



First Nations
Health Human Resources
Tripartite Strategic Approach

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Preamble

In the years after signing the Tripartite First Nations Health Plan and the BC Tripartite Framework Agreement on First Nations Health Governance, the Tripartite partners have worked together to develop strategic approaches and tools for the various Health Actions strategy areas. This joint work has brought together a wealth of information and enabled the Tripartite partners to develop relationships and create new opportunities for collaboration throughout the initial years of the Tripartite process.

With the historic transfer of Health Canada First Nations and Inuit Health Branch programs and services to the First Nations Health Authority on October 1, 2013, the path forward is now to shift towards a renewed focus on supporting the work and priorities of the regions. As regions, sub-regions and communities go forward with their planning processes, the documents created by the FNHA and Tripartite partners can provide information and tools that may inform or assist in the development of the plans. They also create a starting point for discussion and lay out for consideration potential opportunities or key areas for work.

Through the process of dialogue and collaboration that will take place as we move forward through planning cycles, it is expected that these documents will be in a continual process of evolution as we work together, share knowledge and learn lessons through implementation.



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TABLE OF CONTENTS

PURPOSE OF THIS DOCUMENT	4
CONTEXT AND BACKGROUND.....	5
Setting the Path	5
Health Actions.....	6
WHAT WE HAVE HEARD	8
Community Engagement Process.....	8
First Nations Community Priorities	9
FIRST NATIONS HEALTH HUMAN RESOURCES TRIPARTITE STRATEGY AREA.....	10
A FRAMEWORK FOR HEALTH HUMAN RESOURCES.....	11
Health Human Resources Wellness Circle.....	11
Priority Areas for Action	14
i. Health Career Promotion.....	14
ii. Training & Professional Development	15
iii. Workforce Recruitment & Retention	15
iv. Planning & Forecasting.....	16
MOVING FORWARD	17
Guiding Principles	17
i. Cultural Competency and Cultural Safety	17
ii. Innovation	17
iii. Communication	17
Suggested Goals and Objectives.....	18
APPENDIX A – Summary of Issues for First Nations Communities in Health Human Resources: Information for Stakeholders of the Health Human Resources Health Actions Node, 2010	20
APPENDIX B – Summary of Key HHR Themes from the Health Actions World Café at the <i>First Nations Health Directors Association Training and Networking Event</i> , March 2012.....	22
APPENDIX C – Summary of Feedback from the HHR Breakout Sessions at Gathering Wisdom for a Shared Journey V, May 2012	24
Health Career Promotion.....	25
Training and Professional Development	26

Workforce Recruitment and Retention26
Planning and Forecasting.....27

PURPOSE OF THIS DOCUMENT

The First Nations Health Human Resources Strategic Approach has been developed by the Tripartite First Nations Health Human Resources Strategy Area to provide province-wide guidance to support the development of Health Human Resources strategies and plans within the regions. The optimal number, skills-mix and distribution of appropriately trained health care providers will not be determined by the Health Human Resources Strategic Approach itself; these details will be determined by community health plans and the models of care supported by the population health strategy areas. Instead, the Health Human Resources Strategic Approach can be understood as a lens that can be applied to community health plans and models of care, to support the achievement of the optimal number, skills-mix and distribution of appropriately trained health care providers, and to increase the number of First Nations people in health careers.

CONTEXT AND BACKGROUND

SETTING THE PATH

British Columbia's First Nations leaders and community members, as well as the federal and provincial governments, have been building collaborative relationships and working together to increase equitable access to health services for First Nations people. This work has been guided by the signing of the Transformative Change Accord: First Nations Health Plan (TCA: FNHP)¹ in 2006 and the Tripartite First Nations Health Plan (TFNHP) in 2007². Both agreements commit the parties to the jointly held vision: to improve the health and wellbeing of First Nations people, to close the health gap between First Nations people and other British Columbians.

These documents identify priority health actions to be addressed by the Tripartite partners³; the following vital components for the vision of First Nations health in BC are drawn from these documents and from engagement processes with First Nations (detailed in section 4):

- First Nations will have greater input into decision-making regarding health
- Reciprocal accountability
- Health services are better aligned with the needs of First Nations
- First Nations will take a leadership role in improving the health of their communities
- Gaps in health services will have been identified and addressed to the fullest extent possible
- Each First Nation and mandated health organization will have a comprehensive health plan
- First Nations individuals in all regions of British Columbia will have access to quality health services
- Health services will be delivered by First Nations

At Gathering Wisdom for a Shared Journey IV in May 2011, First Nations Chiefs and leaders endorsed the *Consensus Paper 2011: BC First Nations Perspectives on a New Health Governance Arrangement*. Among other things, this document endorsed the signing of the *Tripartite Framework Agreement on First Nations Health Governance* and set the Seven Directives on how the new health governance structure must operate at the community, regional and provincial levels:

1. Community-Driven, Nation-Based
2. Increase First Nations Decision-Making and control
3. Improve Services
4. Foster Meaningful Collaboration and Partnership

¹http://www.health.gov.bc.ca/library/publications/year/2006/first_nations_health_implementation_plan.pdf

² http://www.health.gov.bc.ca/library/publications/year/2007/tripartite_plan.pdf

³ The Tripartite partners include the Government of Canada, Province of BC, and the BC First Nations Health Council. For the purpose of this work, the partners are represented by Health Canada - First Nations and Inuit Health Branch, BC Ministry of Health, and BC First Nations Health Authority.

5. Develop Human and Economic Capacity
6. Be Without Prejudice to First Nations Interests
7. Function at High Operational Standard

The *Tripartite Framework Agreement on First Nations Health Governance*⁴ (“Framework Agreement”) was signed in October 2011. The purpose of the Framework Agreement is to legally establish commitments for federal and provincial governments and First Nations to work together to transfer the operations of First Nations and Inuit Health Branch - BC Region to a First Nations Health Authority, and to provide a greater role for First Nations in the broader health system in Canada and BC with respect to First Nations health needs. The First Nations Health Authority is guided in this work by seven directives endorsed by First Nations Chiefs and leaders at Gathering Wisdom for a Shared Journey IV in 2011 regarding operation of the new health governance structure at the community, regional and provincial levels:

1. Community Driven, Nation Based
2. Increase First Nations Decision-Making
3. Improve Services
4. Foster Meaningful Collaboration and Partnership
5. Develop Human and Economic Capacity
6. Be Without Prejudice to First Nations Interests
7. Function at High Operational Standard

Further direction for the work of the First Nations Health Authority is laid out in the *Consensus Paper 2012: Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure*, which was endorsed by Chiefs and leaders at Gathering Wisdom for a Shared Journey V in May 2012. This agreement sets the standards and structure of the new health governance arrangement, in addition to setting the next steps and key stages of transition and transformation, and affirms commitments made in the 2011 *Consensus Paper* to high standards of reciprocal accountability and engagement.

HEALTH ACTIONS

Over 30 health actions have been identified through the TCA: FNHP, TFNHP, and subsequent discussions. To realize the vision of First Nations health in BC illustrated in the TCA: FNHP and TFNHP, the Tripartite partners have grouped these actions into seven Strategy Areas:

- Primary Care & Public Health
- Mental Wellness & Substance Use
- Maternal & Child Health
- eHealth
- Health Human Resources

⁴ <http://www.fnhc.ca/pdf/framework-accord-cadre-eng1.pdf>

- Health Knowledge & Information
- Health Planning & Capital

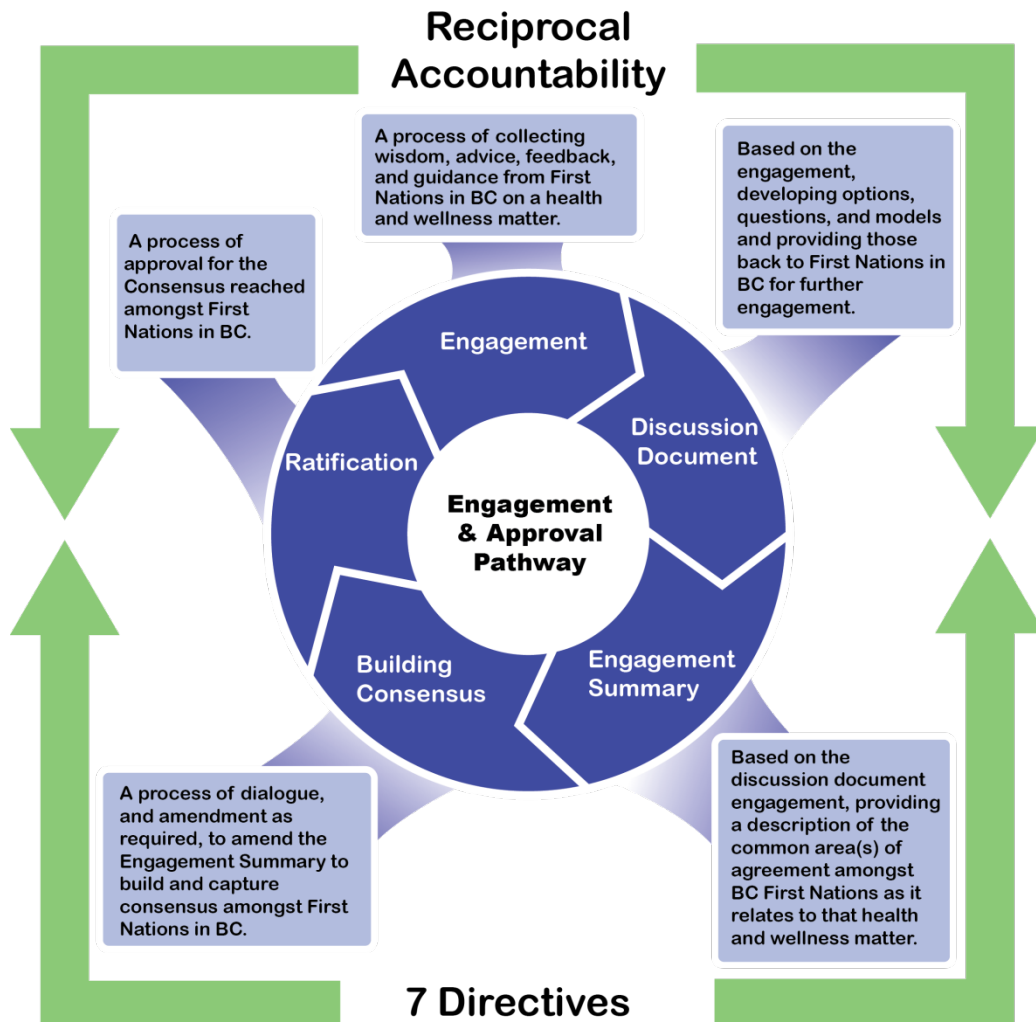
Together, the Tripartite partners are building working relationships in each Strategy Area, and facilitating the systems-level change necessary to support transition to a First Nations-directed health system and transformation toward wellness-based health policies and services for First Nations people.

WHAT WE HAVE HEARD

COMMUNITY ENGAGEMENT PROCESS

Community engagement is critical to the Community-Driven, Nation-Based Directive of Tripartite work. To inform work in the Health Human Resources strategy area, the First Nations Health Authority has led a community engagement process, consistent with the Community-Driven, Nation-Based directive from First Nations Chiefs and leaders. The Engagement and Approval Pathway shown in Figure 1 below has been adapted for use in health actions work from a governance-focused Engagement and Approval pathway endorsed by First Nations leadership in the *Consensus Paper: Navigating the Currents of Change (2012)*. It describes a consistent process for First Nations to provide direction for the work moving forward, and has been used as a tool by the Tripartite Partners to guide the development of this Strategic Approach. This pathway contains five key steps - engagement, discussion document, engagement summary, priority setting, and Tripartite action, within the context of reciprocal accountability. This is a non-linear pathway; it can move forward and backward, and components can be repeated as necessary.

Figure 1: Engagement and Approval Pathway



The *Engagement, Discussion Document, Engagement Summary* and *Priority Setting* phases of this modified Pathway provides an initial picture of Health Human Resources priorities for First Nations communities. These priorities are described in Section 3.2 below. In summary, information was initially gathered and synthesized from a number of opportunities including the *First Nations Health Blue Print for British Columbia*, 2005; the BC Aboriginal Health Human Resources Initiative Environmental Scans, 2007-2009; Gathering Wisdom for a Shared Journey I, II, and III; a Health Director's Forum, 2008; and BC First Nations Regional Caucuses, 2008 – 2010. Additional engagement on these priority areas has occurred through a presentation to the First Nations Health Directors Association Board in October 2011, a world café event at the First Nations Health Directors Association Training and Networking Event in March 2012 and Breakout Sessions at Gathering Wisdom for a Shared Journey V in May 2012.

FIRST NATIONS COMMUNITY PRIORITIES

Information gathered from 2005 through 2010 informed the initial development of the Health Human Resources priority areas described in Section 5: A Framework for Health Human Resources. This information was summarized in the document *Issues for First Nations Communities in Health Human Resources: Information for Stakeholders of the Health Human Resources Health Actions Node*, 2010 ("Issues Paper")⁵; a synopsis of this paper can be found in Appendix A.

Additional input gathered since 2010, including information gathered at the Health Directors Training and Networking Event in March 2012 (see Appendix B) and Gathering Wisdom for a Shared Journey V in May 2012 (see Appendix C). It has continued to inform priority setting and refinement of both the Health Human Resources priority areas and potential goals and objectives outlined in Section 5.

Key Health Human Resources opportunities and challenges that have been identified through these information sources include:

- Children and youth are not fostered to excel in math and science;
- Early childhood development, family supports and K-12 education are critical for the future of a successful and effective First Nations health workforce;
- People are not fully aware of the wide range of health careers which should be promoted more within communities, especially early on among youth;
- Affording an education is the most commonly stated challenge for prospective First Nations students in BC. High tuition fees, costs of living, and the need to leave their community impede opportunities for higher-level education;

⁵ *Issues for First Nations Communities in Health Human Resources: Information for Stakeholders of the Health Human Resources Health Actions Node*. First Nations Health Council. Un-published. July 2010.

- Mentorship among students and professionals is valuable;
- Recruitment and retention of health professionals is still a large barrier for some communities and causes a large drain on resources when having to retrain many people for the same position;
- Wage and workload issues in First Nations health systems are a primary issue in BC;
- Job availability and inequitable pay scales are identified as large barriers to encouraging community members to return and work within their communities;
- The lack of cultural competence of many care providers, in provincial and regional health services, private practice (physicians), labs, pharmacies, and outpatient services, results in a lack of cultural safety for First Nations people, and can be a significant barrier for First Nations people in their attempts to access health services in British Columbia;
- Fee-for-service does not meet relationship building and patient-centered care requirements;
- Health Human Resources planning in isolation can be costly, with unintended impacts, mismatch between supply and demand, and duplication or gaps in services; and
- Community-based workforce planning will require resources and partnerships with health authorities.

FIRST NATIONS HEALTH HUMAN RESOURCES TRIPARTITE STRATEGY AREA

The purpose of the Health Human Resources Strategy Area is to effectively facilitate and support, at a systems-level, the development of a culturally competent workforce that meets the health service delivery needs of First Nations people, and to increase the number of First Nations people in health careers. Included in this mandate are the six TCA: TFNPH action items that relate directly to health human resources, some of which are already underway:

- Dedicate post-secondary seats to Aboriginal health professionals
- Develop a cultural competency curriculum for health authorities
- Designate a senior individual responsible for Aboriginal health in each of the Health Service Delivery Areas
- Further develop the role for nurse practitioners and enhance physician participation in Aboriginal health and healing centres
- Increase the number of professional and skilled trades First Nations in health professions
- Increase the number of Aboriginal Hospital Liaison staff employed by health authorities

The Tripartite partners working within the Health Human Resources Strategy Area have engaged and built relationships with stakeholders at various levels of the health care and education systems, and representatives from the First Nations Health Authority, federal and provincial governments, First Nations education stakeholders, and provincial government stakeholders have worked together to develop this Health Human Resources Strategic Approach. The goals and objectives suggested within this document have been informed by input provided by First Nations communities, along with the perspectives and knowledge brought to the table by the Tripartite

representatives and other stakeholders. The input from First Nations communities is summarized in Section 3: What We Have Heard.

The Health Human Resources Strategy Area acquired funding from Health Canada's Health Services Integration Fund to support the development of a First Nations Health Human Resources Electronic Information System. Phase one of the project has been completed, including an environmental scan, evaluation strategy, initial discussion around indicators, and a data access strategy. Once developed, this system would be a key tool to help forecast and plan for future health workforce needs in BC. It would also assist with monitoring progress toward achievement of a well-trained and culturally safe health workforce serving First Nations people, including an increased number of First Nations people in health careers.

A FRAMEWORK FOR HEALTH HUMAN RESOURCES

HEALTH HUMAN RESOURCES WELLNESS CIRCLE

The Health Human Resources Wellness Circle provides a framework that can be used to guide the development of health human resources priorities and goals that align with a wellness approach across the continuum of care. It has been created through a process of building common understanding among the Tripartite partners of a holistic view of health human resources. The First Nations Health Authority, First Nations and Inuit Health Branch of Health Canada, and BC Ministries of Health, Education, and Advanced Education, all shared perspectives from their own systems and what they have heard from community during the development of this framework. This is a living document that can be used by individuals, communities or regions to help identify their priorities and goals or to develop their own wellness circle.

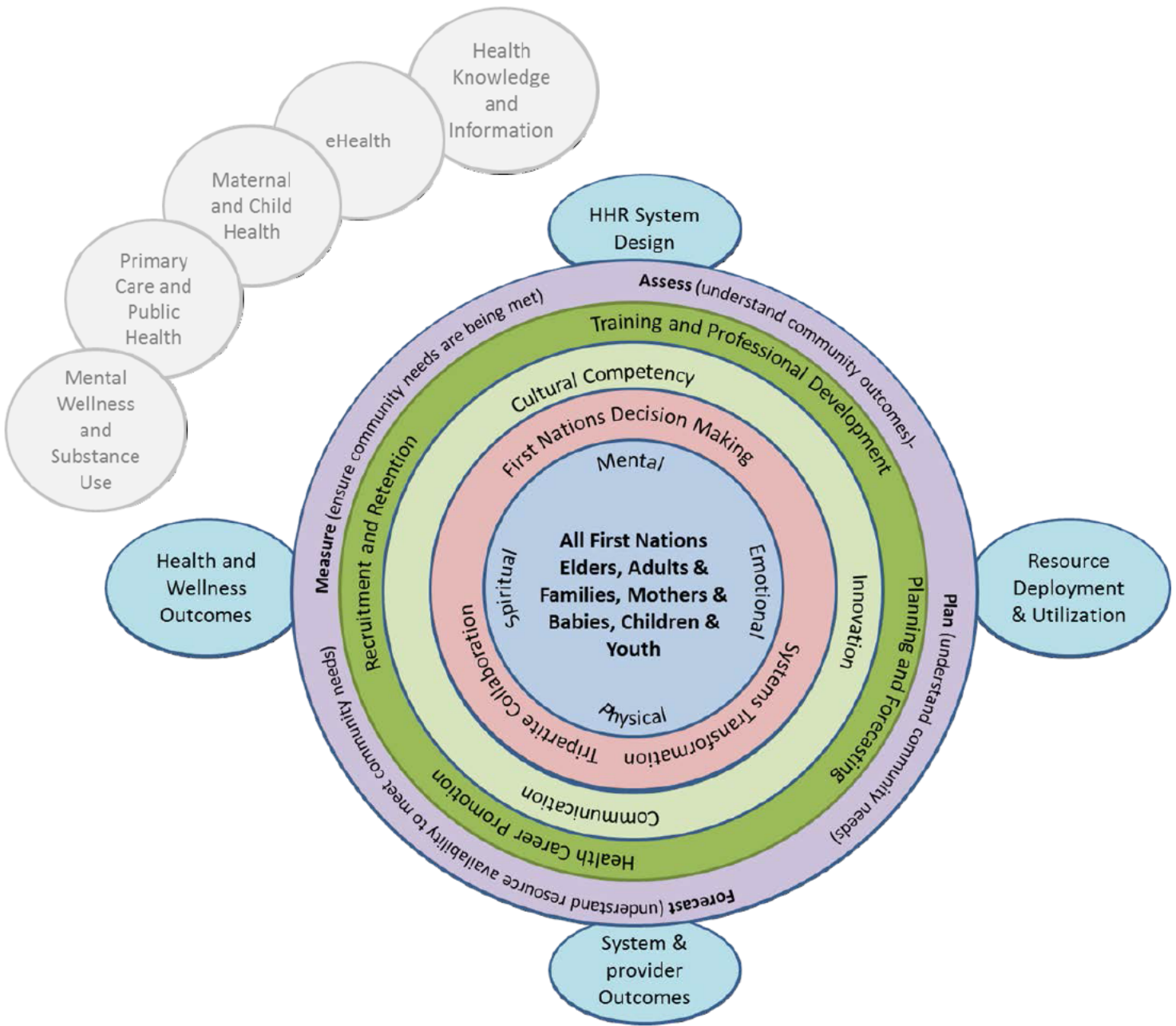


Figure 2: First Nation Health Human Resources Wellness Circles

Health Human Resources Wellness Circle Legend:

- **Blue Centre - All First Nations Elders, Adults and Families, Mothers and Babies, Children and Youth:** This work is intended to benefit all First Nations people of all ages, living in all locations within BC.
- **Blue Centre - Spiritual, Mental, Emotional, Physical:** This work will honor First Nations holistic perspectives on wellbeing which reach far beyond just the physical. For a person to be truly and completely well, their spirit, mind and emotions must also be taken care of. This way of knowing provides space for the social determinants of health.
- **Red Ring - First Nations Decision Making, Tripartite Collaboration, Systems Transformation:** These three Health Actions Implementation Principles⁶ guide work within all of the Health Actions Tripartite Strategy Areas.
- **Light Green Ring - Cultural Competency, Innovation, Communication:** These are the Guiding Principles which are intended to guide the work throughout all of the First Nations Health Human Resources priority areas.
- **Dark Green Ring - Health Career Promotion, Training and Professional Development, Recruitment and Retention, and Planning and Forecasting:** These are the First Nations Health Human Resources priority areas within which goals and objectives have been suggested (see Section 6: Moving Forward).
- **Purple Ring - Assess, Plan, Forecast, Measure:** This pathway was derived from the Health Human Resources System Design pathway that is featured in the *Health System and Health Human Resources Conceptual Model* (O'Brian-Pallas et al, 2001) which is included in the *Framework for Collaborative Pan-Canadian Health Human Resources Planning* and used by the Ministry of Health to guide Health Human Resources Strategies. The phases of this pathway are intended to be non-linear (can occur in any order and move in a forward or backward direction).
- **Teal Ovals - Health Human Resources System Design, Resource Deployment and Utilization, System and Provider Outcomes, Health and Wellness Outcomes:** These are the key elements of Health Human Resources planning that have been selected from the *Health System and Health Human Resources Conceptual Model* (O'Brian-Pallas et al, 2001) and fit within the pathway of community needs. The scope of each of these elements includes:
 - o Health Human Resources System Design – supply; training and professional development, planning and forecasting; communication/systems integration; innovation; cultural competency; financial resources; management, organization and delivery of services
 - o Resource Deployment and Utilization – the amount and nature of resources available; the utilization of resources; and how resources will be deployed

⁶ The Tripartite partners have agreed, through the 2011 *Tripartite 'Health Actions' Implementation Approach*, that these three fundamental principles “must underpin the approach to addressing health actions from the TCA:FNHP and the TFNHP”.

- System and Provider Outcomes – provider health status; turnover rates; job satisfaction; retention rates; cultural competency; access to services; hospitalization and readmission rates; number of people treated in each sector; cost efficiency; etc.
- Health and Wellness Outcomes – premature mortality rates; life expectancy; mortality from cancer, injury, chronic disease; disease incidence; wellness; birth outcomes; etc.
- **Grey Circles - Other Health Actions Strategy Areas:** The grey circles representing the other strategy areas are intended to show that Health Human Resources is a lens that is applied to all areas of health; that it cannot exist in isolation and that it is critical to the success of all health sectors.

PRIORITY AREAS FOR ACTION

Four priority areas have been identified within the First Nations Health Human Resources Strategy Area. They were originally identified during the development of the *Discussion Paper to Support the First Nations Health Human Resources Cluster (2011)* and have been further refined by the FNHHR Tripartite Strategy Table. These priority areas focus on broad, province-wide factors contributing to First Nations Health Human Resources and reflect:

- The six Health Actions outlined in the TCA: FNHP that are directly relevant to Health Human Resources;
- Information that has been gathered from First Nations communities through the *First Nations Health Blue Print for British Columbia 2005*, BC Aboriginal Health Human Resources Initiative Environmental Scans (2007-2009), *Gathering Wisdom for a Shared Journey* (2007, 2008, 2009), Health Director's Forum (2008), and BC First Nations Health Regional Caucuses (2008 to 2010), as summarized in *Issues for First Nations Communities in Health Human Resources (2010)*;
- Additional information gathered more recently at the First Nations Health Directors Association Training and Networking Event (March 2012) and *Gathering Wisdom for a Shared Journey* (2012); and
- Input from Tripartite partners and other stakeholders who contribute perspective from the systems that they work within and enable insights, linkages and alignments to occur where appropriate.

Following is a brief description of the scope and key considerations for each of the four priority areas:

I. HEALTH CAREER PROMOTION

The purpose of the health career promotion priority area is to develop an action plan for actively promoting health careers within the K-12 system and preparing and supporting First Nations communities to encourage more persons to enter into health career training programs. This is sometimes referred to as 'Early Recruitment.'

Currently, one of the most significant barriers for First Nations people entering health career programs is the limited success First Nations students experience in math and science through the K-12 system. The Ministry of Education *How Are We Doing Report 2008-09* shows that of the 6,319 grade 10 Aboriginal students that year, only 24% are taking and passing (C- or better) *Principles of Math* and only 48% are taking and passing (C- or better) *Science 10*. The data is limited in that it does not include the number of Aboriginal students taking and passing math and sciences courses at the grade 12 level, which are the prerequisites for entry to health career programming.

II. TRAINING & PROFESSIONAL DEVELOPMENT

The training and professional development priority area consists of two main components: formal training through post-secondary institutes; and informal training or professional development, largely for individuals who are already working in health careers.

The purpose of this priority area is to examine the post-secondary education system and determine whether there is sufficient capacity to produce health care workers through formal training programs - including developing professionals and para-professionals, developing curricula, and the extent to which the current curricula aligns with emerging health systems' needs. It will also be important to examine the availability, accessibility and suitability of informal training or professional development opportunities currently offered through professional associations, regulatory bodies, First Nations communities, post-secondary institutions and others.

III. WORKFORCE RECRUITMENT & RETENTION

The objective of the recruitment and retention priority area is to develop action plans that will increase the success of workforce recruitment and retention practices within First Nations and BC health care systems; including employers in First Nations communities and BC health authorities. The priority area includes, but is not limited to: compensation, career paths, and workplace supports.

Improving workforce recruitment and retention practices will enhance the ability of the health care system to build and maintain a sustainable labour force in culturally competent and safe work environments. Attention should be paid to laddering and career mobility opportunities for individuals who work in the public and private health sectors.

Care must be taken to ensure that the First Nations Health Authority does not take Health Human Resources away from the communities. The whole health system that serves First Nations people, including provincial, regional and community levels, must be considered an employer of choice. This could potentially be facilitated by strengthening the network between these levels of employment, and enabling mobility within the system to ensure worker satisfaction and best fit between the people and the jobs that they are doing.

Due to insufficient local human resources in the short-term, workforce recruitment will need to draw from a variety of sources that include local First Nations professionals, local non-First Nations professionals and international professionals. Immigration is a key contributor to human resources on a broad provincial level and cannot be ignored within First Nations HHR; therefore, attention

should be paid to the standardized assessments that are employed in the selection of the immigration workforce and currently do not address cultural competency.

IV. PLANNING & FORECASTING

The purpose of this priority area is twofold. The first aspect is to identify requirements for “new” health care providers to meet the needs of First Nations people, which will be dependant of the structure and implementation of health care services within First Nations communities and other health providers serving First Nations people for example, if prevention is a priority focus area, we will need to develop culturally appropriate prevention workers). The second aspect is to inform, monitor and evaluate the development and implementation of First Nations Health Human Resources strategies. This will include enumeration data to serve as a baseline, forecasting modeling, and other activities as required. This priority area will need to work with the other strategy areas to incorporate the health care service structure developed within the various health sector areas. In particular, work in this area will require close collaboration with the Health Knowledge and Information and eHealth strategy areas, to ensure there is no duplication of effort or outcomes.

At present, there is no database to capture the number or mix of Aboriginal workers in the health care system employed by the Province of BC (including health authorities), First Nations communities or organizations. This information is critical to creating a baseline for performance measurement in this area. There are a number of agencies, public and First Nations, who have as part of their mandate responsibility for tracking Aboriginal health care professionals, however, to date this data is either still not collected and/or not integrated into a common province-wide repository.

The data collected through these processes will inform the development and evaluation of Health Plans; for both First Nations and public health authorities. Data will inform health care service providers with information regarding pending challenges such as the upcoming retirement of a significant number of health professionals and para-professionals and can be used to develop strategies to address challenges through strategic investments. Once capacity for centralized data collection has been established, subsequent data analysis, along with timely information sharing, can be used to improve policies and procedures that will enable better health outcomes. Data could also be analyzed to track improvements and to identify opportunities for improvement in administration and provision of services.

MOVING FORWARD

GUIDING PRINCIPLES

The following guiding principles are critical pieces that span all four of the priority areas described above.

I. CULTURAL COMPETENCY AND CULTURAL SAFETY

There are several definitions for the terms *cultural competency* and *cultural safety*. In this work, the term *cultural competency* refers to self-awareness, knowledge, skills and actions that redress power imbalances in relationships between First Nations people and health care providers. The term *cultural safety* is a determination made by a First Nations person about whether the health services available/delivered are culturally safe.

All First Nations people in BC should have health care services available which they determine to be culturally safe, and all of the FNHHR goals should contribute to the realization of this guiding principle. The area of cultural safety, cultural competency, and their interrelationships, is an emerging field that still requires significant work. The process for undertaking this work should be led by First Nations and include all health system stakeholders. Cultural competency and safety must be addressed at systemic, organizational and individual levels within the education and health systems. The process for continued work in this area will need to solicit input from many sources including First Nations, Aboriginal Health Leads within the Health Authorities, Professional Associations, and many others to develop common understanding and potential action plans.

II. INNOVATION

Opportunities for innovation should be sought and incorporated during the implementation of the First Nations Health Human Resources strategy, to increase the success, timeliness, efficiency, reach and sustainability of the progress that is made toward each of the First Nations Health Human Resources goals. These innovations may arise through various sources such as identification of 'best-practices', demonstration projects, innovations from other locations, sectors or jurisdictions and literature reviews. The innovations identified as 'promising' for First Nations Health Human Resources in BC should be applied within the strategies that are developed to achieve each of the First Nations Health Human Resources goals.

III. COMMUNICATION

The First Nations Health Human Resources strategy should both inform and be informed by the contexts, priorities and activities of the communities, systems and sectors that it is working within. Communication should occur with communities and stakeholders from all sectors and jurisdictions of the health services spectrum to enable information sharing, collaboration and integration that results in the development of relevant First Nations Health Human Resources strategic priorities which reflect the true HHR needs of the First Nations health system and leverages the work and resources that already exists. Communication will not only enable input into the First Nations

Health Human Resources strategy, but will also facilitate transformation and accountability within and between health actions strategy areas, community-based health services, health authorities and other stakeholders to inform and support them to develop their own innovative workforce visions.

SUGGESTED GOALS AND OBJECTIVES

The potential goals and objectives presented in Table 1 on the next page have been developed by the First Nations Health Human Resources Tripartite Strategy Table. They are suggestions that can be used to guide work within the regions.

Table 1: Potential goals and objectives for First Nation Health Human Resources, divided by priority area

Health Career Promotion Priority Area	Training and Professional Development Priority Area	Workforce Recruitment and Retention Priority Area	Planning and Forecasting Priority Area
First Nations ways of knowing and being should ultimately inform and direct all of the work undertaken to address these goals and objectives			
<p>Goal 1: The number of First Nations people who choose health careers increases <i>Obj 1.1: Collaborate with the K-12 system to support the effective preparation of students for post-secondary health programs</i></p> <p><i>Obj 1.2: Support communities and PSIs to encourage First Nations people to pursue health careers⁷</i></p>	<p>Goal 2: The post-secondary education system has the capacity and supports to effectively supply health professionals with the appropriate skills mix to adequately meet demand within the health system <i>Obj 2.1: Ensure that health career training aligns with current and forecasted workforce demands</i></p> <p><i>Obj 2.2: Ensure that post-secondary institutions financially and structurally support First Nations people pursuing health careers⁸</i></p> <p><i>Obj 2.3: Ensure that training and professional development opportunities are accessible to working health professionals</i></p> <p><i>Obj 2.4: Ensure that health professionals are provided with the training and tools to provide culturally competent health services</i></p>	<p>Goal 3: Health employers have the capacity and supports to effectively recruit and retain health professionals with the appropriate skills mix to adequately meet demand within the health system <i>Obj 3.1: Support innovative workforce recruitment and retention practices (prioritizing recruitment of health professionals from within BC, but also developing strategies to fill any remaining gaps with recruitment from outside of BC)⁹</i></p> <p><i>Obj 3.2: Ensure that institutional policies support the provision of culturally competent health services (including culturally competent health leadership)¹⁰</i></p> <p><i>Obj 3.3: Ensure sustainability of health programs and HHR positions throughout the health system transfer, transition, transformation and beyond</i></p>	<p>Goal 4: Key data and information is collected and used to effectively inform, monitor and evaluate First Nations HHR strategies <i>Obj 4.1: Ensure that meaningful indicators are developed¹¹</i></p> <p><i>Obj 4.2: Ensure that relevant data, information and community input is available and accessible to inform meaningful indicators and that any data and information gaps are addressed</i></p> <p><i>Obj 4.3: Ensure that the infrastructure and capacity exists to manage and analyze data and information to inform the development, monitoring and evaluation of First Nations HHR strategies</i></p> <p><i>Obj 4.4: Ensure communities are supported in the development and realization of their HHR plans</i></p>

⁷ Encouragement to pursue health careers may include access to role models and mentors, development of supportive social norms, and provision of extracurricular activities such as targeted career fairs, science summer camps and job shadowing.

⁸ Financial and structural supports to pursue health careers should include both direct financial supports, dedicated seats and wrap-around services such as child care, transportation and cultural supports.

⁹ Innovative recruitment and retention practices may include fostering healthy workforce environments, ensuring culturally competent work environments (including incorporation of holistic supports and First Nations ways of knowing and being), strengthening engagement and leadership within the workplace and the provision of competitive salaries.

¹⁰ The meaning of culturally competent services is unique for each territory and should be defined by the territory or territories that are being served.

¹¹ Meaningful indicators should align with both First Nations' perspectives of wellbeing and quality health service, as well as relevant indicators used by other stakeholders.

APPENDIX A – SUMMARY OF ISSUES FOR FIRST NATIONS COMMUNITIES IN HEALTH HUMAN RESOURCES: INFORMATION FOR STAKEHOLDERS OF THE HEALTH HUMAN RESOURCES HEALTH ACTIONS NODE, 2010

The goal is to access health services that are better tailored to the specific needs of First Nations and **more often delivered by First Nations health professionals**. However, notable Health Human Resource (HHR) gaps exist in First Nations communities where First Nations are under-represented in all health care fields, compared to the general population (AFN, 2008). With a supply and demand gap, jurisdictional ambiguities, and system barriers, First Nations on/off reserve in British Columbia (BC) experience increasing stress as they struggle to access the HHR and services required.

This paper highlights some of the key HHR issues raised by First Nations throughout the province. This information was obtained from a variety of sources including the First Nations Health Blue Print for British Columbia 2005; BC Aboriginal Health Human Resources Initiative Environmental Scans (2007-2009); Gathering Wisdom for a Shared Journey (2007, 2008 & 2009); Health Director's Forum (2008); and BC First Nations Health Regional Caucuses (2008 to 2010). Based on the review, these were some of the key issues and challenges:

Education & Awareness

- Children and youth are not fostered to excel in math and science;
- First Nations are not fully aware of the range of health careers; and
- Affording an education is the most commonly stated challenge for prospective First Nations students in BC. High tuition fees, costs of living, and leaving the community impede opportunities for higher-level education.

Workforce Development

- Wage and workload issues in First Nations health systems are a primary issue in BC;
- The lack of cultural competence of many care providers in provincial and regional health services, private practice (physicians), labs, pharmacies, and outpatient services is a significant barrier for First Nations people in their attempts to access health services in British Columbia;
- Fee-for-service does not meet relationship building and patient-centered care requirements; and
- HHR Planning in Isolation: costly; unintended impacts; mismatch between supply and demand; duplication or gaps in services.

Building a capable and competent First Nations health work force is fundamental for providing care that is sustainable, holistic, and culturally appropriate. The paper presents the following recommendations:

- Develop a First Nations Health Workforce Development Strategy that addresses life-long learning and identifies supports needed at each transitional stage;

- Improve First Nations health through the eradication of poverty for First Nations so that they can afford educational opportunities. This must include commitments to: quality education employment and economic opportunity, suitable and affordable housing, safe working conditions, and the elimination of systemic barriers;
- Revise allocation formulae for transfer agreements to ensure that funding for First Nations health infrastructure provides the capacity to offer competitive salaries and employment opportunities;
- Further development of First Nations health career specific fellowships, scholarships and bursaries, and also actively promote and use the INAC clearinghouse website www.aboriginallearning.ca; and
- A standardized, comprehensive method of data reporting to ensure accurate monitoring of Aboriginal health human resource preparation and education.

APPENDIX B – SUMMARY OF KEY HHR THEMES FROM THE HEALTH ACTIONS WORLD CAFÉ AT THE *FIRST NATIONS HEALTH DIRECTORS ASSOCIATION TRAINING AND NETWORKING EVENT, MARCH 2012*

Main themes captured in the feedback from Health Directors (divided by priority areas):

Training and Professional Development

- Training should be offered in communities (especially rural and remote) or be mobile and move between communities
- Mentoring and practice education is valuable, but confidentiality and liability regulations sometimes cause barriers
- Train the trainer is valuable

Health Career Promotion

- Health careers must be encouraged within communities
- Mentorship is valuable in promoting health careers among high school students (consider Alaska's Mentorship Model which includes mentorship through high school and links to employment upon graduation)

Recruitment and retention

- Need for more recruitment and retention of doctors, dentist, nurses, etc (Doctor shortage in Northern BC)
- Need to provide work for spouses to increase retention of health professionals
- Need to improve retention so we don't have to keep starting from scratch
- Enable/encourage community members to return and work within their communities (ie. availability of jobs and community health centre pay scales on par with health authorities)

Planning and Integration

- Community input into HHR strategy:
 - o Health directors require resources to enable research into and development of community-based workforce models and identification of their workforce needs
 - o Need to communicate successes (ie. Seabird Island's adult education, early childhood education, mobile diabetes program, etc.)to inform strategies in other communities
- Linkages:
 - o Communities want relationships with regional health authorities, including access to databases
 - o There needs to be a connections between education and health workforce demands

- Ensure consideration of the whole spectrum of HHR
 - o All health professions (including, for example, nurse practitioners and health care assistants) must be acknowledged as important (not just doctors and nurses)
 - o Need to supply health care support staff (ie. maintenance, IT, etc.), in addition to health professionals
 - o Focus on workforce to support wellness and prevention

Other feedback that links to other areas:

- Planning and Capital Strategy Area:
 - o Facilities management is not local (safety and technology needs filled by people that travel in from Vancouver)
 - o No capital is provided by MCH/HCC programs – communities need resources for infrastructure, equipment and facilities
- iFNHA Transitions Team:
 - o iFNHA is moving too fast – there’s not enough time for the transition to take place
 - o Concern that there won’t be enough staff to deliver FNIIH programs when they transition into the iFNHA
- FNHDA:
 - o Health Directors identified their need for training in occupancy agreements, occupational health and safety, contracts, liability, etc.
 - o Need assistance in developing community and wellness plans
 - o Health directors need an outlet to voice their issues and concerns (this does not always happen via the political voices in their communities)

APPENDIX C – SUMMARY OF FEEDBACK FROM THE HHR BREAKOUT SESSIONS AT GATHERING WISDOM FOR A SHARED JOURNEY V, MAY 2012

Introduction

The Health Human Resources (HHR) Strategy Council has identified four proposed priority areas, with the assistance of past community input, environmental scans, and tripartite and stakeholder discussions: **Health Career Promotion; Training and Professional Development; Workforce Recruitment and Retention;** and **Planning and Forecasting.**

Input on this Strategy Area was sought at Gathering Wisdom for a Shared Journey V, held May 15-17, 2012 in Vancouver¹². During this forum, the Health Human Resources (HHR) strategy area held three breakout sessions, attended by a total of 60 participants.

At each session, Christa Williams, Lead of the HHR strategy area, provided information on progress to date and proposed priority areas developed with the assistance of past community input, environmental scans, and tripartite and stakeholder discussions. Small group discussions were then facilitated by members of the HHR Strategy Council and other staff of member organizations. Participants had the opportunity to discuss:

- whether identified priority areas are truly priorities within communities;
- if there are gaps in the identified priority areas;
- what the most critical priorities are for communities;
- how their communities would be best engaged in HHR priority setting in the future; and
- the top health service needs within their communities.

Highlights of Feedback

Participant feedback indicated strong support for the four proposed priority areas. Due to the diversity within and between communities, as well as the relatively small number of people who attended these sessions, it is important to note that this feedback may not be representative of all of the communities in the province. Among many other themes, some of the recurring themes in the feedback were:

¹² **Gathering Wisdom for a Shared Journey V**, a three-day forum, brought together BC First Nation Chiefs and Health Directors, as well as Provincial and Federal Partners, to discuss the future of health for First Nations in BC (http://www.fnhc.ca/index.php/news/gathering_wisdom).

- The importance of early childhood development, family, and K-12 education for the future of a successful and effective First Nations health workforce (“The seed is planted early”).
- The need for increased community-based education opportunities and the importance of culture, identity, and traditional teachings.
- The necessity of adequate and sustainable program funding for effective recruitment and retention of health professionals in communities. Without this, wage inequities, overwhelming workload, and a lack of jobs for community members to return to, currently cause large barriers for the provision of effective, community-based health services.

Feedback by Priority Area

HEALTH CAREER PROMOTION

- Young people should have **early exposure** to and **increased awareness** of health career opportunities through venues such as career fairs, summer science programs, “bring your child to work” days, job shadowing, role-modelling of health careers by health care professionals, high school career planning, and youth centres/gatherings.
- Programs and learning centres should provide First Nations people with the **skills and tools to pursue health careers**. These should include the specific process for accessing health careers, information about the wide range of health career options to choose from and the skills that are necessary to achieve them (ie. time management).
- Preparation for health careers should **begin in early childhood**, including family supports to ensure children are well nurtured, and early screening and interventions to ensure that children are healthy and able to learn.
- Young people should have **targeted supports in school**, including linkage of education to health careers, timely information about course/program prerequisites, encouragement of math and sciences, and early access to practica. Lack of high schools in some communities is a barrier.
- **Early mentorship** is important, through First Nations role models and youth mentors, with stories shared about overcoming barriers.
- **Financial support** for training, and **funding within communities to hire health professionals**, are important factors in encouraging people to transition into health careers.
- Bring awareness to communities through **partnerships with educational institutions** (e.g. Nicola Valley Institute of Technology).

TRAINING AND PROFESSIONAL DEVELOPMENT

- **Targeted supports** are important, including:
 - **mentoring** (especially from those in the home community or elders) and city orientation of buddy system (potentially through Friendship Centres);
 - **financial support** (e.g. scholarships/bursaries) aligned with programs, including \$ for certificate programs which aren't funded as easily;
 - **opportunities and support for professional development**, including distance education, funding for career advancement, support from employers, certificate/accredited training to ensure transferability of training on and off-reserve
 - focus on skills/strategies to **increase success and avoid drop-out**
 - **identifying transferable credits** for both horizontal and vertical laddering programs
- Learners should have **access to First Nations community-based learning**, (especially for rural/remote communities) that reflects community needs (community care qualifications may differ from existing curriculum) and promotes learners' wellness and self-determination, with a **focus on building community capacity**. Examples include post-secondary institutes located close to community (e.g. Nicola Valley Institute of Technology), formal links/partnerships between community and health authorities (e.g. nursing program with Seabird and FHA, UVic Partnership Program), and community-based practicum.
- Training needs to be **culturally competent**, with mandatory historical impact training and cultural components more applicable to community, and include **traditional knowledge and practice**
- It is important to **leverage existing training programs and national organizations** (e.g. Aboriginal Financial Officers Association of Canada (AFOA), BC Nurses Union)

WORKFORCE RECRUITMENT AND RETENTION

- Attracting students back home to stay requires attention to barriers such as: lack of jobs, lack of full-time jobs, low pay, short term proposal-based work, lateral violence, need to recognize and build upon skills/talent within community, and remoteness of communities.¹³
- Steps need to be taken to **make the work environment more attractive and build capacity**, including:

¹³ Contextual note: in smaller communities, per capita funding may be a factor contributing to inadequate health service funding.

- **providing adequate financial compensation:** addressing pay inequities between employers (e.g. community vs. Health Authorities) and within organizations, ensuring good benefits, and linking incentive packages to commitments;
- **strategizing** for difficult-to-fill positions
- **promoting a supportive and healthy workplace**, e.g. : taking steps to avoid burnout with staff recognition, ensuring good fit between employee and job, and promotion of self-care and work-life balance (e.g. honouring commitments to staff such as time off; 24/7 on-call expectation can be a burden); focus on morale- and team-building; start with healing within the community, as lateral violence causes difficult work environments; and employers supporting capacity-building and employees' training
- **mentorship programs** for practitioners
- **Training in business management** (for employer organizations and managers), Human Resources departments, and an Aboriginal Human Resources Aboriginal Strategy would be useful
- **Strategies to ensure sustainability** of jobs and programs are important; suggestions include business/economic development that can generate income to invest in programs, and longer-term contracts
- **Cultural competency** is needed, including sharing cultural knowledge and norms for jobs filled from outside of community, and building relationships between practitioners and community

PLANNING AND FORECASTING

- Identifying HHR needs requires **succession planning** to inform mentoring of new professionals; **planning, prioritizing, and setting long-term goals** are important steps
- Need to **take advantage of existing data**, and **build capacity to do a comprehensive needs assessment** to identify current and forecasted HHR needs, and ensure access to information gathered; some organizations have already begun setting a foundation for improved HHR planning and forecasting (e.g. Chilcotin's survey regarding training needs and supports; IHA's Aboriginal Self-identification Project; Capacity Building Toolkit by BC Treaty Commission; Wage Subsidy Scan by MoH; Harmony Management grant from BC Hydro for comprehensive community planning)
- Should **track education** of students/graduates¹⁴
- A **holistic health system**, including elders to retain traditional knowledge and practices, is needed, with consistent standards from community to community (part-time care providers shared among communities doesn't provide adequate care); it important to

¹⁴ Contextual note: This may also enhance the ability of education and health professionals (e.g. health directors) to work together to support and recruit students into health careers.

include health administration as well as clinical staff, and be aware of “less conventional” professionals (e.g. naturopaths)

- Need to **remove systemic barriers to improving HHR models** (e.g. work toward nurse practitioner integration; accessible dental services)
- It’s important to **work with health partners**, including Health Canada, health authorities, communities and others (e.g. BC Ambulance Service to meet need for Emergency Medical Technicians) to enable collaboration and avoid overlap

Feedback on Community Engagement

- Engagement should be **community-designed and directed**, working with partners, with Health directors and HUB coordinators involved in more meaningful ways.
- We must **ensure people know that their feedback is used**, with communication going both ways.
- Participants at the breakout sessions were invited to rank which communication and engagement tools they found most useful from a list of tools. In order of priority, participants ranked Publications (reports, brochures, posters) as the most preferred tool, followed by the iFNHA InfoBulletin, iFNHA eBlast, FNHC website, UBC Learning Circles, online videos, iFNHA social media (Facebook, Twitter), online surveys, and Thoughtstream.
- Participants emphasized the importance of **communication that takes place within the community** (ie. at community events, Community Engagement HUBs or Regional Caucuses).

Health Service Priorities for Communities

Participants in the HHR breakout sessions were invited to fill out input forms individually to identify the top three health services needed in their community. Specific priorities varied by community. Common themes included the need to focus on issues relating to mental wellness and substance use, the need for trained and supported health professionals, and the need for prevention/health promotion in communities.