Northern Regional Partnership Accord Evaluation

NORTHERN REGION
First Nations Health Authority

November 2019

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Executive Summary

Introduction

The Northern Partnership Accord (Partnership Accord) is a relationship document intended to increase involvement of Northern Region First Nations in decisions regarding health services that affect them through strengthened collaboration between the Northern Regional Caucus, the First Nations Health Authority (FNHA) and Northern Health (Northern Health). The Partnership Accord was signed in May 2012. It is anticipated that the results from the current evaluation will help to inform a refreshed version of the PA and the Northern First Nations Health and Wellness Plan.

Evaluation Purpose & Methodology

The Northern Partnership Accord Evaluation fulfils the commitment to monitor and report on progress and support the growth of the partnership between Northern Regional Caucus, the FNHA and Northern Health as outlined in Section 6c of the Accord. Evaluation work was undertaken between May 2017 and August 2019. A final draft of the report was presented to the Northern Regional Table and Northern First Nations Health Partnership Committee in November 2019. The Partnership Accord evaluation methodology was co-created by the Northern Regional Table, the FNHA and Northern Health through a collaborative process led by a Northern Partnership Accord Evaluation Working Group that was established in December 2017. Data were gathered by way of surveys, interviews and focus groups from a number of different participant groups, including: Northern First Nations Health Partnership Committee members (including Northern Regional Table members), Northern First Nations Chief Councillors and Health Leads, selected Northern Health and FNHA Northern Regional staff. Findings from the evaluation will be used to inform a refresh of the Northern Partnership Accord.

Key Findings and Recommendations

Governance

Because of the Partnership Accord, Northern First Nations, the FNHA and Northern Health are now sitting together at various tables. The Partnership Accord and the structures/ processes borne of it have been successful at identifying priorities, guiding Partners' ongoing efforts and enabling shared problem-solving and relationship-building across various levels. While relationships have grown and collaboration improved, partnership responses to identified issues are often reliant on individual relationships or are ad-hoc in nature. Further, progress in

operationalizing Partnership Accord commitments and advancing partnership work is slower than it might be on some partnership tables, which participants attributed in part to their composition, unclear scope of decision-making authority, competing demands on time and resource constraints. The recent creation of an operational table to support senior-level discussions at the NFNHP table is aimed at streamlining discussions.

Improvement Opportunities:

1. Compiling, prioritizing and reporting back upon cycles of engagement at sub-regional and the Regional Health Assembly to support progress and accountability.
2. Increase awareness and linkages to the front-line levels.
3. Review mandate, make-up and decision-making authority of partnership tables.
4. Develop systemic solutions to assist in more proactive, long-term initiatives.

Roles and Responsibilities

Evaluation findings suggests that, while there is an improved awareness of the contribution that each partner plays in advancing the objectives of the partnership, a lack of clarity persists in some areas. Responsibility for service delivery improvements in First Nation communities (particularly when multiple funding streams are present); issue escalation processes, the role of CECs and the respective roles and decision-making authorities of partnership working groups were raised as areas where additional clarity on roles and responsibilities may be beneficial.

Communication

Communication has improved over time with Partners now communicating on a regular basis. Regularly-scheduled, structured communications have been perceived to promote communication, the exchange of ideas, and the resolution of issues. Partners have been able to work through difficult conversations together. While not always possible, face-to-face meetings are preferred by participants over other modes and there is interest in meeting more often; a challenge given the significant time and resource pressures facing the Partners. Opportunities exist for improving communication processes, products and clarifying communication pathways between communities and the FNHA/ Northern Health.

Improvement Opportunities:

5. Engage through dialogue rather than one-way reporting.
6. Improve onboarding processes and packages.

7. Increase communications and meeting frequency at senior-level tables, and ensure senior-level NH attendance at key governance forums.

Engagement

As a result of the Partnership Accord, there is greater awareness of the importance of involving First Nations in discussions and decisions that directly affect them and, as a result, has led to an increase in requests for input from community leadership, FNHC members and FNHA staff. Strides have been made to ensure that First Nations are involved in planning and monitoring of health services and influencing the decisions that impact First Nations communities in the Northern Region, for example, through the creation of the First Nations Health and Wellness Plan and Primary Care Network planning. Facilitators to engagement identified included conducting work through ceremony and/or in-community, the strengths of individual staff and roles, and aligning engagement efforts between the FNHA and Northern Health. It was noted that in some instances engagement is considered a formality, with input provided through engagement not being integrated into final outcomes. Minimizing the burden of multiple engagement events and meetings for community leadership and increasing FNHA regional team capacity to conduct events were noted as areas that would support engagement efficacy. More work is needed to ensure that First Nations are operating as full Partners in the decision-making processes by focusing on addressing priorities identified by communities, and ensuring solutions proposed align with the underlying needs identified by communities.

Improvement Opportunities:

8. Address the priorities, needs and solutions voiced by community.
9. Identify opportunities to move up the engagement 'spectrum'.
10. Provide clarity on purpose of engagement and report back on how engagement was used.
11. Coordinate and align engagement opportunities.
12. Consider additional administrative capacity for FNHA regional engagement teams.
13. Engage in community and through ceremony.
14. Include broader scope of roles at the table.

Relationships

There is a perception that one of the greatest achievements of the Partnership Accord thus far has been the building and strengthening of relationships between Northern Region First Nations, Northern Health, and First Nations Health Authority

across multiple levels, however relationships have not been strong in all areas. Partners have invested time into relationship-building efforts and recognize that continuing to the nurture relationships is key, particularly when there is turnover in staffing. Quality relationships are sometimes hampered by a lack of time and resources to support meaningful conversations and by Partners not upholding individual commitments made.

Improvement Opportunities:

15. Continue to invest time, resources and commitment to nurturing relationship, particularly when there is turnover in staff.
16. Build trust through demonstration of follow-through on partnership initiatives.

Collaboration & Partnership

Both the quality and quantity of partnerships have increased over time in many areas of work of the PA. Examples of collaboration included the co-development of educational tools for frontline providers, collaboration during the 2017 and 2018 forest fires, joint development and implementation of the MST JPB project and the 2018 Welcoming Feast held in Smithers. Partners are committed to collaborating with one another to enhance health services for Northern First Nations at both the strategic and operational level. Facilitators to effective collaboration and partnership among Partners include the implementation of the Partnership Accord itself, regular meetings, shared commitment to the objectives of the partnership and individual champions and roles. Still, there is a perception that partnership efforts are not as balanced as they could be with respect to decision-making across multiple levels (establishing directives; setting agendas; reporting on findings) and investment of human and financial resources and that progress can be hindered in some cases by individuals with divergent perspectives. Moving forward, the Partnership Accord refresh represents an opportunity for defining what 'partnership' means in practice. The refresh of the Partnership Accord presents an opportunity to clarify roles and responsibilities as well as support the understanding of each Partner's financial capacity, resource constraints, corporate culture, funding structures, timelines, mandates and geographical realities.

Improvement Opportunities:

17. Operationalize the term "partnership" in the refreshed Partnership Accord in order to promote a shared understanding of what the term means for joint work and decision-making at different levels of collaboration.
18. Develop mechanisms/forums for partners to increase understanding of organizational contexts (size, complexity, scope, structure, constraints,

funding structure, funding constraints, time pressures, decision-making processes).

Integration and Coordination

There is evidence of enhanced health service integration and coordination as a result of the PA. Supported by multilateral committees and processes, strategic conversations are now occurring to better align the planning and delivery of health services for Northern First Nations. Partnership working groups, IHIC/AHICs, JPB MST PACs, patient journey mapping exercises and regular meetings between FNHA and Northern Health staff to collaborate on technical matters were identified as mechanisms for integration and coordination. Still, opportunities for greater integration and coordinate exist, particularly relating to services delivered in First Nation communities. Moving forward, opportunities identified to support greater integration and coordination include increasing awareness of services offered in First Nations communities, sharing of clinical information within the circle of care and improving discharge planning processes through policies and tools informed by the realities of service offerings available in First Nation communities. Opportunities/ solutions could be addressed through technical forums on key issues.

Improvement Opportunities:

19. Clarify service delivery policies for on-/off-reserve.
20. Improve discharge and care coordination planning tools/information (service offerings in community).
21. Consider opportunities to conduct more joint planning.
22. Identify mechanisms to support the sharing of clinical information.
23. Hold forums on key topics to identify opportunities for integration/coordination.

Cultural Safety & Humility

There is a growing awareness and understanding of cultural safety and humility within Northern Health and a perception among some participants that cultural safety has improved since the signing of the Accord. Examples of community orientations to new providers within then JPB MST project, increased flexibility for family visitations in hospital, the regional cultural safety work of IHIC/AHICs were all identified, among others, as examples of work in this area. There was also a sense that there is a greater willingness to openly acknowledge issues, which was viewed as positive. Still, much work still needs to be done, with racism continuing to be a pervasive problem in some areas, and little outcome data to track progress. What information exists suggests culturally safe care is experienced less frequently by

self-identified Aboriginal patients than non-Aboriginal patients. Future opportunities exist to strengthen supports/ incentives for training of frontline staff, enrich existing training with localized content, simplify complaints processes, and to develop measures to assess progress in improving cultural safety.

Improvement Opportunities:

24. Encourage participation in cultural learning events in the region.
25. Consider mandatory online cultural safety training.
26. Supplement online training with localized content, in-person training and cultural event attendance.
27. Consider policies and written materials from a cultural safety and humility lens.
28. Streamline and make complaints process available online to ensure that individuals feel safe and encouraged to register complaints.

First Nations Perspective on Wellness

Partners have put initiatives into action that have promoted greater awareness/ recognition of traditional wellness among Partners and others. While Partners have embedded supports for traditional wellness into a small number of projects (e.g. Mental Wellness Substance Use Mobile Support Teams (MST) there is a perception that the First Nations Perspective on Wellness is not yet broadly reflected in health services in the North. Ensuring increased and sustained recognition of/ resources for traditional wellness approaches, and enhancing understanding of North First Nations cultures were identified as areas for improvement moving forward.

Improvement Opportunities:

29. Increasing recognition, acknowledgment and remuneration of traditional knowledge, traditional healing and cultural supports and knowledge.

Access, Availability and Quality of Services

Specific projects have increased the accessibility of certain health services for North First Nation communities, for instance the JPB MST project, primary care network planning and cultural safety and humility initiatives. There are also increased opportunities for Partners to become aware of access challenges. Service gaps and disparities in service access between communities remains a challenge, with First Nations communities identifying many service needs and challenges. Constraints to improving service access included geographic remoteness; recruitment and retention of health care workers, especially in remote communities; and time-limited funding. Patient transportation barriers exist and include difficulty arranging transportation, and inadequate meal and accommodation compensation through

the FNHA's Medical Travel First Nations Health Benefit program. The development of standardized outcome measures may enable the Partners to better measure improvements moving forward.

Improvement Opportunities:

30. Increase in-community service delivery and availability of services outside of regional centre (either through Northern Health or through more direct service-delivery by communities).
31. Increase availability of services outside of regional centres and in First Nations communities.
32. Greater choice in health service offerings.
33. Integration of traditional healing, medicines and approaches into care.
34. Increased communication regarding services available.

Resources and Capacity Building

Findings suggest there have been perceived improvements in funding opportunities and that processes to access/ administer funding have been simplified. Future opportunities exist to increase awareness around all funding sources available to communities, to implement alternatives to grant and one-time funding streams and to increase the flow of funding to communities. Partnership investment in opportunities to support human resource capacity building, training and infrastructure may be beneficial at the community level.

Improvement Opportunities:

35. FNHA leverage additional funding sources and act as financial host to increase flexibility. Identify alternatives to grant/one-time funding to support increased sustainability.
36. Provide information on funding opportunities and funding recipients.
37. Simplify applications and reporting.
38. Build capacity and infrastructure within First Nations communities - Support increased opportunities for capacity-building and learning in community (e.g. through training, mentorship and job shadowing).
39. Support investment in accommodations, workspaces and permanent equipment to enable community visits by health professionals and enhance community capacity to care for community members who require more intensive medical supervision.

Monitoring Progress and Evaluation

Evaluation is considered integral to the improvement of health services for First Nations in the Northern Region. Formal evaluation is considered an essential tool

for reviewing gaps and priorities and for determining progress over time. Moving forward, the refreshed Partnership Accord represents a timely opportunity for Partners to outline measurable success indicators and expected short, interim and longer-term outcomes to better track Partnership Accord performance.

Improvement Opportunities:

40. Commit to regular formal reviews, evaluations and timelines.

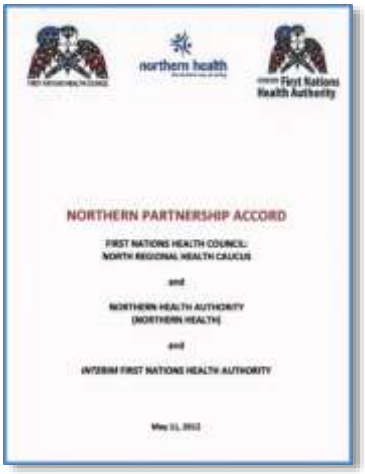
41. Improve accountability measures and timelines for commitments in refreshed Partnership Accord.

42. Outline specific short (less than a year), interim (1-3 years) and longer-term (3+ years) outcomes and performance measures in the refreshed PA to track progress.

Introduction

Background

The Northern Regional Caucus, the First Nations Health Authority and Northern Health (the Partners) signed the historic Northern Partnership Accord (PA or 'the Accord') in May 2012, creating the foundation for meaningful collaboration and cooperation between the Partners.



The purpose of the Partnership Accord is to improve health outcomes and to enter into a mutually beneficial relationship that enables collaboration in the planning, implementation and evaluation of culturally appropriate, safe and effective services for First Nations living in the Northern Region (Section 2b of the PA).

Evaluation Purpose

The evaluation will fulfil Section 6.c of the PA[1]. Regional Partnership Accord evaluations, including the Northern Partnership Accord Evaluation contribute to fulfilling the Partners' legal requirement to evaluate the Tripartite Framework Agreement on First Nation Health Governance (TFA) and will inform the upcoming renewal of the PA and Northern First Nations Health and Wellness Plan. The evaluation will also identify lessons learned, successes and challenges of the partnerships.

About the Northern Region

Despite being home to only 6% of the total provincial population, the Northern region occupies nearly 65% of BC's land mass. Population density is the lowest amongst all of the regions, with only 0.4 individuals per square kilometer. The north has the largest number of First Nations communities, the largest First Nations population and largest number of First Nations living on-reserve. The percentage of the regional population that is Aboriginal is the highest among all regions (20% of the population in the North is Aboriginal). The Interior has the next highest percentage of residents who are Aboriginal (8% of the population in the Interior is Aboriginal). One half of BC's First Nations communities with fly-in-only/ boat-only

[1] Note that Section 6.c states that the Partners will "review progress in achieving the Northern First Nations Health and Wellness Plan goals and objectives and progress in developing the relationship outlines in this Accord"

access (i.e. no access by road) are also in this region (n=10). The largest Census Metropolitan Areas for Indigenous and First Nations residents in the north are Prince George, Prince Rupert and Terrace, with populations of 7,000, 4,000 and nearly 3,000 First Nations individuals in 2016. These centres have some of the highest percentage of Aboriginal and First Nations residents out of all census metropolitan areas in the province. See Appendix C for other demographic, geographical and health system information.

First Nations Regional Health Governance Structure – Northern Region

As depicted in Figure 1 below, the following are the key governance structures within the Northern Region:

- Northern Shared Regional Health Assembly[2];
- Sub-Regional Sessions;
- Northern Regional Table;
- Northern First Nations Health Partnership Committee & Operation Committee; and
- Five Partnership Working Groups.

There are also entities and groups under Northern Health and FNHA structures that are bringing Partners together for specific initiatives or around particular geographies that are not formally part of the First Nations Health Governance Structure in the Northern Region, but that are important fora for collaboration and partnership between Partner staff. These include:

Under Northern Health:

- Eight Indigenous/Aboriginal Health Improvement Committees (IHIC/AHICs)

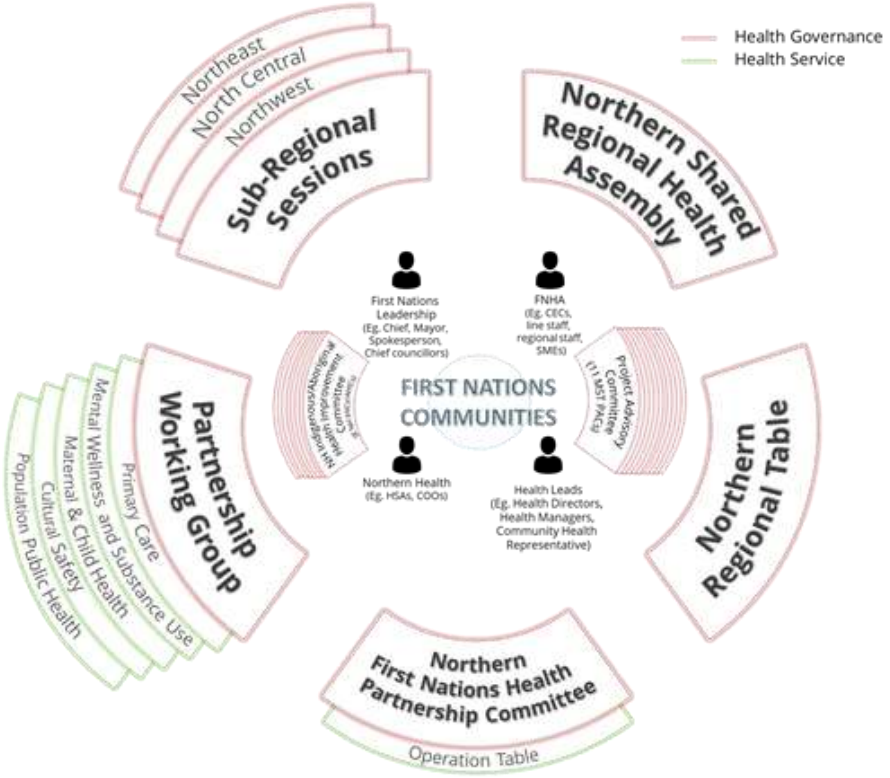
Under the FNHA/Northern Health:

- Eleven[3] Project Advisory Committees developed to support the implementation of the Joint Project Board Mobile Support Team project.

[2] In fall 2019, the Northern Health Caucus sessions were renamed 'Northern Shared Regional Health Assembly"

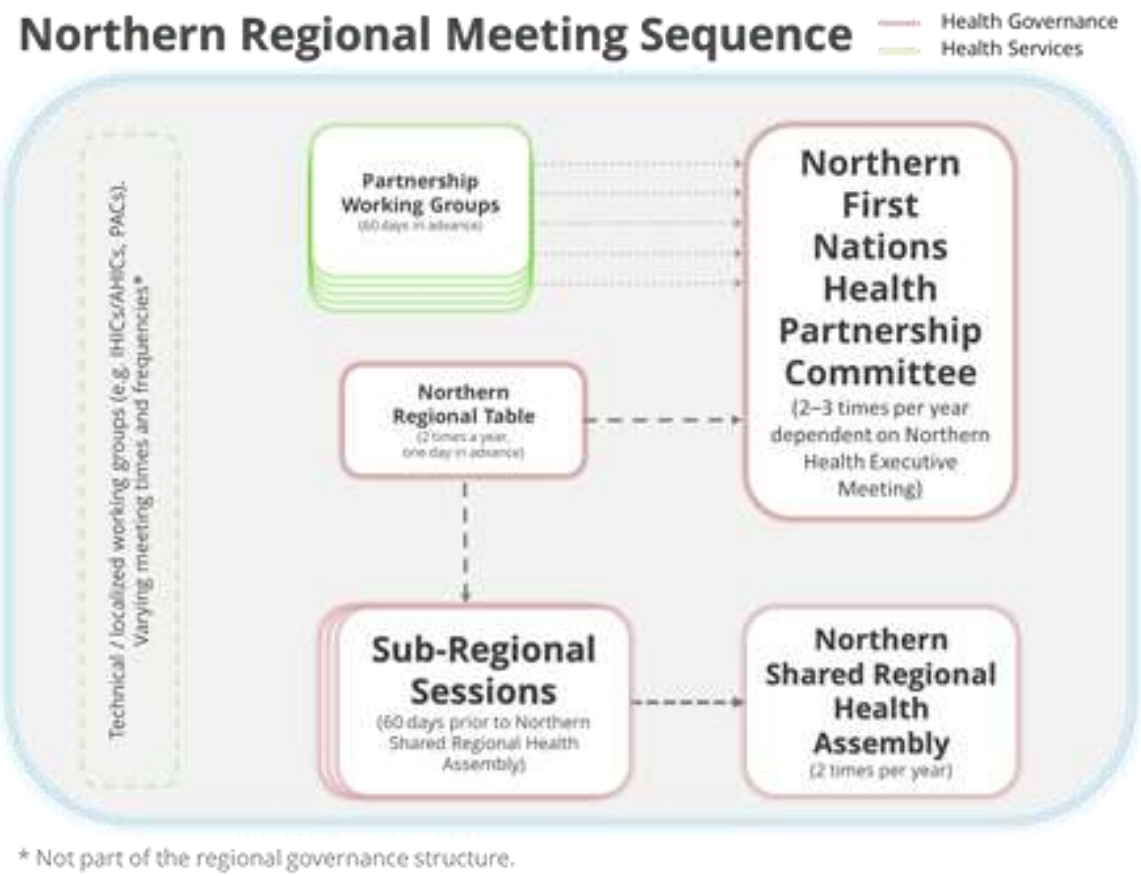
[3] At the time of the writing of this evaluation report, the PACs are in various stages of implementation so this number may change over time.

Figure 1: Working groups, committees, organizational players and roles within the Northern First Nations Health Regional Structure



As displayed below in Figure 2, there are reporting/sequencing of meetings for these various technical (health services) and governance tables. For example, the five Partnership Working Groups meet up to 60 days in advance, and report to, the NFNHPC. The NFNHPC meets following the Northern Health Executive Meeting. The Northern Regional Table meets one-day prior to, and reports to, the NFNHPC. Sub-regional sessions occur up to 60 days prior to the Health Assembly. A variety of localized working groups (8 IHIC/AHICs and 11 JPB MST PACs) meet at various frequencies.

Figure 2: Northern Regional Meeting Sequence

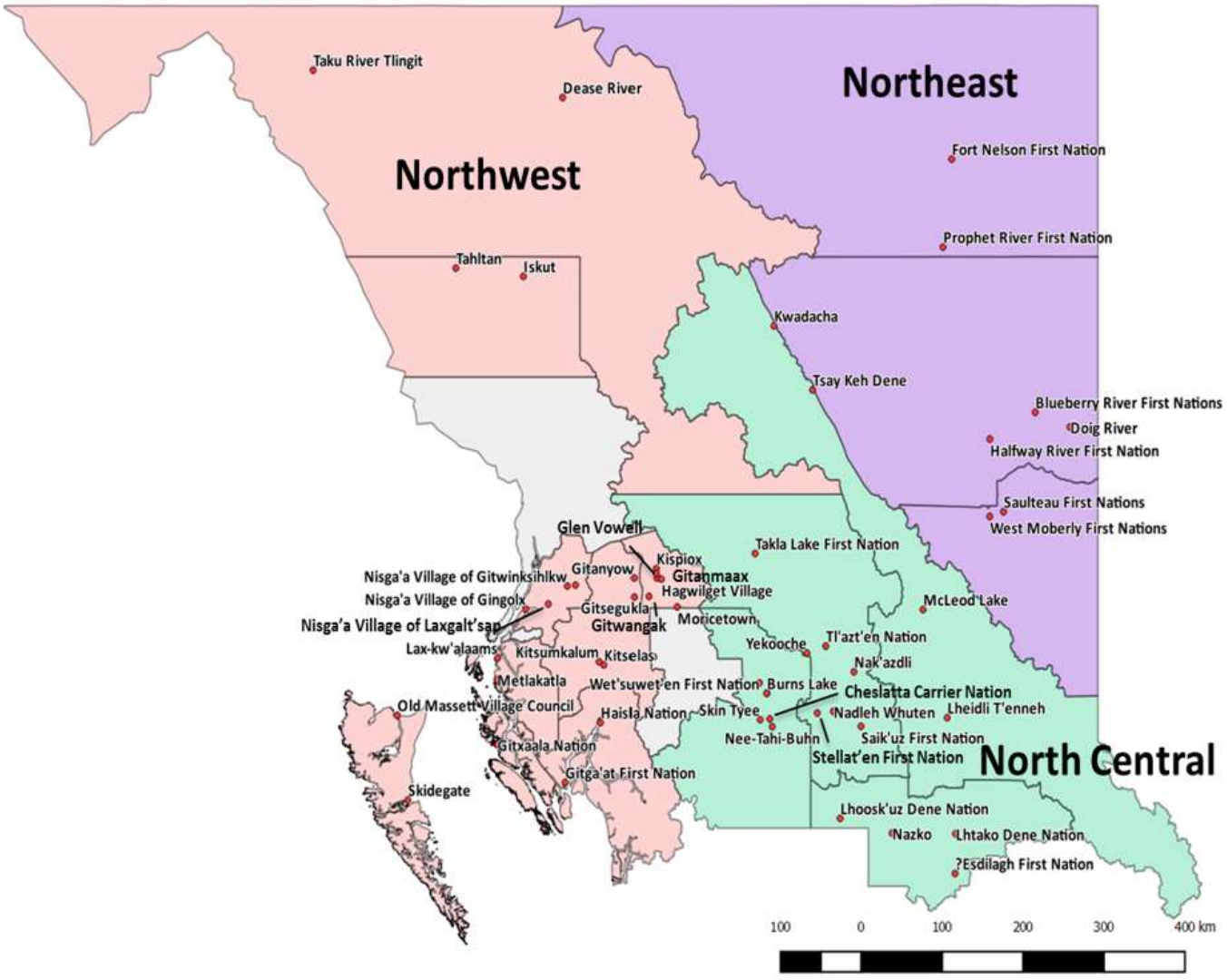


Northern Shared Regional Health Assembly

The Northern Shared Regional Health Assembly consists of membership from each of the 55[4] Nations in the Northern Region (see map in Figure 3 below). Political, technical, and social leads from each of the 55 communities come together at Sub-Regional gatherings to discuss health priority issues.

[4] In 2019, one of the Tl'azt'en Nations split off to form the Binche Whu'ten Nation (Band number 730), bringing the total number of Nations in the Northern Region up to 55. In the Northeast, there were 7 Nations and one Nation (Mcleod Lake) choose in 2018 to associate with the North Central sub-region.

Figure 3: First Nations in the Northern Region (Northern Regional Profile, 2018)



Sub-Regional Sessions

The 55 Northern First Nations have organized themselves into three sub-regions: (1) Northwest (NW) (26 Nations); (2) North Central (NC) (22 Nations); and (3) Northeast (NE) (7 Nations) to allow for localized conversations regarding health needs. Sub-regional political,[5] technical and social representatives meet twice per year at Sub-Regional Session events, prior to the Health Assembly gatherings, although attendees tend to be primarily technical and social First Nation community representatives. Political representatives who are unable to attend sub-regional sessions will send a proxy to report back to Chief & Council. The

[5] Different titles are used to denote political leadership across communities (e.g. Chief (highest elected person), Mayor, Spokesperson, Chief counselors). In some areas the term 'Chief' refers to hereditary Chief, so the preferred term for engagement is 'Chief counsellor.'

Northern Regional Table representatives report back to Sub-Regional Sessions. Northern Health staff (e.g. Health System Administrators, Chief Operating Officers of the sub-region) are invited as observers to Sub-Regional Sessions.

Northern Regional Table

Established by the Northern Regional Caucus, the Northern Regional Table is an advocacy body that is representative of and accountable to Northern First Nations.

The Northern Regional Table is comprised of three representatives from each sub-region: the appointed FNHC representative from the sub-region; a technical representative from the FNHDA elected by the Sub-Regional Session; and a community representative from each sub-region, elected by the Sub-Regional Sessions. All representatives are elected to a three-year term and collectively represent the political, technical and community perspectives of Northern First Nations.

The Northern Regional Table meets on a regular basis at least twice a year prior to the NFNHPC as well as informal monthly touch-base updates. All members of the Northern Regional Table are invited to attend the Northern First Nations Health Partnership Committee. Representatives sitting at the Northern Regional Table report back to their respective sub-regional Leadership regarding Northern Regional Table and NFNHPC activities at Sub-Regional Sessions and the Health Assembly.

Northern First Nations Health Partnership Committee

The Northern First Nations Health Partnership Committee (NFNHPC)[6] is a forum for senior representatives from each party to collaborate in developing and overseeing the implementation of a Northern First Nations Health and Wellness Plan (NFNH&WP). The Plan is noted as a foundational guiding document: working groups and action plans have been created based on the priority areas identified in the plan, originating from the health actions outlined in the Tripartite First Nations Health Plan, and reports are being produced to monitor progress.

According to its terms of reference, the NFNHPC meets three times a year, although in both 2018 and 2017 only two meetings occurred.

Members of the NFNHPC include:

[6] originally referred to as the Northern First Nations Health and Wellness Planning Committee

Northern Regional Table members	- NW FNHC elected rep - NC FNHC elected rep - NE FNHC elected rep - NW FNHDA elected rep - NC FNHDA elected rep - NE FNHDA elected rep	- NW community elected rep - NC community elected rep - NE community elected rep
Northern Health	- CEO - VP Aboriginal Health - COO east - COO west - COO central	- Chief Medical Health Officer - VP, Clinical Programs - Chief Nursing Officer - Regional Director, Aboriginal Health
FNHA	- CEO - Ex-Officio - COO - Ex-Officio - Regional Executive Director, Northern Region - Ex-Officio - Regional Program Liaison – Ex-Officio (provides secretariat support)	

A public facing communiqué is produced after every meeting of the Northern Regional Table and NFNHPC that describes the business conducted at each meeting.

Northern First Nations Health Operation Table

In 2018, an operations table was developed to support the operational discussions of the NFNHPC.

Partnership Working Groups

Five Partnership Working Groups are each co-chaired by NFNHPC members, with varied membership, including:

- Northern Health staff (e.g. Indigenous Health staff, HSAs, COOs, and executive leads for specific program areas (e.g. Child & Youth Health));
- FNHA staff (e.g. program and project developers, nursing manager, FNHA central staff); and
- six of the nine representatives from the Northern Regional Table are assigned to different working groups (one-two per working group, with some overlap).

The frequency of Working Group meetings varies by group. Working groups were established to address priority issues pertaining to the following health areas:

- Primary Care;
- Mental Wellness and Substance Use;
- Maternal & Child Health;
- Cultural Safety; and
- Population Public Health.

Northern Health

Northern Health is a signatory to the PA.

Northern Health's operations are the responsibility of an executive team, headed by a CEO. The executive team is responsible for functions that include (but are not limited to):

- Developing operational plans for objectives set out by Northern Health's Board and making sure that those plans are acted upon;
- Preparation of budget, capital, and human resources plans;
- Approving consistent regional standards for programs and services; and
- Approval of regional policies for the organization.[7]

In 2013, the Northern Health Board of Directors created a new position for a Vice President of Aboriginal Health at the executive leadership level.

Northern Health has over 7,000 staff delivering acute, mental health and addictions, public health and home and community care in over two dozen hospitals, 14 long-term care facilities, and public health units.[8]

Services are delivered within three geographic operating divisions ('Health Service Delivery Areas' (HSDAs)): the Northeast, Northern Interior, and Northwest.

A Chief Operating Officer (COO) manages each HSDA and reports directly to Northern Health's CEO. Health Service Administrators (HSAs) report to the respective HSDA COO and provide day-to-day provision of services in a community cluster. There are 15 HSAs at Northern Health.

Northern Health Indigenous/Aboriginal Health Improvement Committees

Northern Health has eight Indigenous/Aboriginal Health Improvement Committees (IHIC/AHIC) whose composition varies but includes FNHA Community Engagement

[7] Source: https://www.northernhealth.ca/about-us/leadership/management-executive-team?keys=coo#executive-team
[8] Source: https://www.northernhealth.ca/about-us/quick-facts

Coordinators (CECs), Northern Health, First Nations and representatives from Indigenous communities and organizations.[9] Each IHIC/AHIC has a small budget ($20,000 per year) and has the flexibility and authority to plan and carry out localized activities. A large gathering of all IHICs/AHICs is held in May each year. The FNHA CECs co-chair the IHIC/AHICs, send reminders, invitation and bring forward issues if individual community representatives cannot attend.

First Nations Health Authority

The First Nations Health Authority is a signatory to the Northern PA. In 2013, the FNHA assumed the programs, services, and responsibilities formerly handled by Health Canada's First Nations Inuit Health Branch – Pacific Region. The FNHA is responsible for a number of strategic areas including working with Partners in the planning, design and delivery of health services, supporting coordination and integration, supplementing health data collection and reporting and integrating First Nations models of wellness into the health care system[10].

The FNHA is regionalized, with a lead office for the North in Prince George. Many FNHA programs and services are centralized.

Mobile Support Team Project Advisory Committees

Eleven Project Advisory Committees (PACs) currently exist to support the implementation and delivery of the Mental Wellness Substance Use Mobile Support Team (MST) Joint Project Board (JPB) projects throughout the region. The MSTs are made up of a combined total of twenty-six positions[11] that will deliver services and help fill a long-recognized service gap in the region. The projects are currently in various stages of implementation and seek to improve access to and address gaps in mental wellness and substance use services in 41 out of the 55 communities in the North. Regional envelope funding[12] is being considered to expand services to remaining communities.

The PAC include representatives from the FNHA/NH, as well as local First Nations communities to jointly provide ideas, expertise, and guidance for the local

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[9] Source: https://www.indigenoushealthnh.ca/sites/default/files/2017-01/AHIC_Mapping_Summary.pdf.

[10] See sections 4.2.2 and 6.1 of the British Columbia Tripartite Framework Agreement on First Nations Health Governance, available from: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/framework-accord-cadre-eng.pdf

[11] Total of 25.7 FTEs: 8.0 FTE (8 x 1.0 FTE) community RN, 15.0 FTE (15 x 1.0 FTE) RSW/RCC, 2.2 FTE (0.6 FTE, 0.8 FTE x 2) NP, 0.5 FTE Outcomes Analyst. Data Source: JPB Standing Briefing - Last Updated June 3, 2019.

[12] Regional envelope funding is available for FNHA regions to invest in their key priority areas. Source: https://www.fnha.ca/about/news-and-events/news/ppss-readies-for-regional-focus

implementation of the project (e.g. identifying local needs, special circumstances, selection of staff, issue identification, operational structures to manage and coordinate staff).

Evaluation Methodology

In May 2017, the Partners approved the establishment of the Northern Partnership Accord Evaluation Working Group (WG) to plan and implement an evaluation of the Accord. The Working Group, consisting of members from the Northern Regional Table, Northern Health Indigenous Health team, the FNHA Northern Regional team, and FNHA evaluation team met starting in December 2017 to carry out the evaluation.

The scope of the evaluation covers three broad areas: governance and relationships, coordination and integration of planning and service delivery, and program and service improvements.

A mixed methods approach was utilized for the Northern Partnership Accord Evaluation. The overall approach to the evaluation was developed through Evaluation Working Group discussions concerning the scope, potential participants and methods. Data were collected by FNHA evaluation staff and Ference & Company Ltd, a consulting firm contracted by the FNHA to support the evaluation work.[13]

Data Sources

The Partnership Accord evaluation incorporates multiple lines of evidence including both primary data sources (Sub-Regional Session Survey, key informant interviews (KIIs), and focus groups (see Appendix A for a listing of all interview/focus group guides) and secondary data sources (review of available patient experience and health outcome data (see Appendix B for a description of these quantitative data sources and Appendix F for results). The KII and focus group guides included semi-structured questions that utilized Likert-type rating scales, and open-ended questions. All data gathering instruments were collaboratively developed by members of the Partnership Accord WG. A breakdown of Partnership Accord evaluation participants by primary data source appears in Table 1 below.

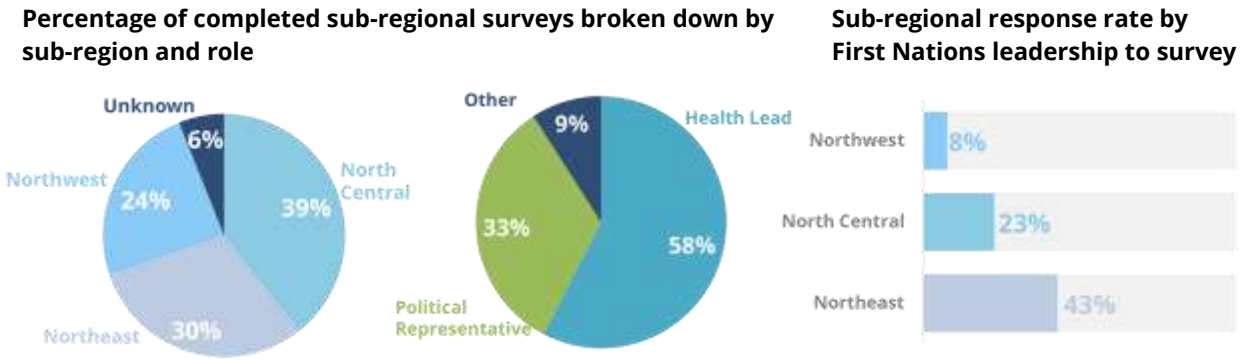
Sub-regional Session Survey & Breakout Discussions

Following a short presentation on the Partnership Accord and the evaluation, community technical and political representatives in attendance at the fall 2018 Sub-Regional Sessions were invited to complete a short survey on the PA. A total of 33 community representatives completed the survey (See Section 1 of Appendix A for quantitative results from these surveys). Participants included 19 health leads,

[13] For more information on Ference & Company Consulting Ltd., please visit http://www.ferenceandco.com/, retrieved online May 28, 2019.

11 First Nation leaders and 2 'other' roles. In terms of geographical participation, there were 8 survey responses from the Northwest, 13 from the North Central sub-region, 10 from the Northeast, and 2 unknowns. Responses from First Nations leaders included 2 from the Northwest (representing 8% of First Nations leaders), 5 from the North Central sub-region (representing 14% of First Nations leaders) and 3 from the Northeast (representing 43% of First Nations leaders) (see Figure 2 below).

Figure 2: Percentage of completed sub-regional session surveys broken down by sub-region and role, response rate by First Nations leadership by sub-region (33 participants in total)



An evaluation analyst was also available throughout the sub-regional sessions to collect individual interview feedback however no participants partook. Community technical and political representatives at three spring 2019 Sub-Regional sessions were similarly invited to participate in breakout discussions regarding their communities' priorities and ways these could be addressed in partnership.

Key Informant Interviews

Members of the NFNHPC (n=13), as well as operational staff members from the FNHA and Northern Health (n=15) were invited to complete semi-structured key informant interviews regarding the Partnership Accord in late 2018/early 2019 (See Section 2 of Appendix D for quantitative results from these surveys).

Focus Group Discussions

Four focus groups were completed by telephone with four of the five partnership working groups related to primary care, maternal and child health, population and public health, and cultural safety in late 2018/early 2019. A focus group was also envisioned for the remaining partnership working group (mental wellness and substance use), but was unfeasible within the data collection period. A total of 24

Northern Health and FNHA partnership working group members participated in the focus groups.

Table 1: Evaluation participants by participant group and data source

Participant Group	Data Source	Target Participants (n)	Evaluation Participants (n)	Unique Participants (n)
Northern First Nation community leaders and health leads	Fall 2018 Surveys	All community representative participating in Caucus (unknown number)	33	33
	Spring 2019 Breakout discussions	All community representative participating in Caucus (unknown number)	Unknown	Unknown
Northern First Nations Health Partnership Committee Members (Current and outgoing members)	Interview	21	13	13
Five (n=5) Partnership Working Groups	Focus Group	Working group members	24 (4 of the 5 WGs had focus groups)	13
Northern Health and FNHA staff	Interviews	16	15	15
Total			**85+**	**74**

Quantitative survey data findings

Survey finding data in this evaluation include quantitative, 'scaled' questions from Sub-Regional Sessions survey and Primary/Secondary key informant interviews respondents as well as findings from the 2016/17 Acute Inpatient Patient Reported Experience Measures (PREMs) survey, 2018 Emergency Department Patient Reported Experience Measures, conducted by the Office of Patient Centred Measurement (see Appendix B for more information about these data sources).

Quantitative findings from the Sub-Regional Sessions survey and Primary/Secondary key informant interviews are presented in Appendix D, but are not heavily referenced in the findings due to the limitations described in the Evaluation Strengths and Limitations section below.

Self-identified Aboriginal patient experience survey findings from the 2016/17 Acute Inpatient and 2018 Emergency Department *Patient-Reported Experience Measurement* survey are presented in Appendix E and referenced in the Cultural Safety & Humility section. Since 2003, the Ministry of Health and Provincial Health Authorities have implemented a program to measure the self-reported experience of patients in a range of healthcare sectors using *Patient-Reported Experience Measurement* surveys and, more recently, *Patient-Reported Outcome Measures* surveys[14]. The surveys are conducted province-wide and in a number of health care sectors including Acute Inpatient hospitals, Emergency Departments, Outpatient Cancer Care services, Mental Health in-patients and Long-term care facility residents. All *Patient Reported Experience Measures* surveys include a First Nations self-identifier variable. All individuals who were discharged from hospital during the survey were randomly selected to participate.

Analysis

To ensure the integrity of the data, KIIs were recorded then transcribed. Key informants were invited to review the transcriptions to support data validity. The qualitative analysis of evaluation findings was conducted by three members of the FNHA evaluation team. Transcriptions of interviewed were thematically coded and synthesized into predominate themes.

Quotes

Non-identifying quotes appear throughout the document and serve to illustrate findings in the words of participants. Where the quotes were deemed to be identifying to an individual or role (but not to an organization, e.g. the FNHA or

[14] Government of BC. Patient Experience Survey Results. Provincial health sector reports available from: https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/patient-experience-survey-results.

Northern Health) the quotes were confirmed prior to inclusion with the individual participant.

Evaluation Timeline

Evaluation of the Northern Partnership Accord was completed between December 2017[15] and September 2019. The timelines of the evaluation were as follows:

Table 2: NPA Evaluation Timelines

Evaluation Stage	Date	Action
Planning	May 2017	Partners approved the establishment of the Northern Partnership Accord Evaluation Working Group to plan and implement an evaluation of the Accord
	December 2017	Evaluation planning begins through regular working group meetings
	Early 2018	Development of data collection tools
Data Collection	Fall 2018	Survey community leaders at Sub-Regional Sessions and interview opportunities
	Fall 2018 – Feb 2019	Key informant interviews
	Dec 2018 – Feb 2019	Working Group focus groups
	March – June 2019	Sub-regional session focus groups
Reporting	May – August 2019	Data analysis and report writing
	September 2019	First draft of NPA report shared with evaluation working group members

A total of 11 evaluation working groups occurred between Dec 2017 and January 2019 as well as updates to the NFNHP and Sub-Regional Sessions, as displayed below in Table 3.

Table 3: Updates to NFNHP and Sub-Regional Session

Presentations	February 2018	Update to the NFNHPC
	November 2018	Update to the NFNHPC
	November 2018	Update at Sub-Regional Sessions
	Spring 2019	Update at Sub-Regional Sessions

[15] Partners approved the establishment of the Northern Partnership Accord Evaluation in May 2017 and the evaluation working group first met in December 2017.

Evaluation Strengths and Limitations

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

Opportunities for bias exist during qualitative data analysis due to the unique experiences and perspectives of each analyst involved with this report. Also, due to the involvement of multiple analysts, opportunities for inconsistencies in perspectives exist. To mitigate inconsistency, the lead evaluator reviewed both the coding and reporting of findings.

The limitations of the evaluation include that data collected for the evaluation were primarily self-reported and, while sampling for KIIs and focus groups was purposive in nature, not all those who were invited to participate did so. Response rates for the Sub-Regional sessions survey in particular were low. In addition, there are some data instrument design limitations; surveys and key informant interview guides comprised questions that used a 5-point Likert type scale (from "1" "Strongly Disagree" to "5"Strongly Agree"), which may have unintentionally diluted findings by requiring a single numerical rating for complex, multidimensional and evolving Partnership Accord processes.

A limitation of the PREMs Acute Inpatient data is the limited number of self-reported Aboriginal respondents, as well as perceived (unquantified) barriers for First Nations participation in this survey. As a voluntary sample survey utilizing voluntary, self-identification of Aboriginal ethnicity, it is unknown to what extent the survey findings reflect the experiences of all First Nations accessing the health system in BC. In the 2016/17 Acute Inpatient survey, for example, 3 per cent of respondents identified as Aboriginal[16], compared to 5.9%[17] of the population, according to the 2016 Census, suggesting the survey underrepresents Aboriginal patients. The surveys were not explicitly created for the purpose of measuring cultural safety & humility.

[16] The surveys collect self-reported ethnicity and four categories include Indigenous ethnicities: 'First Nations,' 'Inuit,' 'Metis' or 'Aboriginal.' Surveys in which individuals selected multiple Aboriginal identifiers (e.g. 'First Nations' and 'Metis') or who selected an Aboriginal identifier (i.e., 'First Nations,' 'Inuit,' 'Metis' or 'Aboriginal') plus another ethnic identifier (e.g. 'Filipino,' 'Chinese') were not included in this data extract.

[17] Source: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/details/page.cfm?Lang=E&Geo1=PR&Code1=59&Data=Count&SearchText=British%20Columbia&SearchType=Begins&B1=Aboriginal%20peoples&C1=All&SEX_ID=1&AGE_ID=1&RESGEO_ID=1

Findings

Several themes emerged over the course of analysis, which are presented below, beginning with the evolution / transformation of the regional governance structure and associated work over time.

Governance

Because of the Partnership Accord, Northern First Nations, the FNHA and Northern Health are now sitting together at various tables.

The Partnership Accord has established a formal and unique structure for facilitating the gathering of Northern First Nations, the FNHA, and Northern Health (see Regional Structure section above).

The Partnership Accord agreement itself is perceived to be a document that outlines the voice and priorities of communities and lays out a structure and framework for regular cross-organizational and cross-geographical communication, relationship-building, problem-solving and coordination to enable Partners to work together to address health service access and health and wellness outcome priorities.

"I think it's helped for the framework for planned conversations, meetings, and decision-making. In the background, there's been a framework to fall back on or hold and honor, and there's a responsibility to."

"Having that regularity in terms of common conversations and common topics coming to that table. It's allowed improved relationships."

Feedback on specific components regional governance structure

The **NFNHPC** is perceived as supporting direct dialogue with appointed / elected First Nations leadership concerning service delivery and health priorities. That said, it was suggested that *more frequent meetings of this table* (i.e. quarterly or fulfilling meeting frequently outlined within the Partnership Accord, i.e. three times annually[18]) would be helpful as would more *timely and complete communications following meetings* to Northern First Nations. Discussions at NFNHPC meetings have tended to focus on operational rather

[18] In 2017 and 2018 the NFNHPC met twice.

than strategic matters and thus the recent creation of an operational table to support the NFNHPC is seen as a positive step to aid in the prioritization of strategic discussions at the NFNHPC table and separation of governance and technical discussions.

"We don't have enough communication. There [is] lots and lots of stuff we would love to bring up, but you've only got a day to do so, and we don't have enough time in the day to do that."

In a similar vein of separating technical and political discussions, the 2019 **Regional Caucus** had separate technical (Health Directors and social leads) and governance discussions on different days[19]. While there was acknowledgement that the separation of political and technical discussion could enable enhanced focus, some participants indicated that the shift could remove an important opportunity for political and technical leads to discuss health services together. The **Northern Shared Regional Health Assembly** is seen as a forum largely driven by provincial FNHA agenda items, with only a limited component of the Caucus agenda dedicated to regional matters. This results in less time for locally-driven discussions, but the presence of regional decision-makers was cited as facilitating more decision-making. The regular *presence of senior Northern Health executives is seen as an important area for future focus, along with beginning sessions with drumming and singing*.

Findings suggest that **Sub-Regional Sessions** are seen to be valuable forums to discuss local issues and priorities. One-on-one problem solving is occurring at Sub-Regional sessions, where communities may identify local issues and others can provide guidance or link to other supports. The presence of sub-regional Northern Health administrators (HSAs, COOs) are seen as being both positive and helpful and the *regular presence of senior Northern Health executives is seen as an important area for future focus*. Participants identified a need, and ongoing efforts, to *compile and prioritize Sub-Regional session discussions, questions and issues of concern for discussion and decision-making at Caucus* such that greater progress, alignment and

[19] In fall 2019, the name of the Northern Regional Caucus was changed to the "Northern Shared Regional Health Assembly"

accountability can be achieved. Participants also identified a need for *greater input into sub-regional sessions by community members.*

"we've been working on [...] ensuring that [when] there is engagement at our Sub-Regional Caucuses with our communities, and that priority areas are being identified, the work is being circled back to ensure we are hearing them. We do all that priority-setting in the Sub-Regionals and then bring it back at the full Caucus to say 'this is what we've heard, and as a result of hearing this from you, this is what we're going to do'."

There was mixed feedback with respect to the five **Partnership Working Groups** set up under the FNFHPC. Some evaluation participants felt that the tables supported the operationalization of the PA and provide a useful table for:

- informal collaboration, brainstorming, relationship-building;
- identifying shared work and priorities;
- taking stock of resources and supports and deploying them in more coordinated ways; and
- clarity on areas of roles and responsibilities.

The Population Health Working Group, for example was credited with the development of several population health approaches to issues of mutual concern such as children's oral health initiatives (Section 4d of the PA – see Collaboration and Partnership). Others expressed that the working groups lacked authority to make decisions and *felt that the presence of engagement staff* (e.g. CECs) *and community staff would help provide local context to the decision-making and support roll-out of work on the ground*. Still others did not know that the Working Groups existed. It was noted that representation of Northern Health and FNHA staff is greater than that of Northern Regional Table members on partnership working groups.

Though not formally part of the governance structure in the North, both the **IHIC/AHICs** and **JPB PACs** were mentioned as localized, action-oriented committees that focus on relevant solutions driven by the voices of local First Nations Partners. IHIC/AHICs, which often include CECs in lead roles, have allowed the Partners to address issues, projects and identify opportunities together and conduct joint planning, and support improved coordination of care at the local level. The availability of a small budget, decision-making

scope and presence of decision-makers (i.e. Northern Health HSAs) were highlighted as facilitators to progress at IHIC/AHIC tables.

The **JPB PACs** were raised as examples of tables where a clearly delineated service/geographic scope is perceived as supporting a clear mandate for the table and advancing partnership work. JPB PACs bring together Partners to support coordinated conversations to support JPB project implementation and improved awareness of available services and community priorities.

Overall feedback on the governance structure

With respect to feedback on the overall governance structure and components, a number of facilitators, challenges and *opportunities for improvement* were noted, as outlined in Table 4 below.

Table 4: Facilitators & Governance successes, Challenges and Opportunities for improvement.

FACILITATOR/SUCCESS	CHALLENGE	OPPORTUNITIES FOR IMPROVEMENT
The recent **separation of governance/political and technical** discussions through creation of the NFNHPC operational table is hoped to enable focused discussions on technical matters. Partnership tables with **sufficient decision-making authority** and presence of decision-makers are seen as facilitating action and progress. Tables with a **clearly delineated service/geographic scope** are perceived to have clearer sense of roles and responsibilities (e.g. JPB PACs).	**Impacts "on the ground"** are not necessarily materializing in a timely manner. Findings indicate that **some issues are raised repeatedly**. It was felt that the **decision-making authority, meeting frequency and composition** of all tables are not calibrated / clear enough to support maximum efficiency/progress. *"You need to give those [partnership] tables the authority to move things through or make clear which things they can't discuss "* *"I think we could use a little more clarity on the role of the [working group], what we have authority over and can do, or whether this is more of just a report-out, "here's what*	Consider completing a **review of partnership tables** to ensure objectives, decision-making authority, meeting frequency and effectiveness to maximize attendance and efficiency. Continue to develop processes of **collating community priority issues** for discussion/decision at Sub-regional sessions and the Health Assembly. Include communities in dialogue on potential solutions/alignment opportunities for issues raised. Partners report back on progress in a timely manner. Enhance regular follow up on agenda / action items at partnership tables. Clarify mechanisms and processes for regular community input, particularly for Health Directors.

	Northern Health is doing [...], and here's what First Nations Health Authority is doing" [...] Do we actually have a mandate to do something together and can we make those decisions?" Partners are under considerable time pressures and the **meeting burden is high**, particularly for First Nations community representatives. **Meeting attendance has been low** in some instances (e.g. First Nation community representatives at Working Group meetings, senior NH executives at the Health Assembly).	**Increase awareness and linkage of the Partnership Accord work to the front line level**. This could be in terms of greater reference to frontline care/staff within the wording of the Partnership Accord, more frontline representation (including FNHA, First Nations, community members, clinicians and/or Elders) on Partnership Working Groups and/or more direct linkage between senior level tables and localized committees. *"There's no voice from frontline care providers in the Accord that I can see highlighted, and I think that's the biggest challenge in cultural safety, sharing and communication, and service delivery that's integrative of First Nations health and wellbeing. It's missing a key group of people that need to either feed into it or need a better understanding of what the Accord is and how it affects their practice"*

Partners have grown more effective in collectively responding to time sensitive issues and the flexible nature of partnership processes is appreciated. *"[…] there's a go-with-the-flow when there's a need to make change, which is significant."*	Perceptions from community leadership representatives indicate some distance / **lack of alignment** between the activities of the partnership tables and community level / front line work. Ad hoc efforts meet an immediate need but limit the ability to address similar issues in the futures.	Prioritize systematic policy, process and system solutions for ongoing issues. *"I think we just have to ensure that the work we do has a long-term length to it. … I think right now we're relying on people and relationships, and that's a fantastic way to start to integrate services and service delivery, but we always need to be looking at how we can embed this into the larger system, so that it doesn't matter who the manager or community health nurse is."* Hardwire/ develop systemic solutions to assist in more proactive, long-term initiatives (e.g. examining systemic policy, technological and Collective Agreement arrangements).

Roles and Responsibilities

Key informants indicate that there is growing understanding of Partners' roles and responsibilities with respect to Partnership Accord commitments, however, a lack of clarity of roles and responsibilities still exists in some areas, most notably:

- **Responsibility, funding and expectations relating to service delivery** (particularly for services delivered **in First Nations communities**, but also for other instances where multiple partners and multiple funding streams may be involved). It was suggested that prior to implementing projects in communities, higher level governance/political conversations may be beneficial to clarify financial details and project scope;
- Clarity on different **issue escalation processes** to ensure issues are marshalled to the appropriate channels, particularly for individuals who may hold different roles/wear different hats (e.g. CECs, Health leads, Aboriginal Patient Liaisons, First Nations leadership, FNHC may hold a variety of political, technical and community roles) and raise issues at a number of forums (e.g. IHIC/AHICs, Sub-regional sessions, direct meetings with government Ministers).
- **Clarity on the role of CECs** in order to facilitate the utility and effectiveness of their role/skill set, and involvement in partnership tables as well as clarity on issue escalation pathways.
- **Roles of Working groups** (see Governance section). Consider establishing forum to brings together partnership working groups to support an understanding of each group's respective scope of shared priorities/ concerns, and to identify opportunities for shared work.

Communication

The Partnership Accord commits Partners to "*Communicate in a timely and effective way*" regarding impediments to achieving partnership work, and sets out "*Improved communication between First Nations and Northern Health*" as an important indicator of success (PA S.4b and S.5).

Evaluation findings show that Partners are **meeting on a regular** basis to discuss and brainstorm issues of relevance. These structured and predictable opportunities are perceived to promote effective communication between the Partners. The ideas that are being exchanged with each other at the table are "really good" (e.g. Maternal Child Health WG table) and there is a sense that exchanging stories has contributed to an even better understanding of the issues that impact the health of First Nations in the region. There is a sense that open, strategic conversations at partnership tables enable Partners to build solutions to barriers, that Partners

remain in communication despite having to work through difficult conversations and that regular communication has supported improved relationships and trust.

> *"I have no problem with picking up the phone and talking to people in the committee [...]. There's a relationship where we can have conversations. Conversation at the table is excellent. The effectiveness of the Partners at the Partnership Committee meetings is excellent. Everyone listens respectfully and with intent. Actively listens to each other"*

Participants expressed a preference for in-person meetings to support more effective communication, and while in-person meetings do occur, travel and other constraints (e.g. geographical; financial) pose important attendance challenges. In such instances, other modes of communication are being relied upon, including email, telephone and video-conferencing. Given the volume of work that is being undertaken, and the time pressure of many competing priorities, **setting aside a sufficient amount of time to have conversations is a challenge**, and alternative modalities to support communications could be considered.

> *"it seems like we don't use video conferencing very much, and we're still expecting people to travel great distances at great expenses in order to have face-to-face communication opportunities, and I think that causes stress on communication. It's difficult for people to leave their First Nations communities [...] We only have certain months of the year where we can actually get out on the road and into community [...] and it's ridiculously expensive to fly in the North"*

Though the structured and predictable meetings have been found to be helpful, some participants indicate that **meetings have not been held as frequently** as envisioned in the Partnership Accord, and that meeting more frequently would be beneficial. Other suggestions to improve communication included booking some meetings well in advance (up to a year in advance for higher-level meetings) and ensuring meeting packages are sent out in advance. Also, promoting and ensuring two-way dialogue of communication, rather than unidirectional flow of information is a preferred approach to communication raised by some evaluation participants.

Evaluation findings indicate that **communication processes have improved** over time. For instance, working groups have achieved a more streamlined approach for organizing meetings and keeping a record of discussions and decisions, and reporting back to the NFNHP table, in particular in relation to the Cultural Safety

Working Group. Northern Health and the FNHA have developed a joint review process before disseminating products to different audiences.

There is a perception among some participants however that there is a **lack of clarity regarding communication pathways** in some areas (e.g. communication pathways for community or Health Service Organization through FNHA and Northern Health), which at times may be further impacted by staff turnover within the FNHA and Northern Health.

There is also opportunity for **improving the onboarding process** and package (e.g. including foundational documents, such as the Transformative Change Accord, TORs, PA) such that all new Partners are briefed on the regional governance structure, foundational documents and the partnership journey thus far.

Useful communication products that were mentioned by participants include the FNHA updates, weekly e-blasts, NFNHP communiqués distributed to community leadership, and contact lists (e.g. FNHA Northern Regional staff hand out contact information that includes roles).

Participants raised the importance of communications across all levels of the partnership, including executive management (e.g. ensuring the right information is being transferred to senior leadership in Northern Health with sufficient detail to support coordination between partners) and local level (e.g. raising awareness around health services in community, discharge planning and communications relating to transitions in care).

Engagement & First Nations Decision-Making

Since the signing of the Partnership Accord there has been increasing awareness, and, in the past year in particular (2018 onwards), a perception of more frequent engagement of First Nations in decision-making.

"Having worked in the Northern Region for decades … the collaboration and communication and opportunities for input to change health services has increased significantly for First Nations communities in recent years. This may be related to the NPA, and the growing importance of relationships and partnerships."

PA conversations didn't happen prior to the PA. We were not meeting specifically to honour and talk about what communities wanted, what their priorities were; 'How do we collectively involve them?' 'How do we make their goals happen?' That wasn't happening."

Community leadership participants shared that their priorities and concerns are being sought and heard by the FNHC and senior FNHA executives, that there is an increased understanding of, and focus on, community needs. Community input and priorities are beginning to be reflected in partnership work and initiatives in new ways.

> *"I cannot think of anybody at the moment that will go into a First Nations community and start changing services without consulting the First Nations communities. So I think they've made themselves clear and we've got to a level of maturity now that anybody knows if you're going to work with a First Nations group, you need to involve the FNHA, to help at least with the design of the service and what it will look like."*

Examples of Engagement and First Nations Involvement in Decision-Making

Both the **PA** and the development of the **Northern First Nations Health and Wellness Plan** in 2013 were identified as examples of plans and documents that were built through strong engagement of Nations, reflect community priorities and integrate First Nations perspectives of health and wellness. Other examples of engagement and First Nations involvement in decision-making include the work to establish **Primary Care Networks**. In the Smithers area, for example, Witset First Nation Health Director and nursing staff were actively engaged in discussions with the Ministry of Health and Northern Health regarding local needs. There is now a Northern Health NP based out of the Witset health centre with joint funding and staffing model. The various structures and committees of the **regional governance structure**, were also raised as being regular forums where engagement with First Nations can take place.

> *"Although there is a lot of complaints, I think our communities have a lot more say in their health services than they ever did before."*

As described in the Governance section however, in some cases, committees and working groups have **struggled to retain active membership** from First Nations **technical and governance representatives**. Evaluation participants indicated that in order for engagements to be successful, participants need to have the time and capacity to engage, feel that they have a role to contribute, that their voice is heard, that their requests and needs are acted upon, and that the table has the authority to make decisions.

Facilitators to engagement & First Nations involvement in decision-making

Some of the facilitators to engagement and supporting First Nations involvement in decision-making identified among evaluation respondents included:

- The **FNHA** is seen as providing a platform for First Nations communities to have a voice in the decisions that affect their health in a way that did not exist before. The capacity, structure and resources of the FNHA facilitates the involvement of local First Nations to be part of health care transformation, such as large-scale planning underway relating to the continuum of healthcare services for people in the North.

  There is a balance however to FNHA's role as a Community-Driven, Nation-based organization that also works both regionally and provincially. Engagement with the FNHA does not constitute engagement with First Nations, as the FNHA does not purport to be the voice for communities.

> *"The idea about being community-driven and having a regional viewpoint; those two things are in tension and that's something we deal with all the time – and Northern Health is trying to be standardized across a really large region and a little bit tailored for community context."*

- In many cases FNHA staff, particularly **Community Engagement Coordinator** positions provide supports for community engagement by scheduling, coordinating and conducting following-up work from a variety of consultations and engagements events, meetings and tables. CECs are knowledgeable about the local communities that they support and can help provide guidance around cultural protocol and demonstrate how to work respectfully in community. CECs also can help escalate local issues at various tables that they attend.

> *"For me as a non-First Nations person […], I find with having the Community Engagement Coordinators that I know who to talk to, and that provides me with some comfort in being a bit more engaging with communities because I'm not worried that I'm going to offend somebody or go through the wrong channels."*

  Capacity challenges do exist. The FNHA Northern regional team is small and the Community Engagement team lacks administrative support. An

engagement review led by the FNHA is currently underway to determine how to best support engagement efforts moving forward.

- **Engaging early** and **allowing sufficient time** for engagement. The early engagement of the FNHA in service and emergency response/recover planning was identified as an example of successfully engaging early on. Participants also indicate that there is a greater understanding among Partner of the time required to engage.

> *""There seems to be a better understanding that that can take a bit of time and that I need to do that engagement piece in order to bring First Nations' interests to some of these working groups, so that's fantastic"*

Additional suggestions that could be considered as future opportunities for engagement include:

- **Focus on making progress on issues and solutions identified by communities.** When asked what would enable and support improvements to healthcare services and what should inform the commitments of a new Accord, Partners cited the continued focus on addressing the priorities and needs identified by communities. Focus should be placed on solutions, integrate community's input into strategies best able to meet needs and include evaluative process and outcome measures.

> *"I think we need to listen to the community members. We need to meet them where they're at. They have the answers. They know what their concerns are for their area and their communities, and we need to be willing to sit down and listen to them."*

- Some participants indicate that achieving more equity in the **partnership decision-making** remains a work in progress and underscore the opportunity to identify ways of **moving up the spectrum of engagement** to more 'collaboration' and 'empowerment' opportunities.[20] In some instances, participants indicated that they felt as though their engagement in initiatives was a "tick-box exercise".

[20] Perhaps utilizing the International Association for Public Participation framework that outlining a spectrum of different levels/purposes of community engagement. The lowest level of impact/input is 'Inform', followed by 'Consult', 'Involve', 'Collaborate' and 'Empower' (for more information, including the goal and outcome of each level, see https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/Spectrum_8.5x11_Print.pdf) © Used with permission from the International Association for Public Participation. Accessed September 17, 2019.

"There's a level of engagement where one is when you ask for people's input, two is when you actually involve them, and three is collaboration-- true partnership. We're just on the early stages of that continuum of growth. We're still just getting input. In some examples there's better collaboration, but we're still not really Partners."

- **Clarify purpose of engagement and report back on use of engagement feedback.** In some instances, participants indicated that they didn't see their feedback integrated into final products/ decisions. Providing clarity on the purpose of different engagement activities (whether the engagement is meant to inform, to consult, to involve, to collaborate or to empower)[21].
- **Coordinating and aligning engagement opportunities and topics** when working on areas of common priority to ensure communities are not engaging on different aspects of the same topic in multiple fora. Working with IHIC/AHICs was suggested as a way to coordinate engagement. Another emerging wise practice raised during the validation of evaluation findings was the gathering of local First Nations community leadership in central locations with Northern Health representatives for a day of open dialogue, relationship-building and discussion;
- **Engaging in Community.** Community leadership evaluation participants suggest that increased visits to community would provide a way to conduct grassroots engagement, learn about communities needs/ priorities, build relationships and support joint planning and decision-making. Time and resource pressures can be a challenge for engaging in communities;
- **Including broader scope of community roles.** Consider broader representation of community participants at partnership tables to include groups of representation such as youth, Elders, First Nations living off-reserve and LGBTQI individuals.

Relationships

There is a perception that one of the **greatest achievements** of the Partnership Accord thus far has been the **building and strengthening of relationships** between Northern Region First Nations, Northern Health, and First Nations Health Authority across multiple levels.

[21] International Association for Public Participation has developed a framework outlining a spectrum of community engagement. The spectrum was designed to articulate different levels of public participation. The lowest level of impact is 'Inform', followed by 'Consult', 'Involve', 'Collaborate' and 'Empower' (for more information, including the goal and outcome of each level, see https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/Spectrum_8.5x11_Print.pdf) © International Association for Public Participation. Accessed September 17, 2019.

Before the Accord, attempts were made to develop relationships and programs, but efforts were frequently stymied by a lack of clarity around roles, responsibilities and decision-making authority. In the early days of the Partnership Accord, initial meetings were strained, with Northern Health staff sitting on one side of the table and First Nations representatives on the other. Since then, Partners have worked to reach a place of familiarity with each other, relationships have developed, trust has been built/rebuilt and Partners are able to discuss and work through difficult issues and problem solve.

"We're no longer strangers, we know each other, you know. We come with history already […] Especially in rural communities up in the North, relationships are everything. It's the glue in the fabric that holds us all together up here."

"I would say advocacy has changed to partnership … in the past, prior to the Accord, there was more kind of trying to be heard from communities … and not necessarily feeling like they're going to get what they want….. It feels like the balance of power has shifted. We're working together; we're working on problems together."

Facilitators to Relationships

A number of factors were identified as supporting the development of relationships, including:

- The **regional structure** has supported relationship-building through regular face-to-face meetings where Partners can learn about each other and their organizations;
- Participants indicate that there is **commitment to the work** and to investing the necessary time to **building relationships**;

'"Let's make sure that we make time for each other. Let's make time to listen and understand. Let's make time to make dialogue and conversation.' That has really improved those working relationships … Everybody really wanted this to be a successful venture."

- Reciprocal accountability;
- Consensus building; and
- Cultural safety work.

Participants stressed the importance of continuing to nurture relationships, particularly as there is turnover among staff.

Challenges to Relationships

Constraints to effective relations raised include **competing goals, perspectives and expectations**, as well as a **lack of trust** and **cultural safety**. Examples of instances where Partners did not follow-through on financial commitments made to joint efforts were also shared, which were perceived to undermine trust. Participants stressed that trust is built by Partners following through on commitments and achieving success together over time. Some participants also admit they are not where they would like to be in terms of their relationships with their Partners, that there are areas where relationships have not been as strong.

Collaboration and Partnership

The Accord commits the Partners to "*support each other in a positive and constructive manner*" (PA Section 4.b).

There is evidence that both the quality and quantity of partnerships has been increasing over time for many areas of work of the PA.

"any of the really large-scale planning we've been doing for the continuum of healthcare services for people in the North, we're never having those conversations in isolation"

"'okay, here's an issue. … It is Indigenous related and health related, therefore it's absolutely Tripartite. Now let's get everyone around the table' is happening much more than it was happening before, and it's happening more naturally now."

Examples of partnership activities shared by participants include:

- Joint development of **new clinical educational tools** for front line service providers;
- Close collaboration during the 2017 and 2018 **forest fire seasons** between Northern Health, the FNHA and the Red Cross;
- Collaboration on **oral health services**.

"First Nations had oral health technicians and we had hygienists, and it was this idea that "well, they need to work together!"

- Partners shared their appreciation for **partnership working groups/ committees**, such the JPB MST PACs that include community-based direction,

advice and support around implementing initiatives. The JPB MST PACs have played a role in bringing community representatives to the table to discuss community needs, select staff, and provides ideas, expertise and guidance on the overall implementation of the project locally. Committees jointly developed job descriptions and formed hiring panels for new clinicians. This new way of working together took time and effort and trust in the process had to be developed by Partners.

- A **sharing/ welcoming feast** hosted in the Smithers area in July 2018 that brought together Northern Health staff, FNHA staff, physicians and community members was an example of new way of engaging Partners and a willingness to apply a community-led approach and conduct work in a culturally appropriate way. The feast was conducted under Gitxsan protocol and was an opportunity for Northern Health and the FNHA to share information and to hear from community about their concerns. It was informative for the clinicians in attendance, many of whom were unfamiliar with the FNHA and its work. The clinicians went back to their clinics equipped with supportive materials and key contacts for future work.

"When you get those concrete examples of kind of down in the grass roots-- Northern Health, First Nations Health Authority, Health Directors, and community members coming together, listening and learning, and truly partnering, that's the magic there."

These specific examples of partnership are seen as having cascading impacts on other areas of work between Partners.

Facilitators to Collaboration & Partnership

Participants highlighted a number of factors which were seen as facilitating collaboration, including:

- the **Accord** itself, and the regular meetings and formalized bodies/processes which serve to convene the Partners on a regular basis;
- a **shared commitment** to the success and objectives of the partnership.
- the role of individual **champions**, due to either their long-term involvement in the work, or because of their skill in supporting cross-organizational work and identifying partnership opportunities. Some Partners indicate that they are selecting new staff on the basis of their skill set for working with in/with First Nations communities;

"I have had great commitment from Northern Health's kind of counterparts, both strategy and operations leadership, in [health area]. I've just had great, positive energy and connections, and there's this willingness and desire to support."

- the participation of specific **roles** which supported collaboration was noted (e.g. CECs, HSAs).

Constraints/Challenges for Collaboration & Partnership

There is a perception among some participants that decision-making and investment in the **partnership may not be as balanced** between the Partners as they might be. Though there have been improvements, there is the sense that Northern Health possesses greater influence in terms of agenda-setting and decision-making. For example, the NFNHPC meeting dates and frequency are set based on the scheduling of Northern Health Executive meetings.

There is also a sense that dedication of **time and resources** to partnership work is **not equitably distributed** between the FNHA and Northern Health. Some participants perceived that the FNHA is contributing a larger share of financial and human resources to partnership initiatives, despite facing greater organizational and human resource capacity constraints (e.g. FNHA has 40 staff regionally and 600 staff provincially, compared to a reported 7,000 within Northern Health[22]).

"When I say a true partnership, […] it's the equal funding, the time that we invest, and the visits and the availability into the community. All of that stuff to me is what a true partnership means. It's that we are working together, walking side-by-side, and holding each other up when needed, and that we're standing shoulder-to-shoulder, carrying the brunt of the work, and ensuring that the communities' needs are met and that the health outcomes are improving as a result of our joint work; however, at times, it feels like we at FNHA carry a disproportionate amount"

While the support of individual champions, staff and leadership is evident, there is also a perception among some participants that **not every individual is as willing to collaborate**. In some instances, divergent perspectives, protectiveness over work have been perceived to hinder progress.

[22] Source: https://www.northernhealth.ca/about-us/quick-facts

"I think some people are still protective, and they find ways to block progress."

As explored elsewhere, time and resource constraints are also a key challenge to the ability to collaborate and partner.

"so there's a lot of pressures that are really not necessarily related to the Tripartite relationship but are just related to keeping things going in a rural, remote healthcare system where we don't naturally overlap or align, except through times of big system change or times of crisis, like with a patient safety issue or complaint [...] sometimes if we're not careful that can get in the way of the upstream collaborative work that is just as important but not knocking on your door."

Future Opportunities

There is an opportunity to **define what "partnership" means in practice**, for different types of initiatives (e.g. joint new initiatives, existing services) and for different types of considerations (e.g. agendas, finances, engagement, policy).

Seek opportunities to **increase understanding and clarify context and realities** of each Partner. Knowledge of partner's size, complexity, scope, structure, constraints, funding structure, time pressures and decision-making processes would be helpful when making decisions, planning or rolling out joint initiatives.

"Working together and getting to know each other and at least begin to understand what some of the problems are, what some of the capacity challenges and the barriers that each other is facing."

"Relationship matters; taking the time to build those relationships. To understand [...] to seek to understand how organizations work, what different ways of knowing are. Those are all time-consuming things and space needs to be created for that to occur. Otherwise we'll lose our way."

Integration and Coordination

The Partnership Accord envisioned the Partners working together in the planning, implementation, and evaluation of services for First Nations in the Northern Region, and speaks to enhancing coordination and alignment of service delivery and planning (Section 2 & 5 of the PA). Findings suggest that there has been progress in

a number of areas of service integration and coordination between Northern Region First Nations, Northern Health, and First Nations Health Authority.

Examples of Integration and Coordination

Examples of efforts to improve integration and coordination among Partners includes:

- Efforts to **coordinate service offerings** and staffing to meet joint objectives. For example, through Partnership Working Groups and JPB MST PACS, Partners are working together to support implementation of services.

> *"We are coming to the table in partnership. I think about children's oral health, and we went through a process of clarifying for each other around the Partnership Table what work we were doing in-community in support of children's oral health, only to discover that we were doing sort of 50% and First Nations Health Authority was doing 50%. It was this sort of epiphany of 'wow. Imagine if we just combined our efforts what we could do together […].' We were fulfilling some of the functions, FNHA was fulfilling some of the functions, and together we create[d] a bit of a whole"*

  FNHA and Northern Health staff meet bi-weekly to address issues and clarify implementation details in support the roll out of JPB MST projects, and Partners have coordinated efforts to address wildfires and to improve the Dangerous Goods Incident Response or Spill Notifications.

- Evidence of supporting some **transitions in care planning/coordination**, including **discharge planning/alignment** and patient journey mapping.

> *"There was a whole group of us in this room until 5 last night working together to solve one person's care. It was the physician, Northern Health specialist team, CEC, nurses and we all walked away with our action plans and how we're going to support this one person. That's fantastic"*

  Northern Health's **Patient Journey Mapping** activities in First Nations communities has supported an improved understanding of the Indigenous patients journeys of care and ways which the Partners can improve continuity, transitions and patient experiences across organizational and geographical transitions in care.

  There is a need for ongoing efforts to **improve discharge planning and tools** was stressed among all evaluation participant groups, including focused efforts to ensure improved discharge planning for patients dealing

with suicide ideation. Such tools/processes should be cognizant of unique service delivery characteristics of each community (e.g. weekend and after hour service capabilities).

- Partners are **beginning to share strategic plans** with one another, which is perceived to support an improved understanding of the Partners' respective directions and opportunities to bridge challenges, differences, or barriers. Still, it was noted that **joint planning between the Partners has not fully matured**.
- The **sharing of clinical information** is being promoted through awareness raising of the Freedom of Information and Privacy Act provisions among some providers. This is leading to an enhanced understanding of information sharing within a localized context (but challenges remain, see section below).

"There's more general encouragement to have practitioners start with the default of "how can we share relevant information with each other in an appropriate way "

Challenges to Integration and Coordination

While fruitful discussions and processes to support improved coordination are emerging, achieving full integration of health services for Indigenous peoples in the North is a work in progress.

- There is a perception among some participants that health services **remain fragmented** in the North and that Partners operate in siloes. Some of this is natural given the large geographical area, but other silos result from lack of clarity or consensus of service delivery roles and responsibilities within First Nations communities. Despite the Partnership Accord's declaration that "*Northern Health provides services to those living within its service delivery area, including First Nations people on and off reserve*"[23] silos of services on- and off-reserve and a focus on jurisdictional scope are perceived to hamper coordination.

"we need more awareness and collaboration between on and off-reserve teams so that we can truly have a seamless transition. There's a lot of "hot potato" going on and also a complete lack of awareness."

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[23] Section 3.g of the Northern Partnership Accord. Available from: https://www.fnha.ca/Documents/Northern_Partnership_Accord.pdf

Some participants indicate that traditional jurisdictional divisions for service delivery in First Nations communities are starting to soften which is enabling access to new services for community members, but some challenges still remain (e.g. funding for medical transcriptions dependent on whether services are delivered on- or off-reserve).

"Telling First Nations communities that they can access the same service that all members of the community can access has been the historical answer. We've now added 'you still have access to those things, but you can now also access in-community these specific supports.'"

Opportunities to coordinate across Partners on joint solutions to common barriers/issues could be considered through dedicated technical forums that address key, systematic issues of concern (similar to annual IHIC/AHIC gathering). The topic of 7 day/week home care supports was raised as an opportunity for more fulsome analysis of possible strategies and alignment opportunities across communities.

"think more of those would be good. So, more gatherings that are larger in nature and are not looking at the specific community problems or issues but are more about how we relate to each other as different nations within one health system."

- In other cases, duplication or gaps are unknown due **to lack of awareness or information on service availability**.
- Lack of **formalized processes** to share medical records and **lack of compatibility/integration of EMR systems** were noted as an ongoing constraint to coordination/ continuity of care. In the absence of access to a shared medical record, participants described ad hoc or informal mechanisms to support the flow of clinical information, including education around privacy legislation, relationship building between care providers, and conversations within the circle of care. However, there is a perception that such efforts are inadequate in a context of changing staff, and that more systemic measures would be beneficial.

"We've developed a relationship that supports open communication so that patients get consistent care, but we haven't really put that into an overarching system, process,

or policy so the next nurse or physician is very clear on what their responsibilities are in terms of sharing information"

Cultural Safety & Humility

Cultural safety is "*an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care*."[24]

Findings suggest there is a growing awareness and understanding of cultural safety and humility within Northern Health that did not exist 6 years ago. Some participants cite this as one of the Accord's key accomplishments.

Strategic conversations are occurring among the Partners to promote cultural safety within Northern Health services and facilities. There is a greater willingness to openly acknowledge cultural safety concerns. The desire to improve cultural safety is "not artificial," but driven by a genuine commitment.

Progress in cultural safety and humility are being supported by a number of factors raised by evaluation participants, including, for example:

- **Training and orientation opportunities**
    - The online San'yas cultural safety and humility training course is available to Northern Health staff and was taken by 353 Northern Health staff in 2018/19.[25] Since 2009, over 5,000 Northern Health staff had completed training[26].

      There is interest in tailoring/supplementing this training to northern region First Nations as the San'yas program provides a BC-wide perspective. It was also noted that there are challenges to enrollment for as training requires paid time and union membership is perceived to "push back" on the necessity of the training if it is not mandatory. There were calls from evaluation participants to make cultural safety and humility training mandatory.

[24] First Nations Health Authority (2017). #itstartswithme: Creating a climate for change. Available from: https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf

[25] 219 had completed their training, 109 were in progress and 25 had not completed their training (90% completion rate).

[26] 5,070 had completed their training, 110 were in progress and 807 had not completed their training (84% completion rate)

"Everybody should take the cultural safety training at a minimum, like online, which we don't-- it's more like if you want to take it you can take it [...] some managers are like 'my staff have to take it,' but others are like 'I've got 16 things they've got to take.'"

There was also interest expressed in providing additional in-person training and/or supporting community-based events.

"we're still relying too much on the thought that this online course is all of a sudden going to make everybody more culturally safe and that it's going to be the answer to everything. I think we're lacking in real-time virtual or in-person, face-to-face communication, understanding of each other's cultures and systems, and an overall patient-centeredness. I think if we truly made everything patient-centered it would be culturally appropriate. [...]"

"One thing that would be good is just the health practitioners do the cultural stepping-out, to come to our events that are culturally bound because it's kind of like-- for me, as a person here in the North, I'm excited if I see someone I know from a professional level come into a cultural event that I'm attending."

  - Community orientations are being provided to new providers as part of the JPB MST project, which includes local customs, traditions and protocols. MST projects also include Elders knowledgeable in traditional ceremony and teachings as part of the Mental Wellness Substance Use Mobile Support Team, alongside clinicians.
  - Piloting supplementary curriculum for Northern health staff and physicians developed by the Northern Health Indigenous Health program; and
  - Local cultural awareness building activities, such as inviting Indigenous drummers and singers into Northern Health facilities.
- Cultural resources
  - Over 60 cultural resources have been developed by A/IHICs and are available on the NH Indigenous website, including videos for Northern Health staff pertaining to death and dying, birthing and cultural components have been developed. Developing tools and supports for frontline workers were raised as opportunities for future work.
- Forums to coordinate, discuss and implement local initiatives

    - The Cultural Safety Partnership Working Group and IHIC/AHICS were identified as key forums for moving forward cultural safety work in their region[27]. Larger training forums, bringing together Partners for the cultural safety training, was identified as a potential future opportunity.
- Funding streams
    - Primary care planning includes provisions for cultural safety & humility.
    - Flexible funding streams such as the FNHA's Regional Envelope are being used to supplement JPB project funding (which funding must be used for hiring regulated health professionals under the BC Health Act)[28].
- Strategic emphasis
    - The Northern Health CEO signed the declaration on cultural safety and humility in 2015. The declaration formalizes the NHA's commitment to supporting improved experiences of care for Indigenous people through actions/ processes intended to embed cultural safety and humility in the health system.
    - Development of a strategic plan for the hiring First Nations individuals within Northern Health, stemming from Northern Health's participation in a Canadian Institutes of Health Research (CIHR) study on how to engage First Nations in the Health profession. While these efforts are acknowledged, some participants suggested that such efforts could be more coordinated between Partners.
    - Ensuring policies, both new and existing, as well as written materials are reviewed from a cultural safety and humility lens was raised as an opportunity.
    - Joint planning is underway to refresh the Northern First Nations Health and Wellness Plan.
- Staffing

[27] For example, a video developed by the North Coast Aboriginal Health Improvement Committee provides information to health care providers about the Haida and Tsimshian Nations culture and history. Source: https://blog.northernhealth.ca/health-care-services/a-video-from-north-coast-first-nations-for-health-care-providers . Accessed September 17, 2019. As another example, the Northern Health's Northwest East (Smithers and area) Indigenous Health Improvement Committee released the Gitxsan Phrasebook for Health Care Providers in 2017 along with a booklet on Gitxsan cultural practices. Source: https://www.indigenoushealthnh.ca/initiatives/AHICs/northwest-east#gitxsan-cultural-practices . Accessed September 17, 2019.

[28] Regional envelope funding is available for FNHA regions to invest in their key priority areas. Source: https://www.fnha.ca/about/news-and-events/news/ppss-readies-for-regional-focus

    - Key positions such as Aboriginal Patient Liaisons were identified as supporting improved cultural safety. Participants identified that initiatives aimed at increasing the numbers of First Nations clinicians and in key positions/ teams (e.g. Indigenous Health staff) as opportunities to further increase the cultural safety and humility of services.
- Physical spaces
    - Efforts to create safe spaces in hospitals, by including signage, artwork and dedicate spaces for cultural healing practices have helped to increase cultural safety of the physical surroundings in acute care facilities. Ensuring artwork and language reflected local areas was an lesson learned as these types of improvements were rolled out.

Cultural Safety & Humility Outcomes

The impact of all of these cultural safety initiatives, policies, resources and training can only be measured by the experience of patients themselves.

While there is the perception that cultural safety practices have occurred and are translating into better experiences, further work is required to understand the impact of Partners' efforts by patients themselves. The scope/ reach of initiatives is uncertain and as there is limited outcome data to determine if encounters with the health system have become more culturally safe and whether impacts on cultural safety are beginning to impact on other downstream areas, such as willingness to access services.

"I get push-back sometimes that 'well, we need to be more aware of all cultures'. 'Yes, absolutely that's right, but there is a history here that has led to certain things that you're seeing that you're not reacting well to, and you're eroding that relationship and making that person's health outcomes even worse because they're not going to come back to you.'"

Anecdotally, evaluation participants indicate that they have witnessed shifts that should theoretically increase the sense of cultural safety and humility for patients, such as greater accommodation of families and loved ones in hospitals.

"If we get a unique request for traditional healing or just supporting a family through birth or dying processes, the days are long gone where the response was structured or hierarchical. It's more around how we can best accommodate the fact that there's going to be 40 people here from the local community [...] That's more the norm now than the

old days of 'well, we can only have 6 to a room, so take turns.' That's at least a decade gone"

One source of cultural safety and humility patient experience information comes from a provincial survey of patient experiences in acute care settings[29]. As portrayed in Figure 4 and 5 below, 69% of self-identified Aboriginal patients felt that their care providers were completely respectful of their culture and traditions, compared to 81% of non-Aboriginal respondents. This 11% difference is statistically significant. Also, only 41% of self-identified Aboriginal patients who felt that their spiritual needs were an important part of their care felt that their spiritual needs were met. This is similar to non-Aboriginal respondents, suggesting room for improvement with respect to spiritual supports in acute settings.

Figure 4: Providers respectful of cultures and traditions, Self-Identified Aboriginal Patients vs Non-Aboriginal Patients, 2016/17 Acute Inpatient Patient Reported Experience Measures Survey, Norther Region

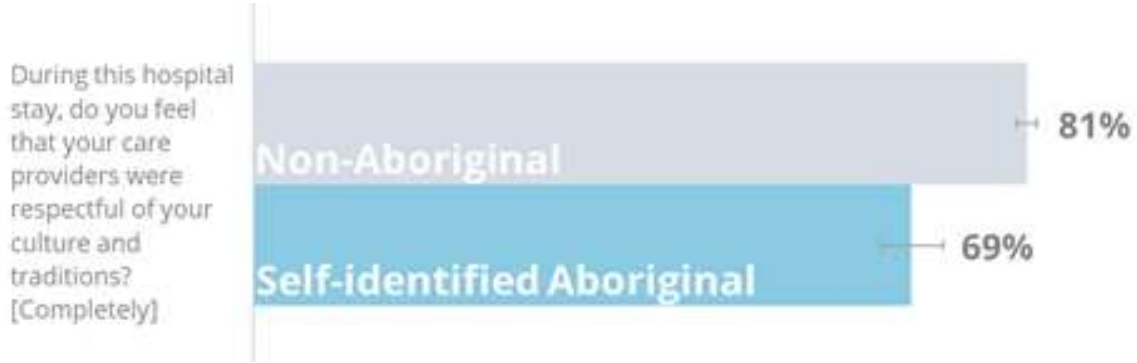
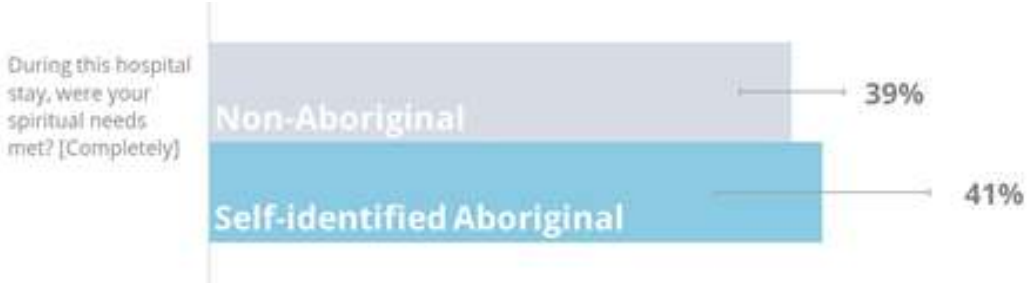


Figure 5: Felt spiritual needs were met, among individuals who identified that spiritual needs were an important part of their overall care, Self-Identified Aboriginal Patients vs Non-Aboriginal Patients, 2016/17 Acute Inpatient Patient Reported Experience Measures Survey, Norther Region



[29] See Appendix C section for more information about this data source.

Other sources of cultural safety and humility data, for example, formal complaints, are suspected to be an underrepresentation of patient issues or concerns. No First Nations identifier data is collected as part of the patient complaints data, so disaggregating patient complaints among First Nations would not be possible at the current time. Evaluation participants' perceptions of the process for addressing culturally unsafe incidents were mixed. While it was noted that an "agreed upon" complaints process, there was a perception among a few participants that the system was not conducive to resolving complaints or that complaints were not being lodged because individuals felt that doing so was fruitless, or that there were too many steps involved to do so[30]. An opportunity was raised to consider establishing an online complaints process that simplifies the process and involves fewer steps.

> *"it would be easier if it was online so people could say what they need to say rather than having to go and talk to the person first, then they have to contact the administrator for the hospital and go from there. They have too many steps for people....., we don't even bother to complain or we feel it's pointless."*

Still, participants acknowledged that improving cultural safety is a work in progress. For instance, it was noted that racism continues to be a pervasive problem in some Northern Health facilities. Conversations around racism are challenging as the nature of the conversation becomes personalized, but moving forward, being able to acknowledge and address racism in care is an important step in the right direction.

> *"I think we really have to work diligently on the issue of racism. It's institutional, and there needs to be a commitment by the workers on the ground to improve that because often times we just get a lot of complaints, and I think it's easily fixed"*

There was also acknowledgement that frontline staff are operating under significant pressure and time constraints, in an atmosphere of limited resources, which may constrain the extent to which cultural safety training is put into practice.

[30] The complaints process outlined on the Northern Health Patient Care Quality websites consists of first speaking with the person who provided the service, or to the manager of the area. Then, if that did not resolve the issue, to reach out to the Patient Care Quality Office. Source: https://www.northernhealth.ca/contact/patient-care-quality-office

"It's super, super interesting how people can just pay lip service to say 'yes, I did it, and I understand,' but it doesn't change their practice or beliefs.[…] I took the course, and honestly it just left me more frustrated with the demands that were being placed on me […] in a really stressful and fractured healthcare system."

First Nations Perspectives on Health and Wellness

Increasing understanding about, and respect for, First Nations traditions, customs and protocol is one of three key commitments of the Partnership Accord[31].

"I really like that there is a statement [in the PA] that articulates respect for First Nations traditions, customs and protocols between Northern Health and Northern Region First Nations, so I think that is really important. Because we don't all come from the same context, same beliefs, the same understanding, the same philosophical world views, I think this agreement does a nice recognition of that, and I find that extraordinarily important in the work as we move it forward."

Findings suggest that Partners have implemented initiatives that are cultivating greater awareness/ recognition of traditional wellness and healing practices as well as the social determinants of health.

"I think there's definitely far more awareness of wellness than there had been before the Accord. I think the healthcare system has always been treatment-oriented, but I think Northern Health has a bigger focus on wellness since FNHA has been pushing that as being key. I think there's more awareness of wellness, but whether programs and services have actually changed to focus on wellness is a good question."

"an increased awareness of social determinants of health and how they impact cultures, communities, and areas in specific regions. People are thinking outside of 'it's all on the person to seek medical care and orchestrate their own health'"

Participants cited positive initiatives undertaken by the Partners to increase understanding about, and respect for, First Nations traditions, customs and protocols, for example:

[31] Section 6.b of the Partnership Accord. Available from: https://www.fnha.ca/Documents/Northern_Partnership_Accord.pdf

- the presence of traditional healers at a Northern Health conference was viewed as providing eye-opening exposure to/appreciation of the importance of traditional healers and promoting understanding of Indigenous culture;

"FNHA and Northern Health are really working towards [...] educating the professionals about our cultures. [...] professional doctors went to the traditional healers and were blown away by that experience."

- Feast with the FNHA, Health directors and community members hosted by Northern Health which followed traditional protocols (See Collaboration & Partnership section); and
- greater visibility of brochures, posters, information and artwork in Northern Health facilities that reflect wellness.

Challenges to Integrating FNPOW

While there may be an emerging awareness of wellness, findings suggest that integration of wellness-based approaches in health services is in its early days. Community leadership representation expressed an interest for increased emphasis on/ supports and recognition (including appropriate remuneration of) traditional healing and cultural knowledge.

"Culture is a living entity, and I think also sometimes Indigenous people are looked at as static and historical. And we're not. We're here, and we're here because of our ancestors paved the way, and we're a living culture. We still practice much of what we share as knowledge"

It was noted that a greater awareness of FNPOW among senior health leaders has not necessarily yet translated into changes in program planning or care plans at the patient level, with the exception of MST JPB projects. Strength

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"We have a very clearly-defined perspective of wellness, and I don't see that being picked up or adopted"

"As far as integrating traditional wellness practices into a person's healthcare plan, I'm not seeing it. Individuals make their own choices, but as far as at the systems level, I don't even think we're on that road yet."

Strengthened commitments in the refreshed Partnership Accord to promote understanding about and respect for First Nations' traditions, customs, and protocols was raised as an opportunity to move this area of work forward, as was increased recognition, acknowledgment and remuneration of traditional knowledge, traditional healing and cultural supports and knowledge.

Access, Availability and Quality of Services

Findings revealed that several specific initiatives have been perceived as improving the access, accessibility and quality of health services but that in general, much work still needs to be done to address service shortcomings.

Examples of progress and initiatives to increase access, accessibility and quality of health services identified by evaluation participants include:

- Efforts to **identify service gaps** and **focus on patient experiences of care** (e.g. joint patient journey mapping exercises);
- Increasing **opportunities/forums** for voicing and identifying access, availability and quality challenges (e.g. regional governance tables and working groups);

> *"We hear about things more often and we do what we can do resolve it and improve care. There is probably a bunch of stuff we don't hear and somethings are not addressed fully."*

- Efforts to **increase availability of services** (e.g. the development and recent implementation of some of the MST JPB projects, Primary Care Network planning, increased access to GP and NP services, efforts by Northern Health to increase the availability of equipment and services in centres outside of Prince George and the Northern Health Connections bus program that provides regularly scheduled routes between communities in the north, regional centres and medical services in the lower mainland).[32]
- Efforts to **increase the cultural safety & humility of services**; and
- Efforts to increase awareness and accessibility of services through **information sharing on how to access services**.

[32] Source: https://nhconnections.ca/

"We wouldn't have made special provisions around accessing service [as a result of the PA], but we would have spent more time articulating what those services look like and how people could become prepared to access those services."

While there was recognition of a shared desire to implement new services to address gaps, participants indicated that **joint implementation** of initiatives to address service gaps is in its infancy**,** that many **gaps** in health services still exist and that **adequate resources** need to be put in place and additional conversations occur first.

"There's been an improvement in some services, but the gap was so large, in my opinion, that it's going to take a lot more programming to shorten that gap."

"Because we have to be more explicit about how we're measuring that and come to an agreement on how we think we know that. [..] There's been small teams that have been developed to support more isolated communities, so I think that's been really key, but I think the work in front of us is to actually do more of a system improvement together."

There were also **anecdotal concerns of poor quality of care** raised (e.g. related to services gaps, misdiagnoses, patient concerns or symptoms being minimized or dismissed), the prevalence and scope of these issues is difficult to ascertain because of standard data sources or measures. Data that does exist, from the provincial health services acute inpatient patient experience survey (see Appendix E), shows that 87% of self-identified Aboriginal patients in Northern Health acute care facilities felt that they had not suffered an injury due to a medical mistake, which was very similar to the 90% of non-self-identified Aboriginal respondents who felt that they had not suffered an injury due to a medical mistake.

Cited challenges to access, accessibility and/or quality of services include:

- geographical distance between communities;
- an overall shortage of health care workers and staff turnover;
- short-term/one-time funding;
- service delivery fragmentation and lack of jurisdictional clarity;
- limited awareness among community members regarding services which are available;
- Northern Health **policies** and **collective bargain/union issues** (e.g. union policies restricting scope of practice, working alone policies, travel policies) that hinder/limit implementation of new initiatives;

- difficult arranging **patient transportation.** In many instances where, due to services gaps, community members are sometimes required to travel long distances to obtain care suitable transportation can be difficult to find/ arrange;
- FNHA First Nations Health Benefit Medical Transportation decisions that are made "down south" without adequate consideration of Northern communities or the realities of the terrain. Funding levels are inadequate; and
- Some concern was raised that service access/improvements may vary by community as a function of capacity for advocacy.

A number of specific opportunities were raised to increase access, accessibility and quality of health services, these included:

- Increased access to services outside regional centres in particular for in-community service delivery (either through Northern Health or through more direct service-delivery by communities).
    - Service needs raised by participants include:
        - mental health services, home care services, wound care, physiotherapy, mobile laboratory/x-ray/ultrasound services, dental hygienist, audiologist, diabetes specialists and cancer specialists;
        - Increased visits by JPB professionals;
        - Increasing rehabilitation and aftercare programs in central locations (e.g. Prince George, Fort Saint John, Nak'azdli);
        - Heavy metal and water studies within some communities to better understand greater perceived prevalence of lupus, cancer, dementia in community; and
        - Learning assessments for youth.
- Increased use of telehealth;
- Greater degree of choice in health service offerings (e.g. ability to choose which substance use treatment centres to attend);
- Need for more traditional approaches, healing and medicines in care (e.g. First Nations-based treatment centre options);
- Information on service availability and health literacy (vaccine information for young parents, FNHA First Nations Health Benefits presentations); and
- Equipment and supplies (Holter Monitors[33], patient travel packages).

[33] Device that measures heart beats to test for heart problems.

Resources & Capacity Building

Throughout this report, **time and human resource constraints** are raised as important challenges for many aspects of partnership work including relationship building, engagement and collaboration and partnership. Partners are stretched thin with large portfolios, many competing internal and external demands and significant meeting burden. Distances are large, expensive and weather-dependent to traverse. Partnership is also hindered by turnover and an overall lack of staffing, particularly for clinicians in remote areas.

Participants shared improvements in the **amounts of funding** that are available to communities. While some improvements are acknowledged, there is a sense that funding amounts **remain inadequate** to meet the needs of communities. Specific areas identified by community leadership to which additional funds might be directed included operations and maintenance funding; long-term care/ assisted living; succession/ transition funding; and shared projects.

It was suggested that First Nations agencies (e.g. FNHA) are playing an increasing role in the allocation of funding provincially (e.g. through the JPB projects), and that this has been helpful in **integrating more First Nations Perspectives on Health** and wellness funding and services (e.g. by supplementing existing funding streams with regional envelope funds for Elders as part of the MST JPB project). This additional flexible funding source, seen as a facilitator from one lens, also involved additional complexity for Partners to maneuver.

To support the implementation of projects, it was suggested for consideration that the FNHA act as financial host in partnership projects to allow for greater flexibility with respect to union policies and timeliness of release of funds. There was also a suggestion that the FNHA might work to leverage additional funding from foundations, philanthropists, and the federal government.

Challenges raised by participants to communities participating in funding opportunities include:

- knowing which funds are available to communities;
    - participants suggested providing lists of funds available to communities,
    - provide transparent reporting with respect to funds provided by Northern Health and the FNHA to communities
- Funding opportunities are complex and/or time consuming to apply for. Applications require considerable time and capacity in communities for grant-writing activities and reporting. There is a perception among some

participants that funding processes have been simplified or made more flexible, in response to community needs. Other suggestions include:
    - Provide clear simplified processes for applying for funds and clear guidelines on what the funds can be used for as well as criteria that will be used for adjudicating submissions; and
    - additional supports be provided to communities to complete grant proposals, such as re-establishing funding for grant-writer positions.
- Funding opportunities can instill competition for resources and strain relationships on the ground.

"We do a lot of one-time funding deals, and I think when you walk away you've just created more tension in the community than you've resolved, and that sense of inequality really starts to grow"

- Make funding sustainable. Many funding opportunities continue to be grants and one-time opportunities which require and lack sustainability over time.
- Reporting requirements are complex and/or time consuming.

Community capacity and infrastructure

Community leadership representation recommended increased opportunities for capacity- building, training and mentorship to build human resource capacity in community. Specific suggestions included:

- Job shadowing;
- Training provided in community (e.g. training for homecare/ adult care workers (e.g. regarding medication, lifting etc.));
- Mentorship and best practice sharing between communities and the Partners;
- Increased funds for personal development; and
- Funding to support capacity-building for self-determination, which is perceived to support improved cultural safety and partnerships.

It was noted that a greater flow of dollars to communities/ health departments directly would enable greater improvements on the ground and enable Nations to hire workers that are perceived to be a good fit for their communities.

"Increased flow of dollars directly to Bands to support work on the ground"

Several community leadership participants identified a need for increased investment in accommodations, workspaces and permanent equipment needed in community for visiting health professionals and to support improved recruitment and retention of workers in community. It was noted that winter conditions can hamper same-day travel for professionals; improved accommodation would allow for overnight stays, thus enabling more appointments during professional visits. An opportunity to improve accommodations in community for individuals requiring more intensive care/ supervision was also noted.

> *"One of the things we face on the mobile support team is the housing issue for people in our [...] communities. When you know that in the winter the weather can be bad, and people can get out there but maybe not get back. So it would be neat, for example, for Northern Health to invest in having housing for professionals so that they could have, I don't know, a modular with trailer with four bedrooms, and professionals, if they are bound by weather, will have a safe place to stay"*

Monitoring & Evaluation

Section 6c of the Partnership Accord committed the Partners to annually review and report on progress in developing the relationship between Partners and in achieving the Northern First Nations Health and Wellness Plan goals.

NRT members indicate that it is important to be bold and push for change and use evaluations to show people what has been done to help. Sometimes change can be scary. Individuals need to feel supported and change needs to be made into a friendlier process.

There is a sense that the success indicators that have been articulated in Section 5 (outlined in Table 5 below) of the Partnership Accord help to guide and bring focus to the work being undertaken by Partners.

Table 5: Potential success indicators listed the Northern Partnership Accord

Measurable success indicators will be developed to provide evidence of progress in achieving objectives outlined in the Northern First Nations Health and Wellness Plans. Examples of potential success indicators include: - improved access and cultural competency of health services for First Nations; - coordination and alignment of planning and service delivery between the North Region's First Nations and Northern Health; - increased accessibility to health care services for remote and isolated communities;

- increased partnership between North Regional First Nations and Northern Health to improve the quality of health services at the local and regional level;
- stronger linkages between Northern Health and First Nations health centres for patient referral and service collaboration and integration;
- improved communication between First Nations and Northern Health;
- increased partnership opportunities between Northern Health, Divisions of Family Practice where these exist in the North and First Nations communities to incorporate the needs of First Nations in primary care development;
- increased coordination of eHealth initiatives in the North Region within the Tripartite approach; and
- recruitment and retention of health professionals in the Northern Region.

Participants described useful, ongoing processes in which Partners reflect on the utility of existing structures and processes, constraints to their effectiveness, and ways they might be improved. First Nations representatives are being invited to participate in conversations concerning Partnership Accord progress. Resources are available to complete evaluation work.

"I chat with the [staff] all the time when something is not going really well […] so we do ongoing evaluation that way. 'What can we do to make this meeting more effective?' […] or 'What are the concerns of Health Directors that we're not addressing? Why are they not coming?' There's lots of that on-the-ground evaluation as we go, and that's really good stuff […]. There's nothing formal except for what you're doing"

"We should be doing this more often or have some more informal structures where things are really reviewed because there's no point when things don't work out but we keep doing them, like the working groups. I don't find them to be terribly effective, yet we keep doing them"

While ad-hoc evaluation-type activities are occurring in some instances and likely provide benefit, there is a perception of the need for **more regular and more formal reviews and evaluations**, including more structured assessments of progress in fulfilling Partnership Accord commitments.

Improve **accountability mechanisms** through clearly identified and measurable actions, accountabilities and timelines for any new priorities and commitments articulated in the refreshed PA and any recommendations identified through evaluation work completed, including this evaluation.

Findings also suggest there is lack of **standardized measures to assess progress in improving the accessibility and quality of services**. Moving forward, the refreshed Partnership Accord presents a timely opportunity for Partners to outline measurable success indicators and expected short (less than a year), interim (1-3 years) and longer-term (3+ years (depending on the initiative)) outcomes to monitor success over time.

Conclusion

Findings from the evaluation show that the existence of the Partnership Accord itself is an indicator of success.

The evaluation revealed transformative shifts that have occurred between the Because of the Partnership Accord, and the governance structure born of it, Northern First Nations, the FNHA and Northern Health are gathering around a common table with a shared purpose and commitment.

Formal engagement processes, such as Sub-Regional sessions are enabling discussions of local issues, problem solving and an exchange of information between communities. While some partnership working groups are perceived to play an important role in advancing partnership work, an opportunity exists to review effectiveness of partnership tables.

Those who have been involved in the work since before the signing of the Partnership Accord in 2012 indicate that relationships have improved, formal and informal communications have increased, and the ability to solve local issues has increased. Now there are more opportunities for collaboration, communication, joint decision-making and input.

Partners since the signing of the Partnership Accord in terms of relationships. Partners are now sitting at the same table and jointly undertaking efforts to move priority work forward. New opportunities to work in partnership have emerged.

Findings suggest that an investment in relationship building is paying off: new relationships have been forged, existing ones strengthened, and relational divisions between Partners are being increasingly identified and challenged. The Partners are able to engage in challenging conversations and build solutions from a place of greater trust. Opportunities for face-to-face interactions, the long-term involvement and skill of individual champions, commitment to the work, and ability to see things from different perspectives were among several factors identified as supporting relationship development. Moving forward, participants stressed the need for continued dedication to building relationships and trust, particularly at frontline levels, and for transforming stronger relations into action.

Partners are meeting and communicating on a regular basis. Opportunities to come together regularly is perceived to be beneficial. Opportunities to strengthen communication moving forward included clarifying communication pathways, and prioritizing and carving out time for regular partnership meeting commitments.

Evaluation findings point to increased engagement of First Nations in discussions and decisions that affect them. Facilitators to engagement included the roles of CECs and HSAs and the multiple avenues available for engagement. Nevertheless, it was noted that engagement is still often considered a formality and that instances of true shared decision-making are still somewhat rare. There is a sense that influence in is not equally distributed among the Partners, and opportunity to ensure that partnership is embodied by a more balanced distribution of influence in decision-making. There is a perception that the FNHA/Northern Health are more involved in some conversations, including partnership working groups and decision-making tables than First Nations community representatives, and that improved communication is mostly felt between Northern Health and the FNHA rather than with First Nations. Moving forward, streamlining engagement on First Nations was identified as an opportunity for consideration.

A greater willingness to collaborate, and more opportunities to do so were noted. There is a sense that benefits of partnership activities, such as heightened awareness regarding policy barriers and linkages to supports for clinicians to improve cultural safety, are beginning to have broader impact.

Competing time/ demands and insufficient human/ financial resources emerged as cross-cutting challenges, perceived to constrain collaboration, relationship building, and full engagement and participation in the work of the partnership. Investment of time was also noted as a critical ingredient for allowing relationships to develop and to engage in meaningful conversations regarding issues.

Findings suggest that the Partners have begun work to improve coordination and integration of planning, service delivery, and implementation. Mechanisms such as MST PACs, partnership working groups, and IHIC/AHICs are viewed as effective in supporting strategic conversations, alignment and joint planning. There is a perception among participants that coordination of care and discharge planning is improving. Still, while relational divisions within the partnership are softening, there is a sense that that many operational siloes remain, and a perception that the greatest gains in coordination have been seen within the confines of structured partnership groups or processes.

Cultural safety is perceived by some participants to be improving, and awareness around the concept has gained traction. Initiatives to support improvements,

including training, cultural learning events, the role of Aboriginal Patient Liaisons, are grounded in a genuine commitment to change and are beginning to have an effect. Moving forward, there is an opportunity to further embed cultural safety within the system through greater prioritization of training among Northern Health staff, enacting policies mandating consideration of cultural safety in development of new policies/ products within Northern Health, and enriching learning with more localized opportunities/ curriculum content. There is an increasing recognition of wellness-based approaches and traditional wellness. The importance of increasing supports and recognition for traditional wellness approaches and healers was stressed moving forward.

The evaluation revealed specific initiatives which are perceived to increase the availability of services in some sub-regions, such as the JPB Projects. In addition, the Partners are better equipped to raise and address access issues. Nevertheless, gaps in services persist, compounded by the ongoing geographic and human resource constraints of delivery care in a geographical region the size of France. The degree/ reach of access improvements afforded by a discrete set of partnership projects is uncertain. There is a need for greater outcome data to determine if accessibility, cultural safety and Indigenous patients' experiences of care are improving.

Participants perceive that the progress in partnerships and relationships translating into service improvements is slow. Addressing barriers identified, including a lack of sharing of clinical information, HR and union policy constraints, and transitioning from reliance on relationships and individual actions toward systemic solutions could represent means to improve coordination, accessibility and accelerate roll out of new initiatives moving forward. The perceived gap in services for First Nations residents is wide. Thus, the Partnership Accord refresh represents an important opportunity to build on the partnership processes, conversations and relationships to redouble efforts for service transformation.

Appendix A: Data collection tools

1) Sub-regional Session Survey

Background

The Northern Partnership Accord, signed in 2012, commits parties to an evaluation of the Partnership Accord, including progress in developing the relationship between parties. Northern Health (NH) and the First Nations Health Authority (FNHA) are presently conducting an evaluation of the Accord to identify successes and challenges under it and to inform considerations for a renewed Accord between parties. We are seeking to learn of your views, experience and wisdom regarding the Partnership Accord. Your participation is entirely voluntary. All information will remain confidential and will be gathered, used and stored in accordance with the Personal Information Protection Act, the Freedom of Information and Protection of Privacy Act and other relevant privacy legislation. Information gathered will be used for the purposes of this evaluation and may also inform other FNHA evaluation work, including the ongoing evaluation of the Tripartite Framework Agreement. An evaluation report, or other summary of findings resulting from this survey will be shared with you. Findings will be reported anonymously and in aggregate. Anonymous quotations obtained through open-ended responses may be included in FNHA reporting. Reports may also be shared with FNHA and Northern Health Authority partners and the public. If you have any questions regarding the project, please feel free to contact Rebecca Love Manager, Evaluation, FNHA at 604-699-3168 or Brian Mairs, Regional Program Liaison – North, FNHA at 250-917-8569. Completed surveys will be collected at Regional Caucus by members of the FNHA North Region team or the FNHA evaluation team.

Introduction
What is your current role?
Which region of the North are you from?

1. How would you rate your understanding of the aims of the Northern Partnership Accord?

Poor	Fair	Good	Very good	Excellent

2. In your view, what have been the most significant changes resulting from the Partnership Accord?

3. In your view, what are most significant changes that need to occur moving forward?

4. Please rate your agreement with the following statements regarding the partnership on a scale of '1' to '5' where '1' means 'strongly disagree' and '5' means 'strongly agree'

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Open-ended questions
As a result of the partnership:	**1**	**2**	**3**	**4**	**5**		
a) Relationships between my Nation and Northern Health have been strengthened (e.g. with local NH service administrators or health services staff in my area)	1	2	3	4	5	Don't know	What has helped strengthen these relationships? What would help strengthen these relationships further?
b) Relationships between my Nation and the FNHA have been strengthened (e.g. with local Community Engagement Coordinators, Regional Office supports and linkage to provincial supports)	1	2	3	4	5	Don't know	
c) Partnership opportunities with Northern Health have increased (e.g. funding and individual service agreements, Aboriginal Health Improvement Committee funding, JPB projects, MST)	1	2	3	4	5	Don't know	
d) Partnership opportunities with the FNHA have increased (e.g. Regional training, regional envelope funded projects)	1	2	3	4	5	Don't know	
e) Processes to identify and address issues brought forward by my Nation have improved (e.g. through Aboriginal Health Improvement Committees, NH complaints pathway, Community Engagement Coordinator meetings, sub-regional and regional caucus sessions)	1	2	3	4	5	Don't know	Which mechanisms are you aware of to raise and address issues within the partnership? What would further enable Nations to raise and resolve issues effectively?
f) Communication between my Nation and Northern Health has improved (e.g. with local NH service administrators or health services staff in my area)	1	2	3	4	5	Don't know	What further changes would you like to see to improve communication?
g) Communication between my Nation the FNHA has improved (e.g. through sub-regional and regional caucus, other engagement opportunities, or regional office support)	1	2	3	4	5	Don't know	
h) Processes to support decision-making by First Nations regarding health services have improved	1	2	3	4	5	Don't know	How could First Nations decision-making be further strengthened?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Open-ended questions
As a result of the partnership:	**1**	**2**	**3**	**4**	**5**		
i) Meaningful engagement of my Nation by Northern Health has improved (e.g. engagement by NH service administrators in my area or other NH staff)	1	2	3	4	5	Don't know	What has enabled meaningful engagement?
j) Meaningful engagement of my Nation by the FNHA has improved (e.g. through sub-regional and regional caucus sessions, Community Engagement Coordinators)	1	2	3	4	5	Don't know	How could engagement be further improved?
k) There is increased coordination of services between my Nation and Northern Health (e.g. with local NH service administrators or health services staff in my area)	1	2	3	4	5	Don't know	What has enabled coordination?
l) There is increased coordination of programs, resources and services between my Nation and the FNHA	1	2	3	4	5	Don't know	How could coordination be further improved?

5. Are there any other views, experiences, or opinions regarding the partnership that you would like to share with us?

2) NFNHPC interview guide

Section 1: Introduction

The *Northern Partnership Accord*, (Accord) signed in 2012, commits partners to an evaluation of the Accord, including progress in developing the relationship between parties. Northern Health (NH) and the First Nations Health Authority (FNHA) are presently conducting an evaluation of the Accord to identify successes and challenges, which will inform considerations for a renewed Accord between parties.

We are seeking your views, experiences and wisdom regarding the Accord. Your participation is entirely voluntary. The interview will take approximately 50 to 60 minutes of your time. Ference & Company has been engaged to support a part of the evaluation including conducting key informant interviews. All information gathered will remain confidential and will be collected, used and stored in accordance with the Personal Information Protection Act, the Freedom of Information and Protection of Privacy Act and other relevant privacy legislation. Information gathered will be used for the purposes of this evaluation and may also inform other FNHA evaluation work, including the ongoing evaluation of the *Tripartite Framework Agreement*.

An evaluation report, or other summary of findings resulting from this interview will be shared with you. Findings will be reported anonymously and in aggregate. Anonymous quotations obtained through open-ended responses may be included in FNHA reporting. Reports may also be shared with FNHA and Northern Health, other partners, and the public. If you have any questions regarding the project, please feel free to contact Rebecca Love Manager, Evaluation, FNHA at 604-699-3168 or Brian Mairs, Regional Program Liaison – North, FNHA at 250-917-8569.

Section 2: Description of Key Informant

Name: _____

Position: _____

Organization: _____

History of Involvement with the Northern Partnership Accord:

_____

Section 3: Northern Partnership Accord Questions

Governance and relationships:

1. The first section of the Accord outlines the Partners to the agreement. In your view, how have relationships between partners (Northern Region First Nations, Northern Health, and First Nations Health Authority) been impacted as a result of the Partnership Accord? Please provide any examples.

1.1 What has supported improved relationships?

1.2 What has constrained improvements? What could further improve relationships between partners?

2. The Northern First Nations Health Partnership Committee is composed of the Northern Regional Table, FNHA, and members of the Executive Team from Northern Health. In your view, how effectively is this Committee operating?

Ineffectively	Somewhat ineffectively	Neither Effectively Nor Ineffectively	Somewhat effectively	Effectively	Don't Know

2.1 What is working well with this structure?

2.2 Are there areas in need of improvement?

3. In your view, how often is there shared decision-making among the partners with respect to the development and delivery of health care services or programs for Northern First Nation communities**?**

Never	Rarely	Sometimes	Often	Always	Don't Know

Please provide an example or rationale for your rating, if appropriate:

4. The Accord commits partners to support each other to collaborate in a positive and constructive manner. In your view, to what extent have partners succeeded in working together in a supportive manner?

Not at all	To a small extent	To a moderate extent	To a great extent	To a very great extent	Don't know

Please provide a rationale or example for your answer:

5. The Accord commits partners to communicate in a timely and effective manner. How would you rate the effectiveness of communication between partners?

Ineffective	Somewhat ineffective	Neither Effective Nor Ineffective	Somewhat effective	Effective	Don't Know

Please provide a rationale or example for your answer:

6. In your view, is there a clear understanding of the roles and responsibilities of all partners as outlined in the Accord?

Unclear understanding	Somewhat unclear understanding	Neither clear nor unclear understanding	Somewhat clear understanding	Clear understanding	Don't Know

Please provide a rationale or example for your answer:

Purpose, Priorities, and Objectives

7. The second section of the Accord outlines the purpose of the agreement. One of the purposes is to involve First Nations leadership in the planning and monitoring of health services that impact First Nations communities.
In your view, how effective has the partnership been at achieving this?

Ineffective	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide any examples if appropriate:

7.1 What has facilitated participation and engagement of First Nations?

7.2 What could further strengthen participation and engagement?

8. Do you feel there are improved processes, as a result of the Accord, to address issues in health care services that impact First Nations communities? Please describe/ explain.

9. The Accord intended to enable collaboration in the planning, implementation, and evaluation of culturally appropriate, safe, and effective services for First Nations residing in the Northern region.

How would you rate the effectiveness of the Partnership with respect to:

a) Strengthening the planning of services

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

b) Strengthening the implementation of services

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

c) Strengthening the coordination and alignment of service delivery

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

d) Strengthening the evaluation of services

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

10. In your view, how successful was the Partnership Committee in developing a First Nations Health and Wellness Plan that addressed the requirements of the Accord, while addressing emerging priorities identified by the partners?

The partners committed to collaboratively develop a plan that included:

- Development of population health approaches
- Approaches to improve access to health care
- Strategies to increase Indigenous representation in health service professions
- Measurement of health indicators/ outcomes

Unsuccessful	Somewhat unsuccessful	Neither unsuccessful nor successful	Somewhat successful	Successful	Don't Know

Please provide any examples if appropriate:

11. The Accord acknowledges that partners work in partnership to close the gaps and remove barriers to accessing and improving services. In your view, how successful has the Partnership been at:

a) Improving health care services for Northern First Nations

Unsuccessful	Somewhat unsuccessful	Neither unsuccessful nor successful	Somewhat successful	Successful	Don't Know

Please provide any examples if appropriate:

b) Improving the accessibility of services

Unsuccessful	Somewhat unsuccessful	Neither unsuccessful nor successful	Somewhat successful	Successful	Don't Know

Please provide any examples if appropriate:

11.1 Have adequate policies, processes and or bodies been established to enable ongoing improvements?

12. In your view, to what extent has the cultural safety of health care programs and services improved as a result of the Accord?

Please provide any examples.

Not at all	To a small extent	To a moderate extent	To a great extent	To a very great extent	Don't know

Considerations for Partnership Accord Renewal

13. The Accord will be renewed this year. From your perspective do the commitments identified in the Accord still reflect the key priorities of the partners? Are there any new priorities or gaps not addressed by the 2012 Accord that should inform commitments of the new Accord?

14. In your view, what have been the greatest achievements or outcomes of the Partnership?

15. What have been the greatest challenges in implementing commitments of the Accord?

16. Are there additional comments you would like to add that you consider important for this evaluation of the Accord?

3) Northern Health Interview guide

1. Involvement with the Northern Partnership Accord:

Governance and relationships:

1. The first section of the Accord outlines the partners to the agreement. In your view, how have relationships between partners (Northern Region First Nations, Northern Health, and First Nations Health Authority) been impacted as a result of the Partnership Accord? Please provide any examples.

1.1. What has supported improved relationships?

1.2 What has constrained improvements? What could further improve relationships between partners?

2. The Accord commits partners to support each other to collaborate in a positive and constructive manner. In your view, to what extent have partners succeeded in working together in a supportive manner?

Unsuccessful	Somewhat unsuccessful	Neither unsuccessful nor successful	Somewhat successful	Successful	Don't Know

Please provide a rationale or example for your answer:

2.1 How have your working relationships with Northern Region First Nations (e.g. with political or technical leaders) changed as a result of the Accord?

2.2 What has facilitated or constrained collaboration?

3. The Accord commits partners to communicate in a timely and effective manner. How would you rate the effectiveness of communication between partners?

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide a rationale or example for your answer:

3.1 What has facilitated effective communication?

3.2 What has constrained effective communication?

Purpose, Priorities, and Objectives

4. The second section of the Accord outlines the purpose of the agreement. One of the purposes is to involve First Nations leadership in the planning and monitoring of health services that impact First Nations communities. In your view, how effective has the partnership been at achieving this?

Ineffective	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide any examples if appropriate:

4.1 What has facilitated participation and engagement of First Nations?

4.2 What could further strengthen participation and engagement?

5. Do you feel there are improved processes, as a result of the Accord, to address issues in health care services that impact First Nations communities? Please describe/ explain.

Not at all	To a small extent	To a moderate extent	To a great extent	To a very great extent	Don't know

Please explain or provide examples:

5.1 Has the FNHA community engagement team been effective in communicating issues raised by First Nations to Northern Health for resolution?

6. The Accord intended to enable collaboration in the planning, implementation, and evaluation of culturally appropriate, safe, and effective services for First Nations residing in the Northern region.

How would you rate the effectiveness of the partnership with respect to:

a) Strengthening the planning of services

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

b) Strengthening the implementation of services

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

c) Increasing partnership activities between the partners

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

d) Strengthening the evaluation of services

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

7. How effective has the partnership been at strengthening the coordination and alignment of service delivery**?**

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

7.1 How has information sharing with First Nations and FNHA changed as a result of the Accord? What new processes or mechanisms have been developed to enable information sharing (e.g. a shared records and information management framework)?

7.2 How has service collaboration, integration and patient referral with First Nations Health Centres changed as a result of the Accord?

8. In your view, to what extent have ideas, expertise and guidance contributed by First Nations and the FNHA been incorporated into the development of collaborative projects with the partners?

Not at all	To a small extent	To a moderate extent	To a great extent	To a very great extent	Don't know

Please provide examples or a rationale for your rating:

8.1 How has input been incorporated or reflected in collaborative projects?

9. The Accord acknowledges that the partners work in partnership to close the gaps and remove barriers to accessing and improving services. In your view, how successful has the partnership been at:

a) Improving health care services for Northern First Nations

Unsuccessful	Somewhat unsuccessful	Neither unsuccessful nor successful	Somewhat successful	Successful	Don't Know

Please provide any examples if appropriate:

b) Improving the accessibility of services

Unsuccessful	Somewhat unsuccessful	Neither unsuccessful nor successful	Somewhat successful	Successful	Don't Know

Please provide any examples if appropriate:

9.1 Moving forward, what would enable and support improvements?

10. In your view, to what extent has the cultural safety of health care programs and services improved as a result of the Accord?

Not at all	To a small extent	To a moderate extent	To a great extent	To a very great extent	Don't know

Please provide any examples.

10.1 What has facilitated improvements? Are processes or structures in place that support ongoing improvements in cultural safety?

11. How has the partnership changed awareness and understanding of First Nations customs, traditions and protocols within Northern Health, if at all? How is this reflected in programs and services?

Considerations for Partnership Accord Renewal

12. In your view, what have been the greatest achievements or outcomes of the Partnership?

13. What have been the greatest challenges in implementing commitments of the Accord?

14. Are there additional comments you would like to add that you consider important for this evaluation of the Accord?

4) FNHA Regional Team interview guide

Governance and relationships:

1. The first section of the Accord outlines the partners to the agreement. In your view, how have relationships between partners (Northern Region First Nations, Northern Health, and First Nations Health Authority) been impacted as a result of the Partnership Accord? Please provide any examples.

1.1 What has supported improved relationships?

1.2 What has constrained improvements? What could further improve relationships between partners?

2. The Accord commits partners to support each other to collaborate in a positive and constructive manner. In your view, to what extent have partners succeeded in working together in a supportive manner?

Unsuccessful	Somewhat unsuccessful	Neither unsuccessful nor successful	Somewhat successful	Successful	Don't Know

Please provide a rationale or example for your answer:

2.1 What has facilitated collaboration?

2.2 What has constrained collaboration?

3. The Accord commits partners to communicate in a timely and effective manner. How would you rate the effectiveness of communication between partners?

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide a rationale or example for your answer:

3.1 What has facilitated effective communication?

3. 2 What has constrained effective communication?

Purpose, Priorities, and Objectives

4. The second section of the Accord outlines the purpose of the agreement. One of the purposes is to involve First Nations leadership in the planning and monitoring of health services that impact First Nations communities. In your view, how effective has the partnership been at achieving this?

Ineffective	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide any examples if appropriate:

5. In your view, how effective have the following been at facilitating participation and engagement of Northern Region First Nations in regional planning and health decision-making?

a) Regional Caucus

Ineffective	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide any examples if appropriate:

b) Sub-regional Caucus sessions

Ineffective	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide any examples if appropriate:

c) Community engagement coordinators

Ineffective	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide any examples if appropriate:

5.1. What has facilitated participation and engagement of First Nations?
5.2. What could further strengthen participation and engagement?

6. Do you feel there are improved processes, as a result of the Accord, to address issues in health care services that impact First Nations communities? Please describe/ explain.

Not at all	To a small extent	To a moderate extent	To a great extent	To a very great extent	Don't know

Please explain or provide examples:

6.1. Has the community engagement team been effective in communicating issues raised by First Nations to Northern Health for resolution?

7. In your view, how have partnership activities between all three partners increased or changed because of the Accord, if at all? Please provide any examples.

8. The Accord intended to enable collaboration in the planning, implementation, and evaluation of culturally appropriate, safe, and effective services for First Nations residing in the Northern region.

How would you rate the effectiveness of the partnership with respect to:

a) Strengthening the planning of services

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

b) Strengthening the implementation of services

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

c) Strengthening the coordination and alignment of service delivery

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

d) Strengthening the evaluation of services

Ineffective	Somewhat Ineffective	Neither Effective Nor Ineffective	Somewhat Effective	Effective	Don't Know

Please provide examples if appropriate:

9. In your view, to what extent have ideas, expertise and guidance contributed by First Nations and the FNHA been incorporated into the development of collaborative projects with the partners?

Not at all	To a small extent	To a moderate extent	To a great extent	To a very great extent	Don't know

Please provide examples or a rationale for your rating:

9.1. How has input been incorporated or reflected in collaborative projects?

10. The Accord acknowledges that partners work in partnership to close the gaps and remove barriers to accessing and improving services. In your view, how successful has the partnership been at:

a) Improving health care services for Northern First Nations

Unsuccessful	Somewhat unsuccessful	Neither unsuccessful nor successful	Somewhat successful	Successful	Don't Know

Please provide any examples if appropriate:

b) improving the accessibility of services

Unsuccessful	Somewhat unsuccessful	Neither unsuccessful nor successful	Somewhat successful	Successful	Don't Know

Please provide any examples if appropriate:

10.1 Have adequate policies, processes and or bodies been established to enable ongoing improvements?

10.2 Moving forward, what would further enable and support improvements?

11. In your view, to what extent has the cultural safety of health care programs and services improved as a result of the Accord?

Not at all	To a small extent	To a moderate extent	To a great extent	To a very great extent	Don't Know

Please provide any examples.

11.1 What has facilitated improvements? Are processes or structures in place that support ongoing improvements in cultural safety?

11.2 What are the key constraints to improving cultural safety? Are there any key areas that remain to be addressed?

12. In your view, how have programs and services become more reflective of the First Nations perspective of wellness as a result of the Accord or designed to support holistic wellness Please provide examples.

Considerations for Partnership Accord Renewal

13. The Partnership Accord will be renewed this year. From your perspective are there any additional/new priorities or gaps not addressed by the 2012 Accord that should inform commitments of the new Accord?

14. In your view, what have been the greatest achievements or outcomes of the Partnership?

15. What have been the greatest challenges in implementing commitments of the Accord?

Are there additional comments you would like to add that you consider important for this evaluation of the Accord?

5) Focus group guides

4.1) Maternal Child Health Working Group

1. What have been the most significant changes or outcomes since the signing of the Partnership Accord in 2012 with respect to the partnership or maternal and child health in the North?
2. How have maternal and child health services for Northern Region First Nations changed since 2012? What has supported or hindered progress?
   Probes:
   - Have services become more culturally safe?
   - Has the availability/ accessibility of services improved?
   - What have been the facilitators and barriers to improvements?
   - Which working group processes are working well to support improvements? What would make the working group more effective? Does the WG have:
     a. The resources and support it needs?
     b. Frequent communication?
     c. Shared sense of the purpose?
     d. Clearly understood roles and functions?
     e. The right people consistently at the table to support progress?
3. What have been the key lessons learned over the past five years?
   Probes:
   a) Do you have any considerations or recommendations of what needs to be included in a renewed version of the Accord?

4.2 Cultural Safety Partnership Working Group

1. What have been the most significant changes or outcomes since the signing of the Partnership Accord in 2012?
2. How has the cultural safety and humility of programs and services for Northern Region First Nations changed since 2012? Please share any examples.

3. How has the working group supported fulfilling the partners' commitments in the Partnership Accord related to cultural safety?
   Commitments include:
   - NH to provide and evaluate cultural competency education for NH personnel
   - NH to work with local First Nations people through the Aboriginal Heath Improvement Committees to improve the cultural competency of NH services at the community level
   - Increase understanding about and respect for First Nations traditions, customs and protocols between NH and North Region First Nations, including through:
     - A cultural responsiveness strategy for NH in the Northern First Nations Health and Wellness Plan
     - Development of cultural guidelines relevant to the First Nations who access services in each of NH's community clusters
     - A protocol for First Nations Health Centre workers to support care for First Nations citizens in NH facilities

4. In what ways have relationships between Northern Health, FNHA and Northern First Nations changed as a result of the partnership? Please describe.
5. What have been the key lessons learned over the past five years?

4.3) Primary Care Working Group

1. What have been the most significant changes or outcomes since the signing of the Partnership Accord in 2012?
2. How has the cultural safety and humility of programs and services for Northern Region First Nations changed since 2012? Please share any examples.
3. How has the working group supported fulfilling the partners' commitments in the Partnership Accord related to cultural safety?
   Commitments include:
   - NH to provide and evaluate cultural competency education for NH personnel
   - NH to work with local First Nations people through the Aboriginal Heath Improvement Committees to improve the cultural competency of NH services at the community level
   - Increase understanding about and respect for First Nations traditions, customs and protocols between NH and North Region First Nations, including through:
     - A cultural responsiveness strategy for NH in the Northern First Nations Health and Wellness Plan
     - Development of cultural guidelines relevant to the First Nations who access services in each of NH's community clusters
     - A protocol for First Nations Health Centre workers to support care for First Nations citizens in NH facilities
4. In what ways have relationships between Northern Health, FNHA and Northern First Nations changed as a result of the partnership? Please describe.
5. What have been the key lessons learned over the past five years?

4.4) Population and Public Health Working Group

1. What have been the most significant changes or outcomes since the signing of the Partnership Accord in 2012?
2. How have population/public health initiatives for Northern Region First Nations changed since 2012? Please share any examples.
3. Are partnership processes to advance the population and public health priorities of the partners working effectively? What is working well? What could be improved?
4. In what ways have relationships between Northern Health, FNHA and Northern First Nations changed as a result of the partnership? Please describe.
5. What have been the key lessons learned over the past five years?

Appendix B: Demographic and Health System Data

Demographic and health system data

Table 6: 2016 First Nations, Status First Nations and Aboriginal Population, geography, health facility and staffing information by region

		Fraser Salish	Interior	Northern	Vancouver Coastal	Vancouver Island
BC Total Population*						
Total Population (4,560,265)(% Prov pop)		**1,695,010 (37.2%)**	722,480 (15.8%)	275,520 (6.0%)	1,110,270 (24.4%)	756,985 (16.6%)
Aboriginal Population±						
Aboriginal population (270,570)(% Abor pop in total pop)		**62,295** (3.7%)	63,845 (8.8%)	56,365 **(20.5%)**	30,850 (2.8%)	57,215 (7.6%)
% of Total BC Aboriginal Pop		23.0%	**23.6%**	20.8%	11.4%	21.2%
First Nations (172,480)(% FN pop in total pop)		35,040 (2.1%)	36,580 (5.1%)	**40,760** (**14.8%**)	22,085 (2.0%)	38,015 (5.0%)
Registered or Treaty Indian Status (70,265)(% Registered/Treaty Indian FN pop)		12,070 (0.7%)	14,860 (2.1%)	**17,935 (6.5%)**	9,410 (0.8%)	15,990 (2.1%)
First Nation communities						
# of First Nation communities		32	52	**55**	14	50
# of communities with <300 people†		29	36	30	6	35
# of communities with no road access‡		0	1	**10**	2	**8**
On/off reserve***						
Aboriginal Identity	On-reserve	4,660 (7.5%)	11,965 (18.9%)	**14,570** (26.0%)	8,040 **(26.1%)**	12,210 (21.4%)
	Off-reserve	**57,265 (92.5%)**	51,210 (81.1%)	41,530 (74.0%)	22,745 (73.9%)	44,725 (78.6%)
First Nations	On-reserve	4,490 (12.9%)	11,105 (31.0%)	**14,450** (35.7%)	7,950 **(36.1%)**	11,995 (31.8%)
	Off-reserve	**30,225 (87.1%)**	24,735 (69.0%)	26,050 (64.3%)	14,070 (63.9%)	25,725 (68.2%)
Household Counts****						
Aboriginal households	On-reserve	1,715	5,145	5,075	2,825	3,870
	Off-reserve	28,765	26,565	19,240	13,910	23,835
	On-reserve	1,605	4,655	5,055	2,770	3,750

Registered or Treaty Indian Status households	Off-reserve	9,745	9,220	10,235	6,260	9,820
Health Staff^						
# of Employees		26,000	20,000	7,000	14,000	22,000
# of Physicians		2,900	1,500	375	2,700	1,900
# of FNHA employees (plus 600 Corporate FNHA staff)		36	35	44	17	49
Geographical Area						
Land size (% Prov land mass)		13,362 (1.4%)	215,000 (22.4%)	**617,271 (64.3%)**	58,560 (6.1%)	56,000 (5.8%)
FNHA Health Facility*		17	36	39	10	34
Total Provincial Health Service Facility**						
Large Peer Group		8	2	1	4	3
Medium Peer Group		3	5	4	2	6
Small Peer Group		1	15	9	5	5
Extra-Small Peer Group		0	13	10	2	7
Total		12	35	24	13	21

*CIRNAC. Data current to December 31, 2018. Data refers to Registered Status Indians only. Three Yukon bands, Taku River Tlingit, Liard First Nation and Dease River are included in Northern Region estimates.

± Statistics Canada, 2016 Census of Population. Aboriginal identity, as refer to Aboriginal population in the table, includes persons who are First Nations (North American Indian), Métis or Inuk (Inuit) and/or those who are Registered or Treaty Indians (that is, registered under the Indian Act of Canada) and/or those who have membership in a First Nation or Indian band. As Census 2016 is organized by Community Health Service Areas (CHSAs) and local health areas (LHAs), it should be noted that three FNHA Vancouver Coastal Region First Nations communities, Samahquam, Skatin and Xa'xtsa, are geographically located in LHA 215 Agassiz/Harrison, which falls within Fraser Health Authority. Fraser Salish Region community, Boothroyd, is geographically located in CHSA 1480, which falls within Interior Health Authority. Two communities, Ulkatcho (Anahim Lake) and Alexandria (?Esdilagh), are part of FNHA Interior Region, but are geographically located in LHAs that are part of the Vancouver Coastal Health and Northern Health Authorities, respectively.

**2018 Emergency Department Patient Reported Experience Measures Survey Technical Report. For definition on peer group see Table 4 below.

† CIRNAC. Data current to December 31, 2018. Based on On Reserve (Own Band) population;

‡ Based on Health Canada Remoteness Index categories 'Isolated' and 'Remote-Isolated', which do not have road access.

***Statistics Canada, 2016 Census of Population. On-reserve includes those census subdivisions (CSDs) in BC with the CSD type: 'Indian Reserve', 'Indian Government District', 'Indian Settlement', or 'Nisga'a Land'. Numbers may not add up to total provincial estimate due to random rounding implemented by Stats Canada.

****Statistics Canada. 2018. Special tabulation, based on 2016 Census. An Aboriginal/Registered or Treaty Indian Status household is one of the following:

i) a non-family household in which at least 50 per cent of household members self-identified as Aboriginal/Registered or Treaty Indian Status people; or

ii) a family household that meets at least one of two criteria:

a) at least one spouse, common-law partner, or lone parent self-identified as an Aboriginal/Registered or Treaty Indian Status person; or

b) at least 50 per cent of household members self-identified as Aboriginal/Registered or Treaty Indian Status people.

An Aboriginal person is anybody identifying as an Aboriginal person (question 18 on 2016 Long-form Census Questionnaire), Treaty Indian or Registered Indian (question 20), or a member of an Indian Band/First Nation (question 21).

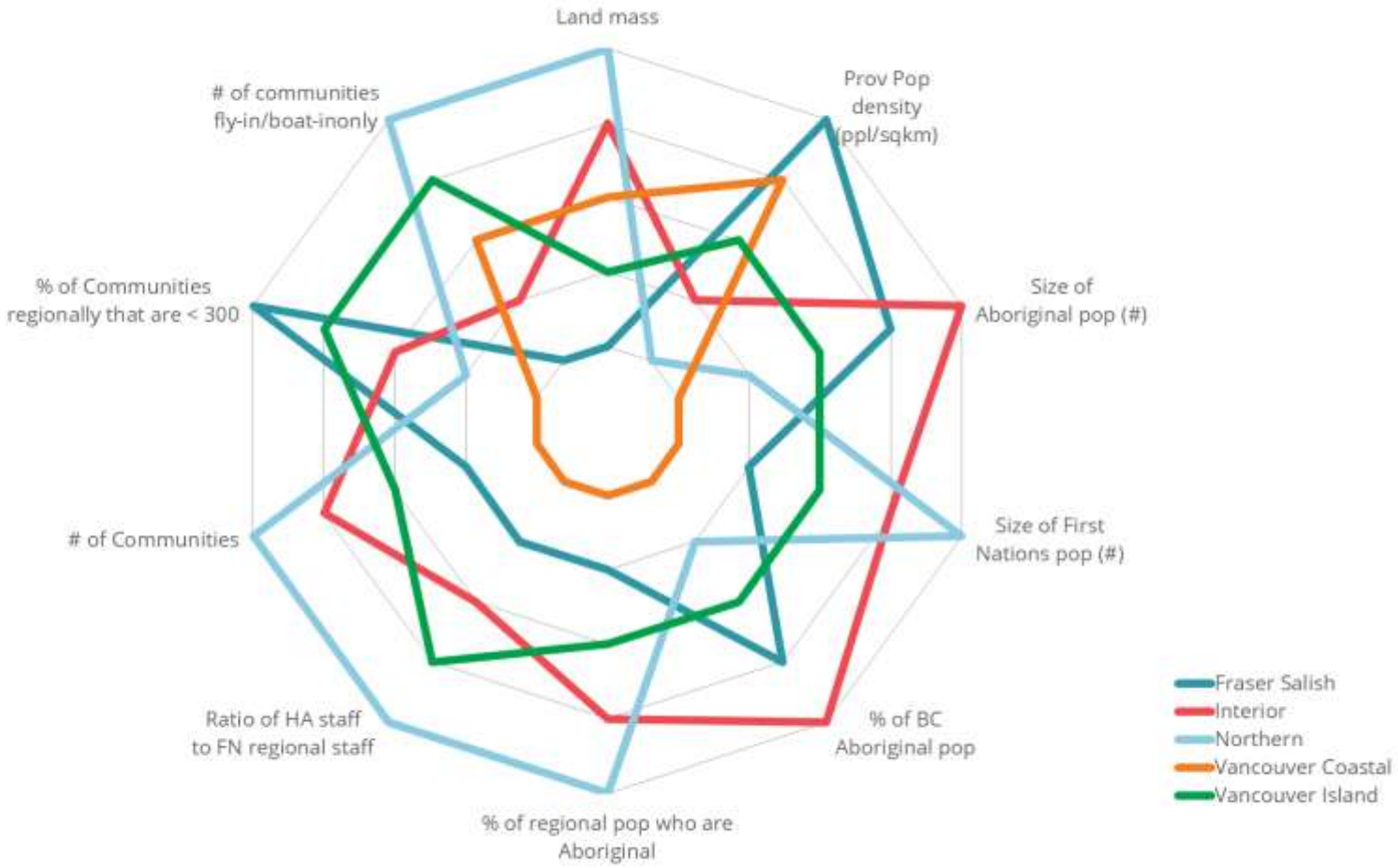
^Factsheet from regional health authorities:

- Fraser retrieved from https://www.fraserhealth.ca/about-us/about-fraser-health/#.Xbd8iOSP5fy
- Interior retrieved from https://www.interiorhealth.ca/AboutUs/QuickFacts/Pages/default.aspx
- Northern retrieved from https://www.northernhealth.ca/about-us/quick-facts
- Vancouver Coastal retrieved from http://www.vch.ca/Documents/VCH-fact-sheet.pdf
- Vancouver Island retrieved from https://www.islandhealth.ca/about-us

Table 7: Regional comparison of select geographic and demographic characteristics

Demographics						Communities and Characteristics			Geography		Staffing
Aboriginal population (#)	% of regional population who are Aboriginal	% of Total BC Aboriginal population	First Nations population (#)	# of First Nations living on-reserve	% of FN living on-reserve	# of First Nation Communities	% of Communities < 300 ppl	# of fly-in/boat-in only Communities	Regional Land mass	Population density (ppl/sqkm)	Ratio of HA staff to FN regional staff
I (63,845)	N (20%)	I (24%)	N (40,760)	N (14,450)	VC (36.1)	N (55)	FS (91%)	N (10)	N (64.29%)	FS (126.85)	N (1:159)
FS (62,295)	I (9%)	FS (23%)	I (36,580)	VI (11,995)	N (35.7%)	I (52)	VI (70%)	VI (8)	I (22.39%)	VC (18.96)	VI (1:449)
VI (57,215)	VI (8%)	VI (21%)	VI (38,015)	I (11,105)	VI (31.8%)	VI (50)	I (69%)	VC (2)	VC (6.10%)	VI (13.52)	I (1:571)
N (56,365)	FS (4%)	N (21%)	FS (35,040)	VC (7,950)	I (31.0%)	FS (32)	N (57%)	I (1)	VI (5.83%)	I (3.36)	FS (1:722)
VC (30,850)	VC (3%)	VC (11%)	VC (22,085)	F (4,490)	F (12.9%)	VC (14)	VC (43%)	FS (0)	FS (1.39%)	N (0.45)	VC (1:823)

Figure15: Ranked order of regional geographic and demographic characteristics



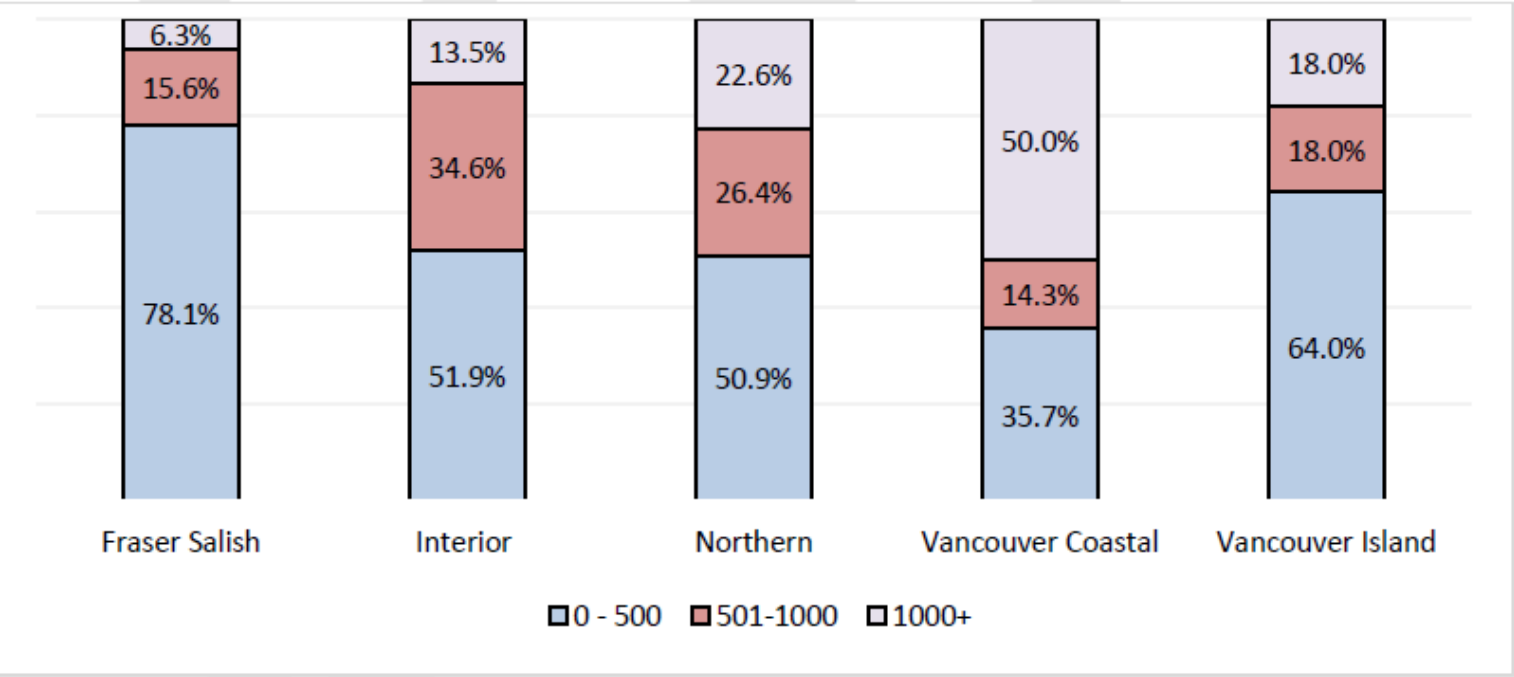
Note: Each region is represented by a line. Lines that are closest to the edge denote that region has a larger percentage/absolute number of the characteristic labelled on that axis. For example, the Northern region has the largest land mass (see Table 5 for the actual number), the next region with the second largest land mass is Interior, followed by VC, VI and FS.

Table 8: 2016 Population size by Census Metropolitan Area

	Total population	Aboriginal Identity	Aboriginal identity, Percent distribution	First Nations	First Nations (North American Indian), Percent distribution
Vancouver	2,426,235	**61,455**	2.5	**35,765**	1.5
Victoria	357,690	**17,245**	4.8	**9,935**	2.8
Prince George	85,135	**12,395**	**14.6**	**7,050**	8.3
Kelowna	190,565	**11,370**	6	5,235	2.7
Kamloops	100,755	10,700	10.6	**6,340**	6.3
Abbotsford - Mission	176,325	9,755	5.5	4,990	2.8
Chilliwack	98,855	9,585	9.7	**6,305**	6.4
Nanaimo	101,985	8,265	8.1	5,145	5
Duncan	43,165	5,775	13.4	4,660	10.8
Prince Rupert	12,515	4,855	**38.8**	4,410	**35.2**
Campbell River	37,105	4,760	12.8	3,420	9.2
Vernon	59,715	4,365	7.3	2,365	4
Port Alberni	24,715	4,210	17	3,035	**12.3**
Terrace	15,460	3,630	**23.5**	2,915	**18.9**
Williams Lake	17,835	3,625	**20.3**	2,800	**15.7**
Penticton	42,105	3,305	7.8	1,695	4
Fort St. John	27,990	3,275	11.7	1,670	6
Quesnel	22,945	3,250	14.2	1,610	7
Courtenay	53,120	3,215	6.1	1,825	3.4
Cranbrook	25,550	2,170	8.5	825	3.2
Dawson Creek	11,785	1,930	16.4	890	7.6
Squamish	19,490	1,275	6.5	870	4.5
Salmon Arm	17,225	1,250	7.3	525	3
Parksville	27,985	1,095	3.9	485	1.7
Powell River	16,360	905	5.5	545	3.3
Nelson	17,960	885	4.9	375	2.1

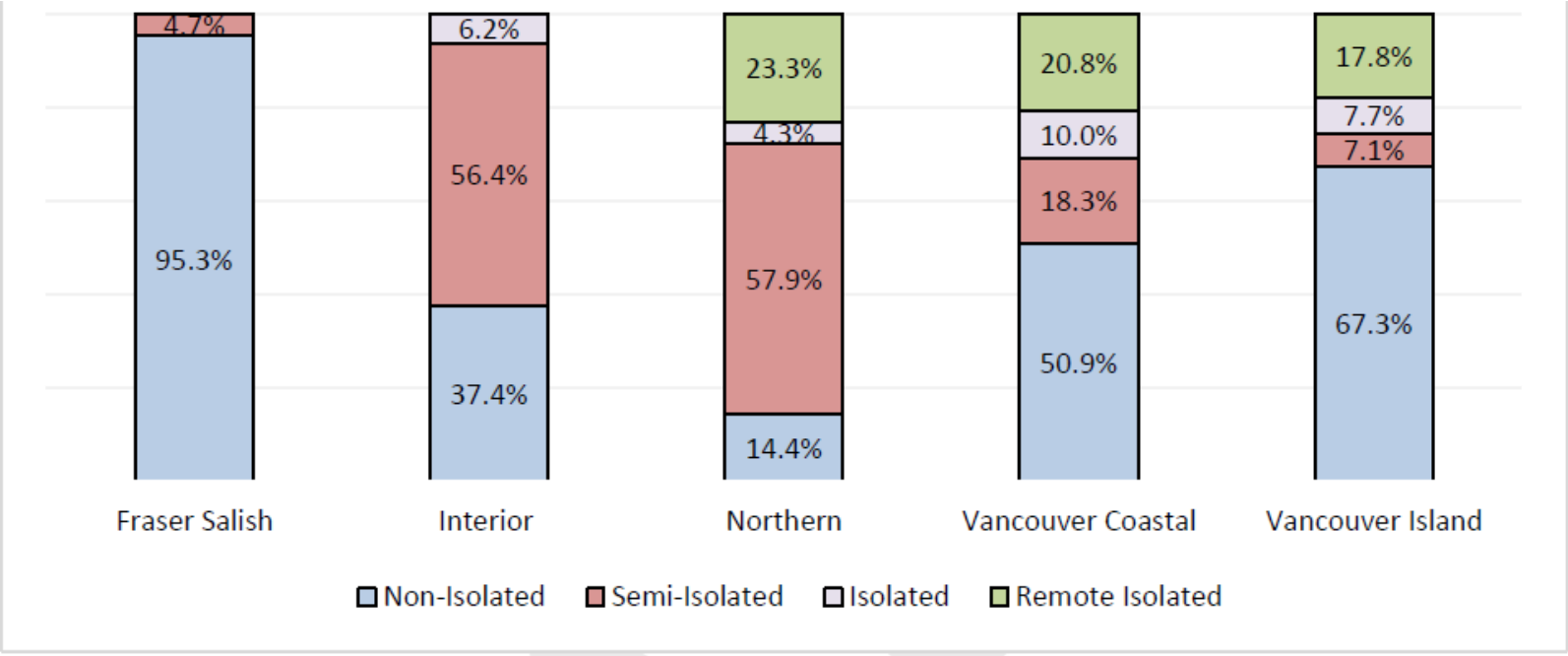
Source: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/abo-aut/Table.cfm?Lang=Eng&T=102&SR=1&S=88&O=A&RPP=9999&PR=0&D1=1&D2=1&D3=1

Figure 16: Proportion of population by community size and region, 2016.



Source: Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC)

Figure 17: Proportion of population by remoteness and region,



Source: Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC)

Table 5: Location and size of acute care facilities by health authority region

	Fraser Salish	Interior	Northern	Vancouver Coastal/PHC†	Vancouver Island	PHSA
Large Peer Group: more than 40,000 annual patient visits n=19	1. Abbotsford Regional General Hospital* 2. Burnaby Hospital* 3. Chilliwack General Hospital* 4. Eagle Ridge Hospital* 5. Langley Memorial Hospital* 6. Peace Arch Hospital* 7. Royal Columbian Hospital* 8. Surrey Memorial Hospital*	1. Kelowna General Hospital* 2. Royal Inland Hospital*	1. University Hospital of Northern British Columbia*	1. Lions Gate Hospital* 2. Richmond Hospital* 3. Vancouver General Hospital* 4. St. Paul's Hospital†*	1. Nanaimo Regional General Hospital* 2. Royal Jubilee Hospital* 3. Victoria General Hospital*	1. BC Children's Hospital*
Medium Peer Group: between 20,000 and 39,999 annual patient visits n=20	1. Delta Hospital* 2. Mission Memorial Hospital* 3. Ridge Meadows Hospital*	1. Cariboo Memorial Hospital 2. East Kootenay Regional Hospital 3. Penticton Regional Hospital 4. Shuswap Lake General Hospital 5. Vernon Jubilee Hospital	1. Dawson Creek and District Hospital 2. Fort St. John Hospital 3. Mills Memorial Hospital 4. Prince Rupert Regional Hospital	1. Whistler Health Care Centre 2. Mount Saint Joseph Hospital†*	1. North Island Hospital Campbell River Campus* 2. Cowichan District Hospital* 3. Oceanside Health Centre 4. Saanich Peninsula Hospital* 5. North Island Hospital Comox Valley Campus* 6. West Coast General Hospital	

	Fraser Salish	Interior	Northern	Vancouver Coastal/PHC†	Vancouver Island	PHSA
Small Peer Group: between 5,000 and 19,999 annual patient visits n=37	1. Fraser Canyon Hospital*	1. 100 Mile District General Hospital 2. Boundary Hospital 3. Castlegar & District Community 4. Chase Health Centre 5. Creston Valley Hospital 6. Elk Valley Hospital 7. Golden and District General 8. Invermere and District Hospital 9. Kootenay Boundary Regional Hospital 10. Kootenay Lake District Hospital 11. Lillooet District Hospital 12. Nicola Valley Health Centre 13. Princeton General Hospital 14. Queen Victoria Hospital 15. South Okanagan General Hospital	1. Bulkley Valley District Hospital 2. Chetwynd General Hospital 3. Fort Nelson General Hospital 4. Kitimat General Hospital 5. Lakes District Hospital and Health Centre 6. MacKenzie and District Hospital and Health Centre 7. St. John Hospital 8. Stuart Lake Hospital 9. Wrinch Memorial Hospital	1. Pemberton Health Care Centre 2. Powell River General Hospital 3. Sechelt Hospital 4. Squamish General Hospital 5. UBC Hospital*	1. Chemainus Health Care Centre 2. Lady Minto Gulf Islands Hospital 3. Ladysmith Community Health Centre 4. Port Hardy Hospital 5. Tofino General Hospital	
Extra-Small Peer Group: fewer than 5,000 annual patient visits n=33		1. Alexis Creek Outpost Hospital 2. Arrow Lakes Hospital 3. Ashcroft and District General	1. Atlin Health Centre 2. Haida Gwaii Hospital and Health Centre – XaaydaGwaayNgaaysdllNaay 3. Houston Health Centre 4. Hudson's Hope Health Centre	1. Bella Coola General Hospital 2. R.W. Large Memorial Hospital	1. Bamfield Health Centre 2. Cormorant Island Health Centre 3. Gold River Health Centre	

	Fraser Salish	Interior	Northern	Vancouver Coastal/PHC†	Vancouver Island	PHSA
		Hospital 4. Barriere Health Centre 5. Blue River Outpost Hospital 6. Dr. Helmcken Memorial Hospital 7. Elkford Health Care Centre 8. Slocan Community Health Centre 9. South Similkameen Health Centre 10. Sparwood Health Care Centre 11. St. Bartholomew's Hospital 12. Victorian Community Health Centre 13. West Chilcotin Health Centre	5. McBride and District Hospital 6. Northern Haida Gwaii Hospital & Health Centre 7. Stewart Health Centre 8. Stikine Health Centre 9. Tumbler Ridge Community Health Centre 10. Valemount Health Centre		4. Kyuquot Health Centre 5. Port Alice Health Centre 6. Port McNeill and District Hospital 7. Tahsis Health Centre	

*indicates one of the 29 National Ambulatory Care Reporting System (NACRS) emergency departments in BC. † Providence Health Care is an affiliate of VCHA;
Source: 2018 Emergency Department Patient Reported Experience Measures Survey Technical Report.

Figure 6: Location of First Nations communities and health facilities, Northern Region

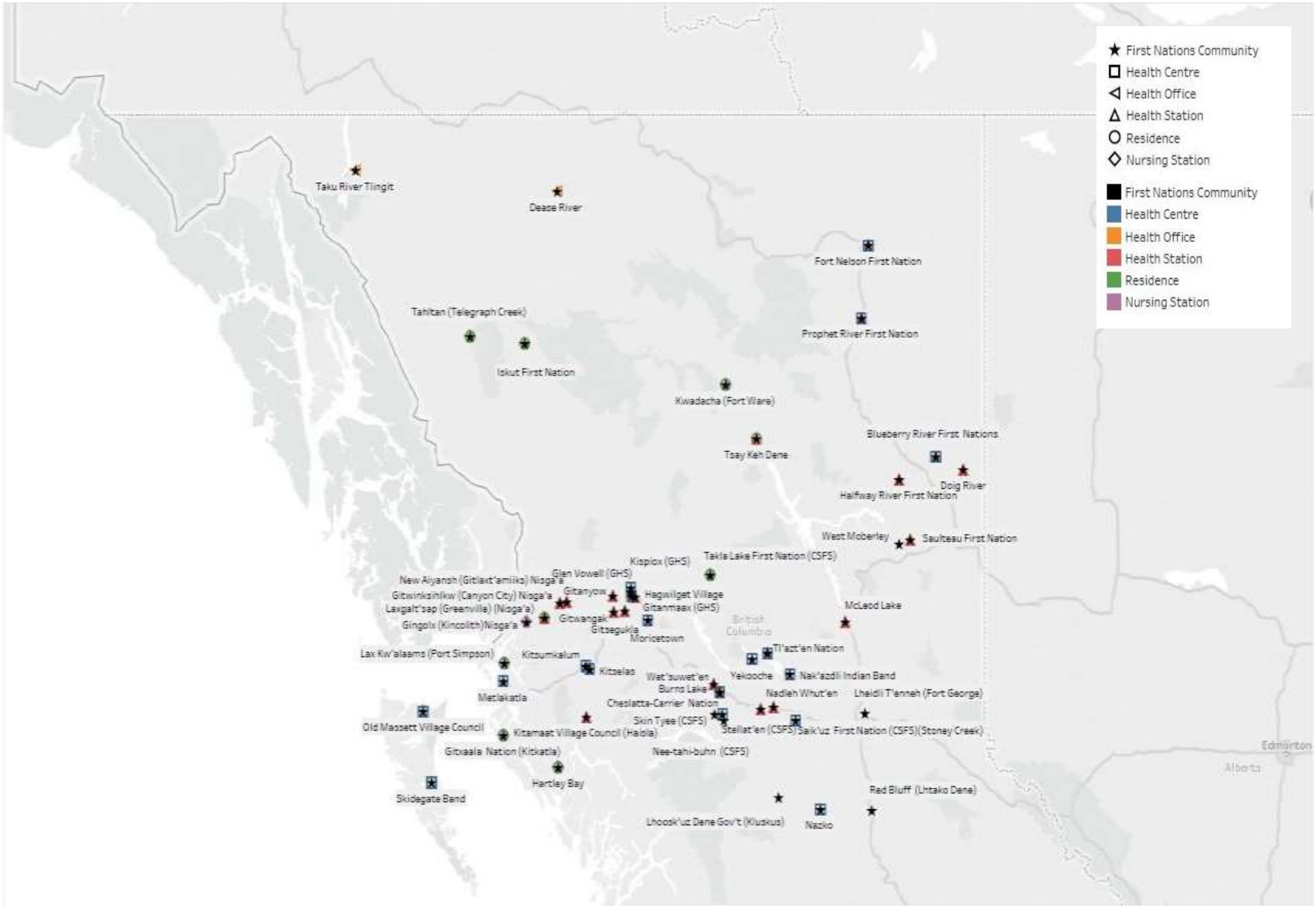
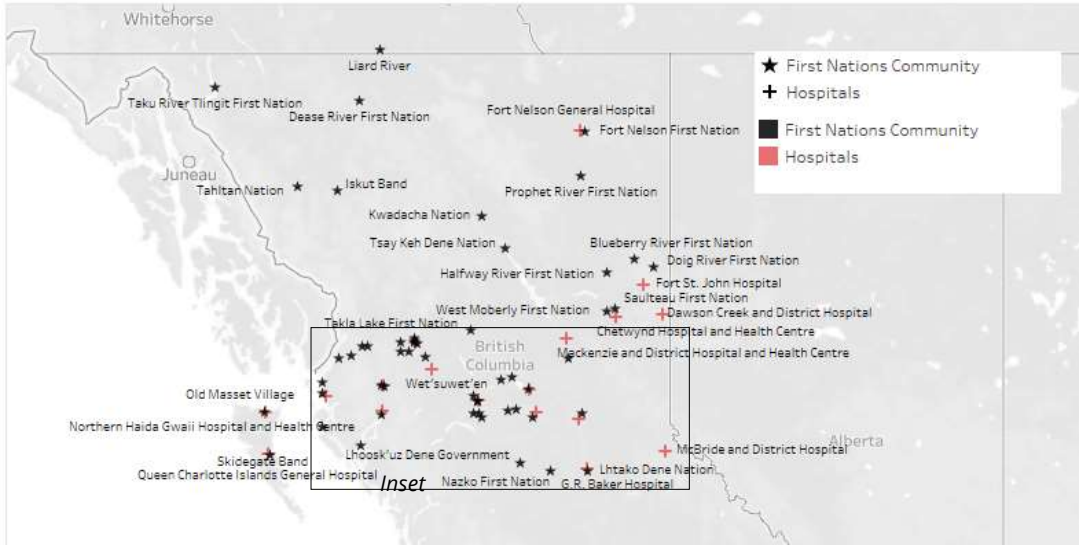
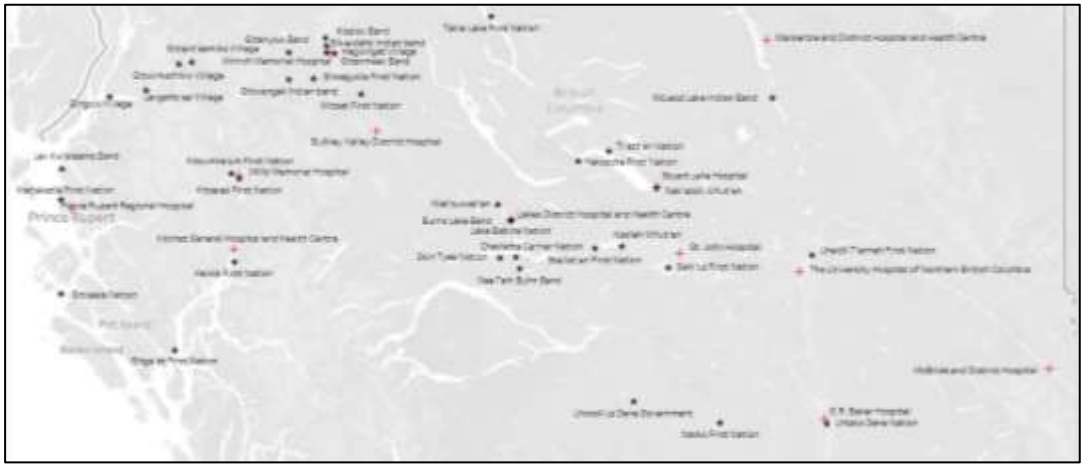


Figure 7: Location of First Nations Communities and hospitals, Northern





Appendix B: Quantitative Data Sources

Various sources of quantitative data are used to help inform this report, namely the Health System Matrix, and Patient Reported Experience Measures surveys and surveys conducted amongst Northern leadership and NFNHPC members.

A common limitation of the HSM and PREMs data sources, with the exception of the 2018 Emergency Department PREMs survey, is the timeliness of the available data. At the time of writing this report, the most recent HSM data is from 2014/15. Effects of initiatives to improve health care access such as the Joint Project Board initiatives are unlikely to be reflected in these data sources findings, which were still early in project implementation in 2014/15. Even if fully implemented, the majority of Joint Project Board (JPB) clinicians are salaried positions, and thus the impacts on access measures such as GP attachment through the HSM would be minimal (which rely on fee-for-service data). This limitation would not affect the ASCS or ED services measures.

Health System Matrix Data

The Health System Matrix is a provincial database that summarizes how people use provincial health services every year. The HSM divides the BC population into population groups according to their usage of available sources of health services data. These groups are aggregated into four health status groups (HSGs): Staying Healthy (non-users and low users), Getting Healthy (major users not included in another HSG), Living with Illness & Chronic Conditions (persons with low, medium and high chronic diseases, cancer and severe MH&SU) and Towards End of Life (frail and palliative individuals).

Most recently available data	Sampling Framework	Method of identifying First Nation respondents	Limitations
The most recent Health System Matrix (HSM) data is from 2014/15 and therefore does not cover most of the evaluation period (between October 2013 and December 2018).	HSM provides an overview of health service utilization of approximately seventy per cent of all provincial health expenditures for individuals who have chosen/been able to access health services. Excluded are service utilization from First Nation community health services, JPB projects, as well as the ~ 30 per cent of provincial expenditures such as population health programs, community	A deterministic linkage with the First Nation Client File identifies records of individuals who are highly likely to be status First Nations. Does not capture individuals who are non-Status or Métis.	Lacking utilization data for First Nation communities, most salaried physicians and Nurse Practitioners may artificially attenuate measures of access to health services. First Nations are believed to be more likely to access health services through alternative payment plans.

	mental health programs and physician services provided via salaried positions, Nurse Practitioners hired through the NP4BC initiative, sessional employment and incentives encouraging physicians to practice in rural environment, as well as data health BC Cancer Agency, BC Renal Agency and the Ministry of Child and Family Development. The HSM does contain a portion of salaried/alternate payment plan physicians who shadow bill (submit fee codes corresponding to the patient's visit).		Shifts in utilization may indicate shifts in access and/or true shifts in underlying condition being measured.

Patient Reported Experience Measurement Surveys / Patient Report Outcome Measures (PREMs/PROMs) Surveys

Since 2003, the Ministry of Health and Provincial Health Authorities have implemented a program to measure the self-reported experience of patients in a range of health care sectors using *Patient-Reported Experience Measurement* surveys and, more recently, *Patient-Reported Outcome Measures* surveys. The surveys are conducted province-wide and in a number of health care sectors including Acute Inpatient hospitals, Emergency Departments, Outpatient Cancer Care services, Mental Health in-patients and Long-term care facility residents. All *Patient Reported Experience Measures* surveys include a First Nations self-identifier variable.

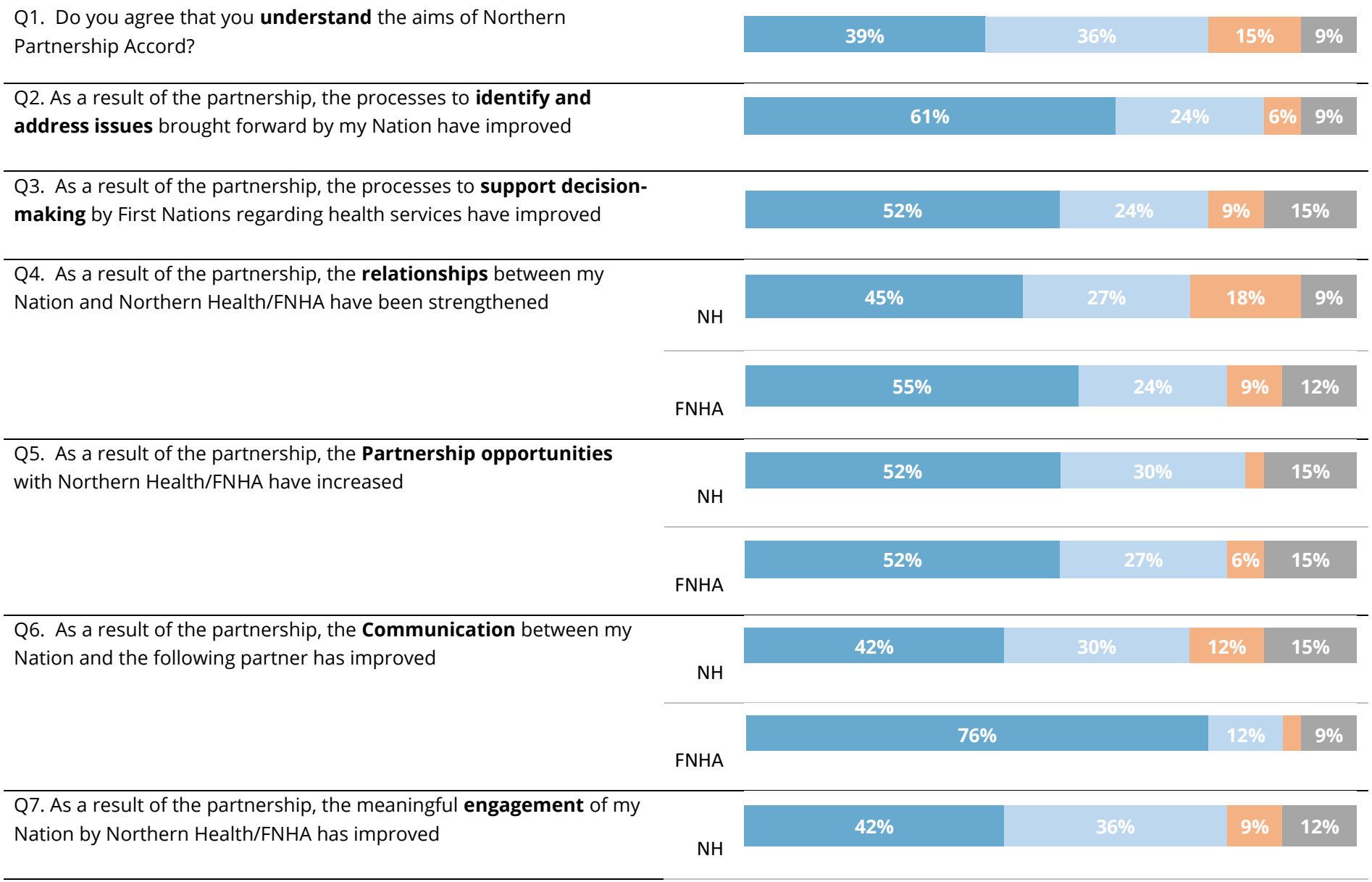
Most recently available data	Sampling Framework	Method of identifying First Nation respondents	Limitations
The PREMs sector surveys are completed in various health sectors. The most recent surveys conducted were the Emergency Department survey (conducted between Jan-March, 2018 in 108 ED facilities across the province) and the Sept-December 2017 survey (conducted among 80 acute care hospitals)	Randomly selected sample of individuals who has been discharged from an ED/Acute inpatient facility	Individual self-identify as Aboriginal	As a voluntary sample survey utilizing voluntary self-identification of Aboriginal ethnicity, it is unknown to what extent the survey findings reflect the experiences of all First Nations accessing the health system in BC. The percentage of respondents identifying as Aboriginal varies between sector surveys. The 2018 ED survey, for example, 5.8 per cent of respondents self-identified as Aboriginal vs. the 2016/17 Acute Inpatient survey, in which only 3

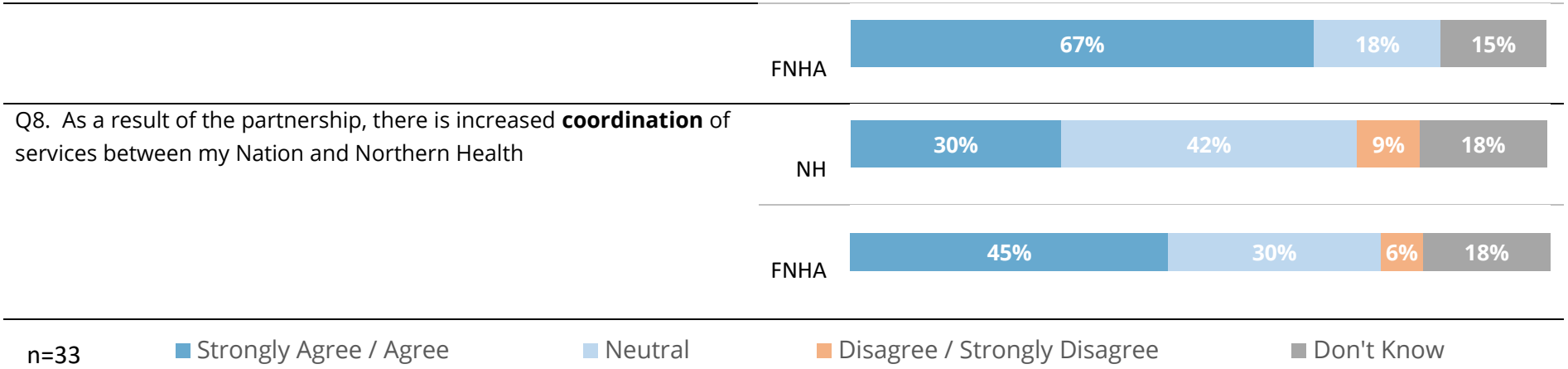
			per cent of respondents identified as Aboriginal[34].

[34] According to the 2016, 5.9 % of the BC population was Aboriginal. Source: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/details/page.cfm?Lang=E&Geo1=PR&Code1=59&Data=Count&SearchText=British%20Columbia&SearchType=Begins&B1=Aboriginal%20peoples&C1=All&SEX_ID=1&AGE_ID=1&RESGEO_ID=1

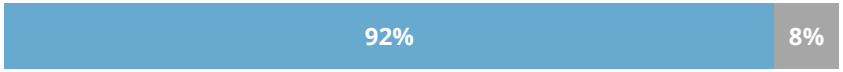
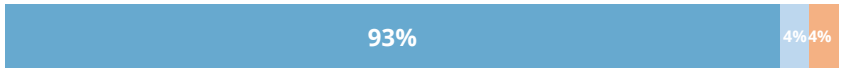
Appendix C: Sub-Regional Session & NFNHPC Survey Results

1. Sub-Regional Session Survey Responses


Q1. Do you agree that you **understand** the aims of Northern Partnership Accord?
39%
36%
15%
9%
Q2. As a result of the partnership, the processes to **identify and address issues** brought forward by my Nation have improved
61%
24%
6%
9%
Q3. As a result of the partnership, the processes to **support decision-making** by First Nations regarding health services have improved
52%
24%
9%
15%
Q4. As a result of the partnership, the **relationships** between my Nation and Northern Health/FNHA have been strengthened
NH
45%
27%
18%
9%
FNHA
55%
24%
9%
12%
Q5. As a result of the partnership, the **Partnership opportunities** with Northern Health/FNHA have increased
NH
52%
30%
15%
FNHA
52%
27%
6%
15%
Q6. As a result of the partnership, the **Communication** between my Nation and the following partner has improved
NH
42%
30%
12%
15%
FNHA
76%
12%
9%
Q7. As a result of the partnership, the meaningful **engagement** of my Nation by Northern Health/FNHA has improved
NH
42%
36%
9%
12%

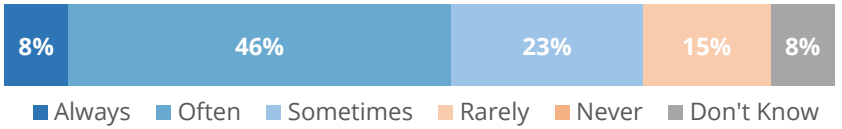
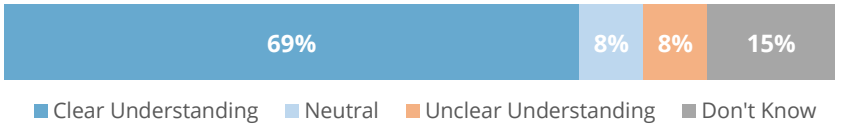
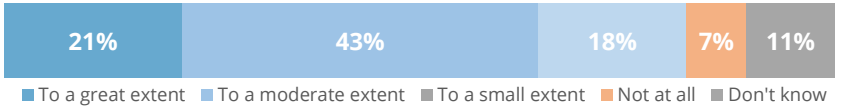

FNHA
67%
18%
15%
Q8. As a result of the partnership, there is increased **coordination** of services between my Nation and Northern Health
NH
30%
42%
9%
18%
FNHA
45%
30%
6%
18%
n=33
Strongly Agree / Agree
Neutral
Disagree / Strongly Disagree
Don't Know

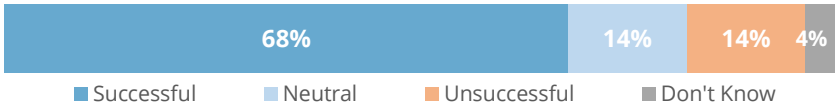
2. NFNHPC participants & Secondary Survey Results

Q1. The NFNHPC is composed of the Northern Regional Table, FNHA, and members of the Executive Team from Northern Health. In your view, how effectively is this Committee operating?	NFNHPC participants N=13	
Q2. The Accord commits Partners to support each other to collaborate in a positive and constructive manner. In your view, to what extent have Partners succeeded in working together in a supportive manner?	NFNHPC + FNHA/NH staff participants (n=28)	
Q3. The Accord commits Partners to communicate in a timely and effective manner. How would you rate the effectiveness of communication between Partners?	NFNHPC + FNHA/NH staff participants (n=28)	
Q4. The second section of the Accord outlines the purpose of the agreement. One of the purposes is to involve First Nations leadership in the planning and monitoring of health services that impact First Nations communities. In your view, how effective has the partnership been at achieving this?	NFNHPC + FNHA/NH staff participants (n=28)	
Q5. The Accord intended to enable collaboration in the planning, implementation, and evaluation of culturally appropriate, safe, and effective services for First Nations residing in the Northern region. How would you rate the effectiveness of the partnership with respect to:		
a)Strengthening the planning of services	NFNHPC + FNHA/NH staff participants (n=28)	

Northe

Effective/ Somewhat Effective Neutral Ineffective/ Somewhat Ineffective Don't Know

b) Strengthening the implementation of services	NFNHPC + FNHA/NH staff participant s (n=28)	
c) Strengthening the coordination and alignment of service delivery	NFNHPC + FNHA/NH staff participant s (n=28)	
d) Strengthening the evaluation of services	NFNHPC + FNHA/NH staff participant s (n=28)	
Q6. In your view, how often is there shared decision-making among the Partners with respect to the development and delivery of health care services or programs for Northern First Nation communities?	Primary	
Q7. In your view, is there a clear understanding of the roles and responsibilities of all Partners as outlined in the Accord?	NFNHPC participants	
Q8. In your view, how successful has the cultural safety of health care programs and services improved as a result of the Accord?	NFNHPC + FNHA/NH staff participant s (n=28)	
Q9. The Accord acknowledges that the Partners work in partnership to close the gaps and remove barriers to accessing and improving services. In your view, how successful has the partnership been at:		

a) Improving health care services for Northern First Nations	NFNHPC + FNHA/NH staff participant s (n=28)	
b) Improving the accessibility of services	NFNHPC + FNHA/NH staff participant s (n=28)	

Appendix D: Northern Partnership Accord Evaluation – PREMs Acute Inpatient 2016/17 variables of interest from a Cultural Safety & Humility perspective

Background
A sub-working group of the Vancouver Island Partnership Accord evaluation working group convened to identify Acute Inpatient and Emergency Department PREMs variables of interest for measuring the patient experience through a cultural safety lens. The working group used the cultural safety and humility measurement framework for patient experience, with some small alterations, developed by H. Johnson. Appendix A outlines the key dimensions of cultural safety, their definitions and some examples of proposed indicators to measure these dimensions.

Methodology
The working group sought to identify existing PREMs survey questions that most closely align with dimensions of cultural safety. There are more sophisticated analyses that could be undertaken to identify key drivers of cultural safety, however, as a first step the working group focused on conceptual alignment of the survey questions with key underlying components of cultural safety.
Additional information about the methodology of the 2016/17 Acute Inpatient PREMs survey is included in Appendix B.

Dimensions of Cultural Safety: Definitions

Self-determination and Equity is a theme encompassing an equal partnership that supports the self-determination of the client, enables him or her to feel heard and in which the provider does not show an attitude of superiority but is in a cooperative and reciprocal relationship with the client. Self-Determination is a principle that advocates for the rights of clients to exercise autonomy and freedom of choice to make their own decisions as much as possible. Health equity is the distribution of health resources to

ensure that they are proportionately allocated according to needs and services that meet the values and cultural beliefs of distinct service users.

Respect includes mutual respect, the feeling of being respected and valued, and the demonstration of respect on the part of a healthcare provider. Involves positive regard or respect is the ability to recognize the inherent worth of people regardless of their behavior; this form of caring is non-possessive

Identity: Cultural safety is strongly associated with a positive acknowledgement or affirmation of identity as an Indigenous person or part of an Indigenous culture. Identity consists of three facets: self, community and external identification. Self-identification means that you are who you say you are. Community identification is reflected through values, beliefs and worldviews. External identification means that others recognize you as who you say you are.

Shame, Vulnerability and Empathy: Shame is the painful feeling or experiences of believing that we are flawed and therefore unworthy of love and belonging. **Vulnerability** is uncertainty, risk and emotional exposure and **Empathy** is the capacity to understand the feelings and views of another person, without imposing our feelings or reactions onto the individual.

Genuineness: The capacity of health care professionals to be open with their reactions and transparency of their feelings in order to demonstrate consistency between what they believe, say and do.

Relation is focused on two-way or shared learning, curiosity, interest, and effective communication facilitated by an understanding of colonialism and its impacts on Indigenous peoples.

Despite not fitting exactly into one of the dimensions of cultural safety and humility the overall **global ratings** scores are also presented because of their overarching perspectives on patient experiences.

Weighted data for all questions of interest were extracted for self-identified individuals of Aboriginal, Inuit, Métis or First Nations ethnicity[35] and non-self-identified individuals of Aboriginal, Inuit, Métis or First Nations ethnicity (non-Aboriginal) from the Ministry of Health' secure data environment (Health*ideas*) by the Office of Patient Centred measurement in February 2019. Please note that there have been no tests of significance between Aboriginal and non-Aboriginal results so it is unknown whether any differences between percentages are statistically significant. The sample sizes are also, in many instances, small so interpret results and differences with caution.

Only the 'top box score' is graphed for each question, i.e., the most positive response category. For example, question #6, "*During this hospital stay, how often did the nurses/doctors listen carefully to you*?", the response categories included: Never, Sometimes, Usually, Always, Don't know and Prefer not to answer. Any 'don't know' or 'prefer not answer' responses were excluded from the analysis and the weighted valid percent for the 'Always' (or equivalently 'best' answer category) were graphed.

Results

A total of 37 questions from the 2016/17 Acute Inpatient survey were included in this analysis across six dimensions of cultural safety & humility (plus the global rating questions):

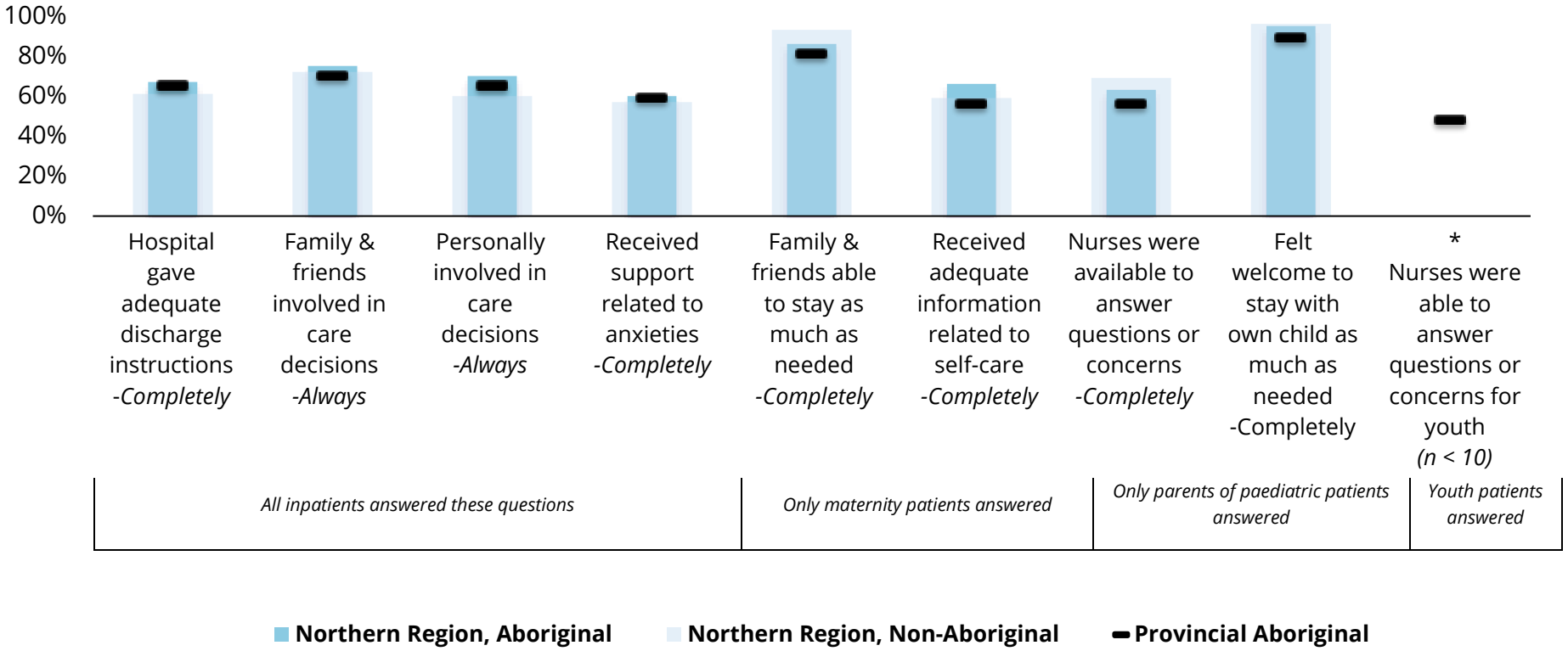
- **Self-determination and equity** (9 questions):
- **Respect** (2 questions)
- **Identity** (2 questions)
- **Genuineness** (1 question)
- **Shame, vulnerability and empathy** (8 questions)
- **Relational care** (11 questions)
- and also **Global rating questions[36]** (4 questions)

Self Determination and Equity

Self-determination and Equity is a theme encompassing an equal partnership that supports the self-determination of the client, enables him or her to feel heard and in which the provider does not show an attitude of superiority but is in a cooperative and reciprocal relationship with the client. Self-Determination is a principle that advocates for the rights of clients to exercise autonomy and freedom of choice to make their own decisions as much as possible. Health equity is the distribution of health resources to ensure that they are proportionately allocated according to needs and services that meet the values and cultural beliefs of distinct service users.

[35] Data from 865 individuals was extracted provincially. Please note that these data include surveys in which the respondent selected either 'First Nations', 'Inuit', 'Metis' or 'Aboriginal'. Surveys in which individuals selected multiple Aboriginal identifies (e.g. 'First Nations' and 'Metis' (n=54)) or who selected an Aboriginal identified (i.e. 'First Nations', 'Inuit' 'Metis' or 'Aboriginal') plus another ethnicity (e.g. 'Filipino', 'Chinese' (n=362)) were not included in this data extract, but will be for future data extracts.

[36] Global rating questions are included as an overall ratings of patient experience


100%
80%
60%
40%
20%
0%
Hospital gave adequate discharge instructions -Completely
Family & friends involved in care decisions -Always
Personally involved in care decisions -Always
Received support related to anxieties -Completely
Family & friends able to stay as much as needed -Completely
Received adequate information related to self-care -Completely
Nurses were available to answer questions or concerns -Completely
Felt welcome to stay with own child as much as needed -Completely
* Nurses were able to answer questions or concerns for youth (n < 10)
All inpatients answered these questions
Only maternity patients answered
Only parents of paediatric patients answered
Youth patients answered
Northern Region, Aboriginal
Northern Region, Non-Aboriginal
Provincial Aboriginal

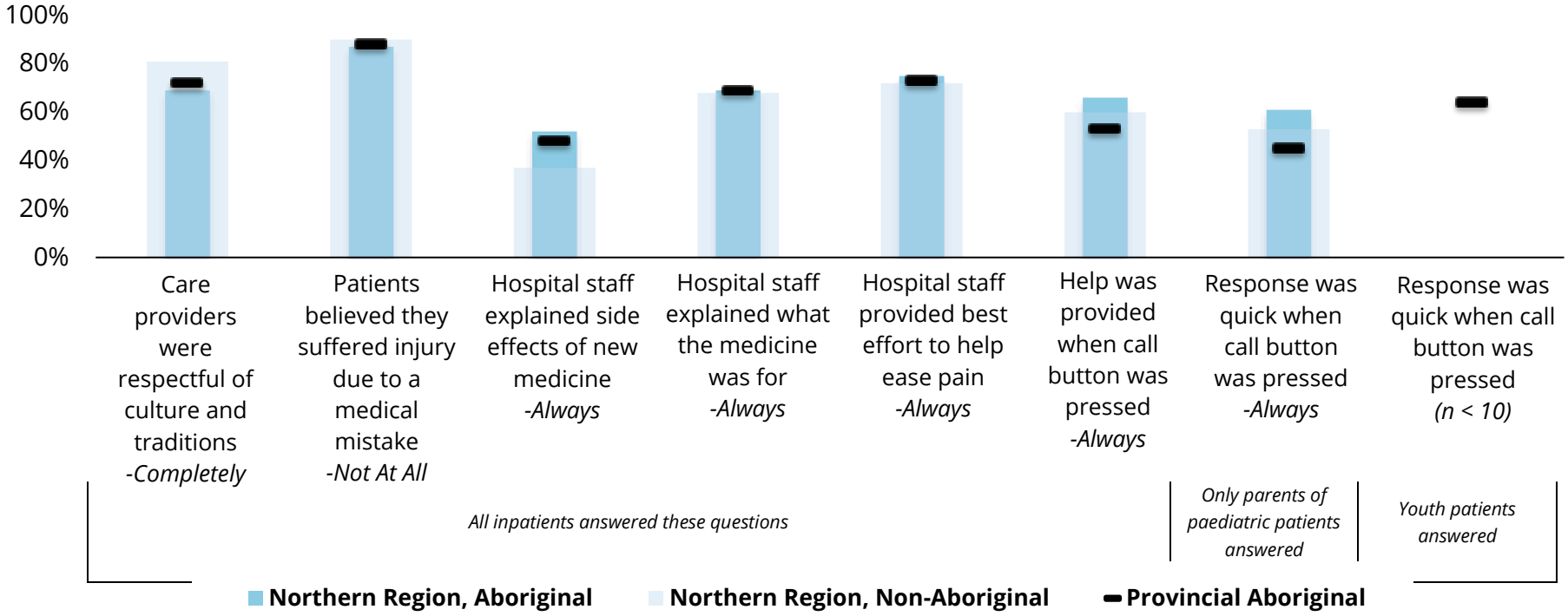
Self Determination and Equity (Data Table)

	Before you left the hospital, did the doctors, nurses or other hospital staff give your family or someone close to you enough information to help care for you? [*Completely*]	During your hospital stay, were your family or friends involved as much as you wanted in decisions about your care and treatment? [*Always*]	Were you involved as much as you wanted to be in decisions about your care and treatment during this hospital stay? [*Always*]	Did you get the support you needed to help with any anxieties, fears, or worries you had during this hospital stay? [*Completely*]	After the birth of your baby, were other family members or those close to you able to stay with you as much as you wanted? [*Completely*]	While in the hospital, did you get enough information about caring for yourself? [*Completely*]	During this hospital stay, were nurses available to answer your questions or concerns when you needed them? [*Completely*]	During this hospital stay, did you feel welcome to stay with your child as much as you wanted? [*Completely*]	During this hospital stay, were the nurses available to answer your questions or concerns when you needed them? [*Completely*]
	Q49	**Q36**	**Q35**	**Q34**	**M14**	**M13**	**P6**	**P2**	**Y6**
Northern Region, Aboriginal	67%	75%	70%	60%	86%	66%	63%	95%	*n < 10*
Northern Region, Aboriginal (n)	181	186	226	171	21	25	15	19	*n < 10*
Northern Region, Non-Aboriginal	61%	72%	60%	57%	93%	59%	69%	96%	*n < 10*
Northern Region, Non-Aboriginal (n)	1,034	1,181	1,385	1,064	164	171	60	61	*n < 10*
Provincial Aboriginal	65%	70%	65%	59%	81%	56%	56%	89%	48%
Provincial Aboriginal (n)	654	710	844	679	73	77	55	62	11

Please Note: Interpret results with caution as sample sizes are small and no tests of significance between Aboriginal and non-Aboriginal repondents was conducted.

Shame, Vulnerability and Empathy

Shame is the painful feeling or experiences of believing that we are flawed and therefore unworthy of love and belonging. ***Vulnerability*** *i*s uncertainty, risk and emotional exposure and ***Empathy*** is the capacity to understand the feelings and views of another person, without imposing our feelings or reactions onto the individual.

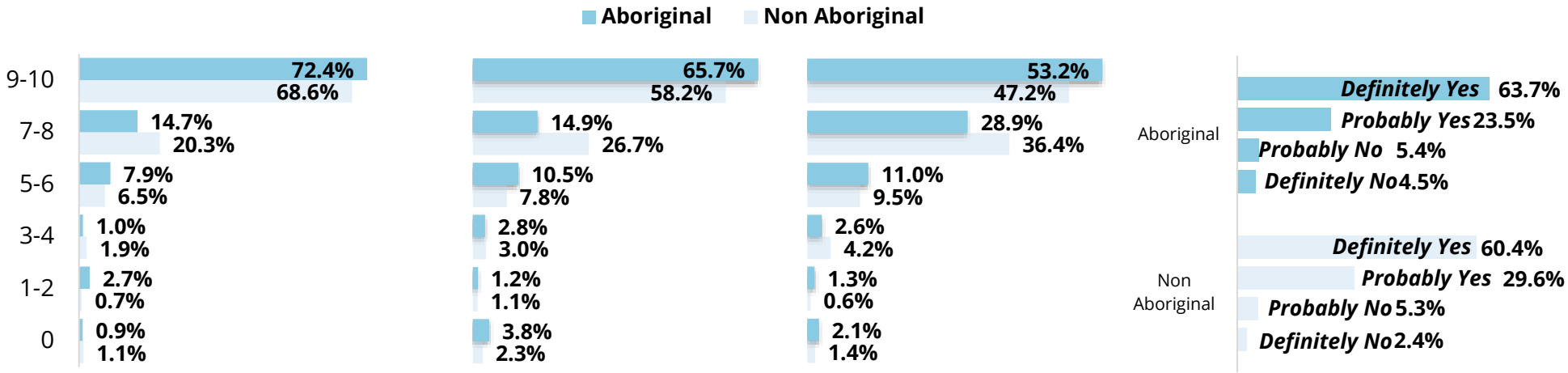


Shame, Vulnerability and Empathy (Data Tables)

	Q72 During this hospital stay, do you feel that your care providers were respectful of your culture and traditions? [Completely]	During this hospital stay, do you believe you or your family members suffered personal injury or harm, which resulted from a medical error or mistake? [Not at all]	Q17 Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? Would you say.... [Always]	Q16 Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Would you say.... [Always]	Q14 During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? Would you say.... [Always]	Q4 During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? [Always]	P9 During this hospital stay, when you or your child used the call button to get help, was the response quick enough? [Always]	Y9 During this hospital stay, when you used the call button to get help, was the response quick enough? [Always]
	Q72	**Q68**	**Q17**	**Q16**	**Q14**	**Q4**	**P9**	**Y9**
Northern Region, Aboriginal	69%	87%	52%	69%	75%	66%	61%	*n < 10*
Northern Region, Aboriginal (n)	212	224	87	92	183	175	14	*n < 10*
Northern Region, Non-Aboriginal	81%	90%	37%	68%	72%	60%	53%	*n < 10*
Northern Region, Non-Aboriginal (n)	1,229	1,384	751	784	1,012	1,092	47	*n < 10*
Provincial Aboriginal	72%	88%	48%	69%	73%	53%	45%	64%
Provincial Aboriginal (n)	795	845	392	397	680	863	45	13

Please Note: Interpret results with caution as sample sizes are small and no tests of significance between Aboriginal and non-Aboriginal repondents was conducted.

Global Rating



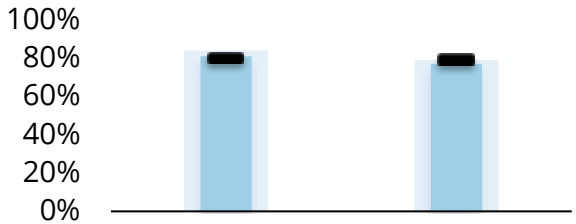
Patients felt they were helped during ED visit

Patients rating of overall experience of the ED visit

Patients rating of care during their ED visit

Patients would recommend ED to friends and family

Respect



Doctors treated patients with courtesy and respect
-Always

Nurses treated patients with courtesy and respect
-Always

Identity

Patients felt spiritual needs are important part of care
-Yes

Patients felt their spiritual needs were met
-Completely

Genuineness

Patients felt they were treated with compassion
-Always

All inpatients answered these questions

Northern Part

Northern Region, Aboriginal **Northern Region, Non-Aboriginal** **Provincial Aboriginal**

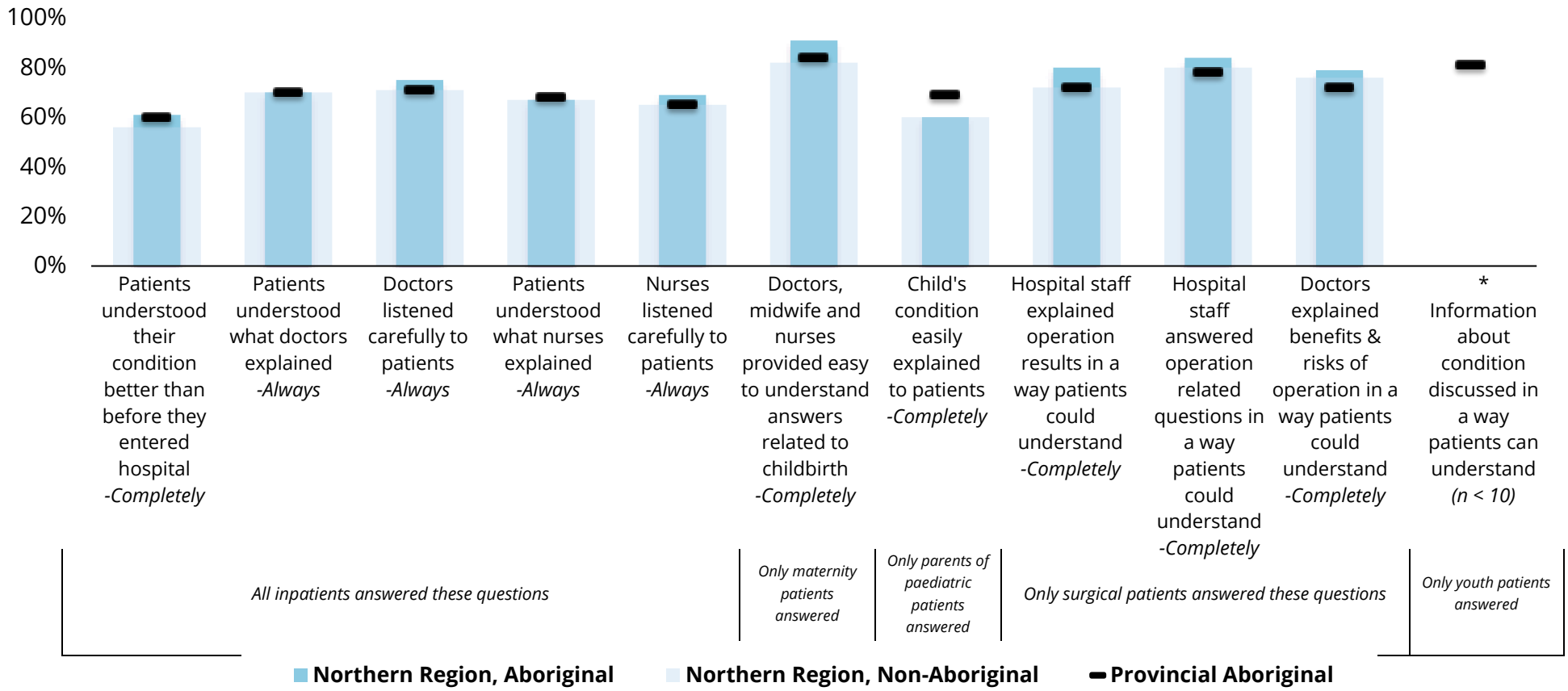
Respect, Identity, Genuineness and Global Rating *(Data Tables)*

	During this hospital stay, do you feel you were treated with compassion? [Always]	Do you feel your spiritual needs are an important part of your overall care? [Yes]	During this hospital stay, were your spiritual needs met? [Completely]	During this hospital stay, how often did doctors treat you with courtesy and respect? [Always]	During this hospital stay, how often did nurses treat you with courtesy and respect? [Always]	On a scale of 0 to 10, what was your overall experience with your hospital stay? [9 or 10]	Overall, on a scale of 0 to 10, do you feel you were helped by your hospital stay? [9 or 10]	Would you recommend <INSERT NAME OF HOSP> to your friends and family? [9 or 10]	Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay? [9 or 10]
	Q71	**Q69**	**Q70**	**Q5**	**Q1**	**Q41**	**Q40**	**Q22**	**Q21**
Northern Region, Aboriginal	67%	77%	41%	81%	77%	66%	73%	66%	54%
Northern Region, Aboriginal (n)	227	150	81	229	230	228	229	223	228
Northern Region, Non-Aboriginal	62%	67%	39%	84%	79%	59%	69%	62%	48%
Northern Region, Non-Aboriginal (n)	1,410	842	388	1,404	1,421	1,411	1,410	1,391	1,414
Provincial Aboriginal	66%	78%	42%	80%	79%	66%	71%	64%	55%
Provincial Aboriginal (n)	857	334	187	853	864	858	860	850	859

Please Note: Interpret results with caution as sample sizes are small and no tests of significance between Aboriginal and non-Aboriginal repondents was conducted

Relational Care

Relational Care is focused on two-way or shared learning, curiosity, interest, and effective communication facilitated by an understanding of colonialism and its impacts on Indigenous peoples.



Relational Care (Data Tables)

	When you left the hospital, did you have a better understanding of your condition than when you entered? [Completely]	During this hospital stay, how often did doctors explain things in a way you could understand? [Always]	During this hospital stay, how often did doctors listen carefully to you? [Always]	During this hospital stay, how often did nurses explain things in a way you could understand? [Always]	During this hospital stay, how often did nurses listen carefully to you? [Always]	While in the hospital, did your doctor, midwife or nurse answer your questions about your childbirth in a way you could understand? [Completely]	During this hospital stay, was information about his or her condition discussed with your child in a way he or she could understand? [Completely]	After your operation, did hospital staff explain how the operation had gone in a way you could understand? [Completely]	Before your operation, did hospital staff answer your questions about the operation in a way you could understand? [Completely]	Before your operation, did hospital staff and/or doctors explain the risks and benefits of the operation in a way you could understand? [Completely]	During this hospital stay, was information about your condition discussed with you in a way you could understand? [Completely]
	Q39	**Q7**	**Q6**	**Q3**	**Q2**	**M2**	**P7**	**S5**	**S3**	**S2**	**Y7**
Northern Region, Aboriginal	61%	70%	75%	67%	69%	91%	60%	80%	84%	79%	*n < 10*
Northern Region, Aboriginal (n)	226	227	228	228	230	172	10	83	71	83	*n < 10*
Northern Region, Non-Aboriginal	56%	70%	71%	67%	65%	82%	60%	72%	80%	76%	*n < 10*
Northern Region, Non-Aboriginal (n)	1,355	1,409	1,404	1,412	1,414	160	15	518	452	506	*n < 10*
Provincial Aboriginal	60%	70%	71%	68%	65%	84%	69%	72%	78%	72%	81%
Provincial Aboriginal (n)	843	848	845	856	862	64	26	327	280	320	17

Please Note: Interpret results with caution as sample sizes are small and no tests of significance between Aboriginal and non-Aboriginal repondents was conducted.

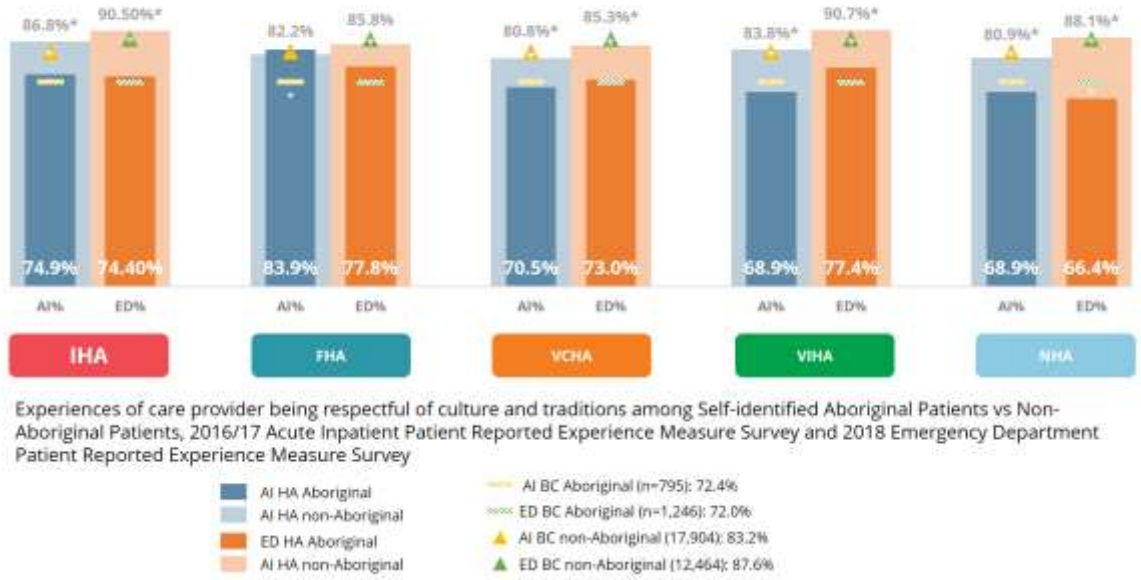
Appendix E: Cross-Regional Patient Reported Experience Measure and Health System Matrix results

Patient Reported Experience Measures

As displayed below in Figure 8, findings from provincial surveys of patient experiences in acute care facilities and Emergency Departments (see Appendix B for more details about these surveys) found that, across all regions and in both hospital and ED settings, self-identified Aboriginal patients reported their care providers were less respectful of their culture and traditions than non-self-identified Aboriginal patients. These differences were significant in both inpatient and ED surveys for all regions expect Fraser. The largest gap between self-identified Aboriginal and non-Aboriginal patient experiences of provider's respect for culture and traditions in EDs were in the North (22% gap), followed by Interior (16%) and the island (13.3%). In Acute care settings, the largest gaps were on the island (15%), followed by the North (12%), Interior (11.9%) and Vancouver Coastal (10.3%).

Figure 8: Experiences of care provider being respectful of culture and traditions among Self-identified Aboriginal Patients vs Non-Aboriginal Patients, 2016/17 Acute Inpatient Patient Reported Experience Measure

Survey and 2018 Emergency Department Patient Reported Experience Measure Survey



An analysis of factors driving overall rating of patient experience amongst the general department was conducted as part of the Emergency Department patient experience survey. This analysis found that four areas/dimensions were primarily responsible for the variability in overall ratings of experience[37]: receiving timely care,

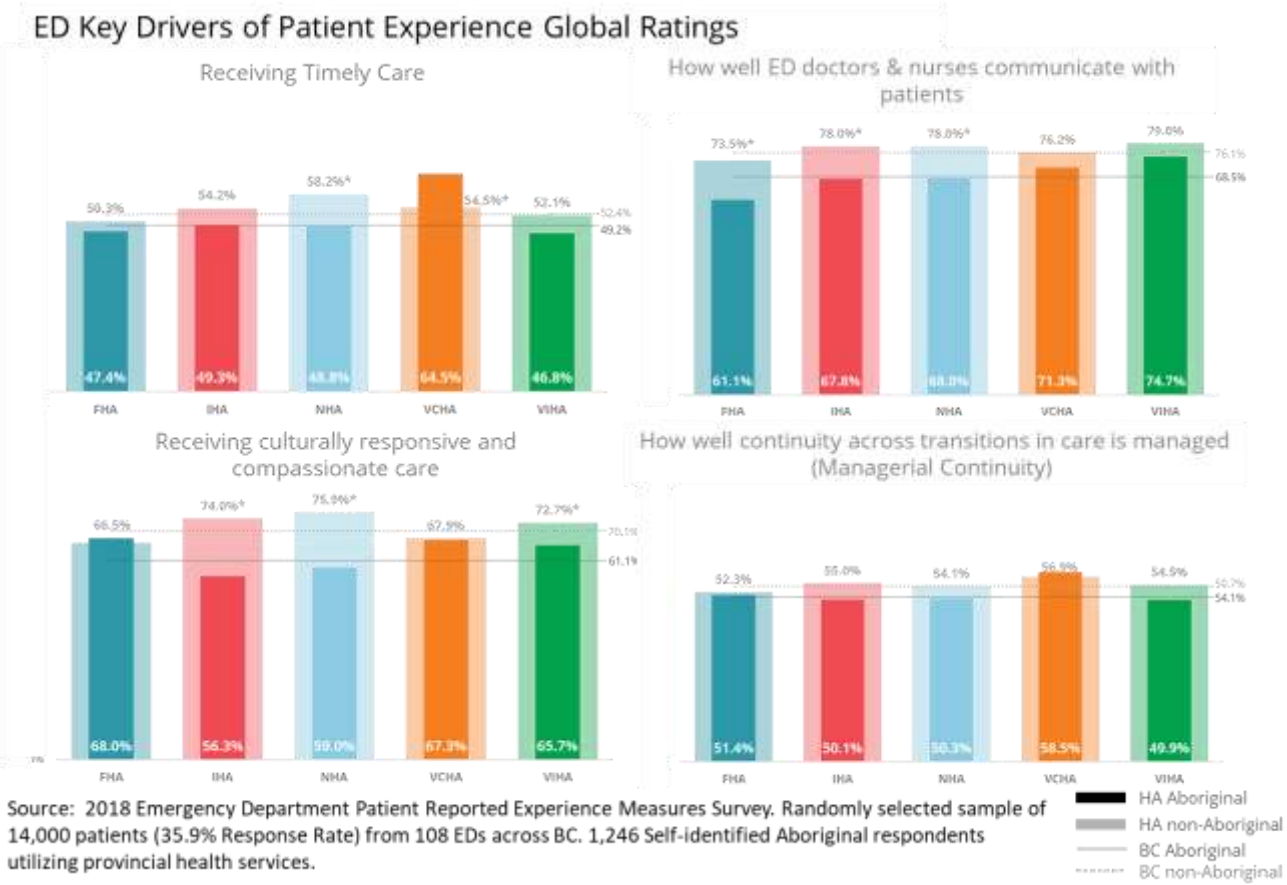
[37] These overall ratings are called 'Global Ratings' and consist of four high-level questions: 1) "ED Rating" (Using any number from 0 to 10, where 0is the worst care possible and10 is the best care possible, what number would you use to rate your care during this emergency department visit?) 2) "ED Visit Helpful" (Overall, on a scale of 0 to 10, do

communications with providers, culturally responsive and compassionate care and how well continuity across transitions in care is managed.

Across all regions and measures self-identified Aboriginal patients tended to rate lower patient experience measures in these dimensions, with some exceptions such as timely care, culturally responsive and compassionate care, and continuity across transitions in VCHA and FHA.

you feel you were helped by your visit to the emergency department? Please answer on a scale where 0 is "not helped at all" and 10 is "helped completely) 3) “ED Experience” (On a scale of 0 to 10, what was your overall experience with your emergency department? Please answer on a scale where 0 is "I had a very poor experience" and 10 is "I had a very good experience.") 4) “Likelihood to Recommend” (Would you recommend this emergency department to your friends and family?)

Figure 9: Key Drivers of Patient Experience Global Ratings



Source: 2018 Emergency Department Patient Reported Experience Measures Survey. Randomly selected sample of 14,000 patients (35.9% Response Rate) from 108 EDs across BC. 1,246 Self-identified Aboriginal respondents utilizing provincial health services.

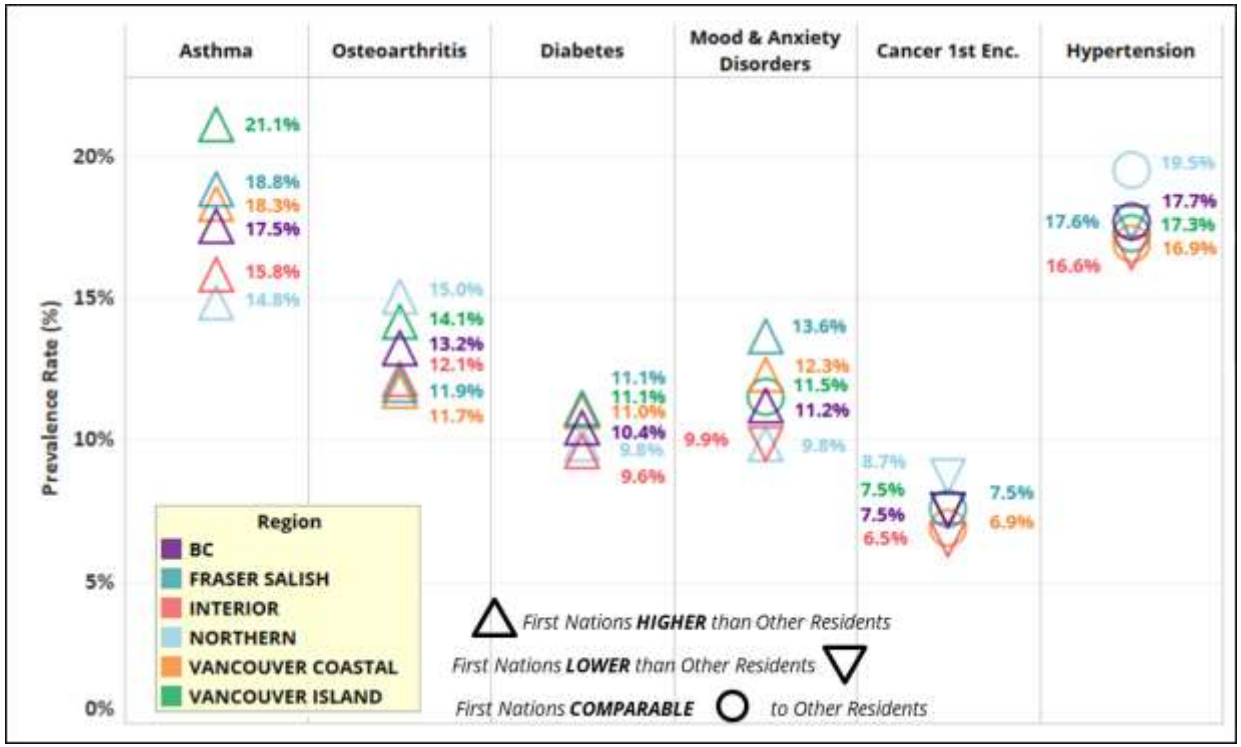
Chronic Conditions

Chronic condition prevalence data provides compelling evidence of the burden of chronic disease in the First Nations population. Provincially, seventeen of 27 monitored chronic condition prevalence rates were higher among First Nations compared to Other Residents. As depicted in Figure 10 below, the prevalence rates of the top six chronic conditions in the First Nations population were variable by region and in comparison to Other Residents.

Age-standardized[38] rates of asthma, osteoarthritis, and diabetes were higher for First Nations relative to Other Residents across all regions. Three of the five regions demonstrated higher mood and anxiety disorder rates among First Nations compared with Other Residents (Fraser Salish, Northern and Vancouver Coastal); the Interior First Nations rate was lower than Other Residents, and Vancouver Island rates were comparable. Three of the five regions demonstrated lower first cancer encounter rates among First Nations than Other Residents (Interior, Northern, and Vancouver Island). Two of the five regions showed lower hypertension rates among First Nations than Other Residents (Fraser Salish, Interior).

[38] Note: unless noted as an age specific rate, all HSM derived rates were age-standardized to allow comparability between the First Nations and Other Resident population.

Figure 10: First Nations Chronic Conditions prevalence rate, and comparison with Other Resident rates, 2014/15 by region



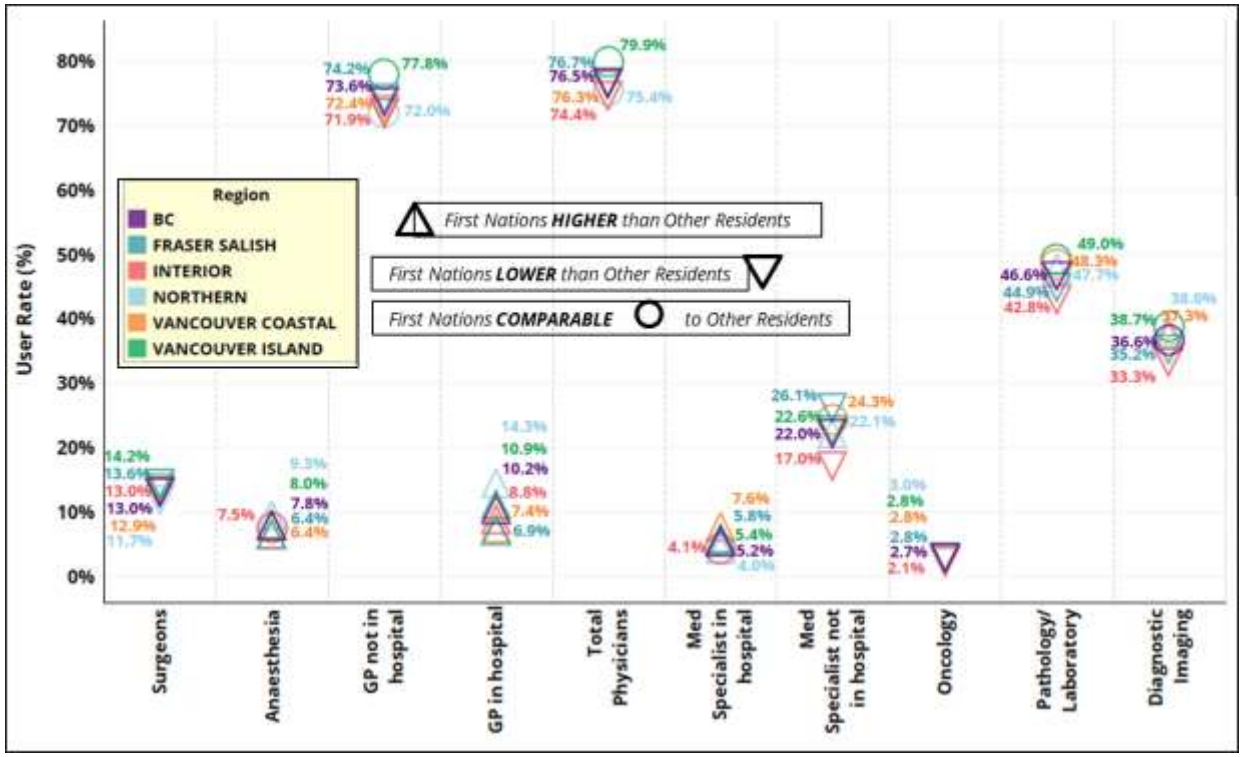
Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Physician Utilization

The provincial trend for utilization of physician services by First Nations showed lower user rates for physicians outside of hospitals, although this was not carried through in all regions. This lower utilization and the associated implied lesser access, is a likely contributor to First Nations being hospitalized to a greater extent than Other Residents (data not shown). As depicted in Figure 11 below, regional physician utilization rates were variable across service lines excepting 'General Practitioner in Hospital', where all rates were higher among "First Nations" compared to "Other Residents". Concerning oncologists and surgeons visited outside of the hospital, all rates were

lower among “First Nations” compared to “Other Residents”, with the exception of Northern Region where the First Nations surgeon rate was higher.

Figure 11: First Nations physician user rate, and comparison with Other Residents, 2014/15 by region



Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Emergency Department (ED) usage rates

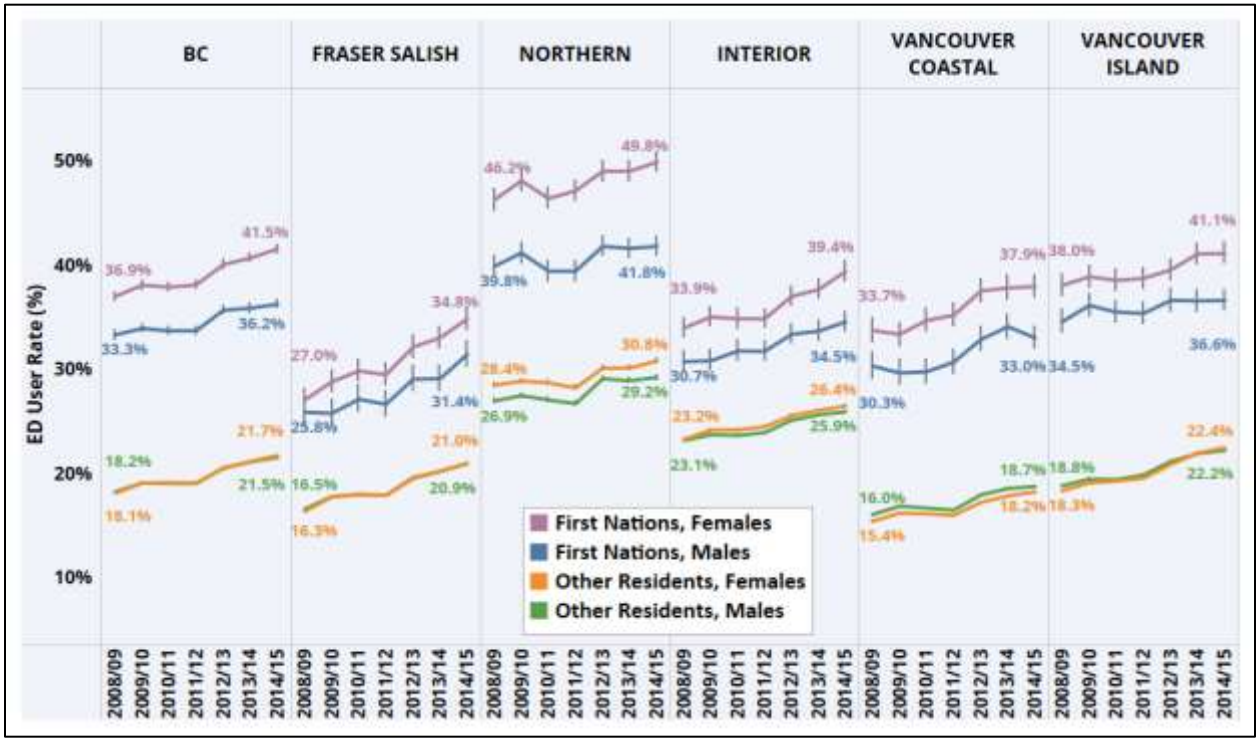
As illustrated in Figure 12, regarding emergency department use, First Nations rates were significantly higher than Other Residents in BC and across regions. In addition:

- First Nations female ED user rates were significantly higher than First Nations males in BC and across regions;

- The disparity between female and male rates was higher in the First Nations population than among Other Residents.
- There was variability across regions in the magnitude of the ED rates across the regions; and
- First Nations, both females and males had the highest rates in Northern Region.

There can be a number of reasons for persons requiring care in EDs other than urgent attention for immediate health needs, including not having a regular family doctor or inability to book an appointment in a timely manner. In addition, GPs in some rural environments may use EDs as extended offices.

Figure 12: First Nations and Other Residents ED user rates, by region and sex, 2014/15

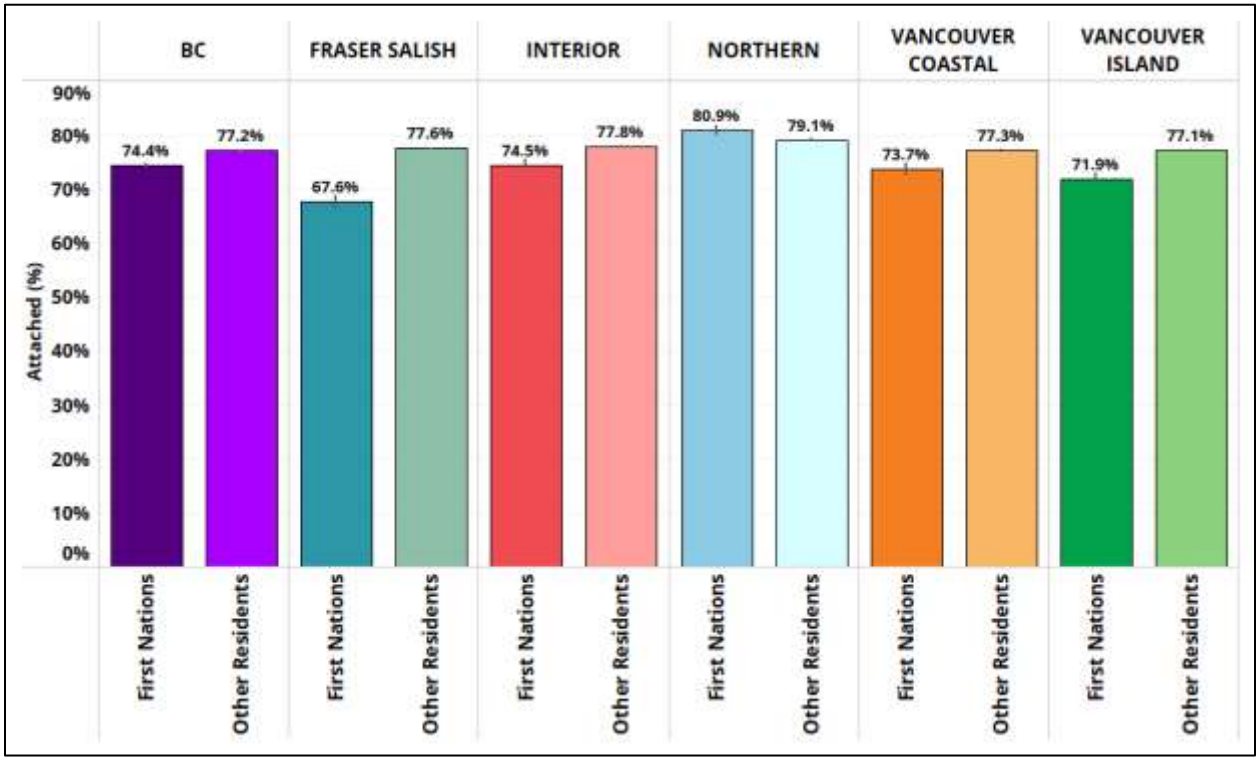


Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

General Practitioner Attachment

Continuity of primary care was investigated through an analysis of the rate of attachment to general practitioners (GPs). [39], As seen in Figure 13, attachment rates were significantly lower among First Nations compared to Other Residents provincially and across regions, except in Northern Region, where the First Nations rate was higher.

Figure 13: First Nations and Other Residents GP attachment rate, 2014/15, by region

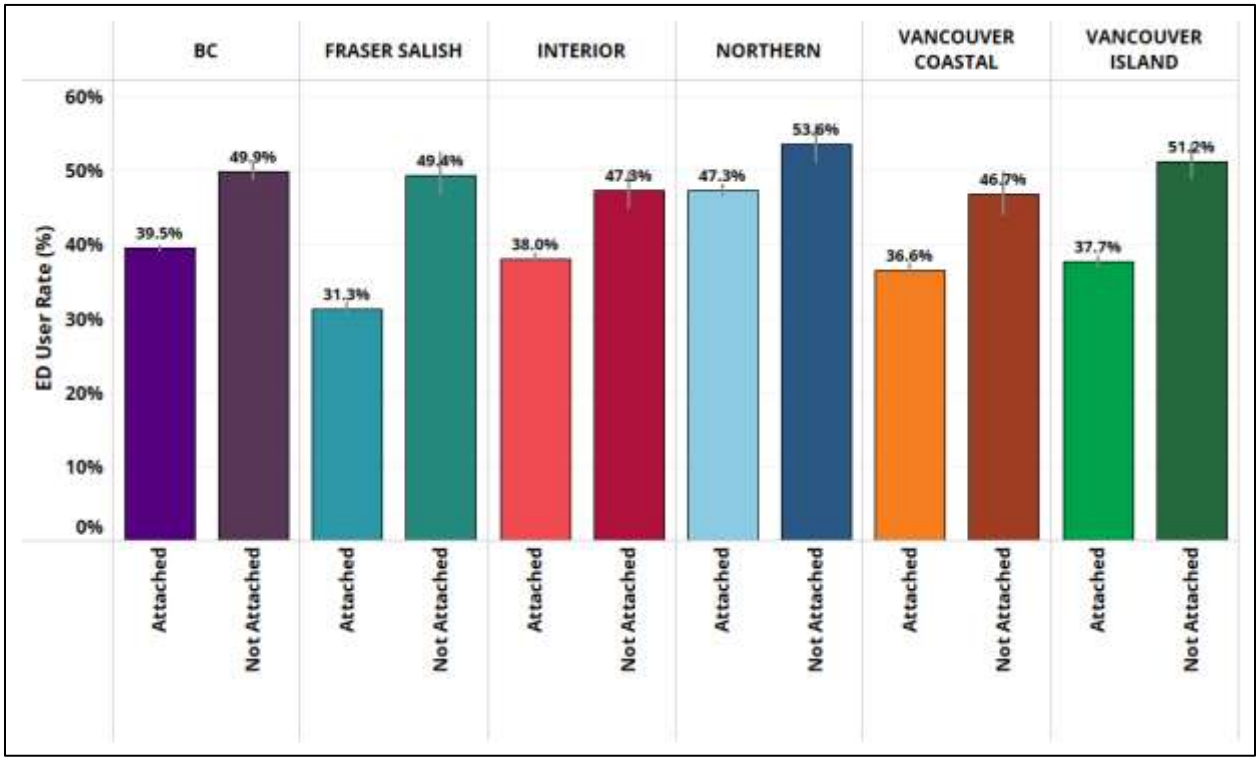


Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

[39] Individuals are considered attached to their GP if at least half of their visits within a given fiscal year were with GPs in a single practice; up to ten years is looked at in order to find at least 5 visits

To further understand continuity of First Nations primary care, patterns of attachment in the utilization of EDs were assessed. As Figure 14 shows, ED user rates were inversely associated with GP attachment: ED user rates were higher in non-attached First Nations than attached across all regions. This data can be interpreted in variety of ways, for example, being a reflection of inadequate access to GPs in an office environment necessitating a visit to the ED, and/or that continuity of care in a single practice increases the likelihood of preventative screening programs and prevents illnesses from escalating to the point that urgent care is required.

Figure 14: First Nations and Other Residents ED user rates, 2014/15 by region

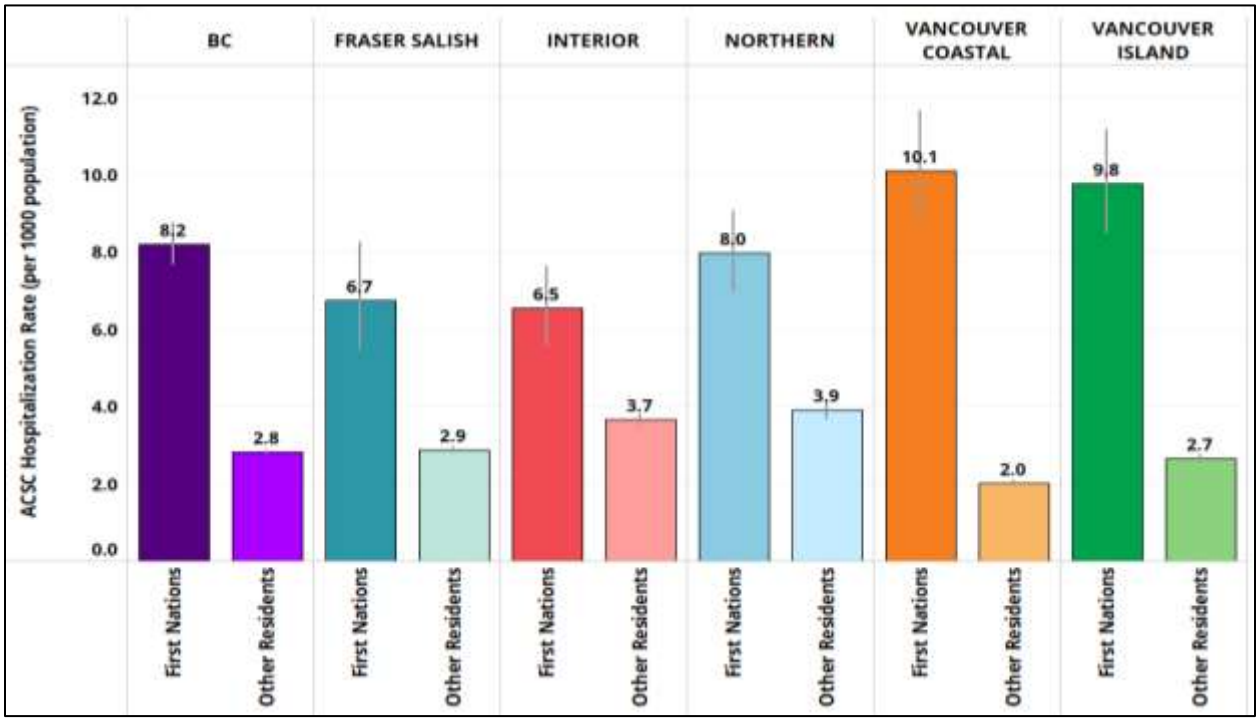


Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Ambulatory Care Sensitive Conditions

Ambulatory Care Sensitive Conditions (ACSCs) are a group of chronic conditions, such as asthma, hypertension, diabetes, angina and epilepsy, that if treated appropriately in a primary care setting, should not lead to hospitalization. Therefore, analyzing rates of ACSC-related hospitalizations can give an indirect indication of access to primary care, and can be viewed as a measure of its performance. With regard to ACSC, in all regions, First Nations hospitalization rates for ACSC were higher than Other Residents, across all age groups (exception: 0-17 years olds in Fraser Salish and Interior Regions) (see Figure 15 below).

Figure 15: First Nations and Other Residents ACSC hospitalization rate, 2014/15, by region

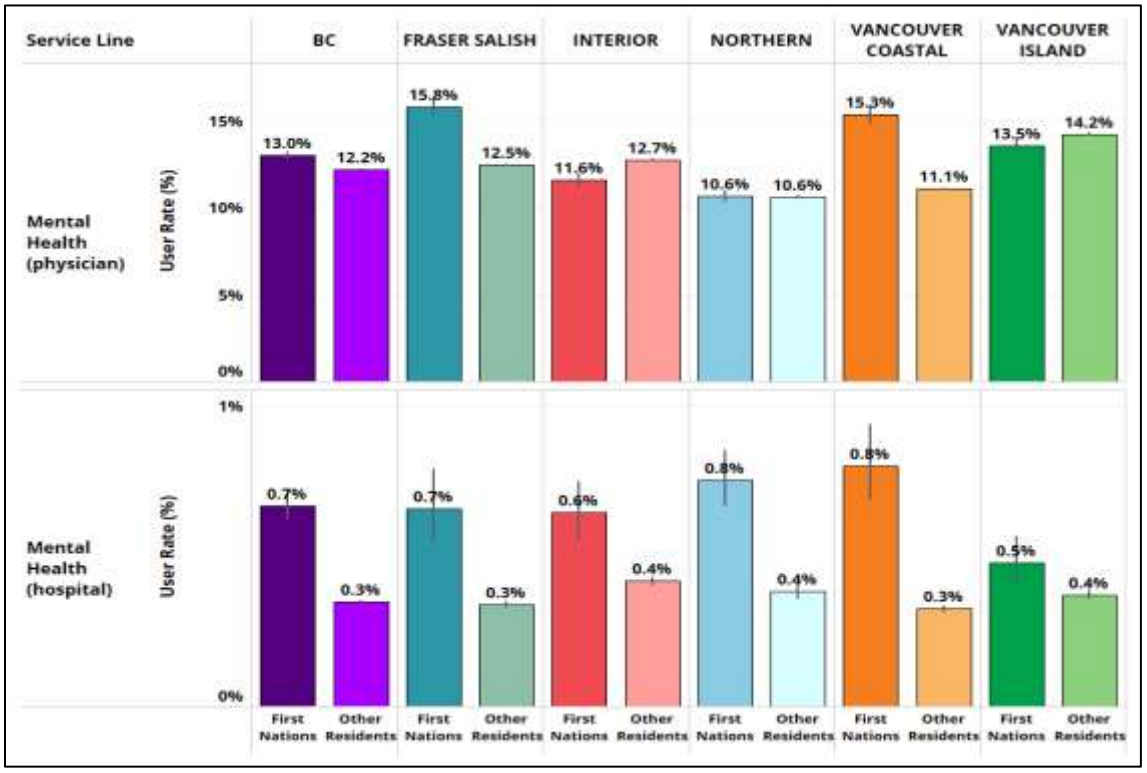


Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Mental Health

Provincially, user rates for mental health services showed a disproportionate use of physician and hospital services by First Nations compared to Other Residents. As indicated in Figure 16, physician rates for mental health reasons were variable across regions, with First Nations rates higher than Other Residents in two regions (Fraser Salish and Vancouver Coastal) and comparable in one (Northern). These First Nations rates were lower in Interior and Vancouver Island. Hospitalization rates for mental health reasons were higher in First Nations compared to Other Residents in all Regions.

Figure 16: First Nations and Other Residents Physician and Hospitalization user rates for mental health reasons, 2014/15 by region



Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

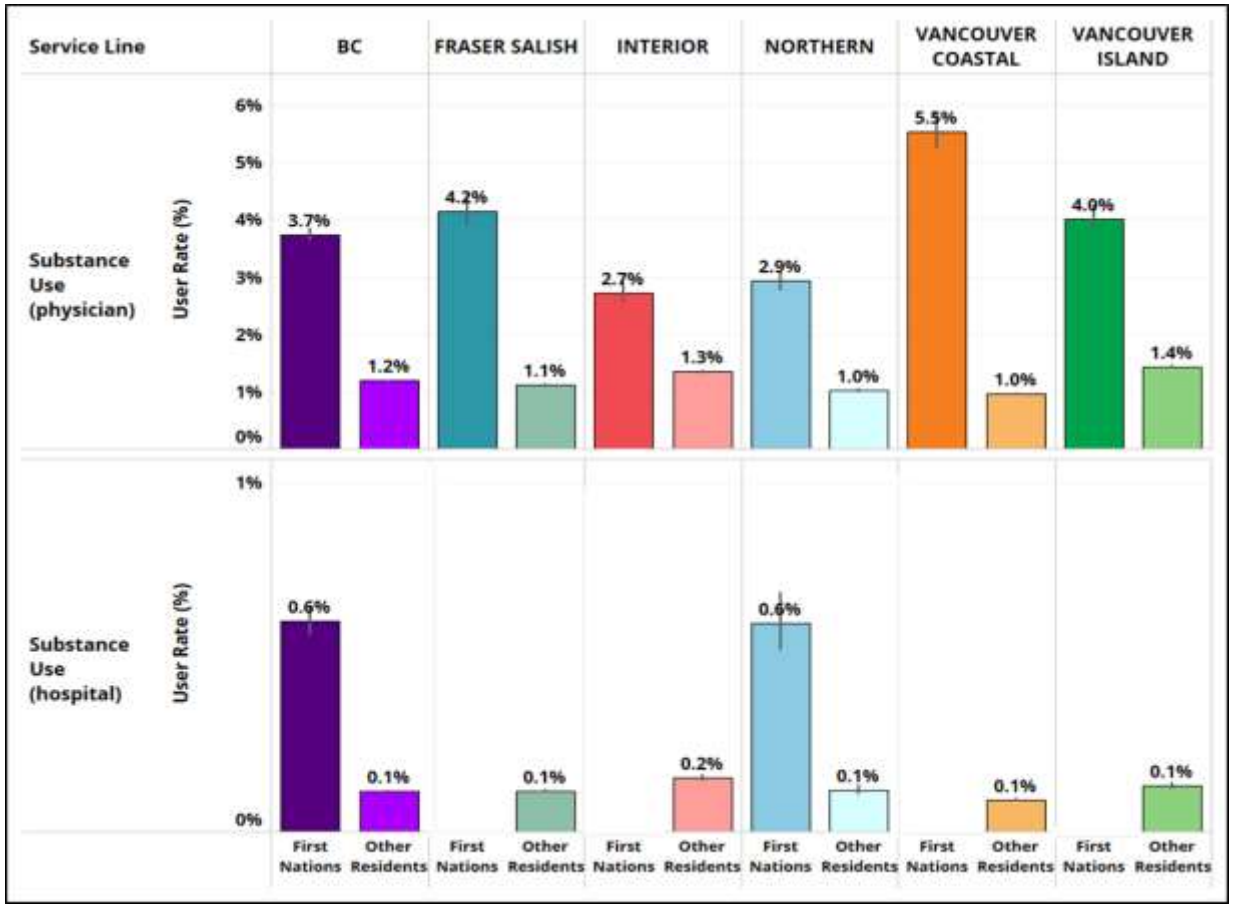
Substance Use

The utilization of substance use services showed a much greater disparity in rates between First Nations and Other Residents that what was seen with mental health services. Concerning Figure 17 below:

- Physician rates for substance use services were approximately 3 times higher for First Nations compared to Other Residents.
- Provincial-level hospital user rates related to substance use were approximately 4 (males) to 7 (females) times higher for First Nations compared to Other Residents; however data were only available for a regional rate calculation in Northern Region (First Nations higher).

There were insufficient data to calculate hospital user rates for substance use for First Nations in Fraser Salish, Interior, Vancouver Coastal, and Vancouver Island Regions.

Figure 17: First Nations and Other Residents physician and hospital substance use user rate, 2014/15 by region



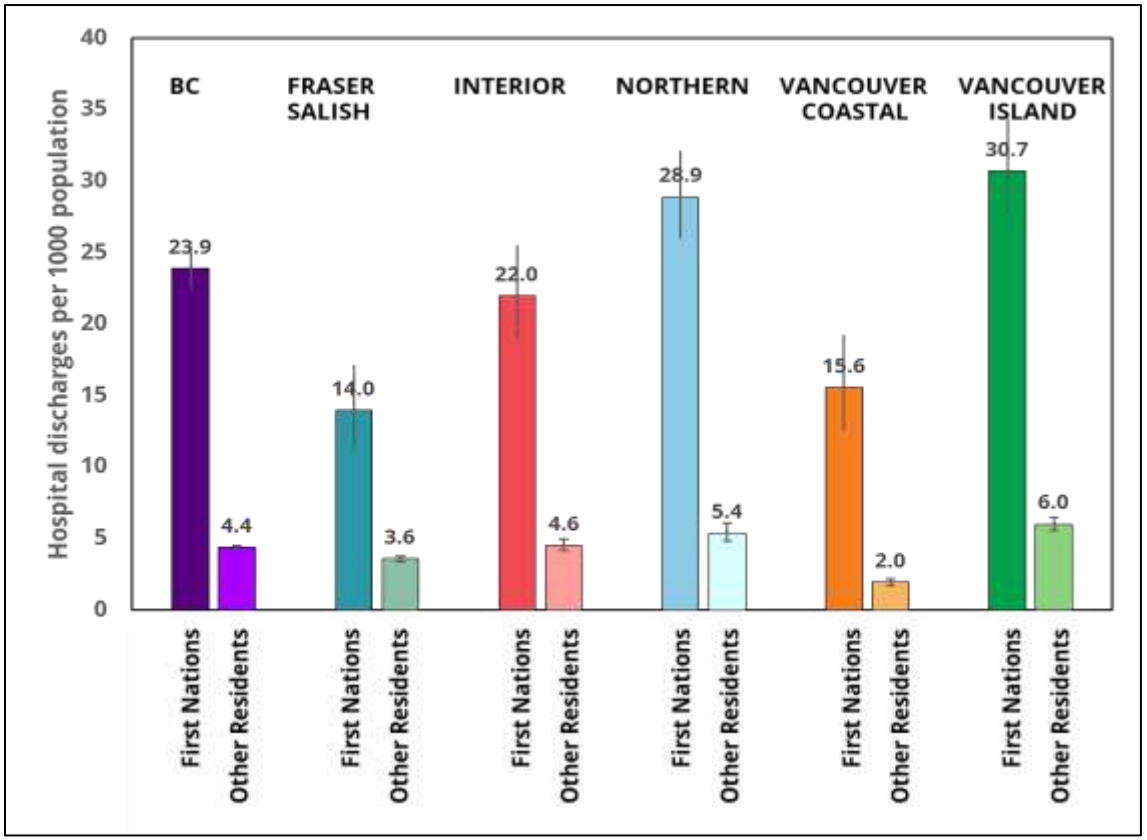
Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Dental Caries Discharge Data

Hospitalizations for children requiring treatment for dental caries is an indicator of the need for effective oral health promotion programming among First Nations. As shown in Figure 18, provincially and regionally, First Nations

dental caries hospitalization rates were generally five to six times higher than Other Residents. There is a complex range of interrelated factors which can influence this observed difference such as the increased availability of private dental offices in urban environments where dental extractions can be performed on small children, generally less availability of regular dental care in First Nations communities, and lack of cultural safety with dental services (both presently and historically). Other factors include the degree of access to fluoridated water, fluoride rinses and varnish treatments, dental hygiene practices, diet, and social determinants of health.

Figure 18: First Nations and Other Residents dental caries hospitalization rate, 2014/15 by region



Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation