

# FRASER SALISH PARTNERSHIP ACCORD EVALUATION REPORT



First Nations Health Authority  
Health through wellness



First Nations  
Health Council

September 2019

## Acknowledgements

The evaluation working group would like to acknowledge the ancestral, traditional and unceded territory of the Coast Salish nations, and each of the 32 communities within the Fraser –Salish region.

We would like to thank everyone who participated in the evaluation and generously donated their time through key informant interviews, focus groups, or participating in the survey. Specifically, we would like to thank the Aboriginal Health Steering Committee for their direction and guidance throughout the process, Fraser Salish community representatives for the insights they shared during Caucus, the FNHDA for providing time during their meeting to share their experiences. These groups collectively enabled the evaluation to proceed.

Kw'as ho:y (Halq'eméylem) Huy ch q'u (Hen'q'emi'ne'm); Kwukwstéyp (Nlaka'ux); HísW̱ke (Senæøten)  
Thank you

## Developments since the completion of data collection

A number of pertinent developments have occurred since the completion of data completion and the composition of the evaluation report relating to the evaluation findings and recommendations.

- Fraser Health signed a Letter of Understanding with Métis Nation BC in June 2019. This addresses the evaluation recommendation to clarify the relationship with MNBC either as part of a renewed partnership accord or in a separate document;
- Fraser Health Authority, First Nations Health Authority, and Fraser Region First Nations Health Council representatives held a joint planning meeting in August 2019 to inform a Joint Action Plan and the renewal of the Partnership Accord;
- Discussions are underway pertaining to the creation of a renewed Regional Health and Wellness Plan; and
- Fraser Health is currently in the process of refreshing the Cultural Safety Framework for 2019-2023. This evaluation is being used to inform the Recommended Actions included in the framework.

## Executive summary

### **Purpose**

The purpose of this evaluation is to assess progress since signing the Fraser Salish Partnership Accord in 2011 and to provide context and considerations prior to signing a new accord. Collectively, the five Regional Partnership Accord evaluations form part of the commitment to evaluate the Tripartite Framework Agreement on First Nation Health Governance (FA) that will be completed in October 2019. The PAs will inform the FA evaluation in terms of (1) governance, tripartite relationships and integration, (2) health and wellness system transformation and (3) health and wellness outcomes.

### **Evaluation Objectives**

The objective of the Fraser Salish Partnership Accord evaluation is to examine the relationship between Fraser Health Authority and Fraser Salish First Nations since the signing of the PA in 2011, as well as their relationship with the FNHA since its establishment in 2013. Specifically, the evaluation explored:

- Satisfaction with the regional structures in the Fraser Salish Region;
- How relationships have evolved as a result of the Partnership Accord;
- Fraser Salish First Nations' involvement in decision-making related to the planning, design, management and delivery of health services;
- Changes in the integration and coordination of services; and
- The quality and accessibility of health services accessed by First Nations

### **Methodology**

The evaluation methodology was co-created through a collaborative and participatory process led by an evaluation working group composed of FNHA and FHA staff. The working group reported to the Aboriginal Health Steering Committee throughout the evaluation. The evaluation utilizes multiple lines of evidence including both primary data sources (interviews, focus groups and a survey) and secondary data sources (document and file review). The evaluation included semi-structured interviews with key informants, three focus groups, and a document/administrative review.

## Acronyms

<b>Term</b>	<b>Acronym</b>
Aboriginal Health Operations Committee	AHOC
Aboriginal Health Steering Committee	AHSC
Aboriginal Wellness Advisory Committee	AWAC
First Nations Health Authority	FNHA
First Nations Health Council	FNHC
First Nations Health Directors Association	FNHDA
First Nations Perspective on Health and Wellness	FNPOHW
Fraser Health Authority	FHA
Fraser Salish Partnership Accord	PA
Health Service Organization	HSO
Ministry of Children and Family Development	MCFD
Royal Canadian Mounted Police	RCMP

### Note on the use of language

This report uses the term “in community” to refer to individuals and services “on-reserve” and “away from home” to refer to Indigenous persons living “off-reserve.”

## Summary of key findings and recommendations

Note that as part of creating a collaborative and participant driven evaluation, only recommendations provided by participants are included. Areas without recommendations mean participants did not provide recommendations.

### Evolution and transformation

Relationship-building has been a steady and ongoing process, which has resulted in strong relationships between the First Nations Health Council, Fraser Health Authority and the First Nations Health Authority. There are regular Aboriginal Health Steering Committee (AHSC) meetings, which include FNHC representatives, the CEOs and other executives from both Fraser Health Authority (FHA) and First Nations Health Authority (FNHA). A greater understanding of shared goals around health is being achieved as partners learn from each other about roles and responsibilities, and how to work optimally with one another. Despite turnover at all levels, all partners remain committed to the work. Evaluation participants perceive the need to refresh the Partnership Accord (PA) and engage in further discussion on how to improve health outcomes; central to this discussion will be the consideration of local- level contexts and associated needs.

### Recommendations

- Refresh the PA and engage in further discussion on how to improve health outcomes while taking local- level context and associated needs into consideration

### Fraser Salish Structure

The right people are sitting at the table, and that the partners understand PA commitments and goals. Evaluation participants regarded the creation of a regional structure as one of the greatest achievements of the PA. Understanding the goals of the PA varies as a function of members' length of tenure and participation and connection to the work. There is an opportunity to improve and sustain staff continuity and participation across multiple levels of the structure to enhance collective understanding and performance. Partnership Accord work is at times hampered by competing priorities, scheduling challenges, and lack of available staff and staff turnover.

Community representatives noted they had less involvement in the structure, and expressed a need for an opportunity to collaborate and communicate on a more regular basis.

The working groups are an effective structures for moving priority work forward. To improve their efficacy, it was also suggested their membership be further clarified.

### Recommendations

- Consider means to improve and sustain continuity and participation across multiple levels of the structure, including AHSC;
- Finalize a Terms of Reference for AHOC;
- Improve the efficacy of the working groups by clarifying membership; and
- Ensure the roles of the committees and working groups are clear (AHSC, AHOC, Aboriginal Wellness Advisory Committees (AWAC), working groups, and the First Nations Health Directors Association (FNHDA).

## Relationships

Key informants shared one of the greatest achievements of the PA is the formation and strengthening of relationships amongst partners. There is a sincere commitment to the relationships being built through the PA, and to the work that is being undertaken. Relationship -building has been fostered through a number of avenues including Caucus, the regionalization process within the FNHA and the appointment of an FNHC representative to the FHA Board of Directors. FHA/FNHA employee turnover and FNHA organizational growth impacted relationship building but did not undermine the strength and commitment to working together.

## Communication

The structure has improved communication between FHA, FNHA and Fraser Salish First Nations. There is open communication between FNHA, FNHC and FHA at AHSC. Direct communication has also increased between Fraser Health and Fraser Salish First Nation communities. Community representatives identified communication between themselves and Fraser Health relies on informal pathways such as FNHC members, or direct relationships with Fraser Health staff, which can be disrupted and leave gaps during turnover.

## Recommendations

- Develop a more effective and concise onboarding and orientation package to communicate the goals of the PA;
- Improve circulation of information and data sharing more generally;
- Increase opportunities for engagement with First Nations at more frequent intervals at a sub-regional<sup>1</sup> or technical levels; and
- Clarify communication channels between Fraser Health and communities by sharing a contact list, and/or outline the structure of the Aboriginal Health department, including a description of roles and how they interact with communities.

## Engagement

There is a greater understanding of the importance of engagement, as well as enhanced clarity concerning engagement pathways. Fraser Salish First Nations communities are now playing a greater role in the design and delivery of programs and services, and are being engaged in discussions more regularly on how to improve FNHA / FHA health services in the region. Moving forward, engagement with Fraser Salish Region First Nations communities could be improved by expanding the time provided for engagement in order to understand unmet needs program design.

## Recommendations

- Increase the amount of time for engagement, including during the design and follow up;
- More flexibility for FHA staff to go into community and Aboriginal urban agencies in order to attend meetings and events;
- Increase opportunities for engagement with First Nations at a sub-regional or technical levels at more frequent intervals;

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<sup>1</sup> Sub regional refers to engaging with communities in smaller groups outside of Caucus, defined by geographic or political organization. For example engaging with communities comprising Stó:lō Nation, Stó:lō Tribal Council and Independent Communities, or communities located in Fraser North, Fraser North, East/North East.

- Create tools to guide the engagement process;
- FHA holding strategic annual or quarterly meetings with communities in order to have a set opportunity for engagement;
- FHA/FNHA work collaboratively to minimize potential for duplication of engagement with communities;
- Employing tools for soliciting feedback from Aboriginal Patient Navigators / Community Engagement Coordinators in an effort to reduce engagement burden;
- Include Métis Nation BC in engagement; and
- Identify an individual within each Fraser Health department to liaise with communities and urban populations to support awareness, knowledge, and understanding of First Nations among decision-makers.

### **Collaboration and partnership**

There is a commitment to collaboration at a service delivery level between FHA and FNHA. The expansion of the FNHA regional office was identified as a key facilitator to collaboration, as there is more FNHA capacity to engage with FHA, and to support community engagement. The size of FHA, and turnover in both FHA and FNHA were identified as barriers to collaboration and partnership.

### **Recommendations**

- Establish more precise targets to drive progress; and
- Clarify and increase the awareness of the role of the FNHA amongst communities.

### **Reciprocal Accountability**

The partners operate in the spirit of reciprocal accountability with AHSC/AHOC members perceiving that it has been well articulated in documents. Relationship-building efforts have led to the gradual integration of reciprocal accountability in practice; still, it was acknowledged that this is not necessarily because of the commitment to reciprocal accountability as articulated in the PA. On occasion, there has been a need for partners at the AHSC/AHOC level to remind each other about the principle of reciprocal accountability.

### **Integration and coordination**

Coordination and integration of services is increasing, exemplified by further alignment of service delivery in order to be more complimentary of each other's and communities' programs, in addition to shared initiatives such as Riverstone and Indigenous Primary Health and Wellness Home. Findings indicated that integration and coordination was enabled by the joint asset mapping program, FHA and FNHA's willingness to provide financial support; and FHA departments becoming more flexible with allowing staff to get out of the office and engage directly with communities. Data governance and patient information sharing between FHA/FNHA and communities was identified as a barrier to further coordination and integration of services, as processes are unclear and there is a lack of capacity to engage on the topic. This barrier is outside of what can be addressed by AHSC/AHOC, with the potential to be addressed at provincial level with the Tripartite Committee on First Nations Health.

### **Recommendations**

- Increasing awareness of services offered by communities, and how FHA could compliment them.



### **Cultural Safety and Humility and First Nations Perspectives on Health and Wellness**

The partners have made significant efforts related to cultural safety improvements. They also shared that there has been a growth in awareness and knowledge of cultural safety issues and a growing interest in cultural safety overall across Fraser Health. The difficulty in delivering San'yas training due to the size of FHA, human and financial resources, as well as the nature and context of care were all listed as barriers to furthering cultural safety and humility among others.

Efforts to promote cultural safety and humility include the establishment of the Cultural Safety and Humility Working Group, Aboriginal Wellness Advisory Committees, the creation of a program-specific, organization wide cultural safety framework across FHA, ongoing cultural safety and humility education, changes to the complaints process, the establishment of the Elders in Residence Program, and hiring a Coordinator for Cultural Safety among others.

#### **Recommendations**

- FHA leadership to continue supporting and championing cultural safety to foster a culture of cultural safety and humility across the organization;
- Increase awareness around Indigenous cultures, specific to the region, including language groups, Nations, and spiritual practices among Fraser Health staff;
- Further consultations with First Nations regarding the hiring of individuals for roles that require traditional knowledge;
- Hire more self-identifying Indigenous staff at FHA;
- Invite FHA staff to community to come together in ceremony or for meals; and
- Engage with communities on the Cultural Safety Framework.

### **First Nations Perspective on Health and Wellness (FNPOHW)**

Work has also started on integrating First Nations perspectives on health and wellness into services, exemplified by establishing an Elder in residence position, establishing ventilated rooms for smudging, and including drumming sessions and art displays. Incorporating the First Nations Perspective on Health and Wellness (FNPOHW) is “at the core” of the work being done with between FNHA and FHA, particularly in shared or jointly funded positions.

#### **Recommendations**

- Expand the number of Elders-in-Residence to include traditional healing;
- FHA departments to set aside funds to provide honorariums for community members to open and participate in meetings;
- A shift towards “two eyed seeing” (inclusion of both Indigenous and Western practices);
- Creating more welcoming spaces by including First Nation art and languages in FHA facilities;
- Inclusion the Truth and Reconciliation Commission Calls to Action in the revised accord.

### **Quality**

The quality of services available to First Nations, particularly in terms of their accessibility and cultural safety, have improved. However, the lack of any ethnicity data prevents measuring changes in quality (accessibility or outcomes) for Indigenous clients with certainty.

## Recommendations

- Involving more individuals from community in the provision of community services, and
- Ensuring staff operating in community are culturally safe.

## Accessibility

There is an increased availability of community-based services being offered to First Nations in the Fraser Salish region, including mobile detox program and Nurse Practitioner services. These new services are complemented by FNHA Wellness System Navigators and FHA Aboriginal-Health Liaisons, who help identify existing services for members. AHSC has established a number of initiatives, most notably the Indigenous Primary Health and Wellness Home, in order to provide a culturally safe wraparound care model in Fraser South.

A number of ongoing barriers to accessing care were identified, including: homelessness, transportation, patient information sharing, ongoing service gaps, and jurisdictional uncertainty between Fraser Health and FNHA, for away-from-home populations. This is in addition to community members who are hesitant to access services or self-identify due to fear of prejudice and differential treatment.

## Resources

Resource sharing has improved since the signing of the PA, and noted that there is still room for improvement moving forward. FNHA/FHA operational staff perceive a need for greater human resources in the areas of Community Nurse Practitioners and acute care.

## Additional Recommendations

- Move to single agreement between FNHA-FHA-FNHC, as presently there is one between Fraser Salish Caucus and FHA (the PA) and another between FNHA and FHA (Document of Intent);
- Consideration of local-level contexts in any further adjustments to the PA;
- Create greater understanding and awareness of the PA regionally, as well as how to work together more efficiently;
- Ensure Indigenous wellness is reflected in the language and priorities of the PA;
- Identify and outline parameters of the PA concerning urban populations and Métis people<sup>2</sup>;
- Include the Ministry of Children and Family Development in the PA; and
- Include procurement opportunities for First Nations in the PA as part of the social determinants of health.

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<sup>2</sup> Fraser Health and Métis Nation British Columbia signed a Letter of Understanding (LOU) on June 25th, 2019

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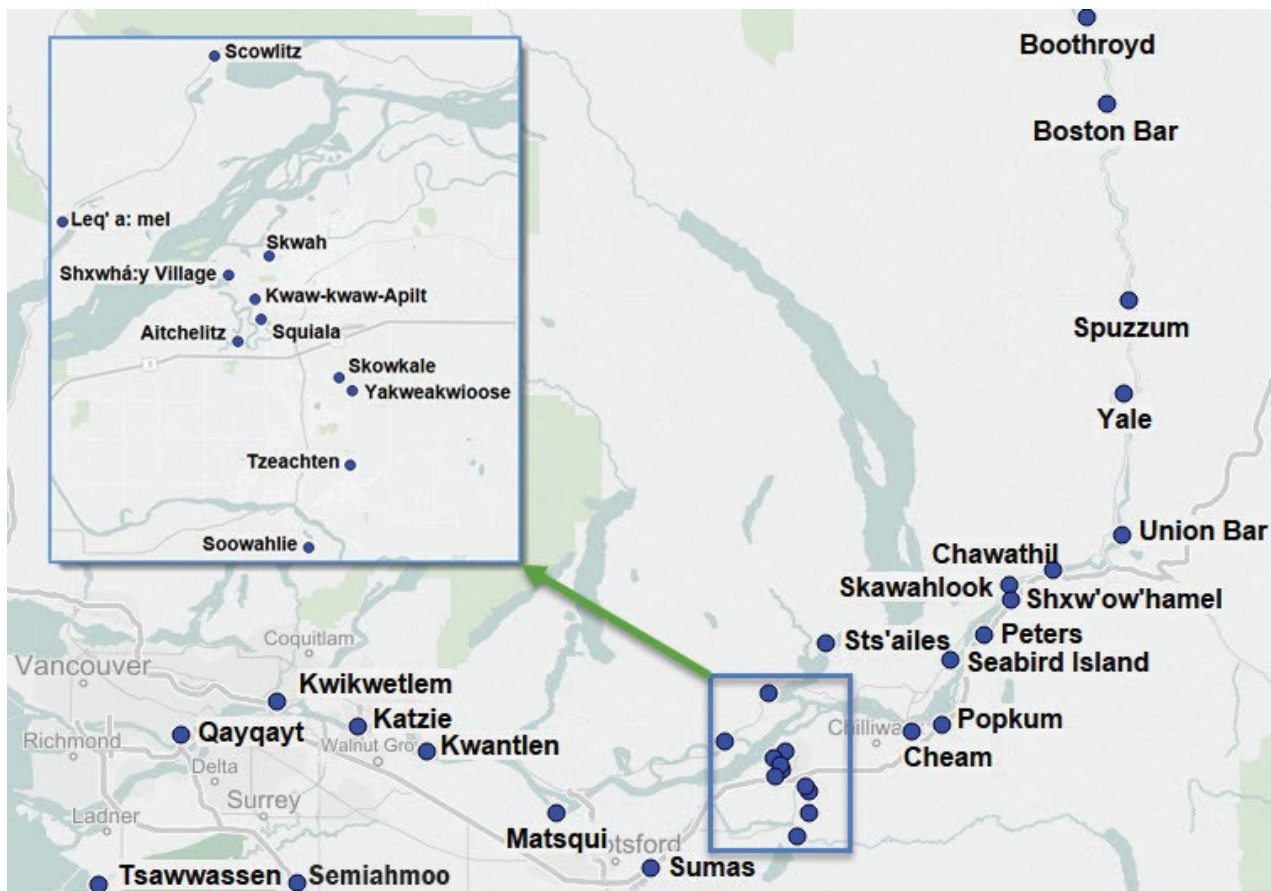
## Purpose

The purpose of this evaluation is to assess progress since the signing of the PA in 2011 and inform considerations for the signing of a new accord. The Regional Partnership Accord evaluations also form part of the commitment to evaluate the Tripartite Framework Agreement on First Nation Health Governance (FA) that will be completed in October 2019. The PAs will inform the FA evaluation in terms of (1) governance, tripartite relationships and integration, (2) health and wellness system transformation and (3) health and wellness outcomes.

## Fraser Salish Regional Structure

Fraser Salish First Nations are organized into three distinct groups Stó:lō Nation, Stó:lō Tribal Council, and Independent Communities that are served by 13 Health Centers across three geographical sub-regions: (1) east / north east; (2) north; and (3) south. Taken together, these represent 32 First Nation Communities, each at a different stage of development and characterized by unique strengths, needs, and approaches to health care.

**Figure 1: Regional Map**



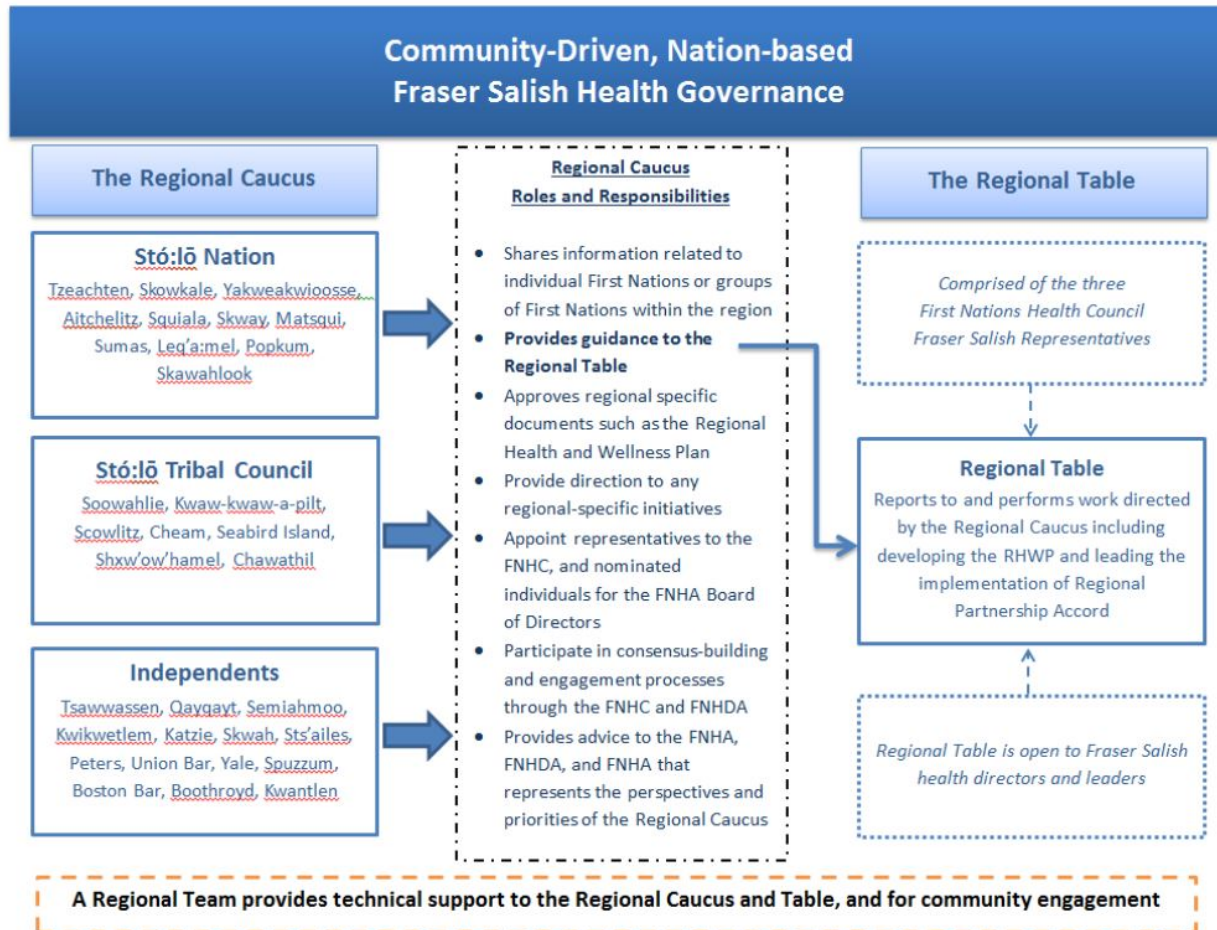
The following bodies and organizations compose the Fraser Salish structure:

- Fraser Salish Regional Caucus;
- Fraser Salish Regional Working Groups;
- Aboriginal Health Steering Committee (AHSC);
- Aboriginal Health Operations Committee (AHOC);
- Fraser Health Authority (FHA); and
- First Nation Health Authority (FNHA).

## Fraser Salish Regional Caucus

First Nations within each sub-region appoint representatives to the Fraser Salish Regional Caucus Table and select three (3) representatives from the 32-member table to sit at the provincial level FNHC table. There is one FNHC representative for Stó:lō Nation, Stó:lō Tribal Council, and Independent communities, listed below in figure 2.

**Figure 2: Caucus Structure for Fraser Salish Region**



**Note:** Retrieved December 9, 2018 at [http://www.fnha.ca/Documents/FNHA-Fraser Salish-Regional-Health-and-Wellness-Plan.pdf](http://www.fnha.ca/Documents/FNHA-Fraser%20Salish-Regional-Health-and-Wellness-Plan.pdf).

Caucus represents an engagement forum for diverse political (Chiefs and council members) and technical leaders (Health Directors, health leads, nurse managers, band managers, health administrator, health leads) from across the region to regularly engage with each other on health-related planning, priority setting and decision-making. A primary role of Caucus is to provide advice to the FNHA, FNHDA, and FNHC concerning Caucus perspectives and priorities. As seen in Figure 2, Caucus also helps guide Fraser Salish Regional Table activities.<sup>3</sup>

<sup>3</sup> For more information please see [http://www.fnha.ca/about/regions/Fraser Salish](http://www.fnha.ca/about/regions/Fraser%20Salish), retrieved online February 1, 2019.



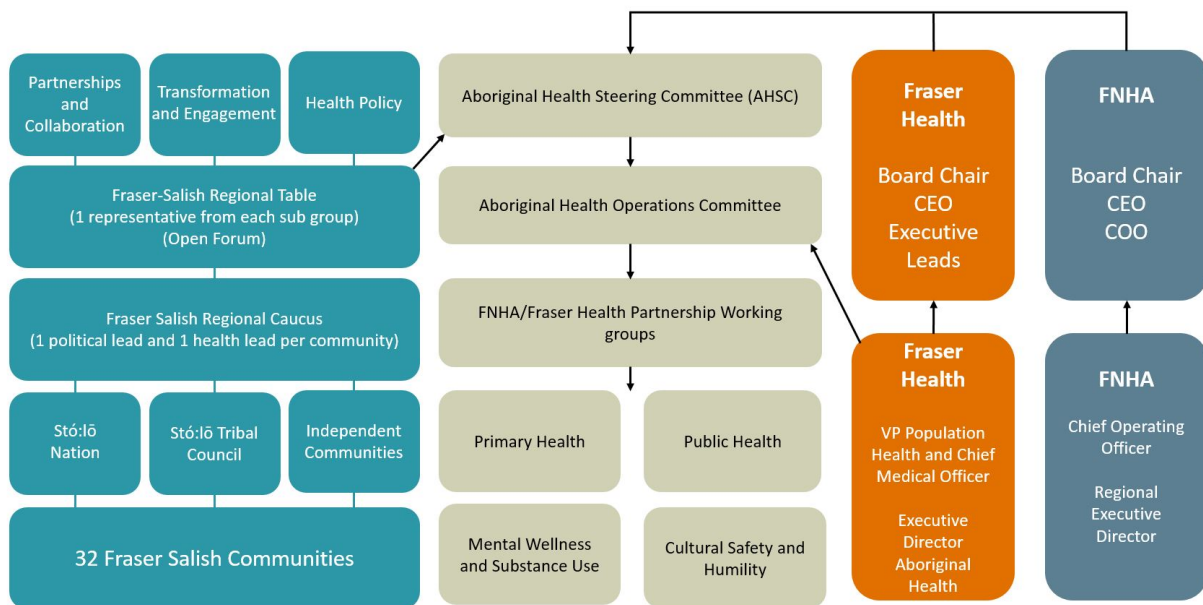
### Fraser Salish Working Groups

There are three working groups chaired by the FNHC: the Collaboration and Partnerships Working Group, Engagement and Transformation Working group and the ad hoc Health Policy working group. The working groups were established to ensure regional perspectives on health and wellness are taken into account and to guide the work being undertaken in the region under the direction of the Fraser Salish Regional Table. The working groups inform shared partnership planning processes with their FNHA and FHA partners in order to advance health and wellness priorities identified in the RHWP.

### Fraser Salish Regional Table

The Fraser Salish Regional Table (the Table) was established by Caucus and includes political (FNHC) and technical (FNHDA) representatives. The Table is a strategic working group for Caucus; it reports to, and performs work for Caucus, and directs the work of the Fraser Salish regional working groups. The Table is an open forum for community members, elders and other federal, provincial and non-profit partners to gather to discuss priorities and health-related matters of interest to the region. The Table is supported by the FHA and other partners as needed. The work undertaken by the Table feeds into the Aboriginal Health Steering Committee and contributes to the Fraser Salish Regional Health and Wellness Plan and Year in Review Report (see Figure 3).

**Figure 3: Fraser Salish Partnership Process**



### First Nations Health Council (FNHC)

The 32-member Regional Caucus appoints 3 representatives to the 15-member FNHC table. The 3 regional representatives provide leadership to regional caucus development and regional caucus meetings, reporting, and activities. They also work together to raise and discuss regional matters at appropriate regional and provincial levels and forums, including AHSC.

### **Aboriginal Health Steering Committee**

The Aboriginal Health Steering Committee is the primary table for addressing matters related to Aboriginal health in the Fraser Salish Region. The Committee meets quarterly, and is tasked with overseeing the implementation of the Fraser Salish PA. It is composed of the following members:

- Three Fraser Salish region FNHC members;
- FHA CEO and Chair of the Board of Directors of both the FHA and FNHA, FNHA Vice President of Programs and Services, VP Clinical Programs, Chief Medical Health Officer of Fraser Health; and
- Members of the Aboriginal Health Operational Committee (AHOC), which includes program leads from the FHA and FNHA.

### **Aboriginal Health Operations Committee**

The Aboriginal Health Operations Committee implements strategies and activities identified by the AHSC, and facilitates shared planning and decision-making at an operations level to improve service integration and delivery. The AHOC is co-chaired by the COO of FNHA and the FHA, VP Population and Public Health and Chief Medical Officer.

### **Partnership Working Groups**

Partnership Working Groups were established to support the development and implementation of regional work plans pursuant to the Regional Health and Wellness Plan in the following areas: Information Management / Information Technology, Public Health, Primary Health and Mental Health and Substance Use, and Cultural Safety and Humility.

### **Fraser Health Authority (FHA)**

The FHA is led by a government-appointed Board that sets strategic vision and direction for the region. The President and CEO maintains the overall responsibility for this work. Aboriginal Health programming is directly supported by VP Clinical Operations, Executive Director Primary Care and Aboriginal Health, and Executive Director, Aboriginal Health.<sup>4</sup>

### **First Nations Health Authority**

FNHA is the first and only province-wide First Nations health authority in Canada and is one of four component entities of the First Nations health governance structure established by BC First Nations leadership (the other entities being the First Nations Health Council, First Nations Health Directors Association, and the Tripartite Committee on First Nations Health). The FNHA is not a signatory to the Fraser Salish Partnership Accord, but is a member of both AHSC and AHOC and signed a Document of Intent with Fraser Health in July 2010.

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<sup>4</sup> For more information see <https://www.fraserhealth.ca/about-us/about-fraser-health>, retrieved online February 1, 2019.



## Methodology

A mixed methods approach was used for this evaluation. Executive leads from FHA and the FNHA regional office were invited by members of the Aboriginal Health Steering Committee (AHSC) in October 2017 to identify suitable working group members to support the evaluation and to discuss the evaluation process. After a meeting with the executives leads in February 2018, an evaluation working group was formed in March.

The evaluation was co-created through a collaborative and participatory process led by an evaluation working group composed of members of the FHA Aboriginal Health Team, the FNHA Fraser Salish Regional Team, and the FNHA Evaluation Team. Ference and Company Consulting Ltd. supported the evaluation by conducting key informant interviews with members of AHSC/AHOC as well as with FNHA and FHA operational staff.

The evaluation incorporated multiple lines of evidence including both primary data sources (interviews, focus groups and a survey) and secondary data sources (document and file review). The evaluation included semi-structured interviews, three focus groups in addition to a document/administrative review and an analysis of available health outcome data. Detailed numbers of participants can be found in the table below.

To ensure the integrity of the data, interviews were recorded then transcribed. The transcriptions were returned to key informants for validation. Ference and Co. then collated the findings in a technical report which was also shared back with AHSC/AHOC members for validation. To ensure inter-coder reliability, the original transcripts were reviewed by an additional two evaluators. Once data were coded, findings were synthesized across data sources and organized by participant group (the preferred unit of analysis for this evaluation). A draft report will be presented to evaluation participants to ensure accuracy before being finalized.

Decisions concerning the design of the evaluation were shared with members of the Aboriginal Health Steering Committee (AHSC) and Aboriginal Health Operational Committee (AHOC) during regularly scheduled meetings for input. Guidance was requested from Committee members on how to engage political and technical representatives for the evaluation, an approach that was later implemented by members of the evaluation working group (for example to hold self-directed discussions with community political and technical leaders during Caucus).

Health Systems Matrix (HSM) data is intended to be included when it becomes available. Patient Reported Experience Measures (PREMS) will be including pending approval by the Office of Patient-Centered Measurement.

Evaluation Timeline		
Event	Date	Purpose
Presentation to AHSC	October 3, 2017	Provided evaluation background, timeline, and context. Requested that AHSC nominate or select members to participate in an evaluation working group
Working group meeting	March 26, 2018	Initial working group meeting, discussed Fraser Region Structure and developed terms of reference
Update to AHOC	June 2018	Presentation of evaluation background, timeline, and approach as well as working group activities to date
Key Informant Interviews with AHSC/AHOC Members	August-September 2018	Conducted by Ference and Company to collect views and experiences on the regional structure, the efficacy of the governance tables and the PA from AHSC/AHOC members
Cultural Safety Working Group Focus Group	September 28, 2018	Data collection with Fraser Health staff, FNHA staff and Métis Nation BC related to cultural safety and humility in the Fraser Salish Region
Interviews with Fraser Region Operational Staff	October-November 2018	Conducted by Ference and Company, these interviews solicited input from Fraser Health and FNHA operational staff on regional change since the signing of the PA
Presentation to AHSC	November 9, 2018	FNHA provided an update to AHSC with activities to date, and requested guidance on how best to engage health directors and political leads. AHSC recommended attending Caucus in December 2018 to conduct table top exercises
Fraser Salish FNHDA Focus Group	November 22, 2018	Focus Group as part of regular Fraser Salish FNHDA meeting

Fraser Salish Caucus	December 10, 2018	A one-hour group discussion at Fraser Salish Caucus with community political and technical representatives (Chiefs, council members, nurse managers, band managers, health administrators, health leads)
Presentation to AHSC	February 15, 2019	Provided update on the status of the evaluation, discussed the release of the evaluation report and the cultural safety review by Lafontaine and associates, as well as survey distribution
Dissemination of Technical Report	March 4, 2019	Distribution of Technical Report with preliminary interview findings to AHSC for review
Presentation of preliminary findings to Collaboration and Partnership Working Group	May 7, 2019	Presented preliminary findings across all data sources to the Collaboration and Partnership Working Group, composed of FNHC, FNHDA and community representatives for validation
Presentation of findings and report to AHSC	June 7 2019	Presented report and findings to AHSC as part of scheduled meeting for review

Total Evaluation Participants, By Type		
Group	Number of Individuals Invited to Participate	Total Participants
AHSC/AHOC members	9	9
FNHA and FHA Operational Staff	12	9
Key informant Interviews with Health Directors	6	1
Survey of health technical representatives <sup>5</sup>	39	3
Cultural Safety Working Group Focus Group	17	8
FNHDA Focus Group	-	3
Community Political and Technical Representatives	All caucus attendees	29-31
Total	-	62-64 <sup>6</sup>

**Evaluation Strengths and Limitations**

The strengths of the current evaluation include the use of multiple lines of evidence to triangulate findings and increase data reliability, co-creation of data collection tools, validation of the transcriptions and findings with participants.

Sampling for focus groups and interviews was purposive, and not all those who were invited to participate did so. As such, results may not represent all views of AHSC/AHOC members, First Nations communities or individuals in the Fraser Salish Region or all FNHA or FNHA staff.

Evaluation participant groups (AHSC/AHOC, FHA/FNHA operational staff, community representatives, Cultural Safety and Humility focus group participants) were selected as the unit of analysis throughout the report in order to highlight converging and diverging experiences with the Partnership Accord based on role within the Fraser Salish structure. When the report refers to AHSC/AHOC member(s), that is to anonymize the respondent and does not mean the view is held by all members.

In addition, in order to limit potential bias on the summary of findings for this evaluation, this report will undergo iterative reviews, revisions, and drafts by the evaluation working group and validation sessions with AHSC, AHOC, and Caucus. Preliminary findings were presented to the Collaboration and Partnership Working Group for validation.

<sup>5</sup> Though there are 32 communities in the Fraser -Salish region, 39 Individuals were invited to participate, as it was distributed to community technical leads in health, including nurse managers, band managers, health administrator, health leads, and councilors as appropriate.

<sup>6</sup> Figure represents the total number of participants across each data collection streams. Due to the number of data collection methods, participants views may have been collected multiple times (for example participating in both Caucus discussions and the Fraser Salish Health Directors focus group)

## Findings - Partnership

### Evolution/ transformation

**PA efforts have continued to evolve since its establishment in 2011. The ongoing transformation can be credited to three main areas: relationships, collaboration, and performance. There are opportunities for a renewed PA to better reflect the current status of the partnership and associated work.**

Representatives from AHSC/AHOC and FNHA/FHA operational staff suggest that relationship-building has been a steady and ongoing process that has resulted in stronger relationships, referred to by one AHSC/AHOC representative as “tried, tested, true.” As these relationships have matured, partners have developed a rhythm for gathering together. Maturation of the relationship between the partners is exemplified by the work being completed at AHSC, where the FNHC representatives meet with both the FHA and FNHA CEOs and members of the respective Board of Directors and senior management to plan partnership work, discuss strategic direction and shared priorities, and identify next steps to improving health outcomes for First Nations and other Aboriginal people in the Fraser Salish region, both living in community and away from home.

There is the perception among AHSC/AHOC and FNHA/FHA operational groups that as partners learn from each other about roles and responsibilities and how to work optimally with one another, a greater understanding of shared goals around health is being achieved. As noted by one FNHA/FHA operational staff participant in the evaluation, “we are in this together and we are working together for the community.” A more focused and reciprocal approach to the work has also been realized over time as the work has evolved. There is the perception that a major achievement of the PA is that it has paved the way for partners to gain a gradual deeper-level understanding of PA commitments, regional structures (Ministry of Health / Health Authority), First Nations health, and how to address emerging priorities.

In terms of performance, the work of the PA has developed over time, as demonstrated by key health initiatives, including the allocation of the joint design and funding for the Indigenous Primary Health and Wellness Home, Population Asset mapping project, and Riverstone Mobile Detox project.

*We had no influence or no say in how to even identify what our priorities were, where our issues were, what we were dealing with on the ground. And they were dictated through Canada or BC. And they told us what our problems were, what the solutions were, and how to fix them. And resources and/or services flowed according to that... we still have the issues on the ground, but now we have the opportunity to change what we determine, at a higher level, are the issues. We have some say or influence to make sure that we are addressing the right things...that are identified by us as First Nations and/or even in the partnership. – FNHC/Caucus*

### **Despite turnover at all levels, partners remain committed to the work**

AHSC/AHOC and FNHA/FHA operational staff indicate that there is a commitment to working through ongoing challenges that have arisen since the signing of the PA. Ongoing staff turnover was flagged as a constraint to effective performance by AHSC/AHOC representatives; however, recent improvements in staffing continuity were noted. Staffing improvements were attributed in part to FNHA's organizational development, especially in the past few years. Representatives from AHSC/AHOC and FNHA/FHA operational staff identified the need to refresh the PA and engage in further discussions on how to improve health outcomes. Central to this discussion will be the consideration of local-level contexts and associated needs.

### **Indigenous Primary Health and Wellness Homes**

In October 2017, AHSC invested in two projects (1) "To establish an Indigenous Primary Health and Wellness Home that provides culturally safe integrated care for Indigenous People in Fraser South" with an estimated cost of \$1.2 – \$1.5 Million, and (2) "To improve Determinants of Health and Chronic Health Conditions using community development and community engagement to initiate, develop, coordinate and support community health and wellness initiatives," with an estimated cost of \$500,000 - \$800,000. In order to provide the greatest benefit to clients, AHSC commissioned a Population Asset Mapping exercise to identify existing services in the region and the best location for the new hub, leading to the decision to establish the home in Surrey.

The Indigenous Primary Health and Wellness Home acts "as the central hub for the provision and coordination of the medical care services" needed by clients. By employing varied staff (General Practitioner /Nurse Practitioner, a case manager and Wellness Coach), the home is able to provide wrap-around care and can focus on public health, prevention, and liaise with the broader health system.

This home addresses an existing geographic service gap, as the other primary care sites in the region are in the west (Kla-how-eya Hub, Fraser Regional Aboriginal Friendship Centre) and the east (Stó:lō Hub).

### **Fraser Salish structure**

**There is fidelity to the original vision and intent of the PA, and the right people are sitting at the table. PA goals, roles and responsibilities are understood, and priorities are being addressed. There is opportunity to further clarify roles and responsibilities, enhance staff retention and participation, plan for partner succession and translate PA commitments into practice on the ground.**

There is a perception among AHSC/AHOC representatives that the right people are sitting at the table and that roles and responsibilities are understood. There is strong participation by senior representation from the FNHA, FNHC and FHA, which enables the group to advance the work effectively.

Evidence suggests that all partners understand the commitments and goals outlined in the PA. For example, one AHSC/AHOC participant shared that members come to meetings with relevant action plans, project proposals and status reports. AHSC/AHOC representatives acknowledged that understanding the goals of the PA vary as a function of members' length of tenure, participation and connection to the work. For example, some AHSC members have been involved with PA work since

before and since its signing in 2011, while others are relatively new additions to the committee. AHSC/AHOC members identified that there is room for further reflection on how to improve staff continuity (for example, changing roles within the organization disrupts PA work) and increase participation across multiple levels to enhance collective understanding and performance.

AHSC/AHOC and FNHA/FHA operational staff noted that an important outcome of signing the PA is the creation of a regional structure to support improving health outcomes for Fraser Salish First Nations. The structure helps to bring focus to the work of the PA across multiple levels. FNHA/FHA operational members perceive the key priority areas as outlined in the Fraser Salish Regional Health and Wellness plan are being addressed (Mental Health and Substance Use, Public Health, Primary Care, Data Governance).

While there is the perception that the PA represents an effective framework for guiding meaningful discussions, including priority setting, both AHSC/AHOC and FNHA/FHA operational groups perceive there has been less success in the translation of PA commitments into practice on the ground. To this point, Caucus attendees indicated that community representatives were less familiar with the PA, with some being unaware of its existence. Moreover, representatives often did not know which activities should be attributed to the PA compared to other factors, such as turnover in hospital management or the creation of the FNHA.

Community representatives also expressed uncertainty around the role and membership of various committees (AWACs, AHSC, AHOC), and suggested they be clarified. Community representatives also identified a need for an opportunity to collaborate and communicate on a more regular basis (with one suggesting every three months) to ensure all communities have an opportunity to share their unique perspectives. Representatives noted there had previously been community engagement hubs which facilitated collaborating as a group on shared issues. Furthermore, community representatives at Caucus and FNHDA focus group participants shared that participation in the First Nations Health Directors Association meetings has waned, reducing its capacity to provide technical feedback on programs as it is less engaged with Fraser Salish communities.

AHSC/AHOC representatives identified there is a need to look at the entities in the structure to ensure they are effectively supporting the goals of the PA. It was suggested to conduct a review of the AHOC and finalize a Terms of Reference ensure the right people are at the table in terms of seniority.

Both AHSC/AHOC and FNHA/FHA operational staff members described working groups as effective structures for moving priority work forward, the most notable being the Mental Wellness and Substance Use Working Group. The Cultural Safety and Humility, Primary Care and Public Health working groups continue to meet. Work related to IM/IT, is now being addressed by the FNHA Regional Executive Director and FHA Executive Director of Aboriginal Health. AHSC/AHOC representatives shared that there is room for improvement in relation to the Public Health Working Group, as there is the perception that this working group has not sufficiently aligned FHA and FNHA community priorities and definitions of public health, and that there are elements of public health in the Regional Health and Wellness Plan that are outside the scope of the FHA.

*Not fully understanding each other's respective roles and responsibilities. Again that, kind of, education... so for First Nations, what is the process? How are the regions established? How are the Health Council members elected or selected or appointed? What influence do they have? Who are they accountable to? And then the same on the other side within the Regional Health Authority, what's the structure? What's the hierarchy or accountabilities? Where are they built-in? What are the commitments or direction they're given around implementation? – FNHC/Caucus*

**Operational barriers at the regional level have impeded partnership performance, including ongoing scheduling challenges and staff turnover**

AHSC/AHOC members indicated that PA work is at times hampered by competing priorities, scheduling challenges, a lack of available staff and staff turnover. They cited the departure of the Director of Aboriginal Health as an example of turnover slowing the progress of PA work. An AHSC/AHOC member perceived Fraser Health's agreements with other bodies, such as physicians, nurses, and paraprofessionals complicates the work of the PA, as they must remain in alignment with these agreements while working to achieving the goals of the PA. Simultaneously, another AHSC/AHOC representative noted the FNHA is often unable respond to enquiries due to the need to engage with Caucus first, and caucus meetings are held twice a year. The regional governance structure relies on the FNHC to raise awareness on community level barriers, though it can be difficult for FNHC/Caucus members to be fully aware of all issues facing Fraser Salish Nations

## Relationships

**A key success of the PA is that it established the foundation to first form and then strengthen relationships. There is commitment among partners to support PA relationships and work.**

**Relationships are proceeding in a positive way, with matured relationships effectively supporting difficult conversations.**

Both AHSC/AHOC and FNHA/FHA operational representatives perceive the formation and strengthening of relationships among partners as one of the greatest achievements of the PA. Both groups shared that since the signing of the PA, a strong relationship has been established between the FNHA and FHA, especially at the service delivery and planning levels. AHSC/AHOC and FHA/FNHA operational representatives feel that existing relationships demonstrate patience, collaboration, and are partnership-oriented and open. FNHA/FHA operational staff reported that a robust relationship has been established between the FNHA and Caucus as a result of the PA, while AHSC/AHOC members perceive the PA as helping to establish contact between FHA and Fraser Salish First Nations. FHA/FNHA operational representatives shared their belief that successful relationship-building has occurred as a result of FHA-FNHA CEOs actively participating in the structure and being committed to the work,



thereby advancing the relationships, despite the fact that there has been recent turnover at the FHA CEO level.

Both AHSC/AHOC and FHA/FNHA operational representatives feel there is a sincere commitment to the relationships being built through the PA, and to the work that is being undertaken. Though occasional disruptions have occurred as a result of changing roles within the organization and staff turnover (including the FHA Aboriginal Health Lead; FNHA staff), from the perspective of FHA/FNHA operational staff, these have not undermined the strength of the commitment to work together. The joint planning session between the FHA Executive Director of Aboriginal Health and FNHA Regional Director positions was cited as an example of the increased working relationship. AHSC/AHOC members also felt that the new FHA Executive Director for Aboriginal Health has brought strength in terms of relationship-building because of their previous work in community. There is a sense that the spirit of relationship-building remains strong, with relationships proceeding in a positive way.

*There is real energy and commitment there, and we're prepared to work together. – FNHC/Caucus*

Relationship success was attributed to several factors. AHSC/AHOC members shared that effective relationship-building has been fostered by way of large meetings, such as Caucus, and through the sharing of information and learnings at such events. FHA/FNHA operational staff offered that the regionalization process within the FNHA has helped to strengthen relationships with community because the process is flexible, allows for in-person meetings and encourages attendance by community representatives. There is an acknowledgement that the growth of the FNHA and the process of learning how to do the work impacted the pace of relationship development between the FNHA and communities, particularly as the transfer of services to the FNHA occurred after the signing of the PA.

AHSC/AHOC members also acknowledged the value of appointing an FNHC representative to the FHA Board of Directors given their unique in-depth knowledge of community-level needs. Simultaneously, this has provided greater understanding of Fraser Health operations, limitations and opportunities at the FNHC. Community representatives also identified having two Indigenous representatives on the FHA Board of Directors as a positive change.

*“Now we are at a place where we can have those tough discussions. We reach an understanding of the issues and we reach an understanding of how we intend to resolve those issues. Now, some of them are pretty significant and we know it will take time. We are mindful of that and respectful of that.” – FNHC/Caucus*

#### Communication

**There is consistent and open communication at AHSC/AHOC tables and between FHA and FNHA, though communication is inconsistent with communities and relies on informal pathways.**

AHSC/AHOC members stated consistent and open communication contributes to the effective performance of the regional structure. Meetings are held regularly and communication between PA partners is prompt. There is the perception among this group that communication has been open, honest and inclusive; however, there is variation in the timeliness and effectiveness of communication, particularly when additional information must be prepared before sharing with others.

Community representatives shared that communication has increased since the signing of the PA. Successes include feeling comfortable contacting Fraser Health operational staff such as Mental Health Workers and Nurse Practitioners, in addition to the Aboriginal Health team. Community representatives identified that communication with Fraser Health is heavily dependent on direct relationships with Fraser Health staff. Though effective, this creates barriers during employee turnover as communities no longer know who to contact. Representatives noted they have had meetings postponed indefinitely as a result of turnover. Communication can be further complicated by communities receiving services from health service organizations, as this means that they do not always have direct communication with FNHA or FHA. In one example, a representative disclosed that they heard about changes to the Director of Aboriginal Health position through informal channels as opposed to a communication from Fraser Health, while others expressed they were uncertain who the current Director of Aboriginal Health was.

Multiple community representatives at Caucus and at the FNHDA focus group shared that FNHC representatives are a conduit for addressing issues and concerns, including issues related to cultural safety and humility. While effective at ensuring issues are addressed, it can be difficult for FNHC/Caucus members to be fully aware of all issues facing Fraser Salish Nations. Community representatives shared that communication could be improved by Fraser Health by (1) sharing an updated contact list, or an outline of the Aboriginal Health Department structure, including a description of roles and how they interact with communities, and (2) establishing a consolidated website or portal, or offering information sessions on FHA services to communities.

AHSC/AHOC representatives noted that it would be beneficial to develop a more effective and concise onboarding and orientation package to communicate the goals of the PA to new staff. There is also room for growth in the circulation of information and data sharing more generally (for example reporting back on existing services). From the perspective of FHA/FNHA operational staff, it may be beneficial to explore additional ways to improve communication. For instance, there are incompatibilities in communication systems (such as Skype) across FNHA/FHA that could be addressed.

*[The structure] relies on the Fraser Salish Nations' representatives to be in full understanding of what the individual Nation's priorities or issues are. So it's heavily reliant on that and it's a little unclear about how well I can bring forward all issues representing the different communities, and similar to my colleagues. So that makes it tough because it just creates a backlog having heavy reliance on representatives having a clear understanding of what those are and carrying that through to Fraser Health. – FNHC/Caucus*

## Engagement

**Both AHSC/AHOC and FHA/FNHA operational representatives indicated there is a greater understanding of the importance of engagement than when the PA was first signed, as well as enhanced clarity concerning engagement pathways. First Nations communities are now playing a greater role in the design and delivery of services. Moving forward, it may be beneficial to reduce engagement burden and pursue meaningful engagement with communities.**

Both AHSC/AHOC and FHA/FNHA operational representatives indicated that there is greater understanding of the importance of engagement now than there was at the signing of the PA. Further, AHSC/AHOC members reported Fraser Salish First Nations communities are now playing a greater role in the design and delivery of programs and services, and are being engaged in discussions more regularly on how to improve FNHA/FHA health services in the region. For instance, FNHA and FHA recently engaged communities in a discussion on residential addiction treatment facilities, including whether any existed in the region, whether Indigenous-specific treatment centres be created, and if so what should these treatment centres look like. Communities were invited to provide input in terms of the design of a treatment facility, including its location, how to incorporate the First Nations Perspective on Wellness and how to enhance cultural safety. Involving communities in the design resulted in an addictions service that incorporated traditional healing, detox workers, as well as addiction specialists and physicians.

FHA now seeks community direction on the design of health services for First Nations prior to implementation. In addition, when feasible and appropriate, community representatives are involved in the hiring process to identify suitable candidates for the delivery of health services. An example of a lesson learned cited by an AHSC/AHOC member is when hiring a First Nations candidate for a position requiring cultural knowledge, it is good practice to contact community members directly to verify the candidate's suitability and cultural background.

AHSC/AHOC members, FHA/FNHA operational staff and community representatives shared a number of examples of the formal and informal engagement pathways between FNHA, FHA, and Fraser Salish communities:

- Communities reach out to FNHC representatives directly, who bring the information to Fraser Health;
- FHA engages with the FNHC during the developmental stages of health service planning through AHSC;
- FNHA engages with community and Caucus;
- Community representatives contacting FHA directly through working relationships with FHA aboriginal Health team;
- Communities work with FHA through Aboriginal Wellness Advisory Committees and working groups;
- FNHA Regional Executive Director engaging directly with communities; and
- Regular engagement of the FHA Aboriginal Health Executive Director with First Nations communities concerning service development and delivery (i.e. supervising nurse practitioners and health nurses).

An FHA/FNHA operational representatives shared that some FHA staff are uncertain on how best to engage First Nations communities. Another noted FHA will occasionally overlook engagement with communities. That said, it was acknowledged that the FHA has been responsive in these situations and has restarted the development process while including engagement with support from the FNHA when needed.

*I see engagement of First Nations, whether it's the clients or leadership, is providing perspectives that I don't think we've previously captured appropriately. – FNHC/Caucus*

**Moving forward, engagement with Fraser Salish Region First Nations communities could be improved by expanding the time provided for engagement.**

FNHA and FHA have made efforts to engage First Nations in response to the large volume of work that has arisen. FHA/FNHA operational representatives shared that communities are often overwhelmed by the sheer volume of engagement requests that come in, which are especially burdensome for smaller communities that have limited human resources. This finding was re-iterated by community representatives at Caucus, some of whom described having multiple roles, leading to scheduling conflicts. To address this, and to support service improvements, FHA/FNHA operational staff recommended expanding the engagement period, including both upfront and follow-up engagement, building in sufficient turnaround time for input into health service design, and supporting community attendance in order to understand unmet needs. Other suggestions from FNHA/FHA operational staff for enhancing meaningful engagement include:

- More flexibility for FHA staff to go into community and Aboriginal urban agencies in order to attend meetings and events;
- Create tools to guide the engagement process;
- FHA holding strategic annual or quarterly meetings with communities in order to have a set opportunity for engagement;
- FHA/FNHA work collaboratively to minimize potential for duplication of engagement with communities;

- Employing tools for soliciting feedback from Aboriginal Patient Navigators/Community Engagement Coordinators in an effort to reduce engagement burden;
- Include Métis Nation BC in engagement; and
- Identifying an individual within each Fraser Health department to liaise with communities and urban populations to support awareness, knowledge, and understanding of First Nations among decision-makers.

*I think the other thing that the PA has really facilitated is where community leaders, like Elders and community members who are leaders in each community, really have a direct say now in terms of how health services are being delivered. That's been a great outcome in terms of the relationships. So we have different venues where we're initiating a new service and before we launch that service, for example, we're going into communities and getting their feedback and input into how they want that service delivered. So I think one of the great outcomes is communities now, much more than before, have direct input into health services. - FHA*

#### Collaboration and partnership

**The shift towards regionalization and the expansion of the FNHA regional office has facilitated collaboration and partnership with FHA and community engagement.**

Both AHSC/AHOC as well as FHA/FNHA operational staff identified both FNHA and FHA are committed to working together at all levels. That said, FHA/FNHA operational staff identified there is an opportunity to increase the consistency of joint decision-making and openness among the partners going forward.

The expansion of the FNHA regional office was seen as a key facilitator to collaboration by FHA/FNHA operational staff, as it increased FNHA capacity to engage with FHA departments seeking guidance on service provision, and to support community engagement. The commitment to the relationship (discussed above under Relationships), was identified as facilitating collaboration and partnership between the partners.

FHA/FNHA operational staff noted the size of FHA as posing a challenge to relationship development, as some staff do not see how their role includes working with First Nations communities. These barriers are complicated by ongoing staff turnovers in both FHA and FNHA.

When asked about opportunities to improve collaboration and partnership, an AHSC/AHOC representative recommended establishing more precise targets to guide the work moving forward, and an FHA/FNHA operational key informant recommended further clarifying the role of the FNHA to communities.

*There is an old adage in our world, ‘whatever gets measured gets done’*

–FHA

### Reciprocal accountability

#### **The partners operate in the spirit of reciprocal accountability.**

Concerning reciprocal accountability, AHSC/AHOC members indicated that it has been well articulated in documents and that partners have been successful at bringing the spirit of reciprocal accountability to the partnership and associated PA work. The complaints process, discussed below as part of Cultural Safety and Humility, was highlighted as an example of reciprocal accountability. There is the perception that relationship-building efforts have led to the gradual integration of reciprocal accountability in practice; still, it was acknowledged that this is not necessarily because of the commitment to reciprocal accountability as articulated in the PA, and there is still room for improvement moving forward. On occasion, there has been a need for partners at the AHSC/AHOC level to remind each other about the principle of reciprocal accountability.

While AHSC/AHOC representatives perceive that partners feel accountable to each other and to the work, an FHA/FNHA operational staff member noted presently, when target dates or actions are not met, partners do not investigate the underlying reasons, suggesting there is opportunity for growth in terms of clarifying roles and responsibilities of each of the partners, as well as identifying milestones and goals.

### Integration and coordination

#### **Now that working relationships have been established, the coordination and integration of services is increasing.**

AHSC/AHOC members observed that the coordination and integration of services is a relatively recent development (within the last 6 months to a year), and that the partners are on the right track.

FHA/FNHA operational staff observed there is less community-level awareness of the role of the FNHA, exemplified by community representatives expressing uncertainty about whether to contact the FNHA Wellness System Navigators or FHA Aboriginal Patient Liaisons.

Representatives from AHSC/AHOC referenced the Indigenous Primary Health and Wellness Home Program (jointly funded by FNHA and FHA) as an example of coordination and integration, as well as the Riverstone Mobile Detox/Daytox Program delivered by FHA through Joint Project Board). AHSC meeting minutes show collaboration between FNHA and FHA on service coordination, including the development of joint work plans, with the intent of identifying and addressing gaps and streamlining service delivery. In addition, the FNHA Fraser Salish regional office is endeavoring to create regional service plans that identify roles in service and how community has provided direction to new investments. The five-year plans will support alignment of services and will include metrics to ensure efficiency and effectiveness.

*[Indigenous Primary Health and Wellness Home], that’s been a jointly made decision. It required the FNHA to contribute. It required Fraser Health to contribute. It required us to work together on an investment*

*strategy. We did. It required us to agree on the investment. We did. It required us to work together. Do we have complaints on those critical issues? Absolutely. We are working together. We are agreeing that we have to make improvements. – FNHC/Caucus*

Community representatives noted the Joint FHA/FNHA Mental Wellness and Substance Use Working Group and the Joint FHA/FNHA Action on Youth Suicide as examples of improved coordination of services. FHA/FNHA operational staff provided a number of other examples around the coordination and integration of services, including:

- FHA Public Health conducting immunization and flu clinics in community;
- FHA working with communities directly to support 8 primary care clinics, in addition to implementing an Information Management (IM) system for these communities;
- FHA supports, including providing Nurse Practitioners to complement existing community services;
- FNHA participating in interviews of FHA staff that will be working in Aboriginal Health and Mental Health and Substance Use in community; and
- Manager-to-Manager meetings between FHA Aboriginal Health Manager and FNHA Regional Manager, both of which are new positions.

FHA/FNHA operational staff also highlighted a number of changes that have facilitated increased coordination and integration of services:

- Better alignment between First Nations and FHA through asset mapping (conducted prior to the establishment of the Indigenous Primary Health and Wellness Home Program);
- FHA and FNHA's willingness to provide financial support; and
- FHA departments becoming more flexible with allowing staff to get out of the office and engage directly with communities.

Both FHA/FNHA Operational staff and AHSC/AHOC members expressed an opportunity for growth in the area of coordination and integration of services, which was noted as being inconsistent across service delivery areas. AHSC/AHOC representatives perceived that not all partners were equally involved, for example, in decision-making related to the allocation of resources. FHA/FNHA operational staff recommended that the coordination and integration of services could be improved by increasing awareness of the services offered by communities and how FHA can better support them.

Community representatives, FHA/FNHA Operational staff and AHSC/AHOC members identified data governance between FHA/FNHA and communities as a barrier to further coordination and integration of services, as processes are unclear and there is a lack of capacity to engage on the topic. FHA/FNHA and communities are working within the constraints of policies dealing with access and use of First Nation patient information. For example, an AHSC/AHOC representative noted they could not say with certainty if the quality of services for First Nations had improved as FHA currently does not capture any ethnicity

data, due to the difficulties in identifying Indigenous clients in a culturally safe way. First Nations families and communities lack access to patient data, which community representatives noted complicates discharge and care planning. Notable exceptions to this was a community that signed an LOU with Fraser health, and a Health Service Organization (HSO) that was integrated into FHA's patient information electronic medical records (EMR) system.

*Many communities have a number of health services that they deliver already and so one of the things that has changed since signing the PA is, we are now working more collaboratively in an integrated way directly with First Nations communities, with their healthcare team that exists directly within community. And then the Fraser Health services are coming in and we're having conversations, "OK, how can we integrate? How can work together as one team? How can we break down silos?" – FHA*



## Findings - Health and wellness system performance

### Cultural safety

**Though partners have made significant advancements related to cultural safety and humility, there remains ongoing opportunities to improve the cultural safety of services.**

AHSC/AHOC members emphasized that work related to cultural safety and humility has progressed since the signing of the PA, but noted there was room for improvement, acknowledging that it would take time for culturally safe practices to permeate across all of FHA. Similarly, FNHA/FHA operational staff emphasized there have been efforts to improve the cultural safety of programs and services (listed below). Cultural Safety and Humility Working Group members equally observed a growing interest in cultural safety and humility across FHA. FHA/FNHA operational staff went so far to describe the work related to cultural safety and humility as one of the “greatest achievements” since signing the PA. An AHSC/AHOC member noted that having First Nations representatives on the FHA Board of Directors presents a unique opportunity to raise awareness of First Nations with top decision makers, hopefully influencing the organization as a whole over time.

*I think it's improved quite a bit. Because I think a number of us have gained a lot of knowledge that we didn't have before, and I think we're in a much better space than we were before. – FHA*

Community representatives, AHSC/AHOC representatives, FHA/FNHA operational staff and Cultural Safety and Humility focus group participants all cited the establishment of the Aboriginal Wellness Advisory Committees as an example of success. They enabled communities to build relationships with senior management at service sites, and were described as a safe space for communities to directly address culturally unsafe experiences as well as barriers to care.

AHSC/AHOC, FHA/FNHA Operational Staff and Cultural Safety and Humility focus group participants identified a number of initiatives as examples of efforts being made to improve the cultural safety of services, including:

- FHA promoting San'yas training, and purchasing additional seats, for a total of 1,000 seats for the 2019-2020 fiscal year;
- Establishing a cultural safety framework across FHA, outlining the expectations at every level of the organization and developing accountability across departments;
- Creating two Elder-in-Residence positions;
- FHA creating an introduction to Indigenous Health e-learning module for staff in collaboration with Métis Nation BC and FNHA;
- Lunch and Learn series to educate FHA staff on Indigenous health topics;
- HR efforts throughout FHA departments to increase the number of First Nations staff;
- Place name tours with management, directors and senior executives;

- Developing a set of Shared Commitments at FHA for both patients and caregivers in order to create a culture that is safe for everyone and;
- Hiring of a Coordinator, Cultural Safety to support the program specific and organization wide implementation of Indigenous Cultural Safety.

While these efforts represent a significant shift in a short period of time, key informants acknowledged that there continue to be complaints and culturally unsafe incidents, and noted a number of ongoing barriers to establishing culturally safe care across the region, including:

- The size of Fraser Health at 26,000 employees, which combined with employee turnover makes it difficult to ensure all staff receive the San’yas training in a timely manner as there are limited spaces available;
- The nature and context of care generally poses a challenge to providing culturally safe services. Service providers may not have sufficient time for meaningful patient interaction, and staff can be stressed when providing services. One participant noted “Hospitals are stressed, particularly in the ER, and as such they are not regarded as safe for anyone;”
- While a Coordinator, Cultural Safety, has been hired further human and financial resources are required;
- Culturally unsafe patients, there as there are incidents of racism between patients when they are sharing space in FHA facilities;
- Union policies were perceived as ‘defending’ employees who had done culturally unsafe things, additionally, hiring policies that favoured seniority over cultural safety or community fit; and
- ‘Pushback’ from people working in programs on the need to change services.

*There is a committee in Chilliwack General Hospital...around cultural safety. It's a committee that's come together with health leadership, FNHA sits at the table and First Nations communities within the Chilliwack area. And so at that table, what we have tried to do is have a discussion around client complaints, clients' experience of care, [and] cultural safety. You know, we don't always get it right as I've said, but this is a table where that can come forward...and it's a very safe space where communities can forward those concerns to health service leaders. And we can have those conversations. Part of what's happened out of that, which is actually quite exciting, is we now have an Elder-in-Residence at Chilliwack General Hospital. And he has been instrumental in educating staff, supporting staff and First Nations individuals who are coming into acute care around cultural safety and cultural aspects to their care within an acute care setting. He has been amazing. - FHA*

Key informants, particularly AHSC/AHOC members, frequently cited changes to the complaints process as an example of collaboration between the partners at AHSC around cultural safety and humility. Presently, FNHC representatives on the AHSC are able to bring complaints forward related to culturally unsafe care directly to FHA representatives at the committee, who share the information with the relevant department, and in order to address it. However, due to privacy/confidentiality rules, FHA is unable to share with FNHC representatives how the complaint they brought forward was resolved. Subsequently, unless the client follows up with the FNHC representative directly, they are unaware of the outcome. Specific reference was made to Section 51 of the *BC Evidence Act* that prohibits the disclosure of information and documentation collected as part of a hospital's quality of care review. Culturally unsafe incidents reported directly to FHA are brought to the Manager, Aboriginal Health, who can then bring in a patient liaison or a support worker as appropriate. The Patient Care Quality office has assigned one officer to act as an Indigenous liaison, and the partners are currently piloting a revised complaints process that allows for the more seamless involvement of families and patient advocates.

*When you are talking about on the ground, in the community, that's the river's edge. When you move up to a Tribal Council or to a broader community, that's the tree top. That's a different perspective, a different view. When you go to province wide, that may be the*

*mountain top. When you are talking about the country, like Canada, that may be the eagle's eye view. What we are talking about here is how do we improve services so that it's felt by the people living at the river's edge. We are hearing it from the mountain top, we are hearing it from the tree top, but it hasn't made its way to the river's edge. That's where we need to get the work next. – FNHC/Caucus*

### **Recommendations to enhance cultural safety**

Evaluation participants provided a number of recommendations on how to improve cultural safety across the region, including:

- FHA leadership to continue supporting and championing cultural safety to foster a culture of cultural safety and humility across the organization;
- Increase awareness around Indigenous cultures, specific to the region, such as language groups, Nations, and spiritual practices among Fraser Health staff;
- Further consultations with First Nations regarding the hiring of individuals for roles that require traditional knowledge;
- Hire more self-identifying Indigenous staff at FHA;
- Invite FHA staff to community to come together in ceremony or for meals; and
- Engage with communities on the Cultural Safety Framework.

### **First Nations Perspective on Health and Wellness**

**The First Nations Perspective on Health and Wellness (FNPOHW) is being integrated into programs and services, particularly when they are provided in partnership between FNHA and FHA.**

Complimenting efforts to promote cultural safety and humility across FHA, AHSC/AHOC and FHA/FNHA operational staff shared a number of initiatives to incorporate First Nations Perspective on Health and Wellness (FNPOHW) into the provision of care.

Key informants consistently referenced the Elder-in-Residence position as an example of successfully incorporating the FNPOHW. FHA/FNHA operational staff commended the Elder in Residence for working with and sharing First Nations cultural beliefs and practices with FHA staff, as well as being able to communicate FHA procedures to First Nations clients. Additionally, FNHA Fraser Region hired a Traditional Wellness Coordinator responsible for developing, implementing, and managing an integrated traditional wellness program.

The Cultural Safety and Humility Focus Group shared FHA is currently piloting the “BeComP,” (Beliefs, Community, Practices) which determines care planning on acute care wards, and identifies spiritual and cultural preferences. The BeComP also represents an opportunity to include the social determinants of health as part of a patient’s care plan.

FHA has also invested in 4 ventilated sacred spaces to allow for smudging in care facilities, as well as Indigenous art to make facilities more welcoming for First Nations patients.

Key informants shared more meetings are beginning with a territorial acknowledgment, including public meetings, as well as Board of Directors meetings. FNHA/FHA operational staff reflected that departments are beginning to bring in Elders and include territorial acknowledgements in their meetings organically rather than being obligated through policy.

FHA/FNHA operational staff remarked that integration of the FNPOHW is at the core of the work being conducted between the FNHA and FHA, particularly in shared or jointly funded positions. The First Nations Primary Health and Wellness Home and the Riverstone Mobile Detox/Daytox programs were highlighted as being inclusive of the FNPOHW. The primary care home includes Elders in care, and recognizes the social determinants of health by connecting clients in person with an Aboriginal Friendship Centre, rather than through referral, in order to access additional services such as housing.

Key informants recommended that the FNPOHW could be further integrated by:

- Expanding the number of Elders-in-Residence to include traditional healing;
- FHA departments setting aside funds to provide honorariums for community members to open and participate in meetings;
- A shift towards “two eyed seeing” (inclusion of both Indigenous and Western practices);
- Creating more welcoming spaces by including First Nation art and languages in FHA facilities;
- Inclusion the Truth and Reconciliation Commission Calls to Action in the revised accord.

## Quality

### **The quality of services available to First Nations have improved since the signing of the PA.**

Both AHSC/AHOC members and FHA/FNHA operational staff perceived the quality of services for First Nations to have improved since the signing of the PA, citing improvements to both the accessibility and cultural safety of services. As discussed above under Integration and Coordination, due to the lack of ethnicity data, there is currently no complete measure of First Nations health outcomes, or service utilization. Subsequently, an AHSC/AHOC member noted they could not say with certainty if the quality of services for First Nations had improved. FHA/FNHA operational staff shared that FHA now recognizes their responsibility for providing care for everyone residing in the region, including in communities. Recommendations to improve the quality of services include involving more individuals from community in the provision of community services, increasing understanding regarding the uniqueness of First Nation health and the need for flexibility in service planning and delivery, in addition to ensuring staff operating in community are culturally safe.

*Aboriginal people often aren't comfortable accessing mainstream, mainline kinds of health services. So I think, in terms of the quality of services being delivered, much more of those services are being delivered more directly within communities, so it reduces barriers to access. And now we're getting into the really fun part of, how do those services need to be adapted so that they're culturally safe and acceptable within community? – FHA*

## Access and availability of services

**Services are being provided “closer to home,” though culturally unsafe services, transportation and uncertainty around jurisdiction among others remain barriers to First Nations clients accessing services.**

AHSC/AHOC members and FHA/FNHA operational staff both agree that more services are being provided “closer to home” for First Nations. For example, they listed substance use treatment at Seabird Island, the provision of Mental Health services, and the expansion of services in Fraser East communities. They further cited the FHA Aboriginal Health department, collaboration between the partners, and FNHA/FHA listening and responding to community needs as key facilitating factors. FNHA Wellness System Navigators and FHA Aboriginal Patient Liaisons were also highlighted as improving the accessibility of services. They, along with Cultural Safety and Humility focus group participants identified that work related to cultural safety and the new complaints process is supporting improvements to accessing services, where communities now have a platform to share barriers and needs, and that FHA is listening and responding in order to make services safer and more accessible. FHA/FNHA operational staff identified that only some communities and facilities have seen quality improvements, so there is more work to be done to achieve a broader impact. Multiple community representatives expressed services have not been distributed evenly across communities in the region. Services for First Nations clients living away from home, as well as mental health services were suggested as areas of improvement going forward.

The document review identified a number of specific activities implemented by the FNHA and FHA to improve access to services in the areas of mental health, suicide prevention and intervention, data sharing and public health, such as:

### **Mental Health**

- Establishing child psychology services in one community (2016);
- Expanding psychiatric services beyond the initial two communities, and discussing the enhancement of existing services in two more (2016);
- Mental Wellness service outreach to First Nations communities (2017);
- FNHA allocating additional resources to support the mental health action team (2017);

### **Suicide Intervention and Prevention**

- Engagement between Fraser Salish region community leadership and partners to identify a shared vision and common understanding of the challenges related to an FNHC-requested Call to Action on Youth Suicide (2015);
- Activities in this area are structured around Hope, Help, Healing (HHH) and Prevention, Intervention or Post-vention (PIP), led by the Suicide PIP Coordinator in the region;
- Continuing discussions and monitoring of suicide in the region by AHSC, and holding a Mental Wellness forum;

### **Overdose**

- Providing training on and distribution of Naloxone kits to First Nations people at and away from home in Fraser East (from Boston Bar to Mission) and Fraser North (Maple Ridge, Pitt Meadows) by the FHA Harm Reduction Coordinators and Overdose Response Public Health Nurses as well as the Riverstone Home and Mobile Detox and Treatment Services’ Aboriginal Outreach team;

- Joint activities between FNHA Communicable Disease Control team, FHA Human Resources team and FHA Mental Health Substance Use Knowledge Exchange and Regional Trauma Informed Practice Leader for the 32 communities in the Fraser Salish region;
- FHA’s Aboriginal Health Lead is a part of their Primary Health Overdose team, helping to cultivate cultural humility and safety within the team; and
- New residential treatment and recovery beds located at Seabird Island First Nation; these are regional beds for Indigenous men and women which is part of a 147 bed expansion by FHA.

Key informants provided a number of ongoing barriers related to accessing care, specifically:

- **Homelessness.** Community representatives and Cultural Safety focus groups participants, as well as key informants noted the growing homeless population in the region as a barrier to accessing care. Focus group participants noted this is exacerbated by a lack of low barrier housing in the region.
- **Transportation.** Barriers related to travel were consistently cited by community representatives as posing a challenge to accessing care. These include a lack of public transportation in parts of the region. Where public transport does exist, both cost and navigability were noted as barriers. The cost of transportation to both individuals and communities were also cited as a barriers. These barriers are further exacerbated by individual health circumstances. Where medical transportation is available, eligibility requirements, such as income (available only to those under a certain income), age (over a certain age), or community membership (need to be a community member, thereby excluding non-members living in community) bars individuals who lack other means of transportation. The geographic accessibility can also make it difficult for FHA to access communities to provide services.
- **Cultural safety.** Despite efforts to make programs more culturally safe, AHSC/AHOC representatives and FHA/FNHA operational staff shared that negative client experiences have deterred clients from accessing care at certain facilities or at FHA facilities more broadly.
- **Service gaps.** Community representatives identified difficulty accessing a number of specific services, including physiotherapy, occupational therapy, detox and recovery, home care, suicide intervention, youth and adult mental health services.
- **Jurisdiction.** Though some community representatives reported improvements, others shared instances of ongoing jurisdictional uncertainty between FHA, Health Service Organizations, and FNHA as complicating service delivery, particularly around home care for individuals away from home, and in-community service provision by FHA. Additionally, as some HSOs are located within municipal boundaries, they provide services to away from home clients that they are not adequately funded to serve. This creates an access barrier for away from home individuals who rely on these services as they are culturally safe.
- **Data.** From a population health perspective, relatively small First Nations population sizes do not align with conventional health authority population health approaches. This is further complicated by difficulties in measuring wait times or primary care access for First Nations clients at a population level.
- **Complexity of the funding relationship between FNHA, Fraser Health and communities.** Community representatives expressed that the funding relationship between FHA, FNHA and themselves is unclear. They are generally aware that new funding had been made available for Indigenous health in the region, but had not seen the funds in community and were uncertain how to access it. Multiple community representatives expressed services have not been



distributed evenly across communities in the region, with neighboring communities receiving additional services they could not access.

## Resources

### **Resource sharing has improved, however, the work is constrained by the availability of human and financial resources.**

AHSC/AHOC members expressed resource sharing had improved since the signing of the PA, and noted that there is still room for improvement moving forward. The joint Primary Health and Wellness home was identified as a good example of resource sharing. Specifically, AHSC/AHOC members saw any new funding as requiring collaboration between partners, though they have not always been brought into discussions concerning the allocation of pre-existing resources. Key informants reported the joint administration of resources could be improved, as currently each party manages their own resources depending on the work they lead. It was suggested that improved understanding of community resources and capacity could also improve resource sharing discussions in the future.

FHA/FNHA operational staff perceived a need for greater human resources in the areas of Community Nurse Practitioners and acute care. The high case load of FHA departments presents a barrier to providing additional services to community, as they lack the resources to do so, even when acknowledging an existing need. Additional supports for acute care consist of the Elder in Residence and three liaisons, who also support service navigation and continuity of care.

FNHA/FHA operational staff provided the following comments regarding resourcing the priority areas listed in the Fraser Salish Health and Wellness Plan and the extent of attention they are receiving in the Fraser Salish region:

- **Cultural Safety and Humility.** While this priority has received a lot of attention, there is still work to do to fully address ongoing issues.
- **Mental Health and Substance Use.** This area, particularly youth suicide and overdoses, does not have enough resources considering the extent and severity of the problem; more services are needed. Community technical representatives also identified this area as needing further supports.
- **Public health and wellness.** More chronic disease strategies are needed as well as an understanding of how to support people through an Indigenous lens to better care for their health. It requires FHA to consider upstream prevention and apply a social determinants of health lens. FNHC is examining the social determinants of health (housing, access to clean water, etc.).
- **Primary Care.** There are many challenges regarding access to primary care such as how to access a family doctor versus walk-in or emergency when there are shortages, as well as improving accessing screening for diseases.

**Data governance and information sharing.** More attention by partners is warranted on this as community nurses need access to FHA information when a patient is in hospital to provide a continuum of care and discharge planning. One suggestion was that personalized electronic medical records (EMRs)



could support this. Personalized EMRs are outside of what can be addressed by AHSC/AHOC, with the

*I think we've made a lot of headway in all of these different areas. But we're still not quite there yet in some of these areas. I think we're better in areas like bringing services closer to home... but not as good [at] sharing resources. And there's a bit of a caveat because the FNHA and Fraser Health are quite good at bringing our resources together. But communities have their own resources and we have not been successful in bringing those resources to the table. – FHA*

potential to be addressed at provincial level.

### Additional opportunities and recommendations

Other single comments and recommendations from evaluation participants include:

- Move to a single agreement between FNHA-FHA-FNHC, as presently there is only one between FNHA and FHA and between Caucus and FHA;
- Consideration of local-level contexts in any further adjustments to the PA;
- Create greater understanding and awareness of the PA regionally, as well as how to work together more efficiently;
- Ensure Indigenous wellness is reflected in the language and priorities of the PA;
- Identify and outline parameters of the PA concerning urban populations and Métis people;
- Include the Ministry of Children and Family Development in the PA;
- Include procurement opportunities for First Nations in the PA as part of the social determinants of health; and
- Include the Truth and Reconciliation Commission Calls to Action related to health into the PA.

### Conclusion

Strong working relationships have been developed between the FNHC, FHA, and the FNHA at AHSC. The relationships and the structure created by the partners were cited as the greatest achievements of the PA to date. Despite staff turnover within both FHA and FNHA, the partners remain committed to the relationship. Collaboration and integration between the FHA and FNHA is increasing at an operational level, facilitated by the growth of the FNHA regional office, which increased FNHA resources in the region to provide support to communities as well as FNHA's capacity to engage with FHA.

The working groups are regarded as an effective means of addressing the priorities outlined in the Regional Health and Wellness plan, though their role and membership could be further clarified in order to increase their efficacy. The foundation of the Indigenous Primary Health and Wellness home was regarded as a successful example of joint investment by partners.

The appointment of two First Nations members to the FHA Board of Directors, one of whom is also an FNHC representative, was perceived as effective in bringing First Nations' perspectives into decision-making around the delivery of care while also providing FNHC insight into FHA operations. That said, there is the opportunity to improve community engagement by providing more time for engagement, and to build on the success of the Aboriginal Wellness Advisory Committees (AWACs) as an avenue for communities to engage with FHA. Expansion of the AWACs may relieve some of the reliance on the three FNHC representatives as the main conduit between communities and Fraser Health.

Significant efforts have been made to improve cultural safety and incorporate the First Nations Perspective on Health and Wellness. Initiatives include the establishment of the Elder-in-Residence position, which was consistently cited as an example of success, as well as Cultural Safety and Humility Training. Though evaluation participants expressed that more work is needed it was suggested that furthering cultural safety will help build up partnerships and improve access to care over time.

Transportation was also consistently cited as a barrier to care for First Nations. FHA Nurse Practitioners as well as the Riverstone Mobile Detox program delivering care in community was regarded as an example of improving access to services. Human and financial resources, as well as geography, the cultural safety of services, and jurisdictional uncertainty are ongoing barriers to the accessibility of care. There is opportunity to ensure that improvements are realized consistently across communities going forward.

Ultimately, the renewal of the PA will allow partners an opportunity to identify more precise targets and clarify their roles and responsibilities to each other and communities. The renewal of the PA will also present an opportunity to further include communities in discussions and build awareness of the PA.

