

January 24, 2019

# Interior Region Partnership Accord: Summary of Evaluation Findings

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Prepared by: Interior Partnership Accord Evaluation Working Group

# Acknowledgments

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We would like to begin by acknowledging the Seven Nation Territories of the Interior Region: Ktunaxa, Nlaka'pamux, Syilx, St'át'imc, Tsilhqot'in, Secwepemc, and Dakelh Dené. We are grateful for their warm welcoming of the evaluation team and for the many learning opportunities we experienced during this collaborative process.

We would also like to acknowledge and thank the many people who generously donated their time and expertise to the evaluation of the Interior Region Partnership Accord. We would specifically like to thank the representatives from the Partnership Accord Leadership Table, the Interior Region Aboriginal Wellness Committee, the seven Nations' Letter of Understanding Tables, and the Interior Region Evaluation Working Group. This evaluation would not have been possible without the collaborative and participatory efforts, knowledge and support of everyone involved.

We would also like to note that this evaluation occurred during the Summer of 2017, the worst wildfire season on record in British Columbia that greatly impacted Interior Region communities and organizations. We would like to say a special thank you to everyone who committed the time to be a part of this work during this challenging and demanding time.



Signing of the Interior Region Partnership Accord November 14th, 2012 in Secwepemc Territory<sup>1</sup>

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<sup>1</sup> (Source: <http://www.fnha.ca/PublishingImages/about/regions/interior/InteriorAccord1.jpg>)

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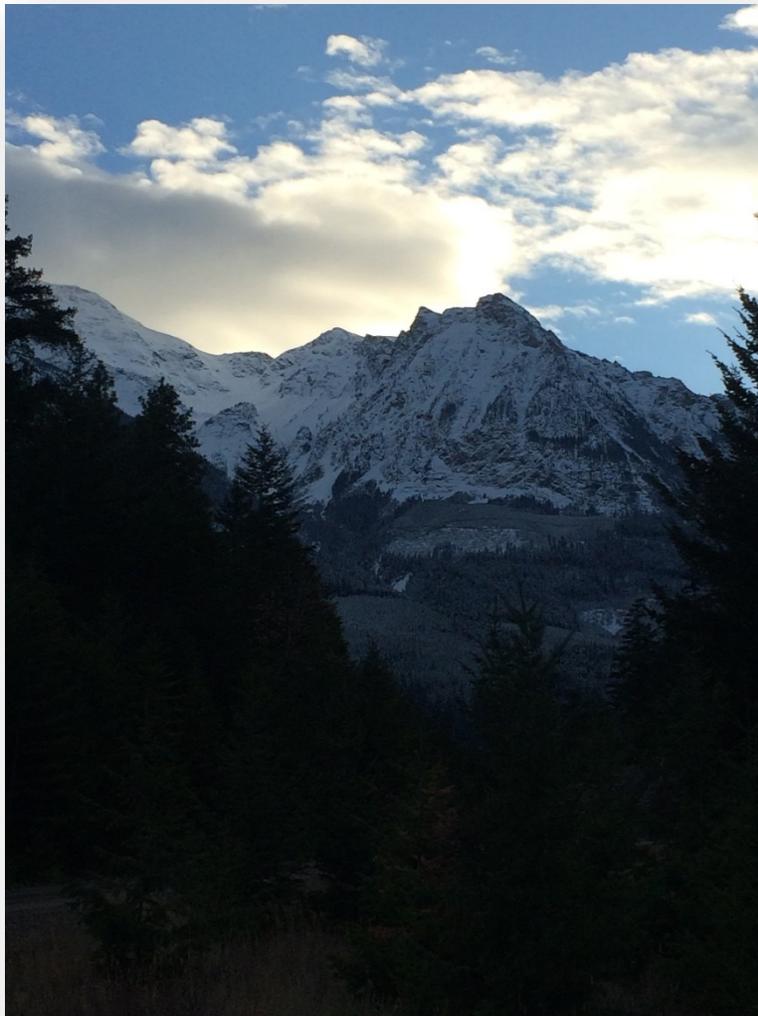
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# Acronyms and Abbreviations

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CEO	Chief Executive Officer
FNHA	First Nations Health Authority
FA	Tripartite Framework Agreement on First Nations Health Governance
IHA	Interior Health Authority
IRAWC	Interior Region Aboriginal Wellness Committee
IRNE	Interior Region Nation Executive
IRTT	Interior Region Technicians Table
LOU	Letter of Understanding
PA	Interior Partnership Accord
PALT	Partnership Accord Leadership Table
ToR	Terms of Reference



**Mt. Brew from Lillooet**

# Executive Summary

## Background

In November 2012, the Interior Region Nation Executive (IRNE) and the Interior Health Authority (IHA), signed the Interior Partnership Accord (PA). The First Nations Health Authority (FNHA) witnessed the signing. The PA represents a commitment to a new relationship between First Nations in the BC Interior, the First Nations Health Council (FNHC) and IHA. The Accord lays out a number of goals, action plans, accountability structures and measureable indicators to gauge its success. Actions stemming from the Accord are intended to improve health and wellness outcomes for First Nations people of the Interior Region.

## Evaluation Objectives

The PA outlines a commitment to evaluate and assess progress on the goals outlined within the PA. The purpose of this evaluation is to assess progress within the first five years of the signing of the PA and to inform considerations for its renewal in 2018. The Regional Partnership Accord evaluations (from all five regions) also form part of the commitment to evaluate the Tripartite Framework Agreement on First Nation Health (FA) that will be completed in 2019. The evaluation of the regional PAs will inform the FA evaluation in terms of (1) governance, Tripartite relationships and integration, (2) health and wellness system transformation and (3) health and wellness outcomes.



**Celebrating the signing of the Interior PA on November 14th, 2012 in Secwepemc Territory**

## Evaluation Methodology

This evaluation was co-created through a collaborative and participatory process led by an evaluation working group composed of members of the FNHA, IHA and Ference & Company Consulting Ltd. The working group reported to and leveraged the expertise of representatives from IRNE, the IRAWC, IHA and the PALT throughout the development of the evaluation plan, data collection tools and evaluation methodologies. The evaluation methodology included direct conversations with participants through key informant interviews or focus groups, a document review and analysis of available health outcome data. This evaluation also drew on responses to questions at the Spring 2017 Interior Region Caucus Meeting. The number of key informants that contributed to the evaluation are outlined in the table below:

Participants & Methodology	Total Number Participants	Number Unique Participants
PALT & FNHA Key Informant Interviews	18	12
IRAWC Focus Group	19	6
LOU Table Focus Groups	68	61

Fall 2018 Nation Assemblies <sup>2</sup>	Approximately 75	-
<b>Total</b>	<b>105/180</b>	<b>79</b>

The table below outlines the groupings that are utilized within this report and executive summary to summarize the frequency of responses to open-ended questions.

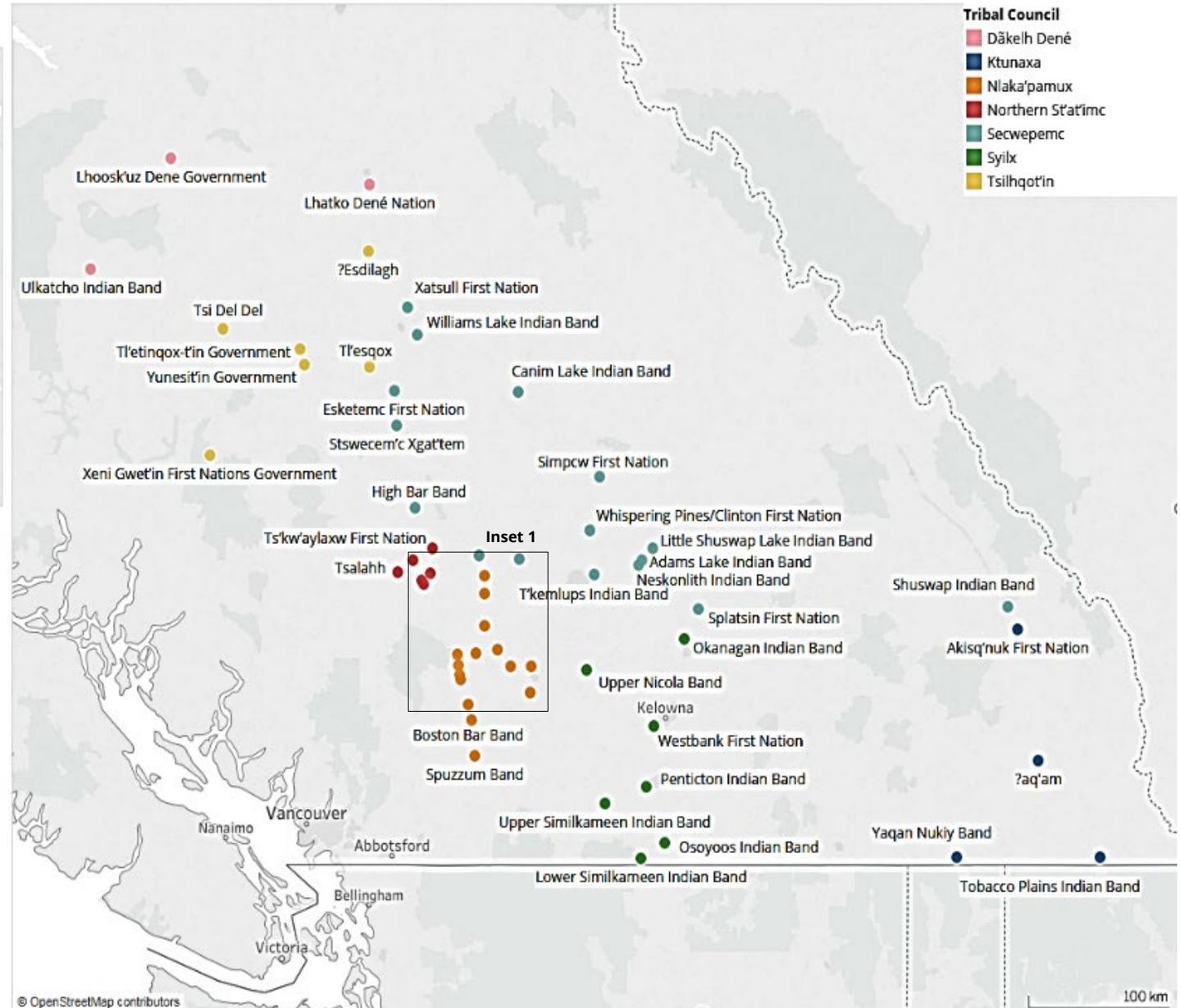
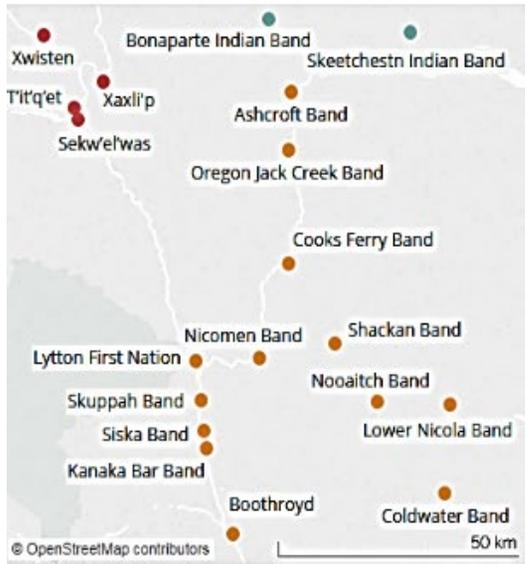
Response Summary	% Response
<b>All</b>	100%
<b>Almost All</b>	80%-99%
<b>Most</b>	55%-79%
<b>Approximately Half</b>	45%-54%
<b>Many or Several</b>	20%-44%
<b>Some</b>	10%-19%
<b>A Few or Small Number</b>	5%-9%

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<sup>2</sup> Participation at Nation Assemblies is an estimate, as the engagements were informal and participation was optional. Feedback was collected anonymously, subsequently, participants cannot be referenced against those who already participated, preventing the calculation of the number of unique participants

# Map of Interior First Nations Communities and Nations

Inset 1



**Notes:** Lhoosk'uz Dené Nation receives services from Northern Health and at times IHA when members are referred; Lhatko Dene Nation receives services from Northern Health; Ulkatcho Indian Band is part of Vancouver Coastal Health but receives services from IHA through a Memorandum of Understanding; and ?Esdilagh receives services from both IHA Northern Health; Ts'kw'aylaxw First Nation part of Secwepemc Nation but works with Northern St'at'imc. **Reference:** *Interior Interim Regional Health and Wellness Plan*, June 2014.

## SUMMARY OF KEY FINDINGS & RECOMMENDATIONS

### INTERIOR REGION STRUCTURE KEY FINDINGS

Partners in this evaluation (i.e. members of the PALT, IRAWC, and LOU tables) indicated that they are generally satisfied with the Interior Region structure. Specifically, evaluation participants reported that the Interior Region structure has the appropriate mechanisms in place for identifying, advancing, and resolving issues and represents a suitable platform for Nations and IHA to communicate, share ideas, and work together to find solutions to healthcare challenges affecting Interior First Nations communities. Further, the LOU tables were identified as a unique and important component of the structure that facilitates collaboration and a direct relationship between the seven Nations and IHA. It is acknowledged that implementation of the Partnership Accord is informed by LOU tables which are a government to government relationship between the Interior Nations and the Provincial government, represented by IHA.

The partners identified that there is a lack of understanding concerning *how* the Interior Region structure functions as a whole to identify, advance, and resolve issues.

### RECOMMENDATIONS:

- Clarify which table to advance issues to (i.e. PALT, IRAWC, IRNE, or LOU tables), in order to decrease uncertainty among the partners
  - Create a communication tool which maps out the pathways for decision making and include an example of an issue was identified, advanced, and resolved (e.g. palliative care)
- Preliminary work should be done prior to issues advancing to higher tables (i.e. PALT) so that issues are more defined when they are brought forward
  - Create services committees in communities to support streamlining issues before the LOU tables
  - Utilize the IRNE table to support streamlining issues before the PALT
  - Utilize IRTT table to streamline issues before the IRAWC

### ROLES AND RESPONSIBILITIES KEY FINDINGS

There is consensus among the partners (i.e. PALT, IRAWC, and LOU table members) that more work could be done to better articulate the roles and responsibilities of the partners listed under the PA Terms of Reference (ToR). There appears to be some uncertainty amongst evaluation participants regarding the role of the PALT, and whether the table should be handling operational and technical issues or focusing solely on governance transformation. Partners in the evaluation noted that new table members can experience a steep learning curve and possible misunderstandings regarding roles and decision-making responsibilities. Partners expressed further uncertainty regarding the specific role of the FNHA, given the FNHA is not a signatory to the PA and indicated this should be given further consideration and clarification.

### RECOMMENDATIONS:

- Create concise but comprehensive communication tool(s) that describe the Interior Region structure and each of the partners (i.e. PALT, IRAWC, IRNE, IRTT, and LOU tables)
  - Include for each entity:
    - Roles and responsibilities
    - Decision-making authorities and processes

- Internal structures, service delivery processes, fiscal restraints and opportunities
- Organizational charts with pictures, titles, departments, and contact information
- Include the diverse structure and decision making processes of the Interior Nations
- Include a description of FNHA in this tool to provide clarity around their role in the PA
- Include the Interior Region’s relationship and mechanism for advancing issues to the Tripartite Committee on First Nations Health

Conduct face-to-face engagement and education around this information as many involved in the PA do not have time to read through long communication tools. Review this information regularly to ensure individuals understand their role as well as their decision-making power, especially new people (i.e. turnover of members at the tables can lead to a steep learning curve regarding the roles and responsibilities of the partners). Consider having an orientation package for new people which includes this information.

## **ACHIEVING THE PRIORITIES AND OBJECTIVES OF THE PARTNERSHIP ACCORD**

Most PALT members reported that at a high level, members understand the aim of the PA (i.e. to improve health and wellness outcomes for First Nations people of the Interior Region). Some evaluation participants indicated that understanding the aim of the PA is an ongoing process that evolves over time as members become more involved and acquainted with the work being undertaken. Most PALT members indicated that the PALT has allowed policy and system barriers to be “identified, advanced, and resolved.” For example, the PALT has the right people at the table, such as the IHA CEO, to be able to address policy and system barriers and issues. Further, the change in IHA leadership (e.g. a new CEO) led to First Nations health being made a priority at IHA and to problems being addressed throughout the organization. First Nations health is not only a priority for the IHA Aboriginal Team (as was the case before) but across all IHA departments. Several PALT members indicated they have been “somewhat successful” at influencing provincial level decisions. When prompted, PALT members agreed that bringing the issue of identifying the payer of palliative care benefits to the Tripartite Committee on First Nations Health is an example of influencing provincial decision making.

Almost all PALT members agreed that they are “*on the right track*” to achieving the major objectives of the PALT such as addressing policy and system barrier issues and influencing provincial level decisions. There was also recognition that it takes a considerable amount of time and consistent effort to change large system barriers, particularly at the provincial level.

## **RECOMMENDATIONS:**

- PALT must continue to maintain their efforts in addressing policy and system barrier issues and influencing provincial level decision making to fully realize these long term objectives

## **RELATIONSHIPS KEY FINDINGS**

There was strong consensus among evaluation participants (i.e. representatives from the PALT, IRAWC, and LOU tables) that relationships have been strengthened because of the PA, in particular between Nations and IHA at both the senior and community levels. As reported by participants, factors that have contributed to strengthened relationships included:

- First Nations health being made a priority by Senior Leadership within IHA and Provincial structures
- Formal structures being put in place to support relationship-building, such as LOU tables which facilitate face-to-face meetings and community visits;
- Personal connections being created to establish a foundation of mutual trust and respect

Evaluation participants also acknowledged that a substantial amount of work had been completed prior to the signing of the PA in terms of building relationships between Interior First Nations and IHA. For example, some of the LOU tables existed prior to the PA, which created a solid foundation for the PA to build on. Many participants noted that an effective structure that facilitates a strong relationship is fundamental to making progress on improving health and wellness outcomes outlined in the PA. Participants did highlight that relationship building has been constrained by turnover in leadership at all levels.

## RECOMMENDATIONS:

- The partners (i.e. the PALT, IRAWC, LOU tables, and FNHA) should continue to invest time in relationship-building to better understand the issues Interior First Nations are facing and how they can effectively work together.
  - Travel to different communities for the PALT, IRNE, and LOU table meetings
  - Have new IHA staff travel to communities
  - Have leadership meet with front line staff in communities
  - Invite IHA staff to participate in informal events and Nation gatherings
- Use the above activities to embed ongoing relationship-building and partnerships with Nations into the structure of IHA, including the front line
- Provide more resources to Interior Nations to support relationship building
  - Travel budgets and compensation for time

## COMMUNICATION AND PLANNING KEY FINDINGS

Most of the PALT members reported that they had either been “successful” or “somewhat successful” in facilitating communication and reporting back to respective Nations and entities (i.e. Chiefs, Health Directors, and LOU tables) regarding the activities at their meetings. Almost all IRAWC and LOU table representatives who participated in this evaluation indicated that improvements are needed with respect to communication and reporting back to respective Nations and entities.

PALT members indicated that Nations and IHA have created shared work plans for the PALT and various initiatives which have supported shared decision-making in the development and delivery of services for Interior First Nations communities. Overall, evaluation participants reported that at higher system levels (e.g. the PALT) shared planning and decision-making might exist between Nations and IHA, but it was unclear to PALT members if this was occurring down the structure (e.g. joint planning and decision-making regarding community-led work at LOU tables). Several challenges were identified by participants in the evaluation about shared decision-making, including lack of engagement with Nations, decisions that are outside the control of IHA (e.g. Ministry of Health priorities and deadlines), and differing Nation priorities.

## RECOMMENDATIONS:

- Formalize and use efficient communication processes to ensure consistent reporting back is occurring to respective Interior Nations and entities
  - Such as targeted briefing notes, newsletters, standing agenda items, website, and face to face engagement
- Interior Nations need a better understanding of IHA service planning efforts so that they can fully engage in the planning process and coordinate and integrate services more effectively
  - Develop a formal engagement strategy so that Interior Nations are involved at the onset of planning

- Invite Interior Nations to IHA planning tables and vice versa to allow for more understanding around planning and more input into the programs and services which will be delivered in communities
- To fully engage in shared decision-making with respect to the development and delivery of services for Interior First Interior Nations communities, more involvement in IHA planning and more power should be given to Interior Nations
  - Additional focus should be given to FNHA and their role in supporting the shared decision-making process
  - Nations, IHA, and FNHA should identify ways to collectively influence the MoH regarding their priorities and deadlines to avoid barriers to meaningful engagement and shared decision making (e.g. the Ministry of Health ten day deadlines for the health authorities to deliver a health services plan)
    - The TCFNH should be engaged to support with this barrier at a provincial level
- Create an opportunity for Interior Nations, the PALT and Health Authorities from the various regions to come together to plan and address issues associated with Interior Nations whose territories encompass more than one Regional Health Authority (e.g. caucus meeting)
  - Examine how FNHA could facilitate Nation to Nation relationships and meetings of this nature

## CULTURAL SAFETY AND HUMILITY KEY FINDINGS

Most of the participants in the evaluation (i.e. PALT, IRAWC, and LOU table members) indicated that significant investments have been made to improve cultural safety and humility but acknowledged that there is still much more that needs to be done. Some examples of investments include:

- The addition of several Aboriginal Patient Navigators in some hospitals to support patients accessing care
- The cultural safety forum held in Williams Lake for IHA to better understand Aboriginal patient experiences
- The IHA CEO and Board Chair visiting communities to understand the challenges related to accessing care
- The Patient Care Quality Process that was put in place to support formal patient complaints
- The online and in-person cultural safety and humility training opportunities available to IHA staff
- The Aboriginal administrative data standard that has been put in place in IHA facilities to better understand healthcare usage by people who identify as Aboriginal

Overall, participants feel some progress has been made towards improving cultural safety and humility and that IHA is continuing to move forward on cultural safety and humility issues. It was also identified that further efforts will be needed in this area to reach all levels of the structure, particularly front-line staff.

## RECOMMENDATIONS:

- Create an overarching cultural safety and humility strategy for the Interior region and identify key indicators of success to measure the progress of this strategy
- Provide cultural safety and humility training that goes beyond online courses and includes ongoing, experiential learning opportunities that provide specific knowledge about the distinctiveness of Interior Nations Territories and communities
- Provide staff with the tools they need to suitably respond to cultural safety and humility issues that may arise (e.g. talking circles as a complaint mechanism or sacred spaces for healing purposes in health care facilities)

- Improve the Patient Care Quality process (e.g. encourage use and have process for oral complaints)
- Embed cultural safety and humility into IHA's organization and create a "culture" of cultural safety and humility
  - Gain support from managers to implement and foster this culture among employees
- Add more Aboriginal Patient Navigators positions

## CAPACITY KEY FINDINGS

It was acknowledged by most of the partners that a significant amount of resources have been committed towards improving First Nations health and wellness outcomes. There was agreement among Nation and IHA Representatives at PALT that more funding and resources are needed for Interior Nations to effectively work towards the objectives of the PA. Providing funding for projects and initiatives is a good step forward, but the infrastructure and resources to implement changes must be there as well. In particular, the LOU tables may identify an issue but do not have the resources to implement the solution. Further, Nations are at different capacities in terms of human and financial resources to address community issues.

## RECOMMENDATIONS:

- More funding and resources are needed for Interior Nations to effectively work towards the objectives of the PA (e.g. the LOU tables require additional resources to implement solutions including the time to strategically plan for changes and the human resources to implement the changes)
- The concept of equal funding should be reviewed as Nations are at different capacities to address community challenges (i.e. the concept of equal funding to all Nations prevents some LOU tables from moving forward)
- More consideration should be given to the geographical area that the Nation Territories are covering and the amount of communities in each Nation Territory to determine appropriate resourcing and funding for Nations and IHA (e.g. consider staffing, time dedications, supervision, and recruitment issues)

A few PALT respondents identified that as a group, the PALT could advocate for more funding to support capacity building. Further, this could be done at a provincial level with all regional Leadership Tables, similar to PALT, asking for additional support for the Nations. The IRAWC also indicated that the FNHC and FNHDA could act as advocates to secure support and funding for the Nations. Ultimately, Nations, FNHA, and IHA must work together to ensure the appropriate resources are in place to support capacity building.

## REVIEWING THE PRIORITIES AND OBJECTIVES LISTED IN THE PARTNERHSIP ACCORD KEY FINDINGS

Almost all the PALT respondents agreed that the current list of priorities and objectives are still relevant. It was indicated that the list contains very broad, long term goals which will take time to fully realize. Most PALT respondents agreed it is good to review the priorities and objectives on an ongoing basis, updating or removing as needed.

The PALT members were asked whether there are areas in the priorities and objectives of the PA that should be given more focus. The following summarizes the PALT members' responses.

## RECOMMENDATIONS:

- The priorities could be more detailed and use clearer language around specific targets, resources needed, implementation plans, and timelines
- The priorities could be reviewed at the PALT meetings and used to guide how the agenda is set
- The PALT could invest more time in ensuring all partners, including each of the 54 communities and IHA, are aware of and understand PA priorities.
- Some specific focus areas include:
  - Establishing indicators and collecting the right data
  - Ensuring data will be shared and reach the right people (i.e. both Nations and IHA)
  - Including front line worker information and perspective in the Regional Health and Wellness plan
  - Adding a priority around recruitment of First Nations into healthcare positions and careers
  - Adding elements from the Truth and Reconciliation Commission's (TRC) 94 Calls to Action
  - Adding information surrounding the roles and responsibilities of FNHA in the PA

A few participants in the evaluation identified that it might be beneficial to bring further clarity to PALT members as well as other partners (i.e. IRAWC and LOU table members) around Nation interests in self-governance in healthcare and other jurisdictions.

## RESPONSES TO EVALUATION RECOMMENDATIONS AND CHALLENGES

Recommendations included in this report have already been acted on by the Interior Region Partners, including amendments to the Accord itself, with re-signing anticipated in May 2019.

- Recommendation: “Additional focus should be given to FNHA and their role in supporting the shared decision-making process”
  - IHA and FNHA teams have collaborated on a joint multiyear work plan, which they aligned with the Interior Region Partnership Accord priorities
  - A description of the FNHA CEO and IHA CEO protocol is included in the renewed version of the Partnership Accord.
  - FNHA and IHA CEOs meet quarterly to address issues and achieve improved coordination in health planning and design and delivery of services
- Challenges: The evaluation report noted home care remains an ongoing challenge in some communities.
  - A regional working group was struck in 2017 to address barriers to home care service delivery on reserve.
  - In September 2018, the IHA CEO brought forward a briefing note to the Tripartite Committee on First Nations Health, which has representation from the BC Ministry of Health and Indigenous Services Canada, for their information and to signal this as a health system priority issue for the Interior region.
  - A provincial working group has also been struck to address the larger issue of identifying responsibility for delivery of home care services on reserve.
- Recommendation: Define the role of the FNHA though they are not a signatory of the accord
  - The new Accord references that the CEO to CEO “protocol sets out a shared agenda that supports executive and operational leadership and partnership in the implementation of the Interior Partnership Accord.” and notes FNHA involvement “supports and strengthens the working relationship between First Nations of the Interior Region and IHA”
- Recommendation: “Create concise but comprehensive communication tools that describe the Interior Region structure and each of the partners (i.e. PALT, IRAWC, IRNE, IRTT, and LOU tables)”
  - The revised Accord now includes a description of the membership, roles and responsibilities of the Partnership Accord Leadership Table, and the Partnership Accord Technical Table.
  - The revised Accord has been updated to include the purpose of the LOUs, which is “to define a collaborative, inclusive Nation level process for engagement and planning of First Nations and Aboriginal people in service delivery design and monitoring within the Interior Region.” The creation of the LOUs was included in the original accord.
  - The IHA/FNHA Joint Workplan includes improving communication processes
- The FNHA continues support for internal/external communication through the development and distribution of two page summaries following each PALT and IRAWC meeting.
  - The Interior FNHA team now has a regional Communications Specialist who will participate in regular meetings with the IHA Communications Team in order to improve overall coordination of communication from the various tables.
- Recommendation: PALT should continue to address systemic policy and system barriers in order to achieve the long term objectives of the Partnership Accord

- Updated language within action plan to emphasize identification of policy issues that are impediments or enablers to the implementation of the Accord and its workplan.
  - Previous language identified PALT to identify policy issue gaps and overlap
  - Five systems issue briefing notes have now been presented to the TCFNH as a means of escalating and resolving.
  - Two IHA and FNHA Working Groups have been struck to address ongoing system barriers (Home Care and Nurse Practitioners)
- Finding: Shared work plans between Nations and IHA have supported shared decision-making
  - The revised PA includes “A joint workplan inclusive of actions, indicators, and timelines is adopted, implemented and monitored bi-annually through progress reports to Interior Region Caucus and IHA Board” as a success indicator, which will continue to support shared decision making
  - All seven Nation LOU Tables operate from a joint workplan
- Finding: Shared decision-making is occurring at the PALT level, but less often at LOU tables
  - The revised PA includes “Nation Letters of Understanding Tables are attended and supported by Nation and Senior Interior Health representatives” as a success indicator, which will facilitate shared decision making going forward
  - LOU priority reports developed and shared at PALT meetings
- Recommendation: Continued efforts related to cultural safety are needed to reach all levels of the structure, particularly front-line staff
  - The Action Plan included in the revised Accord includes for PALT to “Develop and foster an environment of cultural safety and humility and lead and enable actions to imbed cultural safety and humility in all health services”
  - Expansion of IHA’s new Cultural Safety program structure includes three Cultural Safety Educators, one Knowledge Coordinator and an Administrative Assistant supported by an Aboriginal Health Practice Lead.

# Interior Region Partnership Accord: Summary of Evaluation Findings

## Section 1: Introduction

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### Background – Interior Region Partnership Accord

In November 2012, Interior Region Nation Executive (IRNE) and the Interior Health Authority (IHA), signed the Interior Partnership Accord (PA). The First Nations Health Authority (FNHA) witnessed the signing. The PA represents a commitment to a new relationship between First Nations in the BC Interior, the First Nations Health Council (FNHC) and the IHA. The Accord lays out a number of goals, action plans, accountability structures and measureable indicators to gauge its success. Actions stemming from the Accord are intended to improve the health and wellness outcomes for First Nations people of the Interior Region

The Accord builds on several key documents and agreements, including the Transformative Change Accord: First Nations Health Plan, Tripartite First Nations Health Plan, British Columbia First Nations Perspectives on a New Health Governance Arrangement: Consensus Paper, Navigating the Currents of Change: Transitioning to a First Nations Health Governance Structure: Consensus Paper, and the British Columbia Tripartite Framework Agreement on First Nations Health Governance

After the signing of the PA, the Partnership Accord Leadership Table (PALT) was formed, consisting of the IRNE and IHA Representatives to govern improvements and address gaps in First Nations health.

Originally, the PA was set to expire after a five-year term in November of 2017, however, following direction from the PALT in August 2017, the PA automatically renewed in November 2017. The PALT gave direction to conduct an evaluation of the PA in order to inform amendments to the new agreement, to be signed in March 2018.

### Interior Region Structure

The Interior Region structure is comprised of several partners and tables including the Partnership Accord Leadership Table (PALT), Interior Region Aboriginal Wellness Committee (IRAWC), IRNE, Interior Region Technicians Table (IRTT) and the seven Nations' Letter of Understanding (LOU) tables with Interior Health. The implementation of the Partnership Accord is informed by LOU tables which are a government to government relationship between the Interior Nations and the Provincial government, represented by IHA. Five of the seven LOUs were signed prior to the PA. The PALT functions as a governance forum for partnership and collaboration on joint efforts related to achievement of First Nations health and wellness priorities that may relate to policy, programs, services and resourcing. The IRAWC provides advice and recommendations to IHA and the PALT on matters pertinent to the improvement of health and wellness and health and wellness services for Aboriginal people. The IRNE table acts as an executive body to the Interior Region Caucus, carrying out directions between Caucus sessions. It offers a more equitable decision-making capacity for Interior First Nations and gives regional direction to the First Nations Health Council. The IRTT is comprised of one representative from each of the seven Nations of the Interior Region and provides recommendations to the IRNE on concerns common to the region. As such, the IRTT influences the decision making at PALT.

IHA is one of five geographically based health authorities in BC. It is responsible for ensuring publicly funded health services are provided to over 750,000 residents of the Southern Interior across a large geographic region; about 7.7 percent of this population are individuals who self-identify as Aboriginal. Aboriginal Health is an integral part of the Population Health portfolio in IHA. The Aboriginal Health and Wellness Strategy (2015-2019) was developed in partnership with First Nations, Métis, Urban service providers, FNHA, the IHA Aboriginal Health team, and others within IHA and acts as a primary guiding document for IHA and Aboriginal partners towards a shared understanding of the promotion of wellness priorities for Aboriginal populations.

The PA reflects a new relationship between the First Nations of the Interior Region and the IHA, built on recognition and respect for the Inherent Rights of Canada's Indigenous People. Therefore, it is acknowledged that the implementation of the PA is to be informed and guided by the individual LOUs signed between each of the seven Interior Nations and the IHA. The purpose of the LOUs is to define a collaborative, inclusive Nation-level process for engagement and planning of First Nations and Aboriginal people in the design and delivery of services and monitoring within the Interior Region. The Interior is the only region in the province with LOUs.

## Evaluation Objectives & Methodology

### Evaluation Objectives

The PA outlines a commitment to evaluate and assess progress on the goals outlined within the PA. The purpose of this evaluation is to assess progress within the first five years of the signing of the PA and inform considerations for the signing of a new accord in 2019. The Regional Partnership Accord evaluations also form part of the commitment to evaluate the Tripartite Framework Agreement on First Nation Health Governance (FA) that will be completed in 2019. The PAs will inform the FA evaluation in terms of (1) governance, tripartite relationships and integration, (2) health and wellness system transformation and (3) health and wellness outcomes.

### Evaluation Methodology

The evaluation was co-created through a collaborative and participatory process led by an evaluation working group composed of members of Interior Health's Aboriginal Health Team, the FNHA Interior Region Team, the FNHA Evaluation Team, Interior Region Aboriginal Wellness Committee (IRAWC) members, PALT members and the consulting firm Ference & Company Consulting Ltd. The working group reported to and leveraged the expertise from representatives from IRNE, IRAWC, IHA and PALT throughout the development of the evaluation plan, data collection tools and methods. The evaluation utilizes multiple lines of evidence including both primary data sources (interviews and focus groups) and secondary data sources (document and file review, health outcome data). The evaluation included semi-structured conversations with 105 participants through key informant interviews and/or focus groups, a document and file review and analysis of available health outcome data. Participants included members from PALT, FNHA, IRAWC, and the Seven Nations Letter of Understanding Tables (LOU) and Nation Health Assemblies. The number of key informants that contributed to the evaluation are outlined in the table below:

Participants & Methodology	Number Total Participants	Number Unique Participants
PALT & FNHA Key Informant Interviews	18	12
IRAWC Focus Group	19	6
LOU Table Focus Groups	68	61

Fall 2018 Interior Nation Assemblies <sup>3</sup>	Approximately 75	-
<b>Total</b>	<b>105/180</b>	<b>79</b>

## Evaluation Process

The evaluation working group membership was established in February 2017 by PALT, and was composed of representatives from the FNHA Evaluation Team, FNHA Regional Office, and Interior Health Aboriginal Health Team. The evaluation working group received direction from and reported to the PALT, who approved the evaluation framework in April 2017. The IRAWC provided technical expertise to the evaluation design, process, tools, key informants and reviewed preliminary evaluation findings and the draft report. Ference and Company consulting supported the working group by conducting key informant interviews and supporting the focus groups with PALT and the LoU tables. Gwen Phillips, Ktunaxa Nation, member of IRNE, PALT, and the FNHC served as an advisor to the working group.

Preliminary findings were presented to PALT in November 2017 and February 2018. During the February 2018 meeting, PALT recommended that the working group conduct additional engagement with political leadership during the fall 2018 Nation assemblies. Representatives from the FNHA Interior team or the FNHA Evaluation team attended each of the 7 Nation Health Assemblies held during that period to solicit additional feedback from political leadership. A detailed timeline can be found in Appendix D.

## Evaluation Strengths and Limitations

The strengths of the current evaluation include the use of multiple lines of evidence to triangulate findings and increase the data reliability, co-creation of data collection tools, validation of the transcriptions and findings with participants, and the use of both quantitative and qualitative data. In addition, the evaluation had a high number of participants (n=105) with representation from all seven Nations, Interior Health and the First Nations Health Authority.

The limitations of the evaluation include that data collected for the evaluation were primarily self-reported and collected at a discrete point in time. As sampling for focus groups and interviews was purposive, results may not represent all views of First Nations individuals in the Interior Region or Interior Health. In addition, although the majority of individuals who were invited to participate agreed to participate in this evaluation, it is not known how views of those individuals who declined to participate may have differed from the views captured in this report.

Initial thematic analysis of qualitative data was conducted by members of the Ference and Co. team in collaboration with the evaluation working group. Opportunities for bias in the distillation of key findings from raw data may have been introduced. The possibility for introduction of biases exists at this stage due to the unique experiences, perspectives, and lenses held by individuals that may shape their analysis and interpretation of qualitative data. To mitigate the potential impact of this bias on the summary of findings for this evaluation, this report has undergone iterative reviews, revisions, and drafts by the evaluation working group and validation sessions with IRWAC and PALT. This limitation will be further addressed through distribution of summary reports and transcriptions of interviews to participants for validation and feedback.

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<sup>3</sup>Participation at Nation Assemblies is an estimate, as the engagements were informal and participation was optional. Feedback was collected anonymously, subsequently, participants cannot be referenced against those who already participated, preventing the calculation of the number of unique participants

Health Services Matrix data were included in the report to track progress for selected outcomes and to set a baseline. As these data are observational, causal linkages could not be established between these outcomes and the Partnership Accord.

## Data Analysis

Data were synthesized from key informant interviews (i.e. PALT) and focus groups (i.e. IRAWC and LOU tables) to provide a summary of the results. The results are presented in aggregate form. However, if one of the partners (i.e. PALT, IRAWC, or LOU tables) shared a different view or indicated a unique theme, it was identified in the summary. Of the 14 potential PALT responses, there were 12 participants.

The key informant interview guide and the focus group guides primarily included open-ended questions. However, there were also several structured questions on the key informant interview guides where PALT respondents were asked to respond on a scale (e.g. satisfied, somewhat satisfied, neither satisfied nor dissatisfied, etc.).

For the open-ended questions, responses were summarized from the key informant interviews and focus groups and utilized the following scale to demonstrate the frequency of responses:

Response Summary	% Response
<b>All</b>	100%
<b>Almost All</b>	80%-99%
<b>Most</b>	55%-79%
<b>Approximately Half</b>	45%-54%
<b>Many or Several</b>	20%-44%
<b>Some</b>	10%-19%
<b>A Few or Small Number</b>	5%-9%

For the structured PALT questions (i.e. scale questions), responses are summarized using graphs throughout the report. Many of the PALT participants provided a clear response to these scales while others chose to provide a more detailed qualitative response but not respond directly to the scale. These more detailed responses are displayed in the graphs as “Did Not Provide Rating”.

It is important to note that if a participant responded to the structured questions, but did not provide a rating, it was not because they were not able to provide a rating, or that they did not understand the question, but rather because the discussions evolved organically. The facilitator did not pause to go back to obtain a specific rating because that would have interrupted the flow of the discussion. As such, caution should be used while interpreting these graphs, particularly when there is a small number of participants who answered directly on the scale.

## Validation of the Findings

Interviews and focus group discussions were transcribed verbatim to accurately capture participants' viewpoints. For the LOU table focus groups, a separate summary was created for each discussion, in addition to the transcript, which may be made available with permission of the LOU tables following this validation period. Over four weeks participants had the opportunity to review and validate the transcriptions and summaries to ensure that an accurate summary had been included. The transcriptions were also reviewed by the PALT members. Once validated, the qualitative data was further synthesized and integrated, with the discussion on

results presented in the current report. Focus group participants were invited to share any additional input following the focus group, either in-person, by email or through a one-on-one phone call with the evaluators.



Interior Wellness Committee

## Section 2: Interior Region Structure

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*“That’s a really unique structure...I really think that when you work with the nation, when you do the nation-driven directive that was provided in the framework agreements... it takes a lot of work to work that way, but it's worth our time. I think we have better outcomes because of it” – LOU Table Member*

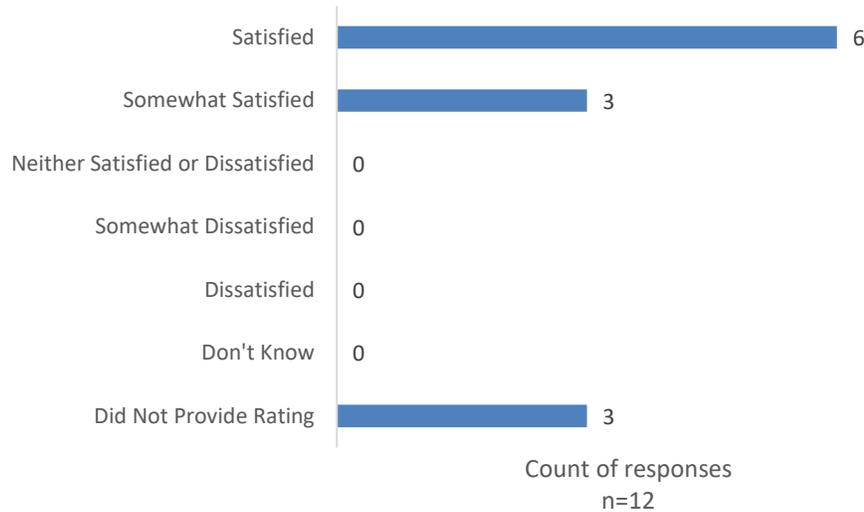
### Background – Interior Region Structure

The Interior Region structure is comprised of several partners including the PALT, the IRAWC, the IRNE Table, the IRTT and the seven Nations’ LOU Tables. The seven LOUs and their respective tables form a direct government to government relationship between Nations and the Provincial Government, represented by Interior health. The PALT functions as a governance forum for partnership and collaboration on joint efforts related to the achievement of First Nations health and wellness priorities that may relate to policy, programs, services and resourcing. The IRAWC provides advice and recommendations to IHA and the PALT on matters pertinent to the improvement of health and health services for Indigenous people in the Interior Region. The IRNE Table acts as an executive body to the Interior Region Caucus, implementing Caucus’ directives and objectives between Caucus sessions. It offers a more equitable decision-making capacity for Interior First Nations and gives regional direction to the First Nations Health Council. The IRTT is comprised of one

representative from each of the seven Nations of the Interior Region and provides recommendations to the IRNE on concerns common to the region. As such, the IRTT influences the decision making at PALT.

## Most of the PALT members reported that they are either “somewhat satisfied” or “satisfied” with the current Interior Region Interior structure?

Figure 1: PALT member responses to the question to what extent are you satisfied with the current structure?



Most of the PALT members reported that they are either “somewhat satisfied” or “satisfied” with the current Interior Region Interior structure. Further, most IRAWC and LOU table members expressed satisfaction with the Interior structure. Several ongoing challenges were also identified throughout the key informant interviews with the PALT members and the focus groups with the IRAWC and LOU tables. The document review found evidence of meetings with the intention of “clarifying lines between governance and operations and processes for collaboration” and “identifying processes to ensure linkage between Interior governance tables (IRNE and PALT) and provincial tables (TCFNH, FNHC),” (IRNE Planning Report 2016) similar to the responses shared by respondents below, indicating that understanding the structure has been a challenge.

The following summarizes responses from the PALT member interviews and the IRAWC and LOU table focus groups regarding their satisfaction with the Interior Structure as well as the areas in need of improvement.

### What areas need improvement?

- The dynamics, processes, and mechanics of inter- and intra-table functions are not clearly understood for many of the respondents: this is especially true for new members of the partner tables and LOU tables
  - Almost all LOU table respondents indicated that the roles and responsibilities of IRNE and/or the processes in setting priorities or conducting decision making at the PALT were not clear
  - Most respondents, and particularly the LOU table respondents, agreed that a concise document or communication tool is needed which outlines each table’s roles, responsibilities and processes which can be shared widely with all partners
- Communication lines between the tables could be strengthened to ensure all relevant partners receive important information

- This includes communication that is advanced upwards to the IRAWC and the PALT as well as communication which is being disseminated down to the LOU tables
  - This was reiterated during the Fall 2018 Nation Health Assemblies
- Nation Representatives at the various tables (e.g. PALT and LOU tables) are stretched for resources and time which hinders their ability to participate fully in meetings, action items, dissemination of information, and orientation of new people
  - It was reported at Nation Health Assemblies that Interior Health is not aware of the time communities put into meetings, and needs to provide capacity support
- There is still work being conducted to ensure the right people are at the tables (e.g. which tables should have a political presence, what is the best composition, etc.)
- A few respondents indicated that Métis and urban Indigenous voices are not represented in the current structure

Generally, almost all the respondents (i.e. PALT, IRAWC, LOU tables, and FNHA senior staff) agreed that the Interior Region structure has the appropriate mechanisms in place to identify, advance, and resolve issues.

Generally, almost all the respondents (i.e. PALT, IRAWC, LOU tables, and FNHA senior staff) agreed that the Interior Region structure has the appropriate mechanisms in place to identify, advance, and resolve issues. Almost all the respondents also identified that improvements are needed for the structure to function more efficiently and effectively.

The following summarizes the responses from the PALT member and FNHA interviews and the IRAWC and LOU table focus groups regarding strengths, successes, and opportunities for improvement in the identification, advancement, and resolution of issues within the structure.

### What is working well?

- The partners in the Interior Region are moving from a stage of relationship building to coordinated implementation to identify, advance, and resolve issues impacting First Nations communities
- The LOU tables are a direct link to communities and can identify concerns occurring on the ground to either resolve, or advance up to higher tables
- The PALT creates a forum for Nations and IHA to work collectively to resolve matters that are identified and advanced
- Most PALT respondents think the right people are at the tables to address issues and move forward with solutions
  - For example, the Interior Health CEO is a member of the PALT which allows for more immediate decision-making
- There were a few examples mentioned by the respondents of topics that were raised to be resolved:
  - Discrimination experienced at hospitals or other healthcare facilities led to a formalized complaint process for patients
  - Lack of mental health support in communities lead to more attention and funding for resources
  - Lack of physicians and access to primary care led to the creation of new Nurse Practitioner positions and discussions around community access to Meditech

### What areas need improvement?

- There is uncertainty among all the main partners (i.e. the PALT, IRAWC, and LOU tables) about the mechanisms and responsibilities for resolving technical and operational problems
  - The PALT is having to address too many technical and operational issues which takes time away from governance and policy matters
  - If a technical issue does not need to be advanced to the PALT for resolution, there should be a clear process to deal with the topic elsewhere to ensure there is capacity among the technicians to address the many concerns that are brought forward
  - If a technical issue must move forward to the PALT, technicians need to be well prepared with all relevant information and can answer any questions the PALT members may have regarding the technical aspects
- The process of how to effectively advance an issue and the appropriate table to which the matter should be brought (e.g. PALT, IRNE, IRAWC, Technicians, etc.) was unclear to almost all the LOU table members
- Almost all LOU table members expressed uncertainty about PALT agenda setting processes and meeting content
  - Respondents agreed that better communication was needed regarding issues that have been addressed and resolved, particularly when it comes to next steps and directives for the LOU tables and communities
- Once an issue is identified and advanced, it can take a long time to be resolved
  - For example, concerns advanced around Elder care and palliative care took a long time to be addressed
  - Some LOU table members feel not all their issues are getting addressed by the PALT
  - A few PALT member indicated that some agenda items are not addressed as quickly as they could be
- The Nations are still learning to coordinate their voices to work collectively on issues
  - Many respondents from across the partners (i.e. the PALT, IRAWC, and LOU tables) feel when there is a collective effort, more topics can be addressed at PALT in a timely manner
- A few LOU tables indicated that there may need to be some preliminary work done prior to concerns coming to the LOU table so that more concrete issues are addressed and other matters can be more appropriately resolved in community (e.g. create services committees in the communities)
  - This may help address concerns that a few LOU tables raised where communities felt their issues were not being dealt with at the LOU tables
- The LOU tables may identify an issue or are given a directive by another table (e.g. the PALT) but do not have the resources to implement solutions
  - This includes the time needed to strategically plan for changes to address the situation and the human resources to implement responses
- The capacity of Nations to address community issues varies and in some cases is constrained by available resources
  - The concept of equal funding to all Nations prevents the targeted allocation of resources to address problems identified by some LOU tables
- A few of the LOU table respondents indicated that the way in which IRAWC functions during their meetings (i.e. long presentations) and the ways in which the LOU tables interact with this table should be reviewed and improved
- A few LOU tables indicated that the agendas at IRAWC do not always reflect Nation priorities. A few senior staff at FNHA indicated that regional structures could be improved if the FNHA was included in the PA as a formal partner
  - FNHA already works closely with the regional executive and operational teams, the service providers, and the communities and could benefit from additional definition around its role at the regional level
  - It was also noted that the FNHA is being included in some of the regional PAs as they are being renewed

- A nation expressed during the Nation Health Assembly that there needs to be additional dialogue and collaboration between their Nation and IHA for them to regard their relationship as a partnership
  - Described the table as a “communication table” and Nations are only engaged in select areas
  - Avenues for having community voices heard and influencing change within IH are not clear

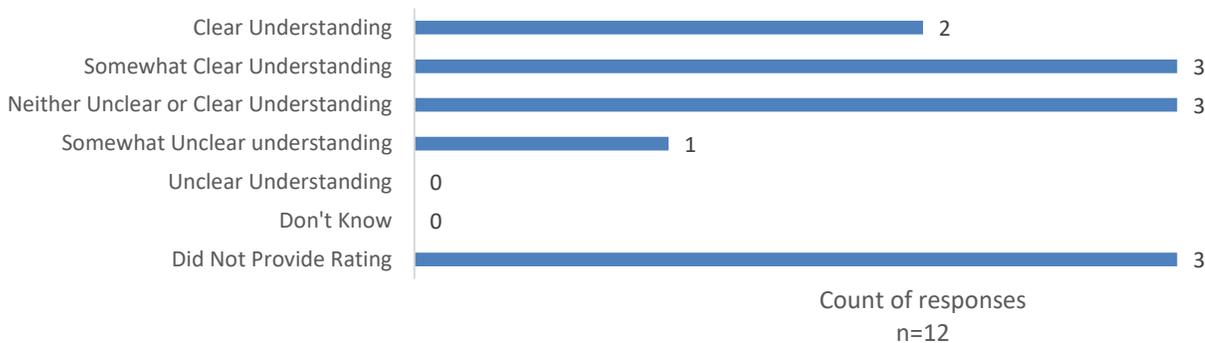


Ulkatcho LOU Table

## Section 3: Roles and Responsibilities

Many of the PALT members indicated that there is a “clear understanding” or a “somewhat clear understanding” of the roles and responsibilities as outlined in the PA ToR by all the partners.

Figure 2: PALT member responses to the question “is there a clear understanding of the roles and responsibilities as outlined in the PA ToR by all partners (IRNE, IHA, and FNHA)?”



Many of the PALT members indicated that there is a “clear understanding” or a “somewhat clear understanding” of the roles and responsibilities as outlined in the PA ToR by all the partners. Almost all PALT and IRAWC

members identified that more work could be done in this area to further clarify the roles and responsibilities of each of the partners, especially for new members.

As mentioned in the previous section, strengthened communication would support the LOU table members' clarity and understanding of the roles and responsibilities of the partners. There is uncertainty among almost all the LOU table members around which partner (i.e. FNHA or IHA) is responsible for certain services and where the funding for certain services comes from.

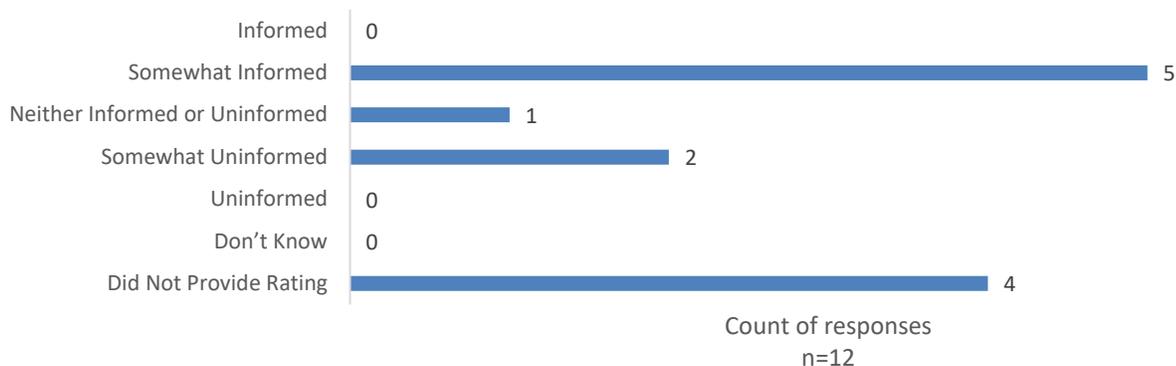
The following summarizes the responses from the PALT member interviews and the IRAWC and LOU table focus groups regarding the areas in need of improvement to ensure all the partners have a clear understanding of the responsibilities as outlined in the PA ToR.

### What areas need improvement?

- There is uncertainty among the IRAWC and LOU tables regarding the PALT's primary role: governance transformation versus service transformation
  - A concise, digestible document or communication tool summarizing the roles and responsibilities outlined in the PA ToR would be useful to keep the conversations focused
- Turnover of members at the PALT can lead to steep learning curves for new members regarding the roles and responsibilities of the PALT and their partners (i.e. IRAWC and LOU tables)
  - Consistency of people at the PALT table is key for moving forward on issues
  - Again, a concise document or communication tool summarizing the roles and responsibilities as outlined in the PA ToR could be useful to orient new people
- Sometimes the partners are uncertain of their specific purpose and decision-making authority
  - For example, a few PALT members and many of the LOU table members may not realize the power of their vote at meetings
  - Respondents indicated a consistent review of the roles and responsibilities as well as the work plan could be helpful to understanding purpose and decision-making capabilities
- Some respondents were unclear on FNHA's role in various aspects of the implementation of the PA and indicated that their role should be better defined

Several of the PALT members indicated that they are "somewhat informed" of each other's structures, service delivery processes, fiscal restraints and opportunities.

Figure 3: PALT member responses to the question "how informed are the partners are of each other's structures, service delivery processes, fiscal restraints and opportunities?"



Several of the PALT members indicated that they are "somewhat informed" of each other's structures, service delivery processes, fiscal restraints and opportunities. This was true for both Nation and IHA Representatives.

Further, almost all the LOU table members indicated that they are also generally unfamiliar with IRNE, IHA, and FNHA's structures, service delivery processes, fiscal restraints and opportunities.

The following summarizes the responses from the PALT member interviews and the IRAWC and LOU table focus groups regarding the key challenges and areas in need of improvement to ensure all partners are informed of each other's structure, processes, restraints and opportunities.

### **What areas need improvement?**

- Almost all the partners (i.e. the PALT, IRAWC, and LOU tables) do not fully understand IHA's administration and structure, this was mentioned by both Nation and IHA Representatives
  - This is primarily due to IHA being a very large organization with many moving parts
- More education could be provided to IHA on the various Nations' diverse processes and decision-making procedures and include education on how information flows down to communities from PALT
  - Face-to-face engagement with communities may help the IHA partners understand Nation structures, service delivery processes, fiscal restraints and opportunities and vice versa
  - Alternatives to communications via email and large documents could be explored to communicate this more effectively; leadership from Nations and IHA do not have the time to read through all the material
  - Opportunities to align processes and create efficiencies should be identified
- There is a helpful document which outlines the various tables (e.g. PALT, IRNE, LOU, etc.)
  - This document could be updated with governance information and used to support partner understanding of the various structures, service delivery processes, fiscal restraints and opportunities
  - LOU table members could also benefit from learning about the structure of other LOU tables to better collaborate on issues and shore up resources
- There is concern regarding a lack of understanding of the Ministry of Health's (MoH's) role with respect to IHA fiscal restraints and opportunities
  - Proper engagement with Nation Representatives is a key element in ensuring the MoH's role in priority setting and funding is communicated and understood by the Nations



Sexqueltqin Health and Wellness Centre  
Adams Lake



St'at'imc LOU Table

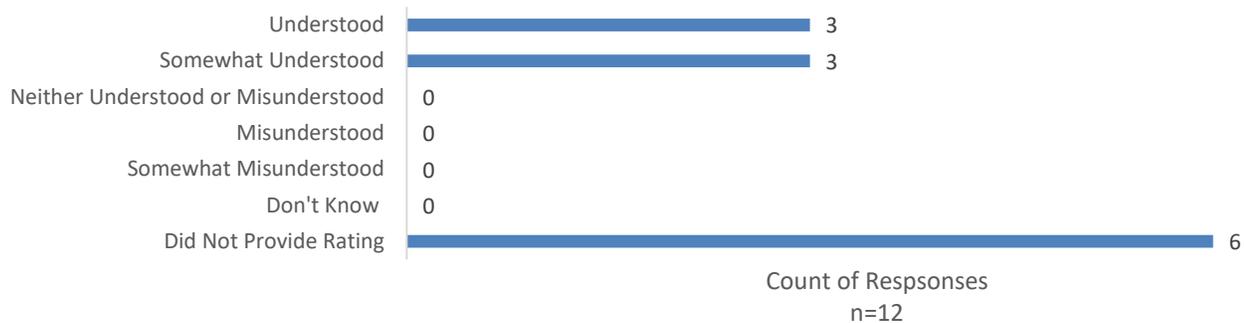
## Section 4: PALT Performance on Key Objectives

### Background – Aim of the Partnership Accord

The aim of the PA is to clarify the roles and relationships of all the partners as they work together to improve the health and wellness outcomes for First Nations people of the Interior Region. PALT members were asked how to what extent the aim of the PA was understood among PALT members as well as how well they are performing on the key objectives of PALT.

Half of the PALT members identified that Interior Nation Representatives, FNHA, and IHA Representatives at PALT “somewhat understand” or “understand” the aim of the PA.

Figure 4: PALT member responses to the question “to what extent do Interior Nation Representatives, FNHA, and IHA representatives understand the aim of the PA?”

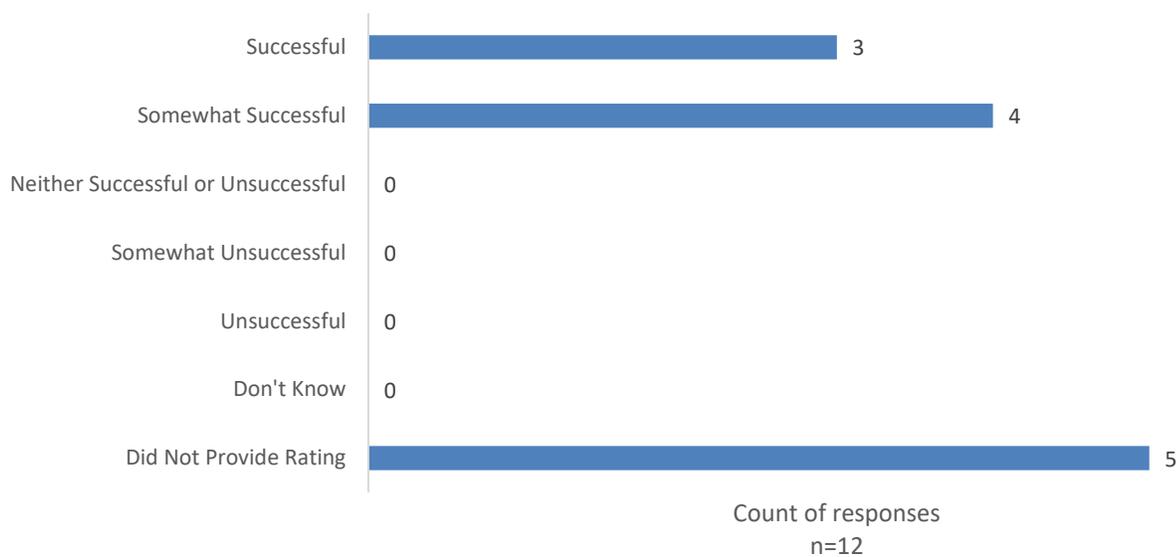


Half of the PALT members identified that Interior Nation Representatives, FNHA, and IHA Representatives “somewhat understand” or “understand” the aim of the PA. Almost all PALT members identified that at a high level, all partners understand the aim is to improve First Nations health outcomes.

Some PALT respondents indicated that understanding the aim of the PA is an ongoing process that evolves as members become more involved in the work. Further, a small number of respondents indicated that more clarity is needed for all partners regarding Nations’ interest in promoting self-governance in healthcare and other areas.

Most PALT members indicated that they have been either “somewhat successful” or “successful” in allowing policy and system barriers and issues to be identified, advanced, and resolved.

Figure 5: PALT member responses to the question “to what extent has PALT been successful in allowing for policy and system barriers and issues to be identified, advanced, and resolved?”



Most PALT members indicated that the PALT has been either “somewhat successful” or “successful” in allowing policy and system barriers and issues to be identified, advanced, and resolved. Further, all PALT respondents feel the table is on the right track towards addressing the major concerns facing First Nations communities. They also indicated that more time is needed before large policy and system changes are realized.

The following summarizes the responses from the PALT member interviews and the IRAWC and LOU table focus groups regarding the success of the Interior Region structure and the PALT in allowing for policy and system barriers to be identified, advanced, and resolved.

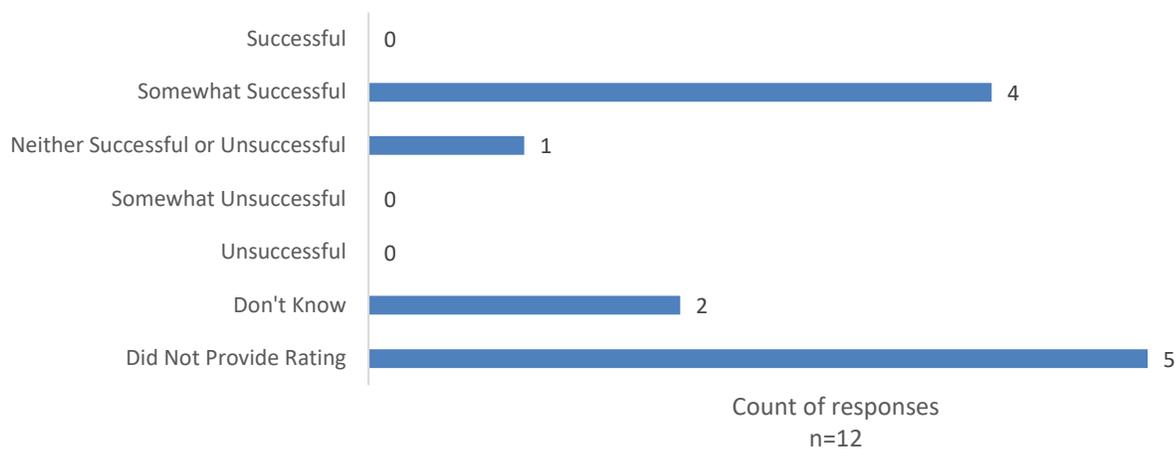
The change in IHA leadership led to the prioritization of First Nations health and to issues being addressed on a larger scale

#### Participant responses to the question “what is working well?”

- The change in IHA leadership (e.g. a new CEO) led to the prioritization of First Nations health at IHA and to problems being addressed throughout the organization.
  - First Nations health is now not only a priority for the IHA Aboriginal Team (as was the case before) but across all IHA departments.
- The PALT has the right people at the table to be able to address policy and system barriers and issues, such as the IHA CEO
  - The IHA CEO is touring communities to understand the policy and system barriers and challenges arising from the remoteness of communities
- The PALT is now in the process of identifying large policy and system barriers facing First Nations communities
  - A considerable portion of the work so far has been focused on building partnerships to allow for constructive conversation regarding key issues facing communities
  - Nations have a productive platform now and are bringing attention to these large system barriers
  - Nations and IHA are examining the large system gaps in healthcare in a coordinated way
  - Nations and IHA are exchanging information on a consistent basis about current activities and upcoming priorities to keep each other informed
- Respondents (i.e. the PALT, IRAWC, and LOU tables) provided some examples of policy and system changes which have already occurred:
  - Some community nurses now have access to IHA-held clinical information through Meditech regarding members of their communities
  - Changes in policy around funding for friendship centres (i.e. adoption of formal accountability mechanisms such as contracts)

Several PALT respondents indicated that they have been “somewhat successful” at influencing provincial level decisions.

Figure 6: PALT member responses to the question to what extent has PALT been successful in influencing provincial level decisions by providing a regional perspective through collaborative recommendations?



Several PALT respondents indicated that they have been “somewhat successful” at influencing provincial level decisions. Some PALT members indicated they “don’t know”. Similar to the question regarding policy and system barriers, almost all the PALT members agreed that more time is needed to influence decisions at the provincial level; however, most PALT respondents indicated that they are on the right track.

The following summarizes the responses from the PALT member interviews regarding their success in influencing provincial level decisions.

### What is working well?

- Many PALT respondents indicated that the example of influencing provincial level decisions provided in the interview guide: *“Palliative care issues that was escalated to the Tripartite Committee on First Nations Health for resolution”* is the key success
  - Focus has been primarily on the Interior Region and on relationship building within the region
- Engagement is better, and there are structures and mechanisms in place to support influence on provincial level decisions
  - For example, the Province is getting information from the First Nations Health Council and the IHA CEO regarding First Nations health issues
  - The Province appears to be receptive to ideas and suggestions being put forward
- The provincial and federal governments are still learning how to work within this system as it is new to B.C. and to Canada; they are on the right track



Interior Region Aboriginal Wellness Committee Focus Group

## Section 5: Relationships

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*“[...] it is really the relationship building of both systems and, and peoples to understand what the needs are at the community level and, and how best to deliver the programs and how best to understand the holistic and the complicated comprehensive trauma and other pieces that people don't know” –LOU Table Member*

There was strong consensus among all respondents (i.e. the PALT, IRAWC, and LOU tables), that relationships have been strengthened as a result of the PA.

There was strong consensus among all respondents (i.e. the PALT, IRAWC, and LOU tables), and corroborated by the document review, that relationships have been strengthened as a result of the PA. Specifically, respondents mentioned strengthened relationships between Nations and IHA at both the administrative and community levels. Respondents also acknowledged that a lot of work had been done prior to the PA in terms of building relationships between Interior First Nations as well as IHA. For example, some of the LOU tables existed prior to the PA.

The document review indicates the relationship between IHA and the FNHA has also been strengthened. The PA has created a foundation for a relationship between the IHA and FNHA CEOs. They have met intermittently since 2014, and have discussed a range of topics including rural strategy, program alignment and cultural safety (TCFNH November 2014, TCFNH May 2015, TCFNH March 2017). Through the Leadership Council, the FNHA

and IHA CEO establish a shared agenda and identify priorities and deliverables each fiscal year. Furthering the relationship between the FNHA and IHA, the May 2015 report to TCFNH referenced “frequent” meetings between the FNHA Interior Regional Director, Lisa Montgomery-Reid, and IHA Director of Aboriginal Health, Brad Anderson.

The PA has also led to increased coordination between Interior Region First Nations, through forums such as the Interior Region Technicians Table, which is comprised of one representative from each of the seven nations (TCFNH November 2014).

Relationships between Interior Region First Nations and IHA are informed by LOUs as well as the PA. LOUs have been signed between each of the seven Interior Nations and IHA. These unique government to government agreements create a strong link between Interior Health and Nations to provide a setting where community health concerns and initiatives can be shared and discussed and local decisions impacting First Nations communities can be made. An audit of the Interior’s seven LOUs was conducted in 2016/17 which found that the agreements were achieving the intended purpose of establishing and improving relationships between Nations and IHA. Although these agreements are in the early stages of maturity, with many opportunities to build upon, the audit found that the LOUs have created strong partnerships, improved local coordination of services and provided a platform to resolve local health problems. The LOU audit also found the LOU tables “provide a forum for Nations to raise health service delivery issues.” (LOU Audit p. 5). The audit identified communication between the PALT and the LOU tables as an area that could be improved. An action plan to address all audit recommendations has been developed in collaboration with the IRAWC.

An example of furthering the relationship between IHA and First Nations, the IHA Board of Directors sought input from PALT and IRNE on competencies for a future IHA CEO.

### **What has facilitated relationship building among the partners?**

- Relationship-building was made a priority at the provincial and regional health authority levels
  - IHA has shown a willingness to listen and learn
  - Nation and IHA leadership are involved and senior staff are interacting
  - IHA’s CEO has travelled to communities, creating personal connections
- Structures were put in place to support relationship building and communication
  - Face to face communications at the meetings and community visits
  - Ongoing and effective communication processes between the PALT members
- Personal connections were established
  - A sense of trust, respect and support has been built among the partners at both the PALT and LOU tables
  - There is a safe space to discuss difficult and personal issues
  - Consistency of the players at the table has supported long standing relationships
- Traditional elements of First Nations culture were brought into meetings
  - For example, blanketing people during meetings
- Strategies and work plans are being harmonized between Nations, FNHA, and IHA so that the partners can work together towards a common goal

### **Responses to the question what has constrained relationship building?**

- The turnover of leadership at all levels as well as IHA restructuring
- Some ideas were not addressed when brought up at the PALT which caused some friction

- When ideas are not acted upon, people feel they are not being listened to
  - Some matters have been elevated to caucus when it should have been addressed at the PALT
- First Nations communities lack funding and resources
  - This can strain relationships with larger organizations with bigger capacity (i.e. IHA and FNHA) who may not understand this constraint
  - Also, it is difficult to expand relationships throughout the structure without funding to enable participation in relationship-building
- Certain issues have led to mild tension
  - For example, the topic surrounding urban Aboriginals and Friendship Centres
- Underutilization of the LOU tables' leverage and authority within the Interior Structure can constrain relationship building among Nations and IHA

**Embed relationships and partnerships with Nations into the structure of IHA, all the way down to the front-line operations, processes, and staff.**

**Responses to the question what could be done to continue to strengthen the relationships moving forward?**

- Continued relationship-building among the partners (i.e. the PALT, IRAWC, and LOU tables) and the communities they are working with will contribute to a better understanding of the issues Interior First Nations are facing
  - Recognize the importance of relationship building at all levels from PALT to front line staff and patient relationships
  - Travel to different communities for the PALT, IRNE, and LOU table meetings
  - Encourage new staff travel to communities
  - Meet with front line staff in communities
  - Participate in informal events and Nation gatherings
- Embed relationships and partnerships with Nations into the structure of IHA, including the front-line operations, processes, and staff
- Work on strengthening the relationship between the PALT and LOU tables
  - Improve communication between these partners
- Provide more resources to Nations to support relationship building
  - Travel and time are large costs which can prevent full participation in the meetings and community visits
  - For example, respondents indicated that some LOU tables do not have a travel budget
- Create organizational charts with individuals' pictures, in addition to titles, departments, and contact information for the partners, so they develop a better and broader sense of the representatives and can contact people when they need support

**For both the PALT and the LOU tables, respondents agreed an environment of trust has been created where all partners feel comfortable to speak up and raise issues**

For both the PALT and the LOU tables, participants agreed an environment of trust has been created where all partners feel comfortable to speak up and raise concerns. Although some topics can be emotional or personal, people are willing to share their thoughts at the table in an open manner.

Some respondents (i.e. the PALT and LOU tables) indicated that the meetings used to be more confrontational but as relationships and trust developed, the environment at the table has improved. There are still moments where a few respondents do not feel completely understood but everyone is aware that people at the table are still listening and being respectful.

A few respondents also indicated that the IRNE table in particular is open and honest. There are people who are openly sharing their vision which allows others to know the individual and have trust in their partnerships.

Key informants noted the role of the FNHA in executing the PA remains unclear, as they are a witness, not a signatory to the accord. The protocol established between the IHA and FNHA CEOs may provide clarity and accountability to the FNHA's role.

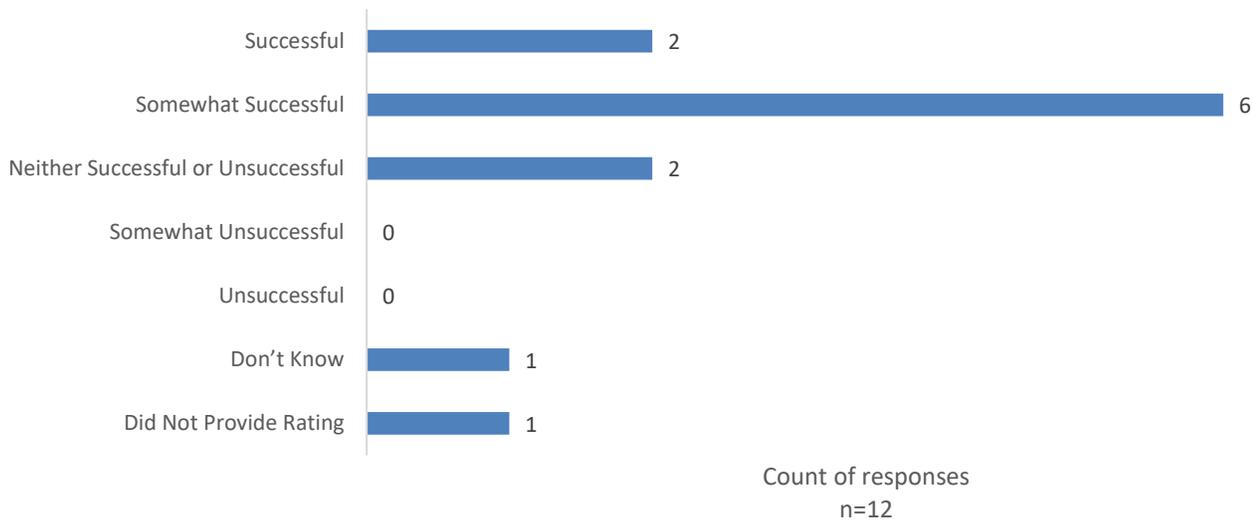
## Section 6: Communication and Planning

*“...you know, they always pick up the phone and call our LOU table and have a conversation if we need to. It’s, it’s been really beneficial” – LOU Table Member*

*“...sometimes it’s what’s happening now is [...] the communication and the information may be stopped at the PALT and it’s not being flowed back through this way, so if [communication and information had] the ability to flow back and forth throughout, then, the transition of understanding the information could be more fluid.” – LOU Table Member*

Most of the PALT respondents identified that they have been either “somewhat successful” or “successful” in facilitating communication and reporting back to respective Nations and entities (i.e. Chiefs, Health Directors, and LOU tables).

Figure 7: PALT member responses regarding their success in facilitating communication and reporting back to respective nations and entities



Almost all respondents from the IRAWC and LOU tables indicated that there was room for improvement in terms of communication and planning. This finding is corroborated by the document review. An Interior Planning document from 2016 revealed the IRNE discussed ways to improve reporting back pertinent information to respective Nations and entities. The fact that these conversations were taking place suggests that there was an awareness of the need for improvement in in this area.

The following summarizes the narrative responses that were shared through PALT member interviews and the IRAWC and LOU table focus groups regarding PALT’s success in facilitating communication and reporting back to respective Nations and entities as well as their suggestions for how to improve communication and reporting back.

## What is working well in facilitating communication and reporting back to respective nations and entities?

- The Nation Representatives from the PALT are able to report directly to Chiefs, Health Directors, and LOU tables about key decisions affecting their Nation Territories
  - IHA leadership attends meetings so they are well informed of decisions and activities occurring at the PALT
    - IHA leadership has been visiting communities to facilitate communication around issues and current activities
  - FNHA is helping Nations with communication processes and disseminating information

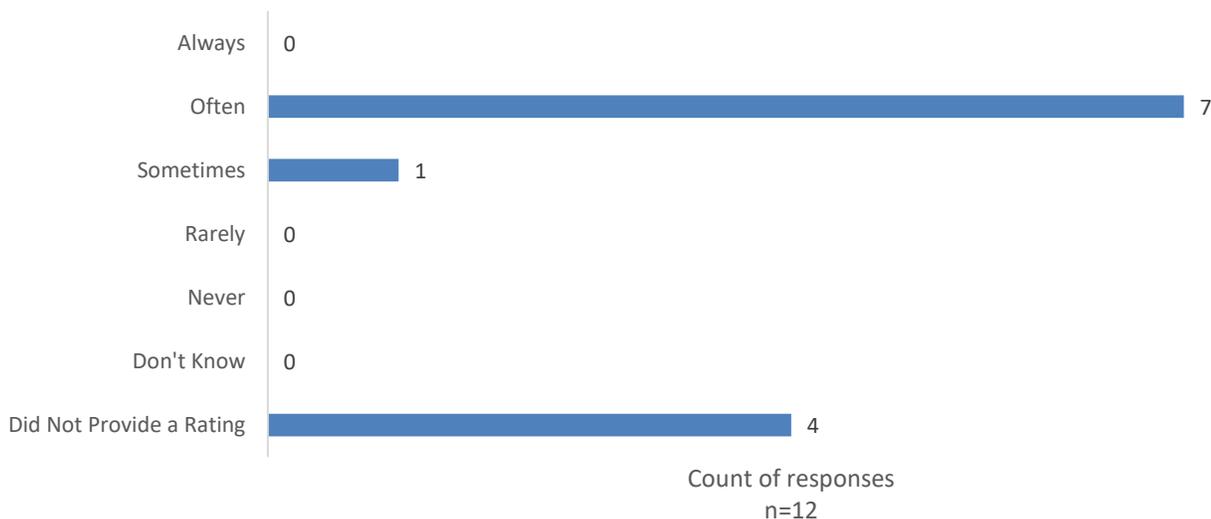
## What can be done to improve communication and reporting back to respective Nations and entities?

- Formalize and use an efficient communication process to ensure consistent reporting back is occurring to respective Nations and entities
  - Providing meeting minutes or long reports on discussions that have transpired at the PALT meetings are ineffective communication tools in terms of ensuring information reaches relevant audiences
  - Targeted briefing notes (i.e. one or two pages long) and/or newsletters (i.e. plain language, pictures, and success stories) might instead be used to disseminate relevant information from the PALT to Nations and LOU tables
    - As another option, there is a newsletter that goes to the Nation Representatives which might be disseminated more broadly if the format is appropriate
  - Create a website as a central place to access information (e.g., PALT minutes, important updates, etc.)
  - As an accountability mechanism, the PALT could have a standing agenda item specifically for reporting back to respective Nations and entities
  - The LOU tables might have a standing agenda item to discuss what happened at the PALT meeting and what other Nations are undertaking, which may be of direct relevance to their Nations
  - The IRAWC might have a standing agenda item to discuss LOU table activities and any important updates coming in from the community
- Use face-to-face communication from Nation Representatives or Community Engagement Coordinators to facilitate reporting back to Nations and respective entities
  - More resources would be needed to support these activities
  - These individuals will need to be aware of their important role in dissemination and trained in effective communication processes
- Provide appropriate communications to Chiefs
  - It is likely that pertinent information is not circling back to all 54 Chiefs regarding PALT's decisions, capacities, and limitations
  - Chiefs are overloaded with information and are dealing with many other matters that are not health-related (e.g. land disputes, education, etc.)
  - Communication needs to be presented in a digestible format that provides timely and relevant information
  - Repeated communication on important issues may help to facilitate dissemination
- In addition to being an administrative responsibility, communication may also be viewed as a personal responsibility
  - Individuals could seek out information so that they are suitably prepared for meetings

- Individuals could consistently reach out to their networks and communicate key information from the PALT meetings
- Utilize social media to reach younger audiences residing within communities
- Translate information for communities and Elders where English is a second language

Slightly more than one-half of the PALT members reported that the PALT agendas are “often” reflective of the most important issues

Figure 8: PALT member responses regarding whether their agendas are reflective of the most important issues



According to the PALT respondents, agendas are informed by collective community issues, which are reported back to the PALT from Nation Representatives and LOU tables, such as Elder care and primary care access. To ensure other unique challenges are being suitably addressed, PALT respondents indicated that Nation Representatives attempt to discuss these at the IRNE table prior to the PALT meetings.

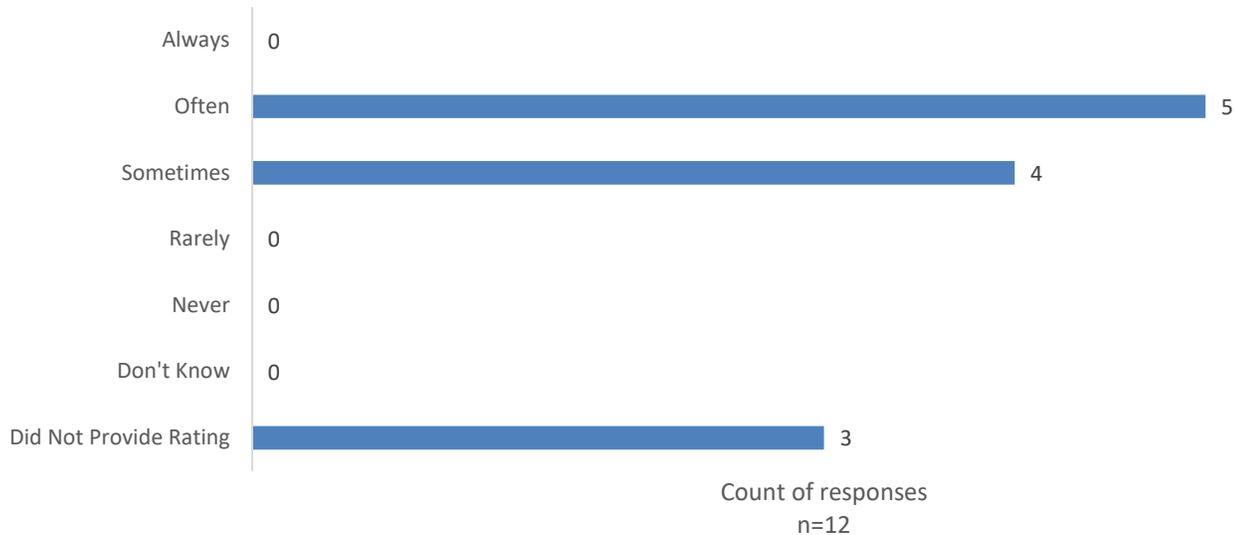
Occasionally, agenda items will shift so that focus may be given to more urgent and time sensitive matters that emerge (e.g. wild fires; opioid overdose crisis). Time permitting, deferred agenda items are returned to at a later date. A few PALT respondents reported that, on occasion, issues will sit at the table for too long without corresponding decisions being made.

A small number of PALT respondents indicated that the agenda fails to go beyond immediate problems facing First Nation communities to address health in a holistic way, such as taking more proactive measures to improve health outcomes (e.g. mental wellness, community participation, family functioning, etc.). Acknowledgement was made that health might be approached more holistically over time as communication processes mature.

Findings emerging from the focus group discussions with LOU table members revealed that there is a general lack of awareness concerning how the PALT agendas and priorities are being set. Moving forward, it might be useful for LOU table members to have information on this so that they are better able to understand what is discussed at the PALT, including strategic directions.

Most of the PALT respondents reported that “sometimes” or “often” there is shared decision-making amongst partners with respect to the development and delivery of services for Interior First Nations communities.

Figure 9: PALT member responses regarding whether there is shared decision making among the partners with respect to the development and delivery of service for Interior First Nations communities



Almost all of PALT, IRAWC, and LOU table respondents agreed that more work needs to be completed in this area. PALT respondents indicated that shared decision-making takes place at the higher system-level (e.g. the PALT) but that they were not sure if this was happening down the structure (e.g. community level work at the LOU tables).

The following summarizes the responses from PALT member interviews and IRAWC and LOU table focus group discussions regarding the strengths and areas of improvement for shared decision-making among the partners with respect to the development and delivery of services for Interior First Nations communities.

**What is working well with respect to shared decision making among the partners in the development and delivery of service for Interior First Nations communities?**

- Nations and IHA have created shared work plans for the PALT and various initiatives
- Several respondents from PALT, IRAWC and LOU tables identified examples where shared decision-making had occurred around the development and delivery of services:
  - Nations near Williams Lake were invited to a ceremony to share with IHA their concerns regarding the accessibility and delivery of healthcare services
    - During the ceremony, First Nations shared personal stories concerning their healthcare system experiences
    - This ceremony educated and changed IHA’s perspectives about how healthcare might be delivered to First Nations
    - Community and IHA leadership have created a cultural safety task force to engage in shared decision-making to resolve challenges without the involvement of the PALT
  - After discussions between the Nations and IHA, it was determined that Telehealth may be an appropriate solution to primary care access issues

- Nations, IHA and FNHA are in discussion with Internet service providers to establish increased bandwidth in certain communities to facilitate primary care services through Telehealth
- Nations and IHA are working together to address funding accountability concerns in connection with urban Aboriginals and Friendship Centres
- Nations and IHA collaborated on how to allocate funds for residential care beds, leading to the Elder's Nursing Enhancement Project
- FNHA is in a unique position to engage in creative solution-building and shared decision-making in the development and delivery of innovative health services for First Nations

Many respondents perceived that IHA holds most of the decision-making power in the development and delivery of service for Interior First Nations communities.

**What areas need improvement with respect to shared decision making among the partners in the development and delivery of service for Interior First Nations communities?**

- Nation Territories do not always share the same priorities. This reality adds a layer of complexity to shared decision-making by IHA partners.
- Decisions may fall beyond the control of the PALT or IHA, such as MoH priorities and funding, which can challenge shared decision-making between Nations and IHA
  - For example, the members of the IRAWC identified that the MoH can set ten day deadlines for the HAs to create and submit plans for health services. This does not allow the HAs enough time to engage in joint decision making with Nations
  - Nations need to be engaged by the MoH prior to HAs receiving directives and deadlines
  - Consideration should be given regarding how Nations, IHA, and FNHA can collectively influence the MoH regarding their engagement plans and deadlines to avoid this barrier to shared decision making.
    - Perhaps this is a matter for the Tripartite Committee to address
- To fully engage in shared decision-making with respect to the development and delivery of services for communities, more power could be shifted to Interior First Nations
  - Many respondents perceived a power imbalance, with the IHA holding most of the decision-making power
  - Some respondents feel Nations are asked for guidance around the development and delivery of services, as opposed to being fully engaged in shared decision-making throughout
  - Shared *planning* of services between Nations and IHA was identified as an important factor for consideration in the realization of shared decision-making
- Without involving Interior First Nations in decision-making, IHA allocated a set number of detox beds for first Nations patients recovering from substance abuse
  - Nations presented their data and demonstrated a need for more beds, which they subsequently received
  - This was a learning opportunity for IHA regarding shared decision-making and engagement with Interior First Nations
- Additional focus should be given to the FNHA and their role in supporting the shared decision-making process
  - Most respondents were unclear of FNHA's role in the context of shared decision-making

Almost all the PALT members indicated that they have been either "somewhat successful" or "successful" in strengthening coordination and integration of planning efforts and services.'

A review of joint reports from IHA and the FNHA to the Tripartite Committee on First Nations Health (TCFNH) revealed there has been extensive efforts to coordinate and align planning of Aboriginal Health programming, as demonstrated by the joint IM/IT strategy, the Aboriginal Client Self-Identifier and the response to the opioid crisis.

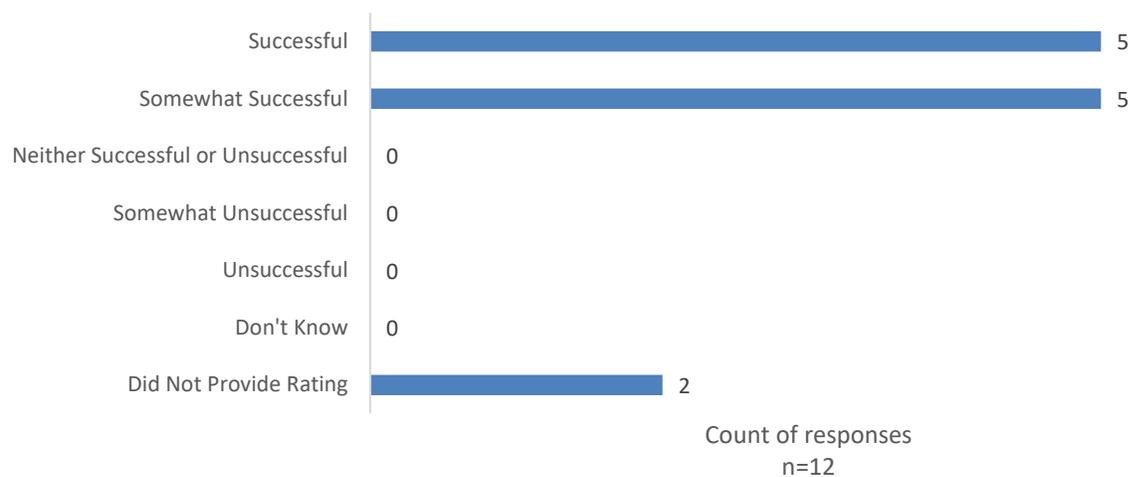
The joint IM/IT strategy provides an example of enhanced coordination of services since the PA. In addition to the IM/IT strategy, the FNHA and IHA have collaborated on connecting communities to IHA's Meditech system. In an effort to improve communication and discharge planning, remote access to IHA's clinical information system for community health nurses has been piloted with Splotsin First Nation and is currently rolled out to four communities, with more communities being added as they meet conformance requirements. Since 2011, IHA has been leading the province in helping to gather data through the creation, development and reporting of the Aboriginal Self-Identification (ASI) Project within the acute care setting. The expansion of this project is being rolled out to community information systems and to primary care and chronic disease management information systems. The third annual volume of ASI acute care data will be shared with Nation partners at IRAWC and LOU tables in early 2018. However, a 2015 report to TCFNH noted "ASI is not a viable medium-long-term solution to the information needs of our Aboriginal partners or IHA. A more comprehensive, Provincial, standardized solution should be investigated and presented to PALT" (TCFNH Report, Spring 2016).

"ASI is not a viable medium-long-term solution to the information needs of our Aboriginal partners or IH[A]. A more comprehensive, Provincial, standardized solution should be investigated and presented to PALT" (TCFNH Report, Spring 2016).

Presently, there is interest from IHA to set up a data sharing agreement concerning the Health Systems Matrix (HSM) data results stewarded by the FNHA, to allow access to this information for program planning, service delivery and to support the PA evaluation. IHA and the FNHA have also coordinated on their response to the ongoing overdose crisis, collaboratively developing an Interior Region Overdose Response Framework. Additional input into the framework is currently being sought through Nation Assemblies, the Interior Region Caucus Session and further engagement with Nation Technicians. The framework identifies scope of response, multi-partner roles, and specific actions at the various levels of service that begin to address the overdose crisis. In September 2016, the FNHA and IHA identified teams to support overdose deaths, in addition to establishing communications channels between IHA, FNHA, and communities. IHA and the Interior FNHA team. In August 2017, the FNHA released a province wide Overdose Report with recommendations including immediate harm reduction measures, developing Nation/regional protocol, communications and information sharing, and enhancing links to timely and equitable services. An IHA Aboriginal Harm Reduction Coordinator supported Take Home Naloxone training for Aboriginal health care partners on reserve as well as urban agencies. This position was able to connect with all Interior First Nation communities and urban agencies to discuss harm reduction education and services. FNHA and IHA staff have been reporting overdose statistics and information at all Nation Health Assemblies (Fall 2017).

As part of the Province's commitment to add 500 additional substance use spaces throughout British Columbia by 2017, IHA announced its plan to open 73 substance use treatment beds within the interior. In collaboration with FNHA, IHA set-up 15 support recovery beds with existing Aboriginal service providers designed specifically for Aboriginal people. Bed locations are as follows: four beds in Cranbrook with the Ktunaxa Nation, six beds in Armstrong with Round Lake Treatment Program, and five beds in Esk'etemc First Nation. These activities illustrate the efforts made to improve planning, coordination and integration of services in the interior region.

Figure 10: PALT member responses regarding the extent of their success in strengthening coordination and integration of planning efforts and services where appropriate



Almost all the PALT members indicated that they have been either “somewhat successful” or “successful” in strengthening coordination and integration of planning efforts and services. Almost all PALT respondents indicated that the PALT allows for Nation priorities to be identified and planned for in a collaborative and coordinated way.

It was also noted by all PALT members that more work is required before full coordination and integration of planning efforts and services are realized.

The following summarizes the responses from the PALT member interviews regarding the extent of their success in strengthening coordination and integration of planning efforts and services to date as well as areas in need of improvement.

Nations can bring forward priorities at the PALT as one entity instead of separate entities. This process has revealed collective Nation priorities such as primary care and mental health care access which allows for coordinated planning.

**Responses to the question “what is working well to strengthen coordination and integration of planning efforts and services?”**

- Improved coordination of planning efforts and services is occurring by having PALT members at the table, sharing ideas, and listening to one another
- Nations can bring forward priorities at the PALT as one entity instead of separate entities
  - This process has revealed collective Nation priorities such as primary care and mental health care access which allows for coordinated planning
- There is a sense of collegiality and common purpose emerging at the PALT which supports coordination and integration
- FNHA planning sessions and caucus meetings, where all partners are invited to attend and participate in the discussions, allow for coordination of planning efforts and services
  - Partners at the tables are held accountable on their action items
- The PALT members described several examples where Nations and IHA coordinated planning efforts and services to address gaps in the healthcare system, such as:
  - The creation of Joint Project Board initiatives

- Coordinated efforts around Elder’s care, palliative care, mental health and substance use beds, and nurse practitioners
- The wild fire response was a learning experience in terms of coordinating services
  - For example, evacuation orders prevented nurses from going into communities so coordination between IHA, Nations, FNHA, and unions became an immediate need
- Other examples of coordinated efforts include planning for the Cariboo Memorial Hospital rebuild and Williams Lake First Nations Wellness Center

Attention to effective communication and engagement when IHA plans for services would better position Nations to fully and more effectively engage in the planning, coordination and integration process.

**Responses to the question “what areas need improvement to strengthen coordination and integration of planning efforts and services?”**

- Attention to effective communication and engagement when IHA plans for services would better position Nations to fully and more effectively engage in the planning, coordination and integration process.
  - This would be beneficial at all levels, right down to on-the-ground work at LOU tables and in communities
- When Nations receive funding from outside the PA, consideration could be given to including IHA in their planning efforts
- Nations and IHA could engage in a proactive versus reactive approach to the coordination of planning efforts and services
  - The PALT is focused on addressing major concerns first and will need to move into more proactive work in the future

Most PALT respondents indicated that more needs to be done to engage First Nations in planning of Interior Health services, programs, policies, and investment decisions.

Almost all respondents had observed improved engagement over the years. Some indicated that First Nations should be more involved in IHA planning tables and process discussions.

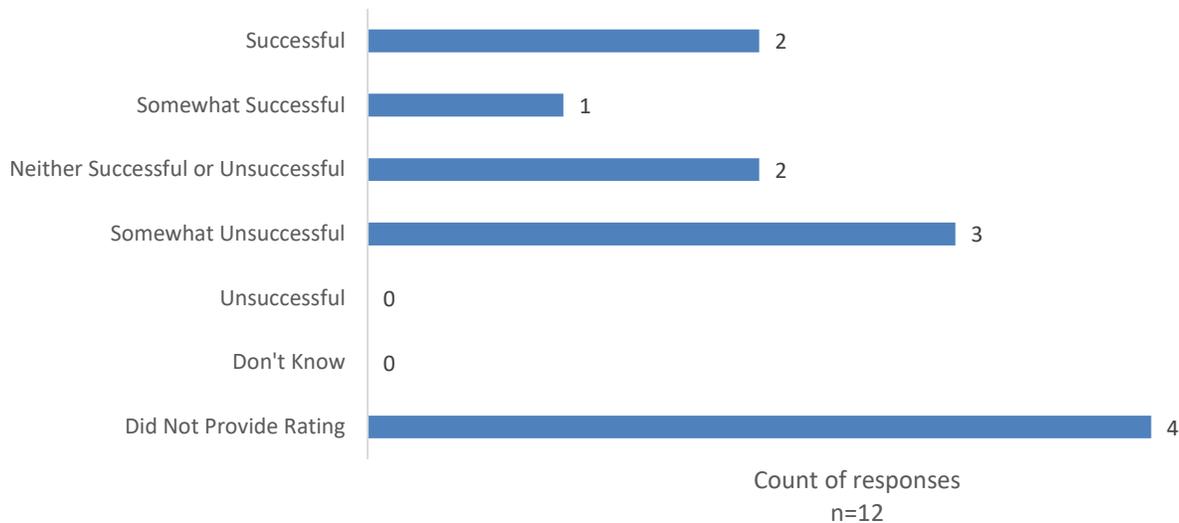
The following summarizes the responses gleaned through PALT member interviews regarding areas of improvement to ensure all representatives at the PALT, IRAWC, IRNE, and LOU tables are involved in planning in the onset and/or engaged at the proper stage with respect to planning of IHA services, programs, policies, and investment decisions.

**What areas need improvement to involve PALT, IRAWC, IRNE, and LOU tables in planning at the onset and/or engaged at the proper stage with respect to Interior Health services, programs, policies, and investment decisions?**

- Develop a formal engagement strategy for including Interior First Nations at the onset of planning
- Invite Nations to IHA planning tables and vice versa, even at the provincial level, to enhance understanding around planning and solicit input into programs and services being delivered in communities

Most of the PALT members identified that no formal mechanisms have been established to address issues of Nations whose territories encompass more than one Regional Health Authority.

Figure 11: PALT member responses regarding the extent of their success in establishing mechanisms to address issues of those Nations whose territories encompass more than one Regional Health Authority



Most of the PALT members identified that no formal mechanisms have been established to address issues of these Nations. Specifically, respondents indicated that they have talked about these Nations at their meetings but have not advanced beyond limited discussion. Some PALT members said they have not heard about any concerns with these Nations.

The IRAWC indicated that one challenge they have noticed is that for Nations whose territories encompass more than one Regional Health Authority, their leadership receives double or possibly triple the amount of communication. The need for these Nations to collaborate with two to three Health Authorities represents a burden to be mindful of when communicating and coordinating with these Nations. Further, an LOU table identified that for these Nations, it may be unclear which health authority is responsible for certain services (e.g. mental health, home care, immunizations, etc.).

Leadership and Health Directors may receive double or triple the amount of communication, placing the burden on the Nation to collaborate with 2 or 3 Health Authorities [...] and it may be unclear which health authority is responsible for services.

**Responses to the question “what areas need improvement to establish mechanism to address issues of those Nations whose territories encompass more than one Regional Health Authority?”**

- The PALT is in a position to address these concerns more formally through the creation of a plan specific to these Nations
- An opportunity or forum could be created for Nations, the Partnership Tables, and Health Authorities from the various regions to come together to plan and address issues of those Nations whose territories encompass more than one Regional Health Authority

- A caucus meeting could be held to collectively discuss problems regarding governance and include a discussion on the mechanics of responding to and supporting the needs and priorities of Nations whose territories encompass more than one Regional Health Authority
- FNHA could facilitate Nation-to-Nation relationships and meetings of this nature
- This matter could be brought forward to TCFNH



Nlaka'pamux LOU Table

## Section 7: Considerations for Renewal

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Respondents listed many great achievements resulting from the PA.

Many of the achievements were identified through other questions during the PALT interviews and IRAWC and LOU table focus groups, therefore; the following provides a concise synthesis of what was heard when we asked this question.

Regarding the greatest achievements of the PA, the following responses were provided by PALT members and FNHA senior staff during interviews, and by IRAWC and LOU table members during focus group discussions.

- Harmonization of the Nations; bringing together 52 communities to work towards a common goal
- Creation of a structure and process for Nations and IHA to work together toward improving health and wellness outcomes for Interior First Nations; this established accountability, and a forum for communities to access decision makers and voice concerns
- Senior leadership from Nations and IHA sitting at one table to speak openly about First Nations health, listen and learn from one another, engage in proactive communication and collaboration, and build genuine relationships that are based on respect and trust
- IHA's receptiveness to new ideas and commitment to First Nation health
  - IHA learning about the history of colonization in B.C., different Nations and communities, and key issues facing these communities
- Identification of gaps within the healthcare system for First Nations and ability to raise concerns in a respectful and non-adversarial way
- Resources committed by the FNHA and IHA to improve First Nations health
- Other specific achievements:
  - Cultural safety work and associated resources
  - More nurse practitioners to be in communities by 2018
  - Prioritizing mental health and substance use through the allocation of more recovery beds and establishment of new facilities down the road
  - Palliative care benefits
- Home and Elder care resources from IHA and FNHA.
  - In November 2017, IHA and FNHA announced a joint \$3 million investment to bring elder care closer to home
  - IHA will contribute \$2 million dollars on an ongoing annual basis, with the FNHA contributing \$1 million dollars to support communities in preparedness.
- Many senior staff from the FNHA indicated that a key achievement of the Interior Region PA was the use of the Health Systems Matrix (HSM) data in identifying the required amount of resources for communities
  - IHA provided additional treatment beds to communities based on population data
  - The decision to invest in elder care was informed by the IHA – FNHA Expenditure Project, which included HSM data
- Improved primary care access through: nurse practitioner advisory committees, Aboriginal Patient Navigator services, and Nation participation in Primary Care Network planning

Senior leadership from both the Nations and IHA indicated that additional work needs to be completed to create more responsive regional health care services, programs and policies.

Senior leadership from both the Nations and IHA indicated that additional work needs to be completed to create more responsive regional health care services, programs and policies. Work to date has focused primarily on building relationships and a structure to accomplish the work. The shift in leadership at IHA was a key factor in moving this process forward. Work is now underway to improve improving the responsiveness of services, programs, and policies.

Senior leadership from both the Nations and IHA indicated that dedicated funding has been set aside to improve the access (e.g. mental health and addictions services in communities)

and quality of health services for Interior First Nations (e.g. cultural safety and humility training opportunities for staff).

Senior leadership from both the Nations and IHA indicated that dedicated funding has been set aside to improve the access (e.g. mental health and addictions services in communities) and quality of health services for Interior First Nations (e.g. cultural safety and humility training opportunities for staff). Measurable impacts from these actions have yet to emerge. Senior leadership respondents reported that as Nations and IHA start to track data more closely, outcomes will demonstrate whether access and quality have been improved over time. The document review revealed a number of areas of collaboration between IHA and the FNHA aimed at improving the quality of health services for Interior First Nations, which are discussed below.



As of 2011, the Aboriginal Health department of Interior Health has been involved in the Aboriginal Doula Initiative. The goal of this program is to “improve maternal health services for Aboriginal women and bringing birthing closer to home and back into the hands of women” (Aboriginal Health Program Report 2011-2012). In December 2016, the IHA Maternal Health Team and the Ministry of Health presented to the Interior Region Wellness Committee on the Nurse Family Partnership (NFP). The goal of the presentation was to gauge communities’ interest in the program, and to learn more about maternal and child health care needs. In June 2017, IHA presented the Maternal Child Health Report, which prompted a request for the FNHA and IHA teams to explore the feasibility of developing an Aboriginal-specific Maternal-Child Health Report. Additionally, in March 2017, IHA confirmed the membership of the “cross portfolio and cross-sector” Infant Mortality Review Committee, with the intent of reducing the total number of infant deaths, and closing the gap in infant mortality between First Nations and non-First nations residents in the interior region (TCFNH March 2017).

Interior Health also engaged its Aboriginal partners on the Mental Health and Wellness Strategy. In December 2016, Interior Health presented its draft Aboriginal Mental Wellness strategy to the Interior Region Aboriginal Wellness Committee, for feedback. To ensure a fulsome engagement of partners, IHA Mental Health leads also attended the LOU meeting tables to discuss the strategy (TCFNH March 2017). By June 2017, the PALT had endorsed the strategy, with the IHA and FNHA having begun plans for implementation.

In January 2017, the FNHA Interior Region hosted and supported trauma training to First Nations Mental Wellness Advisory Members; Interior region seats were available for Provincial Roots of Trauma Training held during winter 2017. A Regional Roots of Trauma Training (80 seats) was held February 28-March 1, 2017.

Presently, Interior Nations are working towards the vision of Nation Shared Services, which is a service delivery model unique to the Interior Region where benefits for communities are maximized through shared delivery via client- and family-centered multi-disciplinary teams providing Nation-wide culturally appropriate and holistic health care services. It is a mechanism for Interior communities to increase capacity and access health professionals through internal collaboration and partnerships with the IHA, FNHA, and other service providers. The IHA Executive Director for Primary and Community Care Transformation is now a standing member on the Interior Region Aboriginal Wellness Committee to ensure continued engagement and alignment.

Other areas where IHA has made efforts to improve access or quality of services for Interior First Nations include:

- Elder Care and Chronic conditions: In January 2017, IHA announced the allocation \$1.5 to \$1.9 million in funding for the Elderly and those suffering from chronic conditions. The funds will be distributed to

communities, with the communities submitting a proposal for how the funding is to be allocated by August 2017 (TCFNH June 2017)

- **Aboriginal Health Contracts:** These contracts are provided to Aboriginal not-for-profit organizations in order to improve aboriginal health. In 2011-2012, IHA distributed 55 contracts worth a combined total of over \$3 million (IHA Aboriginal Health Program Report 2011-2012)  
**Aboriginal Patient Navigator Program:** The goal of the Aboriginal Patient Navigator Program is to improve access and create culturally safe care for Aboriginal clients in IHA. There are 5.5 FTEs distributed across the IHA region. (IHA Aboriginal Health Program Report 2011-2012.)
- **Suicide prevention and intervention:** - In 2015, IHA acknowledged that resources needed to be directed at suicide prevention and intervention with the goal of building community resilience. The IHA Youth Suicide Action Plan was then designed around three goals: (1) Improve Mental Health and Resilience among the Population (2) Deliver Quality Acute and Community Based Services for Suicide Prevention and Surveillance, (3) Monitoring and Program Evaluation.

Overall, respondents feel some progress has been made and that IHA is continuing to move forward on improving cultural safety and humility.

Both the document review and direct conversations with PALT, IRAWC and the LOU tables indicate that a lot of work has been completed on enhancing the cultural safety and appropriateness of health care programs and services.

All PALT, IRAWC, and LOU table members indicated that much more work will be needed in this area to reach all levels of health program and service delivery, particularly in relation to front-line staff. Further, many respondents said that cultural safety and humility training needs to go beyond online courses and include successive experiential learning opportunities, which provide specific knowledge about the uniqueness of Interior First Nations and communities. During the fall 2018 Nation Assemblies, participants expressed Cultural Safety has improved at the executive level, but not at the frontline. While participants acknowledged the process of dispelling ingrained racism and racist views held by employees is slow, cultural safety is an aspect of employee performance and therefore is the employer's and management's responsibility to address.



The document review revealed Interior Health has made efforts to promote cultural safety and humility through three main streams: human resources (HR) in the form of employee self-identification; Indigenous Cultural Competency (ICC) Training; and changes to the complaints process for IHA clients. This section discusses the activities that have been undertaken across these three areas.

With regard to HR in the form of employee self-identification, the goal of IHA's Aboriginal Human Resources strategy is to achieve 10% aboriginal representation in the workforce by 2025 (TCFNH June 2017). As of June 2017, more than 760 active Interior Health employees self-identified as Aboriginal, 3.8% of total active workforce. In working towards the goal of 10% self-identification, IHA has hired an Aboriginal Recruiter, to support recruitment and retention of aboriginal candidates, in addition to launching four videos on YouTube and the IHA website (TCFNH report, Fall 2015). As of November 6 2017, the four recruitment videos combined had over 3,000 views.

Regarding ICC training, IHA has participated in training offered by the PHSA since August 2009. Since then, approximately 3,700 IHA employees have completed ICC training, with IHA purchasing 500 seats per year. To complement PHSA's ICC training, in August 2015, IHA hired a Cultural Safety Educator, and hired a second

Aboriginal Cultural Safety educator in fall 2017 to help facilitate additional training. In June 2017, IHA approved a “three-year Aboriginal Cultural Safety Education Plan (2017-2020)” (TCFNH June 2017).

Lastly, concerning changes to the complaints process for IHA clients, in March 2017, IHA launched “Cultural Safety: A People’s Story’ which is a full-day, facilitated, in-person session that will the goal of reaching 600 IHA employees between May 2016 and May 2017” (TCFNH March 2017). Between March and October 2017, 484 Interior Health staff completed the training, which is still in its pilot stage. The training has since evolved into a three-part Cultural Safety Education Series. The training will be allotted in regions and departments based on previous cultural breaches. (TCFNH October 2017). The first session focuses on “how the colonial narratives impact the present day realities of Aboriginal people through interactive activities that demonstrate practical educational interventions” (TCFNH October 2017). The first of the revised Cultural Safety Education series have already begun, with 298 IHA employees having completed the training as of October 17, 2017 (TCFNH October 2017).

In addition to training, cultural safety is being promoted through the six sacred spaces within Interior Health facilities for people of all faiths and cultures to practice individually or with their families. The most recent space opened in February 2017 in Kelowna General Hospital and was blessed through ceremony and prayer by a local First Nations Elder.

IHA, FNHA, and Interior First Nations have collaborated on addressing cultural safety and humility. In November 2016, both IHA and FNHA received a complaint letter regarding the treatment of a First Nations Elder at an IHA facility. This led to a meeting of a working group composed of Secwepemc, Tsilhqot’in and Ulkatcho First Nations representatives, who were joined by FNHA and IHA leaders in February 2017. The working group signed a Declaration of Commitment and are working on an action plan to embed a culture of safety and humility in the healthcare system. Simultaneously, Interior Health began offering Peacemaking Circles as an alternative complaints process (TCFNH Spring 2016).

In order to augment ongoing cultural safety and humility efforts, IHA has created an evaluation rubric to conduct an organizational self-assessment of Indigenous cultural competency and cultural safety. The evaluation was developed through discussions with a stakeholder working group and an environmental scan of literature, models and frameworks related to evaluation of cultural competency at an organizational level. IHA is working in collaboration with PHSA to utilize the rubric/tool to score the organization and complete the evaluation. Administration and governance and Planning, Monitoring, Evaluation and research domains within the organization were identified as initial assessment priorities and will be implemented in 2017. The HR domain has been validated and IHA HR will be developing an action plan specific to the recommendations.

The following summarizes responses that were provided during PALT member interviews and IRAWC and LOU table focus group discussions regarding cultural safety and appropriateness of health care programs and services, including the key successes and areas for improvement.

#### **What is working well with respect to cultural safety and humility?**

- Nations and IHA Representatives are working together at the PALT and are being held accountable for implementing changes to address cultural safety and humility concerns
- The IHA Board has been made aware of systemic racism and the CEO has made a commitment to work towards remedying this situation



- The CEO is touring communities and listening to stories on cultural safety and humility
- A Patient Care Quality Process has been established to manage and record complaints
- There are Aboriginal Patient Navigators in some of the Emergency Rooms to better support First Nation patients during their visit
- Cultural safety facilitators have been hired to complete in-person training sessions with staff
- Online training is available, ranging from frontline staff to Board members
- An impactful community forum near Williams Lake was held to share stories and discuss First Nations' experiences in healthcare facilities
- A recruiter was hired by the IHA to fill First Nations healthcare positions (i.e. goal is to have Aboriginal people represent 10% of IHA's workforce by 2025)
- Data collection is occurring in the Emergency Rooms and hospitals so that outcomes can be tracked more accurately (i.e. patients are asked whether they self-identify as Aboriginal)
- Anecdotally, some respondents have heard about, or have personally seen, improvements in culturally safe care



### What more could be done with respect to cultural safety and humility?

- Cultural safety and humility training should be ongoing
  - This training must go beyond the basics into deeper-level concepts
- Encourage more education in the school systems, from Kindergarten to Grade 12 and beyond
- Create an overarching cultural safety strategy for the Interior
  - Identify key indicators to measure cultural safety and humility improvements
  - Work towards embedding cultural safety into the healthcare system, which is in everyone's portfolios
  - Focus has been given to areas that need immediate attention (e.g. Williams Lake Hospital); attention should be paid to all levels and areas of IHA, including front line staff at the community level and across the Interior
- Create training programs based on the Interior Nation Territories, with specific information about different cultures, including traditions, ceremonies, and language
  - Have different people delivering training, and utilize the Traditional Wellness Coordinators and Nation Experts
- Hold more community forums, Culture Camps and in-community training and practicums for experiential learning purposes
- Provide staff with tools to address cultural safety matters
  - When a patient indicates that s/he has cultural needs, staff need options to provide to their patients to support these identified needs
  - Incorporate more traditional elements, such as talking circles as a complaint mechanism or sacred facilities for healing purposes in health care facilities, so that staff can direct patients towards these as appropriate
- Improve the Patient Care Quality process
  - Encourage people to use the system so that Nations and IHA are aware of the problems as some patients are scared to share their stories
  - May need a process for oral complaints as some community members do not want to write things down
- Create a zero-tolerance policy concerning culturally unsafe behaviours and practices

- Cultural safety is a humanity issue. Healthcare professionals should bear this in mind when working with patients
  - Support will be needed from the managers at the healthcare facilities to implement this and related principles
  - Move towards cultural safety becoming the culture within all IHA and have performance measurements which evaluate cultural safety and humility
- Add more Aboriginal Patient Navigators so that this service is available to all communities and patients
  - Ensure these navigators have an Aboriginal background so that they understand cultural traditions, Indigenous language(s), and Elder needs
  - Consider whether the dates and times these navigators are available are sufficient to meet patient needs and if remote support is an option to support 24/7 care
- Create culturally safe treatment options for Aboriginal people experiencing addiction (e.g. culture camps before and after attending treatment centres)
- Ministry of Health and FNHA should seek regional input when developing indicators related to cultural safety and humility
  - This regional partnership is key
- Increase opportunities for IHA employees to be seconded to First Nations communities in order for them to gain more experience working in community
  - This would also increase community capacity
- Expand community involvement in hiring IHA staff who will be working in the community
- Prioritize cultural safety training for Emergency Departments

Several lessons learned from the first five years of the partnership were identified as important to consider for moving forward.

The PALT respondents identified several lessons learned from the first five years of implementation of the partnership that they feel are important to consider moving forward. The following outlines these key lessons.

#### **Lessons to consider moving forward:**

- Practice patience and continue to meet to deliver key messages
  - Good engagement takes time and work must be done at the pace of the Interior Nations to improve levels of trust
  - Respect the process of engagement
- Strengthening relationships and the Interior Structure are integral to moving forward together on shared priorities, issues, and actions
- The right people need to be at the table to influence real change
- Consistency of the people at the table is important to keep everyone informed and moving forward
  - Need to equip new people with the right information in a digestible format (e.g. provide new people with an orientation meeting and package)
- Identify how to solidify progress so that external threats, such as a change in leadership or government, does not affect the work that has been done to date
- Moving forward, be proactive in planning and less reactive to situations
- Document successes, challenges and processes being built
  - This is a new concept and people can learn from it
- Examine the Nation-to-Nation relationship and how Interior Nations can learn from one another to support governance transformation

- Interior Nations are at different stages in their journey and can share learnings to avoid reinventing the wheel

Several challenges need to be addressed to ensure the success of the PA moving forward.

The IRAWC and LOU tables identified the greatest challenges regarding the PA that need to be addressed moving forward to ensure its success. Many of these themes were also identified through the other questions in the interview and focus groups so the following provides a brief synthesis of what was heard from the key stakeholders.

#### **Greatest challenges that need to be addressed:**

- There is a lack of clarity on how the Interior Region Interior Structure functions and how issues should be identified, advanced, and resolved
- Information that is reported back from the PALT is often not filtered down to the appropriate person; communication is getting lost on the way to the community
- There is a lack of capacity and funding for Interior First Nations to implement initiatives, travel to numerous meetings, and disseminate information to appropriate tables and communities
- Flexibility and adaptability within engagement across the diverse Interior Structures of partners will support effectively working together
- Priorities can vary from Nation to Nation and it can be difficult to identify common themes
- There is a need to examine how the FNHA fits into the Interior Region Interior Structure and if they should sit at tables that they currently do not (e.g. the PALT)
- Other healthcare entities can bypass the PA and get funding for projects if they go directly to the MoH, this contributes to a lack of consultation with Nations
- Home care for certain Nations appears to be an ongoing challenge (e.g. there is not enough home care support in the communities, there may be barriers to getting a home care nurse such as eligibility requirements and having to prove a need for the support, if the home environment is deemed by Work Safe BC as unsafe, it prevents IHA employees from providing care and creates more burden for the Nations to provide services on their own, etc.)
- The Joint Project Board requires clinicians and healthcare providers to have professional registration which is a barrier for some people in community who may be qualified but do not have these certifications
- While IHA is aiming to hire more First Nations, some consideration should be given to the impact this will have on Nations filling positions in their communities and their lack of ability to compete with salaries and benefits of a large health authority
- Physician access remains an ongoing challenge
- There is an interest and appetite to explore alternatives to western models of care and to take a holistic approach to care
- There is a need for wrap-around family supports for fetal alcohol syndrome

Spring Caucus Attendees identified the most significant things that need to change.

During the 2017 spring Caucus, there were 110 attendees from the seven Interior Nations at, including Health Directors, Chiefs, Councillors, and managers. The attendees were invited to discuss the three questions listed below:

1. The Partnership Accord Leadership Table is comprised of Interior Nation and Interior Health representatives. What would be your key message to the team at this Table?
2. The Framework Agreement was signed in 2011. The Partnership Accord was signed in 2012. Transfer occurred in 2013. What is the most significant thing that has changed?
3. What is the most significant thing that still needs change?

The responses from the attendees were collated and summarized by Nation. Three key themes emerged from the discussions:

1. Seek opportunities to incorporate community/Nation healing and wellness practices within the medical model; be respectful and inclusive on Indigenous approaches to health and healing
2. Include Aboriginal perspective beyond the Interior Health Aboriginal Team/Ensure the relationship goes beyond personal connection and embed partnership into processes
3. Use of data to inform approaches: population, geography, health statistics etc.

**PALT respondents agreed that the three themes identified at caucus are important issues, which need to be tackled moving forward**

Most members indicated that work has started on the second and third themes regarding embedding partnerships into processes (e.g. IHA's cross organizational framework) and using data to inform approaches (e.g. Interior First Nations' HSM).

**Many respondents said it will require creative, "out of the box" thinking that is Nation-based / community-driven to incorporate community healing and wellness practices within the medical model particularly, within hospitals and other IHA healthcare facilities.**

Almost all the PALT respondents indicated that more planning was needed around the first theme, including what this vision looks like. Specifically, many respondents said it will require creative, "out of the box" thinking that is Nation-based / community-driven to incorporate community healing and wellness practices within the medical model particularly, within hospitals and other IHA healthcare facilities. Some PALT respondents indicated the FNHA has a big role to play in incorporating community practices.

Most of the PALT respondents specifically spoke to the third theme regarding the use of data. The following summarizes some of their key comments.

#### **How should data be used to inform approaches?**

- The collection and use of data are important steps moving forward
- Data are very powerful education tools that can influence change
- Data will support informed decision-making and effective allocation of funding for communities
  - For example, Interior First Nations were able to demonstrate through data the need for more mental health and substance use recovery beds which they subsequently received
- Data collection should be proactive and anticipate future information needs

Greater consideration should be given to identifying social indicators of health (e.g. emotional health, spiritual connection, self-actualization, etc.), which are more difficult to measure than other indicators of health.

Almost all the PALT respondents agreed that the current list of priorities and objectives identified in the PA are still relevant.

The PALT respondents were asked to review the key priorities and objectives from the PA and identify if these were still the key priorities. The following list was provided in the interview guide.

#### **Key priorities and objectives in the PA:**

- *Establish a coordinated and integrated First Nations health and wellness system*
- *Contribute to the achievement of Interior Nations' wellness goal*
- *Improve the: quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs and services for First Nations*
- *Develop a consistent and harmonized Planning and Evaluation Framework*
- *Develop a Regional Health and Wellness Plan that builds upon Community/Nation Health Plans and Interior Health Plans (including setting standards, targets, outcomes and measurements)*
- *Develop a Regional Health and Wellness Plan that builds upon Community/Nation Health Plans and Interior Health Plans*
- *Localize cultural competency training throughout the Interior Health Region*
- *Develop service delivery systems to better reflect the needs of First Nation people in the Interior Region*
- *Develop a comprehensive health human resources strategy*
- *Establish common indicators, targets, milestones, benchmarks*
- *Engage in dialogue, identify linkages and establish networks with other Aboriginal and non-Aboriginal stakeholders*
- *Identify those matters including policy issues that will address gaps and eliminate overlaps*
- *Establish, at the program level, communications with the First Nations Health Authority and at the governance level, with the First Nations Health Council.*

Almost all the PALT respondents agreed that the current list of priorities and objectives are still relevant. It was indicated that the list contains very broad, long-term goals which will take time to fully realize. Most PALT respondents agreed it is good to review the priorities and objectives on an ongoing basis, updating or removing as needed.

The PALT members were then asked whether there are areas in the priorities and objectives of the PA that should be given more focus. The following summarizes the PALT members' responses.

The priorities in the PA could be more detailed and clearer language could be used concerning specific targets, required resources, implementation plans, and timelines.

#### **Are there priorities and objectives within the PA that need to be given more focus?**

- *More detail and clearer language promotes a higher level of accountability*
- *Priorities could be reviewed at the PALT meetings and guide how the agenda is set*

- Priorities and objectives set out in PALT agendas and meetings could be structured in a more practical and processed way around themes
  - Such a review structure would facilitate the easier implementation of changes or updates overtime
- The PALT could invest more time in ensuring all partners, including the 54 First Nations communities, are aware of these priorities and understand them
  - Face-to-face meetings with the communities may be a good option
- Some specific areas that were identified by the PALT as needing more focus included:
  - Establishing indicators, collecting the right data, and ensuring that data will be shared and reach the right people (i.e. both Nations and IHA)
  - The Regional Health and Wellness plan could include information and perspective from front line workers
  - Add a priority around recruitment of First Nations into healthcare positions and careers
  - Add pieces from the Truth and Reconciliation Commission (TRC)
  - Add information surrounding the roles and responsibilities of FNHA in the PA

Almost all the PALT respondents indicated that Nations do not have sufficient time or resources to fully achieve objectives.

Capable Nation Representatives and others at all levels are often overworked and under-resourced. Many individuals are wearing multiple hats and working “*off the side of their desk*” to achieve set goals. There was agreement among PALT Nation and IHA Representatives that more funding and resources were needed for Nations to realize key objectives. A few PALT respondents and LOU table members identified that, as a group, the PALT could lobby for more funding to support capacity building efforts. Further, this could be done at a provincial level with all regional PALTs asking for additional support for the Nations.

There was agreement among PALT Nation and IHA Representatives that more funding and resources were needed for Nations to effectively work towards key objectives.

In comparison, respondents indicated that IHA has many resources (including staff and funding) and a strong commitment from leadership. Some PALT respondents reported a perceived imbalance of resources between the Nations and IHA. There were a few respondents who indicated that IHA staff also cover many geographical areas (e.g. multiple LOU tables) which can stretch their resources and capacity to the limit.

## Section 8: Health Indicators Data

The Interior Partnership Accord includes as a success indicator “improved health outcomes for the First Nations people of the Interior region.” The FNHA Evaluation team received permission from the Data and Information Planning Committee, a committee that stewards the First Nations Client File housed at the Ministry of Health, to employ Health Systems Matrix (HSM) data in the evaluation. These data are from 2008/2009 to 2013/2014. As these data precede the Interior PA, these indicators are to serve as a baseline for future evaluations. Further indicators could be considered to include in the PA and monitor progress over time. Future measures could include strengths-based or wellness indicators, such as social, cultural, environmental, mental, physical and emotional well-being. Examples include the indicators developed by the Provincial Health Officer and the FNHA Chief Medical Officer included in *Indigenous Health and Well-being: Final Update July 1, 2018*.

Please note that these data have been sourced from a data linkage with the HSM, Interior Region, 2008/09 through to and including 2013/14. Age standardized rates were used to adjust for different age structures in populations and allow valid comparisons of First Nations populations to other residents in the Interior Region.

Confidence intervals for point measures are contained for all measures in this report. The 95% confidence interval (CI) is provided in brackets behind the point estimate.<sup>4</sup> Results where change has been noted are statistically significant. The following definitions should be used when interpreting the data.

<i>Attachment Group</i>	<i>Definition</i>
<b>Attached to a GP</b>	50% or more of visits in the fiscal year were with GPs in a single practice. If less than five visits in the fiscal year, then up to ten previous years are included to find at least five visits.
<b>Not attached to a GP</b>	Individuals who use GP services but were not attached to a single practice (i.e. no GP practice provided at least 50% of their care)
<b>Unknown</b>	Individuals who had less than five visits with a GP over the last ten fiscal years.

### Population Segment Definitions

Low Complex Chronic Conditions (LCCC): People with osteoporosis, diabetes, hypertension, osteoarthritis, depression, epilepsy or asthma, and do not have high or medium co-morbidities.

The following four population segments have been combined into a single category:

- High Complex Chronic Conditions (HCCC): People who have dementia, Alzheimer's, cystic fibrosis, heart failure, are on dialysis for chronic kidney disease, have had a stroke or organ transplant, or a complex combination of chronic conditions who do not use services provided by the health authorities to support activities of daily living.
- Frail in the Community: People who are living in the community and using publicly provided assistance with activities of daily living.
- Frail in Residential Care: People with complex care needs who are in long term residential care.
- Palliative Care: People who received health care services specifically for palliative care

### Ambulatory Care Sensitive Conditions

<sup>4</sup> The 95% CI indicates that 19 times out of 20, the actual measure will fall within the bounds set by the CI.

Ambulatory Care Sensitive Conditions (ACSC) are health outcomes that are anticipated to be preventable with appropriate and timely primary care. Appendix 1 contains a definition of ACSCs. Briefly, they include grand mal status and other epileptic convulsions, chronic obstructive pulmonary disease, asthma, diabetes, heart failure and pulmonary edema, hypertension and angina.

The ACSC hospitalization rate was calculated by dividing total number of ACSC admissions of persons aged 74 years and younger by the total number of individuals admitted to hospital for each fiscal year. The ACSC hospitalization rate was 2.9% [2.4-3.4] in 2008/09 and 2.5% [2.1-2.9] in 2013/14.

When compared to other residents in 2013/14, First Nations people had a considerably higher rate of hospital admissions due to ACSC than other residents (2.5% [2.1-2.9] vs 1.8% [1.7-1.9]).

This finding is congruent with other reported data from the HSM which show that First Nations experienced a lower rate of diagnostic test use and were less likely, compared to other residents, to visit a general practitioner or medical specialist.<sup>5</sup>

### **Attachment to a GP**

In the HSM, if a person has 50% or more of visits in the fiscal year with general practitioners (GPs) in a single practice, this person is considered attached. If a person has less than five visits in the fiscal year, then up to ten previous years are included to find at least five visits (please see Appendix 1 for a complete definition of attachment). Rates for this indicator were calculated by dividing the total number of individuals attached to a GP by the total number of individuals overall for each fiscal year.

In 2013/14 First Nations had a lower rate of attachment to a general practitioner (GP) (44.2% [44.7-45.9]) in 2013/14 than other residents (46.6% [46.6-46.8]) in 2013/14.

Attachment rates did not change between 2008/09 and 2013/14 for First Nations (45.3% [44.7-45.9] vs 44.2% [43.7-44.7]).

### **ED User Rate**

The emergency department (ED) user rate was calculated by dividing the number of individuals who visited the emergency department at least once by the total population. These visits included those provided by fee-for-service (FFS) emergency medicine specialists or GP or specialists in the ED (based on FFS location code and fee-for-service fee codes, and ED visits reported in the National Ambulatory Care Reporting System [NACRS] for facilities which do not report FFS encounters).

There was an increase in the ED user rates for First Nations between 2008/09 and 2013/14 (31.7% [CI: 31.2-32.2%] and 34.5% [34.0-35.0]). Proportionally more First Nations than other residents used EDs in 2013/14 (34.5% [34.0-35.0] vs 25.2% [25.1-25.3]). One of the reasons for this higher utilization could be their decreased access to GPs as noted above.

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<sup>5</sup> First Nations Health Authority. SUMMARY OF KEY FINDINGS, First Nations Health Status and Health Services Utilization 2008/09 and 2013/14. September 2016.

One of the reasons for this higher utilization could be their decreased access to GPs and medical specialists as noted above in the ACSC indicator.

### **ED User Rate by Attachment**

ED user rate by GP attachment examines ED physician use by individuals that are either attached or not attached to a GP.

As noted above, First Nations were more likely to use EDs for physician services than other residents. Continuity of care from a GP does appear to have an influence on the ED rate.

If First Nations were attached to a GP in 2013/14, their rate of ED utilization was lower than for those First Nations who were not attached (35.4% [34.8-36.0] vs 44.5% [43.3-45.7])

In comparison to other residents, First Nations 2013/14 rates of ED utilization were higher regardless of attachment status:

A higher percentage of First Nations who were attached to a GP used an ED (35.4% [34.8-36.0] compared to other GP attached residents (25.2% [25.1-25.3])).

Similarly, First Nations not attached to a GP were more likely to use the ED (44.5% [43.3-45.7]) compared to other 'non-attached' residents (35.5% [35.2-35.8]).

### **Pediatric Specialist Utilization**

Comparatively fewer First Nations children accessed pediatrician specialist care (10.7% [10.0-11.4]) compared to other resident children (12.5% [12.3-12.8]) in 2013/14.

Pediatrician utilization rates rose for both First Nations and other resident children between 2008/09 and 2013/14 (First Nations: 7.1% [6.6-7.6] vs 10.7% [10.0-11.4]). Herein, the rate was calculated by dividing the number of individuals who saw a pediatric physician at least once, by the total number of individuals for the 0 - 17 age group.

### **Mental Illness admissions through ED, 18-49 years**

This measure considers the proportion of individuals that are admitted for mental illness directly from the ED (number of ED mental illness admissions over total admissions). Please see Appendix 1 for a definition of mental illness as used in this indicator.

First Nations were admitted to hospital for mental illness via the ED at a higher rate than other residents in 2013/14 (10.4% [CI 9.2-11.6] vs 5.8% [5.6-6.0]).

Rates of admission directly from the ED rose between 2008/09 and 2013/14 for both First Nations and other residents, with the First Nations rate growing by over 80% (5.7% [4.8-6.6] vs 10.4% [9.2-11.6]).

There may be a multitude of factors associated with this rise, such as a low utilization of community-based mental health supports including traditional healers, nurse practitioners and other primary care providers, and mental health clinicians.<sup>6</sup>

### **Readmission for Mental Illness within 30 days from discharge, 18-49 years**

This rate is calculated by dividing the total readmission mental illness episodes of care (within 30 days of discharge) by all mental illness episodes of care.

The proportion of mental illness readmission in 2013/14 for First Nations was 20.6% (15.9-25.3) and 16.7% (15.1-18.3) for other residents. During 2008/09 25.7% (18.9-32.5) of mental illness cases among First Nations were readmitted, in 2013/14 20.6% (15.9-25.4) were.

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<sup>6</sup> First Nations Health Authority, 2016.

# Section 9: Summary of Recommendations

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The following section is a summary of the recommendations which were identified by the partners during the evaluation (i.e. the PALT interviews, IRAWC focus group, and the LOU table focus groups) and included previously throughout the report. The purpose of this section is to provide a clear overview of the recommendations we heard from the key stakeholders.

## Interior Region Structure Recommendations

### 1. Clarify how issues are identified, advanced and resolved within the structure:

- Clarify which table to advance issues to, in order to decrease uncertainty among the partners:
  - Create a communication tool which maps out the pathways for decision making, perhaps through a case study example of how issues were identified, advanced, and resolved (e.g. palliative care)
  - If a technical matter does not need to move forward to the PALT, outline a clear process to address the issue elsewhere and ensure there is capacity among the technicians to address the many concerns that are brought forward
  - If a technical issue must move forward to the PALT, ensure technicians are well prepared with all relevant information and can answer any questions the PALT members may have regarding the technical aspects
  - Ensure these processes are conducted in a timely manner
- Preliminary work could be done prior to issues advancing to higher tables so that issues are more defined when they are brought forward
  - Create services committees in communities to support streamlining issues before the LOU tables
  - Utilize the IRNE table to support streamlining issues before the PALT
  - Utilize the IRTT table to streamline issues before the IRAWC

Respondents indicated when Interior Nations have a collective voice, more issues can be identified, advanced and resolved in a timely manner. While this is a challenging task, this appears to be vital in moving forward. As mentioned previously, where appropriate, problems could be brought first to IRNE for discussion and identification of clear outcomes prior to being brought to the PALT.

### 2. Better define the roles and responsibilities of the partners:

- Create concise but comprehensive communication tools that describe the Interior Region Structure and each of the partners' (i.e. PALT, IRAWC, IRNE, and LOU tables)
  - Include for each entity:
    - Roles and responsibilities
    - Decision-making authorities and processes
    - Interior Structures, service delivery processes, fiscal restraints and opportunities
    - Organizational charts with pictures, titles, departments, and contact information
  - Include the diverse structure and decision making processes of the Interior Nations Include a description of FNHA in this tool to provide clarity around their role in the PA
  - Include the Interior Region's connection to the Tripartite Committee on First Nations Health

Conduct face to face engagement and education around this information as many involved in the PA do not have time to read through long communication tools. Review this information regularly to ensure individuals understand their role as well as their decision-making power, especially new people (i.e. turnover of members at the tables can lead to a steep learning curve regarding the roles and responsibilities of the partners).

## Relationship Recommendations

### 3. Continue to strengthen relationships among the partners:

- The partners (i.e. the PALT, IRAWC, and LOU tables) should continue to get to invest time in relationship building to better understand the issues Interior First Interior Nations are facing and how they can effectively work together
  - Recognize the importance of relationship building at all levels from PALT to front line staff and client relationships
  - Travel to different communities for the PALT, IRNE, and LOU table meetings
  - Have new staff travel to communities
  - Have leadership meet with front line staff in communities
  - Participate in informal events and Nation gatherings
- Embed relationship building and partnerships with Nations into the structure of IHA through formal mechanisms, all the way down to the front-line structures and staff
- Provide more resources to Interior Nations to support relationship building
  - Travel budgets and compensation for time

## Communication and Planning Recommendations

### 4. Streamline and improve communication among the partners as well as communities:

- Formalize and use an efficient communication process to ensure consistent reporting back is occurring to respective Interior Nations and entities
  - Targeted briefing notes (i.e. one or two pages long) and/or newsletters (i.e. plain language, pictures, and success stories) could be used to disseminate relevant information from the PALT to Interior Nations and LOU tables
    - There is a newsletter that goes to the Nation Representatives which could be disseminated more widely if the format is appropriate
  - Create a website as a central place to access information (e.g., PALT minutes, important updates, etc.)
  - Include a standing agenda item on the PALT, IRAWC, and LOU table agendas specifically for discussing updates and current activities as well as reporting back to respective Interior Nations and entities
- Face to face communication from Nation Representatives or Community Engagement Coordinators may be effective in facilitating reporting to Interior Nations and respective entities
  - More resources would be needed to support these activities

- Ensure that these individuals are aware of their important role in dissemination and trained in an effective process to communicate
- Provide appropriate communications to Chiefs
  - Communication needs to be presented in a digestible format that provides quick and relevant information
  - Repeated communication on important matters may help facilitate dissemination
- Communication up and down the structure could be viewed as a personal responsibility as well as administrative
  - Individuals could seek out information so that they are prepared for meetings
  - Individuals could consistently reach out to their networks and communicate key information from the PALT
- Consider translation for communities and Elders where English is a second language
- Use social media to reach the younger generations in communities

#### 5. Improve joint planning of efforts and services among the partners:

- Provide Interior Nations with a better understanding of how IHA plans for services so that they can fully engage in the planning process and coordinate and integrate services effectively
- Develop a formal engagement strategy so that Interior Nations are involved at the onset of planning
- Invite Interior Nations to IHA planning tables and vice versa, including at the provincial level, to allow for more understanding around planning and more input on the programs and services which will be delivered in communities
- When Interior Nations receive funding from outside the PA, they should look to continue to include IHA in their planning efforts
- In the future, it will be important to engage in proactive coordination of planning efforts and services rather than reacting to emergency issues

#### 6. Continue to work towards shared decision making among the partners:

- To fully engage in shared decision making with respect to the development and delivery of services for Interior First Interior Nations communities, more power could be given to Interior Nations
  - Shared planning of services between Interior Nations and IHA is a key factor in reaching shared decision making
- Additional focus should be given to FNHA and their role in supporting the shared decision-making process
- Consideration should be given regarding how Nations, IHA, and FNHA can collectively influence the MoH regarding their compressed deadlines (e.g. ten day deadlines for the health authorities to deliver a health services plan) to avoid barriers to meaningful engagement and shared decision making.
  - Consider elevating this barrier to the Tripartite Committee
- The International Association for Public Participation (IAP2) presents a scale for public participation ranging from “Informing” to “Empowering” (see Appendix B) for full scale
  - Shared decision making would fall under the categories of “Collaborate” or “Empower” on the IAP2 spectrum
  - Presently, when deadlines occur, Nations are Consulted rather than being Collaborated with or Empowered in decision making Shared decision making could be improved by further clarifying the terms of engagement between the partners

## 7. Engage in more planning for Interior Nations whose territories encompass more than one regional health authority:

- Create an opportunity for Interior Nations, the PALT and Health Authorities from the various regions to come together to plan and address issues associated with Interior Nations whose territories encompass more than one Regional Health Authority
  - Hold a caucus meeting to collectively discuss matters regarding governance and include a discussion about the mechanics to deal with Interior Nations whose territories encompass more than one Regional Health Authority
- Examine how FNHA could facilitate Nation to Nation relationships and meetings of this nature

## Cultural Safety and Humility Recommendations

### 8. Continue to work towards cultural safety and humility in the BC health system:

- Cultural safety and humility training should be ongoing (e.g. every six months to a year)
  - This training must go beyond the basics and into deeper concepts and include experiential learning opportunities
- Encourage integration of education on cultural safety and cultural humility awareness into the school systems including kindergarten to grade 12, colleges, and universities
- Jointly create an overarching cultural safety strategy for the Interior
  - Cultural safety needs to be an integrated part of the health system which is in everyone's portfolios
  - It needs to reach all levels and areas of IHA including front line staff at the community level and across the Interior
  - Identify key indicators to measure cultural safety and humility improvements
- Create training programs based on the Interior Nation Territories, with specific information about the different cultures including traditions, ceremonies, and language
  - Have multiple different people delivering training and utilize the Traditional Wellness Coordinators and Nation Experts
- Hold more community forums, Culture Camps and in community training for experiential learning
- Provide staff with the tools and resources to address cultural safety issues
  - Increase the number of sacred spaces for healing purposes in health care facilities
- Improve the Patient Care Quality process
  - Encourage people to use the system in order for Nations and IHA to be aware of the issues
  - Consider a process for oral complaints as some community members do not want submit a written complaint
  - Incorporate traditional elements, such as talking circles as a complaint resolution mechanism
- Embed cultural safety and humility into IHA's organization and create a "culture" of cultural safety
  - Gain support from managers to implement and encourage this culture among employees
  - Create performance measures to assess and evaluate progress towards creating a culture of cultural safety within IHA
- Create more Aboriginal Patient Navigator positions so that this service is available to all communities and patients
  - Ensure navigators have an Aboriginal background so that they understand cultural traditions, Indigenous language(s), and Elder needs

- Consider whether the dates and times these navigators are available are sufficient to meet patient needs and if remote support is an option to support 24/7 care

## Capacity Recommendations

### 9. Increase the capacity of Nations and IHA:

- More funding and resources are needed for Interior Nations to effectively work towards the objectives of the PA
  - The LOU tables required additional resources to implement solutions including the time to strategically plan for changes and the human resources to implement the changes
  - The concept of equal funding may need to be reviewed as Nations are at different capacities to address community challenges the concept of equal funding to all Nations prevents some LOU tables from moving forward
- More consideration could be given to the geographical area that the Nation Territories are covering and the amount of communities in each Nation Territory to determine appropriate resourcing and funding
  - IHA staff cover many geographical areas (e.g. health managers at multiple LOU tables) which also stretch their resources and capacity for change
- Increase shared training opportunities for FNHA and IHA nurses, and expand to other areas as identified
- Continue to involve communities in shared hiring and co-positions

A few PALT respondents identified that as a group, the PALT could advocate for more funding to support capacity building. Further, this could be done at a provincial level with all regional Leadership Tables, similar to PALT, asking for additional support for the Nations. Ultimately, Nations, FNHA, and IHA must work together to ensure the appropriate resources are in place to support capacity building

## PA Priorities and Objectives Recommendations

### 10. Suggested changes to the priorities and objectives of the PA:

- The priorities could be more detailed and use specific language around targets, resources needed, implementation plans, and timelines
  - Provides a higher level of accountability
- The priorities could be reviewed at the PALT meetings and guide how the agenda is set
  - The priorities could be grouped into themes to structure the PALT agendas and meetings around the objectives in a practical and processed way
  - This would also allow for any necessary changes or updates to be made overtime
- The PALT could invest more time in ensuring all partners including each of the 54 communities are aware of these priorities and understand them
  - Face to face meetings with the communities could be an option
- Some specific focus areas included:
  - Establishing indicators and collecting the right data is a key focus
    - Ensure the data will be shared and reach the right people (i.e. both Nations and IHA)
  - The Regional Health and Wellness plan could include information and perspective from front line workers
  - Add a priority around recruitment of First Nations into healthcare positions and careers
  - Add elements from the Truth and Reconciliation Commission's (TRC) 94 Calls to Action

- Add information surrounding the roles and responsibilities of FNHA in the PA

## Considerations for Moving Forward

### Lessons Learned

- Practice patience and continue to meet to deliver the message
  - Good engagement takes time and work must be done at the pace of the Interior Nations to improve trust levels
  - Respect the process of engagement
- Strong relationships and the Interior Structure are the foundation to be able to address issues
- The right people need to be at the table to influence real change
- Consistency of the people at the table is important to keep everyone informed and moving forward
  - Need to equip new people with the right information in a digestible format (e.g. provide new people with an orientation package and meeting)
- Continue to hardwire and formalize processes so changes in leadership or government does not affect progress
- Moving forward, be proactive in planning and less reactive to situations
- Document successes, challenges and processes being built
  - This is a new concept and people can learn from it
- Examine the Nation to Nation relationship and how Interior Nations can learn from one another to support governance transformation
  - Interior Nations are at different stages in their journey and can share learnings to avoid reinventing the wheel

### Caucus Attendees Responses to Most Significant Thing that Needs to Change

- *“Incorporate Nation healing and wellness practices within the medical model”*: Respondents said it will require creative, “out of the box” thinking that is Nation driven and supported by FNHA to address this change
- *“Use data to inform approaches”*: Respondents indicated that data collection should be proactive and anticipate future information needs and include indicators of health that are difficult to measure (e.g. emotional health, spiritual connection, self actualization, etc.). Respondents noted that data is a very powerful tool for education and influencing change and it will support informed decision making and effective allocation of funding for communities.

### Other Challenges to be Addressed

- While IHA is aiming to hire more indigenous staff, some consideration should be given to the impact this will have on Nations filling positions in their communities and their lack of ability to compete with salaries and benefits of a large health authority
- Entities can bypass the PA and get funding for projects if they go directly to the MoH
  - Lack of consultation occurring with Nation when this happens
- Home care for certain Nations appears to be an ongoing challenge
  - There is not enough home care support in the communities
  - There may be barriers to getting a home care nurse such as eligibility requirements and having to prove a need for the support

- If the home environment is deemed by Work Safe BC as unsafe, it prevents IHA employees from providing care and creates more burden for the Nations to provide services on their own
- The Joint Project Board requires clinicians and healthcare providers to have professional registration which is a barrier for some people in community who may be qualified, though do not have these certifications
- Isolated communities do not have the accommodation to attract and keep qualified healthcare providers