

HEARING FROM FIRST NATIONS IN BC

FNHA AND BC TRIPARTITE
FRAMEWORK AGREEMENT
EVALUATIONS

**What We Heard Report,
Northern Region, June 2024**



INTRODUCTION

PURPOSE OF THIS REPORT

This report summarizes input received during the Northern Region community engagement sessions held on June 3rd, 2024 and June 5th, 2024. A total of 31 Chiefs, Health Directors and Health Leads participated in the two sessions. See Appendix A for the list of communities that were present. The list reflects all communities that were present for any portion of the sessions.

During the sessions, the following issues were discussed:

- Improvements in programs and services over the past five years and the impact of these improvements on health outcomes
- Constraining factors and challenges related to the delivery of community health services
- Recommendations for improvement

This report is intended to provide an opportunity for validation from participating Chiefs, Health Directors, and Health Leads, serve as a reference for those unable to attend, and outline additional opportunities to provide input.

CONTEXT

The two evaluations are a mandatory requirement under the British Columbia Tripartite Framework Agreement on First Nations Health Governance (Tripartite Framework Agreement). The scope of the evaluations also reflects the strategic priority areas identified by First Nations and Health Governance Partners.

- **Evaluation of the BC Tripartite Framework Agreement (BC TFA).** The BC TFA Evaluation tells the story of the Health Governance Partnership's progress over the past five years. It aims to support the Partners in their decision-making, continuous learning, and improvement to serve First Nations in BC.
- **Evaluation of the First Nations Health Authority (FNHA).** The FNHA evaluation tells the story of FNHA's progress against its mission, goals, and strategies over the past five years, including aligning its health programs with First Nations perspectives and ways of knowing and being. It is intended to provide timely information to support results-based decision making and continuous learning and improvements at the FNHA, as well as support partner efforts in learning, growing, and maturing their relationship to advance shared goals.

Since the two evaluations address interrelated issues and engage with many of the same people and organizations, an integrated evaluation approach was developed to reduce the burden on the communities and organizations.

Evaluation planning started in the summer of 2023 with a review of engagements and priorities identified over the previous two years, and by obtaining input on the draft frameworks from First Nations Chiefs, Health Directors, Health Leads, First Nations Health Council (FNHC), First Nations Health Directors Association (FNHDA), Canada, the province, and regional health authorities.

SUMMARY OF WHAT WE HEARD

FNHA-FUNDED AND DELIVERED PROGRAMS AND SERVICES

Integration of Traditional and Cultural Healing and Wellness Practices

- There has been greater recognition and focus on holistic and traditional health and wellness practices within FNHA-funded and delivered community health services, due in part to the creation of new funding, regionalization of funding allocation, and enhanced funding flexibility. This has been well-received and impactful for community members, who have become more engaged in their health and healing journey. Examples include:
 - FNHA-funded, community-driven land-based healing and cultural camps, including those targeted to youth to support revitalization of culture, relationship building and social skill development.
 - FNHA support for traditional healers alongside doctors and other medical services.
- Despite progress, more work is needed to reduce barriers for implementing traditional and cultural health and wellness initiatives.
 - Need for the Land-Based Healing Fund to become part of core funding, rather than a short-term, proposal-based grant and contribution agreement funding stream. Traditional healing practices are not always included in health service agreements or funding provisions, which means communities cannot rely on consistent support for these practices.
 - Communities struggle to access traditional healers due to logistical and financial barriers including geographic isolation, lack of funding and infrastructure, and varying levels of support from health authorities. Development and maintenance of a comprehensive publicly available list of traditional healers covered by FNHA (similar to counsellors) would facilitate easier access for communities.
 - Community-led solutions should be supported. For example, one community proposed creating a grandmother house for members and families to drop in and heal, learn about healthy living and land-based healing, and receive support from the community.

Other FNHA Funded and Delivered Programs and Services

- FNHA's Virtual Doctor of the Day has been a helpful resource for community members, especially Elders.
- FNHA's regionalization has supported innovative and flexible approaches to health program expansions and culturally relevant programming (e.g., programs for Elders and traditional healers).
- There continues to be unmet needs for harm reduction, mental health and substance use treatment services in communities.
 - Communities struggle to find support for individuals with substance use disorders, and some members must travel long distances to access treatment.

- There is a lack of after-care support for individuals returning to communities after treatment, leading to perceived high relapse rates and ongoing health challenges.
- There is limited access to specialists, particularly psychiatrists (i.e., there is only one psychiatrist serving the entire North East region).
- Concerns were raised about the April 2024 change to restrict FNHA's mental health and wellness counselling supports to status First Nations individuals, especially given the current context of the toxic drug supply crisis and BC's Decriminalization Policy.
- Communities lack adequate prenatal and postnatal care services, and traditional midwifery practices face liability issues, making it difficult to provide comprehensive maternal health care.
- The Aboriginal Headstart on Reserve Program should focus on more outreach to parents, prevention, preparedness, and keeping families together, to strengthen social determinants of health.

FNHA's Relationships and Engagement with Communities

- There has been increased engagement and communication between the FNHA and communities about needs and priorities, what is working and what is not, and community-designed solutions. Communities value having had more opportunities to share the Northern region's unique perspectives and needs.
- Although a work in progress, partnerships between the FNHA and communities have been strengthening.
 - The FNHA has increased responsiveness on specific issues (e.g. funding to provide Elders with phones during COVID).
 - FNHA Community Engagement Coordinators are important resources for those who are in new roles, and effectively support communication and collaboration efforts.
 - FNHA supports community-driven initiatives, allowing communities to prioritize and customize their health services. This approach has led to successful programs that are tailored to the specific needs of different First Nations.
- Despite improvements in communication and engagement, the pace of change is slow, and the process is often bogged down by bureaucracy. This has resulted in frustration among some communities about the lack of action resulting from engagement. Some feel that because they are remote, FNHA representatives do not often visit or understand their unique needs, and they are often left to deal with crises without getting adequate support.

FNHA Funding and Reporting Structures

- The FNHA has been innovative in supporting program expansions through flexible funding options, which has supported communities' self-determination over health priorities.

- There have been improvements to community block/set/flex funding agreements, but there continue to be unmet needs, especially around health human resources and capital infrastructure.
 - Some representatives noted a small increase in funding for health programs and human resources (e.g., nurses, dermatology, an optometrist, and a mobile clinic), but many human resources gaps still exist for key health positions.
 - Many participants noted that the current funding structures, particularly set funding agreements, are inadequate for meeting community needs. Some challenges identified include:
 - Inequity in funding for community wages (e.g., community primary care staff and Wellness Navigators) and provincial wage guidelines, which makes it very challenging to recruit and retain staff, particularly in remote communities.
 - A significant gap in capital funding. This limitation restricts the ability of communities to build and maintain necessary health infrastructure. *"All the funding is for programs, but there is no funding for capital. We can't host these programs and grow our programs without the space to do so. We need programming space; we need housing for staff. There is not enough."*
 - Limited funding for specific programs such as diabetes support and mental health services. There are calls to change physiotherapy and occupational therapy to core funding.
- Funding provided through special purpose grant and contribution agreement funds is useful, but the short-term, insecure funding cycles create challenges for planning and implementing programming that is considered essential (e.g. mental health and wellness), impede staff recruitment and retention, result in significant gaps in service delivery and increase the administrative burden.
 - The timing of funding agreements (Oct to Oct) makes it challenging to manage programming and allocate funds.
 - There are disparities in how funding is allocated across regions, with more remote areas often receiving fewer resources due to smaller populations. This inequity makes it challenging for these communities to access necessary health services.
 - The number of funding applications for different programs, reporting requirements, and the overall bureaucratic process to access funding hinders effective management and service delivery. For example, some suggested that First Nations are the most highly monitored group regarding funding and accountability, leaving communities overburdened with reporting requirements.
 - There is a strong call for more sustainable and core funding structures that allow for consistent delivery of essential services without the constant need for proposals and temporary grants.

Human Resources

- There is a need for the FNHDA to provide more training and resources to support Health Directors in the important and complex roles they hold (e.g., proposal writing, funding options, best practices, or recruitment).
- There is a need for more opportunities for Nation-to-Nation learning and for Health Directors and Chiefs to share best practices and solutions implemented in other communities.
- Northern Region faces significant challenges recruiting and retaining staff due to remoteness, the lack of housing for staff in communities, burnout, and the inability of small, remote Northern communities to offer competitive compensation.
- There is a need for the FNHA and Tripartite Partners to ensure wage equity to support community recruitment and retention efforts.
 - Compensation for positions in First Nation communities is below that of Northern Health Authority, the FNHA and other health organizations. Participants expressed a need for funding to pay health providers fair and competitive wages to help with recruitment and retention.
 - Funding arrangements do not address higher living costs for Northern regions and do not allow First Nations to provide wage increases to reflect inflation.
- There is a need for Tripartite Partners to further efforts to address ongoing health human resource shortages.
 - The Northern Region has limited access to doctors, specialists, mental health workers and drugs and alcohol support workers. Further pressures on limited resources are linked to the influx of the transient worker population in industries like oil and gas. This is particularly pronounced in the Northeast region, where the impact is felt on a wide range of services.
 - Existing staff face a heavy workload. The limited ability to go home between reallocation across communities is contributing to burnout and disengagement. Health staff also take the blame from the community when services cannot be met, which leads to added stress and increased staff turnover.
 - Health directors and new staff members face challenges due to extensive reporting requirements, limited training and guidelines, and lack of administrative support, which impact their ability to manage health programs effectively.
 - There is a need for a comprehensive plan to address current and future health resource shortages to prevent further challenges with access to care. Tripartite Partners should create more opportunities to involve young people in health care.

Cultural Safety and Humility

- One participant had met with local hospital directors to discuss cultural safety and humility and the complaint processes.
- There has not been enough focus on implementing cultural safety and humility efforts across partner organizations. Health professionals lack an understanding of specific community protocols when visiting communities and are not incorporating trauma-informed care that reflects the understanding of historical and ongoing trauma experienced by First Nations communities.
- There is a need for a greater understanding of the root causes of health outcomes, such as the social determinants of health among service providers.
- Elders often feel uncomfortable and disrespected in medical settings, leading to a lack of engagement with healthcare providers. This discomfort stems from a lack of cultural understanding and respect from healthcare professionals.

Tripartite Partner Roles and Responsibilities

- Northern Health Authority policies, programs and services do not always align with the needs and realities of First Nations communities. For example:
 - There is a lack of support for diabetes despite rising rates in First Nations communities, leading to poor health outcomes.
 - Northern Health Authority hospital diversions and lack of emergency care facilities in some areas significantly impact communities. For example, the Fort St John Hospital was closed for weeks, requiring community members to travel to Dawson Creek or Chetwynd. Lack of access to a hospital in the opioid crisis can be a matter of life-or-death.
- There are unmet funding needs from Indigenous Services Canada:
 - There is a critical need for funding to build and maintain health infrastructure and housing for health staff. Without proper facilities, it is challenging to support health programs effectively.
 - There are issues with Indigenous Services Canada funding and exclusion of services for Urban and Away-from-Home (i.e. not on-reserve).
- There is a need for greater advocacy by the Tripartite Partners, specially FNHC, at the provincial and federal levels to address systemic issues and secure more resources for First Nations communities.

Governance and Integration

- There are concerns about the First Nations Health Governance Structure. Regional Partnership Accords are often seen as symbolic rather than actionable. They do not always result in meaningful changes or implementation practices that adhere to the commitments they outline, limiting their effectiveness. There is also a perceived lack of recognition and implementation of Treaty rights. The flow of funding to Treaty Nations is unclear and requires greater accountability.
 - The Northeast communities raised concerns that because they are a smaller region with fewer communities their voices are not always heard.
- There is a need for increased transparency and information about the development of FNHA health plans (e.g., FNHA's 10-year funding agreement) and the integration of available programs and funding opportunities.
- There are ongoing discussions about data stewardship and integrating Electronic Medical Records (EMR) systems, but progress is slow and impedes the integration of services.
- There is a need for more funding for emergency preparedness and training staff for emergency and crisis response.

APPENDIX A - FOCUS GROUP METHODOLOGY

This engagement session was conducted virtually over Zoom. The engagement was facilitated by the Qatalyst Research Group consultants.

NATIONS AND FAMILIES OR ORGANIZATIONS REPRESENTED

Northwest Sub-Region

Anspayaxw Health
Gitanmaax Village
Gitga'at Nation
Gitwangak Village
Haisla Nation
Kitsumkalum Band
Lax Kw'alaama First Nation
Metlakatla First Nation
Nisga'a Nation
Tahltan Nation

North-Central Sub-Region

Binche Whut'en
Kwadacha Nation
Lheidli T'enneh
Nadleh Whute
Takla Nation
Tl'azt'en Nation

Northeast Sub-Region

Blueberry River First Nation
Saulteau First Nations