



# First Nations Health Authority

Health through wellness

Supporting Me on the Path That I'm On:  
He na qwa ("Keep Going")

Kwakwaka'wakw Primary Maternal, Child and Family  
Health Collaborative Project  
Implementation Evaluation

*March 10, 2021*



Families who participated in this evaluation chose the phrase “Supporting me on the path that I’m on” for the title of this report.

The secondary title “He na qwa”, which means “keep going” in Kwakwala, was given by Elder Mabel James.



## Acknowledgements

The Evaluation Working Group acknowledge that this evaluation was conducted on the traditional unceded territories of the Kwakwaka'wakw Nation.

We humbly thank the families who shared their experiences as participants in the Kwakwaka'wakw Primary Maternal, Child and Family Health Collaborative Project.

The Evaluation Working Group would like to acknowledge the guidance of the Kwakwaka'wakw Steering Committee members as well as the dedicated project staff, system partners and clinicians who support women and their families in their health and wellness journeys.

### **Kwakwaka'wakw Steering Committee Members**

| <b>Organization</b>                                    | <b>Position</b>                | <b>2019 Representative</b> |
|--|--------------------------------|----------------------------|
| Kwakiutl Health Centre                                 | Health Director (or designate) | Marie Hunt                 |
| Gwa'sala-Nakwaxda'xw Nation Health and Family Services | Health Director (or designate) | Dean Wilson                |
| Dzawada'enuxw First Nation Health Centre               | Health Director (or designate) | Charlene Dawson            |
| Quatsino First Nation Health Centre                    | Health Director (or designate) | Jen Nelson                 |
| Namgis Health Centre                                   | Health Director (or designate) | Georgia Cook               |
| Kwakiutl District Council Health                       | Health Director (or designate) | Kim Roberts                |

| <b>Organization</b>   | <b>Position</b>   | <b>2019 Representative</b>                 |
|---|---|--|
| Mowachaht/Muchalaht First Nation  | Health and Family Services Manager (or designate)   | Rose Jack                                  |
| Elder   |   | Christine Joseph                           |
| Patient Representative  | At least one mother that has recent experience using the antenatal system in the north island | Dea-ta Dawson/ Marijo Willie               |
| First Nations Health Authority  | Regional Director   | Brennan MacDonald                          |
| First Nations Health Authority  | Senior Medical Officer  | Shannon McDonald                           |
| First Nations Health Authority  | Community Engagement Coordinator  | Cary-Lee Calder                            |
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| Island Health   | Executive Medical Director, Geo 1   | Dr Jeff Beselt                             |
| Island Health   | Medical Director, Geo 1   | Dr Shannon Waters                          |
| Island Health   | Director, Mount Waddington and Strathcona   | Alison Mitchell                            |
| Island Health   | Medical Director, Mount Waddington and Strathcona   | Dr Prean Armogam                           |
| Island Health   | Director, Aboriginal Health   | Ian Knipe                                  |
| Island Health   | Manager, Aboriginal Health North Island   | Michelle Tochacek                          |
| Island Health   | Director, Public Health   | Jan Tatlock                                |
| Island Health   | Director, Child Youth and Family  | Deb Chaplain                               |
| Island Health   | Local Public Health Campbell River/ Mount Waddington  | Carolyn Hutton/ Vicky Janse                |
| Island Health   | Leader, Perinatal Program Development   | Erin O'Sullivan                            |
| Island Health   | Nurse Practitioner  | Chaundra Willms/ Lisa Greer/ Kate Scoular  |
| Island Health   | Acute Care/ MORE-OB Rep   | Theresa Light/ Angelika Starr              |
| Division of Rural and Remote Family Practice/ Campbell River and District Division of Family Practice | Physician Reps  | Dr David Whittaker/ Dr Jennifer Kask       |
| Midwifery Reps  |   | Jill Pearman / Misty Wasyluk/ Sheila Jager |
| Doula Reps  |   | Nadine McGee/ Jackie Jack                  |
| Ministry for Children and Family Development  | Social Worker   | Arelis Tavarez                             |
| Sacred Wolf Friendship Centre   | Executive Director  | Janet Hanuse                               |
| Building Blocks   | Coordinator   | Stephanie Nelson                           |

### **Kwakwaka'wakw Project Team Members**

| <b>Name</b>      | <b>Position</b>               |
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### **Kwakwaka'wakw Evaluation Working Group members**

| <b>Organization</b>        | <b>Position</b>  |
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| Island Health              | Diane Sawchuck, Lead, Evidence, Evaluation & Knowledge Translation |
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# Executive Summary

The Kwakwaka'wakw Primary Maternal, Child and Family Health Collaborative Project (hereafter, the Kwakwaka'wakw Project or project) is one of 27 projects funded across BC by the Joint Project Board (JPB). The Kwakwaka'wakw Project was co-developed by local First Nations communities, First Nations Health Authority (FNHA) regional staff and health authority partners to fill a specific service need: the lack of maternal care and birthing services on northern Vancouver Island. The Kwakwaka'wakw Project aims to improve maternal-fetal, newborn, child and family health by providing high-quality, accessible maternity care that is closer to home, culturally safe, trauma-informed and family-centred.

An implementation evaluation was conducted to assess the project's implementation, fidelity in meeting the original proposed model, delivery and performance, including the achievement of intended short-term outcomes. The evaluation period spanned fiscal years 2014/15-2018/19, but the project report was delayed due to other evaluative reporting requirements as well as the COVID-19 pandemic. This report therefore provides a retrospective view of the project's implementation and also includes November 2020 updates. Data sources for this evaluation include a document and financial review, participant interviews, a key informant survey among partner organizations and a staff focus group session.

The conclusions from the evaluation are as follows:

## Implementation and Fidelity

Despite challenges in project implementation, including difficulty filling the team lead position, fragmented charting and technological platforms, and reticence from some partners to transform service delivery models for maternity care on northern Vancouver Island, the project has successfully initiated services in a growing number of First Nations communities and urban locations on northern Vancouver Island.

Difficulties attracting candidates to a nurse-led team lead position (due to challenges with incompatible collective agreements) led to the shift from a nursing team lead to a midwife team lead. Two midwives have been contracted to provide clinical and patient education, prenatal care and birthing services, but challenges with providing administrative support to the contracted midwives and having contracted providers taking on leadership responsibilities has meant that the project continues to lack the clinical leadership envisioned at the outset. There are indications that the project has started to integrate telehealth, and that the availability of doulas, traditional healers and project services in outlying First Nations communities has increased as originally intended in the project proposal.

However, as a consequence of the delayed implementation of the service delivery model, particularly in staffing all positions, the Kwakwaka'wakw Project operated with a significant unused

amount of allocated project funding.

## **Delivery**

The Kwakwaka'wakw Project developed a set of principles to guide service delivery. Key informants felt that the provision of women- and family-centred care, culturally safe care, team-based care and services close to home was being demonstrated by the project.

Before midwifery services were made available, project services consisted primarily of supporting transportation (by supporting travel arrangements and/or providing transportation with the use of fleet/staff vehicles), helping to navigate and coordinate health care and social services, and offering practical supports as requested and guided by families. Arranging First Nations Health Benefit (FNHB) medical transportation paperwork in particular, though valued, took time away from other services that staff could be providing, such as lifestyle or cultural supports. Some challenges with the FNHB medical transportation benefit were also identified, such as a lack of flexibility when travel plans changed or requiring clients to pay upfront for travel in some instances.

Cultural safety and humility is a central principle that guides the work of the project and the approach of its staff. Examples of efforts to embody and increase cultural safety and humility include staff's respectful communication style, meeting clients where they are at (in terms of geographical location of service delivery, but also in terms of taking a client-driven approach to communication and service offerings), efforts to increase access to services and resources requested by clients (midwifery services, doula supports, Ministry of Child and Family Development supports, traditional teaching and resources) and embedded presence within the acute care setting to support communication and liaisons as part of health care teams. Additional resources relating to traditional cultural practices around pregnancy, birth and parenting are of interest to families, as are resources geared towards fathers.

Team-based care was another highly rated guiding principle, pointing to the important coordination and navigation work being undertaken by the project. However, challenges were raised with respect to keeping partners informed of relevant clinical and social information when working across multiple providers and settings, particularly within a fragmented system of patient records, large geographical distances and socially complex situations. There was a need identified to balance the privacy of individuals with a clinician's needs for information, particularly for highly sensitive social information.

## **Performance**

Quantitative performance results, including health and wellness outcomes, the number of births on northern Vancouver Island and the sustainability of health care services are not possible given the nature of the data collected as part of the evaluation. However, recent updates point to promising progress. The two contracted midwives are supporting local hospital deliveries and increasing the availability, accommodation and accessibility of prenatal services. Efforts are being made by project staff and health system partners to maintain family unity, which are anecdotally perceived to be reducing the number of children removed from their families at birth. Women interviewed reported

the importance of the project outreach and practical/emotional supports for helping reduce their stress. This project and a concurrent research study are bringing together the right individuals to support the development of strong interprofessional maternity care teams and increased provider confidence for local births on northern Vancouver Island.

## Recommendations

- 1. The FNHA should examine the systematic challenges and barriers within JPB projects, including those challenges and barriers that have resulted in high levels of unused project funds.**
  - 1.1. Explore and find innovative approaches to improve recruitment of staff for all JPB projects where needed.
  - 1.2. Provide guidance to the project regarding the use of project funds and carry-forward dollars, particularly with respect to supporting client-centred service delivery and traditional practitioners.
- 2. The FNHA should address identified FNHB medical transportation benefit challenges.**
  - 2.1. Increase flexibility for clients who need to change travel plans or have urgent travel needs, identify alternative processes for those with difficulty paying upfront costs and clients without identification cards/bank accounts, and ensure reimbursements are paid on time and, in some instances, increase the frequency of direct deposit for meal allowances.
  - 2.2. Continue to support knowledge translation activities and resources to support greater understanding of the FNHA medical transportation benefit processes and procedures.
- 3. The Kwakwaka'wakw Project and its partners should continue to navigate and transform models of care across multiple organizations.**
  - 3.1. Bring together partners every two to three years to review the vision, current status and environmental shifts of the project.
  - 3.2. Support linkages between project staff and senior FNHA leaders and health authority leaders to navigate the complex interprofessional conversations and health system change and transformation.
  - 3.3. Put in place a long-term electronic medical records solution with sufficient technical support to replace the numerous electronic charting systems currently in place.
  - 3.4. Explore the potential of telehealth services as an ongoing service delivery mechanism to further expand the geographical reach of project services.
- 4. The Kwakwaka'wakw Project and its partners should strengthen information sharing among clinicians and support the integration of cultural safety and humility, and traditional and cultural practices, in the health system.**
  - 4.1. Develop training and resources that support appropriate circle of care information sharing among clinicians serving the families of the Kwakwaka'wakw Project.

- 4.2. Ensure that all acute care and community providers serving Kwakwaka'wakw Project families complete cultural safety and humility training.
- 4.3. Consider increasing the availability of midwives and doulas.
- 4.4. Create and support opportunities for acute care and community providers to participate in relational, practical experiences with First Nations communities on northern Vancouver Island, including exposure to the traditional and cultural practices of communities.
- 4.5. Support further development of traditional cultural supports, programming and resources during pregnancy, birth and early parenting, including supports for fathers.

**5. The Kwakwaka'wakw Project should implement a performance monitoring process.**

- 5.1. Develop performance monitoring processes and tools to monitor the project's efficiency and effectiveness. This could include data on the number of deliveries on northern Vancouver Island, gestational age at first enrolment with the project, and quantitative measures of health and wellness outcomes as a result of the project, potentially through analysis of the Perinatal Services BC Data Repository data.

# Response Plan

## 1. The FNHA should examine the systematic challenges and barriers within JPB projects, including those challenges and barriers that have resulted in high levels of unused project funds.

1.1. Explore and find innovative approaches to improve recruitment of staff for all JPB projects where needed.

### Progress highlights

- The project has contracted two midwives. A RFP in December 2021 for a third midwife did not receive any applicants. Internal FNHA HR capacity continues to be a challenge for fulfilling staffing matters/processes.

### Response Plan

- 1.1.1. Undertake a case study of Joint Project Board Health Human Resources to gather evidence to inform future strategy.**
- 1.1.2. Support continuous quality improvement of FNHA-employed JPB positions recruitment processes through continuous improvement of Technology and HR processes.**
- 1.1.3. Continue to make progress on the First Nations Health Human Resources Tripartite Approach.**

1.2. Provide guidance to the project regarding the use of project funds and carry-forward dollars, particularly with respect to supporting client-centred service delivery and traditional practitioners.

### Progress highlights

- Approach to JPB funding is shifting. Written policy guidance and/or principles would be helpful to have an ability to support urgent client needs that otherwise impede access to services and/or would require significant staff time to work around (e.g. funding birth certificate fee as opposed to working to identify payee of fee). This may be helpful for First Nations Primary Care Initiative projects.
- Physiotherapy is not covered by FNHB. The project has created a contribution agreement with a Pelvic floor physiotherapist from the South Island who is willing to travel (covering travel, presentations and some client sessions).

### Response Plan

- 1.2.1 Develop updated guidelines on eligible expenditures.**

## 2. The FNHA should address identified FNHB medical transportation benefit challenges.

2.1. Increase flexibility for clients who need to change travel plans or have urgent travel needs, identify alternative processes for those with difficulty paying upfront costs and clients without identification cards/bank accounts, and ensure reimbursements are paid on time and, in some instances, increase the frequency of direct deposit for meal allowances.

### Progress highlights

- FNHB is completing a comprehensive Medical Transportation (MT) program review.
- Project staff and a FNHB policy analyst work to address issues as they arise.
- Alternative accommodation options are being investigated during busy holiday periods and recent completion of family accommodation in Campbell River (Qualayu House) and plans by the Vancouver Island Children Foundation for a similar facility in Nanaimo will help meet needs for safe and accessible accommodation while staying at southern hospital.
- Opportunities to reduce upfront financial costs for families are being investigated, including arrangements with relevant facilities or hotel providers to charge meals to the room account, and providing upfront costs is possible under certain circumstances (for mileage, meals and taxis).

### Response Plan

**2.1.1 Ongoing enhancements and transformation of the Medication Transportation Program following release of the Medication Transportation Engagement Report in May 2022.**

**2.1.2 Continued collaboration between the project and a FNHB policy analyst to address concerns that impact accessibility of FNHB as they are raised (e.g. accommodations during busy holiday seasons, access to expensive medical equipment such as breast pumps).**

- 2.2. Continue to support knowledge translation activities and resources to support greater understanding of the FNHA medical transportation benefit processes and procedures.

Progress highlights

- The FNHA website contains updated information about First Nations Health Benefits as well access to relevant documents such as the Health Benefits Guide, Medical Transportation Benefit Schedule.
- Through the MT Transformation project, significant changes have been made to increase the frequency and scope of MT training to ensure that clerks have the information and training they need to adjudicate the MT benefit.

**Response Plan**

**Resolved.**

**3. The Kwakwaka'wakw Project and its partners should continue to navigate and transform models of care across multiple organizations.**

- 3.1. Bring together partners every two to three years to review the vision, current status and environmental shifts of the project.

Progress highlights

- The Steering Committee has not met since prior to 2019.

**Response Plan**

**3.1.1 Schedule a Steering Committee meeting to review the evaluation findings and discuss project changes, successes and challenges.**

- 3.2. Support linkages between project staff and senior FNHA leaders and health authority leaders to navigate the complex interprofessional conversations and health system change and transformation.

Progress highlights

- Challenge has continued over the COVID-19 pandemic.

**Response Plan**

**3.2.1 Project Manager and FNHA Vancouver Island Region to discuss approach for engaging Tripartite partners on system transformation and leveraging learnings from a Division of Family Practice project supporting relationships between GPs and midwives in the North Island.**

- 3.3. Put in place a long-term electronic medical records solution with sufficient technical support to replace the numerous electronic charting systems currently in place.

Progress highlights

- Working with the FNHA eHealth team to implement MOIS (Electronic Medical Record) for project team scheduling. MOIS would not be directly connected with Island Health records. MOIS is also currently not accessible to locums and students. A briefing note has been prepared to address this concern.

**Response Plan**

- 3.3.1 Conduct a needs assessment (technical, clinical and privacy/security) for clinics looking to adopt MOIS which will allow for team scheduling, client charting and client information sharing between providers. Training resources and technical support be provided. Further investigate interoperability between MOIS and partner health systems.**

- 3.4. Explore the potential of telehealth services as an ongoing service delivery mechanism to further expand the geographical reach of project services.

Progress highlights

- Midwives are able to connect with women by phone, Zoom or telehealth.

**Response Plan**

- 3.4.1 Examine opportunities to leverage the Maternity and Babies Advice Line / FN Virtual Doctor of the Day to support women in First Nation communities outside of the Port Hardy, Port McNeill and Namgis areas**

**4. The Kwakwaka'wakw Project and its partners should strengthen information sharing among clinicians and support the integration of cultural safety and humility, and traditional and cultural practices, in the health system.**

4.1. Develop training and resources that support appropriate circle of care information sharing among clinicians serving the families of the Kwakwaka'wakw Project.

Progress highlights

- Working with Shared Care to improve relationships between midwives, GPs and obstetricians.

**Response Plan**

**4.1.1 Develop briefing material to support collaborative care and appropriate circle of care information sharing.**

4.2. Ensure that all acute care and community providers serving Kwakwaka'wakw Project families complete cultural safety and humility training.

Progress highlights

- Midwives and students are required to take cultural safety training.

**Response Plan**

**4.2.1 Identify current Cultural Safety & Humility training levels among maternity care providers and nurses in Port Hardy, Port McNeill and Campbell River acute care facilities. Identify opportunities to increase training coverage.**

4.3. Consider increasing the availability of midwives and doulas.

Progress highlights

- The project now has two midwives, with the hope of contracting one more. The project has conducted doula training. The project also supports one full time doula position out of the Sacred Wolf Friendship Centre through a one-year contribution agreement (hiring in progress).

**Response Plan**

- 4.3.1 Encourage recruitment of midwives and doulas by sharing the benefits of these providers on patient experiences and outcomes.**
- 4.3.2 Encourage retention of midwives and doulas in partnership with Partners (Island health and Sacred Wolf Friendship Centre) through promotion of services, capacity building and supports for workload management.**
- 4.3.3 Expand and coordinate recruitment efforts to create a greater upstream supply of Indigenous candidates trained to fill health occupations both in community and in rural and remote locations. HR has filled the role of Talent Acquisition Business Partner who will be focusing on recruitment of Indigenous candidates.**

4.4. Create and support opportunities for acute care and community providers to participate in relational, practical experiences with First Nations communities on northern Vancouver Island, including exposure to the traditional and cultural practices of communities.

Progress highlights

- The facility-based Cultural safety committees in acute care hospitals were a bridge – but current Community Engagement Coordinator vacancies have meant fewer internal resources to support these committees.

**Response Plan**

- 4.4.1 The project team does not have the capacity alone to move forward this recommendation and the facility-based committees lack the Community Engagement Coordinators to support. Revisit in future in partnership with partners and other FNHA teams such as the Traditional Wellness team.**

- 4.5. Support further development of traditional cultural supports, programming and resources during pregnancy, birth and early parenting, including supports for fathers.

Progress highlights

- Working with Doula programs, Building Blocks, Sacred Wolf, Gwa'sala-'Nakwaxda'xw Council and other communities to provide additional supports for communities.

**Response Plan**

- 4.5.1 Continue to work with other family-serving organizations to provide support for training, cultural supports.**

**5. The Kwakwaka'wakw Project should implement a performance monitoring process.**

- 5.1. Develop performance monitoring processes and tools to monitor the project's efficiency and effectiveness. This could include data on the number of deliveries on northern Vancouver Island, gestational age at first enrolment with the project, and quantitative measures of health and wellness outcomes as a result of the project, potentially through analysis of the Perinatal Services BC Data Repository data.

Progress highlights

- With the upcoming implementation of MOIS Electronic Medical Record, performance monitoring will become more streamlined. A data access request to Perinatal Services BC Perinatal Data Registry from 2015 is now producing some data for the north island.

**Response Actions**

- 5.1.1 Implement MOIS and identify feasible Performance Measures of interest.**
- 5.1.2 Investigate data access to Island Health data.**
- 5.1.3 Work with the FNHA surveillance team to identify perinatal indicators of ongoing interest to measure.**

# Introduction

## 1.1 Kwakwaka'wakw Primary Maternal, Child and Family Health Collaborative Project

The Kwakwaka'wakw Primary Maternal, Child and Family Health Collaborative Project (hereafter, the Kwakwaka'wakw Project or project) is a partnership between the First Nations Health Authority (FNHA) and the Vancouver Island Health Authority (hereafter, Island Health). As one of 27 projects funded by a bilateral forum between the BC Ministry of Health and the FNHA, the Kwakwaka'wakw Project, approved in October 2014, was the prototype Joint Project Board (JPB) project for the Vancouver Island Region.

The Kwakwaka'wakw Project aims to improve maternal-fetal, newborn, child and family health by providing high-quality, accessible maternity care that is closer to home, culturally safe, trauma-informed and family-centred.

## 1.2 Purpose of the Evaluation

An implementation evaluation was conducted to assess the project's implementation, fidelity to the original proposed model, delivery and performance, including the achievement of intended short-term outcomes.

## 1.3 Structure of the Report

Chapter 2 provides an overview of the Kwakwaka'wakw Project. Chapter 3 outlines the evaluation approach, including the evaluation scope and themes, methods and considerations. Chapters 4 to 6 present the evaluation findings in relation to the following three themes: implementation and fidelity, delivery and performance results. Lastly, Chapter 7 provides the evaluation conclusions and recommendations.

# 1. Kwakwaka'wakw Project

## 2.1 Background

### Rural and Remote Communities of Northern Vancouver Island

The Mount Waddington region extends north of the city of Campbell River on Vancouver Island and covers over 20,000 square kilometres. The region includes some sections of the BC mainland and is largely comprised of small rural and remote communities. In 2016, the region had a population of just over 11,000 people.

The region is the home of the Kwakwaka'wakw People as well as several Nuu-chah-nulth communities. Nine of the 14 First Nations communities in the region have fewer than 100 members living in the community (See [Appendix A](#)).<sup>1</sup>

The city of Campbell River, situated south of Mount Waddington, is the largest neighbouring urban centre. In 2016, Campbell River was home to approximately 32,000 people. Almost 2,000 Indigenous women of child-bearing age (aged 15-54) reside in the Mount Waddington region or the city of Campbell River.<sup>2</sup> The majority of Indigenous women of child-bearing age live in urban areas such as in the city of Campbell River (1,045 woman) or Port Hardy (280 woman). The First Nations communities with the largest population of Indigenous women aged 15-54 are, Gwa'sala-Nakwaxda'xw (110 women), Namgis (95 women) and Campbell River reserve (75 women).<sup>3</sup> A smaller number of women live in the 13 Kwakwaka'wakw and Nuu-chah-nulth communities, which have populations of fewer than 250 people, as well as the remaining small municipalities spread throughout the region.

The rural and remote nature of many of the region's First Nations communities, and the significant distance between many communities and the urban centres of Port Hardy and Campbell River, are illustrated in Figure 1 below, which depicts the population of Indigenous women of child-bearing age throughout the region.

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<sup>1</sup> Statistics Canada, 2016 Census.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

**Figure 1:** Map of the Population of Indigenous Women of Child-bearing Age (age 15-54) Living in Northern Vancouver Island, in First Nations Communities and Urban Areas, 2016. Source: Statistics Canada 2016 Census, Crown-Indigenous Relations and Northern Affairs [First Nations Profiles](#).



### Availability of Maternal, Child and Family Health Services

There have been longstanding concerns about the lack of local birthing services and the associated health inequities and burden placed on Indigenous women, their families and First Nations communities in the Mount Waddington region.

As with many regions of BC, the provision of maternity care at rural and remote hospitals has declined during the past two decades.<sup>4</sup> At the time of the project design, low-risk births and maternity care services were available in Port McNeill (the designated site for low-risk births without caesarean section capabilities); high-risk births were referred to the North Island Hospital Campbell River and District campus located 200 kilometres away or hospitals even farther away (i.e., those in Comox, Nanaimo, Victoria and Vancouver). Patients relocating for delivery typically travelled two to three weeks prior to their due date in the case of low-risk pregnancies, and longer in the case of high-risk pregnancies. Physicians used a locally developed risk assessment tool to determine risk,

<sup>4</sup> Centre for Rural Health Research (2009). *Providing Birthing Support for Women on the North Island: An Aboriginal Demonstration Project*.

although some questioned the clinical evidence for some risk criteria such as the categorization of all first babies as high risk. While various other maternal, child and family health services were available within the region when the project was implemented, availability and accessibility varied widely among communities.

### **Negative Impacts Resulting from the Lack of Local Birthing Services**

A literature review revealed consolidated evidence that a lack of access to safe maternity care as close to home as possible, and the corresponding need to relocate/evacuate for delivery, contributes to health, psychosocial, financial and cultural consequences that are often more acutely felt by Indigenous women and communities. A 2009 study by the Centre for Rural Health Research, for example, reported that the psychosocial stress of having to travel to give birth accentuated vulnerability and contributed to increased intervention rates; financial loss; separation from spouse, children and community; and disruption of local traditional and sacred practices – resulting in a lack of continuity of care around birth.<sup>5</sup>

The financial burden associated with travel to access maternity services was exacerbated by the limited availability of public transportation in the Mount Waddington region.<sup>6</sup> This disproportionately affected economically disadvantaged families without a vehicle or funds for public transit. In 2019, 30 per cent of all children and 60 per cent of children in lone-parent households on northern Vancouver Island lived in poverty, the second-highest rate in British Columbia.<sup>7</sup>

Benefits to offset travel costs (e.g., transportation, accommodation and food) are available to First Nations people with Indian status who live in BC through the FNHA's First Nations Health Benefit (FNHB) medical transportation benefit (non-status First Nations people are not eligible for FNHB benefits). For those living in First Nations communities, community patient travel clerks are available to assist families with FNHB medical transportation benefit paperwork, but until recently, no such administrative supports existed for First Nations people with Indian status living off-reserve on northern Vancouver Island.

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<sup>5</sup> Centre for Rural Health Research (2009). *Providing Birthing Support for Women on the North Island: An Aboriginal Demonstration Project*.

<sup>6</sup> BC Transit offers services on northern Vancouver Island but buses are infrequent: <https://www.bctransit.com/mount-waddington/home>; some First Nation communities have transit/medical transportation vehicles; and some non-profits provide non-emergency transit for medical appointments by donation: <http://www.wheelsforwellness.com/index.html>.

<sup>7</sup> First Call, 2019.

## 2.2 Joint Project Board Funding Agreement

Effective July 2, 2013, Health Canada transferred the funds it had historically used to pay Medical Services Plan (MSP) premiums<sup>8</sup> on behalf of First Nations people with Indian status who live in BC to the FNHA, a total contribution of \$61.3 million over three years (July 2, 2013 to March 31, 2016). Of this transfer, 25 per cent of the financial contribution (or \$15.33 million over three years) was set aside by the FNHA in support of JPB projects and initiatives related to MSP services. This funding is now ongoing, with the Ministry of Health contributing up to \$15.33 million annually<sup>9</sup> for JPB projects.

The JPB is a senior bilateral forum established in 2013 between assistant deputy ministers of the Ministry of Health and the chief operating officer and vice presidents of the FNHA to enhance primary care services and delivery by advancing joint strategic priorities, overcoming policy barriers, supporting regional priorities, and enabling integration of services and strategies across the province. The primary function of the JPB for the first five years (2013-2018) was to support regions in planning and expending the funding made available for service improvements.

In fiscal years (FY) 2014/15 and FY2015/16, the JPB selected 27 new and innovative projects province-wide to receive funding. Communities, FNHA regional teams and regional health authorities co-developed the project proposals. Projects were selected based on their targeted response to an identified need within the region and had to improve one or more of the following for First Nations people: access to primary care; increased service delivery by regulated health service professionals; or increased sustainability of services. Integration and collaboration with regional health authorities or other care delivery partners was also a criterion. The Kwakwaka'wakw cultural family submitted a proposal for the Kwakwaka'wakw Project to the JPB in September 2014, and the project was approved in October 2014.

## 2.3 Partnership Roles and Responsibilities

The roles and responsibilities of the major contributing partners to the Kwakwaka'wakw Project are as follows:

### Joint Project Board

- Jointly administers the funding;
- Provides oversight of implementation and service delivery of JPB projects;
- Provides technical advice to JPB projects as needed; and
- Supports efforts to address implementation and service delivery barriers.

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<sup>8</sup> MSP premiums were a monthly health care fee collected for all BC residents to access publicly funded health care services in BC. MSP premiums were eliminated as of January 1, 2020.

<sup>9</sup> Funding for FNHA JPB projects is paid by the BC Ministry of Health based on forecasts at the beginning of the fiscal year. Therefore, only forecasted expense amounts are paid to the FNHA for each fiscal year, not the entire annualized budget amount.

## **BC Ministry of Health**

- Serves as the JPB co-chair and provides overall leadership, direction and administrative oversight; and
- Provides annual project funding.

## **First Nations Health Authority**

- Serves as the JPB co-chair and provides overall leadership, direction and administrative oversight;
- Developed/supported the development of the project proposal;
- Provides secretariat support for the Steering Committee and working groups, administrative support and subject matter expertise (e.g., eHealth, privacy, evaluation); and
- Hires/manages Kwakwaka'wakw project staff, manages project implementation and a large proportion of the project budget.

## **Island Health**

- Participates in the shared governance model, Steering Committee and working groups;
- Contributes funding to support project staffing (e.g., project manager), resources, sessional funding and cultural safety initiatives;
- Provides in-kind contributions of office space and accommodations for project staff;
- Encourages staff to attend collaborative forums; and
- Provides subject matter and methodologic expertise for evaluation through the Research and Capacity Building Department.

## **Other Stakeholders**

A number of other key stakeholders also make vital contributions:

- First Nations community representatives (e.g., Health Directors, community health nurses, community patient travel clerks):
  - Participate on the Steering Committee and working groups to guide the project direction and support integration of cultural and traditional supports/teachings;
  - Provide physical space within the Gwa'sala-Nakwaxda'xw's Health Centre for Kwakwaka'wakw staff;
  - Coordinate with Kwakwaka'wakw project staff to support local families;
  - Provide referrals; and
  - Collaborate with Kwakwaka'wakw staff to support travel arrangements and streamline FNHB medical transportation benefit processes.
- Divisions of Family Practice community health care professionals (e.g., nurse practitioners, general practitioners, midwives, public health nurses), Campbell River Maternity Clinic, and

infant and child programming<sup>10</sup> representatives participated on the Steering Committee and working groups to provide guidance of project direction and cultural safety initiatives.

- A Perinatal Services BC representative participated in the Steering Committee and evaluation working group.
- Other social services/programs (e.g., Ministry of Child and Family Development, Sacred Wolf Friendship Centre in Port Hardy) and food banks collaborated with project staff to support families.

## 2.4 Governance Structure

The Kwakwaka'wakw Project Steering Committee oversees the project. The Steering Committee was established in May 2017 to provide advice, support and guidance to facilitate the successful implementation of the project and to collaborate on other items of interest. The Steering Committee is comprised of representatives from First Nations community health centres, Elders, patient partners, the FNHA, Island Health, the Division of Rural and Remote Family Practice, the Ministry of Child and Family Development, and the Sacred Wolf Friendship Centre.

The Kwakwaka'wakw Project reports to the JPB through annual project narrative and financial reports.

The health coaches and family wellness care nurse, as FNHA staff, report through the project manager (now the regional manager of maternal, child and family health) to the FNHA Vancouver Island regional executive director.

## 2.5 Project Objectives and Guiding Principles

### Project Objectives

The project is designed to complement existing care, programs and services through navigation and coordination in order to increase the level of contact with women and families both before and after birth, and to provide more generalized health, wellness and parenting support.

The objectives of the Kwakwaka'wakw Project are to:

- Support access to optimal, seamless, culturally safe, trauma-informed and coordinated maternity care;
- Support care closer to home through collaborative care models that support safe low-risk rural births;
- Support care that interweaves safe cultural and traditional practices and practitioners throughout pregnancy, birthing and early parenting;

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<sup>10</sup> Promising Babies Program (a federally funded program operating out of Port Hardy's Family Place), Aboriginal Infant Development Program, Building Blocks to Sustainable Rural Maternity Care: The North Island Project.

- Provide care, support and advocacy focused on the wholistic and practical needs of the woman, her partner and her family within their social, cultural and economic contexts (e.g., addressing and supporting social determinants of health); and
- Support women and their families to develop the confidence, self-efficacy and knowledge to engage in a meaningful way with the systems in their lives (health, child and family services, social services, education, etc.).





Figure 2: Original Infographics for the Kwakwaka'wakw Project.

## Guiding Principles

The following principles guide service delivery for the Kwakwaka'wakw Project:

1. Care is wholistic based on **First Nations Perspective on Health and Wellness**;
2. Care and support is **culturally safe** and weaves in traditional practices and community resources;
3. Care demonstrates a **trauma-informed/harm-reduction** approach;
4. Care and support **centers on the needs** of the woman and her family;
5. Care and support is provided **as close to home** as possible;
6. Care and support is **accessible** (available, affordable, accommodating);
7. Women, families, care providers and partner agencies **collaborate** and **increase knowledge** and **capacity**;
8. Care and information flow is **seamless** within the teamlet and with community partners and external agencies; and
9. Care and support are **evidence-informed** and **contextualized** to meet the individualized needs of the woman and her family.

## 2.6 Project Inputs

## Financial Inputs

Over the four years between FY2015/16 and FY2018/19, the Kwakwaka'wakw Project spent a total of \$818,000, significantly under the budget allocation of \$2.29 million. In FY2018/19 and FY2019/20, the project spent roughly half of its budget.

## Staffing/Human Resources

As outlined in Table 1 below, project staff include:

**Table 1:** Kwakwaka'wakw Project Human Resources, 2018.

| Resource   | Description  |
|--|--|
| <b>1.0 Full-time equivalent (FTE) contracted project manager</b> | Responsible for project implementation/coordination, staff recruitment, team development/management and integration of the team into existing services. Contract funding was available for this position from December 2015 to March 2018. A single project manager based in Nanaimo held this role until March 2018, who then transitioned to a permanent role with the FNHA with this project under their portfolio of responsibilities.   |
| <b>2.5 FTE health coach/family wellness care nurse staff</b>     | <p>Responsible for health service navigation, linkages to other practical supports and programming during the prenatal and post-partum periods, engaging clients on a more personal level with home visits, pre-meeting visits and visits in health centres. Support social determinants of health (providing transportation, supporting service access, helping to support access to key identification cards (e.g., birth certificate or status identification card) and financial supports). Provide emotional and parenting support both throughout prenatal and post-partum periods.<sup>11</sup></p> <p>FNHA employees:</p> <ul style="list-style-type: none"> <li>• FTE health coach – Port Hardy: Hired in July 2017, this registered social worker works out of the Gwa'sala-Nakwaxda'xw's Health Centre (with outreach to Namgis) and supports families with more complex social needs (e.g., involvement with the Ministry of Child and Family Development) in the Port Hardy area.</li> <li>• FTE family wellness care nurse – Quatsino: Hired in August 2017, this licensed practical nurse works out of the Quatsino FNHA office and supports more medically complex clients as well as clients based in Quatsino and Port Hardy.</li> <li>• 0.5 FTE health coach – Campbell River: Hired in June 2017, this registered social worker provides part-time support to local Campbell River families as well as any families travelling to Campbell River prior to and immediately following birth and has an office at the North Island Hospital, Campbell River &amp; District campus.</li> </ul> |

<sup>11</sup> FNHA, 2014.

|  |  |
|--|--|
| <p><b>Other human resource supports and enablers</b></p> | <ul style="list-style-type: none"> <li>• Sessional coverage and travel funding for physicians and nurse practitioners to attend cultural competency training and discussions relating to changes to the model of maternity care.</li> <li>• Funding for a 0.5 FTE medical office assistant for the Campbell River Maternity Clinic.</li> </ul> |
|--|--|

**Infrastructure Inputs**

The project required physical and information management/information technology infrastructure (Table 2).

**Table 2:** Kwakwaka'wakw Project Infrastructure Inputs, 2018.

| Expense type                         | Description   |
|--------------------------------------|---|
| <p><b>Office space</b></p>           | <ul style="list-style-type: none"> <li>• In-kind office space within the Island Health North Island Campbell River Hospital facility.</li> <li>• In-kind use of Gwa'sala-Nakwaxda'xw Building Block program space (Port Hardy) for project use and event services.</li> <li>• Office space in the FNHA Quatsino office.</li> <li>• In-kind office space at the Gwa'sala-Nakwaxda'xw Health Centre.</li> </ul> |
| <p><b>Vehicles</b></p>               | <ul style="list-style-type: none"> <li>• Leased project minivan, primarily used by the Port Hardy-based health coach.</li> <li>• Personal vehicles used by staff based in Quatsino/Campbell River and Nanaimo.</li> </ul>   |
| <p><b>Information technology</b></p> | <ul style="list-style-type: none"> <li>• In-kind (FNHA) laptops, phones, printers/scanners/fax machines.</li> <li>• Charting/electronic medical records applications include team charting on the FNHA SharePoint site and OSCAR Electronic Medical Records (for clients using the Campbell River Maternity Clinic).</li> </ul>   |

**Update as of November 2020:**

- The project now includes the services of two midwives; the first began work in early 2018 as a contracted educator to provide community-based education for clients and staff and was granted privileges to conduct deliveries at the Port McNeill and Port Hardy hospitals in July 2019. A second midwife was funded by the FNHA in August 2020. Once a new, longer-term service contract is signed, half of the funding for the second midwife will come from the BC Ministry of Health.
- In FY2019/20 and FY2020/21, funding provided to Island Health for nursing and other education included access to the Neonatal Resuscitation Program, Acute Care of At-Risk Newborns, and British Columbia Institute of Technology perinatal nursing courses for local registered nurses, as well as travel and wage costs for nurses to participate in a higher volume of births in referral centres.

**2.7 Project Activities and Intended Outcomes**

## Project Activities

The Kwakwaka'wakw Project provides individual-level support to women and families to facilitate access and coordination to a wide range of existing medical, social, cultural and economic supports. The supports offered vary by geographical location as well as the amount and type of supports required/requested by families. During the period covered by the evaluation, women living in the vicinity of Port Hardy and Campbell River could access the navigation and transportation services of project staff, while all women could access prenatal and birth supports when delivering their babies in Campbell River. The project also supports higher-level initiatives to bring care closer to home and make services more culturally safe, coordinated and sustainable. See Table 3 for a comprehensive listing of services/supports provided.

**Table 3:** Kwakwaka'wakw Project Services, 2018.

| Support  | Description   |
|--|---|
| <b>Medical needs</b>   |   |
| <b>Transportation</b>  | <ul style="list-style-type: none"> <li>Helping to arrange/provide transportation to local programs and services and when travelling to give birth.</li> <li>Supporting FNHB medical transportation benefit funding applications and alternatives for off-reserve, First Nations women with Indian status.</li> <li>Advocating for changes to FNHB medical transportation benefit policies and procedures.</li> </ul>  |
| <b>Care coordination and planning</b>                                    | <ul style="list-style-type: none"> <li>Conducting intake assessments.</li> <li>Creating care plans.</li> <li>Coordinating care with partner agencies/clinicians (attending prenatal rounds, contacting clinicians).</li> <li>Providing reminders and outreach to families about upcoming appointments.</li> <li>Helping women apply for other funding sources (e.g., Jordan's Principle, doula funding).</li> <li>Charting within team's SharePoint site. For women receiving care at the Campbell River Maternity Clinic, additional charting within the clinic's Electronic Medical Record.</li> </ul>  |
| <b>Health advocacy, health literacy and cultural safety and humility</b> | <ul style="list-style-type: none"> <li>Attending Ministry of Child and Family Development appointments and developing plans in advance of birth to support family unity.</li> <li>Attending medical appointments to support and advocate for culturally sensitive care and support health literacy.</li> <li>Disseminating educational resources to families.</li> <li>Supporting culturally safe care by facilitating communication and the sharing of applicable social contexts of families with clinical staff.</li> <li>Supporting cultural safety and humility training and initiatives (and offering sessional payments for general practitioners and nurse practitioners to participate in such training).</li> </ul> |
| <b>Supporting socio-economic needs and practical supports</b>            |   |
|  | <ul style="list-style-type: none"> <li>Assisting in accessing childcare subsidies, employment insurance, social assistance, bank accounts, identification cards (e.g., birth certificates and status identification cards).</li> <li>Providing respite and practical supports (watching children for mother, dropping off</li> </ul>  |

|   |  |
|---|--|
|   | <p>prescriptions at the pharmacy, helping with family events).</p> <ul style="list-style-type: none"> <li>• Assisting with inter-partner communication.</li> <li>• Providing supplies to families travelling to give birth (personal products for mothers and their partners while in the hospital).</li> </ul>  |
| <b>Emotional needs</b>  |  |
|   | <ul style="list-style-type: none"> <li>• Being a source of emotional support for mothers (checking-in on them, taking them for coffee).</li> </ul>   |
| <b>Cultural needs</b>   |  |
|   | <ul style="list-style-type: none"> <li>• Supporting access to cultural resources and traditional teachings.</li> <li>• Supporting the development and integration of traditional teachings and knowledge into care and programming.</li> </ul>   |
| <b>Longer-term sustainability/quality of rural maternity services</b> |  |
|   | <ul style="list-style-type: none"> <li>• Supporting discussions relating to inter-professional models of care delivery (and offering sessional payment for general practitioners and nurse practitioners to participate in such discussions).</li> <li>• Supporting discussions relating to sustainability of rural maternity care services (as well as through a joint research project).</li> <li>• Advocating for increased service delivery in northern Vancouver Island (e.g., ultrasound staff in Port Hardy, bilirubin testing and light therapy in northern Vancouver Island).</li> <li>• Supporting capacity building and training events with Island Health and First Nations clinical staff.</li> <li>• Temporarily funding a medical office assistant at the Campbell River Maternity Clinic.</li> </ul> |

## Intended Outcomes

The activities described above are intended to result in a number of individual participant and project/population outcomes.

### Individual Participant Outcomes

- Physical and emotional health needs of pregnancy are met through effective, accessible and accommodating medical care.
- Women receive trauma-informed, culturally safe services that meet their needs where they are at.
- Women have the information they need to make decisions around their pregnancy and birth.
- First Nations Perspectives on Wellness are incorporated and local cultural and traditional practices are interwoven into care.

### Project/Population Outcomes

- Increased coordination/integration and continuity of care/services.
- More accessible and optimal prenatal and clinical services and care.
- Increased access to antenatal care.
- Improved travel and accommodations for women.
- Increased collaboration/partnerships with non-health supports, services and programs.

- Increased knowledge among family, staff and other care providers of traditional pregnancy, birth and parenting practices.
- Decreased rate of preterm birth.
- Increased rate of healthy birth weight.
- Increased number of safe local births.
- Sustained health literacy for future pregnancies and births (intergenerational knowledge translation).

#### Secondary Population/Project Outcomes

- Increased availability/range and maternal care in northern Vancouver Island.
- Increased sustainability of maternal health services on northern Vancouver Island.
- Increased acceptability and cultural safety of the health services women receive.



## 2. Evaluation Approach

### 3.1 Evaluation Approach

In alignment with the FNHA, First Nations Health Council and First Nations Health Directors Association 7 Directives, the implementation evaluation employed a participatory approach. Evaluation design and implementation were overseen by an Evaluation Working Group established in January 2017, comprised of representatives of the FNHA evaluation team, Perinatal Services BC, the Island Health research department and the Kwakwaka'wakw project manager.

The Evaluation Working Group developed project outcomes, indicators and evaluation methods. The Kwakwaka'wakw Project Steering Committee was engaged to provide input on the project philosophy, outcomes and logic model and to confirm evaluation questions.

### 3.2 Evaluation Scope and Themes

The evaluation period spanned FY2014/15 to FY2018/19 and includes November 2020 updates. The evaluation covered the themes of implementation and fidelity, delivery and performance results.

### 3.3 Evaluation Methodology

The following lines of evidence informed the evaluation.

#### **Document and File Review**

Project documents and files were examined to develop the project profile and obtain evidence on the project's relevance, fidelity, delivery and performance. Examples of documents reviewed include the original project proposal and project reporting (JPB project quarterly and annual reports).

#### **Financial Review**

Financial data for the project for FY2015/16 to FY2018/19 was extracted on March 1, 2020, from the FNHA finance department.

#### **Project Participant Interviews**

Semi-structured interviews with 11 women who participated in the project (out of a sample of 16 invited, a 69% response rate) were conducted in person in Port Hardy in July 2018. Project staff developed the convenience sample of participants to be largely representative of the majority of participants served by the project during the first months of service.

## Key Informant Survey

Members of the Steering Committee and other partner organizations (e.g., clinicians, Island Health managers, FNHA regional staff and academics) were identified by the evaluation working group and surveyed online between May and September 2018. Twenty of the 47 invited individuals responded (a 43% response rate). No Health Directors from First Nations communities took part.

**Table 4:** Kwakwaka'wakw Maternal Child Health Teamlet, Key Informant Survey Respondents by Role, Summer 2018.

| Group  | Number invited | Number responded | Response rate | Overall % of respondents |
|--|----------------|------------------|---------------|--------------------------|
| Project staff  | 4              | 4                | 100%          | 20%                      |
| FNHA regional staff  | 5              | 4                | 80%           | 20%                      |
| Island Health managers/administrators                          | 9              | 4                | 44%           | 20%                      |
| Physicians/general practitioners/ nurse practitioners/midwives | 16             | 5                | 31%           | 25%                      |
| Provincial/academic supports                                   | 6              | 3                | 50%           | 15%                      |
| First Nations community Health Directors                       | 7              | 0                | 0%            | 0%                       |
| <b>Total</b>   | <b>47</b>      | <b>20</b>        | <b>43%</b>    | <b>100%</b>              |

## Focus Group with FNHA Project Staff

A focus group with health professionals and project staff was conducted in person in July 2018.

### 3.4 Evaluation Considerations

There are several methodologic limitations associated with this evaluation.

- The survey of key informants received low participation from First Nations community Health Directors and physicians in Port Hardy and Port McNeill.
- Interviews with project participants captured input from individuals living in the Port Hardy area, but did not capture the experience of women with low-risk pregnancies, women who delivered their babies outside of Campbell River and primipara women (first delivery).
- There was the potential for a response bias among project beneficiaries and staff involved in the project design and delivery.
- Minimal project performance and outcome data was available.

Data was collected during the summer of 2018, but due to other mandatory evaluation requirements, completion of the report was delayed until 2020. As a result, this evaluation portrays a retrospective view of project implementation and functioning during the early stages of the project. Where possible, updates effective to November 2020 obtained from the JPB Project 2019/20 Annual Report - Kwakwaka'wakw Project and from the project manager have been provided.

Findings from the report were validated. In March 2019, client perspectives were validated with families at an in-person session. A total of 17 mothers and partners participated, a few of whom overlapped with the initial interviewees. Additional comments and stories from participants were recorded, transcribed and integrated into the findings. Findings pertinent to various FNHA departments (including finance, health benefits and human resources) were validated with relevant FNHA staff.



## 3. Key Findings: Implementation and Fidelity

The following chapter presents the evaluation findings relating to project implementation and fidelity against the original design as outlined in the project proposal. Section 4.1 describes the implementation progress of the project; Section 4.2 provides an assessment of fidelity to the original project design and describes aspects of the project that had evolved or had yet to be implemented; and Section 4.3 describes project funding expenditures.

### 4.1 Project Implementation

**The project has recruited staff and midwives, procured office space and technical infrastructure, established processes and policies, and developed relationships with key partners. The majority of key informants were satisfied with project operations and indicated that the project was meeting their expectations. Clients were receiving services in the Port Hardy and Campbell River areas and, increasingly, in outlying First Nations communities. Key facilitators to project implementation included the existence of the Steering Committee, the approach and expertise of project staff, the availability of a senior Island Health champion, an emphasis on training and relationship building, and the availability of sessional payments for clinician engagement.**

**Challenges to implementation included delays in the FNHA hiring processes, difficulties attracting candidates for the registered nurse team lead position, the complexity of navigating and transforming models of care across multiple organizations where some partner groups may be reticent to change, providing administrative supports or designated leadership responsibilities for contracted midwives, a fragmented approach to electronic charting of patient records, and a lack of technical supports.**

Approximately three-quarters of surveyed key informants were satisfied or very satisfied with overall project operations to date. Similarly, a majority (70%) reported that the project was meeting their expectations.

#### Staff Recruitment and Training

The early stages of implementation involved team recruitment and training. The project successfully recruited a contracted project manager, two registered social worker health coaches and a family wellness care nurse. Although significant efforts were made to fill the registered nurse team lead position, these efforts were unsuccessful due to incompatible collective agreements that prevented eligible candidates from transferring their benefits, vacation, seniority and sick time to the FNHA-based collective agreement. Although the potential of a secondment was investigated, time limits

for secondments and supervision challenges made this an unviable solution. In the absence of a team lead, the contracted project manager has served as both project manager for the implementation of the team as well as the team lead position. This constrained the effectiveness, sustainability and ability of the project to deliver services as originally planned. There were significant delays in hiring due to changes and limited capacity within the FNHA's human resources department.

The Kwakwaka'wakw Project and its partners conducted training sessions that were open to a variety of partner agencies and clinicians (e.g., Island Health staff, local community health workers).<sup>12</sup> Key informants identified the emphasis on training and professional development as a key facilitator to implementation and a positive outcome of the project.

#### **Update as of November 2020:**

- Concerted efforts are underway to work with the FNHA's Nursing Operations to identify recruitment strategies – such as career fairs, ad campaigns and out-of-province recruitment – to attract staff with relevant skills to support and deliver the project.
- The FNHA human resource department has also been involved with targeted recruitment, secondments and contract for services to support this type of project.
- San'yas Indigenous Cultural Training is mandatory for FNHA staff.
- Contract for services currently negotiated and under way for trauma-informed care training for FNHA staff.

### **Building Relationships**

Early efforts were made to develop relationships with key partners in the Mount Waddington Region. The skillset and efforts of Kwakwaka'wakw Project staff in relationship-building and awareness-raising through outreach and attendance at community events were credited with developing awareness, trust and confidence in project services, as well as developing a sense of partnership among stakeholders.

The existence and regularity of Steering Committee meetings was helpful for keeping project stakeholders informed. However, some individuals felt that membership on the Steering Committee was too broad and that greater progress might be achieved by establishing smaller, more focused

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<sup>12</sup> These training opportunities included postpartum depression training (online), cultural safety training (online), BCAA Child Passenger Safety Technician training, SharePoint training, circle of security training, integrated home visitor training, trauma-informed practice, motivational interviewing, brief action planning, traditional parenting training, 'Touchpoints' training and applied suicide intervention training.

working groups on specific topics. Keeping all partner groups briefed and involved in the project was a challenge, particularly for clinicians or partners who work part-time.

### Update as of November 2020:

- To facilitate increased collaboration between Island Health, the FNHA, local physicians and midwives, and to support a more integrated maternity model in the area, the Steering Committee was replaced with a series of working groups to address health care provider confidence and competence, interprofessional care and planned births.

### Working with partners to implement a new service delivery model

The complexity of navigating different systems and processes was a challenge to project implementation. Key informant survey participants recognized the complexity of creating and integrating a new project into existing services and that it would take time to implement shifts in policies, protocols and relationships between Island Health, First Nations communities and service providers. Contributors to the development of a new service delivery model included a common commitment to the work across partners as well as the provision of sessional payments to support clinicians' participation in working groups. Continued efforts will be required to come together to review the vision, current status and environmental shifts as the project continues to be implemented and evolve.

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*"Having a clear vision of where we want the program to be has been key to working through some of the challenges as they arise [...] when significant change is happening, some resistance or pushback is common"*

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Island Health was identified as an important partner during project implementation. A senior-level champion was involved early on and supported strategic conversations. After this person left their role, Kwakwaka'wakw Project staff struggled to meet regularly with Island Health and FNHA executive staff to advance strategic discussions around the introduction of midwifery services. Not all physician groups supported autonomous midwifery services. Project staff viewed the absence of direct links to senior FNHA and Island Health leadership to support the navigation of complex interprofessional conversations and major health system change and transformation as a barrier to progress. Project staff indicated that this barrier took time to overcome and was done so by fostering new working relationships.

## **Supporting Infrastructure and Expertise**

### Physical and Technical Infrastructure

The project procured physical and technical infrastructure (e.g., laptops, printers, cell phones, fax machines) across a number of geographical and organizational settings during the early phases of implementation.

Partners played an instrumental role in supporting the Kwakwaka'wakw Project's physical infrastructure needs. Island Health provided office space within the North Island Hospital Campbell River & District campus for the Campbell River-based health coach, and overnight accommodations for the Kwakwaka'wakw project manager while travelling to Port Hardy. Gwa'sala-Nakwaxda'xw provided physical space within the Port Hardy Building Block's building for project activities. Gwa'sala-Nakwaxda'xw also provided office space for a project staff member.

A single leased project minivan was used to transport clients in the Port Hardy area; staff in other locations relied on personal vehicles for transporting clients, which was not always appropriate when more than two clients required transportation.

The project anticipated the need for long-term electronic medical record solutions to replace the numerous electronic charting systems in use, along with the requirement for additional technical guidance from the FNHA for this area of project operations.

### Project Policies, Procedures and Administrative Supports

The Kwakwaka'wakw Project team implemented an interim charting program, policies and procedures, and created project documentation, processes, policies and resources (including assessment and referral forms, intake criteria, consent for release of information and informational brochures). Project staff and key informant survey participants reported a need for increased clarity regarding operational policies relating to intake, charting, discharge planning and case conferencing.

### Update as of November 2020:

- The FNHA office space with a clinic for midwives and other visiting professionals opened in September 2020.
- Electronic charting of patient records remains fragmented across numerous electronic systems. The current charting system has limited capacity for sharing or compiling project data. Because project staff are not Island Health staff, they do not have access to the Island Health PowerChart maternity unit chart. While the project has explored introducing an electronic medical record solution, the implementation of a region-wide solution has been delayed (Ministry of Health, 2017) and a lack of technical expertise and supports in this area has been a challenge.
- The team lacks sufficient centralized administrative support. Medical office assistant positions to support scheduling for the two midwives has never been filled due to contractual challenges in providing administrative support to contractors. The availability of administrative support for midwives would be expected to further increase the efficiency of service delivery.

## 4.2 Fidelity to the Original Project Design

**Some aspects of the Kwakwaka'wakw Project varied or evolved from the original design, with the most notable being the shift in the team leadership role from a registered nurse position to a role divided between two midwives and to the current arrangement of team leadership overseen by the original project manager. Although two midwives were successfully contracted, constraints over the extent of leadership functions for contracted positions precluded them from having any leadership role or being able to provide them with administrative support. Thus, the overall leadership of the project remains with the original project manager and is funded through the FNHA Vancouver Island regional envelope. There are signs that the project has begun to integrate telehealth, and that the availability of doulas and traditional healers and project services in outlying First Nations communities has increased as originally envisioned in the project proposal. There is limited evidence that some of the originally planned project services and supports were implemented, such as services focused on family planning, lifestyle supports and a registry of pregnant women on northern Vancouver Island.**

### Changes to Project Staff Roles/Functions and Supports

#### Midwife Team Lead

The original project proposal outlined the intention of hiring a registered nurse team lead, with leadership skills and experience providing perinatal care, to educate local acute care nurses. Because of the early challenge faced when staffing the team lead position, as well as the identified demand for midwifery services, the team lead position was shifted from a registered nurse to two midwives.

Midwifery services were part of the original proposal for the Kwakwaka'wakw Project, but not as the main clinical lead. The original project proposal outlined the work of exploring readiness for a “shared care model with physicians and midwifery working as partners” and the budget included midwifery services starting in year three (FY2016/17) of the project.

#### **Update as of November 2020:**

- Two midwives are currently working with the project. It was originally envisioned that the project leadership would be divided between these two midwives; one midwife focused on team administration and the other on educational supports for acute care nurses. Both midwives provide clinical care and serve as backup for the other when attending births, taking leaves and travelling to outlying communities. Due to contractual limitations, however, a leadership role is not possible for the contracted midwives. Team leadership remains with the original project manager, funded through the FNHA Vancouver Island regional envelope, who continues to provide clinical supervision to the health coaches and family wellness care nurse.

#### Geographical Scope

In the original project design, three health coaches positioned in Port Hardy/Port McNeill, Alert Bay and Campbell River/Gold River were to travel to clients in surrounding rural and remote communities to ensure access to prenatal and post-partum supports. By 2018, health coach services were being offered in the Port Hardy and Campbell River areas, with services for women in rural and remote communities limited to monthly outreach to Alert Bay by the Port Hardy-based health coach, and delivery and prenatal supports while in Campbell River awaiting birth.

#### **Update as of November 2020:**

- Clients in communities including Alert Bay (Namgis), Gilford Island and Kingcome now receive services on an as-needed basis from the midwife, health coaches and family wellness care nurse.

#### **Scope of Services Offered**

Some services described in the original project proposal are not being offered, most notably family planning supports and a registry of pregnant women on northern Vancouver Island.

#### Use of Doulas and Traditional Healers

The original project proposal outlined that doulas and traditional healers would be available eight hours per week across all communities on northern Vancouver Island by request, compensated through honorariums.

A doula is a non-medical professional who provides physical, emotional, informational and spiritual support to expectant mothers before, during and after birth. Doula services are not covered under

the public health system; they practice privately and are hired directly by clients.<sup>13</sup> Doulas can make positive contributions, particularly for Indigenous women who, due to ongoing impacts of colonialism, have been distanced from traditional knowledge and birth practices. Doulas were identified as a facilitator to culturally safe, accessible and wellness-based services.

Project staff made several attempts to secure funding and doula supports through the Aboriginal doula program<sup>14</sup> but encountered challenges and delays that limited provision of these services.

Integration of traditional healers into care was also limited. Some of the challenges cited include a lack of funding, a lack of formal acknowledgement and equal partnership of traditional healers and cultural support in circles of care; uncertainty over comfort and protocols for incorporating cultural teachings, ceremonies and knowledge; and uncertainty over how to identify healers.

### Update as of November 2020:

- In November 2019, an Indigenous Doula Collective (the Ekwi'7tl Doula Collective) provided doula training for 18 local Indigenous women on northern Vancouver Island and has been working to develop a Kwakwaka'wakw Doula Collective.
- While Elders are not an eligible expense under JPB project funding, the project is working closely with Building Blocks to Sustainable Rural Maternity Care: The North Island Project, Sacred Wolf and Gwa'sala- 'Nakwaxda'xw to provide cultural supports and work with Elders and Knowledge Keepers.
- In FY2020/21, the FNHA is funding a traditional healer to provide traditional medicines to pregnant women and education to families on how to harvest and prepare medicines.

### Role of the Health Coach

In the original project design, the health coach role included providing lifestyle coaching support to clients. By 2018, this service was not seen to be a focus of this position.

### **Service Delivery Tools**

The project proposal outlined a desire to develop a registry of women expected to give birth on northern Vancouver Island. JPB project annual reports for the Kwakwaka'wakw Project suggested that a single registry of women would require a large amount of effort in collaboration with Island Health, and that no such registry exists.

Telehealth was identified in the project proposal as a service delivery mechanism, but was not explicitly referenced as currently being offered in any feedback from staff or project reporting prior to 2019.

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<sup>13</sup> BC Centre for Aboriginal Friendship Centre, 2019.

<sup>14</sup> <https://bcaafc.com/dafgp/>.

### Update as of November 2020:

- In response to the COVID-19 pandemic, services and supports have been modified, where appropriate and feasible, and are delivered remotely via Zoom.

## 4.3 Funding Expenditure

**As a consequence of delayed implementation and staffing challenges, the Kwakwaka'wakw Project operated with a significant portion of unused allocated project funding during the evaluation period. Between FY2015/16 and FY2018/19, annual budgets totalled \$2.29 million, of which \$0.82 million was spent. This finding is not unique to the Kwakwaka'wakw Project; similar findings were found in provincial-level analyses of other JPB projects. This may suggest the need for more guidance and support of strategic efforts to increase staffing; guidelines around the use of project funds and carry-forward dollars, particularly with respect to supporting client-centred service delivery and traditional practitioners; and/or re-profiling of annualized budgets for JPB projects.**

### Expenditures Relative to Budget<sup>15</sup>

Project funding flowed from JPB to the following funding recipients:

- The FNHA received 88 per cent of the total project funding between FY2015/16 and FY2018/19;
- Island Health received five per cent of project funding to cover the costs of a 0.5 FTE medical office assistant; and
- The Kwakiutl District Council Society received seven per cent of project funding to cover the costs of a mental health clinician in FY2017/18.

Between FY2015/16 and FY2018/19, JPB annual budgets allocated totalled \$2.29 million while the project spent \$0.82 million.<sup>16</sup> Ten per cent of project funding was expended in FY2015/16 and the figure increased to 54% in FY2018/19 (see Figure 4 below). The significant unused amount can be attributed to delayed implementation of the service delivery model, particular in staffing all positions. This finding is not unique to the Kwakwaka'wakw Project. In FY2018/19, across all 27 JPB projects in the province, 58 per cent of available funding was spent, mainly due to unfilled

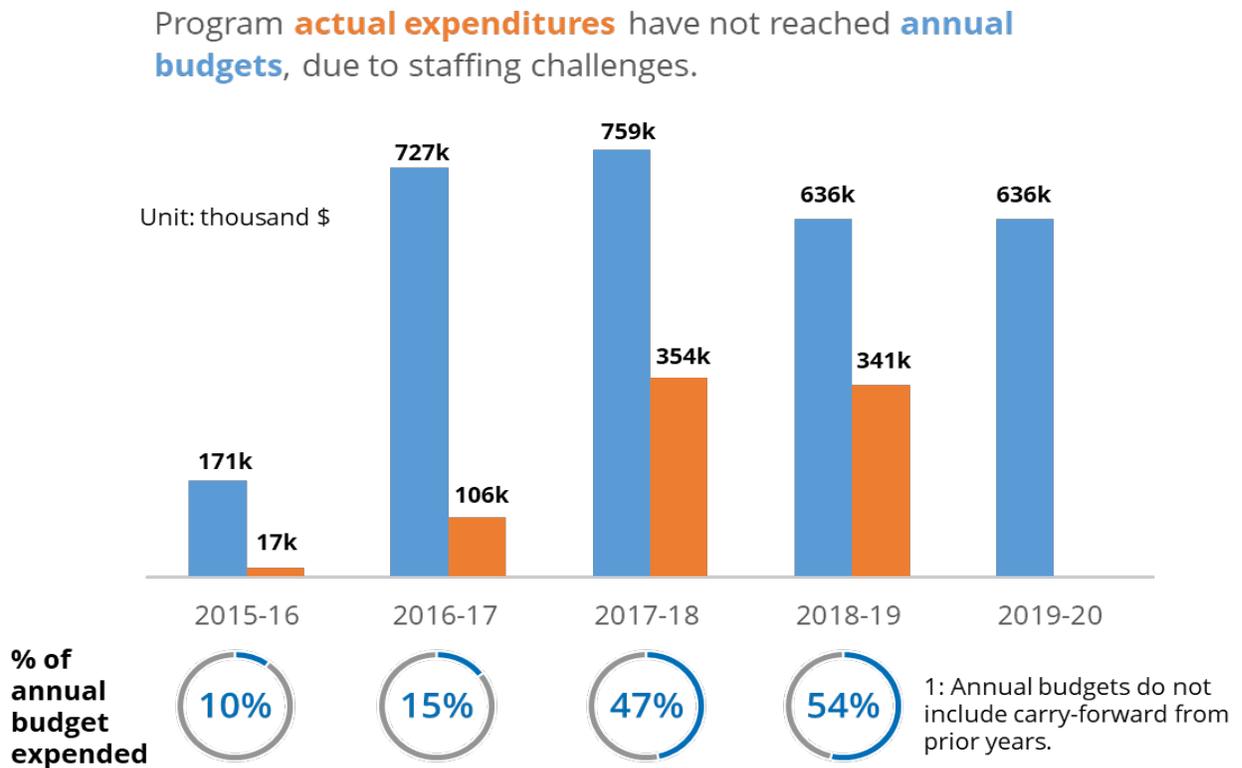
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<sup>15</sup> Financial data was extracted on March 1, 2020.

<sup>16</sup> The unused amount in each fiscal year is either recovered to FNHA or approved to be carried forward to the next fiscal year. The project's allocated funds within a fiscal year is the combination of its annual budget and carry forward from the previous year. In FY2018/19, \$0.34 million was approved to be carried forward.

positions.<sup>17</sup> This may suggest the need to re-profile annualized budgets and the need to support strategic efforts to increase staffing for all JPB projects.

**Figure 4:** Actual Expenditures Versus Annual Budgets for the Kwakwaka'wakw Project, FY2015/16-FY2018/19.

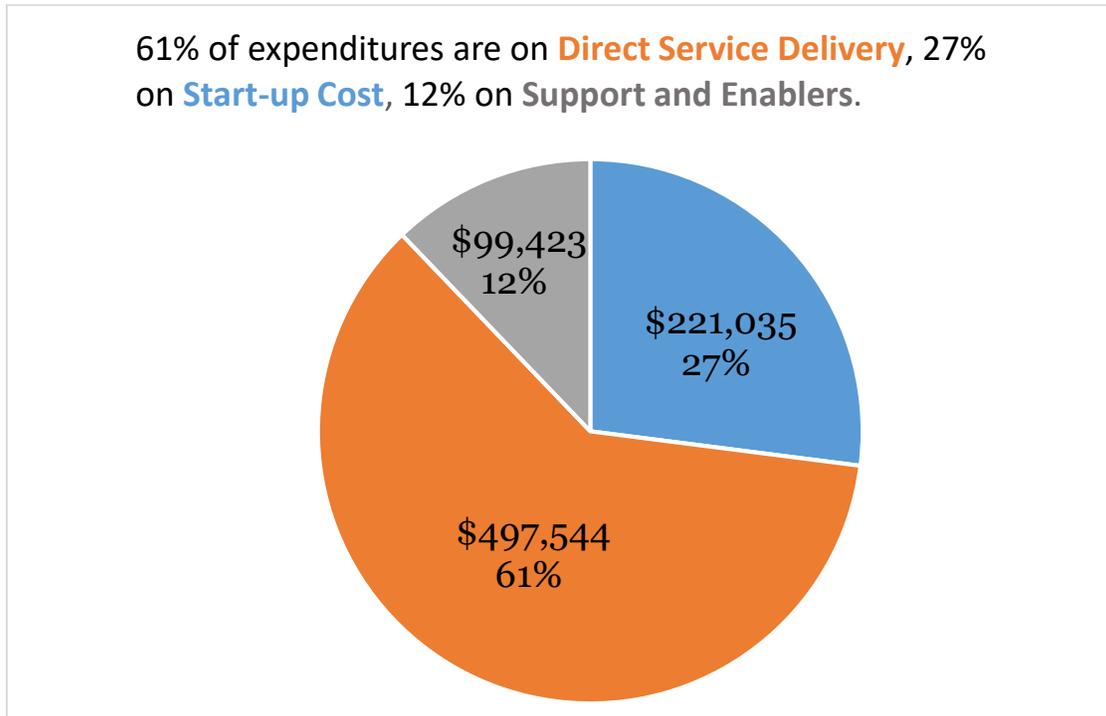


### Expenditures by Category

In total, between FY2015/16 and FY2018/19, the project directed 61 per cent of expenditures towards direct service delivery expenses, 27 per cent to start-up costs and 12 per cent to supports and enablers (see Figure 5 below).

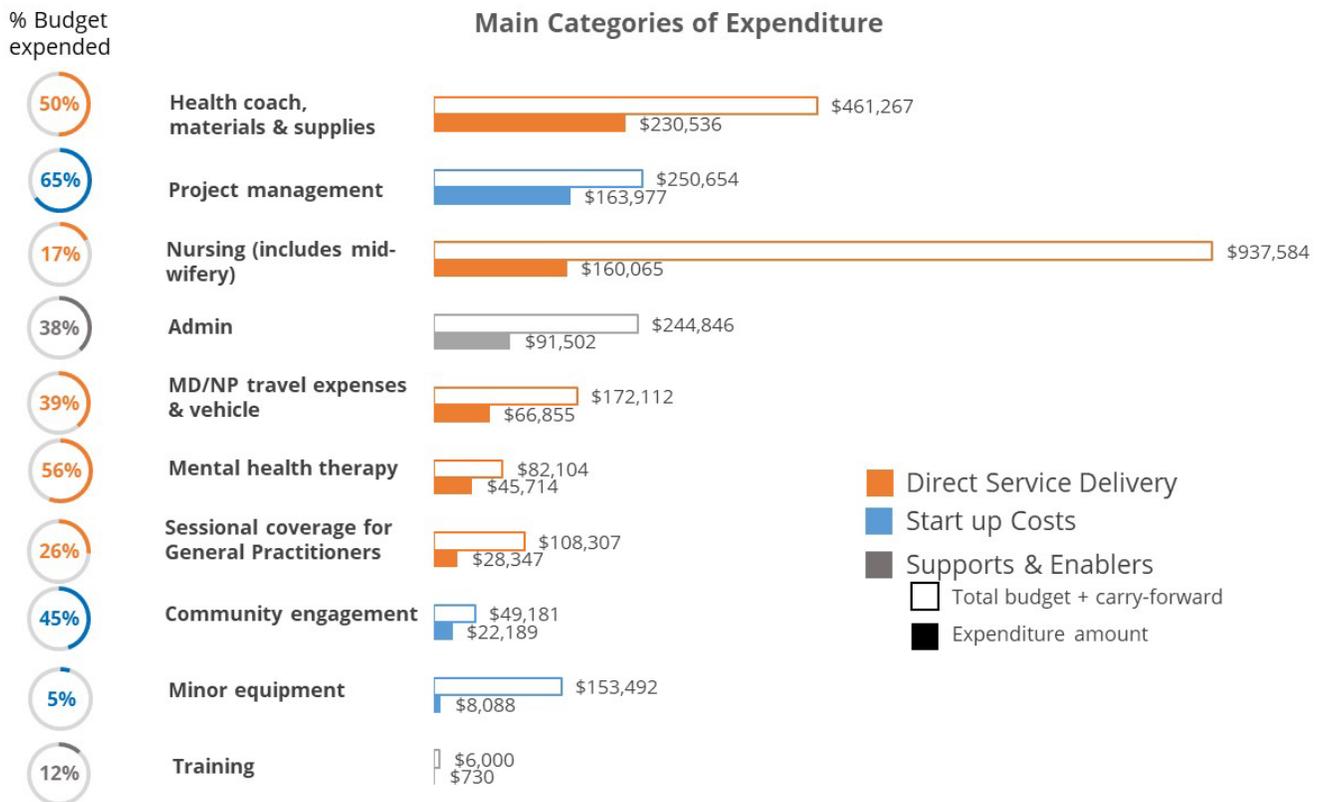
<sup>17</sup> <https://www.fnha.ca/Documents/FNHA-Joint-Project-Board-2018-2019-Annual-Report.pdf>.

**Figure 5:** Total Kwakwaka'wakw Project Expenditures by Direct Service Delivery Costs, Start-up Costs and Supports and Enablers across FY2015/16 to FY2018/19.



As displayed in Figure 6 below, the main costs relating to direct service delivery were the health coach positions, nursing, midwifery top-up funding and mental health clinician services. Midwives bill MSP for services delivered to women, but receive a “top-up” daily rate through their contract with the FNHA that supports supplementary clinical and educational services not compensated through MSP billing. Other direct service delivery cost categories included general practitioner/nurse practitioner travel for meetings and training, vehicle rental and sessional coverage for nurse practitioners/general practitioners. Expenditure levels were less than half the budgeted amounts across all categories of direct service delivery except mental health therapy (which spent 56% of its budget). Nursing services spent the least amount of their allocated budget over the three years (17%), given the difficulties faced in staffing the team lead position.

**Figure 6:** Major Categories of Expenditures in Direct Service Delivery, Project Start-up and Enablers /Supports, Kwakwaka'wakw Project, FY2015/16- FY2018/19.



Start-up costs include one-time expenses required for project planning and implementation, including capital improvements and renovations (less than \$100,000), project management, laptops, phones, furniture, office and clinical supplies, professional development, recruitment, and physician engagement. The main start-up related costs between FY2015/16 and FY2018/19 were for project management, travel and community engagement.

Major categories of costs relating to supports and enablers include administrative costs (leased office space in Campbell River in FY2017/18 and FY2018/19, funding for a 0.5 FTE medical office assistant in FY2016/17 and FY2017/18, administrative fees for partner organizations, office supplies, IT and telecommunication costs), client supplies and training.

More guidance from the FNHA in terms of guidelines around the use of project funds, carry-forward dollars (particularly with respect to supporting client-centred service delivery and traditional practitioners) was identified as a support that would be beneficial to project staff.

## 4. Key Findings: Delivery

The following chapter presents the evaluation findings relating to project delivery. Section 5.1 provides an overview of the project's reach and number of clients served, and Section 5.2 summarizes feedback on the project's adherence to its guiding principles.

### 5.1 Clients Served and Type of Services Offered

**During early project implementation, the number of clients and visits per client were below the annual targets envisioned in the original project proposal. Both measures have been increasing over time, which can be partially attributed to the project's maturation as well as the co-location and open-door policy of the midwife practitioners that are now involved.**

#### Clients Served

In the five months between October 2017, when the project began serving clients, and March 2018, the project served 37 unique clients with an average of nine visits per client. In FY2018/19, the project served 74 unique clients with an average of 13 visits per client. The number of clients served and number of interactions per client were lower than the annual targets included in the original project proposal, which targeted 160 clients per year and 25 interactions with each client per year.<sup>18</sup>

Almost three-quarters of clients who received services/supports were from northern Vancouver Island and one-quarter were from the Campbell River area.<sup>19</sup> Data on clients' community of residence was not tracked.

At the time of the evaluation, data on the number of pregnant women in northern Vancouver Island eligible for the project was not available. Therefore, it is not possible to accurately quantify the project's reach. Staff indicated that they received referrals for women who were already well-served by other programs and services, and that they were also aware of women who had travelled to give birth without receiving any project services. Similarly, no data exists regarding the gestational age at which women were being first seen by the Kwakwaka'wakw Project, but there is a recognition that some women are referred/enrolled later in their pregnancy than is ideal. It is anticipated that increased awareness of the program and stronger relationships with families will lead to more women being offered supports early in their pregnancies. One mother echoed this sentiment, sharing that it would have relieved some of her stress to have known about the services of the Kwakwaka'wakw Project earlier. Feedback from mothers in the Port Hardy area indicated that women were hearing about the Kwakwaka'wakw Project through a variety of sources. Clients did not seem to differentiate between the programming offered by the project and other partner

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<sup>18</sup> FNHA, 2014.

<sup>19</sup> Source: JPB Project 2018/19 Annual Report - Kwakwaka'wakw Project.

programming, particularly in Port Hardy, which suggests a family-centred and coordinated approach.

When asked about their awareness of the project's service offerings, most clients knew about supports such as being connected to health care providers, transportation to health care appointments and meetings, and assistance securing FNHB medical transportation benefits. Approximately half of the clients knew about the advocacy and support services related to Ministry of Child and Family Development and social determinants of health (such as helping to get birth certificates and status identification cards).

Evaluation findings suggest that project demand may increase with greater awareness among clinicians, particularly in Campbell River, which is home to a greater number of programs, clinicians and services yet has a smaller project staff presence. There were also suggestions to increase the project reach to some of the smaller outlying First Nations communities, such as Mowachaht/Muchalaht.

#### **Update as of November 2020:**

- Utilization of project services has increased. In FY2019/20, the health coaches and licensed practical nurse made 786 visits to 73 unique families/clients, for an average of 11 visits per client. The midwife team made 2,111 visits to 118 unique families/clients for an average of 18 visits per client.
- An extract from the JPB Project 2018/19 Annual Report - Kwakwaka'wakw Project provides some context for this increase in services. *"The Health Coach in Campbell River noted that nursing staff at Campbell River Hospital Maternity Unit were very surprised that a mother had 33 antenatal visits, as they are accustomed to vulnerable families having very limited prenatal care. The midwife is willing to meet families where they are at – she works at the Pregnancy Outreach Program (where she has access to an office) and will have people come to get a blood pressure taken when she sees them walk by. Families have responded very positively to the engaging and open style the midwife brings to her practice."*

### **Service Delivery Mechanisms**

The location and mechanism of service delivery for the project includes clinical settings, home visits and texting/phone calls (see Table 5 below). All staff reported a significant percentage of service delivery taking place via text messages and by phone. Staff reported service delivery in community settings and homes.

#### **Update as of November 2020:**

- The project has started to integrate telehealth as a result of the COVID-19 pandemic.

**Table 5:** Service Delivery Mode/Location of Kwakwaka'wakw Staff, FY2017/18 and FY2018/19 JPB Project Annual Reports

|                                |           | FY 2017/18                            | FY2018/19                                 |                          |         |  |
|--------------------------------|-----------|---------------------------------------|---|--------------------------|---------|--|
| Service delivery mode/location | All Staff | Registered social worker – Port Hardy | Registered social worker – Campbell River | Licensed practical nurse | Midwife |  |
| In clinic                      | 40%       | 14%                                   | 54%                                       | 40%                      | 10%     |  |
| Home visit                     | 10%       | 15%                                   | 1%  | 25%                      | 6%      |  |
| Telehealth                     | -         | -                                     | -   | -                        | -       |  |
| Text/phone                     | 15%       | 38%                                   | 29%                                       | 35%                      | 64%     |  |
| Transporting families          | 15%       | -                                     | -   | -                        | -       |  |
| Advocacy                       | 20%       | -                                     | -   | -                        | -       |  |
| Community settings             | -         | 32%                                   | 16%                                       | -                        | 15%     |  |
| Other                          | -         | 1%                                    | -   | -                        | 5%      |  |

### 5.2 Alignment of Services with the Project’s Guiding Principles

The project is integrating a number of its guiding principles into the way it approaches and prioritizes its work, most notably in providing women- and family-centred care, providing culturally safe services, collaborating with a team-based approach and providing services closer to home.

Women are often referred to the Kwakwaka'wakw Project with immediate and specific needs relating to transportation and health system navigation. These navigation supports and services, though valued, come at the cost of other programming elements that staff could be emphasizing or supporting, such as lifestyle and cultural supports. Staff, families, clinicians and key informant survey participants identified a number of challenges to the current FNHB medical transportation benefit, primarily the lack of flexibility for changing travel plans in the event of changing clinical circumstances, and the challenge of paying upfront for travel costs in some instances.

Cultural safety and humility are embedded in project documents and a key consideration of the services and supports offered to clients. The use of midwives and doulas was identified as particularly effective in facilitating cultural safety and integrating traditional practices during birth. Opportunities to increase cultural safety and humility include ensuring all clinical staff are trained in this area and that opportunities exist to support relational

**practice experiences with, and in, First Nations communities. Keeping all partners and clinicians informed of relevant clinical and social information when working across multiple providers and settings is a challenge, particularly given the fragmented system of patient records and large geographical distances. There is a need to balance privacy and information relevant for culturally safe and family-centred care. Increased supports relating to traditional cultural practices during pregnancy, birth and parenting were of interest to families, as was programming, resources and supports for fathers.**

As demonstrated in Figure 7 below, surveyed Steering Committee and partner organization members indicated that to a large degree, project services were aligned with the project's guiding principles, most notable being providing women- and family-centred care, providing services in a culturally safe manner, employing a collaborative and team-based approach and providing services closer to home. The integration of cultural practices and traditions into current services and operations was rated lowest on average by key informants.

There was very little feedback on the integration of harm reduction and trauma-informed care principles into project services other than the suggestion that such areas of work require specialized knowledge, suggesting that these skills and/or areas of focus are not yet developed or a priority for the project.

**Figure 7:** Alignment of Project Services and Operations with Project Guiding Principles, Kwakwaka'wakw Key Informant Survey Participants, Summer 2018.

*Rating on a scale of 0-10 where 0 is a complete lack of integration of a given element of the program's philosophical framework into current program services and operations and 10 is full integration of a given element of the program's philosophical framework into current services and operation?*



Note: "Don't know" response are excluded in the average rating calculation.

### Women- and Family-Centred Care

The project is designed to support a range of services through pregnancy and early parenting, spanning a wide range of medical, social, cultural and economic supports for women and their families.

The project has developed comprehensive intake assessment forms and, although these forms were found to be useful, assessments were not consistently employed because clients were often referred with immediate and specific needs late in their pregnancy, or were under the care of a clinician who conducted their own assessments.

### Transportation Supports

The majority of clients indicated that they were aware of, and utilized, the supports of the Kwakwaka'wakw Project to arrange or provide transportation to health services, whether for attending local services (for families living on northern Vancouver Island) or when planning for delivery in Campbell River/Port McNeill.

Staff indicated that they spent a significant amount of time supporting access to the FNHB medical transportation benefit. There was no direct duplication of services in the provision of transportation assistance by health coaches for off-reserve families, as patient travel clerks in First Nations communities support on-reserve First Nations families; however, the significant administrative burden associated with providing this service may not be an efficient and cost-effective use of the registered social worker's time, as reported by project staff.

The flexibility and complexity of the FNHB medical transportation benefit processes and policies were raised as consistent barriers by project staff, families, clinicians and key informant survey participants. Any deviation from approved travel plans required resubmitting paperwork, which could be a challenge if immediate travel was required and it was near the end of the work day or work week.<sup>20</sup> Clinician respondents indicated that the current FNHB medical transportation benefit policies and procedures are not ideal.

In addition, some families did not have the financial resources to pay for hotel and food expenses upfront or did not have the identification cards or bank accounts required for the direct deposit of funds. There were no structured processes for instances where retrospective reimbursement is a challenge or where weekly meal allowance payments were delayed. Families spoke of going without food while waiting for the once-per-week meal allowance deposits. Pre-approved hotels did not always have the amenities supportive for healthy eating (e.g., kitchenettes and continental breakfasts), which is of particular concern during longer-term stays. Staff were bridging gaps by coordinating access to other existing services (e.g., local food banks) and creative use of project funds (e.g., using gift cards) but budget policies on this practice were unclear.

Project staff worked to better understand the FNHB medical transportation benefit processes and procedures so as to enable them to better assist families. They compiled resource lists (pre-approved accommodations, different methods of transportation), met with patient travel clerks (who support patient travel coordination with the FNHB medical transportation benefit for families living in First Nations communities) to discuss solutions to common concerns and submitted briefings to the FNHA FNHB team regarding systematic issues.

Examples of the suggestions given to increase the flexibility and responsiveness of the FNHB medical transportation benefit include:

- Developing mechanisms to address urgent patient travel needs that arise after hours (e.g., a contribution agreement that would give staff the flexibility to arrange last-minute travel plans);

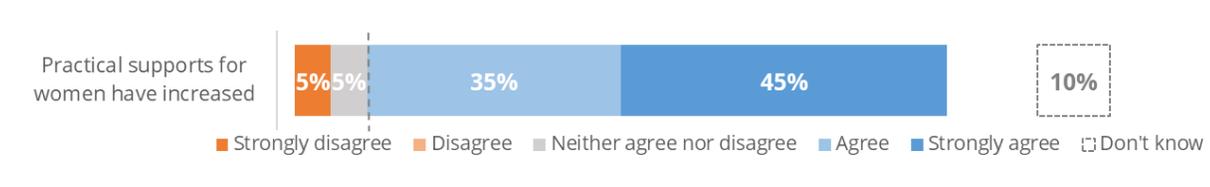
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<sup>20</sup> The FNHB program operates Monday to Friday, 8:00 am – 4:00 pm.

- Developing policies and guidelines for administering the dispersal of meal allowances by way of gift cards, particularly for families who are away for one to two days, for families whose meal allowances are not received/delayed for any reason or who are not in a financial position to pay for costs upfront; and
- Increasing the frequency of direct deposits of meal allowance payments to twice per week.

Findings from the key informant survey and from project participants indicate that the project has increased practical supports and that the accessibility of the FNHA FNHB medical transportation program has improved since the project’s inception (see Figure 8 and 9 below).

**Figure 8:** Increase in Practical Supports (e.g., Accommodation, Travel Assistance) as a Result of the Project, Key Informant Survey Participants, Summer 2018.



**Figure 9:** Accessibility of Health Services, Key Informant Survey Participants, Summer 2018.



*“[It’s] a lot more different now than it was when I had my daughter five years ago because I did everything on my own.” Mother*

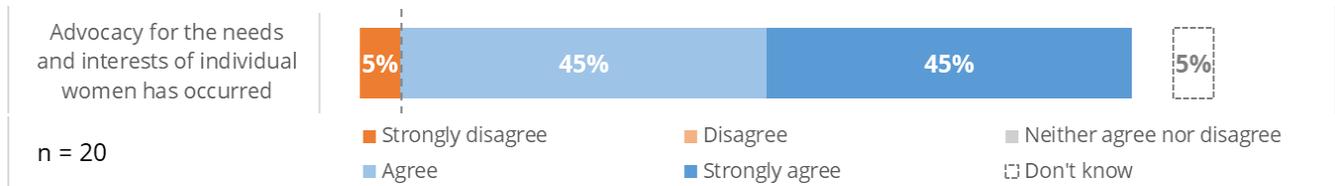
**Update as of November 2020:**

- Gwa'sala-Nakwaxda'xw First Nation has expanded patient travel support for off-reserve families in the Port Hardy area.
- Although FNHB medical transportation processes have become more streamlined and simpler, they still pose some challenges. The project continues to, on occasion, provide meal allowances.
- Qwalayu House, which is adjacent to the North Island Hospital Campbell River & District campus, is under construction. Owned and operated by the Children's Health Foundation of Vancouver Island, the home will be complete by mid-2021 and will shelter expectant mothers and members of their family from the northern region of Vancouver Island when delivering their babies in Campbell River. (<https://www.nationalobserver.com/2020/06/25/news/vancouver-islands-qwalayu-house-will-keep-families-close-when-care-far-home>).

### Advocacy

Project staff advocated for services and supports based on individual client needs. Staff advocated for travel funding to attend midwife appointments in Campbell River, as well as funding for prenatal vitamins and doula services. The vast majority of key informant survey participants also shared the perception that the project was advocating for the needs of women (see Figure 10 below).

**Figure 10:** Advocacy for the Needs of Women as a Result of the Project, Key Informant Survey Participants, Summer 2018.



### Emotional Supports

Clients valued and appreciated the emotional support provided by project staff. Clients spoke of the important role of the project in supporting their emotional needs through one-on-one support and check-ins. Project staff's ability to listen, talk through parenting and personal challenges and provide a change of scenery was valued.

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*"She [Kwakwaka'wakw staff] came, she called a lot just to check up. She always told me if you don't want me to come by just let me know. I had a hard time after birth [...] and they helped when I needed help to shower or a ten-minute break." Mother*

*"So she's basically just teaching me how to be who I need to be for me and my kids, supporting me on the path that I'm on" Mother*

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### Suggestions to Further Support Women and Their Families

Project staff suggested women- and family-centred services could be further enhanced by increasing the clarity of existing expense policies and creating a flexible budget line to support lifestyle programming/expenses (e.g., taking a client for coffee, buying groceries for healthy meal preparation). Project staff described having taken clients out for coffee or lunch in between appointments/programs and, in some instances, ended up paying for items out of pocket as expense policies were unclear. Situations arise where a small amount of flexible funding could support efficient and responsive service delivery, particularly for needs arising after-hours or on, or close to, weekends. For example, a family travelling for health care service lost one of their bus tickets, which would have required the entire family to stay overnight and purchase a new set of bus tickets for the following day if funds had not been made available to replace the lost ticket.

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*"It would be very helpful to have a small fund to support food security, unanticipated travel needs, bus tickets, status card and birth certificate fees, and other small costs. Sometimes not having this kind of funding can lead to considerable stress for both families and staff and can lead staff to spend large amounts of time on things that could be easily mitigated by a few dollars."*

JPB Project 2017/18 Annual Report - Kwakwaka'wakw Project

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### Update as of November 2020:

- Project staff have supported client-centred needs using project funds and there has been no issue with respect to remuneration or approval.

Clients suggested further programming and supports such as facilitating access to local fitness programming/infrastructure (e.g., passes and transportation to the pool and gym) as well as additional programming for fathers. Fathers play a critical role in supporting the health and wellness of their families and have fewer opportunities to participate and learn about pregnancy, birth and early parenting. A father indicated that he valued the programming offered by health partners and services in Port Hardy, but additional programming and resources for fathers would be welcome. Additional ideas for resources for fathers included a companion document to *Our Sacred Journey: Aboriginal Pregnancy Passport*<sup>21</sup> and a men-only group.

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*"It would be nice to see a lot more programs for fathers to learn more. [...] A men-only group would be nice because there's a few shy ones here [...] All these programs help me speak out more and they help me with all the stuff I need to know about birth and my wife being pregnant. I've learned a lot through all these programs, and I appreciate all the programs here. I appreciate you guys coming to teach more. It's pretty cool."* Father

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## Culturally Safe Services

Cultural safety is defined as "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care."<sup>22</sup> Cultural humility is "a process of self-reflection to understand personal and systemic biases and to develop

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<sup>21</sup> <http://www.perinatalservicesbc.ca/Documents/Resources/Aboriginal/AboriginalPregnancyPassport.pdf>.

<sup>22</sup> FNHA, 2017.

and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience."<sup>23</sup>

At the time of the evaluation, the project was supporting the delivery of culturally safe services in a number of ways:

- Distributing tools and resources that encouraged a complete and wholistic view of women and their families, such as the Kwakwaka'wakw assessment forms and *Our Sacred Journey: Aboriginal Pregnancy Passport*;<sup>24</sup>
- Supporting training sessions to increase knowledge and awareness of cultural safety and humility, including the provision of sessional payments for physicians/nurse practitioners to attend cultural safety training; and
- Liaising between families and care providers. The very presence of the team, with its focus on relationship-building and advocacy, was seen as increasing cultural safety.

Project staff spoke of the importance of embodying a respectful and gentle approach to working with families that is accessible and yet unobtrusive. The project aimed to provide a safe space for women to voice their needs and wishes, and clients indicated this was appreciated.

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*"Both really kind and non-judgmental. Didn't feel judged."* Mother

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The availability of midwifery and doula services was raised as an important factor supporting culturally safe services, along with the integration of traditional protocols and ceremonies. Women who utilized the services of a midwife appreciated the support, openness and responsiveness to their needs during pregnancy, birth and early parenting and indicated that they felt doula services should be more accessible, both financially and practically.

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*"I mentioned to my midwife that I wanted to cleanse the birthing room [...] My midwife was so supportive [...] That was one of the most important things about having her was that she was really supportive of cultural practices"* Mother

*"I found that having a doula was extremely important for helping me with the ceremonies."* Mother

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Key informant survey participants spoke of how they have been working towards increased cultural safety and humility in their work by attending various training opportunities, providing longer appointment times, openly communicating, being patient and increasing their knowledge of local First Nations communities. Clinicians also spoke of the importance they place on never turning

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<sup>23</sup> Ibid.

<sup>24</sup> <http://www.perinatalservicesbc.ca/Documents/Resources/Aboriginal/AboriginalPregnancyPassport.pdf>.

families away from services, even if families present late in pregnancy, and to endeavour to discuss patient preferences and values as part of their care.

Quantitative feedback from the key informant survey participants (see Figure 11 below) suggested that although a majority (70%) of project staff and clinicians indicated that they feel that adequate policies and training opportunities exist within their practice/organization to support cultural safety, not all do. Qualitative feedback indicated that there continues to be structural and systemic racist practices and policies embedded in the health system.

**Figure 11:** Availability of Adequate Policies and Training Opportunities to Support Cultural Safety, Key Informant Survey Clinical and Project Staff Participants, Summer 2018.



Opportunities to increase cultural safety and humility identified by evaluation participants include ensuring all clinical staff are trained in cultural safety and humility and that opportunities exist to support relational practice experiences with, and in, First Nations communities. Participation of project staff in acute care facility cultural safety committees was raised as an opportunity, as was focusing on systemic or strategic changes to support cultural safety and humility.

**Update as of November 2020:**

- Access to midwifery care has been very beneficial in improving the cultural safety of the services provided. The midwife is available for after-hours support.

**Weaving Traditional Cultural Practices into Care**

The ongoing impacts of colonialism and the recent history of women having to leave their communities to give birth has disrupted many traditional practices around pregnancy and birth.<sup>25</sup> Some women interviewed highlighted the importance of cultural practices and programming; however, the majority of families indicated that they did not learn of or integrate traditional cultural practices into their pregnancy, birth and early parenting practices. Despite this, nearly all women indicated that they were interested in learning more about traditional practices around pregnancy, birth and parenting through a variety of mediums, including written resources, face-to-face teachings and videos.

The original project proposal outlined the intent for the Kwakwaka'wakw Project to work with local

<sup>25</sup> Bachlakova, October 25, 2016.

community Knowledge Keepers to determine how best to incorporate culture into care. Project staff recognized that cultural protocols vary by community/family and that their role is to connect individuals to cultural resources rather than to be cultural resources themselves. Staff link families with existing cultural supports and programming, particularly on northern Vancouver Island, where a number of supports are available such as blanket making, cedar weaving, drumming, singing and dancing, and ceremonial supports (e.g., 10-month ceremonies and name-giving ceremonies).

For women travelling to give birth, being away from home and the different teachings and cultural protocols practiced on northern Vancouver Island can limit the types of cultural and traditional practices or ceremonies possible.

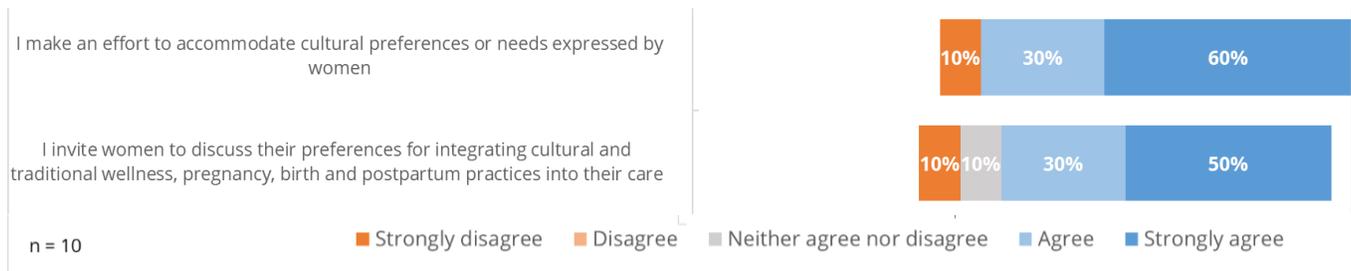
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*“they asked if I wanted to keep the placenta and I thought ‘I have no place to put it [...] I was going to be down in Campbell River for another week.’” Mother*

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Key informant survey participants indicated that they had a “minimal increase” in knowledge about local First Nations traditions and practices around pregnancy and birth since the beginning of their involvement in the project, but many indicated that they make an effort to accommodate cultural preferences and discuss preferences with women (see Figure 12 below).

**Figure 12:** Integration of Cultural Preferences and Supports, Key informant Survey, Clinical and Project Staff Participants, Summer 2018.



Suggestions for further integration of cultural practices into care include committing to humble lifelong learning, hosting traditional birthing celebrations, integrating local community Elders into care, and having further technical support from the FNHA to guide the integration of traditional healers and traditional healing practices in care.

**Update as of November 2020:**

- The FNHA is currently funding a traditional healer to provide traditional medicines to pregnant women. The traditional healer is also providing education to families to learn how to harvest and prepare medicines.
- The family wellness care nurse has been working to indigenize parenting course content to make it more culturally safe for families.
- A baby welcoming ceremony was held in the Kwakiutl Big House in January 2020. Forty families had their babies honoured in a ceremony that brought Elders, families and several organizations together. The ceremony was jointly planned between the Kwakwaka'wakw Project, Sacred Wolf Friendship Centre, Building Blocks to Sustainable Rural Maternity Care: The North Island Project, and the Aboriginal Infant Development Program.

**Collaboration and Team-Based Approach**

The consistency of staff whose primary roles are to develop care plans and discharge plans, and smooth system issues, has helped address a fragmented system of care that does not always enable good communication between care providers. The project has supported coordination for women travelling to give birth by raising awareness of services. Staff were connecting with other supports, programs and clinicians to identify complementary services. There was evidence of partner agencies providing back-up support to each other. For example, the Campbell River-based health coach works closely with staff from Kwakiutl District Council, who provide coverage when they are away, and the Kwakwaka'wakw health coaches supported travel arrangements for patients in the Port Hardy Hospital when the Island Health Aboriginal liaison nurse position was vacant.

Key informant survey participants reported the Kwakwaka'wakw Project supported greater integration and coordination of health services. While no formal written agreements (e.g., memorandums of understanding) had been created between partners, a number of forums and mechanisms were being used to coordinate across services and health care providers. This includes regularly scheduled rounds, case conferencing, texting, co-location of project staff (which was indicated as being advantageous for informal interactions and relationship-building) and formal working groups. Despite evidence of progress, not all surveyed Steering Committee and partner organization members indicated that the project had affected their experience of delivering care.

### Information Sharing

There were challenges in keeping all partners and clinicians informed of relevant clinical and social information when working across multiple providers/settings. This was exacerbated by the geographical spread of services, complexities relating to extended travel arrangements that sometimes involved significant social complexities, multiple incompatible charting systems, and a desire to balance information sharing and privacy.

Some clinician respondents to the key informant survey felt that they had a better idea of the needs of their patients as a result of the project, whereas others felt that they did not have sufficient or reliable information about the stability of housing/relationships and follow-up plans post discharge. Perspectives varied on how much information should be shared, particularly relating to more sensitive information (e.g., Ministry of Child and Family Development involvement). Some key informant survey participants indicated that strict confidentiality rather than implied shared care between health care providers complicates work and results in less seamless care. The project had developed referral and release of information forms identifying with who Kwakwaka'wakw Project staff could and could not share information. A suggestion was made to develop training and resources to support circle of care information sharing that meets the needs of clinicians while balancing the rights and privacy of clients.

## 5. Key Findings: Performance Results

The following chapter presents the evaluation findings relating to performance results. Section 6.1 describes the impact of the project on the number of births taking place on northern Vancouver Island. Sections 6.2 and 6.3 describe health and wellness outcomes and impacts on family unity. Section 6.4 describes the impacts of the project on access to other health services, including midwives and doulas, and Section 6.5 describes the impact of the project on the sustainability of maternity services on northern Vancouver Island.

### 6.1 Bringing Births Closer to Home

**Sufficient data was not available to assess the impact of the project on increasing the number of deliveries on northern Vancouver Island; however, recent reporting indicates that midwives are supporting local hospital deliveries. Feedback from women indicated that they desire to give birth as close to their homes and families as possible. Key informant survey participants reported an improved understanding of the benefits of local births and limitations of local services among communities, an increased ability of women to make an informed choice on place of birth, and greater capacity of providers to accommodate women's place of birth preferences.**

There was limited data available to assess whether the number of births that occurred in northern Vancouver Island had increased as a result of the project. Perinatal Services BC data indicated that in FY2015/16, less than two out of 10 pregnant women in northern Vancouver Island delivered their babies in northern Vancouver Island.<sup>26</sup> The original Kwakwaka'wakw Project proposal outlined the goal of increasing the number of deliveries in Port McNeill within the first year from 10 to 20 births per year.<sup>27</sup> It is unknown whether this goal was met, as no data was available. Of the 11 women interviewed, two women delivered their babies in Port McNeill.

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<sup>26</sup> Six per cent (seven out of the 110 pregnancies) of births on northern Vancouver Island were in Port McNeill (the designated site for low-risk births without caesarean section capabilities) and 11 per cent (12 out of the 100 pregnancies) were in Port Hardy (Centre for Rural Health Research, 2018).

<sup>27</sup> FNHA, 2014,

### Update as of November 2020:

- As of November 2020, the project has made progress in providing birthing services closer to home. A midwife contracted with the project received privileges to deliver babies at the Port Hardy and Port McNeill hospitals in July 2019.
- The midwife and Kwakwaka'wakw team supported a family from a local community. It was the first birth for that community in many years and the FNHA provided financial support for a baby welcoming ceremony to commemorate the occasion for the community.

Many families mentioned the complexities and stress of traveling for prenatal care and childbirth. When asked about their choices of place of birth for their babies, women spoke of a number of considerations, including a desire to give birth closer to home to minimize the impact on their families. Women spoke of the financial difficulties of having to leave home, as well as the challenges of the extended period of time away from home, work, partners and other children. If travelling to give birth, women expressed preferences for a particular centre near family supports, or where older children were born.

Many women felt that they did not have a choice in the place of birth for their baby and that the location was decided because of clinical considerations (e.g., requiring a caesarean section, first-time pregnancy, complications).

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*"It wasn't my decision." Mother*

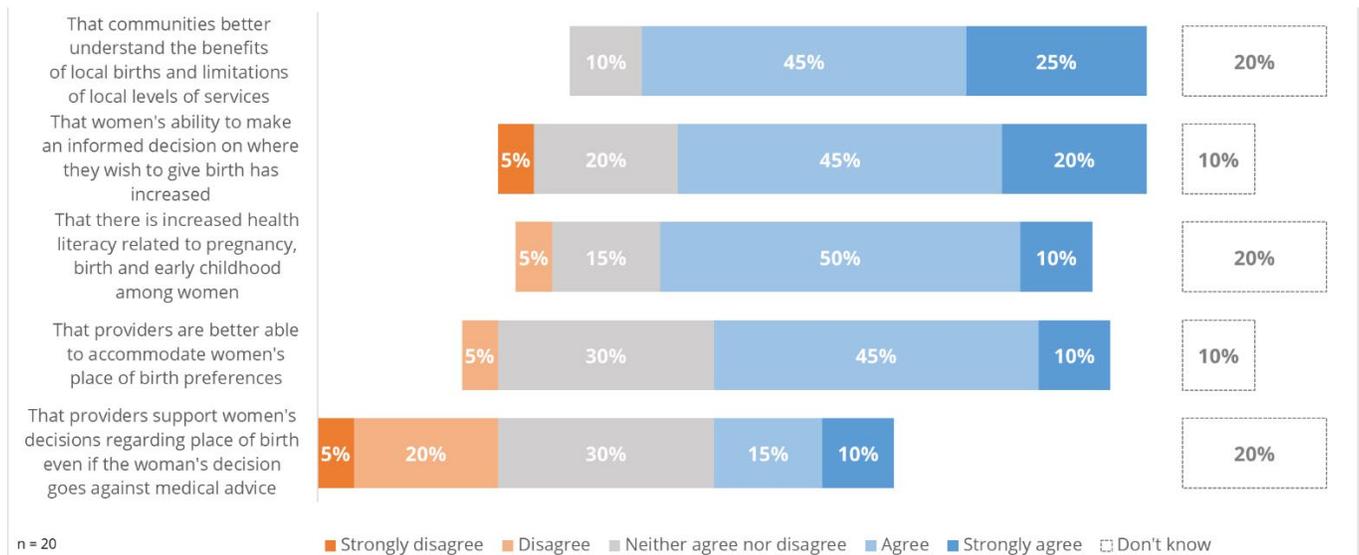
*"You're not really given a choice here in the north island you have to give birth in the big city centre."  
Mother*

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The need for more assurances and supports for women wishing to give birth on northern Vancouver Island was raised by clients. Instances were shared of women who were told that they would be able to deliver their babies on northern Vancouver Island and then having those plans shift due to changing clinical opinions. Project staff have started creating back-up plans to reduce stress for families should their place of birth have to change.

Findings from the key informant survey participants indicate that, generally, the benefits of local births and the limitations of local services are now better understood by communities, that a woman's ability to make an informed choice on where they wish to give birth has increased, and that providers are better able to accommodate a woman's place of birth preferences (see Figure 13).

**Figure 13:** Choice in Place of Birth Sentiments, Kwakwaka'wakw Key Informant Survey Participants, Summer 2018.



**Update as of November 2020:**

- Presentations about the benefits and potential risks of local births are being made by the midwife and local general physician to community leadership and Elders in First Nations communities to ensure communities are aware of the changes occurring with maternity care.

## 6.2 Health and Wellness Outcomes and Health Literacy

**Supports to health and wellness, particularly relating to emotional wellness and reduction of stress through staff outreach and practical supports were reported by clients. Quantitative measures of health and wellness outcomes, such as an increased rate of healthy birth weights, were not available. Increased health literacy, another project outcome, was often reported as being supported by other clinical and programming supports rather than the Kwakwaka'wakw Project.**

No quantifiable data existed at the time of the evaluation to measure the project's impact on physical, emotional, spiritual or mental health outcomes; however, the linkage of Perinatal Services BC's Perinatal Data Registry with the First Nations Client File<sup>28</sup> is underway. Future analysis of this data source for northern Vancouver Island may provide high-level trends on key perinatal health

<sup>28</sup> The First Nations Client File is a data file that can be used in a process of record matching to identify First Nations clients with Indian status and their entitled descents in administrative datasets that contain Personal Health Numbers (such as Perinatal Data BC's Perinatal Data Registry). The First Nations Client File is built by linking the federal government's Indian Registry, the BC Ministry of Health Client Roster and BC Vital Statistics Agency records, and its use is governed jointly by the BC Ministry of Health and the FNHA.

outcomes of interest.

Clients spoke to the effects of the project on helping reduce their stress and support their mental well-being. One participant indicated that she required additional counselling and mental health supports, but that local services were inadequate to meet her needs.

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*“I was stressed out a lot and had really bad heart burn and she kinda helped me to get the right medication that I needed and the right advice. Once I got that the heart burn went down and the stress went down.” Mother*

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Participants indicated that they were learning about their own health and wellness, although most suggested this was not a direct result of the Kwakwaka'wakw Project itself. Clients reported learning from other resources and supports, such as their health care practitioner and a variety of health programming offered by Port Hardy-based agencies. The project has been working to customize and deliver training materials to families, such as parenting courses.

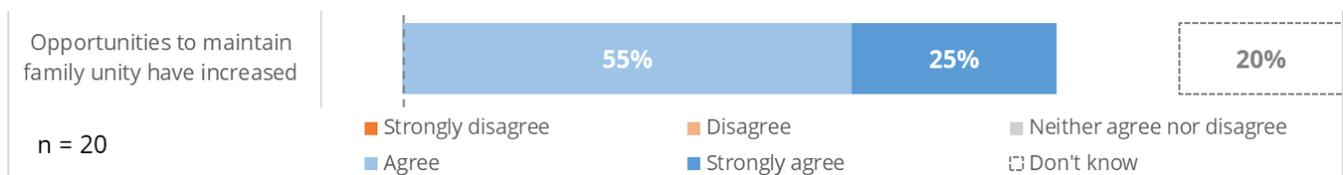
### 6.3 Family Unity

**Efforts are being made by project staff and health system partners to support and maintain family unity, which is anecdotally perceived as having reduced the number of children removed from their families at birth since project inception.**

A small percentage of families being served by the Kwakwaka'wakw Project have Ministry of Child and Family Development involvement in their family life. Project staff support these families by advocating on their behalf, helping to put plans in place for families at risk of having their child placed in care, and ensuring vulnerable families are able to attend key appointments. Women expressed that the support of the project has been helpful in their interactions with the Ministry of Child and Family Development.

The majority of key informant survey participants (80%) agree that opportunities to maintain family unity have increased as a result of the project (see Figure 14 below).

**Figure 14:** Opportunities to Maintain Family Unity as a Result of the Project, Key Informant Survey Participants, Summer 2018.

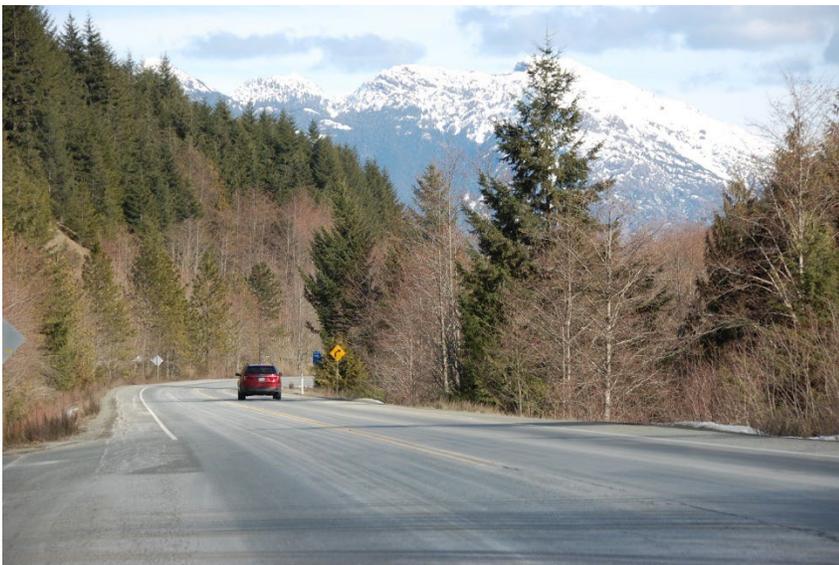


### Update as of November 2020:

- The JPB Project 2018/19 Annual Report – Kwakwaka'wakw Project indicates that almost no families working with the project have had their newborn babies removed at birth between the project's introduction in the fall of 2017 and March 2019. This could be attributed to families being encouraged to build relationships and develop plans with the Ministry of Child and Family Development prior to their baby being born, as well as strong partnerships and supports from community and acute care staff (e.g., supporting a longer hospital stay to ensure plans are put in place). Closer coordination and communication between Ministry of Child and Family Development staff across northern Vancouver Island was raised as an opportunity to improve communication and support for families.

## 6.4 Increasing Access to Health Services, Midwives and Doulas

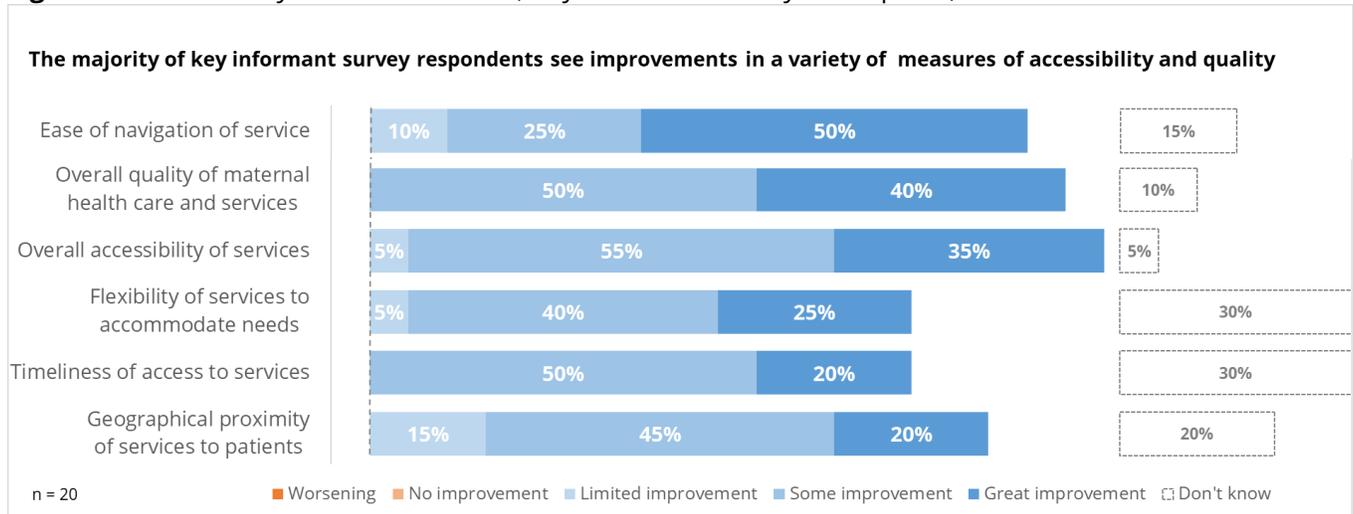
**The project supported connection to existing health services and programming by supporting outreach and navigation, providing and facilitating transportation, and undertaking efforts to increase the availability of midwives and doulas on northern Vancouver Island. The project is seen as supporting women to receive prenatal care and is attempting to reduce low acuity emergency department visits by supporting access and availability of alternative supports (e.g., health coaches and midwives). More recently, the project has developed contracts with two midwives, which has supported greater geographical access to services as well as greater availability and accommodation of services with after-hour supports and flexible service delivery locations. The project also conducted training sessions to train more local doulas.**



**Figure 15:** Highway 19, just north of Sayward, BC. This is the view women see on their way south to Campbell River from northern Vancouver Island to deliver their babies and/or attend specialist care.

Evaluation findings reveal the project has successfully increased access to existing care and services through outreach, navigation and transportation services. Key informant survey participants saw improvement in the ease of navigation of services, overall quality of maternal health care services, and overall accessibility of services (see Figure 16 below). Key informant survey participants reported less improvement to the flexibility of services to accommodate needs, timeliness and geographical proximity of services.

**Figure 16:** Accessibility of Health Services, Key Informant Survey Participants, Summer 2018.



Most women interviewed as part of this evaluation were already connected to a primary care provider. Project staff supported access to existing agencies, clinicians and supports by sending reminders, providing transportation, strategizing around prenatal care needs or helping drop off and pick up prescription medication. These navigation services were identified by both clinicians and women as being valuable.

*"I'm not one to go and ask for lots of help so even if it's just there it was really nice to have it without having to search for it." Mother*

The mobile nature of the team allows staff to meet clients where they are at, to follow-up with families in ways that clinicians tied to a particular agency or physical location cannot, and to support families that do not typically attend or reach out to other programs or services.

There was a perception shared by local clinicians that the local emergency department is sometimes used by families to access services that could be better served in a primary care setting. The Kwakwaka'wakw Project is hoping to reduce low acuity emergency department visits through the increased availability of additional health care supports such as the health coaches and midwives, thereby providing more seamless and culturally safe care. One mother indicated that the availability and reassurances of her midwife helped to alleviate her fears and helped avoid one such trip to the local emergency department.

The project has supported women's access to midwives and doulas, in alignment with the original project proposal and as driven by family requests. As no midwives were practising on northern Vancouver Island prior to 2018, the Kwakwaka'wakw Project supported funding applications for one mother to travel for monthly midwife appointments in Campbell River and supported another mother's referral to a local midwife while awaiting the birth of her child in a southern referral site.

## 6.5 Transformation and Sustainability of Maternity Care Services

**The Kwakwaka'wakw Project has undertaken efforts to increase the sustainability of maternity services on northern Vancouver Island. The Kwakwaka'wakw Project and a concurrent research study (the Building Blocks to Sustainable Rural Maternity Care: The North Island Project) have supported efforts to this end, principally through the establishment of midwifery services and consistent efforts to bring together the partners necessary for the development of strong interprofessional maternity care teams and increased provider confidence for local births.**

The majority of key informant survey participants observed some project contributions to the sustainability of maternal health services on northern Vancouver Island, although they indicated there is still work to be done. For example, the JPB project funding provides top-up to support a financially viable midwifery practice on northern Vancouver Island. In smaller communities, however, it can be challenging for midwifery practices to develop financially viable practices due to the intermittent and relatively fewer number of births.

The Kwakwaka'wakw Project was deemed by key informants to have brought together the partners necessary for developing strong interprofessional maternity care teams and increasing provider confidence for local births. Key partners for these discussions include Island Health Midwifery and Geo 1 executive leads; the Divisions of Family Practice Remote and Rural Campbell River and District; clinicians based out of the Campbell River Maternity Clinic, Port Hardy and Port McNeill; and the research team at the UBC Centre for Rural Health Research Building Blocks to Sustainable Rural Maternity Care: The North Island Project. This latter project, in particular, was credited by Kwakwaka'wakw key informants as having been an important avenue for maintaining a spotlight on the sustainability of rural maternity services.

### **Update as of November 2020:**

- The project is currently supported by two midwives: the first was recruited in early 2018 and the second started in August 2020. The presence of a second midwife is important to support the sustainability of the model, including support for coverage, outreach and leaves.
- In FY2019/20 and FY2020/21, project funding was provided to Island Health for nursing and other education. This included funding for programs such as the neonatal resuscitation and acute care of the at-risk newborn; perinatal nursing courses for local registered nurses at British Columbia Institute of Technology; and travel and wage costs for nurses to participate in more births at referral centres.

## 6. Conclusions and Recommendations

### 7.1 Conclusions

The conclusions arising from the evaluation are as follows:

#### Implementation and Fidelity

- The project has recruited staff and midwives, procured office space and technical infrastructure, established processes and policies, and developed relationships with key partners. Clients are receiving services in the Port Hardy and Campbell River areas and increasingly in outlying First Nations communities. Key facilitators to the successful project implementation include the existence of the Steering Committee, the approach and expertise of project staff, the early availability of a senior Island Health champion, the project's early emphasis on training/relationship building, and the availability of sessional payments for clinician engagement.
- Challenges to implementation included delays in the FNHA hiring processes, difficulty attracting candidates for the registered nurse team lead position due to incompatible collective agreements, the complexity of navigating and transforming models of care across multiple organizations where some partner groups may be reticent to change, and challenges with respect to administrative supports for the contracted midwife positions. A fragmented approach to electronic charting of patient records and a lack of technical supports also presented implementation challenges.
- Some aspects of the Kwakwaka'wakw Project had varied or evolved from the original design, most notably the shift in the leadership role from a registered nurse position, to a role split between two midwives to the current arrangement of team leadership overseen by the original project manager. Although two midwives were successfully contracted, constraints over the extent of leadership functions for contracted positions precluded them from having any leadership role or administrative support. Therefore, the overall leadership of the project remains with the original project manager, funded through the FNHA Vancouver Island regional envelope.
- As a consequence of delayed implementation of the service delivery model, particularly with regards to staffing, the Kwakwaka'wakw Project operated with a significant unused amount of its allocated project funding. This finding is not unique to the Kwakwaka'wakw Project as similar findings were found in provincial-level analyses of other JPB projects. This may suggest the need for more guidance and support of strategic efforts to increase staffing, guidelines around the use of project funds and carry-forward dollars (particularly with respect to supporting client-centred service delivery and traditional practitioners) and/or re-profiling of annualized budgets for JPB projects.

## Delivery

- Initially, the number of clients and the number of visits per client was below the annual targets envisioned for the project; however, these numbers have been increasing and can be partially attributed to the co-location and open-door policy of the midwife practitioners.
- The project is integrating a number of its guiding principles into the way it approaches and prioritizes its work, most notably in providing women- and family-centred care, providing culturally safe services, collaborating with a team-based approach and providing services closer to home. There was very little feedback on the integration of harm reduction and trauma-informed care principles into project services.
- Women are often referred to the Kwakwaka'wakw Project with immediate and specific needs relating to transportation and health system navigation. These navigation supports and services, though valued, come at the cost of other programming elements that the staff could be emphasizing/supporting, such as lifestyle and cultural supports.
- A number of challenges to the current FNHB medical transportation benefit were identified, including a lack of flexibility for changing travel plans and the challenge of paying upfront for travel costs. The flexibility and complexity of the FNHB medical transportation benefit processes and policies were raised as consistent barriers by project staff, families, clinicians and key informant survey participants.
- Cultural safety and humility are embedded in project documents and a key consideration of the services and supports offered to clients. The use of midwives and doulas was identified by women as being particularly effective in facilitating cultural safety during birth and incorporating traditional ceremony. Opportunities to increase cultural safety and humility include ensuring all clinical staff are trained in cultural safety and humility, and that opportunities exist to support relational practice experiences with, and in, First Nations communities.
- Keeping all partners and clinicians informed of relevant clinical and social information when working across multiple providers and settings is a challenge, particularly with a fragmented system of patient records and large geographical distances. There is a need to balance privacy with information relevant for culturally safe and family-centred care.
- Increased supports relating to traditional cultural practices during pregnancy, birth and parenting were of interest to families, as was programming, resources and supports geared towards fathers.

## Performance Results

- Although sufficient data was not available to assess the impact of the project on increasing the number of deliveries on northern Vancouver Island and supporting the intended result

of bringing births closer to home, recent reporting indicates that midwives are supporting local hospital deliveries. There has been improved understanding of the benefits of local births, an increased ability of women to make an informed choice on place of birth, and greater capacity of providers to accommodate women's place of birth preferences even though there remain limitations in terms of available local services.

- Supports to health and wellness, particularly relating to emotional wellness and reduction of stress through staff outreach and practical supports, were reported by client families. Quantitative measures of health and wellness outcomes of the project, such as the increased rate of healthy birth weights, were not available. Increased health literacy, another project outcome, was often reported as being supported by other clinical and programming supports rather than the Kwakwaka'wakw Project. Efforts are being made by project staff and health system partners to support and maintain family unity, which are anecdotally perceived to be reducing the number of children removed from their families at birth.
- Women served by the project were already connected to a primary care provider, but the project increased accessibility to existing health services and programming by supporting outreach, navigation and transportation. The project also worked to increase the availability of midwives and doulas.
- The Kwakwaka'wakw Project has undertaken efforts to increase the sustainability of maternity services on northern Vancouver Island. The project, and a concurrent research study, have supported efforts to this end, principally by establishing midwifery services and consistent efforts to bring together the people necessary for the development of strong interprofessional maternity care teams and increased provider confidence for local births.

## 7.2 Recommendations

The recommendations arising from the evaluation are as follows:

**6. The FNHA should examine the systematic challenges and barriers within JPB projects, including those challenges and barriers that have resulted in high levels of unused project funds.**

- 6.1. Explore and find innovative approaches to improve recruitment of staff for all JPB projects where needed.
- 6.2. Provide guidance to the project regarding the use of project funds and carry-forward dollars, particularly with respect to supporting client-centred service delivery and traditional practitioners.

**7. The FNHA should address identified FNHB medical transportation benefit challenges.**

- 7.1. Increase flexibility for clients who need to change travel plans or have urgent travel needs, identify alternative processes for those with difficulty paying upfront costs and clients without identification cards/bank accounts, and ensure reimbursements are paid on time and, in some instances, increase the frequency of direct deposit for meal allowances.
- 7.2. Continue to support knowledge translation activities and resources to support greater understanding of the FNHA medical transportation benefit processes and procedures.

**8. The Kwakwaka'wakw Project and its partners should continue to navigate and transform models of care across multiple organizations.**

- 8.1. Bring together partners every two to three years to review the vision, current status and environmental shifts of the project.
- 8.2. Support linkages between project staff and senior FNHA leaders and health authority leaders to navigate the complex interprofessional conversations and health system change and transformation.
- 8.3. Put in place a long-term electronic medical records solution with sufficient technical support to replace the numerous electronic charting systems currently in place.
- 8.4. Explore the potential of telehealth services as an ongoing service delivery mechanism to further expand the geographical reach of project services.

**9. The Kwakwaka'wakw Project and its partners should strengthen information sharing among clinicians and support the integration of cultural safety and humility, and traditional and cultural practices, in the health system.**

- 9.1. Develop training and resources that support appropriate circle of care information sharing among clinicians serving the families of the Kwakwaka'wakw Project.
- 9.2. Ensure that all acute care and community providers serving Kwakwaka'wakw Project families complete cultural safety and humility training.
- 9.3. Consider increasing the availability of midwives and doulas.
- 9.4. Create and support opportunities for acute care and community providers to participate in

relational, practical experiences with First Nations communities on northern Vancouver Island, including exposure to the traditional and cultural practices of communities.

9.5. Support further development of traditional cultural supports, programming and resources during pregnancy, birth and early parenting, including supports for fathers.

**10. The Kwakwaka'wakw Project should implement a performance monitoring process.**

10.1. Develop performance monitoring processes and tools to monitor the project's efficiency and effectiveness. This could include data on the number of deliveries on northern Vancouver Island, gestational age at first enrolment with the project, and quantitative measures of health and wellness outcomes as a result of the project, potentially through analysis of the Perinatal Services BC Data Repository data.

## Appendix A: Region Demographics

**Table 6:** Population Counts of Women in Northern Vancouver Island Urban Centres and First Nations Communities, 2016

| Community name                                   | Statistics Canada 2016 Census  |                                    |                                  |  |                    |
|--|--|------------------------------------|----------------------------------|--|--------------------|
|  | Total pop.   | Registered or Treaty Indian Status |                                  | Indigenous/Aboriginal Identity <sup>29</sup> |                    |
|  |  | Total pop.                         | Females aged 15-54 <sup>30</sup> | Total pop.                                   | Females aged 15-54 |
| Campbell River <sup>31</sup>                     | 31,960   | 1,810                              | 590                              | 3,675  | 1,045              |
| Port Hardy                                       | 4,075  | 740                                | 185                              | 1,050  | 280                |
| Namgis (Alert Bay)                               | 450  | 440                                | 95                               | 440  | 95                 |
| Gwa'sala-Nakwaxda'xw                             | 430  | 420                                | 105                              | 425  | 110                |
| Campbell River (Reserve)                         | 360  | 300                                | 75                               | 310  | 75                 |
| Port McNeill                                     | 2,330  | 105                                | 30                               | 265  | 60                 |
| Quatsino   | 220  | 210                                | 65                               | 210  | 65                 |
| Kwakiutl (Fort Rupert)                           | 250  | 235                                | 60                               | 245  | 65                 |
| Ka:'yu:'k't'h'/Che:k:tles7et'h'<br>' (Kyoquot)   | 180  | 180                                | 50                               | 180  | 50                 |
| Mowachaht/Muchalaht                              | 195  | 195                                | 35                               | 195  | 35                 |
| Ehatteshaht                                      | 85   | 85                                 | 25                               | 85   | 30                 |
| Dzawada'enuxw<br>(Tsawataineuk) (Kingcome Inlet) | 75   | 75                                 | 20                               | 75   | 20                 |
| Gold River                                       | 1,205  | 55                                 | 15                               | 100  | 35                 |
| Zeballos   | 100  | 20                                 | 10                               | 20   | 10                 |
| Tahsis   | 215  | 0                                  | 0                                | 10   | 0                  |
| Kwikwasut'inuxw<br>Haxwa'mis (Gilford Island)    | Census population data not available, but population figures are available through Crown-Indigenous Relations and Northern Affairs Canada, First Nations Community Profiles: Available from: <a href="https://fnppn.aadnc-aandc.gc.ca/fnp/Main/Search/SearchFN.aspx?lang=eng">https://fnppn.aadnc-aandc.gc.ca/fnp/Main/Search/SearchFN.aspx?lang=eng</a> . |                                    |                                  |  |                    |
| Tlatlasikwala                                    |  |                                    |                                  |  |                    |
| Nuchatlaht                                       |  |                                    |                                  |  |                    |
| Da'naxda'xw (formerly Tanakteuk)                 |  |                                    |                                  |  |                    |
| Mamalilikulla-Qwe-Qwa'Sot'Em                     |  |                                    |                                  |  |                    |
| Gwawenuk Tribe (Hopetown)                        |  |                                    |                                  |  |                    |

<sup>29</sup> Indigenous/Aboriginal Identity populations include Registered or Treaty Indian Status populations.

<sup>30</sup> Women of child-bearing age are typically 15-49. Available Statistics Canada data is for ages 15-54, so population counts presented are higher than the actual count of child-bearing aged women.

<sup>31</sup> Campbell River is not technically part of the Mount Waddington geographical region, but some project services are provided in Campbell River.

|                 |  |
|-----------------|--|
| Tlowitsis Tribe |  |
|-----------------|--|

| <i>Total Population Counts of Women (15-54) where census information available in Northern Vancouver Island Urban Centres and First Nations Communities, 2016</i> | <b>First Nation women with Indian status</b> | <b>Women with Indigenous / Aboriginal identity</b> |
|---|--|--|
| Number (per cent) of women (15-54) age living <i>in-community</i>   | 530 (39%)                                    | 545 (28%)  |
| Number (per cent) of women (15-54) living in urban areas  | 830 (61%)                                    | 1,430 (72%)  |
| <b>Total</b>  | <b>1,463</b>                                 | <b>1,975</b>                                       |

Source: Statistics Canada 2016 Census. Available from: <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/index.cfm?Lang=E>

Urban areas are highlighted in blue.

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