over the next 5 – 10 years.

FIRST NATIONS RELATIONSHIPS WITH LOCAL PARTNERS

As well as the formal relationships among the 14 First Nations (engagement teams, sub-regions, VCC, Regional table) and the committees created by the Partnership Accord (AHSC and AHOC), the First Nations in the region also have their own localized relationships with their health partners.

INTEGRATED PRIMARY AND COMMUNITY CARE (IPCC) TABLES

VCH has been implementing the provincial initiative for "Integrated Primary and Community Care (IPCC)" which seeks to build an 'integrated' system of primary and community care, in which health care providers in the community work together in teams to support patients. This is designed to create an effective continuum of care between community-based and hospital-based services for the local community. The IPCC tables meet regularly in the following areas and include First Nations Health Directors, VCH service leads and physician representatives:

- Pemberton (including 5 First Nations communities)
- North Shore (including 2 First Nations communities)
- Powell River (including 1 First Nations community)
- Squamish Valley (including the northern community of Squamish Nation)

Some of the issues that IPCC tables address include: discharge planning challenges (discharging community members from hospital back to community); improving knowledge of each other's services and Telehealth implementation.

HOME HEALTH REDESIGN

Home Health is a key service accessed by First Nations and Aboriginal peoples and is usually provided when people are discharged from hospital and need care provided in the home. However, not all Home Health services are provided to patients following discharge from hospital. Sometimes clients are referred for Home Health by their physician. This program includes:

- Assessment and Case Management
- Rehabilitation (dieticians, physiotherapy, occupational therapy)
- Personal Care
- Nursing services (e.g. wound care)
- Palliative (end of life) care
- Medication Reviews
- Medical Supplies (e.g. continence supplies) and equipment (e.g. wheelchairs)

The FNHA Home and Community Care (HCC) program inherited from Health Canada also funds some First Nations communities to provide aspects of Home Health such as HCC Nursing, wound care, and personal care through Personal Care Workers or Home Support Workers. VCH is currently re-designing the Home Health program and engaging with First Nations so services are well connected between VCH and on-Reserve services and that Nations know who to contact.

NURSE PRACTITIONERS (THE NP4BC INITIATIVE)

The Nurse Practitioners for British Columbia (NP4BC) initiative funded by the Ministry of Health and FNHA supports the optimized use of Nurse Practitioner (NP) skills and competencies for primary health care by providing opportunities for NPs to be utilized as independent health practitioners. Through funding from the provincial government, a total of 27 new NP positions were allocated to the Vancouver Coastal Region since 2012. VCH supported several First Nations communities to develop their proposals for the NP4BC program and now NP positions have been approved for:

- Pemberton (including Mt Currie and Southern Stl'atl'imx) operational
- Tla'amin operational
- Nuxalk recruiting
- Central Coast Heiltsuk, Wuikinuxv and Kitasoo recruiting
- North Shore includes Squamish Nation and Tsleil-Waututh operational
- Urban Native Youth Association (UNYA) recruiting
- A decision is pending for Musqueam Indian Band at the time of writing this plan.

ROLLOUT OF HIV/AIDS "HOPE TO HEALTH" INITIATIVE

FNHA, VCH, Providence Health and the BCCDC are partnering to develop and implement "Hope to Health" for the 14 First Nation communities in the Vancouver Coastal region. The VCH HIV team is currently supporting First Nation communities to address HIV/AIDS through strengthening prevention, testing, care and treatment services.

TELEHEALTH

Telehealth is the use of communication technologies, such as videoconferencing, to deliver health, wellness and educational services from a distance (e.g. tele-psychiatry). Telehealth technology is now in place in several First Nation communities in the Vancouver Coastal region including Southern Stl'atl'imx, Heiltsuk and Tla'amin. As broadband improvements are made to strengthen the telecommunication lines into rural and remote areas, other communities including Nuxalk, Kitasoo and Mt. Currie will be brought online. Some have already received the equipment. The opportunities for using Telehealth services include: oncology, mental health/ psychiatry, maternal/fetal medicine, medical genetics, orthopedics, pharmacy, thoracic surgery, trauma, and wound care, as well as special services for children.

Regional Priorities, Goals, and Actions

Community engagement to date has revealed several key priority areas which have been organized in alignment with the Seven Directives to ensure we can report on implementation at a regional and provincial level. Feedback from a variety of sources was reviewed for this plan (see Appendix C). Health Priorities and information have been collected from these meetings, as well as from meetings with VCH Directors.

SWOT ANALYSIS - STARTING POINT FOR OUR PLAN

STRENGTHS

- Small number of Nations in region ability to unify quickly
- Baseline information (PHC mapping, MWSU engagement, prior engagement as summarized in Appendix C)
- IPCC tables and relationships
- FNHA & VCH highly engaged with communities and highly motivated to make a difference - committed leadership
- Cultural Competency Framework done
- · Engagement Framework done
- Growing capacity of VCH & FNHA to support
- Willingness of physicians / Divisions to work with First Nations communities
- Increased number of NPs in communities

CHALLENGES

- Lack of good data no EMRs in Health Centers and no Aboriginal Identifier being routinely collected by VCH
- · Remoteness of some communities and lack of access to basic services - weather dependent
- Health issues facing community members are often complex and acute
- · Meeting needs for IRS Survivors and intergenerational trauma in a sustainable way
- Policies not meeting needs (e.g. patient travel)
- Three urban Nations without Health Centers to bring services on-Reserve
- Complexity of health system makes it difficult to inform lay community members and political leaders in a concise yet detailed way so they can make an informed contribution

OPPORTUNITIES

- Consistent EMRs across the region
- Small group able to work together easier to develop regional consensus
- Cultural competency improvements
- Providing healthcare to non-First Nations, non-BC First Nations / Aboriginal clients and for off-Reserve members – looking for other revenue streams
- Collaborating with neighboring communities (through hub collaborations) to bring in more services by working together
- Transforming expenditure on Patient Travel and other FN health benefits
- Aligning Urban Health services with aspirations of urban-based Nations

THREATS

- Social networking creates pressures for youth particularly (isolates people)
- Funding often insufficient to meet demand never enough money to do what is needed
- Continued migration of population off-Reserve to urban areas may affect funding and viability of services on-Reserve



LONG TERM GOALS FOR VC REGION FIRST NATIONS HEALTH

VISION:

- 1. All of the VC region communities have a Community Health Plan and are funded at maximum level by FNHA for achievement of their plans.
- 2. Services delivered by FNHA, VCH, Physicians and other partners are high quality, culturally competent and responsive and culturally safe for our community members, and we have positive respectful relationships with each other as service providers.
- 3. Our Regional Health and Wellness Plan informs FNHA and VCH plans, service improvements and investments
- 4. All First Nations Health Centres are viable efficient operations, connected electronically and able to collect consistent data on our service delivery to our communities, and impact of this on their health status.

DIRECTIVE 1: COMMUNITY-DRIVEN NATION-BASED

- This principle is overarching and foundational to the entire health governance arrangement.
- Program, service and policy development must be informed and driven by the grassroots level.
- First Nations community health agreements and programs must be protected and enhanced.
- Autonomy and authority of First Nations will not be compromised.

CONTEXT

In the VC region, the 14 First Nations communities are at different stages in the Health Transfer process. The goal is that all communities have the greatest level of control and flexibility with managing, designing and delivering their own health programs. Communities that are not yet in Flexible Transfer need to be supported to reach this goal. Once all 14 Nations are at the same stage – they will be fully empowered to drive their own program design and delivery for their Nations.

• Set / Transitional: Musqueam, Tsleil-Waututh, Nuxalk, Wuikinuxv, Kitasoo

• Flexible Transfer: Heiltsuk, Squamish, Sliammon (in Treaty process currently), Southern Stl'atl'imx, Lil'Wat

Self-Governing: Sechelt

Even when communities develop their Community Health Plan these plans are required to meet the criteria of the former Health Canada health transfer process. The Health Transfer Contribution Agreement process of Set, Transitional and Flexible agreements is also inherited from Health Canada. It is our goal to transform the Community Health Plan and Contribution Agreement process so that they align better with the BC First Nations Perspective on Wellness.

Finally, there is a need for the voice of First Nations to be expressed, heard and documented at a grassroots level so that these voices contribute to the operation of the Nation's health service, as well as the services of health partners. The voice needs to influence:

- Collaborations with the engagement team and what the sub-regional communities work together on
- Sub-regional discussions and Regional Caucus decisions
- Any initiatives affecting service improvements for the delivery of care to communities
- Regional Health and Wellness Plans

We have many structures in place to hear the community voice and to bring the information to the various health tables – we need to be sure that the process loops back to communities to keep informing members about where their information has gone, what has happened and what decisions have been made.

Directive 1: **Goal One**

All communities in the VC region have a 5-10 year Community Health Plan (and are in Flexible Transfer)

ACTION1.1: Priorities in the Community Health Plans inform the Regional Health and Wellness Plan *

ACTION1.2: FNHA and communities work together to ensure Community Health Plans and Health Transfer Agreements focus on Wellness *

ACTION1.3: Musqueam, Tsleil-Waututh, Nuxalk, Kitasoo and Wulkinuxv are supported by the FNHA to move to Flexible Transfer Agreements

Directive 1: Goal Two

All communities are supported to engage locally to contribute to sub-regional and regional planning and decisions

ACTION1.4: All communities are supported to engage locally in IPCC tables and engagement team collaborations

ACTION1.5: An ongoing process exists for all communities to participate in sub-regional and regional planning and decisions

ACTION1.6: Report back processes are established to validate implementation of decisions

Directive 1: **Goal Three**

Significant regional resources are utilized to advance and execute priorities in the Regional Health and Wellness Plan (RHWP)

ACTION1.7: Communities have increased flexibility and control over their Health Transfer funding including patient travel in order to deliver their Community Health **Plans**

ACTION1.8: FNHA regionally-based and VCH Aboriginal dedicated financial and human resources are directed towards achieving the priorities of the RHWP. Central FNHA resources are leveraged for the same purpose

DIRECTIVE 2: INCREASE FIRST NATIONS DECISION-MAKING AND CONTROL

- Increase First Nations influence in health program and service philosophy, design and delivery at the local, regional, provincial, national and international levels.
- Develop a wellness approach to health including prioritizing health promotion and disease and injury prevention.
- Implement greater local control over community-level health services.
- Involve First Nations in federal and provincial decision-making about health services for First Nations at the highest levels.
- Increase community-level flexibility in spending decisions to meet their own needs and priorities.
- Implement the OCAP (ownership, control, access and possession) principle regarding First Nations health data, including leading First Nations health reporting.
- Recognize the authority of individual BC First Nations in their governance of health services in their communities and devolve the delivery of programs to local and regional levels as much as possible and when appropriate and feasible.
- FNHA and VCH are responsible for orienting and training new leadership on community partners, initiatives, and agreements. This will ensure the continuity and delivery programs and services at the community level.

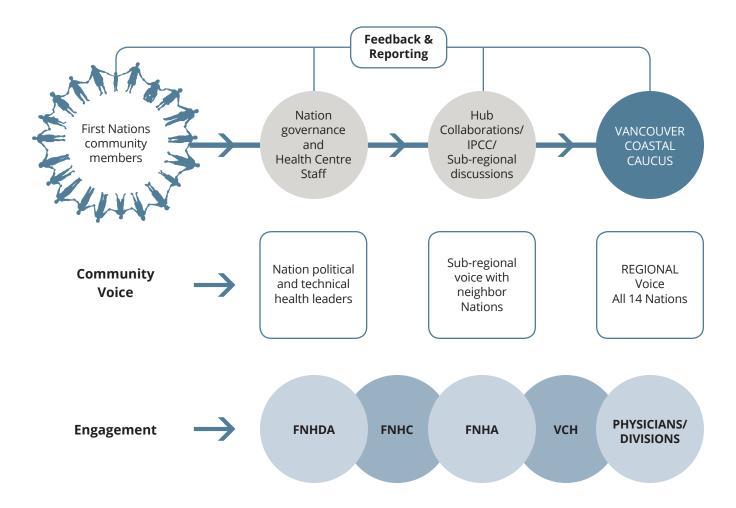
CONTEXT

First Nations seek to make informed decisions about their health care and health services. The "Engagement and Approval Pathway" (see Figure 11) developed by the FNHC sets out a process to gather First Nations input and guidance for strategic-level decisions of the First Nations health governance and health transformation. In 2013 the FNHA Vancouver Coastal Caucus and VCH developed a Community Engagement Framework which adapted the pathway.

REGIONAL ENGAGEMENT PROCESS

The FNHA Regional Office supports regional efforts in communication, collaboration, and planning, and serves as a main contact for information between FNHC, FNHA, and communities. The FNHA Regional Office partners with VCH to streamline and integrate community engagement efforts (see Figure 11).

Figure 11: Communications & Engagement Pathway



The Joint FNHA / VCH Community Engagement Framework (Jan, 2013) outlines the agreed roles and processes summarized below:

- Nation Political and Technical leaders gather information from their communities for their own Community Health Plans and priority list of issues and transformative ideas. They bring these ideas and issues to the VCC
- In between Caucus meetings, First Nations or groups of First Nations share information on current initiatives or issues with the Community Engagement Coordinator
- The VCC forum of all 14 Nations discusses and sets priorities for action at Caucus meetings. The Regional Health and Wellness Plan is updated along with the annual work plan
- The FNHA Regional Office meets with Community Engagement Coordinators and VCH Aboriginal Health and Community Engagement staff to plan community engagement processes on priorities outlined by the Caucus and the Regional Health and Wellness Plan
- Community Engagement Coordinators facilitate the engagement processes with support of FNHA and VCH Aboriginal / Service Leaders as needed, gather information and analyze results.
- Results are rolled up into a form of "consensus" document (draft Regional Action Plan) and taken back out to communities by the engagement team to validate findings and affirm or amend proposed actions

- Recommended actions are presented to Caucus for approval to implement based on the community engagement process, and to assign necessary resources
- FNHA and VCH implement approved actions from the Caucus meeting approval

As well as engagement on specific issues for the Regional Health and Wellness Plan, appointees from the Caucus (three political leads and three technical leads) sit on the Regional Table, as well as the AHSC and AHOC Committees in partnership with VCH.

PROVINCIAL ENGAGEMENT PROCESS

The Vancouver Coastal Caucus influences the work undertaken at the provincial level in a number of ways. The Caucus appoints three representatives to the FNHC. The FNHC provides political health leadership working with Tripartite partners the provincial Ministry of Health, Health Authorities and Health Canada at the provincial table "Tripartite Committee on First Nations Health". The three VC region FNHCs members take their direction from the VCC and the Regional Health and Wellness Plan.

COMMUNICATIONS

As well as community engagement on specific issues, there is a need for ongoing communications and information to flow from communities to the FNHA and VCH, and vice versa.

Directive 2: **Goal One**

As part of an effective engagement strategy, the FNHA VC Regional Office, FNHC and VCH will coordinate all First Nations community enegagement effort.

- ACTION 2.1: The joint FNHA & VCH Community Engagement Strategy will be annually reviewed in order to adapt processes, tools and goals in order to ensure there is a shared understanding with First Nations communities. The strategy will be aligned with Caucus decisions & Community Engagement Coordination efforts.
- ACTION 2.2: Engagement costs will be shared wherever possible when working with communities.
- ACTION 2.3: FNHA engagement teams, other regional and VCH engagement personnel shall meet routinely to maintain operational collaboration and support engagement efforts.

Directive 2: **Goal Two**

Regional and Provincial tables, committees and meetings will be coordinated to support effective engagement with Health Directors, political and technical representatives who sit at these tables.

- ACTION 2.4: FNHA Regional Office will maintain a calendar of 'committee' meetings (Regional Table, VC Caucus, FHHDA, FNHC, Engagement team, AHSC, AHOC) to ensure engagement efforts do not clash with these and over-burden First Nation representatives.
- **ACTION 2.5:** First Nation representatives will be supported to provide feedback and accountability to all 14 communities through regular communication to all Caucus politcal and technical leads and engagement staff.

Directive 2: Goal Three

FNHA Regional Office and VCH shall maintain current information for communities in an accessible and useable medium

- **ACTION 2.6:** FNHA/FNHC/FNHDA website/nresletters and VCH website/newsletters maintain current information on First Nations & Aboriginal health activity in the VC region.
- ACTION 2.7: FNHA Regional Office and VCH shall produce an Annual Report of individual and joint achievements to keep communities informed.
- **ACTION 2.8:** FNHA will develop a Communications strategy in order to ensure effective ongoing communication in the VC region

DIRECTIVE 3: IMPROVE SERVICES

- Protect, incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into all health programs and services that serve BC First Nations.
- Improve and revitalize the Health Benefits program.
- · Increase access to primary care, physicians, nurses, dental care and other allied health care by First Nations communities.
- Through the creation of a First Nations Health Authority and supporting a First Nations population health approach, First Nations will work collectively to improve all health services accessed by First Nations.
- Support health and wellness planning and the development of health program and service delivery models at local and regional levels

CONTEXT

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

First Nation:

The Nation itself provides some programs to the community with funding from the FNHA. If they have a Flexible Contribution Agreement they are managing and delivering the programs according to their own perspectives although some elements must be mandatorily provided and cannot be ceased or changed by the Nation (e.g. communicable disease prevention). Programs delivered may include maternal / child health programs; alcohol and drug programs; some home and community care;

FNHA:

Some communities (Kitasoo and Nuxalk) have not assumed full transfer of functions from the FNHA so the FNHA employed staff continue to provide some services on-Reserve through Nurses and Environmental Health Officers. Find out the full scope of FNHA services at: www.fnha.ca/what-we-do.

VCH:

VCH provides some services on-Reserve but most are provided in the general community (e.g. at a local health centre) or in a hospital. These may include acute / surgical care; primary care; home health; mental health and addictions (e.g. psychiatric units, detox, and addiction beds); public health programs; specialist services.

Health

Practitioners: Physicians provide a range of medical and clinical services for community members. Often these are accessed by community members in the nearest township but some physicians

do travel to communities to provide care in clinics and homes (e.g. fly-in Doctor for Southern Stl'atl'imx communities from Pemberton or boat-in Doctor to Kitasoo from Bella Bella). Community members are covered by MSP to access these services. More communities now have Nurse Practitioners who operate in the First Nations health centers even though they are formally VCH employees (e.g. Tla'Amin). Members also access dentists, optometrists, pharmacy and other practitioners for their health needs, and sometimes these costs are supported by

the FNHA First Nations Health Benefits program.

Birthing: Some communities in the VC region do not have local birthing / maternity services (e.g. central

> coast) so community members are required to be flown to Vancouver or elsewhere to have their babies. Most times there is a need to support this with Patient Travel funding from the First Nations Health Benefits program which may either be managed by the Nation or by the

FNHA.

Specialists: Most specialty care is available in hospitals and often community members have to travel to

specialist appointments or for surgery or to see specialists for dental, eye problems, kidney and liver problems, cancer / oncology etc. Some of these specialized services are delivered by

PHSA rather than VCH.

Figure 12: Health Service Delivery for First Nations communities



CURRENT ACCESS TO SERVICES

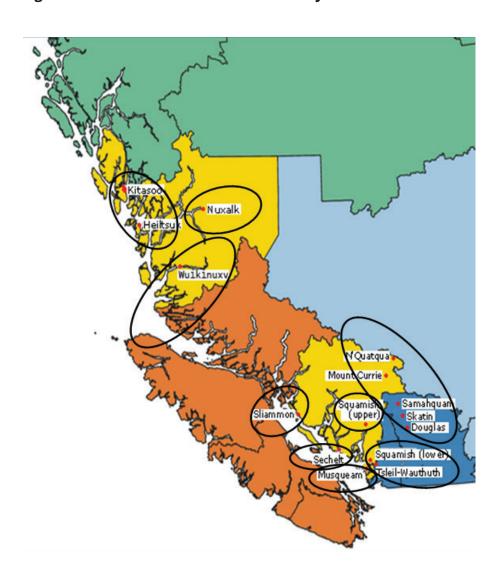
Even though the services may be available from the above providers – community members may have difficulty accessing them. This can be for a number of reasons – lack of or absence of services to meet all the community's needs; distance / transport challenges; cost; or cultural appropriateness of services.

Figure 13 displays the geographic location of the fourteen communities. The circles represent health service delivery areas where Nations share health service providers or have access to health care in neighboring communities. There are nine service delivery areas in the Vancouver Coastal region. Each service delivery area is centered on where First Nations community members access local physicians and hospital services, or secondary care services, as well as other community-based services from the provincial system. It is important to identify these service delivery areas because they determine where service improvements need to occur.

- Heiltsuk members access services from the Hailika'as Heiltsuk Health Centre, and from three physicians and various hospital and community services from Waglisla (including R. W. Large Hospital at Waglisla) operated by Vancouver Coastal Health (VCH)
- Kitasoo's nearest access to physicians, hospital, and community services is in Bella Bella, approximately 80km away by ferry.
- Wuikinuxv community members access services along Pacific Coastal flight routes, which include the Port Hardy and Port McNeil hospitals, in the Island Health authority region. The visiting physician is also based at Port McNeil.
- Tla'Amin accesses services from Powell River Township including VCH's hospital and community services, and local physician care from several practices in Powell River, some members travel by ferry to Comox for health services, since this is a regular BC Ferries route and because there are historical and cultural familial relationships.
- The Squamish Nation community in the upper Squamish Valley accesses physicians from 3 main practices in Squamish Township; from VCH's Sea to Sky community services, and from Squamish General Hospital (SGH). The Squamish Nation community on the North Shore of Burrard Inlet accesses health services from the Yúustway Health Services department on-Reserve, and from North Shore physicians, VCH's Lions Gate Hospital (LGH), and community services.
- Lil'wat community members also access services from VCH's Pemberton Health Centre; physicians at Pemberton and from VCH's Squamish General Hospital (SGH) and Sea to Sky community services which cover the Sea to Sky corridor
- Musqueam community members access services from VCH's Pacific Spirit physicians and community services, as well as other South Vancouver physician practices and from Vancouver-based hospitals operated by VCH and Providence Health.
- Sechelt community members access services from Sechelt Township, including VCH's St. Mary's Hospital and community services, and from six physician practices including sixteen physicians in the community.
- Nuxalk members accesses services from Bella Coola Hospital (including community services) operated by VCH. There are also three physicians who operate from this hospital. There is no regular transport route between Bella Coola and Bella Bella.
- SSHS Community members also access services from VCH's Pemberton Health Centre; physicians at Pemberton and from VCH's Squamish General Hospital (SGH) and Sea to Sky community services which cover the Sea to Sky corridor.

² VCH assumed management of these services on April 1st, 2014 from United Church Services





ACCESS TO COMMUNITY-BASED SERVICES

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

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

According to the findings of this review, the Health Directors identified that communities had good access to around 2/3 (68%) of the services that should be available. The most accessible services were Family Health Services (child health, women's health etc.) followed by Home and Community Care and Health Practitioners. Health Directors identified services that were available but would benefit from aspects of quality improvement (average of 19%). The areas needing most quality improvement were in the availability of Traditional, Cultural and Spiritual Wellness supports (e.g. elders, healers, language, cultural activities) and Mental Wellness and Substance Use services. The majority of quality improvements identified include for example:

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

ACCESS TO SPECIALIST / HOSPITAL SERVICES

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

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

IDEAS FOR SERVICE IMPROVEMENT

First Nations in the VC region have already done a considerable amount of work to identify their own priorities prior to this plan being completed, and to recommend ways to improve services.

³ VCH report "Availability and levels of access to primary health care services in the 14 first nations communities (on-reserve), Vancouver Coastal Region, June 13, 2013"

COMMUNITY HEALTH PLANS

Community health plans often identify priorities through community member health surveys. According to a review of Community Health Plans inherited from Health Canada (FNIHB) the following health and wellness priority areas and needs were most often mentioned (please see footnote for caveats regarding this information):

- 1. Mental Wellness and Substance Use (100%)
- 2. Youth Health (86%)
- 3. Lifestyles Factors (71%)
- 4. Health Promotion (71%)
- 5. Child Health (71%)

VANCOUVER COASTAL CAUCUS AND OTHER ENGAGEMENT MEETINGS 2010 - 2013

First Nations have long-expressed priorities for health at various Vancouver Coastal meetings. There is a strong alignment between the gaps identified by Health Directors and those of Chiefs, Health Managers and staff over the years.

Mental Wellness and Substance Use arose as the top priority at the Aboriginal Conversation on Health in the VC region, and this is reinforced at the VCH / FNHC Implementation Forum. Most other issues related to Elder care, access to primary health care, mobile services, integration of traditional models of wellness are all reinforced in this work. Finally the views and perspectives of First Nations to incorporate traditional models and concepts of wellness including acknowledgement of the land, family, community and Nation (also discussed in the FNHA health and wellness model) are also a high priority.

PRIMARY HEALTH CARE ACCESS REVIEW JUNE 2013

Through the Primary Health Care review process Health Directors agreed on regional priorities that they wanted to address together:

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

Vancouver Coastal Health Directors also developed and co-signed a regional proposal to acquire and implement the Mustimuhw community EMR in all 11 Health Centers so that they could collect and report data consistently across the region, and develop joint strategies to health needs identified from this. That proposal was submitted to the FNHA later in 2013 and at the time of this plan being written a decision is still pending.

⁴ These priority areas are presented with the caveats that they represent qualitative themes and are not based on quantitative data. They do not necessarily reflect the priorities of the Vancouver Coastal Nations. The review only included those communities with Community Health Plans. These health plans were prepared in order to receive funding and may not represent all of a community's priorities in place.

Mental Wellness and Substance Use (MWSU) has been identified by previous engagements; the review of Community Health Plans; Caucus meetings and by the VCH Service Review as the number one priority for the region. Three priority areas pertaining to MWSU includes:

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

These three areas emerged as the main gaps and concerns for First Nations communities and Health Directors arising from the Primary Health Care access mapping project conducted with VCH. This focus was validated by the Regional Table members at a Working Group meeting.

The Regional Planning Forum was held on February 25th 2014 at Musqueam Indian Band Recreation Centre and attended by key stakeholders from the 14 First Nations communities (2 people funded per community of political / technical representatives); Vancouver Coastal Caucus, First Nations Health Council and Regional Table members; First Nations Health Authority staff from the Policy, Planning and Strategic Services unit (Regional Office; Policy and Planning; Community Engagement, Communications, Research and Knowledge Management); Vancouver Coastal Health staff (Aboriginal Health, Primary Health Care, Mental Health & Addictions services, Population Health) and Musqueam representatives as hosts and participants.

Key priorities identified from the Regional Forum validated the same community-based MWSU gaps and needs that had been indicated by Health Directors in the June 2013 Service Review. However participants identified additional needs in secondary / specialist MWSU services – especially for crisis / psychiatric / clinical services that could support the community-based MWSU services better.

During 2014/2015 the FNHA Regional Office and VCH will develop a draft Action Plan and work with Hub Coordinators / Regional Engagement Liaisons to take this draft Action Plan out to communities for validation before full implementation. In the meantime some of the excellent feedback from the Regional Forum is being used to help inform FNHA Regional Envelope investments available in 2014.

Directive 3: Goal One

FNHA, VCH and other health partners continue to work with First Nations communities to identify key health service prioities and to address service gaps

- ACTION 3.1: The MWSU Regional Action Plan will be implemented to address health service priorities and gaps identified by VC region (Feb 2014), including: Suicide prevention, intervention and postvention (PIP) strategies; cultural competency strategies; workforce development and capacity strategies.
- ACTION 3.2: Primary Health Care service gaps identified by Health Directors in June 2013 are prioritized for VCH and FNHA Regional Envelope funding.
- ACTION 3.3: Complete engagement on the MWSU Regional Action Plan and incorporate endorsed plan and resourcing into the Regional Health and Wellness Plan.
- ACTION 3.4: Injury prevention programs and services for First Nations communities are reviewed with Health Directors and a 'transformation plan' developed with FNHA and VCH support.
- ACTION 3.5: Health Directors and staff are supported to develop models of prevention/ wellness tha can be used for preventative health (smoking cessation, HIV/STI prevention, violence, alcohol and drug prevention etc) and incorporate cultural competency strategies and traditional healing.

Directive 3: Goal Two

Continue to improve the cultural competency and responsiveness of VCH health services delivered for First Nations & Aboriginal peoples as agreed in the FNHC, FNHA & VCH Partnership Accord and MWSU Action Plan.

- **ACTION 3.6:** A strategy is developed for trasfer of provincial Nurse Practitioner positions working in communities from VCH to First Nations to improve access to, and integration of medical/clinical care on-reserve.
- ACTION 3.7: VCH Board, management and staff continue to increase their First Nations and Aboriginal cultural competency through indigenous cultural competency (ICC) training, cultural days and site visits within communities.
- ACTION 3.8: FNHA, VC Caucus and VCH continue to finalize and implement the "VCH First Nations and Aboriginal Culturally Competent and Responsive Strategic Framework" Plan.

Directive 3: **Goal Three**

Complete and implement the Urban Vancouver Aboriginal Health Strategy advisory framework agreed in the FNHC, FNHA & VCH Partnership Accord.

ACTION 3.9: Urban Vancouver Aboriginal Health Strategy (UVAHS) advisory framework is completed in 2014-2015 and an implementation plan is endorsed by key stakeholders.

ACTION 3.10: Plan for engagement for urban/off-reserve engagement in other areas of the region outside of urban Vancouver to determine needs of other off-reserve Aboriginal populations.

Directive 3: Goal Four

FNHA works with First Nations to transform the First Natiuons Health Benefits (FNHB) program particularly with respect to their interests in improving access to primary and secondary care by community members,

ACTION 3.11: First Nations communities are given opportunities to manage and transform their Patient Travel budget and to reinvest savings into more health services for communities.

ACTION 3.12: Administrative processes/paperwork involved in accessing the FNHB are reviewed and streamlined to avoid this being a barrier to independent nservice providers accepting First Nations patients.

Directive 3: **Goal Five**

Barriers to access contiue to be addressed at local/sub-regional tables with Health partners (see also 3.7)

ACTION 3.13: VCH and FNHA continue to support First Nations Health Directors to participate in local relationships with Health partners (e.g. IPCC tables, engagement team meetings, Health Directors meetings) *

ACTION 3.14: Increase the number of and provide support to Aboriginal Patient Navigators in order to improve quality of services available to support and advocate for First Nations/Aboriginal patients using VCH hospitals and services.

ACTION 3.15: Access to specialist services through tele-health opportunities continue to be implemented with First Nations communities.

Directive 3: Goal Six

Service improvement initiatives have strong input and participation by First Nations Health Directors and their staff.

ACTION 3.16: First Nations are engaged on key service improvement initiatives (e.g. Hope to Health for HIV/AIDS; Home Health Re-design).

ACTION 3.17: First Nations Health Directors and staff are supported to work with Physicians and Divisions of Family Practice to ensure all community members have a regualr GP.

DIRECTIVE 4: FOSTER MEANINGFUL COLLABORATION AND PARTNERSHIP

- Collaborate with other First Nations and non-First Nations organizations and governments to address social and environmental determinants of First Nations health (e.g. poverty, water quality, housing, etc.).
- Partnerships are critical to our collective success. First Nations will create opportunities through working collaboratively with federal, provincial, and regional partners.
- Foster collaboration in research and reporting at all levels.
- · Support community engagement hubs.
- Enable relationship-building between First Nations and the regional health authorities and the First Nations Health Authority with the goal of aligning health care with First Nations priorities and community health plans where applicable.

CONTEXT

The Transformative Change Accord: First Nations Health Plan (2006) explains why partnerships and collaboration are important. The current multi-jurisdictional health care system for First Nations at times creates gaps, discontinuities and inadequacies in services. On the other side, programs are often developed independently by one or more of the provincial, federal or First Nations partners, so that well intentioned initiatives may create overlaps or duplication and hence inefficiencies. Partnerships are critical to our collective success. Thus, First Nations of BC provided clear instruction to "Foster Meaningful Collaboration and Partnerships".

This Directive is already being implemented in the VC region but is always open to further improvement and enhancement. As identified in a previous section of this plan, the key partners in this Regional Health and Wellness Plan are:

- 14 First Nations
- First Nations Health Authority with linkages to FNHC and FNHDA
- Vancouver Coastal Health
- Physicians and Divisions of Family Practice
- Other Health Practitioners (dentists, optometrists, pharmacists etc.)
- Provincial Health Services Authority (PHSA) agencies
- · Community-based non-profit organizations (e.g. Heart and Stroke Foundation; Aboriginal Sport Physical Activity and Recreation Partners Council)

Each Nation also has other 'departments' that operate in the community such as Child & Family Services; Corporate office; Environmental, Recreation & Facilities; Social Development; Treaty and Cultural teams; etc. It is important to acknowledge that First Nations Health Centres work across other departments within the Nation / Band as well as externally with the above partners. This consumes time and effort of Health Directors and their teams, so any external partnerships add to their workloads.

Generally to "give life" to the partnerships, VC First Nations political and technical leaders engage at different tables and Committees to foster collaboration and influence service improvements and resources for their communities. Because there are so many different "structures" it is vital that logistics of these partnership tables and committees are well planned so as not to over-burden communities. Generally the timeline for First Nations-specific and partnership engagement could be described as follows:

Figure 14: A General Annual Timeline for "Living the Partnerships"

GENERAL TIMING	FIRST NATIONS SPECIFIC HEALTH GOVERNANCE	PARTNERSHIP MEETINGS
April	 Spring VC Caucus meeting (14 FNs + FNHA + VCH) Review progress since last Caucus on Regional Health and Wellness Plan Set priorities for engagement on specific initiatives in the Regional Health and Wellness Plan (to determine FNHA Regional Office & Hub engagement work plan) 	
May – Sept (5 months)	 Community engagement on specific initiatives (e.g. MWSU Action Plan) via Hubs Bi-monthly Regional Table meetings to oversee implementation of Caucus directions Bi-monthly FNHDA meetings and ongoing FNHC meetings 	 Engagement on specific initiatives (e.g. Hope to Health, Urban Vancouver Aboriginal Health Strategy) AHOC / AHSC Committee & working group meetings Ongoing IPCC meetings in each service delivery area: FNs with VCH and Physicians
October	 Fall VC Caucus meeting: (14 FNs + FNHA + VCH) Review progress since last Caucus on Regional Health and Wellness Plan Set priorities for updating Regional Health and Wellness Plan including Regional Envelope investments for following fiscal year 	
November – March (5 months)	 Bi-monthly Regional Table meetings to oversee implementation of Caucus directions Bi-monthly FNHDA meetings and ongoing FNHC meetings 	 AHOC / AHSC Committee meetings Ongoing IPCC meetings in each service delivery area: FNs with VCH and Physicians

Directive 4: **Goal One**

Expand engagement with other agencies whose mandate impacts on the social determination of health.

ACTION 4.1: FNHA Regional Office and VCH work community engagement coordinators and other key partners share the priorities of the RHWP with other relevent agencies to seek their participation in its success (e.g. MCFD, AANDC, Police/Probation/Courts, BC Housing) *

Directive 4: **Goal Two**

In the spirit of the Partnership Accord principles, FNHA and VCH coordinate partnership tables/committees to ensure First Nations communities are not over-burdened

ACTION 4.2: Successful indicators for the Partnership Accord are identified and measureds in time to inform the review of the Accord in March 2015 *

ACTION 4.3: VC Caucus political and technical leads work with FNHA Regional Office & VCH to plan and conduct all VC Regional Caucus meetings efficiently and effectively around the joint Regional Health and Wellness Plan priorities.

ACTION 4.4: The Partnership Accord is reviewed and updated by AHSC by March 2015. *

Directive 4: Goal Three

Formalize service delivery arrangements for First Nations communities in the VC region who are served by other Health Authorities and physicians (and communities in other regions served by VCH) to prevent jurisdictional problems.

ACTION 4.5: Vancouver Island Health and VCH to formalize a transfer of services of communities served by VIHA to VBCH to improve delivery and access to health care. **

ACTION 4.6: First Nations will formalize health agreements with health authorities where needed.

Directive 4: Goal Four

The FNHA, VCH and PHSA will collaborate to address priorities identified by **First Nations.**

ACTION 4.7: The FNHA, VCH and PHSA will work together on improving access to the First Nations Health Benefits and the Aboriginal Patient Navigator Program.

DIRECTIVE 5: DEVELOP HUMAN AND ECONOMIC CAPACITY

- Develop current and future health professionals at all levels through a variety of education and training methods and opportunities.
- Result in opportunities to leverage additional funding and investment and services from federal and provincial sources for First Nations in BC.
- Result in economic opportunities to generate additional resources for First Nations health programs.

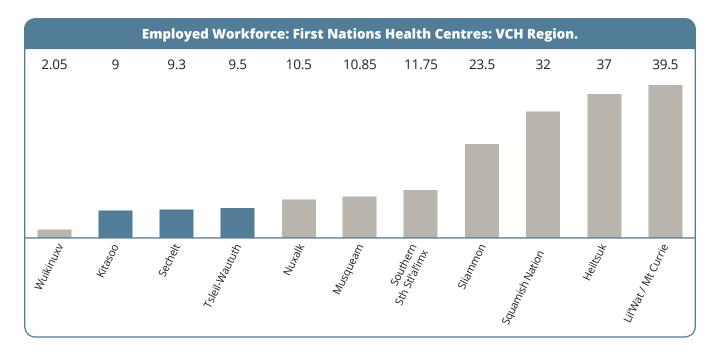
CONTEXT

The FNHA Health Careers Program was created in an effort to address the growing need for more BC First Nations and Aboriginal health professionals in the province. Consisting of two streams, *Health Career Promotion* and Health Career Support, the overall goal of the program is to support and increase the number of First Nations and Aboriginal students pursuing health education, and to assist with their transition into the health field as working professionals.

VCH has long had Aboriginal workforce development as a key priority for the organization, Investments in the Native Education College, various educational initiatives, sponsorships, research and knowledge exchanges have all been implemented towards this goal. VCH accepts many interns and student placements and encourages Aboriginal students or students interested in Aboriginal health to spend time with the Aboriginal Health Strategic Initiatives team and other departments within VCH.

Each community and Nation is different from the other in terms of needs and stages of human resource development. The Health Centres have all identified their current staffing (June 2013 Primary Health Care Mapping report) which identified:

Figure 15: Health Workforce on-Reserve in First Nations communities (June 2013)



This reveals that even though Squamish Nation is the largest community, it has a smaller workforce than two other communities who are less than half their size. This anomaly is due to Heiltsuk and Mount Currie being funded more to employ a higher level of staff due to their isolation from many other health services (See Appendix F: Dashboard Summary of VC Region Primary Health Care Access and Appendix G: Workforce Gaps Identified by Health Directors)

CURRENT GAPS IN HUMAN CAPACITY TO MEET HEALTH NEEDS

Workforce gaps have been identified by the 11 Health Directors (June 2013 Primary Health Care access review) and identified a need for almost 58.3 FTEs in communities. Over half or 52% (30.3 FTEs) of the 58.3 FTEs are in the Mental Wellness and Substance Use area:

Mental Wellness and Substance Use (30.3 FTEs or 52% of total need)

 8.5 FTE Clinical Counsellors; 7.5 FTE Clinical Psychologists; 8 FTE Social Workers; 3 FTE clinical counsellors; 3.3 FTE Suicide Response / Postvention Coordinators

Home and Community Care (10.4 FTEs or 18% of total need)

• 3.4 FTE HCC Registered Nurses; 4 FTE certified Personal Care Aides; 1 FTE Recreational Therapist; 2 FTE Dieticians

Family Health Services & Community Health & Wellness (7.5 FTE or 13% of total need)

• 1 FTE Maternal Child Health (MCH) Nurse; 1 FTE Elders Coordinator; 2.5 FTE Youth Workers; 2 FTE Health Promoters; 1 FTE Community Health Nurse

Traditional, Cultural and Spiritual Wellness (7.7 FTEs or 13% of total need)

• 7.7 FTF Cultural Facilitators

Health Practitioners (3 FTE or 4% of total need)

• 3 FTE Medical Office Assistants (MOAs) or Office Assistants

The above are the human capacity gaps in community-based services only. This does not include human capacity or services needed to meet acute psychiatric and crisis response needs of community members with severe mental illness or addiction issues, as identified during the MWSU Regional engagement process in 2014.

PROJECTED GAPS IN HUMAN CAPACITY

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. More First Nations people are needed in the field of:

- Social work
- Personal Care Workers and Home Care
- Nursing and Nurse Practitioners
- Clinical counselling
- Home Care
- Rehabilitation services (dieticians, occupational therapists, physiotherapists)

Additionally 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 the FNHA and VCH at a provincial level since there is a need across the province. Local initiatives can occur through Health Career promotional activities and encouraging young First Nations and Aboriginal students to aspire to health jobs.

PARTNERSHIPS WITH DIVISIONS OF FAMILY PRACTICE & POST-SECONDARY INSTITUTIONS

One key initiative being implemented by the North Shore Division of Family Practice in 2014 is a new Family Practice Residency program. The program includes Doctors in training who have completed 4 years of basic medicine + 4 year's Family Practice training. They are required to do 2 years of residency (practicum) under supervision of experienced GPs across BC.

From July 1st 2014 the current North Shore / Central Coast / Pemberton / Sunshine Coast Doctors will supervise 8 new residents in this region for a 4 month term. For the 8 residents coming in to VC region the intent is to try to retain them in the region. Working in First Nations communities and having exposure to the unique cultures is a key incentive to promote resident placements and retain the graduating Doctors in the VC region. Attracting Aboriginal graduates is an even greater vision for First Nations communities.

Other programs that graduate new health professionals that are important to First Nations communities are Psychiatry, Psychology, Social work, clinical counselling, midwifery, nursing and nurse practitioner training and dentistry. FNHA and VCH will continue to work with post-secondary institutions and communities to promote localized training in First Nations communities, especially where there are opportunities for training to be done in community either on-line or in local community education colleges.

ECONOMIC CAPACITY DEVELOPMENT

Communities have a variety of options for generating economic capacity through their health service delivery. For some this may involve expanding their current health services to provide care to off-Reserve citizens, which may include First Nations or non-First Nations community members. For others it may mean buying or establishing a medical or dental practice in their local community to serve their own community members as well as others in order to attract more revenues from Employer Health Plans and other sources.

Communities who have physicians or wish to have physicians working on-Reserve will want to maximize the claims / reimbursements that they can attract to make these services viable. VCH's Practice Support Program has already assisted one community to look into these opportunities.

The FNHA and VCH will continue to provide expertise and support to those communities wishing to create economic opportunities and to grow their health care business to create revenue-generating opportunities. Directive 5: **Goal One**

FNHA and VCH works to increase the number of Aboriginal health professionals, managers and staff delivering health care services.

ACTION 5.1: As part of the First Nations Health Human Resources Tripartite Strategic Approach, the FNHA will focus on health career promotion, training and professional development, workforce recruitment and retention. This is also a component of "VCH First Nations & Aboriginal Framework" and MWSU workforce development strategies. *

Directive 5: Goal Two

FNHA and VCH support First Nations health centres to attract, retain and evelop a high quality workforce able to meet the needs of their local communities.

ACTION 5.2: Implementation MWSU workforce development capacity strategies with a focus on promoting MWSU careers among youth.

ACTION 5.3: FNHA and VCH work together to support existing workforce in First Nations Health Centres with clinical/supervision, training opportunities, peer learning opportunities, exchanges and placements to grow their capabilities.

ACTION 5.4: First Nations health centres are encouraged to have qualified staff and to support staff to gain qualifications.

ACTION 5.5: FNHA and VCH work together to support reviews of scope, renumeration and competencies of key positions where First Nations, FNHA and VCH deliver similar services (e.g. MWSU workers, nursing, mental health, home care).

Directive 5: **Goal Three**

FNHA, VCH and other partners support health practitioners to work with/in First Nations communities.

ACTION 5.6: FNHA and VCH work to support the Coastal Family Practice residency program and placement of physicians in First Nations communities (operated by North Shore Division of Family Practice).

ACTION 5.7: VCH's Professional Practice reams work with post-secondary institutions to encourage students (esp. Aboriginal students) to undertake practicum in First Nations communities.

Directive 5: **Goal Four**

Work with First Nations to develop opportunities for creating economic and business opportunities in health care.

ACTION 3.11: VCH & FNHA identify with each Nation their aspirations for provision of services to off-reserve and non-First Nations community members and support them to expand their services and revenues to do so. *

ACTION 3.12: Work with First Nations to support aspirations to operate own dental, physician, vision, pharmacy and other health practices that may generate income while providing more accessible services for their local community.

DIRECTIVE 6: BE WITHOUT PREJUDICE TO FIRST NATIONS INTERESTS

- Not impact on Aboriginal Title and Rights or the treaty rights of First Nations, and be without prejudice to any self-government agreements or court proceedings.
- Not impact on the fiduciary duty of the Crown.
- Not impact on existing federal funding agreement with individual First Nations, unless First Nations want the agreements to change.

CONTEXT

In the VC region only Tla'amin has entered into a Treaty agreement with the Federal and Provincial governments and the Final Agreement was signed in April 2014. FNHA and VCH will respect the existence of this Final Agreement and any impact on the way that Tla'amin chooses to plan and deliver its FNHA or VCH funded programs and initiatives.

The Sechelt Indian Band Self-Government Act 1986 also lays out conditions for the self-government of Sechelt Indian Band. As with Tla'amin, the FNHA and VCH will continue to respect and acknowledge Sechelt Indian Band's self-governance status and its desire to govern on Sechelt land, particularly in its working relationship with local VCH services (@ St Mary's Hospital) and with FNHA services and programs.

Wuikinuxv (Owekeeno) is currently negotiating a treaty with BC and Canada and has been in the process since 1993. Wuikinuxv is in stage 4 of the 6-stage treaty process and working towards an Agreement in Principle and Final agreement with community member support. Heiltsuk Nation, Squamish Nation and Tsleil-Waututh Nation all completed a Treaty Negotiation Framework Agreement in 1997 and Musqueam Indian Band completed a similar agreement in 2005. They are now progressing to Agreements in Principle as they progress toward Final Agreements with BC and Canada.

Other Nations in the region are not known to be in Treaty or Self-Governing processes; however FNHA and VCH still have the responsibility to respect and acknowledge the governance of their traditional territories, local customs, traditions and protocols. As health partners with VC region's First Nations, the FNHA and VCH will not undertake any activity that prejudices or impacts Aboriginal title and rights.

Directive 6: **Goal One**

FNHA and VCH acknowledge the rights and responsibilities of First Nations and will not undermine or interfere with the rights of First Nations to govern in their own health service delivery.

- ACTION 6.1: FNHA and VCH will ensure that any developments (e.g. Urban Vancouver Aboriginal Health and Wellness Strategy advisory framework) does not prejudice the rights or interests of local First Nations. *
- **ACTION 6.2:** FNHA and VCH will ensure staff working with First Nations are aware of and respect their Treaty/Self-governing status in their relationships with these Nations.
- ACTION 6.3: FNHA and VCH will ensure staff respect the protocols and customs of the 14 First Nations in the VC region.
- ACTION 6.4: FNHA and VCH will ensure that any commitments to non-BC First Nations and Aboriginal peoples residing in the traditional territories of VC region First Nations does not prejudice First Nations interests or aspirations.

Directive 6: Goal Two

FNHA will not impact any Contribution Agreement with VC region First Nations without their approval.

ACTION 6.5: FNHA will only amend Contribution Agreements at the request of the Nation/Band and will not amend without express agreement of the Nation/Band.

DIRECTIVE 7: FUNCTION AT A HIGH OPERATIONAL STANDARD

- 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.
- Operate with clear governance documents, policies, and procedures, including for conflict of interest and dispute resolution.

CONTEXT

In order for First Nations health services to function at a high operational standard, each of the Nation's health services and health centers needs to have a sound infrastructure, policies, procedures and systems that support effective service delivery. These may include:

- Quality management systems (and/or being accredited) including documented Policies and Procedures for all operations of the Health Center; and regular internal audit and review of those systems
- Workforce Competency Development Plans for staff to continually build their skills
- Electronic Medical Records to collect patient / client data, analyze and report on performance and health status (e.g. number of diabetics; numbers immunized; numbers of registered clients)
- Safe and well equipped health facilities
- Reporting and Accountability mechanisms (for Chiefs and Councils, Health Boards / Committees, Funders and community)

QUALITY MANAGEMENT SYSTEMS

It is important for the effective and efficient operations of the First Nations Health Centers that the way in which they operate is documented within Policies and Procedures for all operations of the Health Center. This helps to create consistent high quality services for community members while ensuring staff are clear on expectations of their roles. These must also be subject to regular internal audit and review to maintain their currency and relevancy to the Health Center and to continually look for opportunities to improve.

The FNHA Quality and Accreditation Team will support those communities who wish to go further than developing consistent policies and procedures within their quality management system. For those who wish to be accredited support can be offered to make this happen. Currently two First Nations Health Centers are accredited in the VC region – Heiltsuk and Tla'amin.

WORKFORCE COMPETENCY DEVELOPMENT

Only one community has good access to training and workforce development opportunities for their staff and a well-developed and implemented workforce development and training plan that is working effectively. All other communities acknowledge that they would benefit from support to develop and implement these plans for their health centre. There is a major challenge in some smaller communities being able to have their staff access training and professional development – due to travel costs and no relief for them while they are absent. This is particularly challenging in remote and rural communities.

Additionally at a provincial level, there is a need to look at creating a competency and qualifications framework for Health Directors and Community Health Representatives (CHRs) – two positions created by the former Federal health system that are unique to First Nations health centers across Canada. While some of their roles are similar to other positions in the mainstream health system, there are unique competencies that they need and possess to undertake their roles within a First Nations-governed setting. There are 14 FTE CHRs and 6 FTE Patient Travel positions in the 14 communities – a total of 20 FTEs who could potentially benefit from a proper development program. This will also result in increased capacity to provide more health services for community members and focus these 20 FTEs less on administrative activities.

ELECTRONIC MEDICAL RECORDS

First Nations Health Center Patient Data Systems

The Primary Health Care access review (June 2013) revealed that only two communities have an Electronic Medical Record (Mustimuhw). Health Directors are having difficulties monitoring health status, service coverage, access to services, attachment to physicians, screening rates and many other requirements that they need to plan and coordinate care effectively.

Despite the challenges, this presents an opportunity to take a regional strategic approach for all 14 VC First Nations communities to implement the same Electronic Medical Record. This will enable anonymous and summary data sharing between and present an overall picture of health care and health status for all Nations in the region. In June 2013 all Health Directors agreed to adopt Mustimuhw and signed a joint proposal to the FNHA to fund all communities for this community EMR.

Tla'amin Health is also operating Panorama at present. Panorama, a Communicable Disease Surveillance and Management system, was designed and developed for implementation and use by provincial and territorial jurisdictions across Canada. The system provides public health professionals with integrated tools that assist in monitoring, managing, and reporting on public health. The system collects the information that is critical for the effective management of health problems, which could potentially pose an outbreak threat.

VCH's Patient Data Systems

VCH services and hospitals do not routinely collect an 'Aboriginal Identifier' when First Nations / Aboriginal clients are admitted. In some sites and hospitals, there are multiple entry and exit points from services and without being able to identify Aboriginal patients, there is no way of knowing what services are (and are not) being used in an equitable way; what health outcomes may be achieved from the services provided; and no electronic way to discharge patients back to their physicians or First Nations communities.

In partnership with Providence Health Care and the Provincial Health Services Authority (PHSA), VCH is working to undertake a significant Clinical and Systems Transformation (CST) project which commenced in 2013. VCH is committed to ensuring that the Aboriginal identifier (aligned with the BC Aboriginal Administrative Data Standard) is a key data item in the new electronic health record and that reporting is able to be produced to monitor Aboriginal use of VCH services across the region.

⁵ A community EMR owned and developed by Cowichan Tribes, Duncan, BC

HEALTH FACILITIES

Six communities in the VC Region have identified that they have good Health buildings for their needs:

- Kitasoo
- Heiltsuk
- Wuikinuxv
- Tla'amin
- Sechelt
- Lil-Wat

Although the communities have identified they have good health buildings for their needs, it should be noted that some of the buildings may require significant upgrades to meet provincial building codes, in Kitasoo for example. Four areas identified that their current facilities present challenges including Nuxalk whose health facility is now too small for the growing population needs. Squamish Nation, Musqueam Indian Band and Tsleil-Waututh Nation – all the Vancouver urban communities – identified that they have no dedicated health center like other communities in the region. Instead they use space in the Band Offices or temporary trailer buildings to operate from. Their desire is that capital is allocated to support them to erect health centers that can enable more services to be brought on Reserve for the growing communities.

On the North Shore there may also be capacity to develop a Health Facility that can cater for on and off-Reserve members since so many reside in the area and there are no Aboriginal urban services on the North Shore for off-Reserve First Nations. In Musqueam, with the growing residential developments around the Reserve, there is capacity for Musqueam to also create a Health Center that can serve Musqueam members as well as others and thereby generate extra revenues for the community. These are concepts yet to be fully explored by the urban-based communities but which offer economic potential as well as sustainability options.

CAPACITY FOR RESEARCH AND KNOWLEDGE TRANSFER

Research BY First Nations FOR First Nations is a key goal to expand the knowledge base on grassroots health service delivery in First Nations communities. The FNHA has research and evaluation capacity through its Research and Knowledge Management (RAKM) team which will also support communities. VCH already has a significant research capacity within the VCH Research Institute as well as specific knowledge exchange and research projects across different departments in the organization. The FNHA and VCH are well placed to conduct regional and provincial research and evaluation and will use the Regional Health and Wellness Plan as a guide to determine research priorities to apply for grants and to jointly work on together.

The generation and management of localized research projects by local First Nations is still an aspiration. In the spirit of OCAP principles (Ownership, Control, Access and Possession) of research processes and outputs, it is important that the FNHA and VCH support communities to conduct their own research. The FNHA Regional Office and VCH will leverage expertise from their own Research departments to support communities wherever this is desired.

Directive 7: **Goal One**

All First Nations Health Centres have fully documented Policies and Prodedures for their operations that are reviewed regularly.

ACTION 7.1: All First Nations Health Centres are supported to develop documented Policies and Procedures or provided support to review current policies.

ACTION 7.2: Those Nations who choose to be accredited, are supported to accredit their quality management system.

Directive 7: Goal Two

First Nations Health Centres have a current Staff or Workforce Development Plan outlining how they will grow the competency and capability of their staff.

ACTION 7.3: Communities are supported by FNHA and VCH to implement their workforce plans through access to training. *

ACTION 7.4: The FNHA works with the FNHDA to access examples of successful Workforce Development Plans to develop templates for communities in the VC region.

ACTION 7.5: VC Region Health Directors and FNHDA develop a pilot project to create a competency and qualifications framework for CHRs (using lessons from the Alaska CHAP program).

Directive 7: Goal Three

Data collection on First Nations and Aboriginal use of health services is improved so that utilization and health outcomes can be tracked and improvements made where needed.

ACTION 7.6: Progress is made to implement standardization EMR in all 14 First Nations communities in 2014-2015.

ACTION 7.7: VCH ensures that collection of the "Aboriginal Identifier" is included in the planning and implementation of the new CST project comprehensive electronic health record.

ACTION 7.8: A Research Analysis and Knowledge Management group is established to oversee and advise on data collection and use for the VC region. First Nations are supported to identify their priorities and to conduct or particiapate in identified research, reporting and evaluation projects.

Directive 7: **Goal Four**

All First Nations Health services in the VC region have sound, safe and accessible health facilities for delivery of their programs and inclusion of visiting health services

ACTION 7.9: Requirements for community health facilities expansion are included in FNHA capital plans. *

Directive 7: **Goal Five**

First Nations are supported toidentify their research priorities and to conduct or participate in identified research projects.

ACTION 7.10: FNHA and VCH Research capacity work with VC Region First Nations to undertake research at a local, regional and provincial level including accessing research grant funds.

Reporting and Accountability

REPORTING ON THE REGIONAL HEALTH AND WELLNESS PLAN

Reporting on this RHWP is a key action for each VC Regional Caucus meeting as explained earlier in this plan. In order to do this, the FNHA Regional Office, working in partnership with communities and with VCH, will take the lead in developing a reporting framework on each of the Goals and Actions. A progress report back to the 14 Nations at each Caucus meeting will be prepared.

EVALUATION OF THE PARTNERSHIP ACCORD

The Vancouver Coastal Partnership Accord (2012) commits the parties to collaboratively develop a list of measurable "Success Indicators". Depending on evidence, best practice literature, and data availability for the Vancouver Coastal region, these indicators may reflect the following:

- 1. A shared vision for health, wellness and health care delivery for First Nation and Aboriginal people is part of the Regional Health and Wellness Plan
- 2. Coordination and outcomes of the Community Engagement Framework and satisfaction of participants with the processes used
- 3. Access to VCH services and programs is improved for First Nations and other Aboriginal peoples (e.g., patients accessing Aboriginal Navigator program; patient satisfaction with access; number of Tele-health sites). This will be achievable once the Aboriginal Identifier is collected routinely across VCH services
- 4. The VCH Culturally Competent and Responsive Strategic Framework (2013) is fully operational and reporting against the baseline measure shows steady progress
- 5. Barriers to accessing services are reduced through improving the appropriateness, quality and acceptability of health services for First Nations and other Aboriginal peoples (e.g., patient satisfaction; number of referrals to Aboriginal navigators and Indigenous practitioners; number of Aboriginal health practice guidelines in place; cultural competency of VCH staff, board and executive).
- 6. First Nation and Aboriginal communities are supported through partnerships with other ministries, municipalities, private sector and non-profit service providers to address the social determinants of Aboriginal health).
- 7. Health and Wellness of First Nations and Aboriginal peoples is improved and the gap in health status is decreased between First Nations and Aboriginal peoples and other residents in the Vancouver Coastal region (e.g., life expectancy, infant mortality, communicable diseases, substance abuse related morbidity, injuries, dental health, self-reported health status and mental health, family connectedness, injury free).

Resourcing the Regional Health and Wellness Plan

RESOURCES FROM THE FNHA

Information in this section is primarily taken from the FNHA's summary service plan (The Year Ahead 2014-2015) available on the FNHA website.

COMMUNITY FUNDING

Over 73% of the FNHA budget is delivered directly to BC First Nations through Contribution Agreements and the First Nations Health Benefits Program. A number of health service improvements will be realized to ensure high quality health services to BC First Nation individuals, families and communities with provincial and other partners.

The FNHA has stated in its 2014-2015 interim Health Plan that this year the FNHA and the First Nations Health Directors Association will begin engagement and a review of current community health planning processes, and will work in partnership with BC First Nations to develop new and workable health planning and reporting processes.

"This year, the FNHA is in a position to ensure that each community Contribution Agreement will enjoy the customary annual increases of 2-3% for certain programs. In addition to the historic increase, the FNHA will also be able to provide additional funding for certain programs to bring the overall increase to 5.5%.

Other key programs included in community Contribution Agreements that did not receive the annual increase will be given an additional 5.5% for this upcoming fiscal year.

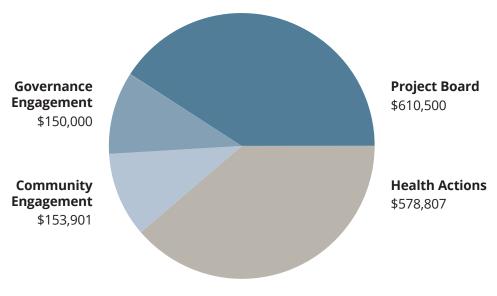
Increases to community contribution agreements will flow through Notice of Budget Adjustment's (NOBA's) this July. The FNHA is committed to getting these funds out early in the year to enable communities to plan for the often busy summer and fall health promotion activities. In total over \$173 million (40%) will flow directly through Contribution Agreements. An extra \$1.2 million will flow to health plan management, to assist those Nations that want to increase local governance and decision-making over programs and services."

REGIONAL FUNDING

To support and enable decision-making at a regional level, the FNHA has deployed Regional Envelopes as a mechanism to pair investment with planning; providing regions with the ability to make decisions around the investment in their key priority areas identified in their RHWPs and Regional Partnership Accords. Health planning and decision-making are being brought closer to home. RHWPs have been prepared in partnership with leadership and technicians in each region. These plans, once formally approved, will trigger regional envelopes.

The initial overall regional investment (for all 5 regions) is \$15.2 million dollars: these funds include \$5.3 million dollars for regional Health Actions implementation, \$5.5 million for Project Board, \$3.2 million for Community Engagement (excluding salaries), and \$1.2 million for Governance Engagement.

Figure 16: Vancouver Coastal region the fiscal year 2015/15 regional envelope (fiscal year 2015/16)



Total Value: \$1,493,208

Joint Project Board Funding is further described below. The above excludes "Flagship project" funding from the MSP funds which is described below.

JOINT PROJECT BOARD FUNDING - FNHA, VCHAND MINISTRY OF HEALTH

In 2014 the FNHA leveraged a \$15 million dollar multi-year commitment from BC through an agreement in lieu of paying MSP premiums. As per the Agreement, the Joint Project Board has a three-year multi-million dollar fund available to initiate primary care projects across the province that will be sustained in future years. Projects funded through this envelope will result in health service improvements and may include such investments as: additional health care providers to previously underserved locations, and the introduction of new, innovative models of health service delivery.

Regional Partnership Accord tables (Aboriginal Health Steering Committee) will be the forum for identifying projects and recommending to Joint Project Board which projects to fund in their region. Joint Project Board investments in Primary Care projects – for regional decision-making will total \$5.55 million for 2014-2015. In additional to the regional planning targets, \$4 million will invested directly by the Joint Project Board to support flagship innovation projects in each region.

The Vancouver Coastal region has been allocated a planning target from JPB funds as:

- \$610,500 for Year 1 (2014/2015) plus a Flagship Project from the re-profiled MSP funds
- \$610,500 base funding plus \$635,800 for Year 2 (2015/2016)= \$1,246,300

These funds are allocated for three years with the opportunity for review, evaluation and re-investment. All projects must provide direct service in the areas of Mental Wellness and Substance Use, Primary Care, Maternal and Child Health, and Oral Health.

FUNDING PRIORITIES

The Health Directors and VC Regional Table have directed that funds be prioritized to address gaps identified in the Primary Health Care access mapping review (See Directive 3 in this plan) and to address priorities arising from the Mental Wellness and Substance Use Regional Forum held in February 2014. The FNHA Regional Office is working with the Regional Table members, VCH and AHSC to identify how best to allocate the available resources to these priorities in a manner that meets the criteria of the different funds. As the known gaps are addressed and further priorities are established in this Regional Health and Wellness Plan, future regional envelope funding shall be aligned to RHWP priorities.

RESOURCES FROM VCH

Currently the majority of VCH's available discretionary funding resources reside with the Population Health team who manages the SMART Fund and the Aboriginal Health Improvement Program (AHIP). Several First Nations communities have benefitted from SMART Fund grants and all of the AHIP resource is allocated each year to Aboriginal service organizations (mostly in greater Vancouver) and to First Nations communities. In total around \$6 million has been invested in Aboriginal and First Nations initiatives.

VCH also invests in Aboriginal Patient Navigators and the Aboriginal Wellness Program which is a dedicated Aboriginal Mental Wellness and Substance Use program mainly serving urban Vancouver Aboriginal citizens. In addition to this a small community engagement budget exists within the operating budget of the VCH Aboriginal Health Strategic Initiatives (AHSI) team. Other departments within VCH such as the Prevention Team Mental Health and Addictions Team and the Primary Care team also invest their own funds in change management, community engagement and additional services to reach First Nations and Aboriginal communities. Examples of this are:

- a shared Concurrent Disorder Clinician with one Nation;
- a shared Public Health Nurse with one Nation;
- payment of sessionals for a physician clinic on Reserve;
- assigning staff to work on-Reserve within their employment scope;
- supporting Nurse Practitioners working on-Reserve;
- providing services such as immunization and Education and Home care on-Reserve

In the future, VCH would like to re-align its grant investments with the RHWP and including consideration of the Urban Vancouver Aboriginal Health Strategy when completed.

References

The following documents were reviewed and inform this plan:

- Vancouver Coastal Partnership Accord (2011)
- Vancouver Coastal Regional Caucus Terms of Reference (2011)
- Vancouver Coastal Caucus Minutes
- Health Directors Meeting Minutes
- First Nations Access to Primary Health Care Report and Model
- Vancouver Coastal Health Aboriginal Health and Wellness Plan (2008-2011)
- BC First Nations Community Health Priorities (Health Canada FNIHB BC)
- First Nations Health Directors Association (2012). World Café Conversation.
- Cultural Competency and Responsive Framework (2013)
- Other documents as provided by Vancouver Coastal Community Engagement Hub

Figure 17: Engagement and Development Process on the iRHWP



APPENDIX A: GAPS IDENTIFIED IN COMMUNITY-BASED SERVICES (JUNE 2013)

KEY GAPS IDENTIFIED FOR SUNSHINE COAST

Sechelt

- Funding for programs for all Traditional / Cultural activity;
- Family Health and Wellness: Resources for Health and Wellness programs including funding to increase 0.5FTE Dietician to 1FTE Dietician
- Increase Nursing capacity 0.4 FTE
- 1 FTE Clinical Counsellor + 1 FTE Social Worker + 0.5 FTE Clinical Psychologist for MH and SU services
- 1 Personal Care Aide for HCC program
- EMR funding; Training / workforce development planning and implementation

Sliammon / Tla'Amin

- 1 FTE Cultural Facilitator for all Traditional and Spiritual Wellness areas
- 1 FTE Social Worker and 0.5 FTE Clinical Psychologist for Mental Wellness and Substance Use support
- 1 FTE Elders Coordinator and program funding for resources for Family Health Services
- 1 FTE Health Promoter and program funding for resources for all Health and Wellness areas
- EMR funding and training / workforce development

KEY GAPS IDENTIFIED IN PEMBERTON - SEA TO SKY

Mount Currie

- Traditional and Spiritual Wellness funding for youth activities
- Health and Wellness (prevention and promotion) funding for smoking, suicide and injury prevention programming
- Family Health services visiting Paediatrician and extended OT time
- Home and Community Care chiropractor funding or time; equipment and supplies to develop equipment cupboard; adult day program funding for recreational therapist
- Mental Wellness and Substance Use Clinical psychologist access; access to psychiatry from Squamish to do outreach on reserve if possible
- Enablers EMR resourcing to implement; identify potential tele-health opportunity for psychiatry / psychologist from Squamish

Southern Stl'atl'imx

- Health and Wellness CHRs in all communities need training, support and resources for all areas of prevention and wellness
- Family Health service youth health is a gap especially sexual and reproductive health
- Mental Wellness and Substance Use Social Worker; Clinical Psychologist; ASCIRT team
- Medical and Clinical services improving access to Pharmacy (prescriptions) for remote communities; Optometry; Visiting specialists (tele-health will assist);
- Enablers EMR; clinical supervision and linkages with VCH HCC and other services

KEY GAPS IDENTIFIED FOR NORTH SHORE

(and Squamish Valley for Squamish Nation)

Squamish Nation

- Spiritual Health and Well-being: Resources for incorporating Elders and funding resources / materials for programs / traditional activities
- Community Health and Wellness (prevention): Dietician time; program funding for most areas including physical activity + nutrition + smoking cessation + suicide prevention + violence prevention + injury prevention + alcohol and drug prevention
- Family Health Services: Funding for youth sexual health awareness program; parenting program (for non-MCFD clients)
- Home and Community Care: Pharmacist to undertake medication reviews; Day program / recreation
- Mental Health and Substance Use: 2 FTE clinical counsellors + Social Worker + Clinical psychologist; funding for pre and post treatment program; ASCIRT for suicide response and postvention
- Medical and Clinical Care: MOA position for Doctor service (physician time could increase to 2 FTE)
- Service Enablers: EMR being installed now. Vision for a Health centre on reserve with clinics (currently in discussion)

Tsleil-Waututh

- Sustainable program / resource funding for all Traditional and Spiritual Wellness areas
- Sustainable program / resource funding for resources for all Health and Wellness areas
- ASCIRT funding and postvention support
- Service Enablers EMR funding; support for a new health centre on reserve; access to workforce development / training

KEY GAPS IDENTIFIED IN SOUTH VANCOUVER

Musqueam

- Traditional and Cultural Wellness some internal improvements to be made
- Health and Wellness (prevention and promotion) Food security program, smoking cessation, youth focused suicide prevention, violence prevention, funding for injury prevention program, drug and alcohol prevention program
- Family Health service sexual health for youth; women's and men's health promotion (screening); Family counselling and parenting
- Home and Community Care Pharmacist to do medication reviews; clinical supervision; social / recreational activity programs
- Mental Wellness and Substance Use women's counselling (need 1 FTE female clinical counsellor); 1 FTE Social Worker; 1 FTE clinical psychologist; ASCIRT funding for suicide crisis response
- Medical and Clinical services desire to establish a physician clinic / Nurse Practitioner; need to train First Responders
- Enablers no EMR, no designated health clinic for client consultations

- 1 FTE Recreational Therapist
- 2 FTE Dieticians

Family Health Services & Community Health & Wellness (7.5 FTE or 13% of total need)

- 1 FTE Maternal Child Health (MCH) Nurse
- 1 FTE Elders Coordinator
- 2.5 FTE Youth Workers
- 2 FTE Health Promoters
- 1 FTE Community Health Nurse

Traditional, Cultural and Spiritual Wellness (7.7 FTEs or 13% of total need)

• 7.7 FTE Cultural Facilitators

Health Practitioners (3 FTE or 4% of total need)

• 3 FTE Medical Office Assistants (MOAs)

These gaps reveal a very strong emphasis on the shortage of mental wellness and substance use practitioners and all communities identified this area as one which is a high priority. They note extensive need and demand for abuse counselling; grief and trauma for Indian Residential School survivors and their families; relationship counselling; social worker counselling and guidance; help to overcome severe drug and alcohol addictions apparent in many communities. As one Health Director stated:

"The healing work with community members must be strengthened – no matter what other health services we organize, they will never do the work they have to, if people are not well in their spirit, heart and mind."

APPENDIX B: DESCRIPTION OF HEALTH TRANSFER CONTRIBUTION AGREEMENTS

Health Transfer

In the 1980s and 1990s, Health Canada created the Health Transfer program. This program enables communities to plan for and negotiate the transfer of Health Canada program delivery from the federal government to the communities themselves. If a community does not go through Health Transfer, they continue to receive services from Health Canada staff (e.g. nurses). There are three phases to the Health Transfer process, reflected in three types of Contribution Agreements, which have been "novated" in preparation of the FNHA taking over the administration of these agreements as of October 1, 2013.

- 1. SET: one- to three-year agreements; least flexibility for allocating funds; no retention of surpluses and no carry forward; programs designed and delivered by HC-FNIHB; no requirement for a separate health management structure; recipient must deliver programs and services as per FNIHB Program Plan;
- 2. FLEXIBLE (transitional): two- to five-year agreements; can move funds across clusters within a Program Authority; Multi-Year Work Plan needed; can carry forward and keep surpluses if there is a plan on intentions to spend; HC-FNIHB designed programs with minimum reporting; health management structure required; mandatory programs must be delivered; no evaluation required; annual report for cluster indicators;
- 3. BLOCK (flexible/ flexible transfer): greatest flexibility for allocating funds. Can move funds within Program Clusters and Program Authorities; can redesign programs completely and use funding across components and authorities; use surpluses to meet needs; foster integration activities with other government arrangements such as integrating health with social services; can consider health surveillance + health planning + health policy functions; can have its own Medical Officer; must deliver mandatory programs/services; five-year evaluations; five- to ten-year agreements

An overview of FNIH programs from the Health Canada 2011-2012 Program Compendium is included in the Appendices along with the link to the full Compendium stored on Health Canada's website.

The stage at which the First Nations are in the Health Transfer process has significant impact on their access to services. Nations in Set Agreements have fewer services on reserve (and are more restricted in their delivery) and they depend more on external services, either by accessing these off reserve or arranging for service provision on reserve.

Additionally, Nations in Set or Flexible Agreements do not have the same extent of funding as others for the management component and are often unable to hire full-time Health Directors or Managers who can engage in external planning efforts. Often, staff members in these communities are in shared roles either as a Community Health Representative/Health Director or as a part-time Health Director with the incumbent having another role in the community. This often impedes their time and availability for external strategic planning or relationship-building discussions.

APPENDIX C: PRIORITIES FROM PREVIOUS ENGAGEMENT WITH VC REGION FIRST NATIONS

REPORTS THAT WERE REVIEWED

Documents that were reviewed to identify priorities raised by Vancouver Coastal region First Nations included Caucus minutes, FNHA reports and VCH reports as follows.

VC REGIONAL CAUCUS MEETING FEEDBACK / GUIDANCE

Meeting minutes for the VCC Caucus meetings held between 2010 and 2012 from the following meetings were reviewed:

- March 2010
- April, 2010
- May 3, 2010
- May 28, 2010
- March 21, 2011
- November 3, 2011
- December 12, 2011
- May, 2012
- October 2012

Statements made and recorded by Caucus attendees were included in the alignment exercise below (as verbatim as possible). The information that was drawn from Caucus minutes focuses only on issues, ideas and concerns raised by First Nations leaders within the Vancouver Coastal region, as they relate to health services - and does NOT summarize governance-related discussions.

TRADITIONAL MODELS OF WELLNESS ENVIRONMENTAL SCAN

In 2009 – 2010 the then First Nations Health Society – on behalf of the First Nations Health Council conducted an environmental scan of Traditional Models of Wellness including traditional medicines and practices in BC. The project was aimed at providing background information for the First Nations Health Society to undertake further work if needed, on promoting traditional models of wellness within BC for First Nations.

Participants were asked about alternative medicines and practices in order to differentiate their responses from those related to traditional practices. The results show that the vast majority of respondents had access to one or more alternative therapies (naturopathy; massage; energy work; chiropractic support and Chinese medicine or acupuncture). Over half however do not integrate these therapies with their health programs while just over one third did. Nearly 34 of respondents, who did not access alternative therapies, said that they would in future if they had the opportunity. Over 87% of all respondents said that alternative therapies needed to follow or be aligned with traditional wellness philosophies if they were to be brought into health centers in their communities.

VCH'S ABORIGINAL HEALTH PLAN 2008-2011

VCH's Aboriginal Health Plan identified priorities for Health System Transformation including improving access to Health Care Services by actively working to address jurisdictional issues with partners, Aboriginal health service delivery silos and overcoming longstanding barriers to health care delivery such as geographic isolation and location. The work which led to the Primary Health Care access review was one of the ways in which VCH aimed to address these goals.

VCH'S ABORIGINAL CONVERSATION ON HEALTH - MARCH 2007

In March 2007, 35 participants from approximately 100 urban organizations and First Nations communities came together from the VCH region to provide the perspective of Aboriginal peoples to incorporate into provincial planning on health care. Arising from the sessions five priority areas were identified and listed in order of priority:

- Addictions and mental Health
- Primary health care
- Health education and human resources
- Flder Care
- Chronic disease management.

VCH AND FNHC: IMPLEMENTATION FORUM ON ABORIGINAL HEALTH - FEBRUARY 2008

On January 31 and February 1, 2008, VCH and the First Nations Health Council co-hosted an implementation forum on Aboriginal Health in Vancouver to set priorities and a framework for measuring progress against these priorities. Specific feedback related to Access to Health Care Services; Mental Health and Addictions; Primary Health Care services; Elder Care and Public health are incorporated into the alignment to the service model below.

INPUT AND PRIORITIES DETERMINED BY VC FIRST NATIONS

Statements, input and guidance from First Nations political and health leaders taken from the reports outlined in the previous section, are re-printed below (as verbatim from the notes as possible):

Philosophy and Approach

The Primary Health Care model developed with VCH (October 2012) helps to clarify the system and make it easier to understand – ensure we define Family programs differently from those funded by MCFD though.

- VCC Caucus

The centre circle (of the FNHA Health and Wellness Model) represents individuals and the fact that it starts with individuals taking responsibility for their own health and wellness (whether they are First Nations or not). The second circle in the model illustrates that Mental, Emotional, Spiritual and Physical aspects are necessary for a healthy, well, and balanced life. It is critically important that there is balance between these aspects of wellness and that they are all nurtured in tandem to create a holistic level of well-being, one in which all four areas are strong and healthy.

- FNHA Health and Wellness Model

Us as Aboriginal people will take on health. We want to ensure our future generations have services that meet their needs. A couple of weeks ago we held an elders forum - heard from them what they would like to see for their health.

- VCC Caucus

Key Strategies for Health Services: Mental Health and Addictions; Primary Health Care services (Access to maternity care; Enhance chronic disease management; Enhance prevention programs and services; Improve coordination and management of co-morbidities; Care for frail elders and Enhance End of Life care).

- VCH Aboriginal Health Plan.

Key concerns that were identified in primary care were transportation challenges, lack of accessible medical and community personnel and the needs to integrate traditional healing methods into current primary health services.

- VCH Aboriginal Conversation on Health

Create primary health care centres that are client-centred and holistic in approach from medical to cultural; community gardens; dental care; mental health services; child services. They do not have to be physician-centred. Look to the medicine wheel to balance spiritual, mental, physical and emotional aspects of health.

– VCH Aboriginal Conversation on Health

Accountability

Conversations are needed on how roles and responsibilities, and reciprocal accountability should be defined. Accountability regarding elder care, chronic disease, mental health and addictions needed to be considered.

- VCC Caucus

VCH Relationship Building / Partnership

It's important to have three equal partners, rather than a 'top down' approach. The VCH service providers are missing the needs of our people. We need to talk with BC and the Health Authorities – they will have to sit down with First Nations - that is the VCC and VCH will have to determine their relationship. Health Canada arrangement accounts for \$320M, the VCH (provincial) is much more than that. We need to prepare ourselves to have those discussions.

- VCC Caucus

When the political agreement is established, we'll be responsible for working with VCHA. AHSI works for VCHA, but is competing for resources. We discussed this with the Aboriginal Community Health Advisory Committee. The real resources for the health system are at the regional level. Patient navigators are employed by VCHA.

Health Planning and Priorities

As identified and prioritized by BC First Nations, every First Nations needs to be supported to make progress in "closing the gaps in health outcomes" that recognizes the remoteness factors and attributes of their communities (i.e. Infrastructure, population, access, social determinants).

- VCC Caucus.

Our communities have to deal with regional health plans; the second key principle discusses health gaps - have these been identified, do we need to create a list of health gaps? Yes, we need to start looking at the health gaps. A list of health gaps in general, they don't have to be specific. We need to define who the stakeholders and service providers are within our region, and identify what is missing in each area. We share similar concerns about services, such as patient travel. We need to identify what we have and what we don't have. Travel is high on everyone's list. The second key principle point states that every BC First Nations be supported. As "identified and prioritized by First Nations" should be added.

- VCC Caucus

The Caucus wants to be involved in the development of the VCHA Aboriginal Health Plan. The VCC sees that it can take in all the community work and bring it to the Health Authority level. VCC needs community input to gather the needs, combine community health plans and develop a regional plan.

- VCC Caucus

We need to create working documents for health outcomes – to close the gaps. "Closing the gaps" we've been conditioned that the services provided are all that there is. How do we get our community members to see that we are going beyond that – beyond what services they already have? We know that the health plans are not working. They are not working because we are following our funder's guidelines – treat it like a symptom and leave the core issues behind. We are doing things differently and need to make sure our communities see that. It has been a top down approach. Health gaps needs to be identified and prioritized by First Nations. Our health plans have to be truly ours if they are going to be effective.

- VCC Caucus

VCH has their health plan out. We can use that as a guide for developing community health plans. In the VCH Aboriginal Health and Wellness Plan they identify goals and objectives. Peter Vlahos attended last meeting – we can invite him to come again. VCHA and the Aboriginal Health Strategic Initiatives – we can look at redoing their health plan and utilize it for the development of a regional health plan. Wellness indicators need to reflect healthy vibrant First Nations communities.

- VCC Caucus

Approaching health from a social determinants of health lens is fundamental. Regional plans need to be unique to the region. More traditional and mindful of cultural uniqueness of the region and each community. Engaging with communities is critical.

We need to address fractious planning and decision and decision-making. Conduct an inventory of needs – ask us! Tailor the job to meet the needs of the community and flexibility to reflect priorities of individual communities. Support community control over questions of access and the coordinated planning in each community. What services do we need in the community versus what should be referred out? How do we get a baseline of service and create a network of services? Integration of services and multiple partners and their staff are needed to make it work.

- VCH/FNHC Implementation Forum on Aboriginal Health

Traditional, Cultural and Spiritual Wellness

The results of the FNHC's Environmental Scan on Traditional Models of wellness demonstrated that the vast majority of First Nations community respondents defined traditional models of wellness as 'having a healthy mind, body and spirit'. There was a common theme that wellness from a traditional perspective encompassed a person feeling well emotionally, physically and spiritually and leading a healthy lifestyle, which involved connection to the land and one's culture and beliefs. Respondents also said that maintaining wellness involved carrying out traditional practices of the community such as fishing, hunting, berry gathering and participating in healing circles, sweats, drumming and learning the language. Identity and connection to culture were seen as integral to maintaining wellness from a traditional perspective.

Some respondents also commented about how difficult and challenging it was for some communities to help individuals and families maintain wellness from the above perspective, because of the impacts of alcohol and drugs; residential schools and other external influences. They also said that learning and sharing the knowledge of healers and elders was also an important element in the practices being undertaken but again this was challenging if there were few elders with the knowledge, or if elders were reluctant to share the knowledge.

Respondents felt that those healers who did not share information or knowledge about traditional practices did not do so because they were concerned about mis-use of the information; were concerned about liability involved or were confining knowledge sharing to specific individuals chosen to do this work.

Participants were asked if they used traditional medicines in their health centers and 50 respondents (56%) said they did not while 31% of respondents (20) said they did. Similarly, in terms of traditional practices, of a total of 72% (52) of respondents, said that no practices were used in the health centre. Additionally, 55% (50) of respondents said that they did include traditional practices in their health programs, while 39% (35) said they did not, and 6% (5) did not know. Where practices were used these were mostly the use of sweat lodge; medicine wheel teachings and bathing ceremonies. The programs that traditional practices were mostly used in were addictions and mental health, and elders and youth programs.

A total of 91% of respondents felt that traditional practices should be integrated into the health centers and no respondents disagreed with this statement.

Other commentary on Traditional Wellness:

I have concerns about the legislation of our traditional medicines. How do we protect our traditional medicine? This comes to mind, with regards to our own cultural healing methods – personal experience and people in our communities – who utilize alternate healing methods. Is there a place to recognize our own healing methods?

Language

Our Elders Session was geared forum was geared towards concerns of the elders. Done in a unique manner spoken mostly in our language. What came out of the forum, the importance of our language and way of life. Healthy language and we were discussing how we could preserve our language. The importance of protecting our territory, practicing our traditional foods and medicines.

- VCC Caucus

COMMUNITY HEALTH AND WELLNESS (PREVENTION AND PROMOTION)

Communicable Disease Prevention

HIV / AIDs services need to extend beyond Vancouver.

- VCC Caucus

HIV / AIDS in Aboriginal populations are identified to be higher than national averages in non-Aboriginal populations and targeted strategies are needed urgently to address this.

- VCH Aboriginal Conversation on Health

Smoking Prevention

Smoking is the leading preventable cause of death in BC, and the use of non-traditional tobacco use in BC and Canada is greater in First Nations than in non-First Nations populations. A large amount of First Nations communities smoke and it is a huge concern. Smoking cessation programs are successful when they occur in partnership with the community and community health nurse. Promote education, counseling tools, health care personal and assistance to quit smoking is needed.

- VCC Caucus

Suicide Prevention

The impacts of colonization and residential schools is concerning. In our community we lost a prominent health model to suicide. This is a problem in many First Nations and can be due to alcohol and drug abuse, or a lack of parenting skills (due to residential schools). Vancouver Coastal Health talks about suicides, but never really addresses the issues. People do not think it is an issue because they have adapted to suicides in the community. How do we capture that in our health plans? In closing the gaps we need people like Dr. Adams, who are schooled in counseling to address these issues.

FASD Prevention

Many children are afflicted by FASD. First Nations communities need assistance to stop the cycle, and learn how to manage in moving forward. We need to find a way to help the people born with afflictions from drug and alcohol abuse. The Ministry doesn't allow our people to be properly assessed. The Ministry says the children won't be returned until they accomplish specific steps. How can First Nations be helped? In our culture, because of extreme alcohol and drug abuse, many of us didn't see our grandparents. Seeing people age is a new thing. We need to think about how we're going to care for the elderly. Community bonding needs to be addressed. Planting the seeds of personal awareness will impact symptoms of health issues.

- VCC Caucus

MENTAL WELLNESS AND SUBSTANCE USE

Pre and Post Care and Residential Treatment

NNADAP Treatment Centres and follow-up after release is an issue.

- VCC Caucus

As Aboriginal people continue to fall through the cracks, it was clearly recommended to address outstanding issues of access to health service issues. In the areas of mental health and addictions as well as elder care recommendations were made for more Aboriginal specific treatment and Assisted Living beds.

- VCH Aboriginal Conversation on Health

Trauma / Indian Residential School Trauma Counselling

Cuts to the residential school funding is a concern, especially being only the second year post-apology

- VCC Caucus

Residential school trauma was identified as a major cause of mental health and addictions concerns within Aboriginal communities. For various reasons, mental health and addictions needs are not being addressed adequately within the Aboriginal population and requires special attention.

- VCH Aboriginal Conversation on Health

Residential school trauma is a multi-generational concern that affects all First Nations communities. Few resources are available to address this root cause of much of the mental health and addictions concerns of our communities.

– VCH Aboriginal Conversation on Health

FAMILY HEALTH SERVICES (AGE AND GENDER SPECIFIC)

Child Health

Needs of special needs children or children with developmental needs / behavioral issues (distinct from Child and Family cases).

- VCC Caucus

Elder Care

Elder Care - Focus on HCC and Residential care services.

- VCH Aboriginal Health Plan

Elder care issues include abuse, access to services, care-giving and funding.

- Aboriginal Conversation on Health

As Aboriginal people continue to fall through the cracks, it was clearly recommended to address outstanding issues of access to health service issues. In the areas of mental health and addictions as well as elder care recommendations were made for more Aboriginal specific treatment and Assisted Living beds.

- VCH Aboriginal Conversation on Health

HEALTH CARE PRACTITIONERS

Relationships

There is a need to strengthen the relationships between health professionals and First Nations.

- VCC Caucus

Chronic Disease Management

Diabetes and rheumatoid arthritis in Aboriginal populations are identified to be higher than national averages and targeted strategies are urgently needed to address this

- VCH Aboriginal Conversation on Health

Physician Care

Access to health care by Doctor's referral – we need to look at this practice. Community control over the guestions of access and the coordinated planning in the community is a priority. We need to address the geographic boundaries through additional services. Physician as gate-keeper e.g. medications, is an issue.

- VCH / FNHC Implementation Forum on Aboriginal health

SERVICE ENABLERS

Mobile / outreach Services

Message from our Elders regarding health service – improvements in travel. Would like to see more mobile clinics come to communities. Mentorship, elders work with others in health. Residential care services in communities.

- VCC Caucus

Creative models are needed (for remote communities or those with poor roads) to expand the primary health care and health campus models that can serve as centres for excellence.

- VCH Aboriginal Conversation on Health

Take programs to communities rather than having people travel to urban areas. Make rural and remote areas attractive to workers.

- VCH / FNHC Implementation Forum on Health

Non-Insured Health Benefits

Patient travel is underfunded. They never increased budgets – just add programs. We have responsibilities to create efficiencies. Why do we spend our money sending people to places is a big issue. Access to quality service is what we are after - mobile treatment facilities. Prevention piece - individual health and wellness plans. Changes to NIHB are a priority, especially changes to medical transportation.

- VCC Caucus

Workforce development

Increasing the number of Aboriginal health care practitioners was a priority and this included adequate resourcing, setting targets for training, developing programs to attract Aboriginal health care practitioners to remote areas, linking secondary and post-secondary education avenues.

- VCH Aboriginal Conversation on Health

Tele-Health

A key priority was "expanding e-health and tele-health"

- VCH Aboriginal Conversation on Health

Electronic Medical Record

Need to address electronic health record - blended staff teams who are certain people that can access the information.

- VCH/FNHC Implementation Forum on Aboriginal Health

Directive 1: Community-Driven, Nation-Based

- Goal 1: All communities in the VC region have a 5-10 year Community Health Plan (and are in Flexible Transfer)
- Goal 2: All communities are supported to engage locally to contribute to sub-regional and regional planning and decisions.
- Goal 3: Significant regional resources are utilized to advance and execute priorities in the Regional Health and Wellness Plan (RHWP).

Directive 2: Increase First Nations Decision-Making and Control

- Goal 1: As part of an effective engagement strategy, the FNHA VC Regional Office, FNHC, FNHDA and VCH will coordinate all First Nations community engagement efforts.
- Goal 2: Regional and Provincial tables/committees will be coordinated to support effective engagement by Health Directors, political and technical representatives who sit at these tables.
- Goal 3: FNHA Regional Office and VCH shall maintain current information for communities in an accessible and useable medium.

Directive 3: Improve Services

- Goal 1: FNHA, VCH and other health partners continue to work with First Nations communities to identify and address key health service priorities and to address service gaps.
- Goal 2: Continue to improve the cultural competency and responsiveness of VCH health services delivered for First Nations & Aboriginal peoples as agreed in the FNHC, FNHA & VCH Partnership Accord and MWSU Action Plan.
- Goal 3: Complete and implement the Urban Vancouver Aboriginal Health and Wellness Strategy advisory framework agreed in the FNHC, FNHA & VCH Partnersip Accord.
- Goal 4: FNHA works with First Nations to transform the First Nations Health Benefits (FNHB) program in the interests of improving access to primary and secondary care by community members.

Goal 5: Barriers to access continue to be addressed at local/sub-regional tables with Health partners.

Goal 6: Service improvement initiatives have strong input and participation by First Nations Health Directors and their staff.

Directive 4: Foster Meaningful Collaboration and Partnership

- Goal 1: Expand engagement with other agencies whose mandate impacts on the social determinants of health.
- Goal 2: In the spirit of the Partnership Accord principles, FNHA and VCH coordinate partnership tables/committees to ensure First Nations communities are not over-burdened.
- Goal 3: Formalize service delivery arrangements for First Nations communities in the VC region who are served by other Health Authorities and physicians (and communities in other regions served by VCH) to prevent jurisdictional problems.
- Goal 4: The FNHA, VCH and PHSA will collaborate to address priorities identified by First Nations.

Directive 5: Develop Human and Economic Capacity

- **Goal 1:** FNHA and VCH works to increase the number of Aboriginal health professionals, managers and staff delivering health care services.
- Goal 2: FNHA and VCH support First Nations health centres to attract, retain and develop a high quality workforce able to meet the needs of their local communities.
- Goal 3: FNHA, VCH and other partners support health practitioners to work with/in First Nations communities.
- Goal 4: Work with First Nations to develop opportunities for creating economic and business opportunities in health care.

Directive 6: Be Without Prejudice to First Nations Interests

- Goal 1: FNHA and VCH acknowledge the rights and responsibilities of First Nations and will not undermine or interfere with the rights of First Nations to govern in their own health service delivery.
- Goal 2: FNHA will not impact any Contribution Agreement with VC region First Nations without their approval.

Directive 7: Function at a High Operational Standard

- **Goal 1:** All First Nations Health Centres have fully documented Policies and Procedures for their operations that are reviewed regularly.
- **Goal 2:** First Nations Health Centres have a current Staff or Workforce Development Plan outlining how they will grow the competency and capability of their staff.
- Goal 3: Data collection on First Nations and Aboriginal use of health services is improved so that utilization and health outcomes can be tracked and improvements made where needed.
- Goal 4: All First Nations Health services in the VC region have sound, safe and accessible health facilities for delivery of their programs and inclusion of visiting health services.
- Goal 5: First Nations are supported to identify their research priorities and to conduct or participate in identified research projects.

APPENDIX E: BRIEFING NOTE VC MWSU REGIONAL FORUM REPORT AND ACTION PLAN

BRIEFING NOTE

DATE: March 31, 2014

PRESENTED BY: Vancouver Coastal Regional Director, Melanie Rivers

SUBJECT: Vancouver Coastal Mental Wellness & Substance Use Regional Forum Report + Action Plan

PURPOSE:

To present the Vancouver Coastal Caucus with the Vancouver Coastal Mental Wellness & Substance Use (MWSU) Regional Forum Summary Report and draft action plan for approval.

BACKGROUND:

"A Path Forward: BC First Nations and Aboriginal People's Mental Wellness & Substance Use 10 Year Plan" was released in April of 2013. "A Path Forward" outlines four quadrants of strategic actions:

- 1. Holistic Wellness for all First Nations and Aboriginal people in BC,
- 2. Community Care for those vulnerable to mental wellness and substance use challenges,
- 3. Integrated Care for those with moderate mental wellness and substance use challenges
- 4. Specialized Care for those with severe and complex mental wellness and substance use challenges

Following engagements with the Vancouver Costal Regional Table, it was decided that several community and Hub-based forums would inform the content of the regional forum.

The Vancouver Coastal Mental Wellness and Substance Use Regional Forum was held on February 25th, 2014 to discuss the implementation of "A Path Forward" as decided by communities within the Vancouver Coastal Region. Both the community forums and regional forum discussed three priorities identified through Integrated Primary & Community Care (IPCC) mapping work completed by Vancouver Coastal Health: The three priorities were identified as follows:

- 1. Suicide Prevention, Intervention, and Postvention
- 2. Cultural Competency
- 3. Workforce Development and Capacity Building

The Draft MWSU Action Plan that follows aims to reflect the community-level discussions and regional forum.

SUICIDE PIP STRATEGIES	OBJECTIVES / ACTIONS
1. Resource / support communi- ties to hire a Suicide PIP Coor- dinator for their community to	A Suicide PIP Coordinator is identified and resourced for each community (who does not currently have one)
lead and coordinate the work on Suicide PIP [job title defined by community]	Facilitate initial and ongoing training opportunities for designated Coordinators
Increase suicide prevention culturally-based activities in FN communities	Resource programs that strengthen family connection and build resiliency (e.g. bringing youth and elders together)
FIN Communicies	School-based strategies are implemented to prevent suicide and build resiliency
	Enhance / expand Indian Residential School: Health Support program for communities
3. Establish Suicide Crisis Response & Postvention (follow-up) Teams "Who do you call?"	Suicide PIP coordinators to facilitate multi-agency forums to establish crisis response (where no crisis response team exists already for larger communities) & Protocol
willo do you call?	VCH establish a VC regional clinical crisis response team to respond and support small, rural and remote communities unable to viably convene a multi-agency crisis response team (Wuikinuxv, SSHS) Safe places / safe houses identified in all 14 communities for people in crisis
	Discharges (from psychiatric units and specialized supports) connected to FN MWSU teams with protocols
	Debriefing / crisis support / advice line for workers involved in suicide incidents in communities
4. Support suicide PIP training and knowledge-building in communities	Provide region-wide training for Coordinators & community members & schools
5. Identify, collate and dissemi- nate Suicide PIP resource pack-	Suicide PIP Resource (Hope Help & Healing) is disseminated to all FN Health Centers to implement and develop own Suicide PIP Plan
ages to all communities	Information Sheets and posters are available listing all services / contacts, crisis phone numbers in Suicide PIP that can be shared with community members, schools and Nation Departments & agencies located in or near communities
	Social Media guidelines and general media guidelines
	Create an Aboriginal Crisis-Line (using existing Crisis-Line to create specific one)
6. Evaluation	FNHA & VCH to work on evaluation framework for all above activities

CULTURAL COMPETENCY STRATEGIES	OBJECTIVES							
1. Resource each community to have Cultural Advisors / Elders / experts attached to FN Health Centers to integrate culture across all services (in- cluding MWSU as a priority)	Cultural advisors, elders, experts are established in all 14 communities to support integration of culture into service delivery including MWSU							
2. Indigenous Cultural Compe- tency (ICC) training	Make ICC on-line training available to community MWSU workforce							
3. Training, learning and educa- tion by MWSU workforce in First Nations in the area and their unique cultures	Shared orientation processes in FNs in each area for MWSU personnel (professional and para-professional) – particularly for workers going into FN communities or working with community members (BEFORE they start working with clients)							
·	Encourage personal learning about local FNs by VCH MWSU workers							
4. Develop informational resources for MWSU personnel to enhance learning about First Nations	Resources are developed with elders from VC region FN communities, validated and disseminated in each community							
5. Provide 'cultural safety' mech- anisms for First Nations & Ab- original MWSU clients – service users	Aboriginal Patient Navigator / Mental Health Liaison position focused on MWSU to help people move between FN community & VCH services including connecting people with cultural experts in community for ceremony, prayer, one-on-one time with elders etc (24/7 service)							
	Integrated Clinical & Cultural Assessment Tools and Treatment approaches							
	FNHA work on a framework for ensuring healers and elders are "safe" to work with vulnerable MWSU clients and families (screening, background checks) and share guidelines with communities and VCH, agencies							
6. Evaluation	FNHA and VCH to develop evaluation framework for the above actions							

NEXT STEPS:

- The Draft MWSY Action Plan will be shared with the Hubs
- Hubs will have the opportunity to validate and provide feedback on the Draft MWSU Action Plan
- The Draft MWSU Action Plan will be amended to incorporate feedback and input
- The Vancouver Coastal Regional Table will review the Draft MWSU Action Plan
- The Draft MWSU Action Plan will inform investment and decision-making in the Vancouver Coastal Region

WORKFORCE DEVELOPMENT STRATEGIES	OBJECTIVES					
1. Promoting MWSU careers to	Support promotion of MWSU careers in FN communities					
youth	Support promotion of MWSU careers In Schools					
	Support at Post-Secondary Institutions					
	Scholarships for MWSU careers offered for Aboriginal and FN students					
	Communications / marketing strategy that makes MWSU careers attractive (and helps to remove the stigma; make MWSU careers "sexy")					
	Use role models – existing MWSU workers who can speak positively and promote MWSU careers to Aboriginal people					
2. Addressing Pay Equity and Employment Conditions	Review of NADAP and MWSU workforce on-reserve and market comparative study including benefits and incentive					
	Development of strategy for moving to equitable remuneration packages that includes recommendations on incentives & benefits					
	Addressing financial value of cultural expertise					
3. Recruitment of MWSU work force	Develop a Recruitment Strategy (with a focus on rural and remote) that encourages MWSU workforce into BC and working with FN communities					
	Develop funding and recruitment plan for the 32.8FTE capacity gap currently in FN communities $$					
4. Retention of MWSU workforce	Pay equity – see # 2 above					
	Peer support, exchanges and placements – see # 5. Below Professional Development					
	Ongoing learning and development opportunities created for FN MWSU workforce `					
	Self-Care / Wellness Planning for the MWSU workforce Guideline (creating supportive workplaces)					
5. Professional development and training of the MWSU workforce	Above strategies apply (pay equity, retention strategies including self-care) Cultural competency learning for the MWSU workforce – see B. Cultural Competency strategies in previous section					
	Develop a Career Pathway / Ladder for MWSU positions based on evidence-based approaches that incorporate Aboriginal / FN skills and expertise / competencies					
	Promote Associations of professional & non-professional MWSU workforce					
	Create a regional MWSU Clinical Supervision service for FN communities MWSU workforce available to communities					
	Create opportunities for learning and sharing between FN and mainstream services					
	Create Train the Trainer capacity in MWSU					
	Provide opportunities for local MWSU workforces (front-line) to come together					
6. Evaluation and Monitoring	FNHA and VCH to develop evaluation framework for the above actions					

APPENDIX F: DASHBOARD SUMMARY OF VC REGION PRIMARY HEALTH CARE ACCESS

DASHROAPD	SUMMARY OF VA	NCOLIVER CO	ASTAI REGI	ON · FIRST NA	TIONS lon-re	serve) (OMM	I INI TIRO – PRITINI I	ΜΔΡΥ ΉΓΔΙ ΤΙ	H CARF ACCES	S (Dec 2012)			
LEG END	SUMMENT OF VA	Service access	/ availability i	s g∞d / accept	able; working re	eding improvem	CH & others	INANI REALI	cessible r limited access				
	Sub-region			CENTRAL COAS	T.		HZMIIZ	NE COAST	PEMBERTON	/SEA TO SKY	NO RTH	SHORE	VANCOUVER
	Jub-legion			CENTRAL COAS			30143111	NECOASI	FEMBERION			SHORE	VANCOUVER
		Kitas∞ (Klemtu)	Heiltsuk (Bella Bella)	Wuikinuxv (Rivers Inlet)	Nuxalk (Bella Coola)	Ulkatcho (Anahim Lake)	Sliammon (Tla'amin) (Powell River)	Sechelt (Sechelt)	Mount Currie (Pemberton)	Southern Stl'atl'imx (Pemberton Valley)	Squarrish Nation (North Shore & Squamish Valley)	T sleil-Waututh (North Shore)	Musqueam (South Vancouver
	Traditional healers & practices	X											
SPIRITUAL	Elders, Advisors												
AND	Traditional / Spiritua												
TRADITIONAL	spaces / facilities												
WELLNE SS	Cultural Ceremonies												
	Tradition al Activities												
	Use of Language												
	Physical Activity												
	Nutrition/Food Security												
	HealthyPregnancies												
	Preventing smoking												
HEALTH AND	smoking œssation Suicide prevention												
WELLNESS	Violence prevention												
(Health	Communicable Disease												
Promotion &	prevention												
Prevention)	Injuryprevention												
	Alcohol and drug addiction prevention												
	Stress management												
	Emergency												
	Preparedness												
	Infant Development												
	Child health services												
	Youth health services												
FAMILY	Women's Health												
HE ALTH	Men's Health												
SERVICE S	Parenting Seniors / Elders												
(Age & Gender	programs												
specific)	Referral / Discharge												
	maternity Referral / Discharge	4											
	Assisted Living / LTC												
	Referral / Discharges												
	Mammograph y Colp.												
	Home Care Nursing Medication Reviews												
	Olinical supervision and												
	education												
	Case Management												
HOME AND COMMUNITY	Community Rehabilitation												
CARE	Adult days upport												
OFFILE	Medical supplies and												
	Equipment												
	Palliative Care												
	Personal care												
	Home Help												

	Sub-region			CENTRAL COAS	T		SUNSHI	NE COAST	PEMBERTON	/ SEA TO SKY	NORTH	I SHORE	VAN COUVER
		Kitæ oo (Klemtu)	Heilts uk (Bella Bella)	Wuikinuxv (Rivers Inlet)	Nuxalk (Bella Coola)	Ulkatcho (Anahim Lake)	Sliamm on (Tla'am in) (Powell River)	Se chelt (Sechelt)	Mount Currie (Pemberton)	Southern Stl'atl'imx (Pemberton Valley)	Squamis h Nation (North Shore & Squamish Valley)	Tsleil-Waututh (North Shore)	Mus queam (South Vancouver)
	Communitybased												
	counselling / therapy Outpatient Therapyand												
	counselling (Social												
	Worker) Clinical psychologist												
	Psychiatrist												
	Crisis support												
MENTAL	Access residential care												
WELLNESS AND	Vocational training etc												
SUBSTANCE	Support for families												
USE	Crisis response system for suicide												
	Postvention support for												
	families, fiends Referral / discharge												
	Resid. Treatment												
	Referral / discharge												
	Psych Units Referral / discharge												
	Detox Physician / Gen Med												
	care												
	Nurse Practitioner												
	Pharmacy/pharmacist												
	Dental therapists / Dentists												
HEALTH	Emergency/Services												
PRA CTITIO NERS	Optometry												
	Alternative Medicine												
	Clinical supervision and education												
	Visiting specialists												
	Referral / Discharge												
	specialists												
	CommunityHealth Representatives (CHRs)												
	Non-Insured Health												
	Benefits (NIHB) / Patient Travel												
	Tele-Health												
	QualityImprovement –												
SERVICE	Accreditation Research and												
ENABLER \$	Evaluation capacity												
	Training, education & workforce development												
	Service outreach, mobile												
	services												
	Electronic Medical Record / Client system												
	(EMR)												
	Health facilities												

APPENDIX G: WORKFORCE GAPS IDENTIFIED BY HEALTH DIRECTORS

Cultur al Ricilitators/Advisor sElders (\$45K)	0.5		0.5		1	0.5	1	1	2	0.5	1	8	\$34 6,5 00	346,500
Maternal Child Health (1.4 FTEs)	addresses g	aps in curre	ntprogram	5										
Community Health Nurse (\$10 oK)						0.4						0.4	\$40,000	MCH
MICH Nurse (\$100 K)				1								1	\$10 0,0 00	140,000
Primary Care & Public Health including Home & Community Care (20.4 FTEs) addresses gaps in current HCC program and strengthens Public Health Primary Care													1.4 FTE gap	
Physicians(\$190K)							1		2			3	\$57 0,0 00	
Re creation all The rapist , O ts / PT et c (\$6 oK)		2					1					3	\$180,000	
Elders Coordinator (\$45K)		0.5			1							1.5	\$67,500	
Dietician (\$8 oK)						0.5			0.5	0.5		1.5	\$12 0,0 00	
H CC LPIN / RIN (\$10 0K)		2				0.4				1		3.4	\$34 0,0 00	
M edical Office / Assistant (\$40 K)							1		1	1		3	\$12 0,0 00	Prim Care
H ealth Promoter (\$,0 K)					1		1				1	3	\$15 0,0 00	22.4FTE gap
Personal Care / Rehabl Aide (\$20 K)		2				1				1		4	\$80,000	\$1,627,500
Mental Wellness & Substance U	se (34.81	FTEs) - ad	dresses co	nsiderable	unmet 'n	eed', demo	and and go	aps in comn	nunities					22.4
Suicide Prevn & Resp. Clinicians (\$50 K)	0.2		0.2	0.5		0.5	0.5	0.5	0.5	0.2	0.2	3.3	\$16 5,0 00	
C linical P sychologists (\$moK)		1	0.2	0.5	0.5	0.5	0.5	0.5	1		0.5	5.2	\$57 2,0 00	
Youth Worker (\$50K)						15					1	2.5	\$12 5,0 00	MWSU
Con ourrent / Clinical Counse Nors (\$65-\$8 oK)	1		0.5	1		2		1	3	1	2	11.5	\$87 5,0 00	30.5FTE gap
Social Workers (\$80K)	1		0.5	1	1	1		0.5	1	1	1	8	\$64 0,0 00	\$2,377,000
TOTAL FOR FTEs	2.7	7.5	1.9	4	4.5	8.3	6	3.5	11	6.2	6.7	62.3	\$4,491,000	
PLUS Program Operating Funding	\$35,000	\$35,000	\$15,000	\$42,000	\$30,000	\$35,000	\$60,000	\$30,000	\$115,000	\$18,000	\$3 5,0 00		\$450,000	
GRAND TOTALS	\$35,000	\$35,000	\$15,000	\$42,000	\$30,000	\$35,000	\$60,000	\$30,000	\$115,000	\$18,000	\$35,000		\$4,941,000	

The Primary Health Care FTE workforce capacity gaps were originally identified and validated by VC region Health Directors in May 2013, and reviewed and valued with Health Directors again in February / March 2014. In total - gaps of 62.3 FTEs valued at \$4,941m were identified – with 50% of this gap being in Mental Wellness and Substance Use services and 36% being in primary care and home health

APPENDIX H: GLOSSARY

AANDC: Aboriginal Affairs and Northern Development

Canada (formerly Indian and Northern Affairs Cana-

da)

AHIP: Aboriginal Health Initiative Program (a VCH

health grants program)

AHOC: Aboriginal Health Operations Council

AHSC: Aboriginal Health Steering Committee

AHSI: Aboriginal Health Strategic Initiatives

AIDS: Acquired Immuno-Deficiency Syndrome

ASCIRT: Aboriginal Suicide and Critical Incident Re-

sponse Team

AWP: Aboriginal Wellness Program

BCCDC: BC Center for Disease Control

CCRF: Culturally Competent and Responsive Frame-

work

CHAP: Community Health Aide Program

CHR: Community Health Representative

CST: Clinical and Systems Transformation

EHO: Environmental Health Officer

EMR: Electronic Medical Records

FNHA: First Nations Health Authority

FNHC: First Nations Health Council

FNHDA: First Nations Health Directors Association

FNIH/FNIHB: First Nations and Inuit Health Branch

(Health Canada)

FTE: Full-Time Equivalent

GP: General Practitioner (doctor)

HC: Health Canada

HCC: Home and Community Care

HIV: Human Immuno-deficiency Virus

ICC: Indigenous Cultural Competency

IHP: Interim Health Plan

IPCC: Integrated Primary and Community Care

iRHWP: interim Regional Health and Wellness Plan

LPN: Licensed Practical Nurse

MCFD: Ministry of Family and Children Development

(Province of BC)

MCH: Maternal and Child Health

MOA: Medical Office Assistant

MWSU: Mental Wellness and Substance Use

MYHP: multi-year health plan

NOBA: Notice of Budget Adjustment

NP4BC: Nurse Practitioner for BC program

OCAP: Ownership, Control, Access, and Possession

PHC: Primary Health Care

PHSA: Provincial Health Services Authority

PIP: Prevention, Intervention, and Post-vention

RAKM: Research, Analysis, and Knowledge Manage-

ment

RHWP: Regional Health and Wellness Plan

RN: Registered Nurse

SGH: Squamish General Hospital

SMART: Sharon Martin Fund

STI: Sexually-Transmitted Infections

TFNHP: Tripartite First Nations Health Plan

VC: Vancouver Coastal

VCC: Vancouver Coastal Caucus

VCH: Vancouver Coastal Health

VIHA: Vancouver Island Health Authority

UVAHS: Urban Vancouver Aboriginal Health Strategy