

Evaluation of the First Nations Health Authority

Final Evaluation Report

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Executive Summary

The First Nations Health Authority

The First Nations Health Authority (FNHA) was created by and for BC First Nations and embedded as part of the BC First Nations health governance structure described in the 2011 British Columbia Tripartite Framework Agreement on First Nation Health Governance (Tripartite Framework Agreement). In 2013, the FNHA assumed responsibility for health programs and services for BC First Nations, formerly held by the Health Canada's First Nations and Inuit Health Branch (FNIHB) – Pacific Region and associated headquarter functions, as part of a broader mandate to work with the Province of British Columbia to improve health services accessed by First Nations in British Columbia (BC).

The FNHA's unique BC First Nations health governance structure also includes the First Nations Health Council (FNHC), which provides political leadership; the First Nations Health Directors Association (FNHDA), which acts as a technical advisory body to the FNHC and the FNHA on research, policy, program planning and design and the implementation of the Health Plans; and the Tripartite Committee on First Nations Health (TCFNH), which is a forum for coordinating and aligning programming and planning efforts between the FNHA, BC regional and provincial health authorities, the BC Ministry of Health and Indigenous Services Canada. The FNHA's mission is to support BC First Nations individuals, families and communities to achieve and enjoy the highest level of health and wellness by working with them on their health and wellness journeys.

Purpose

This report presents the results of an evaluation of the activities and programming delivered by the FNHA from the fiscal years 2013/14 to 2019/20. The purpose of this evaluation is to tell the story of change resulting from the creation of the FNHA, describing the progress that the FNHA has made against its mandate and strategic plan. The evaluation was required under the Tripartite Framework Agreement – Schedule 1 (CF8) and the Canada Funding Agreement – Section 10.1. The evaluation addressed a range of mandatory areas of FNHA activities as well as examined how the FNHA acted as a change catalyst within this health ecosystem and how its role interfaced with the roles and responsibilities of other partners.

Method of Study

The methodology used to undertake this evaluation included:

- An extensive review of documents and files related to activities and operations of the FNHA.
- Interviews with 50 key informants, including 25 FNHA staff members; 13 federal, provincial and TCFNH representatives; 7 FNHA Board Members; 2 FNHC representatives and 3 FNHDA representatives.
- Focus group sessions with the FNHA and FNHDA Board of Directors. The FNHC was also invited to participate in a focus group session in addition to participating in key informant interviews.

- Eleven case studies which provided an in-depth review of specific areas of FNHA operations, including:
 - Organizational Development of the FNHA
 - Wellness
 - Client and Community Engagement
 - Urban (Home/Away from Home)
 - Mental Health and Wellness
 - Transformation of Health Benefits
 - Population and Public Health (Chief Medical Officer) Function
 - Nursing Service Model Evolution
 - Increase in Funding and Change Funding Relationships
 - Emergency Planning and Response
 - Changes to FNHA Corporate Services and Functions

The case study methodologies were comprehensive and included a detailed review of the documents and administrative files associated with each area as well as interviews with FNHA staff members, provincial and federal partners, community representatives, clients and representatives of service delivery organizations. In total, 110 interviews were conducted to complete 11 case studies.

Major Findings and Conclusions

Major findings and conclusions arising from the evaluation are as follows:

1. **Significant, ongoing health disparities between First Nations and other residents of BC led to the decision by the First Nations leadership in BC to gain ownership of the First Nations healthcare system in BC.**

Prior to 2013, the delivery of healthcare in First Nations communities was based on a colonial approach of division of responsibilities between the provincial and federal governments. It was long evident that this approach to healthcare delivery was not effective in reducing ongoing disparities in health status. BC First Nations leadership made the decision to take ownership of First Nation healthcare and create a new approach responding to First Nations health needs.

2. **Creating a new governance structure and transitioning to a new approach took almost a decade to complete and was marked by a series of accords, plans and agreements that set the stage for renewed relationships.**

Signing of the 2011 Tripartite Framework Agreement created the new First Nations health governance structure in BC. Significant political, bureaucratic and administrative challenges had to be overcome to gain agreement on a new approach and achieve transition to a new model of healthcare delivery for BC First Nations. The solidarity and commitment of BC First Nations leadership, combined with growing recognition by federal and provincial governments of the need for better dialogue with First Nations, created conditions that facilitated transition to a new approach.

3. **The new mandate given to the FNHA by BC First Nations is much broader than that previously held by FNIHB. The new mandate requires the FNHA to adopt a much more strategic and long-term approach in its activities and focus on transforming the health system for BC First Nations, rather than simply delivering mandated programs and services.**

Relative to FNIHB, the new mandate places greater responsibilities on the FNHA in areas such as, involving First Nations communities in decision-making processes, responding in culturally appropriate ways, representing the interests of all First Nations living in BC, generating evidence through data and conducting specific research, providing population and public health leadership, and focusing on prevention, wellness and social determinants of health.

4. **Although further work is needed, the FNHA has been successful in building the organizational capacity needed to take on more roles, implement a range of new programs and services and improve existing operations.**

Within a short period of time, a complex transfer process was implemented, building new systems and structures, assuming assets, taking over programs and services and creating a new shared organizational culture, while ensuring no disruptions and minimal adjustments for BC First Nations and program providers. Using the dedicated funds, the FNHA built strong strategic planning, headquarter, finance and senior corporate functions within the organization to be able to deliver effective programs and services. Over time, the FNHA has worked to develop an organizational culture based on First Nations traditions, bring services closer to communities by building a strong regional presence, and establish a strong governance model and organizational culture also based on First Nations traditions.

Some of the organizational challenges currently facing the FNHA include the need to develop an operating model that can effectively function at provincial, regional and community levels and that balances the benefits of regionalization and centralized services; address issues related to governance and leadership (e.g., creating a cohesive leadership team and reducing turnover); and facilitate greater cooperation and communication among staff.

5. **The FNHA has achieved significant progress in implementing important changes to First Nations healthcare in BC by advancing excellence in programs and services, championing the BC First Nations perspective on health and wellness, enhancing First Nations health governance, and operating as an efficient and effective First Nations health organization.**

The FNHA has introduced many changes to the healthcare system including improvements to existing programs, services and practices as well as important new programs and services. The FNHA has, for instance:

- Developed a close partnership with the provincial government, which has been critical in helping the FNHA leverage additional resources and increase the range of programs and services that it can deliver. The partnership has also helped to improve quality and accessibility of the continuum of programs and services that First Nations receive from the provincial health system.

- Helped to improve community, regional and organizational planning. The FNHA has provided significant funding and organizational support to assist First Nations communities and health providers (communities, Tribal Councils, or First Nations organizations funded to provide First Nations health programs) in developing, implementing and evaluating their health and wellness plans, which are also used by the FNHA to develop its multi-year and annual health plans.
- Leveraged \$257.6 million in new funding from different sources, accounting for 9.3% of FNHA's total gross revenues, over the six-year period covered under the evaluation.
- The FNHA defined and incorporated the concept of wellness into its operations, policies and programs, provided funding to support community wellness programs and activities, created indicators to measure wellness, and recruited the Chief Medical Officer to provide health and wellness leadership. The FNHA also worked with the provincial government to incorporate the concept of wellness into a wide range of provincial policies and programs, becoming a catalyst for change in the provincial healthcare system overall.
- Employed a strategic approach in making program improvements, which commonly involves first identifying community and client needs. The FNHA has learned about community and client needs and priorities through working with the FNHC and FNHDA, participating in Regional Caucus meetings and Gathering Wisdom for a Shared Journey conferences, and undertaking research, surveys, engagement sessions, journey mapping, and independent assessments.
- Improved nursing services by creating a nursing leadership team to represent nurses at the senior level within the FNHA, restructuring nursing operations to bring services closer to the communities, delivering a range of nursing support services, improving nurse recruitment practices, developing nurse practice standards, and achieving greater integration of the nurses with other care professionals including traditional Knowledge Keepers to provide strength-based, culturally safe, and trauma-informed services and practices.
- Transferred delivery of Health Benefit programs from FNIHB to BC-based providers. The transfer provides greater control to the FNHA over program decisions, enabling the organization to influence formularies, benefits, and coverage rules. The transition has resulted in increased utilization of the health benefits across a range of key metrics and reduction in administrative cost.
- Developed a Policy on Mental Health and Wellness in 2018 and worked to establish a Mental Health and Wellness Fund which supports First Nations communities and aggregations of First Nations to come together to plan, design and deliver a full continuum of culture and strengths-based mental health and wellness services.
- Established regional offices to bring services closer to communities and developed strong corporate capacity to support effective operations and service delivery. In 2019, 18% of all FNHA positions were located within its five regional offices.

- Increased access to services for clients living in urban areas and away from home. The FNHA has a mandate to represent the interests of all First Nations in BC. As such, it implemented a range of programming targeted at addressing the needs of First Nations living in urban areas and away from home.
- The regional envelope funding process was created to provide streamlined access to new funding opportunities. The approach allows First Nations to access new and more targeted sources of funding in addition to that received through contribution agreements.
- Gained access to First Nations specific health data through partnerships with the provincial government, developed protocols and systems for First Nation specific data, conducted surveys, and expanded the range of data that it collects and reports from various sources. Increased access to data has enabled the FNHA to develop new programs and policies, leverage additional funding and make informed decisions.

The evaluation also highlighted various challenges and opportunities for further improvement in areas such as the equitable allocation of funding, reporting, meeting rising community and client expectations, balancing demand for services with available resources, further integrating First Nations concept of wellness into mainstream healthcare, addressing nurse turnover and use of agency nurses, and being able to access First Nations specific health data in a timely manner.

6. Going forward, the FNHA has positioned itself to continue to make significant improvements in healthcare delivery.

The FNHA has necessary capacity, aspirations and plans to continue influencing health care delivery and transformation. The next five years should see significant changes in terms of more resources, wholistic and innovation-driven approaches to health, more integration of the First Nations perspectives into provincial healthcare system and improved availability and accessibility of a continuum of care for First Nations peoples.

Recommendations

The recommendations arising from the evaluation are as follows:

1. Maintain a strong, strategic focus on transforming the healthcare system.

The mission of the FNHA is to transform the health system for BC First Nations, not just to simply deliver mandated programs and services. Significant, systemic change is needed to address the consequences of centuries long colonialism and to improve health and wellness for BC First Nations. Achieving that systemic change requires:

- A clear strategic vision regarding the future healthcare system for BC First Nations and the role of the FNHA in creating that system.
- Organizational capacity, including a cohesive leadership team and Board of Directors, needed to support the development and implementation of that strategy. As part of this step, it may be useful to conduct a review of the governance structure to assess the role

of the Board and determine how it can best lead and support an organizational mandate focused on system transformation.

- Continuing strong governance partnership with provincial and federal partners, grounded in the perspectives of BC First Nations. As the partners play key roles in delivering health care programs and services, securing their support and participation will be critical to improving health and wellness outcomes for BC First Nations.
- Organizational unity and the ability to serve as a common voice representing BC First Nations, including through ongoing engagement and involvement of the FNHC and FNHDA supported by clear roles and responsibilities and working protocols.
- Continued research, data analysis and policy development that supports evidence-based decision-making and strategic planning by the FNHA and its health system partners.

2. Focus on developing an operating model that can function effectively at the provincial, regional and community levels.

There is a need for the FNHA to establish an operational model that will function effectively at provincial, regional and community levels while maintaining the sustainability of the organization. Some of the key elements to consider include:

- Review existing operations and functions and engage with members of key staff within the FNHA (and health governance partners such as the FNHDA and FNHC) to determine which organizational structures, functions and activities are best implemented regionally and which centrally. As part of the process, identify advantages and disadvantages (including potential risks and challenges) of different models of operation and determine feasibility and sustainability of transferring certain functions or programs to the regions.
- Given that growth in program and services generally requires proportionate increases in corporate services and enabling functions, determine the structure and size of the corporate services that needs to be maintained to support the operating model. As part of this step, develop metrics (e.g., timeliness of response, staff satisfaction, etc.) to regularly measure and monitor the quality of corporate services and function and alignment with operations.
- Conduct a comprehensive review of the regionalization activities undertaken in Phase I and study the experience of similar organizations (e.g., provincial health authorities) to identify best practices in structuring and delivering effective services. Identify some of the key lessons and best practices that can be adapted to operations of the FNHA.
- Develop a multi-phased plan to regionalize FNHA activities and strengthen regional capabilities while maintaining strength of other areas of organizational capacity.
- Ensure that the new operating model maintains organizational unity, shared values, culture and a common voice in representing BC First Nations while also building on the advantages gained from being a strong, provincial entity (e.g., policy, data, intergovernmental, economies of scale, etc.).

3. Continue strengthening organizational capacity and effectiveness of programs and services.

The FNHA has developed strong capacity, organizational culture and systems to deliver effective programming. The effectiveness of FNHA operations and programs can further be strengthened by:

- Reviewing and revising funding formulas to ensure funding is allocated based on need, and that improvements in programs and services can equally benefit all client groups.
- Identifying more strategic ways to address rising community and client expectations and demand for services. Some of the approaches to be considered include confirming the FNHA's identity in various program and service areas (e.g. funder, partner, deliverer), leveraging resources and services from provincial and other partners, and focusing on areas of need where the FNHA can generate more substantial impacts.
- Enhancing efforts to build a strong organizational culture based on BC First Nations traditions, improving internal communication and transparency and promoting shared organizational values to build mutual trust and a strong team environment.
- Addressing some of the other program and service challenges identified by the evaluation, such as: strengthening efforts to serve First Nations clients living in urban areas and away from home; developing systems, guides and standard procedures to guide disengagements; finalizing emergency management processes and the FNHA's mandate in this area; improving recruitment and retention of nurses; developing a formal strategy for client and community engagement and improving practices on how engagement results are documented and shared within the organization; and supporting the development of resources, standards and certification to support the advancement of traditional wellness practices.

4. Develop a comprehensive Performance Measurement and Evaluation Strategy to guide the collection and usage of performance measurement data.

The FNHA is collecting a range of data from different sources to measure effectiveness of operations and is participating extensively in work associated with the performance of the overall health system. However, the consistency of performance data would be improved by creating a comprehensive Performance Measurement and Evaluation Strategy that enables ongoing assessment and reporting on the FNHA's operations, programs and services. Because the FNHA is delivering a wide range of complex programs and services covering a large number of communities, evaluations and studies focused on specific programs would provide more in-depth assessments of specific areas and would identify best practices.

1. Introduction

1.1 The First Nations Health Authority

In 2013, the First Nations Health Authority (FNHA) assumed responsibility for programs and services formerly delivered by Health Canada's First Nations and Inuit Health Branch (FNIHB) – Pacific Region and associated headquarter functions, as part of a broader mandate to work with the Province of British Columbia to improve health services accessed by First Nations in British Columbia (BC). The FNHA is the first province-wide First Nations health authority of its kind in Canada.

The FNHA seeks to improve the health and well-being of BC First Nations through effective health system partnership and integration, as well as management and funding of First Nations Health Programs. For the FNHA, success is marked not only by how well it fulfills its commitments under the British Columbia Tripartite Framework Agreement on First Nation Health Governance (Tripartite Framework Agreement) and the Consensus Papers, but also by how effectively it advances First Nations values, perspectives and principles in the broader health system through which meaningful partnerships and change in health outcomes can be accomplished.

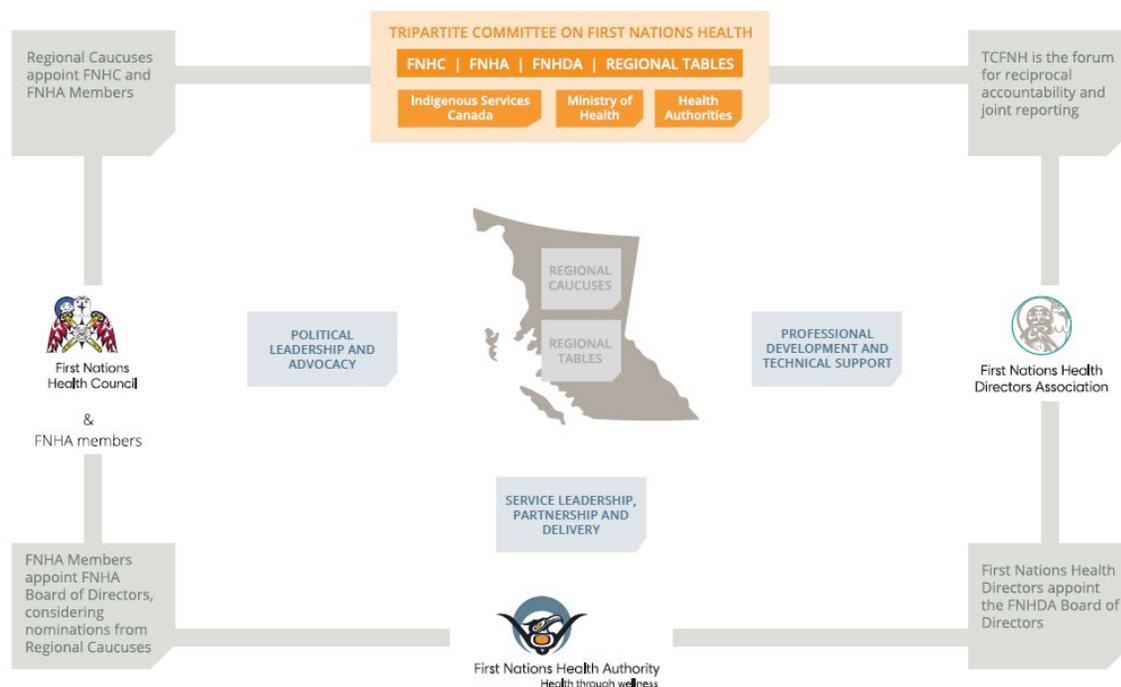
The FNHA's mission is to support BC First Nations individuals, families and communities to achieve and enjoy the highest level of health and wellness by working with them on their health and wellness journeys; honouring traditions and cultures; and championing First Nations health and wellness within the FNHA organization and with all of its partners.

The FNHA is part of a unique First Nations health governance structure, which is founded on the principle of reciprocal accountability. The structure includes the:

- **First Nations Health Authority (FNHA)**, which is responsible for planning, management, service delivery and funding of health programs previously delivered by FNIHB.
- **First Nations Health Council (FNHC)**, which provides political leadership for implementation of tripartite commitments and supports health priorities for BC First Nations. Additionally, the FNHC members serve a dual role as the members of the FNHA.
- **First Nations Health Directors Association (FNHDA)**, which consists of Health Directors and managers working in First Nations communities. The FNHDA supports education, knowledge transfer, professional development and best practices for Health Directors and managers. It acts as a technical advisory body to the FNHC and the FNHA on research, policy, program planning and design and the implementation of the Health Plans.
- **Tripartite Committee on First Nations Health (TCFNH)**, which is a forum for coordinating and aligning programming and planning efforts between the FNHA, BC regional and provincial health authorities, the BC Ministry of Health and Indigenous Services Canada.

The Shared Vision of the FNHA, FNHC and FNHDA is Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities. The following diagram outlines the roles of each of these bodies.

BC First Nations Health Governance Structure



The work of the FNHA and its partners is guided by 7 Directives which were established by BC First Nations Chiefs and Leaders through a process involving hundreds of Regional and sub-Regional Caucus meetings and Health Partnership Workbooks. These directives describe the fundamental standards and instructions for the new health governance relationship.

7 Directives

Directive	Overview
#1: Community-Driven, Nation-Based	<ul style="list-style-type: none"> The Community-Driven, Nation-Based 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.
#2: Increase First Nations Decision-Making and Control	<ul style="list-style-type: none"> 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.

Directive	Overview
	<ul style="list-style-type: none"> • 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.
#3: Improve Services	<ul style="list-style-type: none"> • 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 Non-Insured 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.
#4: Foster Meaningful Collaboration and Partnership	<ul style="list-style-type: none"> • 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.
#5: Develop Human and Economic Capacity	<ul style="list-style-type: none"> • 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.
#6: Be Without Prejudice to First Nations Interests	<ul style="list-style-type: none"> • 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.
#7: Function at a High Operational Standard	<ul style="list-style-type: none"> • 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.

1.2 Purpose of the Evaluation

The purpose of this evaluation is to tell the story of change resulting from the creation of the FNHA, describing the progress that the FNHA has made against its mandate and strategic plan. More specifically, the evaluation outlines what existed prior to the transfer from FNIHB to the FNHA, acknowledges the broader mandate that was established for the FNHA by BC First Nations Chiefs, and describes the progress made to date against that expanded mandate and the organization's goals outlined in its Interim and Multi-Year Health Plans (MYHPs) from 2013/14 to 2019/20:

- Achieving Transition
- Enhancing First Nations Health Governance
- Championing the BC First Nations Perspective on Health and Wellness
- Advancing Excellence in Programs and Services
- Operating as an Efficient and Effective First Nations Health Organization

This is a mandatory evaluation as required under the Tripartite Framework Agreement – Schedule 1 (CF8) and the Canada Funding Agreement – Section 10.1. The evaluation is intended to provide timely information to support results-based decision making and continuous learning and improvements at the FNHA. It is also intended to support the efforts of the FNHA and its partners to learn, grow and mature their relationships in order to advance shared goals.

1.3 Scope of the Evaluation

The evaluation covers the fiscal years 2013/14 to 2019/20. Pursuant to the requirements set out in the Canada Funding Agreement and the Tripartite Framework Agreement, the evaluation addresses the following areas:

- Plans and programs
- Organizational structure and organizational effectiveness
- Management of First Nations health provider relationships and health benefit provider relationships

The evaluation has addressed these mandatory requirements in a manner that is relevant to the FNHA and BC First Nations. The evaluation also examined, more broadly, how the health system in BC has been transformed due to the creation of the FNHA. This included examining how the FNHA acted as a change catalyst within this health ecosystem and how its role interfaced with the roles and responsibilities of other partners. While federal health programs are a main focal point of this evaluation, other activities and programs were also assessed to provide a more fulsome picture of the progress made by the FNHA.

The following areas were excluded from the scope of the evaluation:

- Evaluation issues covered through other FNHA evaluations (i.e. the Evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance; FNHA-FNHDA-FNHC Relationship Agreement Evaluation; Evaluation of Health Benefits – Pharmacy Program for BC First Nations; and Evaluation of Performance of FNHA Directors).
- Evaluation of the agreements themselves (Tripartite Framework Agreement / Canada Funding Agreement).
- A full in-depth review of all programming areas.



1.4 Evaluation Methodologies

The evaluation was undertaken in two phases. The first phase consisted of initial interviews as well as a file and document review leading to the development of a detailed Evaluation Plan including data collection tools and methodologies, which was then implemented in the second phase of the evaluation. The field research undertaken in the second phase of the evaluation included:

- **A detailed review of documents and files related to the FNHA.** Over 100 background documents were reviewed including agreements (e.g., Tripartite Framework Agreement, Canada Funding Agreement), annual reports, financial statements, strategic plans and multi-year health plans, policy frameworks, communication materials, evaluation reports, risk register, briefing notes and other relevant documents and files.
- **Interviews with 50 key informants.** The FNHA provided a list of 68 key informants to be interviewed as part of the evaluation. The list included representatives of the federal and provincial governments, senior members of the FNHA staff, members of the FNHA Board of Directors, and representatives of the FNHC and FNHDA. As demonstrated in the following table, a total of 50 interviews were completed of which 13 were completed with federal, provincial and TCFNH representatives, 25 interviews with the FNHA senior executive team members, seven with FNHA Board Members, two with FNHC representatives and three with FNHDA representatives.

Key Informant Interviews

Category	Contacted	Completed	Response Rate
Federal, Provincial TCFNH Representatives	14	13	93%
Senior Executive Team / Executive Directors	28	25	89%
FNHA Board Members	9	7	78%
FNHC Representatives	13	2	15%
FNHDA Representatives	4	3	75%
Total	68	50	74%

- **Focus groups with the FNHA and FNHDA Boards of Directors.** A focus group discussion was conducted with both the FNHA Board of Directors and FNHDA Board of Directors. The FNHC was invited to participate in a focus group session in addition to key informant interviews. Focus group discussions covered key areas including the success of the FNHA in achieving its mandate, role and responsibilities, effectiveness of its governance structure operations and programming, key challenges it faced, lessons learned and opportunities for improvement going forward.
- **Eleven case studies were conducted.** The case studies provided an in-depth review of specific areas of FNHA operations, evolution of these areas over time, impacts of the key changes introduced, some challenges faced and mitigating strategies. Based on preliminary interviews with FNHA staff members, key areas of the FNHA operations and governance were selected to be further studied through case studies. The topics for the case studies were selected based on importance of the area for the FNHA (e.g., organizational development, corporate services, etc.), innovative nature of the activities implemented (e.g., need to identify key lessons and best practices) and potential importance for making future decisions. As demonstrated in the

following table, the case studies explored a wide range of key areas of FNHA operations and programming, corporate capacity and governance.

Case Study Descriptions

#	Case Study Name	Case Study Description
1	Organizational Development of the FNHA	Explores the growth of the FNHA and development of its capacity over time to undertake new programs and roles. It also identifies some of the key challenges faced and lessons learned and provide recommendations.
2	Wellness	Explores the extent to which the FNHA's focus on defining and promoting the concept of wellness has been successful.
3	Client and Community Engagement	Reviews how the FNHA engaged clients and communities in its activities to shape decisions and define its priorities.
4	Urban (Home/Away from Home)	Reviews the FNHA's efforts to serve the needs of First Nations clients living in urban areas and away from home.
5	Mental Health and Wellness	Reviews the progress made by the FNHA in addressing the mental health and wellness needs of First Nations in BC.
6	Transformation of Health Benefits	Reviews how the FNHA transitioned delivery of FNIHB's Health Benefit program to BC-based providers. It also identifies challenges and lessons learned associated with the transfer.
7	Population and Public Health (Chief Medical Officer) Function	Explores success of the FNHA in creating the position of a public physician who can represent BC First Nations and speak on their behalf.
8	Nursing Service Model Evolution	Explores effectiveness of the efforts by the FNHA to transform nursing services to better meet community needs and priorities.
9	Increase in Funding and Change Funding Relationships	Explores how the FNHA leveraged additional sources of funding and reformed funding relationships with the communities and service providers.
10	Emergency Planning and Response	Explores the FNHA's involvement in emergency response and planning and identifies some of the key lessons learned and opportunities for improvement.
11	Changes to FNHA Corporate Services and Functions	Explores evolution and growth of FNHA corporate capacity, identifies some of the critical challenges and lessons learned, and provides recommendations going forward.

The case study methodologies were comprehensive and included a detailed review of the documents and administrative files associated with each area as well as interviews with FNHA staff members, provincial and federal partners, community representatives, clients, and representatives of service delivery organizations. In total, 110 interviews were conducted to complete 11 case studies. An open opportunity was provided through the FNHDA for all communities to participate in the case studies. The findings of case studies were summarized into a Case Study Technical Report, which is bound separately from this report.

1.5 Evaluation Considerations and Challenges

The main strategy to achieve high reliability of the findings has been the inclusion of multiple lines of evidence in the methodology. Interviews were conducted with a broad cross-section of stakeholders involved in or affected by FNHA activities and operations. In addition, an extensive document and administrative data review was conducted. Most representatives of the FNHA who

were involved in the transition process or the design and delivery of the FNHA activities and programming were interviewed. Case study methodologies were comprehensive allowing an in-depth assessment of specific areas of FNHA activities and functions. The key findings and conclusions presented in this report have been triangulated and confirmed with two or more lines of evidence to ensure reliability. As part of this step, the strengths and limitations of each line of inquiry were considered.

Despite these steps, it is important to acknowledge certain limitations. The main limitation is the potential for respondent bias. Many of the respondents are direct beneficiaries of FNHA activities and programming, which can lead to possible bias in their responses. Several measures were implemented in order to reduce the effect of respondent bias, including the following: (i) the purpose of this evaluation, its design and methodology, and strict confidentiality of responses were clearly communicated to respondents; (ii) the interviews were conducted by skilled interviewers; and (iii) answers from each sample of respondents were cross-checked with the other groups for consistency and validation. For example, findings of the interviews were cross validated by results of case studies and document and file review.

1.6 Structure of the Report

This report is structured as follows: to describe what existed in BC region prior to the creation of the First Nations health governance structure and the FNHA; to describe the creation of the FNHA and its expanded mandate when compared with FNIHB; and to assess the FNHA's progress relative to the five goals it has established in its strategic plan since 2013:

- Transition
- Enhance First Nation Health Governance
- Champion the BC First Nations Perspective on Health and Wellness
- Advance excellence in programs and services
- Operate as an efficient, effective and excellent First Nations health organization

Therefore, the next chapter provides an overview of the context in which the FNHA was created and the FNHA's work to address its goal of Transition – assuming roles and responsibilities previously held by FNIHB. Chapter 3 describes the progress made by the FNHA in enhancing First Nations health governance. Chapter 4 discusses the progress in terms of embedding the BC First Nations perspective on health and wellness into health care, influencing system change at the provincial level, including with respect to data and evidence. Chapter 5 highlights major findings from the evaluation related to the FNHA's efforts to advance excellence in programs and services. Chapter 6 describes progress made in terms of organizational excellence, including providing effective corporate support services and systems, leveraging additional resources and funding, and building strong organizational culture, staffing and leadership team. Finally, Chapter 7 contains overarching conclusions and recommendations.

2. Planning and Implementing the Transition

This chapter provides an overview of the context and process through which the FNHA was created and responsibilities for the First Nations healthcare in BC were transitioned from FNIHB. The results of the evaluation indicate that the decision to develop a new approach was made largely in response to significant and ongoing health disparities between First Nations and other residents of BC, which were not being resolved by the existing healthcare system. The transition process took almost a decade to be completed and involved numerous challenges which were overcome only through the concerted efforts of First Nations leadership and provincial and federal partners. The process resulted in the establishment of the FNHA, which possesses a mandate which is much broader than that previously held by FNIHB.

2.1 The Need for Change – Health System in BC Before FNHA

The decision by the First Nations leadership in BC to take ownership of the First Nations healthcare system was made in response to the significant ongoing health disparities existing between First Nations and the other residents of BC. The parties recognized that a new approach was needed.

A review of academic literature indicates that First Nations peoples and communities historically had strong and rich traditions of land-based health and wellness. First Nations enjoyed good health due to an active lifestyle (e.g., traditions of hunting, fishing and the gathering of traditional foods and medicines) and healthy traditional diets. Oral history suggests the population was characterized by good health and longevity, enhanced by ceremonial and spiritual practices for well-being.

Contact with European settlers marked a significant change in BC First Nations health and wellness. Colonialism and colonial policies devastated First Nations peoples' health through forced displacement from their traditional territories and disconnection from cultures, families and communities, ceremonies, languages, knowledge and traditions. Transformation of social and family structures through the introduction of European and Christian norms and values, the introduction of residential schools and the resulting intergenerational trauma created disparities in the social determinants of health and health outcomes of BC First Nations people. Ongoing social processes of colonialism, systemic interpersonal and internalized racism, and inequitable access to opportunities continue to be experienced today, contributing to ongoing health disparities experienced by First Nations peoples in BC.

Health disparities were further impacted by the availability, accessibility and quality of healthcare available for BC First Nations. According to key informants, the healthcare programming delivered for First Nations did not meet their specific needs and was not sufficient to address health disparities. In particular, a lack of clarity with regard to division of powers (under the Canadian Constitution, provinces have responsibility of organizing and delivering healthcare services, while the federal government has power over "Indians and land reserved for Indians") led to jurisdictional wrangling between provincial and federal governments over the delivery of healthcare for First Nations. While the provincial government delivered hospital, physician and public health programs to all Canadians, it generally did not operate direct health services on-reserve. Delivery of healthcare programming in First Nations communities has been a federal government responsibility. Though

the regional office of FNIHB delivered and administered a range of programs and services in BC, strategic direction was set from headquarters in Ottawa. This approach did not allow for the flexibility, relationships or scope required to meet the specific needs of BC First Nations. FNIHB programs were often delivered in silos, lacking adequate integration and flexibility to address community needs.

Furthermore, First Nations experienced challenges with accessing services due to remote and isolated locations and systemic racism. Healthcare did not incorporate First Nations cultural and traditional practices or First Nations perspectives on health and wellness. The healthcare programming accessed by First Nations communities often lacked cultural safety and humility and First Nations consistently faced embedded racism and discrimination when accessing services.

Several key events served as a catalyst for change. A 2001 report entitled *The Health and Well-being of the Aboriginal People in British Columbia* by the Provincial Health Officer drew attention to significant gaps in health outcomes and provided a range of recommendations for improvement. According to the report, Indigenous people in BC had a standard of living that was likely to be 20% below the provincial average, lived an average 7.5 years less than other BC residents, were significantly more likely to have chronic health conditions, and were less likely to rate their health as excellent or very good. The report recommended taking a more wholistic approach towards Indigenous health to address health disparities and highlighted the importance of providing genuine decision-making power and control to First Nations over health programming.

In 2004, two important court cases involving First Nations of BC triggered a new relationship between the province and First Nations. The Haida Nation and Taku River Tlingit cases clarified the roles, responsibilities and duty of the Crown to consult and accommodate First Nations rights and title to lands and resources affected by government decisions. The decision of the Courts created an opportunity to achieve real progress on First Nations title and rights issues. BC First Nations recognized that they would be able to take fullest advantage of this opportunity through unity amongst themselves. Consequently, the First Nations leadership signed the Leadership Accord affirming mutual respect and formalized cooperative working; and created the First Nations Leadership Council to oversee strategies and actions to bring about significant changes to government policy that will benefit all First Nations in BC. At the same time, the provincial government acknowledged its duty to consult with First Nations and the importance of considering First Nations perspectives when making key decisions. These developments created an opportunity for open dialogue between the provincial government and First Nations on a range of key issues including delivery of health programming and services.

2.2 Establishing a New Approach and Governance Structure

Creation of a new governance structure and transition to a new approach took almost a decade to complete and was marked by a series of accords, plans and agreements that set the stage for renewed relationships.

As demonstrated in the following table, the transition process took almost a decade to complete and was marked by a series of accords, plans and agreements that facilitated a new tripartite health partnership. This process faced a number of challenges that were overcome by consistent efforts by the First Nations leadership and provincial and federal partners.

Key Steps and Milestones Leading to the Transition to a New Approach

Timeline	Key Steps, Agreements and Accords
2001	A report on The Health and Well-being of the Aboriginal People in British Columbia by the Provincial Health Officer drew attention to significant gaps in health outcomes and provided a range of recommendations for improvement.
2004	Court cases related to Haida Nation and Taku River Tlingit clarified the roles, responsibilities and duty of the Crown to consult and accommodate First Nations rights and titles to lands and resources affected by government decisions.
March 2005	The BC Assembly of First Nations, Union of BC Indian Chiefs and First Nations Summit signed a Leadership Accord and created the First Nations Leadership Council to lead the discussion with the provincial government.
May 2005	Release of The New Relationship document between the provincial government and First Nations leadership affirmed a new government-to-government relationship based on respect, recognition and accommodation of Aboriginal title and rights and a commitment to work together to close the gaps in quality of life between First Nations and other British Columbians.
July 2005	In preparation for the November 2005 First Ministers Meeting, a First Nations Health Blueprint for British Columbia was prepared, which described key issues and challenges faced by the First Nations communities in delivering and accessing healthcare, and provided a new vision and approach for health service delivery.
November 2005	First Ministers Meeting on Aboriginal Issues held in Kelowna. Kelowna Accord reached, which set out a number of investments and measures. The Transformative Change Accord signed by the Province of BC, First Nations Leadership Council and Government of Canada to strengthen relationships and demonstrate commitment to close gaps over the next 10 years in five areas, including health.
2006	The Transformative Change Accord: First Nations Health Plan was released by the First Nations Leadership Council and the Province of BC, identifying priorities and 29 areas of action to close the health gaps.
2007	The Tripartite First Nations Health Plan was signed, bringing the federal government into the actions outlined in the Transformative Change Accord: First Nations Health Plan and committing to the development of a new First Nations Health Governance Structure in BC.
2009	First Nations Health Society, a non-profit organization, was established to act as an administrative and funding arm of the FNHC and be in charge of advancing First Nations health.
2011	British Columbia Tripartite Framework Agreement on First Nation Health Governance signed.
2011	At Gathering Wisdom for a Shared Journey IV, First Nations Chiefs directed the First Nations Health Society to take steps to become the interim First Nations Health Authority.
2012	A range of sub-agreements were signed. At Gathering Wisdom for a Shared Journey V, First Nations Chiefs supported the interim First Nations Health Authority to become the permanent FNHA.
2013	Transfer of programs and roles and responsibilities to the FNHA.

Following a series of discussions amongst the Province of British Columbia and the three BC First Nations political organizations, the New Relationship document was released in May 2005. Guided by principles of trust, recognition and respect for First Nations title and rights, the parties agreed to work together to close the gaps in quality of life between First Nations and other British Columbians. According to key informants, the New Relationship established common ground between First Nations and the provincial government on which they could begin addressing the health and socio-economic gaps which existed for First Nations of BC.

In parallel, work was undertaken among First Nations leadership to develop the First Nations Health Blueprint for British Columbia, which detailed key issues and challenges faced by the First Nations communities in delivering and accessing healthcare and outlined a new vision and approach for health service delivery and access. The document was developed with input from representatives of most First Nations in a forum organized by the BC Assembly of First Nations, and was submitted to inform an upcoming First Ministers Meeting on Aboriginal Issues.

On November 24-25, 2005, then Prime Minister Paul Martin, Indigenous leaders and the premiers from across Canada met in Kelowna, BC for the First Ministers Meeting on Aboriginal Issues. The Kelowna Accord, titled First Ministers and National Aboriginal Leaders: Strengthening Relationships and Closing the Gap, was established, which set out a number of measures as well as an agreement to work together.¹ During this meeting, the Province of British Columbia, the First Nations Leadership Council and the Government of Canada also signed a historic agreement entitled the Transformative Change Accord. The Accord recognized the need to strengthen relationships on a government-to-government basis and confirmed commitment to close the gaps between First Nations and other British Columbians through 10-year action plans in the areas of education, health, housing and economic opportunities and establish a new relationship based on mutual respect and recognition.

The following year, in November of 2006, the Transformative Change Accord: First Nations Health Plan was released by the First Nations Leadership Council and the Province of BC. The plan was developed based on the findings and recommendations of the 2001 report by the BC Provincial Health Officer on the health and well-being of Aboriginal people and the First Nations Health Blueprint developed in 2005. It identified priorities and 29 areas of action to close the health gaps between First Nations and other British Columbians. In 2006, the federal government also joined to support the activities of the Transformative Change Accord: First Nations Health Plan by signing the First Nations Health Plan Memorandum of Understanding.

As a key requirement of the Memorandum of Understanding, in 2007 the parties engaged in development of the Tripartite First Nations Health Plan. In order to successfully develop, complete and implement the Plan, discussions were started with First Nations communities and other health professionals. The First Nations Health Forum: Gathering Wisdom for a Shared Journey was organized to bring First Nations leadership, health professionals and health managers together to draft the action plan. The comprehensive plan was developed and signed on June 11, 2007, which laid the groundwork for development of the new First Nations Health Governance Structure in BC. According to the Tripartite First Nations Health Plan, this structure was to be comprised of a number of essential elements including:

- A First Nations Health Governing Body
- A First Nations Health Council
- A Provincial Advisory Committee of First Nations Health
- A First Nations Health Directors Association

¹ Most of the recommendations stemming from the Kelowna Accord were not implemented following the change in government after the 2006 federal election.

The Tripartite First Nations Health Plan also called for a plan to transfer the design, management and delivery of federal health services to First Nations to the First Nations Health Governing Body to be developed within three years.

The FNHC was established in 2007 to provide political leadership for implementation of these health plans. In 2009, the First Nations Health Society, a non-profit organization, was established to act as an administrative and funding arm of the FNHC. The society was established at arms length from the FNHC with a board of directors to ensure division of politics and operations.

Significant political, bureaucratic and administrative challenges had to be overcome to gain agreement on a new approach and achieve transition to a new model of healthcare delivery for BC First Nations.

According to key informants, tremendous challenges had to be overcome to obtain agreement on a new approach and ensure a successful transition. It was difficult to build relationships between parties that never worked together before. There was a significant need for education and increased awareness for all parties. Partners needed to assess the political, legal and administrative implications of a wide range of options and conduct extensive briefings to build support from leadership and senior officials. First Nations and governments needed to learn how to engage with each other as partners, and to learn more about one another's processes. This took time, given the historical issues preceding and affecting this type of new relationship. For example, the development of negotiations mandates on both sides took years.

Periodic changes in governments slowed progress, as it required time for each new government to become familiar with the work and demonstrate commitment to continue the process. For example, in 2006, when a new federal government was elected, it took the new government a number of months to confirm commitment to the process. In 2008, the BC Ministry of Health restructured and split into two ministries – the Ministry of Healthy Living and Sport and the Ministry of Health Services. In 2010, they restructured again to bring the two ministries back together. Each change brought new representatives to the table, requiring additional efforts with education and onboarding.

The work undertaken by BC First Nations was unprecedented and ambitious. It required a set of health reforms, close coordination with federal and provincial partners, and the meaningful participation of BC First Nations. It was a new journey for all of the partners, including First Nations communities. No other province in Canada had attempted to sign a similar health agreement and no other First Nations organization in Canada had undertaken such an ambitious reform initiative. As noted by key informants, the scale of the initiative created scepticism and concerns among some partners with regards to First Nations' ability to deliver on the commitments. Furthermore, each partner had to discuss each step within their respective teams, understand the implications, and ensure that the vision and objectives of the agreements and health plans could be achieved given the circumstances. With each progressive agreement, the relationship between the partners was further clarified and deepened.

According to key informants, one of the major issues expressed by First Nations was a concern that, by transferring the responsibilities of health programming, the federal government would abandon its fiduciary duty to First Nations. There was concern that the federal government would transfer responsibilities to First Nations without adequate on-going funding and partnership to address any arising issues. To address these concerns, transfer of administrative responsibilities (as opposed to

jurisdictional duty) was a key part of the tripartite negotiation processes and provisions were included in the agreements ensuring an increase in annual funding. An independent legal opinion was commissioned to confirm that the arrangement did not compromise the fiduciary duty of the Crown.

The solidarity and commitment of First Nations leadership, combined with growing recognition by federal and provincial governments of the need for better dialogue with First Nations, created conditions that facilitated transition to a new approach.

According to key informants, political unity and commitment across the First Nations leadership was critical to moving the process forward. Key informants noted that there can be political divisions between BC First Nations, fostered in part by a long history of government policies focused on creating political divisions and competition for resources. However, First Nation leadership in BC demonstrated a high level of unity and commitment. In 2011, 87% of BC First Nations leadership present at Gathering Wisdom for a Shared Journey IV voted in favour of establishing the BC First Nations health governance structure and transferring federal health programs and functions to its control. Leadership further resolved that the First Nations Health Society take steps to become the interim First Nations Health Authority and begin implementing the new health governance arrangement. The term “interim” was used to signal that further community engagement was needed to determine a final model for the FNHA. These decisions were formalized during the Gathering Wisdom for a Shared Journey V forum. In May 2012, the interim First Nations Health Authority transitioned into a permanent FNHA. Although this process of community engagement and consensus-building was led by and for BC First Nations, it was consistently supported politically, technically and through funding from both federal and provincial governments.

The 2011 Tripartite Framework Agreement on BC First Nation Health Governance formalized the new First Nation Health Governance structure in BC.

The new governance structure includes:

- Political advocacy, oversight and support provided by the FNHC.
- Technical support, advice and professional development provided by the FNHDA.
- Planning, management, service delivery and funding of health programs, policy and evidence development provided by the FNHA.

The roles and responsibilities undertaken by three different entities are complementary and require collaboration and cooperation amongst the FNHC, FNHDA and FNHA to ensure the effective and efficient functioning of the First Nations health governance structure.

The First Nations health governance structure also includes the TCFNH. The TCFNH brings together representatives of First Nations and provincial and federal governments and plays an important forum for political- and executive-level relationships to be fostered and maintained between First Nations leaders and government partners. It coordinates and aligns planning, programming and service delivery between the FNHA, BC Health Authorities and the BC Ministry of Health and provides a forum for discussion on the progress and implementation of the Tripartite Framework Agreement and the health plans and agreements.

2.3 An Expanded Mandate for the FNHA

The new mandate given to the FNHA by BC First Nations is much broader than that previously held by FNIHB. The mandate places greater responsibilities on the FNHA in areas such as involving First Nations communities in decision-making processes, responding in culturally appropriate ways, representing the interests of all First Nations living in BC, providing population and public health leadership, and focusing on prevention, wellness and social determinants of health.

Derived from the 1979 Indian Health Policy, FNIHB's mandate focused on providing health programs and services primarily to BC First Nations residing on-reserve as well as health benefits to all eligible registered First Nations. However, according to key informants, BC First Nations recognized that a much broader mandate was needed for the FNHA to be able to address the critical shortcomings of the old approach, address root causes of health disparities, and build a new approach representing First Nations interests and priorities well. Key foundational and governance documents such as Tripartite Framework Agreement, Transformative Change Accord: First Nations Health Plan, Tripartite First Nations Health Plan and the Consensus Papers (including the 7 Directives), provided a new mandate to the FNHA. Some aspects of FNHA's mandate which were not previously covered by FNIHB include:

- *Being community-driven and Nation-based*, upholding the 7 Directives, and implementing mechanisms to support engagement and decision-making processes among BC First Nations to guide the work.
- *Responding in ways that are culturally appropriate* and incorporating and promoting First Nations knowledge, beliefs, values, practices, medicines and models of health and healing.
- *Representing the interests of all First Nations in BC*, regardless of their residence, within the healthcare system and working with them on their health and wellness journeys as a health and wellness partner.
- *Collaborating with the provincial government* to coordinate and integrate their respective health programs and services to achieve better health outcomes for BC First Nations.
- *Modifying and redesigning existing programs or creating new health programs* and services through a collaborative and transparent process with BC First Nations to better meet health and wellness needs - implementing a two-way accountability model of reciprocal accountability between the FNHA and funding arrangement holders.
- *Providing population and public health leadership* by undertaking First Nations-specific research, health status monitoring, gathering knowledge and collecting and maintaining clinical information and patient records.
- *Prioritizing disease and injury prevention and a wellness approach* in health and building multi-sectoral partnerships to better address the social determinants affecting the health status of First Nations.

The new mandate requires the FNHA to adopt a more strategic and long-term approach in its activities and focus on transforming the health system for BC First Nations, rather than simply delivering mandated programs and services.

According to key informants, to be able to deliver on its new mandate, the FNHA had to change approaches that were based on a colonial system. In particular, the FNHA had to take a much more strategic and systemic approach and work to address root causes of health disparities, such as consequences of colonialism, systemic racism and social determinants of health. The new mandate also expanded the range of clientele that the FNHA represents. The foundational documents required the FNHA to serve the needs of all First Nations in BC, and not only those living in communities, engage with clients and communities as equal partners in the decision-making process, and be closely connected to learn their specific needs.

The new mandate meant that the FNHA had to make changes to existing programs and services, and secure additional funding and resources to deliver new programs and services to address unmet needs. This also required a need to coordinate activities closely with provincial, federal and other service delivery partners and engage in partnerships to influence policies and programs implemented by partners and become highly flexible, agile and innovative in its approach (instead of working by policies and programs).

2.4 Transition

Transferring responsibilities from FNIHB to the FNHA required building new systems and structures, transferring staff, assuming assets, and taking over programs and services while ensuring no disruptions and minimal adjustments for BC First Nations and program providers.

The signing of the Tripartite Framework Agreement in October 2011 marked the start of a complex transfer and transition process. As per the FNHA's strategic plans in 2013/14 and 2014/15, a complete and smooth transition of FNIHB's responsibilities to the FNHA while ensuring continuity of programs was the most important strategic priority for the organization during the early days of the transition. To achieve this objective, the transfer was implemented in two phases. Phase I was completed by July 2, 2013 and primarily involved FNIHB headquarter functions. Phase II was largely completed by October 1, 2013 and primarily involved regional functions². Some of the key elements of the transfer included:

- *Finalizing various sub-agreements governing specific areas of operations.* The Tripartite Framework Agreement required the transfer to take place within a two-year timeframe (i.e. by October 2013). To make this happen, the parties had to sign a series of sub-agreements describing the logistics and legalities of transferring the people, assets, facilities, funding and other functions that supported the FNIHB-BC regional operations to the FNHA. The sub-agreements focused on specific areas of operations and included:

² Some components of the transfer continued throughout the period covered under the evaluation. In particular, the transition of the Health Benefit program only started in 2017 and was completed by September 16, 2019.

- Human Resources Sub-Agreement governing terms of transitioning human resources
 - Health Benefits Sub-Agreement focused on transfer of the Non-Insured Health Benefits program
 - Information Sharing Sub-Agreement
 - Records Transfer Sub-Agreement
 - Novation Sub-Agreement (Contribution Agreements): over 104 agreements with First Nations communities and service providers were transferred from FNIHB to the FNHA
 - Accommodations Sub-Agreement
 - Capital Planning Sub-Agreement
 - Assets and Software Sub-Agreement
 - Service Continuity Agreement(s)
- *Transitioned infrastructure such as the Information Management, Information Technology (IMIT) assets, applications and systems.* The process also involved creating new systems and structures, reconciling Health Canada systems and migrating network files, replacing dated infrastructure (e.g., over 213 desktop devices), and developing organizational policies, processes, guidelines, and structures. On March 26, 2015, the FNHA officially unplugged from the federal network, marking independence from Health Canada's Information Technology infrastructure with the exception of health benefits programming. Some of the infrastructure transferred included vehicles, leases and contracts.
 - *Building the organization and creating corporate structures.* The Canada Funding Agreement allocated dedicating funding and resources to build corporate and management capacity within the FNHA to fulfill its commitments to deliver on programs and services. Using these resources, the FNHA built strategic planning, headquarters, finance and senior corporate functions within the organization. Significant resources and management efforts were invested in creating organizational structures, systems, policies and corporate structures functions (e.g., corporate services, human resources, finance, IMIT) within a short period of time.
 - *Transferring FNIHB staff.* Prior to the final transfer, 100 FNHA staff positions were in place, primarily at the executive, corporate, administrative, FNHA and FNHDA secretariat and programming levels. After extensive negotiations with respective unions, the FNHA provided job offers to eligible FNIHB staff. On October 1, 2013, 133 permanent and term positions transferred from FNIHB to the FNHA.

The transfer process was guided by the following success factors:

- Ensuring no disruption and minimal adjustment for individual First Nations people and communities in the continuation of their health services or health benefits.
- Ensuring minimal disruption and minimal added work burden on First Nations program providers who deliver community programs.
- Respecting the 7 Directives.
- Respecting the vision and principles of the Tripartite Framework Agreement and creating a solid foundation for its continuing implementation.

Although there were some challenges, key informants noted that the transfer was implemented well overall and required minimal adjustments for BC First Nations and service providers.

3. Enhancing First Nations Health Governance

This chapter describes the progress that the FNHA made towards its strategic goal to enhance First Nations health governance. According to the FNHA MYHP 2016/2017-2020/2021, the FNHA works to support sustainable and accountable governance structures to provide leadership and enable the health systems transformation envisioned in the tripartite health plans and agreements. To achieve this goal, the MYHP outlined three objectives, each with associated strategies:

- Strengthen regional decision-making approaches.
- Collaborate with the FNHC and the FNHDA to achieve our Shared Vision.
- Partner with federal and provincial governments to implement the tripartite health plan and agreements.

As mentioned in Chapter 1, a number of evaluations are being conducted covering different areas of the BC First Nations health governance. One of these evaluations is focused on assessing the relationship between the FNHC, FNHDA and FNHA and thus, a review of the relationship between the governance partners was excluded from the scope of this evaluation and not discussed in this section. The governance partnership with federal and provincial governments, particularly the provincial government, is discussed in Chapters 4 and 5 of this report. This chapter reviews the progress made by the FNHA in strengthening engagement and regional decision-making. It also identifies some of the broader and specific challenges that affect FNHA efforts to enhance health governance.

3.1 Engaging with Communities, Clients and Partners

The FNHA has enhanced the BC First Nations health governance by undertaking extensive engagement with First Nations communities, clients and governance partners and using the results of the engagement to make more informed program and policy decisions.

The process of engaging First Nations communities in health governance was started as part of the tripartite process. A review of FNHA documents and files indicates that, in 2007/08, efforts began to implement a more coordinated community consultation process. Consequently, 32 community engagement hubs were created where community representatives (e.g., health staff and leadership) could come to talk about and discuss issues related to their health and wellness. By 2013, 180 communities had participated in the hub process. The hubs continued to operate until 2014, when engagement resources and staff were transitioned to the FNHA.

Engaging with First Nations communities and involving them in decision-making is part of the 7 Directives guiding the activities of the FNHA, which requires all organizational activities and major decisions to be community-driven and Nation-based. Therefore, community engagement has been a critical part of the FNHA activities and programming. The FNHA has engaged with First Nations communities through:

- *Extensive consultations with the FNHDA and FNHC.* As per the First Nations Health Governance Structure, both the FNHDA and FNHC are critical in decision-making processes.

- *Participation in Regional Caucus meetings and Gathering Wisdom for a Shared Journey conferences.* The Regional Caucuses are composed of First Nations leaders and health professional representatives in each region. Through caucus sessions, the regions approve regional health and wellness plans which serve as the basis of the FNHA MYHP. Gathering Wisdom for a Shared Journey is a forum held approximately every 18 months which includes First Nations leadership, Health Directors and governance partners. According to key informants, the forum provides a key engagement opportunity to communicate progress and to gain additional direction and feedback from BC First Nations to advance the health reform process.
- *Recruiting Regional Community Engagement Coordinators.* In 2014, the FNHA created Regional Community Engagement Coordinator positions across BC to help support community engagement and communication efforts. The coordinators play a critical role in engaging with community members and in keeping the lines of communication open with community leadership and health staff members.

According to key informants, the main impact of the FNHA efforts to engage with communities has been an improved understanding of community needs and priorities. As per the 7 Directives, most key decisions have been made based on guidance the FNHA received through Regional Caucus meetings, Gathering Wisdom for a Shared Journey conferences, and on-going engagement with the FNHC and FNHDA.

The role of the FNHA in engaging with First Nation clients and interacting and communicating with them directly has evolved and increased over time. According to the findings of case studies, at the initial stages following transfer, the FNHA largely did not engage or communicate with clients directly as it did not have a service delivery role (with the exception of nursing stations run by the FNHA, and some components of the Health Benefits program). However, the FNHA gradually increased its efforts to engage and communicate directly with clients and to learn their perspectives on specific issues and needs.

According to key informants and FNHA files and documents, a range of avenues were used by the FNHA to engage and interact directly with First Nations clients. In particular, the FNHA has engaged clients online (website and social media), through regular surveys conducted by the FNHA (e.g., Health Attitudes Survey, Health Benefits Client Surveys, and several Regional Health Surveys), by participating at various events (e.g., Elders Gatherings, Gathering Our Voices Youth Conference, etc.) and in the Patient Voices Network, and by undertaking client journey mapping (e.g., mapping of client experiences through their health and wellness journey). The FNHA also engaged directly with clients living in communities when launching the Health Benefits Program. For example, as part of the Phase II transition, the FNHA organized 51 group sessions in 2018 and 2019 with clients covering 97 communities to learn their needs. The findings were used to design a new Health Benefits Program and the staff went back to the same groups to inform them of how their perspectives were incorporated into the design.

According to key informants, the main impacts of FNHA efforts to engage with clients have been improved understanding of client needs and their perspectives on specific issues. The results of the engagement activities are used to bridge the gap between clients and the organization and to bring client voices into decision-making. This knowledge is used to shape the FNHA's activities and information campaigns to better target client needs. For example, according to case study findings, the FNHA used the results of the Health Attitudes and Beliefs Survey to create and implement an Indigenous Strength campaign to address misinformation among Indigenous youth regarding the

harmful effects of cannabis. It also targeted older generations to change attitudes towards harm reduction practices. Client engagement also helped to improve the reputation of the FNHA as well as to promote client self-esteem and a sense of control over decisions affecting their lives. For example, according to case study participants, when the FNHA went back to the same communities to inform them of how their recommendations were used in developing the design of the Health Benefits program, it enhanced client perceptions of the FNHA and improved their sense of control over program decisions.

Finally, according to key informants and case study participants, engaging and communicating with communities and clients has allowed the FNHA to continuously learn and grow. Through constant communication and engagement, the FNHA has been able to avoid repeating the mistakes of the past. Ongoing engagement and communication activities have made the FNHA more agile and flexible so that it can more quickly make decisions and adapt to community and client needs.

3.2 Increasing Regional Decision-Making for Funding

The FNHA has developed innovative mechanisms to distribute new funds to enhance regional decision-making, eliminate competition for funding, encourage and support collaboration and partnership, and identify concepts that can address root causes of health issues and problems. For example, the FNHA created a regional envelope funding process to provide streamlined access to new funding opportunities. The approach allows First Nations to access new and more targeted sources of funding in addition to funding received through contribution agreements. Using the sources of new funding (e.g., provincial funding and new federal funding streams), the FNHA has allocated dedicated funding envelopes for the regions. Regional teams work closely with First Nations and health providers to secure funding for specific needs and priorities or for project ideas that communities and regions have identified. Provided that a proposed project/initiative fits within the funding criteria, regional teams work with the community to develop a project proposal. The proposals are developed, not to compete for funding but rather to articulate community-driven ideas around health priorities and needs, and request the grant money.

Similarly, the FNHA and partners have created a new system to distribute the Mental Health and Wellness Fund to communities. The Fund supports First Nations communities and aggregations of First Nations to come together to plan, design and deliver a full continuum of culture and strengths-based mental health and wellness services over two years (2019-2021). The FNHA regional teams work closely with First Nations to prepare a Statement of Readiness that outlines the activities and outcomes that the funding will support. The communities are supported by the FNHA at all stages of accessing funds, including from the “Pre-Plan or Plan” stage, to the development of partnerships, to project design and demonstration of the project results. A tripartite Mental Health and Wellness Table reviews Statements of Readiness from a wholistic, strengths-based, family-focused and Nation-based perspective.

3.3 Enhancing Regional Capacity

As per the mandate given by First Nations in the 2012 Consensus Paper³, the FNHA placed a strong focus on bringing services and programs closer to the communities by establishing regional offices.

³ Consensus Paper 2012: Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure.

According to key informants, establishing a presence in the regions is critical because regional staff members can be better positioned to understand local needs, build close relationships with communities and deliver effective services. First Nations communities are also more willing to work with a staff member with whom they can meet regularly, communicate directly and build trusted relationships.

A phased approach is being used to implement regionalization. The first phase of regionalization involved the creation of regional offices in 2015/16 and recruitment of Regional Directors (who became Regional Executive Director positions in 2018/19). Efforts have been undertaken to hire additional regional staff, re-assign existing employees to regions, allocate more resources and programming to the regions (e.g., regional envelopes and Health Actions funding, Environmental Public Health, Aboriginal Head Start On-Reserve and some Primary Care positions) and develop regional infrastructure. At the time of this evaluation, all five regions employed a range of staff in senior (e.g., Regional Executive Directors) and service delivery positions (nurse managers, practice consultants, mental health and wellness specialists, crisis response teams, emergency coordinators, and engagement teams.). To date, the increase in regional staffing has been one of the main areas contributing to growth in the size of the organization; in 2019, 18% of all FNHA positions were located within its five regional offices. Chapter 6 provides more detailed information regarding the organizational growth and some of the associated challenges with regionalization.

3.4 Challenges

The FNHA's efforts to enhance the First Nations health governance have been constrained by a number of challenges. This section describes some of the significant challenges identified by the evaluation.

Clarity with regards to roles and expectations amongst the FNHC, FNHDA, and FNHA.

Key informants noted that the BC First Nations governance is complex and creates many lines of accountability. For example, the FNHC provides political support and also plays a role in appointing the FNHA Board of Directors⁴, and FNHDA members provide technical support and also deliver programming at the community level. Given this complexity, it is necessary to have clarity around roles and responsibilities and how the decisions are made. Case study interviewees mentioned that when coordinated well, these layers of accountability and interactions can create alignment and contribute to overall success. When they are not managed well, which happens at times, the complexity can create impediments and challenges (e.g., political interference, bureaucracy), thus affecting progress. For example, in 2017, miscommunication between the FNHA and FNHDA as part of the transition of pharmacy benefits from the Non-Insured Health Benefits program to BC Pharmacare resulted in confusion. While the FNHA expected that the FNHDA would take a leading role in spreading the message about the transition and preparing the communities for the

⁴ FNHC members have a dual role in the BC First Nations health governance structure, and these roles are meant to be carried out separately from each other. In addition to being representatives of the FNHC, these individuals also serve as the members of the FNHA non-profit society. In this role as members, these individuals collectively appoint the members of the FNHA Board and assess their performance, amongst other duties outlined in the FNHA constitution and bylaws.

transition, Health Directors felt they were not adequately engaged or prepared to respond to questions received from the community.

The FNHA has experienced challenges with reaching out to and engaging with clients, particularly those from urban areas.

According to key informants and case study participants, FNHA communication activities typically reach only a small fraction of its client base, primarily residents on-reserve. The organization lacks contact information for many clients as well as an effective mechanism for reaching them. Particular challenges have been experienced with reaching out to and engaging First Nation clients living in urban areas and away from home. While some research and communication activities include an urban focus (e.g., customer survey, health attitude survey, journey mapping and social media), most are focused at the community level. For example, the FNHA's Community Engagement Coordinators work mostly with communities and do not typically engage clients living in urban areas and away from home. Case study participants also noted the importance of fully documenting the results of the client and community engagement activities and sharing the results with others in the organization.

Challenges with building consensus on key issues affecting health and well-being of First Nations.

The perspectives of First Nations in BC can vary widely from community to community. Key informants suggested that Nation building efforts are necessary to develop governance structures that help build common positions and create economies of scale. To address this issue, the FNHA executive team has been encouraging a Nation-based approach to service administration and allocation of resources. Case study participants noted that this will take time and extensive efforts, supported by continued reliance on culture and the principles/values outlined in the Consensus Papers.

Lack of clarity with regards to roles and responsibilities and processes involved in managing disengagements.

Disengagement refers to the process by which a community voluntarily chooses to withdraw from a multi-community agreement to deliver services directly to its members or enters into a different multi-community agreement. There are various reasons for disengagement, including changes in organizational structures, organizational or community maturity (e.g., when a community has enough capacity to deliver services by own), mutually agreed-upon reasons, or relationship challenges that the FNHA inherited from FNIHB. At the time of this evaluation, a review of the FNHA documents indicated that ten communities had requested disengagement from multi-community agreements that they had with service delivery organizations or Tribal Councils. In addition, the FNHA terminated two agreements with the Inter Tribal Health Authority, a decision that impacted 31 communities. According to key informants and case study participants, disengagements and reengagements usually increase administrative efforts in which the FNHA has to invest to ensure continuity of the services and can result in legal costs. During interviews, case study participants noted that the FNHA needs to develop disengagement protocols and processes to ensure consistent approaches of disengagement are implemented with different Nations, and that this process needs to include clarification of the roles of the FNHC and FNHDA.

4. Champion the BC First Nations Perspective on Health and Wellness

The BC First Nations Perspective on Health and Wellness articulates a wholistic view of well-being in which the health and wellness journeys of human beings are owned by those self-determining individuals. This chapter describes the progress that the FNHA has made towards its strategic goal of championing the BC First Nations Perspective on Health and Wellness. According to its MYHP, the FNHA was to champion this perspective through:

- Working with partners to transform from a sickness system to a wellness system, such as through promoting cultural safety and humility, embedding First Nations perspectives in provincial strategies and initiatives, and shifting the paradigm in data and evidence.
- Partnering with First Nations individuals, families and communities in their health and wellness journeys, such as through lateral kindness, sharing health and wellness stories, and supporting tools, resources and initiatives.

4.1 Embedding the First Nations Perspective on Health and Wellness

The FNHA has moved strategically from a “deficits of health” approach (i.e., illness, injury and negative health outcomes) to a model based on wellness, in order to better address the effects of colonialism, and promote and build on First Nations strengths and resilience.

Prior to the transition, the health system for BC First Nations focused primarily on the deficits of health including illness, injury and poor health outcomes. Similarly, much of the research on First Nations health was focused on health deficits and the ‘gaps’ in health status that exist between the First Nations population and the non-First Nations population. According to key informants, although identifying gaps and health disparities have some value in helping guide program and policy decisions, this approach does not address underlying causes and does not support an individual’s wellness journey. A different approach was needed, which focused on monitoring and reporting both health disparities as a result of being subject to colonial practices and policies as well as assets and areas of strengths of First Nations individuals and communities.

The first step towards adopting a wellness-based approach to its work was to undertake extensive engagement with First Nation clients, Elders and healers. That resulted in the development of the First Nations Perspective on Health and Wellness, a wholistic vision of wellness shared by BC First Nations. The FNHA has defined wellness as: *“a strengths-based and wholistic approach to achieving health and well-being that is identified by self-determining individuals, families, communities, Nations, and organizations.”*⁵ The main difference between the First Nations Perspective on Health and Wellness and that of mainstream, western approaches to health is that the First Nations perspective is focused on wellness rather than a system focused predominantly on diagnosing and treating illness. The First Nations approach is designed to support strengths and resiliency in people. According to key informants and case study participants, taking a strengths-based approach was a

⁵ FNHA. 2019. FNHA’s Policy on Wellness

deliberate shift away from a deficits-based narrative. It moves healthcare towards an approach that promotes and builds on strengths and acknowledges the structures and environments that enable First Nations to be healthy and thrive.

At the provincial level, the FNHA integrated First Nations perspectives on health and wellness into provincial programs and policies, intended to benefit all First Nations, including those who live in communities and away from home.

The provincial government plays a key role in delivering healthcare for BC First Nations. By developing strong partnerships with the provincial government, in effect by becoming hardwired into the provincial system, the FNHA was able to act as catalyst for change in the provincial healthcare system to the benefit of First Nation clients and more generally all residents of BC.

Towards that end, the FNHA has represented the interests of First Nations at health tables and forums at both the most senior levels (e.g., Chief Executive Officer to Deputy Minister through creation of collaborative governance structures with the Ministry of Health and Ministry of Mental Health and Addiction) and at the service delivery levels (e.g., through direct engagement with regional health authorities and service delivery agencies as well as providing tools and guidelines on First Nations approaches to health). These efforts help provincial services to become more responsive to the needs of all First Nations clients. Through these strong partnerships, the FNHA has been able to influence provincial policies and services by incorporating First Nations perspectives throughout the healthcare system.

The case studies identified various areas where the FNHA has enabled First Nations perspectives of health and wellness to be incorporated into provincial policies and programs. Examples include:

- The BC Ministry of Mental Health and Addictions Service Plan 2019/20 to 2021/22 which identifies key areas where the provincial government will invest resources to support First Nations health and wellness. These areas include the social determinants of health, areas that connect the mental, physical, emotional and spiritual dimensions of well-being, and actions that ensure services are culturally safe and respectful.
- A wellness plan being developed by the Ministry of Health at the time of this evaluation which is expected to include First Nations perspectives on wellness.
- Extensive work undertaken by the provincial service delivery organizations to incorporate cultural safety and humility into their work. Based largely on efforts by the FNHA, most provincial service delivery organizations and government representatives have signed declarations on cultural safety and humility indicating their commitment to incorporate cultural safety and humility into their work.
- Representing First Nations at key provincial tables and committees (e.g., the Ministry of Health Prevention and Health Promotion Policy Advisory Committee, Provincial Injury Prevention Committee, Provincial Food Security Committee, Healthy Communities Committee, etc.).
- Supporting investments in primary care clinics for First Nation clients through Joint Project Board funding, and developing a new primary care clinic in Surrey (i.e., the Indigenous Primary Health and Wellness Home), which offers culturally safe and wholistic healthcare to 17,000 First Nations, Métis and Inuit people in Surrey.

Case study participants noted that policy and program changes have already translated into increased funding for programs and services focused on First Nations perspectives of health and wellness, which will eventually affect the quality of the services received on the ground by clients.

Several factors have facilitated the FNHA's ability to influence a system change. The most important factor, according to key informants, is that the FNHA has a mandate to speak as a common voice representing all First Nations in BC, regardless of residence. As a result, the FNHA integrated the interests and perspectives of urban and away from home populations in its activities, programming and policy decisions. For example, all key policies and strategies (e.g., Indigenous Cancer Strategy, the opioid response, and the Cultural Safety and Humility Standard, etc.) included interests and perspectives of urban and away from home clients. Additionally, the FNHA's focus on governance partnerships has been key to ensuring First Nations are hardwired into processes of decision-making. Finally, Calls to Action of the Truth and Reconciliation Commission and an increased focus on reconciliation have created an environment where the FNHA is able to work productively with partners influencing system change.

The FNHA has created the Chief Medical Officer function to provide health and wellness leadership.

In 2014, the FNHA created the Chief Medical Officer function to provide health and wellness leadership. In addition to public health issues and concerns that have western evidence and scientific backing, the Office of the Chief Medical Officer is able to engage and promote traditional foods, medicines and healing practices as well as address issues that relate to the social determinants of health (e.g., the intergenerational effects of trauma and colonialism). As Watchmon, a role of the Office of the Chief Medical Officer is to communicate with people and guide them through all types of health and wellness challenges that they face as well as raise issues with respect to the health and wellness of the population. The Office of the Chief Medical Officer participates in a wide range of health system committees to convey First Nations perspectives on health and wellness through a medical and population health lens, and influences the system to better address these perspectives.

4.2 Supporting Wellness Through Plans, Programs and Campaigns

The FNHA has integrated wellness into its activities and programming, and allocated resources to advance wellness.

The FNHA applied a wellness lens to all areas of the FNHA mandate, including the services that it delivers or funds as well as programs and policies implemented by the federal and provincial system partners. Some of the key activities implemented by the FNHA to promote wellness, as identified in case studies, included reviewing and revising the FNHA's internal policies, programs and operations to focus on wellness and support its wellness agenda; engaging staff to develop a plan of action to better coordinate the FNHA and community activities focused on promoting wellness; and ensuring wellness forms part of key messages that the FNHA communicates to communities, clients and partners.

The FNHA has also implemented various activities designed to promote the health and well-being of First Nations clients and communities including:

- Organizing lifestyle campaigns and challenges to promote physical activity and sports and implementing educational campaigns to encourage healthy behaviours (e.g., risks and benefits of cannabis use among First Nations youth, silver ribbon events to raise awareness of the overdose crisis, importance of peer involvement in harm reduction, recognizing the signs of suicide).
- Organizing or supporting an array of campaigns targeted at specific events or wellness priorities (e.g., World Breastfeeding Week, International Day of the World's Indigenous People, etc.).
- Implementing a cancer awareness and screening campaign.
- Supporting and participating in numerous key events focused on promoting wellness (e.g., BC Aboriginal Diabetes Conference, Annual Gathering our Voices Youth Conference, Annual Elders Gathering, etc.) and supporting partners that promote wellness through active lifestyles (e.g., engaged SportMed BC to support the Aboriginal RunWalk Program and engaged BC Indigenous Sports, Physical Activity and Recreation Council to deliver culturally safe Indigenous programming focused on healthy living).

The FNHA also dedicated specific funding to support wellness activities on the ground and at the community and service delivery levels. FNHA documents demonstrate that, of the 556 community-based projects which received Health Actions funding from 2014 to 2019, almost all identified First Nations perspectives on health and wellness as their priority. The FNHA launched Winter Wellness Grants and the Indigenous Peoples Day of Wellness Grants to support First Nations communities in hosting community-led wellness events grounded in ceremony, traditional practices and BC First Nations cultures. The events were designed to encourage and sustain wellness in individuals, families and communities by promoting community ties, active lifestyles, healthy eating, nurturing spirit and respecting tobacco.

The FNHA also conducted extensive efforts to support the development of traditional wellness. Traditional wellness is a term that encompasses traditional medicines, practices, approaches and knowledge. As traditional wellness was identified as one of the key priorities for First Nations health and well-being, the FNHA developed the Traditional Wellness Framework to outline key objectives and strategies for supporting traditional wellness activities. The FNHA also supported advancement of traditional medicines and practices as well as a Traditional Healers Gathering and brought together traditional healers at different working groups and advisory committees to coordinate activities.

As a result of efforts by the FNHA, First Nations perspectives on wellness are a key component of health planning within the FNHA, at the community level, and within the provincial government. Case studies highlighted associated benefits such as increased funding for wellness activities, strengthened community bonds and individual self-esteem, and changing client attitudes and behaviours.

During interviews, key informants noted that wellness has become one of the key components of First Nations health and wellness planning. A review of a sample of regional First Nations health and wellness plans indicates that considerable emphasis across all regions has been placed on the integration of wholistic models of prevention and wellness and traditional wellness activities into regional and community programming.

According to key informants and case study participants, the FNHA's focus on wellness is already making a difference in the lives of clients and within communities. Increased funding for wellness

has enabled First Nations to come together to celebrate their cultures and traditions, increased community bonds and improved individual self-esteem and confidence. The FNHA Chief Medical Officer function has provided a stronger voice for First Nations communities and clients, using culturally appropriate language while communicating the root causes of health problems and disparities. During interviews, case study participants noted that health promotion campaigns undertaken by the FNHA have had some initial impacts on the attitudes and beliefs of clients and communities. Examples of changes in attitudes and beliefs mentioned by case study participants, included feeling more in control of one's own health, an increase in self-esteem and a sense of self determination, a decrease in stigma around mental health and addictions challenges (e.g., acknowledging the issue and talking about it), an openness to use harm reduction techniques, and increased screening for cancer. According to case study participants, due to the trust that the FNHA has been able to build with communities, campaigns have been more effective in empowering clients and communities and creating changes in attitudes and beliefs. Incorporating traditional wellness activities into healthcare programming has contributed to more welcoming environments and increased service utilization rates.

4.3 Supporting First Nations Health Data Governance

The FNHA has gained access to First Nations specific health data through partnerships with the provincial government, developed protocols and systems for First Nation specific research, conducted research and surveys, developed performance measurement frameworks and expanded the range of data that it collects and reports from various sources.

According to case study findings, the FNHA has gained access to First Nations-specific population and public health data collected by the provincial government. As a provincial health institution, the FNHA has been able to establish close partnerships with the provincial government around data management and governance. In 2010, as part of the transition, the FNHA signed the Tripartite Data Quality and Sharing Agreement with the federal and provincial governments. The Agreement supports the development of the First Nations Client File which can then be linked with various other health databases, making the data on the First Nations population identifiable. Joint protocols and decision-making processes have been established to balance the need for high-quality First Nations health data with the need to protect individual and community privacy while respecting the principles of First Nations health information governance. These processes and protocols guide all aspects of data governance, including analysis, interpretation and release. Key reports have been prepared using the new data accessed through the First Nations Client File in areas such as health system utilization, cancer and overdose. Furthermore, a close partnership with the Provincial Health Officer on data has resulted in regular reports on the core indicators outlined in the Transformative Change Accord: First Nations Health Plan, and led to new initiatives and innovative projects, such as the Indigenous Women Health Report (forthcoming in August 2020), and the Population Health and Wellness Agenda baseline report (forthcoming in January 2020).

The FNHA also administers a number of surveys itself (e.g., the First Nations Health Attitudes and Beliefs Survey in 2019) and in partnership with other organizations such as the First Nations Information Governance Centre (e.g., the Regional Health Survey, the First Nations Labour and Economic Development Survey, and the First Nations Regional Early Childhood, Education and Employment Survey). According to case study participants and key informants, the FNHA uses findings from these surveys to better understand community and client needs and health priorities and shape its programs and policies to better target client needs.

In addition, the FNHA has access to a wide range of data through its Health Benefits program. Starting with the transfer in 2013, the FNHA assumed responsibility for the delivery of the Non-Insured Health Benefits Program (called simply the Health Benefits program within the FNHA). Through the program, the FNHA stores and/or has access to pharmacy, dental, vision, medical transportation and mental health crisis response data. The data is used to make programming decisions.

The FNHA conducts evaluations and prepares regular quarterly and annual performance reports, to monitor its activities and report on its progress in achieving objectives. Regular and timely reporting and evaluations have enabled the FNHA to make more informed decisions and demonstrate the success of its activities to stakeholders. High quality and engaging reports have outlined the accomplishments of the FNHA and challenges that it faces, improving the reputation of the organization.

Increased access to data has enabled the FNHA to develop new programs and policies, leverage additional funding and make informed decisions.

The enhanced access to new data and evidence has led to the establishment of new health priorities and the development of programs and services. The most notable examples, identified through case studies, key informant interviews and a review of documents, included:

- The FNHA leveraged \$20 million in provincial funding in 2017 to address the opioid crisis, when data demonstrated that First Nations people were more likely to experience and die from an overdose.
- Access to First Nations specific data through the First Nations Client File enabled the FNHA to map cancer patient journeys and identify disparities in cancer outcomes for First Nations clients. This led to the development of the Indigenous Cancer Strategy in 2017.
- Data on First Nations rates of hospitalization and physician utilization helped to shape priorities and policies around primary care, Elders care and mental health and wellness across the health system.
- The results of the numerous surveys have helped the FNHA to understand key community and client needs and shape its annual and multi-year plans and priorities to better target those needs.

In close collaboration with provincial and federal partners, the FNHA has changed how First Nations specific health data is governed, interpreted and reported, providing greater control to First Nations.

According to key informants and case studies, the FNHA has reformed how First Nations specific data is collected, stored and reported internally, and at the provincial and national levels. In particular, to better manage First Nations-specific data internally, the FNHA has developed processes and procedures of sharing First Nations-specific data based on OCAP® Principles. Some of the internal procedures include not collecting data that will not be used; working with specific regions/communities to manage their data; obtaining approvals before the data is shared with others; and reporting back the data in aggregate formats to protect confidentiality and client privacy. At the provincial level, as a steward for First Nations data, the FNHA is helping its partners to uphold the principles of the First Nations health data governance. For example, the *Joint Statement on First Nations Data Governance*, in draft at the time of this evaluation, is an FNHA

initiative with two external partners: the Canadian Institute for Health Information and the Ministry of Health. Through adoption of this joint statement by external partners, First Nations interests and perspectives will be upheld when partner organizations collect, analyze and report data on First Nations health.

The FNHA has developed indicators to measure and report on wellness.

In partnership with the Provincial Health Officer, the FNHA engaged extensively with First Nations stakeholders to develop indicators to measure and report on wellness captured in a Population Health and Wellness Agenda. The new wellness indicators are based on First Nations ways of knowing, have an available data source, and are reflective of the priorities identified by communities during the engagement sessions. The FNHA and the Provincial Health Officer were expected to release a baseline report on the status of these indicators in January 2020.

Key informants noted that implementation of wellness indicators is expected to result in a paradigm shift in measuring and reporting on the health status of First Nations. Measuring and reporting on indicators related to land, family and community (e.g., community strength and resilience, ecological wellness and connection to land) and health systems (e.g., experience of cultural safety and humility in receiving healthcare, avoidable hospitalizations) is expected to shift attention and direct resources into areas that help to build individual and community wellness (instead of focusing on addressing gaps or sickness).

4.4 Challenges

The FNHA's efforts to promote wellness have been constrained by a number of challenges. This section describes some of the most significant challenges identified by the evaluation.

Focusing on wellness represents a significant change for the healthcare system. That, combined with competing priorities, resource constraints and challenges in coordinating activities within the FNHA, serve to slow the progress made in implementing the FNHA's wellness agenda.

As a new concept, it is difficult for the mainstream healthcare system to understand, support and implement the concept of wellness. For example, according to case study participants, creating a system that recognizes the skills and competencies of traditional healers, and which accredits and compensates them, will take time and effort. Similar efforts are required to clarify, classify and incorporate traditional medicine into mainstream healthcare.

Within the FNHA, competing priorities can make it difficult to take a proactive approach on wellness. The situation was especially difficult when the FNHA did not allocate dedicated resources to focus on wellness. The hiring of Traditional Wellness Coordinators within regional offices has helped with efforts to promote wellness at the regional level. The recent creation of a dedicated wellness team within the Office of the Chief Medical Officer is expected to play a key role in promoting wellness among First Nations at the provincial level.

Within the First Nations community context, health and wellness are affected by a range of other conditions and social determinants (e.g., food security, access to housing, poverty, etc.), many of which go well beyond the mandate for which the FNHA receives funding. The issue creates

challenges for the FNHA to promote a wellness agenda when there are many other competing issues that affect First Nations individuals and communities.

Despite improvements, significant challenges persist with respect to accessing and reporting health and performance data.

Despite significant improvements in recent years, case study reviews identified that the availability and quality of the First Nations-specific health data continues to be a challenge. The FNHA does not have access to row-level data due to constraints of privacy legislation. Furthermore, the provincial government often has insufficient capacity to provide timely data linkages. The evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance (separate from this FNHA Evaluation) includes a data governance case study that describes issues and recommendations around data governance more in detail.

5. Advance Excellence in Programs and Services

This chapter describes the progress that the FNHA has made towards its strategic goal of advancing excellence in programs and services. According to its MYHP, the FNHA was to focus on the quality of programs and services available to First Nations individuals, families and communities in three key areas: partnering with the provincial health system to enhance the performance of its programs and services; improving FNHA-delivered programs and services; and partnering with BC First Nations to support their delivery of high quality health programs and services that are funded by the FNHA.

5.1 Improvements to FNHA Programs and Services

The FNHA has employed a strategic and evidence-based approach to program improvements, which commonly involved first identifying community and client needs and then developing innovative programming strategies to better address those needs.

The FNHA inherited a range of programs and services from FNIHB. According to its Program Activity Architecture Structure, FNIHB delivered 27 programs in BC related to primary care, health promotion and disease prevention, public health protection, supplementary health benefits, and health infrastructure support. The FNHA is committed to the principle of continuous improvement, through making improvement in existing programs and services, as well as introducing new areas of programming and services, as needed, to fulfill its expanded mandate.

Key informants noted that, in the initial stages of the transition, the FNHA focused primarily on completing a seamless transition of programs and services from FNIHB with no disruption in service. However, gradually as the transition was completed, the FNHA began to focus on developing a better understanding of community and client needs and then determining what would be needed to better meet those needs. Case study reviews identified numerous examples of how the FNHA used research and needs assessment to improve its programming and services. Three examples are summarized as follows:

- *Mental Health and Wellness:* Post-transfer, the FNHA undertook reviews of the existing mental health and wellness programs and services available to First Nations in BC. Extensive engagement was undertaken with First Nations (e.g., regional mental health and wellness forums, regional health and wellness plans, journey mapping and surveys) to better understand First Nations perspectives and needs. Based on the findings, the FNHA released a Policy on Mental Health and Wellness in 2018. The Policy establishes a vision where all First Nations experience support for positive mental health and wellness and have access to a full continuum of wholistic and culturally safe programs and services. The Policy recommends action to shift the focus from looking to 'cure' to addressing root causes and 'strength-based' approaches, focusing on integrative system design and service delivery, and adhering to principles of family- and community-centred, wellness-focused and recovery-oriented, trauma-informed, and culturally safe services.
- *Nursing:* In 2015, the FNHA conducted a review of its Nursing Services. The findings identified various issues and gaps and provided a range of recommendations for improvement. The review identified that nurses in some communities were not well

supported by the FNHA, that nurse turnover and use of agency nurses was high, and that relationships between the regional health authorities, communities and the FNHA were not formalized to support nurses. The review also provided a range of recommendations for the FNHA to improve nursing services, which have been in the process of implementation since the review's conclusion.

- *Health Benefits:* The decision to transfer health benefits away from the Non-Insured Health Benefits program to a BC-based provider reflected the results of extensive engagement conducted as part of the tripartite negotiation process, and was therefore embedded as a requirement of the Tripartite Framework Agreement. Engagement highlighted challenges associated with the program related to its inability to target the specific needs of BC First Nations and a range of issues around coverage, criteria and accessibility. It was decided that the transfer of the program to a BC-based provider would allow the FNHA to have greater control over the program and adjust health benefits to the specific needs of BC First Nations. This was completed in a two-phase process concluding in 2019.

Significant progress has been made to date to improve key aspects of the program and service relationship between the FNHA and First Nations communities and service delivery organizations.

The relationship between the FNHA and the communities and organizations it funds is captured in a funding agreement, and this relationship is supported through processes of planning and reporting. Although, as per the direction of leadership, no changes were made in the first two years post-transfer, improvements have been underway since 2015/16.

The major improvement to funding agreements includes providing communities with greater flexibility over funding decisions, as well as increased funding allocations. The FNHA has worked extensively with communities to transition them into more flexible funding arrangements. At the time of this evaluation, only 23 communities were still receiving their funding under the 'Set model', which is more restrictive; the FNHA continues to work with these communities to transition them to more flexible arrangements. The FNHA has also introduced a Surplus Reinvestment Plan to give communities flexibility in retaining and reinvesting unspent funding. During interviews, community representatives noted that it has become much easier for communities to receive approvals from the FNHA to divert funds to other areas of healthcare and feel they are adequately supported in undertaking such activities. Other important improvements include simplifying financial schedules and clarifying requirements related to the FNHA audits and evaluations as well as processes to terminate agreements. The allocation of funding to support community health programming provided through funding agreements increased 39% in the last four years from \$168.5 million in 2014/15 to \$234 million in 2018/19.

Planning is one of the most critical aspects of delivering quality healthcare programming. A review of the FNHA documents demonstrated that the FNHA has provided significant funding and organizational support for First Nations communities and their health service organizations in developing, implementing and evaluating their health and wellness plans. In addition, the FNHA works with communities to develop Regional Health and Wellness plans, which are used by the FNHA in developing FNHA's MYHP. According to key informants, this approach to planning respects community and regionally driven processes and is a ground up approach which ensures that regional and community priorities, goals and perspectives guide planning and investments.

Recently, a new planning toolkit was launched, providing a wholistic, relational and flexible approach to community health and wellness planning.

At the time of this evaluation, the FNHA was undertaking a reporting transformation initiative to streamline reporting requirements and make reporting more meaningful to the communities. During the initial stages of the transition, the reporting requirements remained largely the same as they were prior to transition. Gradually, however, the FNHA allowed for more flexibility and offered more reporting support to the communities. As of 2017, the FNHA no longer required the submission of the Health Canada's Community-Based Reporting Template describing program activities. Instead, it accepts financial reports as well as annual reports from the community to its own people (based on what matters to the community). Examples of other initiatives implemented by the FNHA to improve reporting included the development of reporting and evaluation toolkits (which provide instructions and guidance on reporting), program advisory services and individual assistance with report preparation.

This evaluation did not focus on the results of individual programs and services and not enough time has elapsed for the impacts of these to be measured in terms of health outcomes. However, early results indicate that improvements have been made in the quality of services provided or funded by the FNHA, including for clients who live in urban areas and away from home.

Case studies documented a range of impacts in terms of the quality of programs and services delivered by the FNHA. For example, as of September 2019, all health benefits in BC were delivered by the FNHA, Pacific Blue Cross and PharmaCare, all BC-based providers. The transfer provided a greater control to the FNHA over program decisions, enabling the organization to influence formularies, benefits and coverage rules. The transition resulted in increased utilization of the health benefits across a range of key metrics and reduction in administrative costs. The new health benefit plan has substantially improved the flexibility, coverage, design and delivery of the benefits and also included cultural safety training for Pacific Blue Cross staff members who work with First Nation clients.

The FNHA improved nursing services substantially by creating a nursing leadership team to represent nurses at the senior level within the FNHA, restructuring the nursing operations to bring services closer to the communities, delivering a range of nursing support services, implementing new nursing service models, improving nurse recruitment practices, developing nurse practice standards, and achieving greater integration of nursing with other care professionals including traditional Knowledge Keepers to provide strengths-based, culturally safe and trauma-informed services and practices.

Historically, FNIHB did not deliver programming and services targeted specifically at the urban populations with the exception of the Non-Insured Health Benefits program, which was delivered to all eligible registered First Nations. The FNHA has been involved extensively in improving and delivering new healthcare programs and services targeted at urban and away from home population. According to the findings of case studies, the quality and availability of primary care services have improved for some urban and away from home clients due to funding partnerships between the FNHA and health authorities. The Lu'Ma Medical Centre, for example, has been able to increase the patient roster, and provide wrap-around care (i.e., integrated and coordinated services) in a culturally safe and appropriate environment. Similarly, a new clinic in Surrey is able to provide culturally appropriate services for urban and away from home populations, which were

previously not available. These clinics often employ Indigenous staff and physicians, include support from Elders as part of the services, and provide wholistic and culturally safe services.

For services delivered directly by communities, case study findings indicated that the additional resources and support provided by the FNHA have been used to recruit more health professionals (e.g., counsellors, physiatrists, mental health workers), which in turn has improved the quality of services that communities and their health service organizations can deliver. Secondary supports have been enhanced due to the increased capacity of regional teams, FNHA training and education, and relationships and coordination with regional health authorities.

Implementing meaningful changes to existing programs and services is complicated and typically requires a strong vision, committed leadership, a strategic approach, effective project management and time.

Significant advancement often involves implementing a series of related initiatives which need to be well-coordinated and managed effectively. This can be particularly complex in the FNHA context, which requires working in close coordination with various groups within the FNHA as well as with community, regional and provincial partners.

A strong vision for change, supported by the senior leadership, has been critical for achieving program improvements. Most major change and improvement initiatives were implemented collaboratively within the FNHA, involved senior representatives from different departments, and were implemented through extensive planning and project management efforts. For example, to facilitate the transition to PharmaCare, the FNHA set up an effective internal governance structure, including an Executive Committee (consisting of the CEO and other senior members of the organization) and five working groups including communications and engagement, finance, organizational changes, information management and privacy, and design of the new plan. Similarly, many other major change management initiatives were implemented through coordination support provided by the FNHA's Strategic Projects Office, which ensured alignment, governance and coordination across departments.

When necessary, the FNHA has demonstrated the ability to respond quickly to rapidly emerging needs.

According to key informants, when critical issues arose, the FNHA has had the necessary flexibility and agility to mobilize resources and undertake large-scale action to address the issues and assist First Nations. Perhaps the best example of this is the FNHA's response to the wildfires in 2017, which affected more than half of the First Nations in the Interior Region. As the FNHA has a limited mandate and capacity to address environmental emergencies, it at first expected the province and Indigenous and Northern Affairs Canada to take the lead role in responding to the emergency and delivering services. However, challenges were experienced with regard to communication and coordination between the province and communities as well as the quality of the services provided (e.g., lack of culturally safe approaches). First Nations sought assistance from the FNHA.

Responding quickly, the FNHA played a critical role in bridging the communication gaps and unmet needs between the province and the residents of communities affected by the wildfires. Due to existing relationships and trust, the FNHA became the key point of contact for most communities (e.g., providing regular information and guidance on air quality and indoor and outdoor instructions and information, providing other evacuation information and instructions). The FNHA utilized its

partnerships with the federal and provincial governments to resolve barriers and challenges. According to key informants, the FNHA assigned culturally competent staff members to the regions and made its resources available 24/7 and facilitated access to a wide range of emergency response services, providing mental health and traditional wellness supports, helping to serve traditional foods, and coordinating activities with provincial partners and other service providers.

The FNHA then initiated a project to develop an efficient and effective FNHA Emergency Response Command Structure, built health emergency response capacity within the organization, recruited and trained qualified staff centrally and also in the regions, and developed and advanced an implementation plan to respond to emergencies. As part of the plan, the FNHA also delivered a range of training and skills-building opportunities for staff members to be involved in emergency response to ensure that appropriate coordination and capacity is in place in times of emergency.

5.2 Improvements to Provincial Programs and Services

Fostering a close partnership with the provincial government has been critical in leveraging resources.

Importance of close partnership, coordination and integration with the provincial health system has been emphasized in various health plans and agreements throughout the transfer and transition process since 2006. According to key informants, as a provincial entity, the FNHA was able to build strong partnership with the provincial health system and achieve greater integration of programs and services, which resulted in significant improvements in quality and accessibility of a range of programs and services available for First Nations.

Partnering with the provincial government has resulted in additional funding for BC First Nations. By creating governance tables with the BC Ministry of Mental Health and Addictions and the Ministry of Health, the FNHA has been able to closely coordinate activities from the most senior level to the operational level, which has resulted in a range of new funding opportunities for First Nations. For example, the creation of the \$30 million tripartite Mental Health and Wellness Fund in 2019 supports First Nations in planning, designing and delivering a continuum of culture and strengths-based mental health and wellness services. Other examples include \$15.33 million in Joint Project Board funding which resulted in 27 primary care and mental health and wellness projects across the province, and \$40 million (\$20 million each from the FNHA and the Province of BC) to support revitalization of treatment centers.⁶ The FNHA also received significant provincial funding in response to the opioid crisis to implement its Framework for Action: Responding to the Overdose/Opioid Public Health Emergency for First Nations.

Existing provincial infrastructure was used by the FNHA to deliver a range of programs and services, reducing the cost of service delivery and improving effectiveness of the programs and services. For example, in 2017, the FNHA transferred the delivery of pharmacy benefits from FNIHB's Non Insured Health Benefit program to PharmaCare, BC's public drug insurance program. PharmaCare provided the needed infrastructure, well-established processes for managing the drug formularies, strong links with service providers (e.g., BC pharmacists and physicians work closely

⁶ The funding commitment of \$20 million by the federal government was pending at the time of this evaluation.

with PharmaCare), full integration with the provincial health care system and alignment with provincial standards, and easier access to pharmacy benefits (e.g., First Nation clients can access the services with a BC Service Card). Despite some initial challenges, the transition resulted in greater utilization of pharmacy benefits, reduced administrative expenditures and better positioned the FNHA to improve pharmacy benefits going forward.

Engagement and close collaboration with the provincial government have also improved the quality and accessibility of provincial programs and services accessed by First Nations.

The FNHA has made considerable progress in enhancing cultural safety of health care services in partnership with the provincial government and service providers, including multiple Declarations of Commitment to Cultural Safety and Humility; the development and delivery of training sessions, webinars, brochures, guides and other information materials which promote cultural safety and humility; and the creation of a new dedicated cultural safety and humility resource team for health system transformation.

The FNHA also played a significant role in the development of Primary Care Networks policies and processes to ensure that First Nations are included as full partners in the process. Additionally, FNHA and the province have committed to establish new First Nations-led primary care projects across BC as part of the provincial Primary Care Networks.

Using the lessons learned from the 2017 wildfires, the FNHA has taken steps to ensure that the emergency response services provided by the provincial partners can address the needs of First Nations clients and communities. In particular, the FNHA and Emergency Management BC signed a Letter of Understanding in May 2019 to clarify roles and responsibilities and coordinate operational activities in responding to emergencies in First Nations communities. It includes commitments around embedding cultural safety and humility in emergency management operations in BC, improving and streamlining communications and engagement between Emergency Management BC, the FNHA and First Nations and sharing information. The FNHA also participated in the development of the Provincial Disaster Recovery Framework to ensure that integrated disaster recovery efforts by the province reflect First Nations perspectives and needs.

While transformation is a long-term process that requires a multi-faceted approach involving a wide range of stakeholders, the FNHA has positioned itself well to continue to make significant improvements in healthcare delivery.

Key informants noted that time and effort will be required to address health disparities and improve First Nations health outcomes. Addressing the consequences of centuries-long colonialism in a few years is not possible. Despite significant progress (e.g., improvements in terms of life expectancy, obesity, youth suicide, diabetes, etc.), most indicators are yet to meet expected targets.⁷ Change takes time and full scale system transformation will require strong leadership, full commitment and greater participation by all Tripartite Partners, and support by the broader Canadian society.

⁷ As improvement in First Nations health outcomes is a responsibility shared by all Tripartite Partners, the Evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance, was completed by the FNHA, the Province of British Columbia and Indigenous Services Canada in December 2019, and provides more detailed information regarding changes in these health indicators.

According to key informants, the FNHA is well positioned to make significant improvements in healthcare delivery in the future. As a provincial institution, hardwired into the provincial healthcare system, the FNHA can continue to influence provincial healthcare policies programs and services by bringing First Nations perspectives to the table. Key informants expect that more resources will be allocated to health promotion, healthy lifestyles, social determinants of health and First Nations perspective on wellness rather than focusing on ‘curing sickness.’ They also expect that communities and First Nations clients will be further empowered to take action to address their needs. First Nations communities will become more self-determined, self-confident, accountable and resilient, and will have greater control over how to spend healthcare funding in their respective communities.

5.3 Challenges

The FNHA’s efforts to improve health programs and services have been constrained by a number of challenges. This section describes some of the most significant challenges identified by the evaluation.

Program and service improvements have not been consistent/equitable across regions and communities.

Key informants and case study participants noted that the innovative approaches and program improvements implemented by the FNHA are not equally available to all First Nations in BC. For example, compared to other areas, progress in improving the quality of the services delivered in isolated and remote First Nations communities has been more limited.

Similarly, the FNHA’s efforts to target the needs of the urban and away from home populations have been slowed somewhat by a lack of clarity regarding its mandate, limited representation of urban and away from home populations within the First Nations health governance structure, and a lack of data on urban client needs. According to key informants, the formulas used by the FNHA to distribute funds have contributed to the problem. In particular, the existing funding model is based on historic formulae developed by FNIHB that take into account community population size (as registered with the band and resident on-reserve) and the degree of remoteness or isolation. The fact that healthcare providers are also servicing residents who are not registered (or their members who live away from home) and that needs for health programs/services and resources vary across communities does not factor into the allocation. Furthermore, the mechanism that is used by the FNHA to distribute funds to communities does not adequately reflect the interests of the urban population. Most of the funding that the FNHA has obtained through tripartite negotiations and the Canada Funding Agreement is specifically designated for First Nations communities. New sources of funding obtained, however, particularly those from the provincial government, tend to have broader eligibility rules. Nevertheless, a disproportionately high share of the new funds have been allocated to communities. According to key informants, for example, although First Nations clients living in urban areas were disproportionately affected by the opioid crisis, the larger share of new opioid funding was distributed to support programming on-reserve.

Clarifying the FNHA's role and identity and managing sustainability.

Key informants noted that the FNHA has faced challenges with clarifying its identity in certain areas, affecting its operations and programming. FNIHB operated mostly as a funder and was not involved in delivering direct services. In addition to providing funding, the First Nations also gave a new mandate for the FNHA to act as a health and wellness partner for all First Nations in BC regardless of their location. The FNHA has also been increasingly involved in delivering services directly to communities. According to key informants, the lack of a clear identity and role has resulted in the FNHA assuming new roles and being involved in a wide range of activities. Although the FNHA's flexibility is its key advantage, operating in all of these areas may pose sustainability challenges in the long run. As community expectations are increasing, the FNHA needs to find strategic and innovative solutions to spend its limited resources in addressing community needs. There is a need for more efforts to align and coordinate the growth of programs and services with availability of resources to ensure the long-term sustainability of the organization. A few key informants noted that instead of trying to address all requests for help, the FNHA may need to identify and focus on the most important areas to be able to produce more robust results. Key informants noted that recent changes in the Health Benefits program have helped to alleviate accessibility challenges and improved coverage rates, while at the same time, the new program has increased client participation and utilization rates. This is expected to increase program expenditures in the future, creating program and organizational sustainability considerations in the long run.

Transformative change takes time, is not solely in the control of the FNHA, and requires coordinated partnerships.

According to key informants and case study participants, many of the changes (e.g., related to program improvements) are new and will require more time and further work to produce results. Most of the improvements in health benefits and nursing services were implemented recently and are yet to translate into substantial changes in client outcomes. Similarly, change in attitudes and behaviours takes time and more extensive efforts are required for cultural safety and humility to become fully integrated into the health system.

Many desired changes are also heavily impacted by external factors. For example, the chronic shortage of nurses in Canada has affected FNHA's ability to deliver effective nursing services. Similarly, the quality of health care programming is affected by many other complex factors such as geography and social determinants of health that are beyond the control or mandate of the FNHA.

Challenges remain with supporting community-based programs and services.

Despite efforts to streamline community-based reporting, producing timely reporting is still a challenge for many communities. For example, in 2018/19 only 11% of funding arrangement holders submitted financial reports and 10% submitted narrative reports by the submission deadline of July 29, 2019. This impacts the FNHA's ability to similarly report back to communities and funders about performance, and impairs its ability to provide secondary support services to communities and their health service organizations.

6. Operate as an Efficient, Effective and Excellent First Nations Health Organization

The FNHA is committed to creating an organization grounded in BC First Nations culture, traditions and teachings. This chapter describes the progress that the FNHA has made towards its strategic goal of operating as an efficient, effective and excellent First Nations health organization. According to its MYHP, the FNHA will be established as a leading edge First Nations health organization by building strong leadership and fostering a First Nations organizational culture, building a healthy and engaging environment that enables personal excellence and achieving excellence in operations.

6.1 Building Organizational Capacity and Culture

The FNHA has experienced rapid organizational growth and built capacity to deliver on its expanded mandate, implemented a range of new programs and services, and improved existing operations.

Prior to transfer, the FNHA consisted of an executive team, a small administrative team, the FNHC and FNHDA Secretariats, and policy and planning staff. By the beginning of fiscal year 2013/14, the FNHA had begun a process of building up its staff in anticipation of the transfer of the FNIHB-BC Region. On October 1, 2013, the FNHA's size expanded with the welcoming of former federal FNIHB employees to the FNHA. Immediately following the transfer, the FNHA increased its staff to 228 positions. Over the subsequent six years, the employee count increased to 748 (as of 2019).

A review of FNHA documents and files demonstrated that the most noticeable employee growth occurred during the first three years after transfer, primarily due to the following factors:

- Transitioned former FNIHB staff.
- Enhanced programs and services, including nursing, repatriating a number of services previously contracted out, and implementing new roles and programs (e.g., emergency management, research, primary health care).
- Built corporate functions and systems.
- Created a regional presence (see Chapter 3).

As the organization matured, growth slowed considerably and was associated primarily with undertaking additional services and implementing new programming, which required proportionate growth in administrative and corporate services. According to case study participants, some of the positions are temporary and will not be needed once a number of major projects are completed (e.g., transitioning IMIT infrastructure, transitioning health benefits from FNIHB, implementing PeopleSoft system).

The FNHA has leveraged significant additional funding from provincial and federal sources to support the enhancement of its functions, services and programs and its organizational growth.

The FNHA's funding agreement with Canada included an annual escalator of 5.5% in the first five years to ensure an increase in the base funding amount every year. Additionally, the Canada

Funding Agreement includes a commitment that the FNHA continue to receive new monies that the FNIHB-BC Region would have received in the absence of the FNHA, and as a result the FNHA has received regular allocations of new federal funding.

Since the transfer, the FNHA has also leveraged additional funding from different sources that were not available for First Nations prior to the transition (including the provincial government and other national and provincial health organizations and research organizations). From 2013/14 to 2018/19, the FNHA leveraged \$257.6 million in new funding, which accounted for 9.3% of all of the FNHA's gross revenues. These funds are attributed to the creation of the FNHA as they would not have been available to the FNIHB-BC Region prior to transfer.

Taken together, these new funds and the escalator have increased FNHA's revenues significantly. FNHA's gross revenues have increased at an average of 8.6% annually for last four years, from \$429.6 million in 2014/15 to \$599.6 million in 2018/19. The FNHA has directed most of the increase in revenues to support programs and services for First Nations across the province. Spending for program services has increased by 42% over the most recent four-year period, from \$357.8 million in 2014/15 to \$507.3 million in 2018/19. Similarly, spending on direct community services funding has increased by 39% during the same period, from \$168.5 million in 2014/15 to \$234 million in 2018/19.

The FNHA has worked to develop an organizational culture based on First Nations traditions.

The FNHA organization growth has been guided with a focus on developing Indigenous capacity and a strong organizational culture based on First Nations traditions. The Indigenous culture has been embedded through teaching the values of the Wolf Clan, a key component of Tseil-Waututh Nation culture on whose shared territory the FNHA head office will be located. First Nations values related to cooperation, mutual respect and responsibility have been promoted through involvement of Knowledge Keepers, territorial acknowledgements, organization of family gatherings and 'We Are Better Together' ceremonies, and constant internal communications through emails, booklets, etc. Processes for hiring, training and promoting Indigenous employees have been created. According to corporate documents, over the period covered under the evaluation, over 35% of the FNHA's employees self-identified as First Nations, Inuit or Métis.

6.2 Building Excellence in Corporate Services

The increase in corporate capacity has enabled the FNHA to undertake new roles and responsibilities, meet contractual and legal obligations and support effective delivery of programs and services.

Development of corporate functions was an expectation of First Nations leadership as outlined in the Consensus Papers and 7 Directives, and included as a requirement in the Tripartite Framework Agreement. The FNHA inherited very few corporate capabilities and staff, as FNIHB's regional office had limited in-house corporate capacity as most corporate services and administrative functions were provided from FNIHB's office in Ottawa (e.g., strategic policy and evaluation), or through the broader federal public service (e.g., finance, human resources and IMIT). The new mandate established for the FNHA by First Nations required the development of functions related to administrative and corporate support. To address the issue, the Tripartite Framework Agreement allocated dedicating funding and resources (e.g., \$42.7 million from 2008/09 to 2013/14) to build and support the corporate and management services needed for the FNHA to fulfill its commitments

to deliver on programs and services. At the time of the evaluation, the FNHA had established the following four major components of its corporate services and functions:

- *Corporate services provided by Policy, Planning and Quality*, which include corporate policy, planning and evaluation and the Strategic Projects Office.
- *Information Management and Information Technology*, which includes information management services, project and risk management services, core technology and user support services, network architecture and information security.
- *Office of Chief Financial Officer and Corporate Services*, which includes financial planning and analysis, accounting, legal, procurement and contracting, travel and events, reception, risk management, office accommodations, fleet services, privacy and communications.
- *Human Resources*, which includes recruitment, employee and labour relations, compensation and benefits, talent management, learning and development, human resource information systems, organizational development, employee health and safety and disability support.

During interviews, case study participants noted that the FNHA was able to build effective corporate services and functions, comparable to and even better in many areas than other similar organizations (e.g., provincial health authorities). In particular, according to case study findings, strong IMIT systems and structures (e.g., data warehouse, help desk) have been built over the past five years and a range of IMIT projects have been implemented to improve the technological capabilities of the organization. The IMIT department has also developed, or is developing, several strategies and frameworks to plan for and enhance organizational information management capabilities and ensure digital security.

Policy, Planning and Quality has created capacity to prepare annual and multi-year plans, produce regular progress and performance reports, and undertake program evaluations, all of which are necessary to fulfill the FNHA's legal and contractual commitments. A three-year corporate policy review cycle has been established and, according to FNHA documents, as of 2019 the corporate policy team completed the drafting or review of 138 organizational policies, 49 executive directives, and 16 procedures and frameworks. According to case study participants, the policies, frameworks, progress reports and multi-year and annual reports developed by Policy, Planning and Quality are of high quality and have the necessary rigor to support consistency across the organization as well as to withstand audit scrutiny. In addition, the Strategic Projects Office was created to support successful strategic projects by ensuring they receive authorization, coordination and support from the senior management team.

Human Resources has created strong human resources policies and quality standards, formalized recruitment processes, partnered with the Communications department to brand the FNHA as an employer of choice for potential employees, negotiated and signed two collective bargaining agreements, created compensation framework and pay rates, and implemented an employee engagement survey to identify FNHA staff satisfaction. In addition, the Human Resources department played a key role in implementing the new Human Resources Information System called the Technology and Resources Enabling Employees (TREE). TREE supports organizational human resource service delivery, enhances the candidate and employee experience, and provides business insight and informs strategy. It provides an automatic system for posting jobs, shortlisting

applicants, scoring their qualifications, scheduling interviews and evaluating applicants. It also provides candidate database search capabilities and automated recruitment reporting on standard metrics.

As part of its corporate services, the FNHA also developed a communications team to increase awareness and help build relationships with First Nations, governments and service delivery partners. The communications team consists of 12 staff, who have established culturally safe communication policies and procedures, and who provide centralized communications support for the FNHA, FNHC and FNHDA. The team supports organizational efforts to communicate with its client base, works to enhance the reputation of the FNHA, and has implemented several successful information campaigns to raise First Nations' awareness of healthy lifestyles and support them in their health and wellness journey. The team established a strong social media and online presence (e.g., the FNHA website that receives over 40,000 visits per quarter) for the FNHA. The communications team also built the FNHA's internal communications systems.

According to key informants, the FNHA Finance department has built a solid financial planning and informed decision-making process to help the organization to predict and identify critical issues when they arise and to support sound decision-making. In particular, the Strategic Financial Framework mapped different sources of funds that the FNHA receives against intended purpose and eligibility and has brought clarity regarding inflow and outflow of funds to the FNHA facilitating financial decision making and positioning the organization well for renegotiation processes. A number of financial reviews and internal audits were undertaken for different areas of FNHA operations and programming. The reviews helped to inform the Senior Executive Team of current FNHA operations, costs, and potential issues, and provide additional information to support a discussion and decision-making around challenges and improvements. The FNHA is able to better support communities with financial planning and reporting (e.g., timely and appropriate guidance in reinvesting surplus funds, financial reporting).

The FNHA has become a successful example of a First Nations organization that can deliver effective health and wellness services and respond to emerging needs.

During interviews, key informants noted that despite some challenges, the FNHA is the first provincial-level First Nations organization in the country and exemplifies building a successful First Nations organization at this level. Case study participants indicated that, in general, there is a sense that ten years of organizational development have been accomplished in five years. The FNHA has become a strong provincial organization that can deliver effective services and respond to emerging needs and challenges of their clients. Case study reviews identified examples of how the success of the FNHA have helped to build a sense of ownership among First Nations, and that First Nations feel more in charge of their own health system. The FNHA's organizational culture is strong and staff dedication to the organizational mission and values is consistent. The development of the FNHA is considered a great achievement and can be used as an example for developing similar First Nations initiatives across the country.

6.3 Challenges

The FNHA's efforts to achieve operational excellence have been constrained by a number of challenges. This section describes some of the most significant challenges identified by the evaluation.

Balancing the costs and benefits of regionalization and centralized services.

It has been a challenge to have all stakeholders agree upon an operating model for the FNHA that can effectively function and balance growth at provincial, regional and local/community levels. Key informants and case study participants noted that the FNHA's organizational growth over the past few years has partially been driven by rising expectations for services. The extent of health inequities between First Nations and the general BC population meant that the FNHA essentially inherited a failed federal system but was expected to redress these inequities quickly. As a First Nations organization, the FNHA faces rising community expectations and mounting demand for new services and programs to address complex needs. To be able to fulfill community and client needs, the FNHA has been increasingly growing its program and service capacity, which also requires an increase in enabling functions and corporate services.

More recently, some First Nations have expressed a need for the FNHA to accelerate the regionalization of its staffing and allocate more corporate capacity (i.e., finance, human resources, IMIT) in the regional offices. Some case study participants recommended that functions of FNHA headquarters be downsized in order to adequately support regional capacity. At the same time, key informants and case study participants stressed the importance of taking a strategic approach to regionalization as it is a complex undertaking that needs to be implemented with planning, engagement and due diligence if the FNHA is to maintain organizational efficiencies, sustainability, and quality and consistency of services. The importance of maintaining organizational unity, shared values and culture and a common voice in representing BC First Nations, particularly in dealing with provincial and federal partners, was emphasized. It was noted that regionalization should not erode a key strength of the FNHA: that of being a strong, provincial entity that is able to partner effectively with the system to generate the value outlined in previous sections of this report (e.g., new investments and sources of funding, changing provincial policies and programs).

Creating and maintaining a cohesive FNHA organizational culture.

FNHA staff consisted largely of former employees of FNIHB, employees of the interim First Nations Health Authority /FNHA, and new employees attracted by the organization's mandate. The FNHA's mandate and philosophy of moving to a culturally informed and community and client-centred approach was markedly different than the approach of FNIHB and many other organizations that FNHA staff had worked with in the past. Therefore, at the time of the transition divisions existed across several dimensions (e.g., union/non-union, region/center, Indigenous/non-Indigenous) and as a result, building a unified organizational culture became a central priority for the leadership team, which was implemented through the Knowledge Keepers and the efforts to promote the values of the Wolf Clan.

A few key informants and case study participants noted that for organizational cohesiveness to be effective, it needs to start at the top, amongst the members of the Board and the FNHA's senior leadership team. According to key informants and case study participants, the operations and organizational culture of the FNHA have been affected by differing views on organizational growth

and strategic directions, the ability of the Board to provide a clear direction on specific areas, and the level of cooperation and mutual support among leadership team members. There has also been high turnover and changes in leadership in recent years affecting operations and continuity of the critical initiatives undertaken by the FNHA as well as staff morale. Key informants noted a need to further enhance the work underway to develop systems to ensure that BC First Nations leaders can grow within the organization, work in a mutually supportive environment, and lead key strategic areas of the organizational growth and development.

According to key informants, the geographic locations of the FNHA offices (e.g., offices located across five regions and also several locations around Vancouver and the Lower Mainland) have affected the level of cooperation among staff. At the time of this evaluation, the FNHA was working to bring staff members at the central office to a single building as part of the Metro Vancouver Office Project.

Enhancing collaboration across the FNHA.

Many FNHA staff members expressed that working for a dynamic and growing organization has been a privilege. However, the rapid change has also created pressure and tensions within the organization, which at times has affected staff morale, resulted in burnout and contributed to staff turnover, particularly at the senior level. Staff engagement results from 2018 and 2019 demonstrated that the FNHA overall had higher employee engagement scores, comparable and even better in many areas, compared to other similar organizations and national averages. However, employees provided lower ratings in the areas related to employee enablement, such as collaboration with staff from other departments, and receiving adequate communication to perform duties. Given the rapid growth of the organization, turnover at a senior leadership level, and differing views on the need for and style of collaboration amongst senior team members, it has been a challenge to create an effective and accepted model for cooperation and collaboration across departments and regions. As a result, at times, there has been a tendency for managers, departments and regions to operate in silos.

The FNHA does not have an integrated performance measurement approach.

The FNHA and its partners monitor a long-standing set of health outcome indicators as well as emerging health system performance and wellness indicators. Similar attention is required on assessing how the FNHA's own performance contributes to these health system indicators. The FNHA's MYHP includes a set of performance measures and standards that are reported on a quarterly and annual basis; however, beyond these indicators, the FNHA lacks a clear set of indicators to measure and adjust its own activities and programs. According to key informants, there is a lack of consensus among senior management with regard to the importance and types of performance data the FNHA should collect and report. In addition, the FNHA is operating in very dynamic environment, which requires constant changes in performance indicators, which makes it difficult to collect consistent data. At the same time, First Nations expect a high degree of accountability from the FNHA, and key informants noted that sharing more performance indicators will help to communicate FNHA's progress and challenges and receive greater buy-in from First Nations. At the time of the evaluation, the FNHA was developing a new Performance Measurement and Evaluation Framework that was expected to address some of the existing challenges with the performance measurement system.

7. Conclusions and Recommendations

This chapter provides conclusions and recommendations resulting from the evaluation of the FNHA.

7.1. Key Findings and Conclusions

The major conclusions arising from the evaluation are as follows:

- 1. Significant, ongoing health disparities between First Nations and other residents of BC led to the decision by the First Nations leadership in BC to gain ownership of the First Nations healthcare system in BC.**

Prior to 2013, the delivery of healthcare in First Nations communities was based on a colonial approach of division of responsibilities between the provincial and federal governments. It was long evident that this approach to healthcare delivery was not effective in reducing on-going disparities in health status. BC First Nations leadership made the decision to take ownership of First Nation healthcare and create a new approach responding to First Nations health needs.

- 2. Creating a new governance structure and transitioning to a new approach took almost a decade to complete and was marked by a series of accords, plans and agreements that set the stage for renewed relationships.**

The signing of the 2011 Tripartite Framework Agreement created the new First Nations health governance structure in BC. Significant political, bureaucratic and administrative challenges had to be overcome to gain agreement on a new approach and achieve transition to a new model of healthcare delivery for BC First Nations. The solidarity and commitment of BC First Nations leadership, combined with growing recognition by federal and provincial governments of the need for better dialogue with First Nations, created conditions that facilitated transition to a new approach.

- 3. The new mandate given to the FNHA by BC First Nations is much broader than that previously held by FNIHB. The new mandate requires the FNHA to adopt a much more strategic and long-term approach in its activities and focus on transforming the health system for BC First Nations, rather than simply delivering mandated programs and services.**

Relative to FNIHB, the new mandate places greater responsibilities on the FNHA in areas such as involving First Nations communities in decision-making processes, responding in culturally appropriate ways, representing the interests of all First Nations living in BC, generating evidence through data and research, providing population and public health leadership, and focusing on prevention, wellness and social determinants of health.

4. Although further work is needed, the FNHA has been successful in building the organizational capacity needed to take on more roles, implement a range of new programs and services, and improve existing operations.

Within a short period of time, a complex transfer process was implemented building new systems and structures, assuming assets, taking over programs and services and creating a new shared organizational culture while ensuring no disruptions and minimal adjustments for BC First Nations and program providers. Using the dedicated funds, the FNHA built strong strategic planning, headquarters, finance and senior corporate functions within the organization to be able to deliver effective programs and services. Over time, the FNHA has worked to develop an organizational culture based on First Nation traditions, bring services closer to communities by building a strong regional presence and establish a strong governance model and organizational culture based on the First Nations traditions.

Some of the organizational challenges currently facing the FNHA include the need to develop an operating model that can effectively function at provincial, regional and community levels and balance the benefits of regionalization and centralized services, address issues related to governance and leadership (e.g., creating a cohesive leadership team and reducing turnover), and facilitate greater cooperation and communication among staff.

5. The FNHA has achieved significant progress in implementing important changes to First Nations healthcare in BC by advancing excellence in programs and services, championing the BC First Nations perspective on health and wellness, enhancing First Nations health governance, and operating as an efficient and effective First Nations health organization.

Initially, the FNHA focused primarily on taking over programs and services previously delivered by FNIHB while ensuring no disruptions and minimal adjustments for BC First Nations and program providers. Since then, the FNHA has introduced many changes to the healthcare system including improvements to existing programs, services and practices as well as important new programs and services. The FNHA has, for instance:

- Developed a close partnership with the provincial government which has been critical in helping the FNHA to leverage additional resources and increase the range of programs and services that it can deliver. The partnership has also helped to improve quality and accessibility of the continuum of programs and services that First Nations receive from the provincial health system.
- Helped to improve community, regional and organizational planning. The FNHA has provided significant funding and organizational support to assist First Nations communities and health providers (communities, Tribal Councils, or First Nations organizations funded to provide First Nations health programs) in developing, implementing and evaluating their health and wellness plans, which were also used by the FNHA to develop its multi-year and annual health plans.
- Leveraged \$257.6 million in new funding from different sources, accounting for 9.3% of FNHA's total gross revenues, over the six-year period covered under the evaluation. The FNHA has become a leading First Nations health organization in Canada with strong

capacity to deliver effective programs and services and influence government policies and programs at the provincial and national levels.

- Promoted the BC First Nations perspective on health and wellness. The FNHA defined and incorporated the concept of wellness into its operations, policies and programs, provided funding to support community wellness programs and activities, created indicators to measure wellness, and recruited the Chief Medical Officer to provide health and wellness leadership. The FNHA also worked with the provincial government to incorporate the concept of wellness into a wide range of provincial policies and programs, becoming a catalyst for change in the provincial healthcare system overall. The efforts to change policy and programs have translated into increased funding for wellness-based programs and services. The First Nations perspective on health and wellness has become a key component of the First Nations health and wellness planning within the FNHA and at the provincial and community levels.
- Employed a strategic approach in making program improvements, which commonly involves first identifying community and client needs. The FNHA has learned about community and client needs and priorities through working with the FNHC and FNHDA, participating in Regional Caucus meetings and Gathering Wisdom for a Shared Journey conferences, and undertaking research, surveys, engagement sessions, journey mapping, and independent assessments. The FNHA then developed and implemented innovative policies and programming strategies to better address the needs and priorities identified.
- Improved nursing services by creating a nursing leadership team to represent nurses at the senior level within the FNHA, restructuring nursing operations to bring services closer to the communities, delivering a range of nursing support services, improving nurse recruitment practices, developing nurse practice standards, and achieving greater integration of the nurses with other care professionals including traditional Knowledge Keepers to provide strengths-based, culturally safe, and trauma-informed services and practices.
- Transferred delivery of Health Benefit programs from the Non-Insured Health Benefits program to BC-based providers. The transfer provides greater control to the FNHA over program decisions, enabling the organization to influence formularies, benefits and coverage rules. The transition has resulted in increased utilization of health benefits across a range of key metrics and in reduction of administrative cost.
- Developed a Policy on Mental Health and Wellness in 2018 and worked to establish a Mental Health and Wellness Fund which supports First Nations communities and aggregations of First Nations to come together to plan, design and deliver a full continuum of culture and strengths-based mental health and wellness services.
- Established regional offices to bring services closer to communities and developed strong corporate capacity to support effective operations and service delivery. In 2019, 18% of all FNHA positions were located within its five regional offices.
- Increased access to services for clients living in urban areas and away from home. The urban and away from home population accounts for over 60% of the First Nations

population in BC. With the exception of the Non-Insured Health Benefits program, prior to transfer, FNIHB provided little support and programming targeted at urban and away from home populations. However, the FNHA has a mandate to represent the interests of all First Nations in BC.

- Introduced new innovative and flexible mechanisms to distribute funds. New mechanisms were developed to eliminate competition for funding, encourage and support collaboration and partnership, and identify innovative concepts that can address root causes of health issues and problems. The regional envelope funding process was created to provide streamlined access to new funding opportunities. The approach allows First Nations to access new and more targeted sources of funding in addition to funding received through contribution agreements.
- Gained access to First Nations-specific health data through partnerships with the provincial government, developed protocols and systems for First Nation specific data, conducted surveys, and expanded the range of data that it collects and reports from various sources. Increased access to data has enabled the FNHA to develop new programs and policies, leverage additional funding and make informed decisions. In close collaboration with provincial and federal partners, the FNHA has changed how First Nations-specific health data is governed, interpreted and reported, providing greater control to First Nations.

The evaluation also highlights various challenges and opportunities for further improvement in areas such as the equitable allocation of funding, reporting, meeting rising community and client expectations, balancing demand for services with available resources, further integrating the First Nations concept of wellness into mainstream healthcare, addressing nurse turnover and use of agency nurses, and being able to access First Nations specific health data in a timely manner.

6. Going forward, the FNHA has positioned itself to continue to make significant improvements in healthcare delivery.

The FNHA has necessary capacity, aspirations and plans to continue influencing health care delivery and transformation. The next five years should see significant changes in terms of more resources, wholistic and innovation-driven approaches to health, more integration of First Nations perspectives into the provincial healthcare system and improved availability and accessibility of a continuum of care for First Nations peoples.

7.2 Recommendations

The recommendations arising from the evaluation are as follows:

1. Maintain a strong, strategic focus on transforming the healthcare system.

The mission for the FNHA is to transform the health system for BC First Nations, not to simply just deliver mandated programs and services. Significant, systemic change is needed to address the consequences of centuries long colonialism and to improve health and wellness for BC First Nations. Achieving that systemic change requires:

- A clear strategic vision regarding the future healthcare system for BC First Nations and the role of the FNHA in creating that system.
- The organizational capacity, including a cohesive leadership team and Board of Directors, needed to support the development and implementation of that strategy. As part of this step, it may be useful to conduct a review of the governance structure to assess the role of the Board and determine how it can best lead and support an organizational mandate focused on system transformation.
- Continuing strong governance partnership with provincial and federal partners, grounded in the perspectives of BC First Nations. As the partners play key roles in delivering health care programs and services, securing their support and participation will be critical to improving health and wellness outcomes for BC First Nations.
- Organizational unity and the ability to serve as a common voice representing BC First Nations, including through ongoing engagement and involvement of the FNHC and FNHDA supported by clear roles and responsibilities and working protocols.
- Continued research, data analysis and policy development that supports evidence-based decision-making and strategic planning by the FNHA and its health system partners.

2. Focus on developing an operating model that can function effectively at the provincial, regional and community levels.

There is a need for the FNHA to establish an operational model that will function effectively at provincial, regional and community levels while maintaining the sustainability of the organization. Some of the key elements to consider include:

- Review existing operations and functions and engage with members of key staff within the FNHA (and health governance partners such as the FNHDA and FNHC) to determine which organizational structures, functions and activities are best implemented regionally and which centrally. As part of the process, identify advantages and disadvantages (including potential risks and challenges) of different models of operation and determine feasibility and sustainability of transferring certain functions or programs to the regions.
- Given that growth in program and services generally requires proportionate increases in corporate services and enabling functions, determine the structure and size of the corporate services that need to be maintained to support the operating model. As part of this step, develop metrics (e.g., timeliness of response, staff satisfaction, etc.) to regularly measure and monitor the quality of corporate services and function and alignment with operations.
- Conduct a comprehensive review of the regionalization activities undertaken in Phase I and study the experience of similar organizations (e.g., provincial health authorities) to identify best practices in structuring and delivering effective services. Identify some of the key lessons and best practices that can be adapted to the operations of the FNHA.

- Develop a multi-phased plan to regionalize FNHA activities and strengthen regional capabilities while maintaining strength in other areas of organizational capacity.
- Ensure that the new operating model maintains organizational unity, shared values, culture and a common voice in representing BC First Nations while also building on the advantages gained from being a strong, provincial entity (e.g., policy, data, intergovernmental, economies of scale, etc.).

3. Continue strengthening organizational capacity and effectiveness of programs and services.

The FNHA has developed strong capacity, organizational culture and systems to deliver effective programming. The effectiveness of FNHA operations and programs can further be strengthened by:

- Reviewing and revising funding formulas to ensure funding is allocated based on need, and that improvements in programs and services can equally benefit all client groups.
- Identifying more strategic ways to address rising community and client expectations and demand for services. Some of the approaches to be considered include confirming FNHA's identity in various program and service areas (e.g., funder, partner, deliverer), leveraging resources and services from provincial and other partners, and focusing on areas of need where the FNHA can generate more substantial impacts.
- Enhancing efforts to build a strong organizational culture based on BC First Nations traditions, improving internal communication and transparency and promoting shared organizational values to build mutual trust and a strong team environment.
- Addressing some of the other program and service challenges identified by the evaluation, such as: strengthening efforts to serve First Nations clients living in urban areas and away from home; developing systems, guides and standard procedures to guide disengagements; finalizing emergency management processes and the FNHA's mandate in this area; improving recruitment and retention of nurses; developing a formal strategy for client and community engagement and improving practices on how engagement results are documented and shared within the organization; and supporting the development of resources, standards and certification to support the advancement of traditional wellness practices.

4. Develop a comprehensive Performance Measurement and Evaluation Strategy to guide the collection and usage of performance measurement data.

The FNHA is collecting a range of data from different sources to measure the effectiveness of operations and is participating extensively in work associated with the performance of the overall health system. However, the consistency of performance data would be improved by creating a comprehensive Performance Measurement and Evaluation Strategy that enables an ongoing assessment and reporting on FNHA's operations, programs, and services. Because the FNHA is delivering a wide range of complex programs and services covering a large number of communities, evaluations and studies focused on specific programs would provide more in-depth assessments of specific areas and would identify best practices.

Annex A: Glossary of Acronyms

BC	British Columbia
FNHA	First Nations Health Authority
FNHC	First Nations Health Council
FNHDA	First Nations Health Directors Association
FNIHB	First Nations and Inuit Health Branch
IMIT	Information Management and Information Technology
MYHP	Multi-Year Health Plan
TCFNH	Tripartite Committee on First Nations Health
TREE	Technology and Resources Enabling Employees Project