Vancouver Coastal Partnership Accord Evaluation

July 2019

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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Purpose

The purpose of this evaluation is to assess progress since the signing of the Vancouver Coastal Partnership Accord (PA) in 2012, and to provide insight into successes, challenges and opportunities for strengthening the partnership moving forward. It is hoped that evaluation findings will help to inform next step considerations and actions designed to support partners in charting a course for the next phase of the partnership by way of a refreshed Accord. This evaluation is also one of five evaluations of the Regional Partnership Accords which collectively form part of the commitment to evaluate the Tripartite Framework Agreement on First Nation Health Governance (FA).

Evaluation Objectives

The objective of the Vancouver Coastal Partnership Accord evaluation is to examine the evolution of the relationship between Vancouver Coastal Health, Vancouver Coastal First Nations and the First Nations Health Authority (FNHA) since the signing of the PA in 2012, as well as assess progress in fulfilling the commitments to the Accord and influencing change within the Vancouver Coastal regional health system. The following topics were explored under the current evaluation:

- Satisfaction with the regional First Nations governance structures in the Vancouver Coastal Region;
- Evolution of relationships as a result of the PA;
- How partners to the Accord are collaborating and working together;
- Vancouver Coastal First Nations' involvement in decision-making related to the planning, design, management and delivery of health services in the region;
- Changes in the integration and coordination of Vancouver Coastal health services; and
- Quality, accessibility and cultural safety of the health services being accessed and utilized by Vancouver Coastal First Nations.

Methodology

The evaluation utilized multiple lines of evidence including both primary (i.e. interviews, focus groups and survey) and secondary data sources (document and file review). More than n=60 unique individuals from across different participant groups partook in this evaluation.

Summary of Key Findings and Recommendations

Themes emerging from the evaluation, each accompanied by its own set of recommendations are noted below. As part of creating a collaborative and participant-driven evaluation, only the recommendations that were provided by participants are included in the current report.

1. GOVERNANCE

The regional structure that has been established as a result of the PA is effective at bringing partners together with a common focus. The new structure has enabled new dialogue and ways of thinking about the health of Indigenous people and provided a strong foundation upon which

respectful relationships and mutual understanding may be built. Aboriginal Health Steering Committee (AHSC) participants perceive that the appropriate people are sitting at the table and that the body itself performs well at building solutions to emergent issues. In addition, partnership working groups are perceived to be addressing key priorities and are credited with developing important deliverables that continue to guide the work that is being undertaken. Infrequent AHSC and WG meetings represent a constraint to progress on partnership work. Participants identified an opportunity to reprioritize the work moving forward, including enhanced participation in partnership meetings, and reconsideration of the composition of both the AHSC and WGs to facilitate more regular meetings and move the work forward more expeditiously. It was suggested that strategic planning discussions may be beneficial to focus the work of the partners and further clarify roles, responsibilities, including accountabilities.

Recommendations:[1]
- Consider the appropriateness of the current composition of the ASCH and partnership WGs to facilitate the scheduling of more frequent meetings
- Engage in strategic planning to guide the work of the AHSC, Executive Committee to Aboriginal Health Steering Committee (EC) and WGs, based on transparent communication of partners' respective strategic goals
- Separate strategic from operational discussions at the AHSC
- Reorganize partnership WGs around specific projects

2. *Roles and responsibilities*

While partners' understanding of the role each plays within the health system has been strengthened, there is a lack of clarity concerning roles and responsibilities within the partnership. Specifically, there are opportunities to clarify the roles of First Nation health governance partners, the distinction between Vancouver Coastal Health (VCH) Operations and VCH Aboriginal Health, and respective responsibilities of the FNHA and VCH in connection with community. There is a perception that progress in the achievement of PA commitments has been slow; there is room for growth in the attainment of reciprocal accountability as envisioned in the PA to support fulfillment of commitments.

Recommendations:
- Further clarify the roles of the partners, including the role of the FNHA relative to the FNHC, the role of the Vancouver Coastal Caucus (VCC) in relation to the AHSC, and role of VCH Aboriginal Health in relation to VCH operational departments
- Enhance accountabilities for PA commitments in the refreshed PA, through articulation of timelines and responsibilities for specific milestones and deliverables
- Clarify decision-making roles, pathways and processes within partnership tables to facilitate more timely decision-making

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[1] An exhaustive list of participant recommendations may be found in the body of the current report.

3. Relationships

The PA supports the strengthening of formalized working relationship among partners. Intentional relationship-building efforts have contributed to these strengthened relationships and have offered new opportunities for the partnership to grow. As is to be expected, strength of relationship varies by level of regional structure, sub-regional family and partnering organization and the extent to which each interacts and meaningfully engages with one other.

Recommendations:
- Continue to create relationship-building opportunities, support inclusion of all partners, and encourage a spirit of trust among partners to facilitate more collective and effective solution-building

4. Collaboration and Partnership

The PA has paved the way for enhanced collaboration and partnership based on joint commitments to the work being undertaken by partners. There is shared commitment to PA work among senior leaders and a willingness to collaborate to move the work forward. Several shared initiatives and opportunities to partner were identified by evaluation participants to underscore this finding. Moving forward, there is opportunity for partners to jointly clarify what "partnership" means in practice. Participants also identified opportunities for growth in the partnership through the equal distribution of work and enhanced partner representation at various tables.

Recommendations:
- Reaffirm partners' commitment to prioritizing the work of the PA across all levels
- Jointly operationalize what "partnership" means in practice
- Develop a shared secretariat body to support the AHSC and EC meetings
- Consider providing remuneration to enable greater community participation in the WGs
- Support VCH participation at Regional Caucus to enable direct communication between the VCH and First Nations

5. Communication

Partners are engaging in open and transparent discussions. There is a perception that there are new opportunities for dialogue. Still, there is an opportunity to strengthen communication between VCH and FNHA at an operational level and with First Nations communities by clarifying communication pathways and point contacts within VCH and FNHA. Participants expressed interest in timelier and more frequent communications, particularly in the context of partnership working groups and joint projects to enable greater progress on partnership deliverables. There is also opportunity to more fully embody PA commitments, and more constructively support one another as partners.

Recommendations:
- Clarify communication pathways and point contacts at all levels

- Ensure more frequent and consistent communications and meetings between the HA and communities, including increased instances of follow up and reporting back to communities and direct contact with VCH
- Strengthen opportunities to gather in person to address issues and support constructive dialogue
- Improve cultural safety across all levels to support improved interpersonal communication

6. *Engagement*

The PA has contributed to improved engagement with First Nations with respect to health service delivery in the region. Sub-regional variations exist; findings suggest there is greater satisfaction with engagement in the South Coast sub-region, compared to other sub-regions, and that there is room for improvement in engagement on the Central Coast in particular. There is increased recognition of the need to engage First Nations in the development of new programs that are meant to serve them. Regional and sub-regional caucuses are effective environments for dialogue, collaboration and the exchange of information among partners. Future opportunities exist for increasing community visits, reducing engagement burden and supporting more consistent engagement across the sub-regions.

Recommendations:
- Jointly develop an engagement strategy to alleviate engagement burden on community leaders
- Increase community presence and visits by partners to facilitate real time communication and responses to questions, provide opportunities to meet directly with community membership and support conversations between VCH and Health Directors

7. *First Nations Decision-making and Influence*

Partners to the Accord are engaging in shared decision-making in the context of some discussions. Evaluation participants provided examples of increased First Nations influence in the design of health programs and services, and stressed the importance of ensuring initiatives continue to be guided by community input. Moving forward it may be beneficial to further clarify which decisions are to be shared by partners; limited opportunities for First Nations to inform resource allocation and funding were noted.

Recommendations:
- Ensure partners' decisions and amendments are approved at the community level in keeping with the FNHA, FNHC and FNHDA Shared Directive 2: community-driven and nation-based
- Ensure opportunities for increased community representation on the partnership WGs
- Increase opportunities for shared-decision making in connection with the utilization and allocation of funding and resources

8. Coordination and Integration

The partners have taken steps to improve service coordination and integration and are engaged in more frequent conversations to support joint planning and identification of shared priorities. Joint planning exercises, such as the development of the Regional Health and Wellness Plan and the Urban Indigenous Health Plan were identified by evaluation participants as key successes. Still, participants perceived that strategic conversations are not yet translating into operational changes as quickly as they might be. Moving forward, opportunities exist for influencing longer term operational planning within VCH to a greater degree and for increased engagement of VCH Operations in the partnership to support operational integration. There is also an interest in continued improvements to coordination of care and discharge planning. Localized committees focused on specific issues were identified as effective in supporting greater coordination at a community level and may represent a means to facilitate implementation of operational changes moving forward.

Recommendations:
- Increase opportunities to involve First Nations in collaborative service planning efforts that are guided by jointly defined agendas
- Share and enable community access to VCH policies, procedures, training protocols and procedures
- Consider aligning partnership discussions with monthly high level operational meetings within each VCH community of care (e.g. by including the FNHA on the agenda), rather than EC meetings to support integration of First Nations' priorities into ongoing VCH business
- Consider establishing localized multilateral committees / working groups that include community representatives to bring greater focus to specific issues and enable community-level input into health service planning and decision-making
- Continue efforts to improve coordination of care at the service delivery level and (including between the transition team and community health centres) to support smoother transitions of care for Indigenous patients

9. Resources

While financial and human resources have supported improvements in health services within the region, greater sustainability would help to further support improvements. Moving forward there are opportunities to simplify funding processes and identify alternative sources of funding. Competing demands and priorities constrain the partners' ability to participate in partnership work, and disproportionately affect community representatives. There are continued opportunities to increase and sustain human resource capacity within communities to address gaps/ disparities in services, to support community-driven planning and service design/delivery, and to alleviate the workload burden borne by individual staff.

Recommendations:
- Support ongoing training opportunities that support community capacity building

- Ensure funding and supports are sustainable and adapted to community need rather than being driven by population-, grant-, or reporting-related considerations
- Continue to support efforts to address recruitment and retention of health care providers
- Consider increasing support / funding for non-clinical staff and support staff within community
- Consider rotating the work schedules of FNHA engagement staff to allow work within community during some days of the week

10. *Monitoring Progress and Evaluation*

At present there are data and information gaps related to Indigenous health outcomes in the region. Moving forward there are opportunities to identify specific indicators and baseline measures to assist with the review of progress over time.

Recommendations:
- Develop specific success measures for all levels of the partnership, including clear baseline measures, and measurement intervals
- Improve data sharing to enable better monitoring of gaps and successes
- Utilize recommended joint planning sessions to inform the development of community based indicators
- Strengthen access to local level First Nations data (e.g. related to home and community care) to support monitoring of progress at a local level

11. *Cultural Safety and Humility*

There have been increased and sustained efforts by partners to improve cultural safety. There is improved awareness of the importance of cultural safety, Indigenous culture and tradition, and the First Nations perspective on wellness. Enhanced awareness is in part attributed to cultural safety training and other knowledge building opportunities. While training cultivates initial awareness among staff, continuous learning opportunities to support ongoing improvements may be beneficial. Future opportunities exist to support more experiential and in-depth training opportunities, to identify outcome data to measure progress in cultural safety over time and across the region, and to expand and improve existing initiatives.

Recommendations:
- Consider offering a greater number of facilities and service providers with VCH-delivered training
- Expand the scope of available training to include local-level, in-depth, experiential, and interactive training
- Ensure complaints are tracked and monitored to ensure appropriate resolution and to facilitate greater understanding of the issues under review
- Continue to create more welcoming and culturally familiar spaces within VCH facilities
- Strengthen and support the Aboriginal Patient Navigator role / services
- Support efforts to increase Indigenous staff representation and support and retain Indigenous staff

12. First Nations Perspective on Health and Wellness

There are emerging opportunities for First Nations to inform how services are addressing the full scope of community wellness needs in alignment with their conceptualizations of wellness. Partners have taken initial steps to support traditional wellness, including the development of new human resource supports for wellness and funding for traditional practitioners in primary care projects. Moving forward there are opportunities for further embedding the First Nations perspective on health and wellness into health services, including safe spaces and traditional protocols and medicines, and strengthening financial supports for and recognition of traditional wellness approaches in community

Recommendations:
- Develop protocols for acknowledging, involving and compensating traditional healers for their services within community
- Consider FNHA coverage of costs for traditional healers to provide services on healing and wellness days and support a train-the-trainer program to support community capacity building
- Continue to embed elements of traditional wellness into conversations related to integrated primary care
- Develop a set of promising practices for communities / health care organizations to support the reintegration of traditional wellness approaches into community-based planning and services

13. Accessibility of Services

While there is evidence to suggest greater availability of / access to health services since the signing of the PA, progress has been slow in addressing challenges affecting rural communities, such as a limited range of services relative to urban centres, limited emergency response services and transportation barriers.

Recommendations:
- Engage with communities at the beginning stages of planning and throughout service implementation to ensure that geographic realities and other community-specific priorities are being taken into consideration
- Focus partnership efforts to improve the availability / accessibility of services in rural areas through telehealth, expanded community-based services or other options
- Strengthen commitments in the refreshed PA to improve the accessibility of services

14. Additional PA Refresh Opportunities

Participants offered suggestions for consideration in the renewal of the PA. While evaluation participants stressed the value of retaining core PA principles additional engagement with First Nations was suggested as a valuable way to inform the refreshed version.

Recommendations:
- Update content based on current data (e.g. data regarding primary care)

- Enhance clarity concerning key PA objectives
- Incorporate more explicit commitment to increase/improve services, including traditional wellness, primary care, mental health wellness, harm reduction, and elder care
- Include more detailed commitments that build on the content of the Urban Indigenous Health Strategy and the Regional Health and Wellness Plan (i.e. commitment to refresh these documents as appropriate)
- Identify areas of the health system for more targeted intervention to improve cultural safety (e.g. acute services)
- Ensure the PA recognizes the distinct needs of communities; consider developing PAs between individual First Nations
- Consider the inclusion of new partners to the Accord (e.g. MOH, Providence Health)

ACRONYMS

Term	Acronym
Aboriginal Health Steering Committee	AHSC
Executive Committee to Aboriginal Health Steering Committee	EC
First Nations Health Authority	FNHA
First Nations Health Council	FNHC
Health Authority / Authorities	HA
Partnership Working Groups	WGs
Vancouver Coastal Caucus	VCC
Vancouver Coastal Health	VCH

Note on the use of language

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

INTRODUCTION

BACKGROUND

The *Vancouver Coastal Partnership Accord* (PA) was signed on May 16, 2012 by the Vancouver Coastal Caucus (VCC), the First Nations Health Authority (FNHA), and Vancouver Coastal Health (VCH) (hereafter referred to as "the partners"). The PA sets out a vision to increase the influence of First Nations regarding health services in the Vancouver Coastal region and calls for improvements in service delivery through greater collaboration between VCH, First Nations communities, the FNHC and FNHA. The First Nations health governance structure, established by First Nations for First Nations, supports and enables decision-making and influence in the health system. First Nations political and technical leaders in the region have been working in partnership with the FNHA and VCH to achieve shared decision-making in relation to health service delivery. The partners seek to improve health outcomes for First Nations and other Indigenous people residing in the Vancouver Coastal region through improved service integration and shared decision-making in relation to engagement and planning; service delivery; and evaluation of   services and systems. The PA builds on several provincial and regional documents: The *Transformative Change Accord: First Nations Health Plan (2006);[2]* the *Tripartite First Nations Health Plan (2007);[3]* and the *Consensus Paper: British Columbia First Nations Perspective on a new Health Governance Arrangement (2011).[4]*

The evaluation of the Vancouver Coastal PA fulfills a commitment outlined in the Accord "to work jointly to develop and measure the effectiveness of the shared governance and decision-making based on reciprocal accountability" (p.6) of the partners and will also support a refreshed version of the accord to be completed in 2019. Further, the Regional PA evaluations (from all five Health Authority Regions) form part of the commitment to evaluate the Tripartite Framework Agreement on First Nation Health Governance (FA) that will be completed in 2019. As a single line of evidence, the evaluation of the regional PAs will help to inform the FA evaluation in terms of (1) governance, Tripartite relationships and integration, (2) health and wellness system transformation and (3) health and wellness outcomes. The purpose of the current report is to share findings on the first ever PA evaluation and lead the path forward into the next phase of planning and partnership.

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[2] https://www.health.gov.bc.ca/library/publications/year/2006/first_nations_health_implementation_plan.pdf
[3] https://www.health.gov.bc.ca/library/publications/year/2007/tripartite_plan.pdf
[4] http://www.fnha.ca/Documents/FNHC_Consensus_Paper.pdf

VANCOUVER COASTAL REGIONAL CONTEXT

First Nations in the Vancouver Coastal Region are a unique family. The Vancouver Coastal First Nations (See Figure 1 and Figure 2) are organized into 3 main sub-regional families that serve 7 Health Centres:

1) Central Coast;
2) Southern Stl'atl'imx; and
3) South Coast.

Collectively, these represent 14 First Nation Communities, each at a different stage of development and characterized by its own unique strengths, needs and approaches to health care.

Figure 1: First Nations Communities within the Vancouver Coastal Region (Vancouver Coastal Regional Profile, 2018)
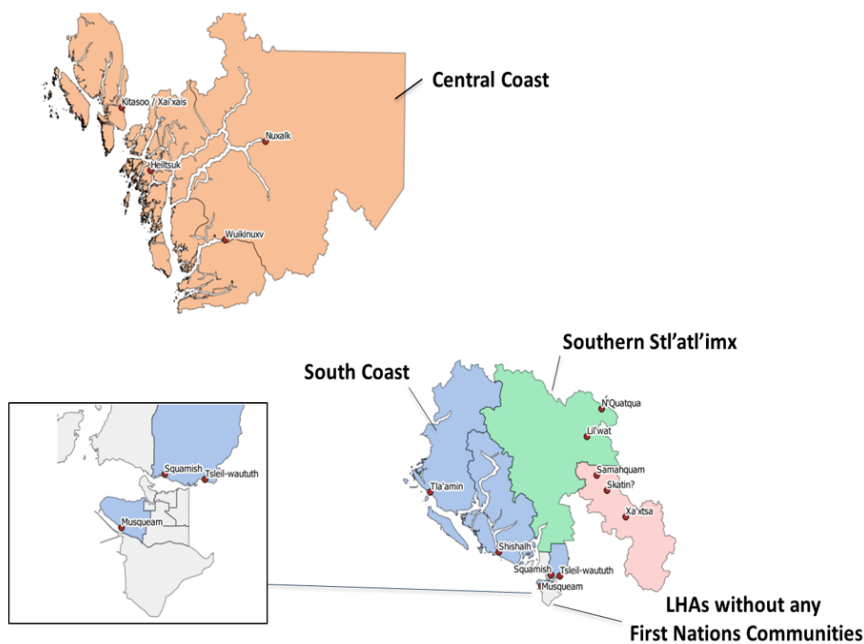
Notes: *****Samahquam, Skatin and Xa'xtsa are part of the Fraser Salish health region. While Ulkatcho First Nation (Anahim Lake) resides within the Vancouver Coastal Region, Interior Health provides health services to Ulkatcho First Nation by way of a Service Agreement arrangement.

Following the signing of the PA, First Nations of the Vancouver Coastal region established governance structures and processes to better coordinate the planning, design and delivery of health programs and services. The following entities are involved in health system governance in the Vancouver Coastal Region (see Figure 2):

- VC Regional Caucus;
- VC Regional Table;
- FNHA;
- AHSC;

- VCHA / FNHA Partnership Working Groups (WGs); and
- VCHA.

Vancouver Coastal Regional Caucus (VCC)

The VCC is comprised of the First Nation communities within the VC Region. Chiefs and Health Directors make up the Vancouver Coastal Regional Caucus. Each of the 14 First Nations listed in Figure 2 designates 1 political (Chief) and 1 technical representative (health service delivery lead) to Caucus, which meets twice per year with the FNHA, FNHDA and FNHC to discuss regional- and provincial-level accountabilities and offer guidance and recommendations to the VC Regional Table concerning work on behalf of the Caucus.

Vancouver Coastal (VC) Regional Table

Three representatives from VCC, 1 per sub-regional family, sit at the 15-member FNHC table. These same representatives also sit at the VC Regional Table, a strategic Working Group for

Figure 2: Vancouver Coastal Health System Governance Framework (Vancouver Coastal Regional Profile, 2018)
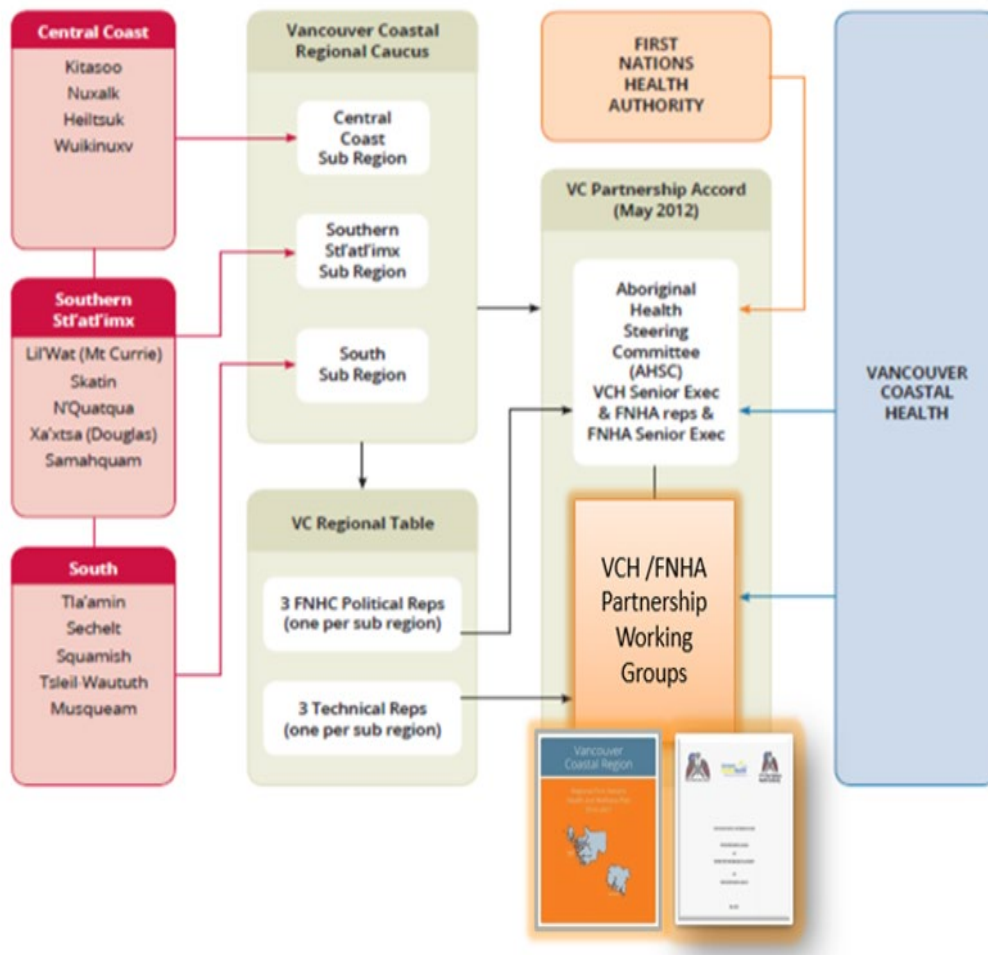
Caucus that comprises 3 technical representatives (one per sub-region). Both the VCC and the Regional Table provide an opportunity for community-driven, nation-based processes to be implemented to support First Nations in setting strategic direction on regional health matters, developing Regional Health and Wellness Plans and implementing the VC PA.

FNHA
The FNHA works with strategic political leadership of the FNHC and provides funding, logistical and technical support to the VCC. It is responsible for planning, management, service delivery and funding of health programs.

Aboriginal Health Steering Committee (ASCH)
The AHSC meets twice per year. It oversees the implementation of the VC PA and serves as a senior and influential forum for partnership, collaboration and joint efforts on First Nations and Aboriginal health priorities, policies, budgets, programs and services in the VC region. Membership includes:

- 3 VC FNHC Representatives;
- FNHA CEO (or designate), COO / Senior team representative (appointed ex-officio), Board Chair; and

- VC Health CEO, Chief Medical Health Officer – Co-Chair; Vice-President of Public Health; and the COO of Coastal Community of Care

AHSC identifies priorities and ensures the execution of initiatives that cover all strategic and operational decision-making commitments of the VC PA.

Vancouver Coastal Health (VCH)
Led by the President and CEO, VCH has overall responsibility for the delivery of health services in the region. Under the direction of the VCH Health Board and CEO, leadership for Aboriginal Health in the VCH region is given to the Executive Director of Aboriginal Health.

Partnership Working Groups (WGs)
Six operational partnership WGs, comprising representatives from the VCH and FNHA, support the development and implementation of regional work plans pursuant to the Regional Health and Wellness Plan. These WGs address the following priority areas: (1) cultural safety and humility; (2) primary care; (3) maternal and child health; (4) public health; (5) mental wellness and substance use; and (6) Indigenous Overdose Response.

THE VANCOUVER COASTAL PARTNERSHIP ACCORD EVALUTATION

METHODOLOGY

A mixed methods approach was utilized for the Vancouver Coastal PA Evaluation. The overall approach to the evaluation began with informal discussions amongst members of the Vancouver Coastal Health Community Engagement Team, and the FNHA Regional and FNHA evaluation teams concerning scope and potential participants for the evaluation. Thereafter a new PA WG was formed to craft the Vancouver Coastal PA Evaluation Plan and reflect on and design an approach to community engagement. The PA WG included representation from Vancouver Coastal Health's Aboriginal Health team, and FNHA's Regional and internal evaluation teams. Ference & Company Consulting Ltd. was contracted by the FNHA, on behalf of the PA WG, to conduct semi-structured key informant interviews (KIIs) with stakeholders involved with the PA to further support evaluation work.[5]

The PA evaluation incorporates multiple lines of evidence including both primary data sources (Sub-regional Caucus Survey, KIIs, and focus groups) and secondary data sources (document and administrative file review of available health outcome data).[6] A breakdown of PA evaluation participants by primary data source appears in Table 1 below. All data gathering instruments were collaboratively developed by members of the PA WG. The KII and focus group guides included semi-structured questions that utilized Likert-type rating scales, and open-ended questions (see Appendices).

Sub-regional Caucus Survey
Following a short presentation on the PA, community technical and political representatives in attendance at the spring 2018 Regional Caucus were invited by the VC Regional team to complete a short survey on the PA. A total of n=34 community representatives completed the survey.

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

[6] Health Systems Matrix (HSM) data are intended to be included when available to track progress for selected outcomes and to set a baseline. As these data are observational in nature, causal linkages may not be established between these outcomes and the PA analysis. Patient Reported Experience Measures (PREMS) may be included pending approval by the Office of Patient-Centered Measurement.

Table 1: Breakdown of PA Evaluation Participants by Primary Data Source

Participant Group	Method	# of Participants (n)	# Unique Participants (n)
AHSC / AHSC Executive Committee (AHSC-EC)	KIIs	10	10
FNHA and VCH operational staff	KIIs	13	13
	Focus Groups	10	5
First Nation Community Leadership Representatives	Survey	34	34
	Focus Groups	16	Unknown
	KIIs	4	Unknown
Total Participants		87	at least 62[7]

Key Informant Interviews

Members of the AHSC and AHSC EC, as well as operational staff members from the FNHA and VCH were invited to complete semi-structured KIIs regarding the PA (total n=23). First Nation Community Representatives who did not partake in focus group discussions were also invited to partake in the PA evaluation based on their involvement in, or knowledge of, related work (n=4).

Focus Group Discussions

Three focus groups were completed either in-person or by telephone with First Nations Community Representatives and some HA operational representatives. A total of n=16 political and technical leaders from across the 3 sub-regional families participated, together with n=10 HA representatives.

To ensure the integrity of the data, KIIs were recorded then transcribed. Key informants were invited to review the transcriptions to support data validity. Ference & Company Consulting Ltd. then collated the findings in a report which was also shared back with AHSC / AHSCEC for validation. To ensure inter-coder reliability, the original transcripts were reviewed by an additional two evaluators. Once data were coded, emergent themes were synthesized across data sources and organized by participant group (the preferred unit of analysis for this evaluation). A draft version of the current report was presented to evaluation participants to ensure accuracy before being finalized.

EVALUATION STRENGTHS AND LIMITATIONS

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

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[7] As the spring 2018 Regional Caucus survey was completed anonymously by VC Region political and technical First Nations leaders, it is unknown how many survey participants also participated in interviews or focus groups. To support a conservative approximation of the total number of unique participants, the estimated number of unique participants (n=62) assumes that all community leadership focus group participants also completed surveys. This estimate represents the minimum number of unique participants possible.

representation from nearly all First Nations in the Vancouver Coastal Region, VCH, and the FNHA. While sampling for KIIs and focus groups was purposive in nature, not all those who were invited to participate did so.

Evaluation participant groups (see Table 1) were selected as the unit of analysis throughout the report:

- First Nations community leadership participants (also referred to as "community leadership participants");
- AHSC and AHSC EC participants (collectively referred to as "AHSC participants" given the considerable degree of overlap in membership between AHSC and EC); and
- FNHA and VCH operational staff ("HA operational staff").

The groupings were utilized to highlight converging and diverging experiences in relation to the PA. When the current report refers to a specific participant group, this is to ensure specific evaluation participants remain anonymous (it does not mean the perception being discussed is held by all members of a single participant group).

In addition, in order to limit potential bias on the summary of findings for this evaluation, this report will undergo iterative reviews, revisions, and drafts by the PA WG and validation sessions with AHSC / AHSCEC, and VCC.

FINDINGS

Governance

Findings from the evaluation show that the regional structure that has been established as a result of the PA is effective at bringing partners together with a common focus and enabling dialogue. Infrequent AHSC and WG meetings represents a constraint to progress on partnership work.

Overall, the PA has helped to transform thinking in relation to the health of Indigenous people and cultivate health service innovation. There is a perception that the establishment of the new regional structure as a result of the PA has been a success (e.g. EC representation perceives the existence of good working relationships and feels issues being brought to the table are being effectively addressed – see Appendix 1). Findings from the evaluation show that the regional structure has evolved into an effective framework for guiding discussions on new opportunities and for jointly building solutions to challenging issues as these arise.

Composition of the AHSC is appropriate and includes senior decision-makers to drive planning and decision-making at the strategic level. There is a perception that some AHSC discussions are beneficial. Still, it was noted that AHSC membership has expanded over time to include 20 members, which at times constrains optimal performance. Moreover, despite the PA commitment to meet on a bi-annual basis, findings from the evaluation suggest this commitment has not been met, which further constrains AHSC's ability to advance PA commitments (e.g. there was a report of a 1.5 year interval since the last AHSC). Scheduling AHSC meetings is a challenge, compounded by last minute cancellations by key individuals. In addition, dialogue around the table is not as strategic as it might be; there is a perception that conversations are too broad and operational in nature. There tends to be a focus on process, politics and administration, which impedes AHSC's ability to implement commitments or shifts the focus to other priorities. AHSC and EC meetings are also too short and meeting agendas too full of informational updates to allow for meaningful discussions on strategic planning to occur. A strategic plan may be beneficial for outlining partners' goals over the coming years, and for focusing discussions and strengthening communication and coordination between different parts of the structure.

It's a big win we are coming together at the same table and we're coming together to strategize, to share updates, to share opportunities, and coming together to find solutions to First Nations interests. – **AHSC participant**

"[The PA has] absolutely created a lot more clarity and awareness in terms of the individuals that we're working with…and as a result, we've identified key activities that we're working on, key areas of focus." **- AHSC participant**

The way we think about the health of Indigenous people has been dramatically changed as a result of the accord and there's a lot more concrete work being done to improve health – **AHSC participant**

"Everyone wants the same thing and everyone is working hard at the end of the day. But we are bogged down in process and politics, it feels stuck." – **AHSC Participant**

At a broad level, it's brought people to the table to start the discussions. And I'm using the word 'start' in a very deliberate way. Because I think we have a long ways to go still to understand how we can work and be together. – **AHSC participant**

There is a sense that the five WGs that have been established as a result of the PA are addressing the right priorities and provide a platform for partners to work in partnership. Since the signing of the PA, the WGs have effectively supported the achievement of important milestones and products including the Urban Indigenous Health Strategy and the Indigenous Cultural Responsiveness Strategic Framework. However it was noted that the latter has not been fully implemented. .

*I believe the structure is strong, it is set up intentionally, and it has all the right partners, the right terms of reference and the right mandate. [...] it's just not meeting enough to advance any of these things. – **AHSC Participant***

Facilitators to PA WG success include: clearly defined objectives that are tied to discrete projects / deliverables with short timelines; the existence of shared work plans; project charters; project management; and logistical support. Still, PA WGs have experienced challenges. One example is the infrequency of meetings. Participants reported that PA WGs were not successfully operationalized and were now on an indefinite pause. Other challenges include an inability to schedule meetings, a perceived lack of commitment to attend and participate in meetings, and lack of guidance from AHSC because it does not meet frequently enough. It was noted that the composition of the WGs was also an issue: some groups do not have the required expertise, while others are too large or involve staff from too many levels of FNHA and VCH. .

Suggestions related to improving the performance of the regional structure include:

- Revisiting the appropriateness of the current composition of the AHSC (e.g. limiting AHSC meetings to VCH and FNHA board chairs and CEOs, 2 co-chairs of the EC to AHSC, and FNHC representatives; separating CEO-to-CEO, and board chair-to-board chair meetings, and meetings between VPs and COOs);
- Clarifying opportunities to formally include new partners (e.g. Providence Health, Ministry of Health);
- Ensuring the right VCH operational staff are attending the WGs (e.g. decision makers) and VCH representatives from localized / sub-regional levels are in attendance to further connect the work of the PA to the service delivery level;
- Improving the scheduling of meetings and enhancing partners commitment to meeting more regularly to ensure consistent work flow and the enabling of action items;
- Conducting strategic planning to guide the work of the AHSC, EC and WGs (clarifying roles and responsibilities; timelines; deliverables)
- Separating operational discussions from strategic ones at the AHSC
- Improving the effectiveness and transparency of communication concerning the partners' strategic goals, priorities and plans to identify how to work together more effectively and support improved conversations and increased coordination); and
- Reformatting the WGs based on specific projects rather than subject areas.

Roles and Responsibilities

Findings show a lack of clarity concerning roles and responsibilities. While there has been gradual progress in the achievement of PA commitments, there is a need for greater accountability in terms of ensuring these are fully realized.

There is an increased recognition and understanding of partners and their roles within the broader regional health context. Further, there is some understanding of roles and responsibilities in relation to those outlined in the PA (see Section D of the Vancouver Coastal PA), especially among those directly involved in its development. However, there is a perception that variation exists in the extent to which partners fully understand roles / responsibilities, especially at the governance and service delivery levels. Such uncertainty constrains effective coordination and integration of planning and service. More specifically, there is a lack of clarity in connection with the following:

- The roles of respective First Nations Health Governance partners;
- The respective roles/responsibilities of VCH and FNHA in relation to community and to the work being undertaken on the ground;
- FNHA roles relative to the FNHC;
- The role of the FNHA in relation to the VCC, and VCC's role in relation to AHSC (e.g. there is a perception that the AHSC Terms of Reference does not specify the latter);
- The role of the FNHC in relation to community;
- The distinction between VCH Aboriginal Health and VCH operational departments; and
- VCH Aboriginal Health's role in relation to rural and remote communities.

Evaluation findings show a lack of discussion on roles and responsibilities over the past six years and that moving forward, roles and responsibilities might be further communicated to community. There is a need for increased clarity and definition of roles and responsibilities in the PA that include timelines relating to specific accountabilities.

"The ability to execute and actually do stuff on the ground is still to this day, very clunky and uneven "– **AHSC Participant**

"there's lots of awesome plans and things that sound fantastic, but I don't see much actual change for the service users at the end." – **HA Operational Participant**

The PA has created a new accountability arrangement for partners to follow towards the fulfillment of key PA milestones and deliverables, including the Aboriginal Health and Wellness Plan and the Indigenous Urban Health Strategy (both identified as important success stories despite taking a long time to develop and having only recently been approved / enacted). Evidence from the evaluation suggests that progress in operationalizing PA commitments in relation to service delivery has been protracted given the length of time the partnership has existed and the operational challenges that persist; moving forward it may be beneficial to accelerate the rollout of different projects to improve service availability in the region. It was noted that each partner has distinct political and decision-making structures; decision-making by consensus within such a context necessarily slows progress when many

representatives must consult within their respective organizations separately before consensus can be reached at partnership tables. Looking to the future, there is a suggestion that clarifying decision-making processes, pathways, and what decisions individuals / groups are empowered to make may be beneficial.

Perhaps providing some insight into a lack of shared understanding of roles and responsibilities, is a sense that awareness of the PA varies within the partnership as a function of level and length of tenure. There is a perception of a lack of awareness among service providers at the frontline / local level, and that awareness of the PA does not extend to VCH operational departments more generally. Survey and focus group findings suggest that awareness of the PA also varies among community leaders and that there may be limited awareness among some community members (see Appendix 2). Findings suggest that varying levels of familiarity with commitments to the Accord, and the extent to which they have been realized exist at the AHSC or EC to AHSC levels. Turnover was cited as a constraining factor to familiarity with the Accord. The PA was intended to formalize the relationships among partners so as to hold each other accountable in the spirit of reciprocity (see Section 5 of the Vancouver Coastal PA). Overall accountability commitments include:

- Clear roles and responsibilities;
- Clear performance expectations which are balanced to partner capacities;
- Credible and timely reporting; and
- Holding each other accountable in the sprit of reciprocal accountability for the commitments in the PA.

Despite the clear articulation of these commitments in the PA, there is a sense that more work needs to be completed to rearticulate PA commitments to ensure their full consideration across different levels of staff and health service lines. Building new and precise accountability mechanisms and performance measures into the renewed PA is just one way of helping to track the progress of the partnership and associated work over time. Refreshing the PA also presents a timely opportunity for establishing protocols for fulfilling specific roles and responsibilities (for instance, there is a perception that there is an increasing role of the FNHA as a governance partner; there is also a perception that the VCH has a responsibility to provide greater support and service access).

"When this partnership was going through […], and Joe Gallagher was online on a webinar and I asked him, 'who's holding the frontline workers accountable to these agreements? With your signature and that of VCH, I think the top, top, top people have signed it. So now, what do we do? Where do we go?'"

- Community Leadership Participant

Relationships

The PA supports the strengthening of formalized working relationship among partners. Intentional relationship-building efforts have contributed to strengthened relationships and the identification of opportunities for growth. Findings show that strength of relationship varies by level of the regional structure, sub-regional family and partnering organization.

"But what I'm seeing […] is the actual grassroots and very purposeful relationship building [between the] *FNHA and the communities and the directors in* [Vancouver] *Coastal; the operational directors. That I see as very effective* **– AHSC Participant**

Evaluation findings show strengthened relationships among partners as a result of the PA (see Appendix 3). There is a perception that the PA has supported the creation of new working relationships and the awareness of key contacts to support operational work being undertaken in the region. Results emphasize the importance of intentionality in the building of relationships. More specifically, there is a perception that since the signing of the PA, relationships have become more "intentional" in nature, a positive dimension of relation that lends itself to the improved performance of partners in their joint efforts to move the work forward.

Prior to the signing of the PA in 2012, no formal relationship existed between Vancouver Coastal First Nations collectively and VCH. The fact that a new relationship has been forged between VCC and VCH as a result of the PA is further evidence of relationship-building success. Positive relationships with individuals and groups within the HA were explicitly noted by community leadership representation (for example, the helpfulness of a VCH Aboriginal Health team lead; approachability and openness of senior staff to work with the Nation). Nonetheless, strength of relationship between First Nations and VCH appear to vary as a function of sub-regional family (See Appendix 3). Evaluation findings also show strengthened relationships between Vancouver Coastal First Nations and the FNHA.

I just can't stress relationship building enough. I think the focus on the building of trust at the Nation level with our Nations' health teams and VCH local health teams-- the relationship in-community between VCH and our Nations needs to be better supported in the building of that **– HA Operational Participant**

Perceived strength of the relationship between the FNHA and VCH differed by group. While AHSC representation generally spoke positively of the new relationship, several HA operational participants suggested there is room for improvement. VCH operational participants in particular noted that on occasion the FNHA was perceived to be leading efforts to move the work forward as opposed to jointly partnering in such efforts. While there is recognition of the important role that the FNHA has played in bridging the relationship gap between Vancouver Coastal First Nations and the VCH since the signing of the PA, there is a perception that the FNHA at times hinders VCH's efforts to connect more directly with community. Mirroring this finding is a perception that there is a stronger bilateral relationship between the FNHA and VCC than between the VCC, the VCH, and the FNHA.

There are future opportunities to improve relationships to achieve the full spirit and intent of the partnership as outlined in the Vancouver Coastal PA. Moving forward it will be beneficial to continue to build trust between partners to support full inclusion of First Nations as equal partners in regional partnership efforts, and to ensure that individuals feel more comfortable raising issues as they emerge over time. Improved relationships between VCH service delivery staff and community members may also promote increased service accessibility.

Collaboration & Partnership

The PA has paved the way for enhanced collaboration and partnership based on joint commitments to the work. Moving forward, there is opportunity for the refreshed PA to further clarify what the true spirit of reciprocal accountability looks like, or means, in practice. Moving forward it may be beneficial to prioritize partnership meetings and investments.

"So I think about the JPB investment sent to some of the urban First Nation communities in Vancouver Coastal. That that did bring together VCH, First Nations and FNHA in a more meaningful way." – AHSC Participant

"I've seen some great projects implemented in communities. I think where it has been successful is where the partnership has come together, so First Nations Health Authority, Vancouver Coastal Health, and the local communities, and where it's been community-driven" – HA Operational Participant

Evidence shows increased partnership opportunities and collaboration between the partners (see Appendix 4). Participants cited the establishment of good working relationships with partners and increased opportunities to work directly with First Nation communities and the FNHA, which was seen as a key accomplishment of the PA. There is also a perception of partners' growing responsiveness to emergent priorities, timeliness, flexibility and openness to innovation and change.

The evaluation revealed areas of successful collaboration and partnership, including Joint Project Board mental health and wellness, and primary care projects. There is a perception that the development of specific PA deliverables demonstrates true partnership, particularly the Urban Indigenous Health Plan. Other successful collaborative efforts that were cited by evaluation participants include the Nəca̓mat wellness event and cultural safety awareness raising effort that took place at one hospital in the region. In addition, collaboration was identified as a facilitator to cultural safety and the fulfillment of PA commitments, and essential for improving service access moving forward. There is a perception that projects are more likely to be successful when developed in partnership with communities during all stages of planning and implementation.

Findings show an opportunity to enhance the collaborative spirit of the partnership in keeping with the partners' commitment to "support each other in a positive and constructive manner" (see Section D.1 of the PA). A few participants perceived a general lack of collaboration or described instances which did not embody the spirit of partnership. For example, one participant noted that HA partners did not have a unified voice around the work of the partnership, which resulted in a perceived lack of collaboration by communities. There is also a sense among a few participants that the FNHA has had a tendency to emphasize perceived shortcomings and monitor VCH's progress on PA deliverables rather than acknowledge VCH's contributions and commitment to the partnership and associated work.

"I think there's room for a lot more collaborative projects with the partners, initiatives, work, and operational integration. I feel like it's really at its infancy level." – HA Operational Participant

"If there could be a really good understanding of each other's intentions, which I know are good on both sides, as well as the realities of what's possible and what's not possible. I feel like there is a lot of finger-pointing from both sides because we don't necessarily understand each other's challenges that well." – HA Operational Participant

The importance of commitment to, and prioritization of, the partnership emerged as a key finding under the current evaluation. There is a shared commitment to the work among senior leaders and clear intent to collaborate across multiple levels. In addition, senior leadership support, and the support and leadership of the FNHA Regional Director and Aboriginal Health Director are considered key enablers of the fulfillment of PA milestones and deliverables. Still, a few participants perceived a need for increased engagement and prioritization of the partnership amongst leadership at levels above the Aboriginal Health Director and Regional Director (for instance, greater accountability and reporting between leadership and their boards). Lack of prioritization or commitment of members to attend both AHSC and partnership WG meetings is also a constraint to collective performance. Moving forward there are opportunities to strengthen the commitments to the Accord to further enable health system transformation within the region.

"[…] when [AHSC members] get around the table, you hear their commitment, you see their commitment, they still […] haven't quite found their footing, but certainly, it's nice to have a table where there is an opportunity to come together." – AHSC Participant

"Transformation will take time but with commitment and [the] partnerships involved, I really believe we're going in the right direction" – AHSC Participant

"I think that direction needs to come from our senior leadership to create a strong clear pathway to share, bridge, [and] link. I think that we're still working in silos in many ways." – AHSC Participant

Participants emphasized the importance of equal participation in partnership activities towards the achievement of a true spirit of reciprocal accountability. There are situations when either FNHA or VCH is not at the table, when it would be beneficial for that HA partner to participate in the discussions taking place, and uncertainty around when both FNHA and VCH would be at the table. For example, a few community leaders expressed interest in greater VCH presence in community, including having an Aboriginal health team lead assigned to the community or attendance during community meetings. It was similarly suggested that having FNHA regional team engagement staff members work within communities once per week to support improved bi-directional information flows and new opportunities for partnership.

Operational HA participants in the evaluation indicated that First Nation representatives do not attend certain partnership activities. For example, it was noted that community representation had not been invited to participate in the PA WGs, resulting in the WGs being less productive than they may have been. There is also a perception that work is not being equitably distributed with respect to AHSC secretarial functions (e.g. sourcing meeting dates; developing meeting materials) or in the context of the PA WGs. Evaluation findings reveal opportunities to strengthen uniformity in participation during Regional Caucuses. While it was noted that VCH Aboriginal Health was often in attendance during these sessions, participants from across groups conveyed interest in greater VCH presence, including VCH senior executive and senior operational leadership representation to hear directly from communities. A few participants noted that VCH representatives occasionally depart immediately following their allotted time on the agenda, and suggested that staying for the full duration of the event would demonstrate greater commitment to the partnership. A few VCH AHSC members expressed interest in participating in, but have yet to be invited to Caucus, or have received last-minute notification of the event making it challenging to attend. Findings suggest that Caucus is perceived as an FNHA event rather than a partnership endeavour, evidenced by late or minimal VCH involvement in the planning process and lack of VCH consultation on dates, creation of the agenda or topics that VCH wishes to engage communities on.

The following opportunities related to strengthening collaboration and partnership emerged from the evaluation:

- Defining collectively what "partnership" means in order to share and discuss constraints and build solutions to challenges;
- Supporting partners' commitment to prioritizing the work (across all levels) and recommitment to the work through ceremony;
- Developing a shared secretariat body rather than relying on one or two people to support the AHSC and EC meetings;
- Providing remuneration to enable greater community participation in PA WGs; and
- Increasing VCH participation at Regional Caucus to enable direct communication between the HA and First Nations.

"We all come as community and we're there for the whole caucus. But VCH comes and they're there for their part and then they're gone. So to me that's not partnership. That is a visitor who is giving one small little piece of information and then leaving. And to me, if you're a true partner, you're there for the duration. You're hearing our voices throughout"
- **Community Leadership Participant**

"I don't even get invited to the caucus so I can't comment on how effective that has been. I would say from the VCH point of view, we would like to be at the caucus table more than we have been. I think we're sometimes only included very peripherally" – AHSC Participant

"It became "these Regional Caucuses and regional tables, etc., are things FNHA owns and runs, and we'll tell VCH when and if we want you to be part of it." The managers I was reporting to were incredibly frustrated by that. They were like "I thought we had reciprocal accountability. I thought we were in this together. I thought this was a partnership."'
- **HA Operational participant**

Communication

Participants perceive that open and transparent conversations are occurring. Still, there are opportunities to strengthen communication between FNHA and VCH t an operational level and with First Nation communities by clarifying communication pathways and point contacts and ensuring more timely communication in the context of joint projects.

"We can be pretty frank with one another, talk about issues, problems as they come to us." – **AHSC Participant**

"You know it is about transparency, openness and everyone receiving the information at the same time. As opposed to piece-mealing it and getting some of it but not all of it. I think communication really is an area that we could focus more." – **AHSC Participant**

Findings show that the PA has supported new opportunities for dialogue between partners and that there is a willingness to engage in discussion among partners at the AHSC. Conversations around issues are open and transparent. One senior VCH executive noted that s/he had personally gone out of her / his way to reach out to FNHA executives more informally to enhance her / his understanding about a few issues. Moving forward there are opportunities to strengthen communication by discussing as a group what "effective communication" looks like in practice, including pathways, protocols and products. .

An effective communication pathway has been established between WGs and the EC to AHSC to report on WG activities and seek guidance on emergent issues; still, gaps and challenges were described by evaluation participants, including inconsistent reporting from a few PAWGs and a "huge disconnect" perceived between certain levels of the structure (WGs, EC, and AHSC). Communication challenges and gaps are also present between the VCH and the FNHA at an operational level. Specific challenges include:

- Communication doesn't always reach the right people (e.g. within the FNHA; communities; Chiefs); and
- Communication is not always timely (for instance, lengthy response times in connection with joint project work and WGs) which is perceived as a constraint to the fulfillment of PA commitments.

Findings suggest an improvement in communication between communities and the other partners; however, this finding varies as a function of sub-regional family and partnering organization (i.e. VCH and FNHA) (see Appendix 5).

Views expressed regarding communication diverged: a few community leaders felt that communication remained a 'big issue' or a significant area requiring improvement moving forward, while another perceived that communication between partners was more open and transparent and that dialogue was ongoing in terms of voicing and addressing need. Survey and other findings suggest there is opportunity to strengthen communication between VCH and First Nations, especially in specific areas (i.e. the Central Coast).

Moving forward there is a need to clarify communication pathways and point contacts within VCH and FNHA. Several participants did not know who communities should contact within the VCH to initiate conversations or whether there was a point contact for their particular community. Similarly, a few community leadership participants in the evaluation suggested an absence of effective pathways for communicating and addressing issues of interest or that there is a continued fragmentation of communication processes. .

" […] if we need any help, we're able to phone them. So we've got a really open dialogue going at all times with VCH, definitely" – **Community Leadership Participant**

"When new opportunities come up she [the VCH Aboriginal Health lead] lets me know"; "If I have any questions they leave a number for me to call at any time and they talk us through some things" – **Community Leadership Participant**

Suggestions for improving communication between the partners include:
- Clarifying communication pathways and point contacts at all levels, including through the development / dissemination of up-to-date employee contact lists that outline who to contact concerning specific issues;
- Ensuring more regular communication and meetings with communities, including more frequent follow-up with and reporting back to communities (e.g. quarterly meetings between VCH, community health department, FNHA) and increased opportunities for communities to communicate directly with VCH; and
- Strengthening opportunities to gather in person to address issues and support meaningful dialogue.
- Improving cultural safety at all levels to support improved interpersonal communication/interactions

Engagement

The PA has contributed to noticeable improvements in the engagement of First Nations in conversations, decisions and actions concerning health service design and delivery in the Vancouver Coastal region; however sub-regional variation exists. There is an increased recognition of the need to engage First Nations in the development of new programs. Future opportunities exist for increased community visits, reducing engagement burden and ensuring consistency in the degree to which each sub-regional family is engaged

Evaluation findings show enhanced engagement with First Nations concerning the design and delivery of health services for First Nations in the Vancouver Coastal region. HA operational and AHSC participants shared that overall, there is a greater expectation and awareness of the need to engage First Nations, particularly among VCH departments. Some VCH participants spoke to an evolving understanding of the engagement process, perceiving that VCH's overall approach to engagement had improved since the signing of the PA; Several examples of successful engagement were noted, including the development of the Regional Health and Wellness plans and the urban Indigenous Health Strategy as deliverables involving robust engagement, as well as the joint engagement of Indigenous women in the downtown eastside, which was perceived to have contributed to several program and service changes. Community leadership participants shared that opportunities to come together for direct and meaningful collaboration have been valuable, for instance caucuses, community-level meetings, and meetings with VCH leadership.

"Ask community, take the time to listen, learn and know if we don't have community input these decision-making plans can fail" - ***Community leadership participant***

"The expectation that we as leaders have [is] that any new initiative that impacts or touches any of our communities has to have a level of engagement prior to being designed. We design with, not to." – ***AHSC Participant***

While there is a perception that the VCH has been undertaking strong engagement work with urban First Nations, engagement by VCH has largely focused on urban issues within the South Coast sub-region; there is opportunity for greater engagement in the other sub-regions, particularly the Central Coast sub-region, a finding mirrored by caucus survey results (see Appendix 6). Similarly, some community leadership participants from the Southern Stl'atl'imx and Central Coast sub-regions indicated that increased community visits and presence of

partners, and VCH in particular, would be beneficial. For example, there is interest in greater VCH Aboriginal Health representation at community meetings and opportunities for community leaders to sit down with VCH representatives to discuss local-level engagement.

Sub-regional and regional caucuses are considered key vehicles for conducting engagement and critical to the overall engagement process and for informing PA work. It was noted that show high participation rates by both the FNHA and VCH Aboriginal Health Team and that community membership at caucus has increased over time, which one participant highlighted as an indicator of success. Caucus events offer the following engagement opportunities:

- Discussion and dialogue on program / service improvements;
- Reports on AHSC activities and validation of directions / outcomes from previous engagement sessions
- Discussion to inform the development/implementation off PA deliverables;
- Communication and exchange of resources and information, for instance, community experience, including needs, challenges and successes; and
- Coordination and collaboration by bringing partners together in the same room and supporting access to VCH Directors in particular.

"I think we're making leaps and bounds as an organization to understand what meaningful and respectful engagement looks like, as well as the protocols around that, so there's been a lot of learning that's gone on. I think now those learnings are starting to get implemented, so yes. We've got a number of initiatives that have definitely been course-corrected or guided by engagement"
- ***HA Operational Participant***

"[…] where we are able to collect that voice, write it up into a report, and tell the system what we heard, and use that to shape and change programs and services. From the first year we did it to now, we've effectively changed how we provide care to Indigenous women"
–AHSC Participant

"[sub-regional and regional caucuses are] a platform for community and nations to see VCH at the table and the gatherings. I think it's a chance for them to be able to speak to Executive Directors and folks from VCH. If there are issues, community normally has a connecting with them […] I think it's created opportunities to have dialogue around cultural safety". – HA operational participant

Nonetheless, room for improvement exists in the engagement of First Nations in discussions on health services in the region. There is a perception that caucus / sub-regional caucus sessions on occasion operate like information sessions, rather than meaningful engagement seeking to inform partnership work. In addition, given the varying degree of participation at certain events, the representativeness of direct community feedback remains uncertain.

Engagement efforts have not been as coordinated as they might be. For instance, FNHA and VCH engagement of First Nations sometimes occurs separately and occasional duplication of engagement effort has led to confusion among community leaders. The continual influx of engagement requests competes with community leaders' ability to attend to the needs of their community, including elder and complex patient care. Difficulty attending meetings due to competing priorities and scheduling conflicts, including those perceived to have arisen as a result of poor coordination by VCH and FNHA, was cited as a challenge. One VCH operational participant recalled the utility of a short-lived shared engagement calendar between FNHA and VCH. It was noted that the joint engagement strategy that the PA committed partners to developing had the potential to reduce engagement duplication; the evaluation shows that it

might be beneficial to sign off on this product. Additional opportunities for improving engagement include:

- An up-to-date engagement strategy based on current priorities and realities to reduce engagement burden and operationalize what meaningful engagement looks like in practice;
- Increased community presence and visits by partners to facilitate real time communication and responses to questions, direct meetings with community members and conversations between VCH and Health Directors;
- Greater engagement of community at all stages, from initial discussions to service implementation to ensure that efforts are community-driven; and
- Greater, more consistent communication between the partners.

First Nations Decision-making and Influence

There is evidence of shared-decision making among partners and increased First Nations influence in the design and delivery of projects and health services. Moving forward it may be beneficial to clarify which decisions may be shared by partners. At present, limited opportunities exist for First Nations to inform funding and resource allocation.

The purpose of the PA includes increasing the influence of First Nations' decisions regarding health services by way of partnership, with the goal of attaining shared decision-making (see Section A). AHSC participants identified that shared decision-making is occurring among the partners, but may not always be occurring when it should be. , , Participants shared that most decisions should be shared, especially those pertaining to planning/ implementation of new initiatives or resources(while, higher operational level decisions that are already outlined in funding agreements (for instance, budgets) may be made by respective service providers). Moving forward there is interest in jointly operationalizing   what shared decision-making looks like in practice.

"We're supposed to be looking jointly at decisions that will impact the care of Indigenous people, we're not always doing that. I think we need to actually better define this". – **AHSC Participant**

Evaluation participants identified opportunities for communities to:
- advocate and voice their needs and priorities by way of the new regional governance structure;
- shape and influence health programming; and
- partake in health governance roles, in contrast to past approaches in which service delivery approaches felt imposed on communities.

It was also noted that certain communities in the region feel more empowered to claim "a seat at the table" and the services they feel they are entitled to. HA operational participants also shared several examples of processes perceived to reflect First Nations' influence, including:
- the incorporation of First Nations' input into the design of Joint Project Board Projects;
- planning processes for events in Vancouver's downtown eastside;
- the development of grant streams within the VCH Aboriginal Health team;

- involvement in new data initiatives, including the collection of community-specific data through the 'My Health, My Community' survey and participation in creating evaluation metrics; and
- First Nation representation in patient advisory committees to identify patient experience measures within hospitals.

Community-led design and community support and buy-in were identified as key facilitators of successful initiatives. Evaluation findings stressed the importance of demonstrating how community input guides PA work through validation during engagement events.

Still, views regarding First Nation influence in decision-making differed among participants. There is a perception among some that First Nations continue to operate in a health system with minimal opportunity for First Nations to provide input, despite a demonstrated willingness/ interest to inform changes. There is interest in enhancing opportunities for input and strengthening influence, including those that allow First Nations to regularly influence VCH decisions regarding the allocation of resources and funding. There is a perception that certain VCH policies constrain communities' ability to provide direct input into the decisions that concern them, such as which health care workers visit communities. It was noted that the PA does not adequately address Shared Directive #1 (Community-Driven, Nation-Based) and #2 (Increase First Nations Decision-Making and Control) and how these may be fully realized by partners. In addition, the importance of First Nations' representative / governance bodies' (for instance, the FNHC) advocacy work being truly based in the priorities communicated by communities was also noted by one participant. It was noted that legislative changes advocated could inhibit communities from doing what they want (e.g. in relation to the social determinants of health) in the absence of meaningful and continuous engagement with communities.

There is a need for greater community representation at strategic tables and a 'voice' in local hospital operations. Revisions to the PA may be required to further support increased First Nations decision-making. Additional areas for improvement include:

"[...] the best way we can contribute is by ensuring some formal process. So as much as the Aboriginal Health Steering Committee makes sense, we're still not engaging on a level where community has been able to influence where dollars go"
- **Community Leadership Participant**

- Ensure partners' decisions and changes are approved at the community level in order to be truly community-driven and nation-based;
- Validate decisions at the sub-regional level and community health and wellness plans;
- Ensure that communities are informing high level governance discussions and that they understand how their input is benefiting these discussions (for instance, through improved reporting back to communities;
- Increase community representation on the WGs to connect VCH operational staff to communities at the service delivery level;

- Identify new formal mechanisms to increase community influence on decisions affecting them, for instance through localized agreements between First Nations and VCH or through localized multilateral bodies committed to improving services;
- Collaborate in the planning, development, and implementation of initiatives;
- Consider the distinct needs of each community, and include these in the refreshed PA and HA partners' approach to engagement; and
- Increase opportunities for shared-decision making related to the use and allocation of funding and resources.

Coordination and Integration of Planning and Services

Partners have taken steps to improve service coordination and integration. Still, key opportunities have been missed to influence long term operational planning within VCH. Several key constraints were noted by evaluation participants.

Findings suggest there has been an increase in the integration and coordination of health service planning by partners (see Appendix 8) as demonstrated by the greater number of conversations taking place to support the coordination of planning, which allows partners to identify priorities and shared areas of interest and focus. However, there is a perception that the FNHA and VCH are still operating as separate entities and that there has been less progress in coordinating and integrating policies, budgets, and programs, particularly in rural and remote areas. There have been missed strategic opportunities at the AHSC level to coordinate planning and there is a perceived need to better connect the goals of the partners to the larger strategic goals of the VCH to enable partnership goals to be actualized within various level of the structure. As an example, it was shared that the AHSC never discussed VCH's strategic, high level master plans for large hospitals, which represented important opportunities for AHSC to influence planning within large departments and hospitals over the long term.

*"[…] in some of the biggest departments, what they call the 'high level master plans'… look at what […] Vancouver Acute hospitals [do]…what does it look like in 2030 and 2035? …that needs [direction] from the AHSC. There should be forecasting and looking at future states and saying, 'where are the big huge chunks of work or big chunks of influence?' – **AHSC Participant***

[…] it's [the Regional Health and Wellness Plan] *straightforward and so useful. It gives us a snapshot of what the health priorities are of the nations in the region, and it […] gives us almost marching order[s]. It lets us know what to focus on and what to work on. We use it a lot."*
- **HA Operational Participant**

"The Regional Health and Wellness Plan that our First Nation communities built has really driven the operational flow of the dollars and resources, as well as new initiatives and models of service delivery"
- **HA Operational Participant**

Participants highlighted a few examples of effective integration and coordination, including:

- the Urban Indigenous Health strategy;
- Regional Health and Wellness Plan (RHWP);
- Joint planning sessions on the coordination of care and discharge planning; and
- Joint planning sessions within communities (for instance, to inform the development of JPB Projects).

The RHWP was described as a foundational document for guiding operational decisions related to resources and service delivery in the FNHA and informing the priorities of work within the VCH Aboriginal Health team. One VCH participant noted the potential for the entire organization to connect its work to the RHWP. Still, the extent to which the RHWP is known or applied more widely within VCH remains uncertain, and one participant observed that VCH had not yet adopted the RHWP. Conversations regarding discharge planning and the coordination of care have been preliminary in nature, and the Urban Indigenous Health Strategy has only recently been approved, and thus both examples are unlikely to have contributed to service delivery changes.

"I think sometimes there is a disconnect between Aboriginal health in VCH and what the communities want and what FNHA perhaps understood and what the operational directors understood. I think we're a bit out of step there."
- **AHSC Participant**

There is a perceived gap between the strategic conversations that are occurring between partners, and ongoing service challenges witnessed on the ground. Service gaps have been identified and there has been ample opportunity to discuss related issues. In addition, meaningful engagement with First Nations has occurred, which has helped to determine what changes are needed. Regardless, there is a perception that operational changes are taking too long to implement. Constraining factors include:
- the size of VCH;
- turnover of individuals involved in partnership work; and
- infrequent communication within the context of partnership WGs or other joint initiatives.

The extent to which priorities, vision and philosophy are aligned emerged as both a facilitator and constraint to the work being completed by partners, with partners making important progress in shared priority areas. In collaborative projects involving multiple communities, differing needs, expectations and geographic distances contributed to bottlenecks in services and other challenges.

Findings suggest there is limited integration of VCH operations into the work of the partnership, which may provide some insight into why the evaluation shows a perceived lack of operational

transformation. Working relationships have not developed with VCH operations management, possibly due to the small size of the FNHA regional team in comparison to VCH. Moving forward it may be beneficial for there to be greater participation of VCH operational leadership during partnership meetings / activities (e.g. Caucus and AHSC or Executive Committee meetings) to support their increased, awareness of, and sense of ownership and inclusion in partnership efforts.

Findings also suggest there are opportunities to build on planning conversations to improve coordination of care and discharge planning between communities and VCH at a service delivery level. Specific challenges described at a service delivery level include poor communication with patients regarding provider changes and the burden associated with changing providers. It was also noted that lack of community access to VCH medical records was an ongoing constraint to effective care coordination between communities and VCH. Instances of poor or inadequate discharge planning were also described. For example, one participant thought that some patients with schizophrenia and addictions were being discharged too early without their mental health needs being adequately addressed first. An increasing number of early discharges also represents a burden for some communities, which has not been alleviated by additional funds or supports.

Localized committees or WGs (such as Aboriginal Health Integration Committees) that involve community representatives / leaders and others (for instance HA managers and Division of Physician members), and that are community-specific and focus on specific issues / topics, are seen as possible solutions for strengthening coordination and increasing community influence in planning and decision making. Other suggestions for improving integration and coordination that were provided by evaluation participants include:

- A sub-regional committee on the Central Coast with representatives from HA, communities, and the FNHC (this previously existed but has since dissolved). This committee was perceived to support coordinated planning centred on community input. The composition of the group was considered an asset as it maintained visibility of issues and priorities of First Nations in the sub-region;
- A small WG comprising community and VCH clinical leads established to address a specific service delivery gap. The WG was perceived to have successfully gained clarity into health issues affecting the community, enabled the identification of solutions and the mobilization of HA resources to address these; and
- Localized health action committees, which have been convened around specific initiatives (e.g. GP4ME) and service improvement areas (e.g. primary care) within sub-regions in HA. The committees reported back to a larger table of HA and First Nations who were able to build solutions to emergent issues.

Differing priorities were perceived as a constraint to effective coordination and progress on joint initiatives. For, example, disagreement between the FNHA and VCH around priority topics on which to engage First Nations contributed to a lack of coordination between the partners and meaningful engagement on certain topics.

Suggestions related to improving coordination and integration of services and planning include:
- Aligning partnership discussions with monthly high level operational meetings within each VCH community of care (e.g. by including FNHA on the agenda), rather than EC meetings to reduce participant burden and improve integration of First Nations' priorities into ongoing VHC operational business and plans;
- Increasing opportunities for collaborative service planning with First Nations, with jointly defined agendas and opportunities for open dialogue;
- Sharing and enabling community access to VCH policies, procedures, training protocols and procedures;
- Improved coordination and communication with VCH (including between the transition team and community health centres) to support smoother transitions of care for Indigenous patients; and
- Clarification of responsibilities related to patients who discharge themselves early.

Resources

While financial and human resources have supported improvements in health services within the region, greater sustainability would help to support further improvements. Moving forward there are opportunities to simplify the funding process, identify alternative sources of funding, and increase and sustain human resource capacity.

Evaluation findings suggest there have been increased funding opportunities within the partnership. Participants noted increased funding within for cultural safety and traditional wellness initiatives, Joint Project Board projects and new programming efforts. A few community members identified new funding opportunities or noted that the HA partners had supported them in securing grant funding for their community.

"What would enable further improvements in cultural safety? Resources." - **AHSC Participant**

There is a perception of the importance of ensuring financially sustainable health programs, and that increased funding is required to address ongoing service gaps and enable service improvements within communities and HA. For example, a few communities described having to divert community funds to cover patient travel costs and the purchase of an emergency transport vehicle.

Views are mixed regarding transformation of funding processes and the ways in which resources are allocated. On the one hand, there is a perception that funding is now allocated to a greater extent based on the unique needs of communities and it was acknowledged that the FNHA has implemented more flexible arrangements within various contribution agreement formats. On the other hand, some perceive that funding and resource allocation processes remain fixed: communities are still expected to "jump through hoops" and funding continues to be proposal- and population-driven, rather than needs-based.

Competing demands and priorities constrain partners' capacity to participate in, and advance the work of, the partnership, including attendance at partnership WG and AHSC meetings. There is a perceived disparity between the size and capacity of VCH relative to the FNHA, with the latter being a smaller organization tasked with guiding partnership work and balancing partner priorities across all regional HAs (rather than one HA as is the case for VCH). Competing FNHA demands are a perceived constraint to advancing partnership work / priorities, and developing working relationship with operational departments within VCH to support and influence strategic operations. While some participants noted that the partnership has supported an increase in capacity and supports for communities, participants also noted communities often have fewer staff, are expected to fulfill various roles requiring greater demands on their time, which limits interest or ability to plan collaboratively with the HA and participate in WG meetings. Administrative burden is increasing among community leads in the absence of additional funding and human resources (e.g. associated with JPB project proposals; new financial reporting).

"[…] we've not had any supports put into the communities for the health directors […] I've had added responsibilities to my plate since we've had that organizational change here. And it is very much like juggling, it's affected my health"
- **Community leadership participant**

"It's the capacity building, it's the resources to actually effect change in the community"
- **Community leadership participant**

Building human resource capacity within community to deliver and improve health services emerged as an important evaluation theme. There is interest in mitigating workload burden and strengthening recruitment and retention processes and practices, especially in relation to administrative and non-clinical support staff, and home support workers, physicians, nurses and counsellors. The perceived benefits of increased human resource capacity within community include:

- reducing disparities in health services;
- addressing health service gaps;
- improving quality through community-designed/delivered service models;
- improving planning at the community level;
- increasing opportunities for communities to apply for more grant funding;
- reducing individual staff workload burden (and burnout);
- Supporting nurses' ability to focus on clinical work rather than administrative tasks; and
- Reducing reliance on patient / provider travel, which might in turn reduce other costs (such as those associated with the wear and tear on vehicles).

The evaluation shows that staff turnover is a constraint to effective partnership. Since the signing of the PA, there has been considerable turnover in leadership across all partnering organizations, which is seen as a constraint to strengthened relationships needed to advance PA work and to contribute to bottlenecks while newly employed staff are brought up to speed on projects. In some cases, new are deemed to be less knowledgeable in their role or of PA WG objectives. It was also noted that the partnership began with ceremony at the AHSC level, which was instrumental in setting the tone and spirit of the work, which newer members had not been exposed to. Changing health care practitioners in community was perceived to result in a lack of

coordination between doctors and nursing stations, to impact continuity of care for patients, and burden patients with re-establishing relationships with care providers.

Suggestions for improving funding, resources and community capacity include:

- Increased funding to support HA program and service improvements aligned with partnership work (e.g. expansion of VCH cultural safety training);
- Development of community training plans and ongoing training opportunities to support community capacity building;
- Sustained funding and supports that are adapted to community need rather than population-, grant-, or report- driven requirements;
- Continued HA efforts to address staff recruitment and retention within community;
- Funding non-clinical staff within communities, including support staff to fulfill coordinator , writer (e.g.to develop policies; procedures), planner, and health lead roles;
- Increased FNHA support on the ground, for instance by adjusting schedules to allow for work within community during the week;
- Commitment to raising awareness and promoting careers in health among Indigenous people, including the incorporation of such a commitment in the refreshed PA; and
- Improved transitions during staffing changes to support continued communication pathways VCH and FNHA

Monitoring Progress and Evaluation

At present there are data and information gaps related to Indigenous health outcomes in the region. Moving forward there is opportunity to identify specific indicators and baseline measures to assist with the review of progress over time.

The evaluation shows that there is value in the ongoing measurement of progress 'on the ground' to determine the effectiveness of health care initiatives. At present there is a lack of existing data to measure outcomes related to cultural safety and service access among First Nations and the effectiveness of new and existing initiatives. There is also a lack of "infrastructure" to collect and store relevant data to measure progress. There is also a need to identify specific success indicators / performance measures across all levels of the partnership, including the establishment of baseline data, and a data collection schedule to track progress over time. There is a perception that directly embedding success indicators and performance measures into the refreshed PA will allow for the determination of accountability to identified commitments. There is a sense that establishing success indicators and performance measures, will bring greater purpose and meaning to PA commitments. Moreover, as quality data have become available over time (for example, *My Health, My Community* data), new opportunities have emerged for monitoring progress.

Suggestions emerging from the evaluation for strengthening the tracking of progress over time include:

- Leveraging available data to measure wellness, program success and inform the development of community-based indicators;
- Improving data sharing between partners to enable better monitoring (e.g. through data sharing agreements);
- Utilizing joint planning sessions to inform the development of success indicators;
- Developing and embedding within the refreshed PA specific success indicators / performance measures across all levels of the partnership, including reference to baseline data and data collection schedule;
- Strengthening the documenting and tracking of challenges (e.g. prioritizing what issues to tackle first) to ensure they are being suitably addressed; and
- Strengthening community access to local-level First Nations data to support the general monitoring of progress at the local level (e.g. related to home and community care).

Cultural Safety & Humility

There have been increased and sustained efforts by partners to improve cultural safety. Findings show improved awareness of the importance of cultural safety, Indigenous culture and tradition and the First Nations perspective on wellness. Enhanced awareness is in part attributed to cultural safety training and other awareness building opportunities. Moving forward, there is an opportunity assess the degree to which initiatives are affecting experiences of care across the system.

VCH's CEO signed the declaration of cultural safety and humility on July 2015, which set a mandate for all health professionals to increase cultural safety and humility within their area of practice. This declaration was established within the broader provincial context as part of ongoing efforts to raise awareness on cultural safety and support reconciliation (for instance through FNHA's provincial awareness strategy; MoH's mandate letter directing VCH to continue to work through partnership tables, such as AHSC, to improve cultural safety).

There have been concerted ongoing efforts by the partners to enhance the cultural safety of services as grounded in a firm shared commitment by partners. While a few community leadership participants perceived improvements in cultural safety, cultural sensitivity and respect for cultural distinctiveness by service delivery staff, it was noted that there are no available outcome data exist to demonstrate the extent to which cultural safety improvements have been achieved, especially as directly informed by First Nations' experiences

Analysis of patient reported outcomes in the VC region, with an emphasis on measures related culturally safe care appear in Appendix 12.[8] Results suggest there are some areas of

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[8] Since 2003 the British Columbia Ministry of Health and the six Health Authorities implemented a program to measure the self-reported experience of patients in a range of healthcare sectors using Patient Reported Experience Measurement (PREMs) surveys and, more recently, Patient Reported Outcome Measures (PROMs) surveys. The surveys are conducted province wide and have been conducted in a number of health care sectors including Acute Inpatient hospitals, Emergency Departments, Outpatient Cancer Care services, Mental Health inpatients and Long-term care facility residents. All PREMs surveys have included a First Nations self-identifier variable.

convergence in terms of reported experiences of care between Indigenous and non-Indigenous patients, as well as room for improvement with respect to a few areas of Indigenous patients' experiences (e.g. to ensure patients feel their culture and traditions are respected). However, as these data represent a discrete measurement in space and time within the regional health system, and as significance testing was not performed, results do not confirm whether Indigenous patients' experiences in the region have changed. Future opportunities exist for exploring this data source to better understand how outcomes related to cultural safety may be changing across the region.

Findings suggest that cultural safety training is expanding within VCH and contributing to an increased awareness of the importance of cultural safety, including provincial San'yas training and the VCH-developed experiential cultural safety learning program implemented in 2016. Over 1200 VCH staff have participated in the latter program, including members of the VCH Senior Executive Team and lead Physicians. Participants shared that VCH has made cultural safety training a priority and that the VCH Aboriginal Health team has championed the development and expansion of this training to ensure ownership by and integration of cultural safety efforts among operational leadership and operational program and plans. It was noted that intensive efforts have been rolled out in different facilities across the region with the goal of ensuring every VCH employee receives cultural safety training.

There is a perception that training has contributed to new perspectives and ways of thinking among staff, including an enhanced awareness of the history and culture of First Nations and the ways in which these influence Indigenous clients' experiences of healthcare, and greater recognition of existing biases among care providers and the need for self-reflection and consideration of cultural safety and humility in the development of services. Participants described a number of practices, policies and supports for improving cultural safety within VCH, including:

- An Aboriginal Practices Guidelines mobile application for VCH clinicians that details cultural practices and protocols to be aware of when interacting with patients, including practices related to cutting hair, birthing and death;
- Improved visitation policies that no longer limit the number of visitors in the Intensive Care unit;
- Bedside and on-the-job support and learning for clinicians within facilities;
- Gradually increases in the hiring of Indigenous staff;
- Improved HR practices, including job descriptions that require cultural competency and the mandate that all employees read and understand cultural safety;
- Significant efforts to create more welcoming facilities for Indigenous clients, such as retrofitting facilities with Indigenous Art, totem poles, and culturally meaningful materials (e.g. cedar), and creating safe spaces for smudging; and
- Increased cultural events within facilities, such as drumming and ceremonies to initiative events, and territorial acknowledgements.

The beneficial role of Aboriginal Patient Navigators was cited by several participants, especially in supporting elders who may require advocacy at the hospital or support in submitting formal complaints about culturally unsafe experiences. However, some participants perceived that Aboriginal Patient Navigators are no longer providing services, or are providing different services than before.

Findings suggest that the VCH complaints system is underutilized by First Nations due to a perceived lack of navigability and responsiveness of the system. One community leadership participant shared that community members bring complaints to the First Nation's health department, as the VCH complaints system is difficult to utilize, which has resulted in an accumulation of unresolved complaints within the health department. However, several recent measures to improve VCH complaints processes were noted by evaluation participants, including:

- Improved acknowledgement, follow-up and tracking of complaints;
- Allowances for third-party reporting of complaints (e.g. by family members);
- Distribution of a leaflet to VC First Nations communities in 2018 outlining how to make a complaint;
- A commitment between the FNHA and VCH to inform each other of complaints brought forward by First Nations and notification of the Aboriginal Health team within VCH of complaints brought forward by Indigenous people;
- Perceived greater commitment and involvement of leadership in addressing complaints.

Evaluation participants from across participant groups noted that improving cultural safety is a continuous process with more work to be done. This included ensuring that cultural safety improvements are not limited to the partners at the table and reach the frontline, and that the partners transition from strategic planning and pilot-testing to implementation and expansion of initiatives. It was noted that short online training may cultivate initial awareness, but such training represents a preliminary step in the process of continuous learning that is required to improve cultural safety and humility. The persistence of ongoing racism and discrimination was acknowledged through the evaluation, as well as the time required for attitudinal shifts to occur. There is a perception that some facilities have been less successful than others in ensuring culturally safe spaces and that some Indigenous clients continue to feel unsafe entering certain facilities and that the services they are receiving are of inferior quality relative to those received by non-Indigenous clients. A few evaluation participants perceived a lack of culturally appropriate behaviour among VCH staff and racism toward community nurses. Moving forward there is an opportunity to fully implement the Cultural Responsiveness Strategic Framework, a PA deliverable which has been in the implementation stage over the past two years within VCH and that has not yet, for reasons unknown, received final endorsement from the FNHA.

It was suggested that cultural safety might be further enhanced by the following:

- Accelerating implementation of the current VCH-delivered training to reach a greater number of facilities and providers within the system, faster, including through additional resources dedicated to training;
- Expanding the scope of available training options to build on basic awareness. Specific suggestions included delivering more local, in-depth, experiential, and interactive training that is trauma-informed;
- Continuing relationship building and strengthening communication among the partners, especially between providers and communities at the frontline;
- Improving the complaints system to ensure it is accessible to First Nations who may wish to provide feedback on the services they have received;
- Ensuring complaints are tracked and monitored to ensure timely and appropriate resolution and to facilitate analysis of the scope of the issues that are arising (e.g. to determine if issues are system-wide or localized or identify service delivery areas that may require focused attention);
- Continuing to create more welcoming spaces in VCH facilities;

"And [the VCH cultural safety training is] *making good progress. I've seen the evaluations, and people are saying what they're learning is life changing. I think it's been very successful [...] they're just going to have to keep picking up all the new staff that come in year after year. It's just embedded in the organization now* **– HA Operational Participant**

"[The training] *really made a difference for a lot of the staff working with First Nations". -* **Community leadership participant**

"I think part of the education has to be ongoing [...] the Indigenous Cultural Safety that's sort of done in small groups over a couple of hours, it's very good and opens people's eyes [...] but a couple hours to cover a significant part of a culture's history is not enough for people to fully understand it and to put it in perspective.
- **HA Operational**

"[...] what we were finding is that the health authorities say there's a low volume of complaints, but from our end we would say there is a high volume of complaints from community, but they're just not using the health authority system for complaints because, from what has been shared by community, there's just no faith that it's going to be resolved in a good way or that they'll even get a response at all."
- **HA Operational**

- Creating a greater role for the FNHA to address complaints and identify an individual to be tasked with improving cultural safety at the regional level;
- Strengthening Aboriginal Patient Navigator roles and services and increasing investments in such roles and services;
- Increasing Indigenous staff representation and improving supports existing Indigenous staff; and
- Full endorsement and implementation of the Indigenous Cultural Responsiveness Strategic Framework.

Accessibility

While there is evidence to suggest greater availability of / access to health services since the signing of the PA, progress has been slow in addressing challenges affecting rural communities. Such challenges include a limited range of services relative to urban centres, limited emergency response services and transportation barriers.

Increasing availability of some services, particularly within primary care and mental health and wellness are viewed as a success of the PA. Participants in the evaluation provided the JPB mental health and wellness flagship project and primary care-focused projects as good illustrations of increased health services in the region including increased access to specific health professionals (e.g. family physicians; nurse practitioners; occupational and physiotherapists). Other areas of perceived service improvement in the form of access include telehealth, family and youth programming, and harm reduction / HIV education, and access to physicians.

"That's [the mental wellness flagship project] amazing and it's what people in the communities want. So I think that's successful improvement in access to health services for First Nation people where developing and rolling out what it is that they want and they need"
-AHSC Participant

"Some things are in [city name] and available on reserve but it's not clear which ones. How do we access it? What is the process to get the support and services that they have available?"
- ***Community leadership participant***

Other participants noted that overall accessibility needs to be enhanced, that community members are not receiving the services they need, and are turned away when trying to access certain services. There is an increasing need for services specific to growing elder populations within community (e.g. residential care; assisted living; and complex care). It was also noted that while there has been an increase in the availability of mental health services, people in Vancouver's downtown eastside are still "totally disconnected" from such services.

"I think from the perspective of urban care and needs, there [have] *been some positive changes. But when [it] comes to rural/remote, it's quite the opposite."*
- **AHSC Participant**

"So I do think we have continued challenges with our very remote communities in being able to access services and there is more work to be done there"
-AHSC Participant

Findings suggest that services are less accessible in rural areas within the region (e.g. the Coastal community of care). Some community leadership representatives perceived a disparity in the range of services, resources / infrastructure within facilities in their area. Specific service gaps in rural areas include:

- Homecare nurses;
- Case management;
- Fulltime physiotherapists and occupational therapists; and
- Services to support serious mental health issues.

An opportunity for increased use of telehealth to facilitate improved access was suggested; however it was noted that this is not an acceptable substitute for in-person care. Remoteness was also cited as a barrier generally to the implementation of new initiatives.

There is a need for continued efforts to support patient transportation. For example, one community had implemented a shuttle service to take patients to appointments in the city, which became overwhelmed and over time ceased to operate. As a result, community members are currently missing health appointments. Lack of access to, or timely responses from, emergency health care services was additionally noted, resulting in one community using its own funds to purchase an emergency service vehicle. There is also a sense among some participants that FNHA's patient travel program is not suitably addressing need. A few participants indicated that patient travel allowances are insufficient (e.g. only 2 trips are permitted per month for elderly patient transportation coverage) and inflexible. Another participant perceived that coverage is driven by FNHA travel policy rather than community's preferences, which results in unacceptable travel burden for community members (e.g. 5 days of travel for one appointment for an elder).

Challenges associated with bringing care providers into community were also noted, including difficult roads, poor weather that grounds flights and a perception that certain VCH safety policies prevent health care providers from traveling to community (e.g. on forest roads). Improved facilities in one community were perceived to partially mitigate such challenges by allowing health care providers to spend more time in community, facilitating the delivery of new services and allowing for a greater number of appointments to be scheduled and attended.

"I think we're way better at identifying the gaps and the needs. So that's really good work that I don't think would have happened without the accord". – **AHSC Participant**

"[…] just by doing the mapping, we found that people weren't even aware of services available to them. We could connect them with services" – **AHSC participant**

Service mapping to identify available services gaps within each community and the urban Indigenous population is considered an early partnership success. Service mapping connected some people to services they were unaware of and informed the partners' design of new primary care JPB projects. A few participants noted the need to reassess the

extent to which new initiatives have addressed the gaps. Community leadership participants identified the need to strengthen awareness of services available within community, including service delivery boundaries. One participant suggested that an inventory of locally available services might be beneficial for supporting an understanding of the disparities and informing service improvement advocacy efforts.

Several suggestions emerged through the evaluation for enabling further improvements in service access:

- Continuing to strengthen relationships and partnership, which lays the groundwork for supporting improved access (e.g. increased understanding of the needs of clients; identification of partnership opportunities, joint planning efforts and meetings); ,
- Engaging with communities at the beginning stages of planning services and throughout to ensure that community's geographic realities and other priorities are built into planning;
- Focusing partnership efforts and collaboration to improve availability and accessibility of services in rural areas (e.g. through telehealth, expanded community-based services);
- Identifying supports and solutions to improve patient travel to and from remote communities (e.g. a pilot study to assess the viability and effectiveness of a new shuttle service); and
- Strengthening accountability to improve the accessibility of services through new commitments in the refreshed Accord that outline how the partners intend to coordinate and address disparities in services.

"We still need to keep those discussions going about how we can improve access to those services because it's important. And when it's important for somebody, it's really, really important and we can't lose sight of that because it could mean somebody's life if we don't have it right"
- ***Community leadership participant***

First Nations Perspective on Health and Wellness

There are emerging opportunities for First Nations to inform how services are addressing the full scope of community wellness needs in alignment with the First Nations Perspective on Health and Wellness. Moving forward there are opportunities for further embedding the First Nations perspective on wellness into health services, including safe spaces and traditional protocols and medicines.

FNHA's conceptualization of First Nations Perspective on Health and Wellness presents a holistic vision of wellness that highlights the numerous factors that shape the wellness of individuals, including individual choices/agency; mental emotional, spiritual, and physical factors; foundational values of wellness (e.g. respect and relationships); social and physical location (e.g. land, community and family); as well as broader environmental, cultural, and socio-economic determinants.[9]

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[9] An explanation of the First Nations Perspective on Health and Wellness is available at: http://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/first-nations-perspective-on-wellness

Participants identified an increased awareness and commitment to consider and incorporate Indigenous perspectives into health services in the region so that they are more responsive to the needs of First Nations. Several participants cited Joint Project Board projects as an example of the efforts that are underway that have been shaped by community need and that utilize community designed models of service delivery. A new patient advisory process that includes Indigenous representation in one VCH facility was provided as another example of quality improvements in experiences of care.

There is a sense that new opportunities have emerged for communities to reconceptualise 'health' in ways that are more cognizant of the community context and a broader range of determinants. For example, excitement about the possibility of First Nations informing definitions of quality and improvements moving forward was expressed. One participant conveyed feeling empowered to embed traditional wellness into health planning for the first time and saw new opportunities for communities to determine what health means to them. Differences between conventional medical models and traditional wellness approaches were underscored among community leadership participants.

"We need to start working more preventatively and start bringing in more of our traditional wellness and whatnot. And we were doing our health planning, [...] it almost felt like we had permission; like we were allowed to do that for the first time."
*- **Community leadership participant***

For example, emphasis is perceived to be placed on the relational aspects of care provided by the community in contrast with a greater focus on monetary considerations perceived to be driving care decisions in the healthcare system. These divergent conceptions of quality were perceived as a barrier to effective care coordination with other providers. Wellness was also understood as integrated into many aspects of life, in which individuals are active contributors to their wellness rather than passive recipients of healthcare.

"[...] how big of an opportunity to be asked how we want to fully experience the health system, from a BC First Nations perspective. What does a good experience look like? [...] I hope that in my time as I transition to an elder, that I am able to see and experience some of that in a better way or at least hear stories of that reality in a better way"
- ***HA Operational participant***

"How would we do a case conference? [...] *because our system is community-based, heart- enriched, kind, caring - looking at [...]all of the circle of care for our client with a team that has no vested interest in our community."*
-Community leadership participant

Similarly, the evaluation revealed interest among individuals and communities to strengthen traditional wellness and healing approaches, in alignment with a broader community focus on Nation rebuilding and incorporation of culture into community programming. One participant noted that some communities may struggle to reintegrate traditional approaches into community service planning/delivery because they may be uncertain of the degree of change "allowed", community leaders may struggle to reach consensus around transformative changes when there is limited precedent.

Findings suggest partners are identifying opportunities to support the incorporation of traditional approaches into health service planning and delivery to ensure the First Nations perspective on health and wellness is suitably reflected in services. Examples identified through the document review include:

- Strategic capacity building initiatives to support improved wellness approaches across the region, including planning to support the development with a regional traditional wellness network (in collaboration with the Fraser Salish region);
- A new FNHA regional traditional wellness coordinator position;
- Funding for new traditional practitioners in FNHA and VCH primary care projects;
- Consideration of traditional and/or holistic wellness in the design or redesign of programs, particularly within mental health and substance use related services;
- Elders are being engaged at VCH activities and facilities to provide teachings, prayers, drumming/singing, openings and/or closings events and providing cultural support and teachings to Indigenous patients.

Participants also shared a number of suggestions to strengthen wellness approaches moving forward, including:

- Greater community presence of traditional healers;
- Formalized processes to compensate and acknowledge the role of traditional healers in communities;
- FNHA coverage of costs for traditional healers to provide services on healing and wellness days and to support a train-the-trainer program to increase capacity for traditional healing in communities;
- Ongoing consideration of traditional wellness in conversations around integrated primary care;

- Development of best or promising practices for communities and health organizations to move from colonized to decolonizes approaches, to identify changes that communities are "allowed" to make and support consensus among community leaders; and
- Increased incorporation Indigenous understanding of wellness and ways of being into services, including the design of facilities and patient flow was to support improved accessibility of services

Service Improvements may not be Attributable to the PA

Several participants commented that improvements to services, including cultural safety and accessibility cannot be directly attributed to the PA. Some participants credited improvements to the efforts of the communities themselves, local leadership and collaborative efforts between communities and HA staff. Other influential factors that were revealed through the evaluation include growing public awareness on Indigenous people, reconciliation and Ministry of Health mandate letters to Has that outlined commitments to work together to improve cultural safety and implement commitments of the UN Declaration on the Rights of Indigenous Peoples, and Calls to Action of the Truth and Reconciliation Commission. Acknowledgement was made through the evaluation of the language of the PA, which did not explicitly hold partners accountable to service improvement at the community level.

"I wouldn't attribute any of the changes directly to the PA, it's mostly done using the groundwork that we do here in the community and then basically inviting people to sit down and talk about services […]"
-Community Leadership Participant

Opportunities for Moving Forward with a Renewed PA

Participants shared considerations regarding the Accord renewal process. While the value of retaining broad overarching principles of the Accord was stressed, others new opportunities were raised for consideration. It was noted that further engagement with First Nations was needed to more fully inform the Accord. Additional suggestions pertaining to the content of a refreshed Accord include:

- Update content based on the results of current data (e.g. data regarding primary care);
- Enhance clarity overall around key objectives;
- More explicit commitment by partners to increase services within community;
- Greater emphasis on traditional wellness, primary care, mental health wellness, harm reduction, and elder care;
- Enhance clarity regarding the ways in which partners might organize themselves in relation to each other, including enhanced clarity concerning VCC to partner pathways;
- Include more explicit commitments that build on the content of the Urban Indigenous Health Strategy and the Regional Health and Wellness Plan;
- Specific commitments to refresh the Urban Indigenous Health Strategy and Regional Health and Wellness Plan;
- Identify areas of the health system for more targeted intervention to improve cultural safety (e.g. acute services);

- Consider developing Accords between individual First Nations and the HA each that is adapted to the unique needs of the community;
- Ensure that the PA takes into consideration the differing needs of community; and
- Consider the inclusion of new partners in the Accord (e.g. MOH, Providence Health)

Conclusion

The regional structure that has been established as a result of the PA represents a new framework and foundation for strategic decision-makers to come together in a more structured way. New opportunities to engage in dialogue with a shared focus were viewed as a key success of the partnership. However, infrequent meetings and a lack of strategic focus within both the WGs and the AHSC have constrained partners' ability to advance partnership work and operationalize changes; there is an opportunity to reconsider the composition of the groups in order to facilitate meetings moving forward. AHSC members shared there is a palpable sense of shared commitment at the table. There is an opportunity for the partners to reaffirm this dedication by reprioritizing partnership meetings moving forward. Moreover, awareness regarding the contributions the partners make within the broader health system has increased, but there is a need to clarify roles and responsibilities.

New working relationships have been forged as a result of the partnership. The partners underscored the intentionality of the relationship, characterized by deliberate efforts among the partners to build relationships and reflected in a sense of increased trust and respect. Still, some participants were unsure how this relationship or partnership was embodied within their community, and identified and ongoing need to strengthen relationships 'on the ground'.

Participants reported that open, meaningful and candid conversations are occurring and there are improved opportunities for the partners to meet together and engage in dialogue. Greater awareness of counterparts and point contacts, and open lines of communication have facilitated communication. Still, some participants were uncertain who to contact within the HA with respect to certain issues, which was compounded by a lack of clarity around roles and responsibilities. Moving forward, there is an opportunity to clarify and enhance awareness of communication pathways, to ensure more timely responses, and to demonstrate the partners' commitment to work together supportively and constructively in all communication.

There is a growing awareness of the need to engage First Nations in the design of programs and services and an evolving understanding of better approaches to do so. Participants shared several examples of initiatives that underwent and were shaped by significant engagement. Formalized engagement processes, such as regional and sub-regional caucus were perceived as effective in supporting an exchange of information between communities and with the HA, and for reporting back on AHSC activities and validating approaches. Opportunities to strengthen engagement included ensuring consistency in engagement across sub-regions/ communities of care, reducing duplication of engagement, and enhancing opportunities for community visits.

Shared decision-making appears to be occurring with respect to some issues. Participants shared examples of increased influence in the design of partnership projects and stressed the importance of ensuring initiatives are guided by community input. Still, moving forward it may be beneficial to further clarify which decisions should be shared between the partners. There is also a desire to increase opportunities for First Nations to inform resource allocation and funding decisions, and influence within the health system more generally.

Overall there is a sense among participants that, while conversations are occurring between the partners, these are not translating into operational changes as quickly as they might be. Some participants feel that partnership deliverables perceived to be mechanisms to support changes (e.g. RHWP; Urban Indigenous Health plan) have not been in place long enough in order to transform outcomes, or that AHSC did not meet regularly enough in order to drive service transformation. There is also a perception that partnership work and objectives have not yet been integrated into VCH operational planning to the extent they might be, which may be accounted for by a limited awareness of the partnership among VCH operational managers. Competing demands on time, priorities, and resources among all partners were perceived to frustrate progress generally. Moving forward, there are opportunities to promote equal participation within partnership activities with a view to support improved coordination and transformation.

The partners are engaged in sustained efforts to improve cultural safety, which have been underpinned by a strong leadership commitment and broader impetus for change within the health system. Participants perceived a growing shift in awareness regarding the history and culture of Indigenous people, the importance of cultural safety, and of individual biases. Participants identified several important initiatives, including VCH-developed cultural safety training, which is steadily being rolled out within HA facilities, the creation of more welcoming facilities, the role of Aboriginal Patient navigators, and improved policies and practices. Additionally, while the VCH complaints system has been underutilized in the past by Indigenous people, it has undergone several recent improvements.

Similarly, the partners are taking measures to improve the accessibility of services, including through the development of new primary care and mental wellness services. An enhanced awareness of service delivery gaps was also noted. Still, continued efforts are needed to ensure that residents in rural and remote areas have access to the same range and level of care as their urban counterparts; that patient transportation needs are met; and that communities are more aware of services available.
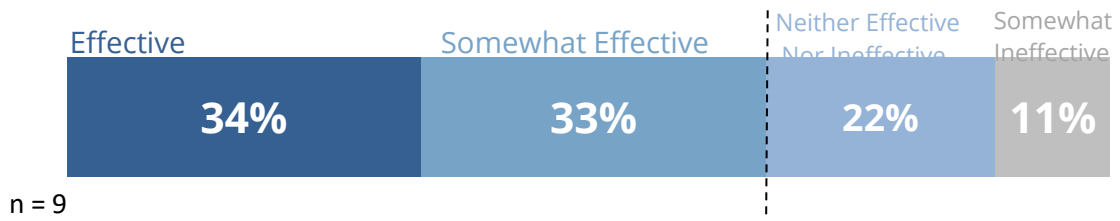
New opportunities to promote wellness and define quality are emerging. Participants identified new opportunities to integrate traditional wellness into their community planning and service roster. Coordination of care and discharge planning were identified as areas for future consideration in order to ensure optimal experiences of care for Indigenous people in the region. In addition, the importance of expanding supports for traditional wellness approaches and practitioners was stressed.

While the partners have implemented new interventions to improve accessibility and cultural safety of services, there are insufficient data at this time to determine if and how these changes are affecting Indigenous people's experiences of care. In the future, there is an opportunity to address data and information gaps to enable more effective measurement of outcomes and progress.
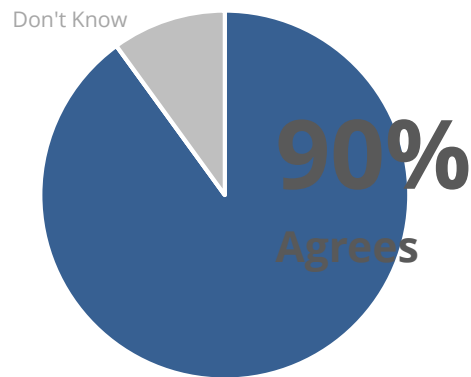
Appendix 1
Figure 1: How effective is the current structure?

Effective	Somewhat Effective	Neither Effective Nor Ineffective	Somewhat Ineffective
34%	**33%**	**22%**	**11%**

n = 9

Figure 2: Are the working groups addressing the *right* priorities?

90% of the primary key informants stated that the working groups are addressing the right priorities.

Don't Know

90%
Agrees

n = 10

Figure 3: How would you rate your understanding of the aims of the Vancouver Coastal Partnership Accord?

About **half** of community leadership participants rated their understanding of the aims of the PA as 'good' or better, while **35%** rated is fair or lower

7% (n=2.5)   28% (n=9.5)   35% (n=12)   15% (n=5)   3% (n=1)   12% (n=4)

Poor   Fair   Good   Very Good   Excellent   No response
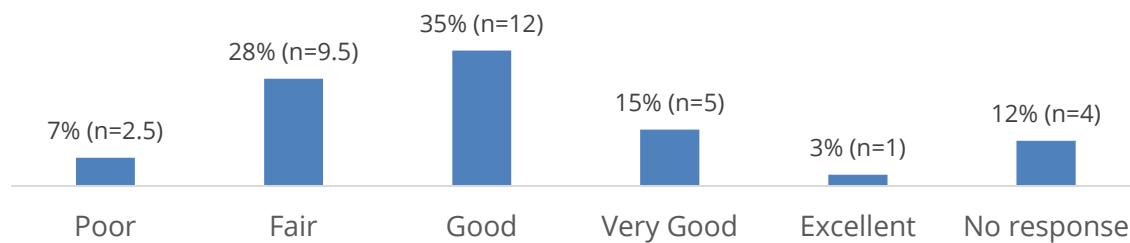
Appendix 2
Figure 3: AHSC members self-rated understanding of roles and responsibilities

Is there a clear understanding of the roles and responsibilities of the partners as outlined in the PA ToR?
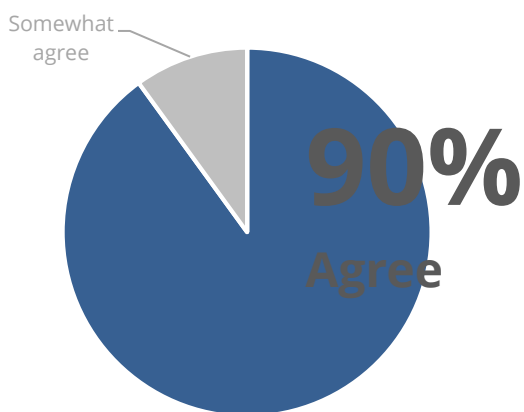
Clear Understanding

Neither Unclear Nor Clear Understnading

Unclear Understanding

| 40% | 30% | 20% | 10% |
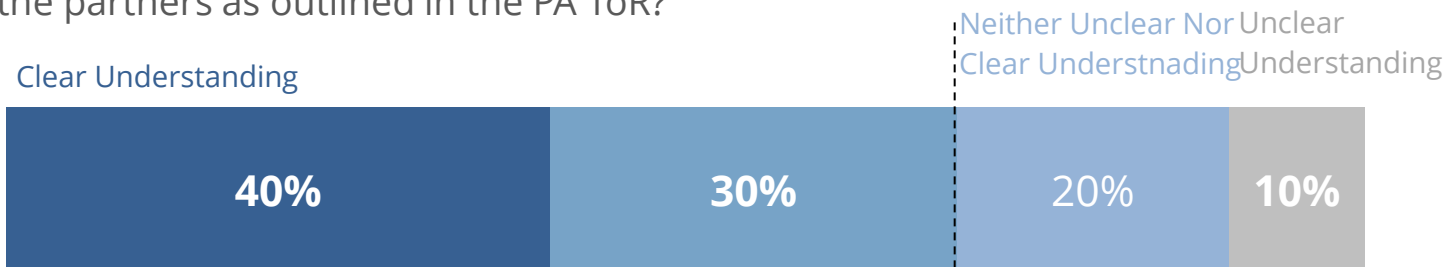
n = 10

Appendix 3
Figure 4: Have relationships between the partners involved been strengthened?

90% of the AHSC key informants stated that the relationships between the partners invovled been strengthened.

Somewhat agree

90%
Agree

n = 10

Figure 5: As a result of this partnership   a) Relationships between my Nation and Vancouver Coastal Health have been strengthened (e.g. with local VCH service administrators or health services staff in my area)
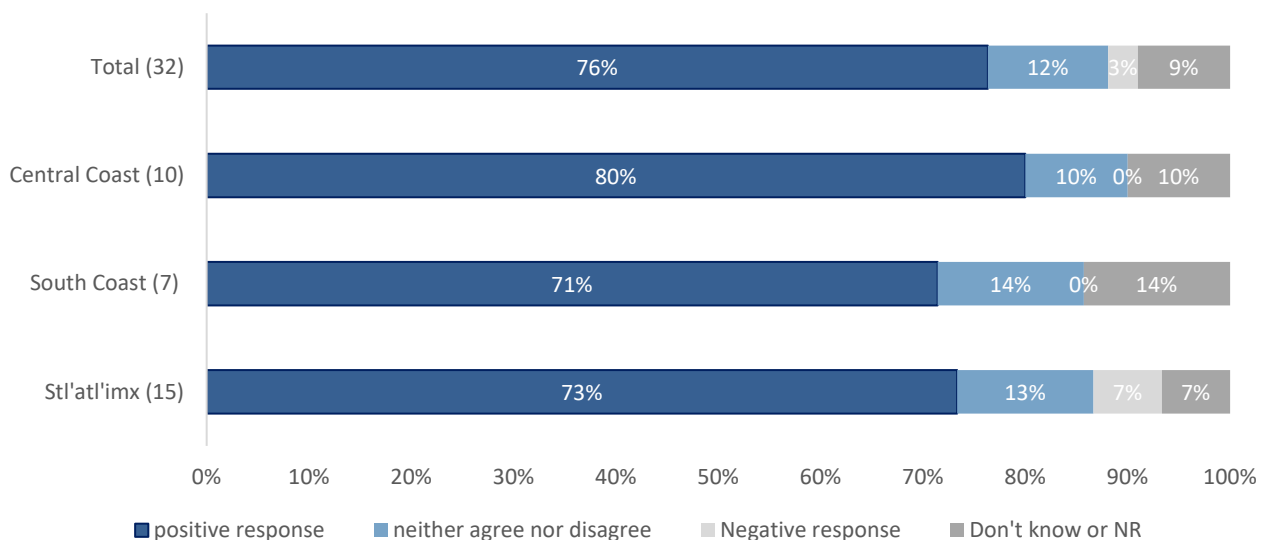

Q4a) Relationships between my Nation and Vancouver Coastal Health have been strengthened
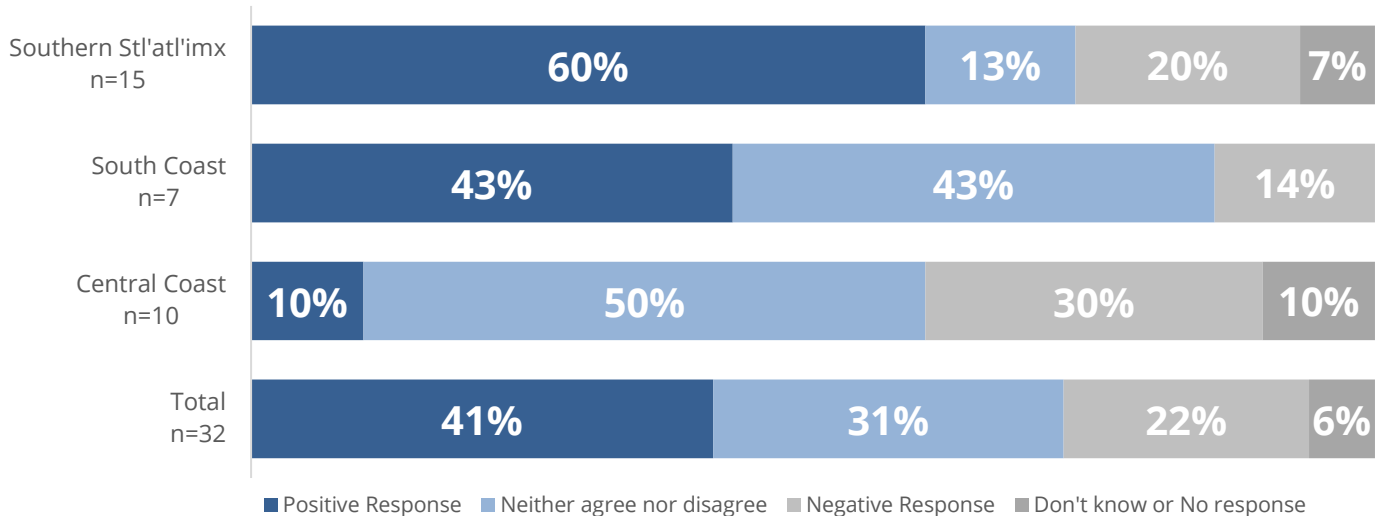
n = 32 participants indicating sub-region

Figure 6: As a result of this partnership   a) Relationships between my Nation and FNHA have been strengthened

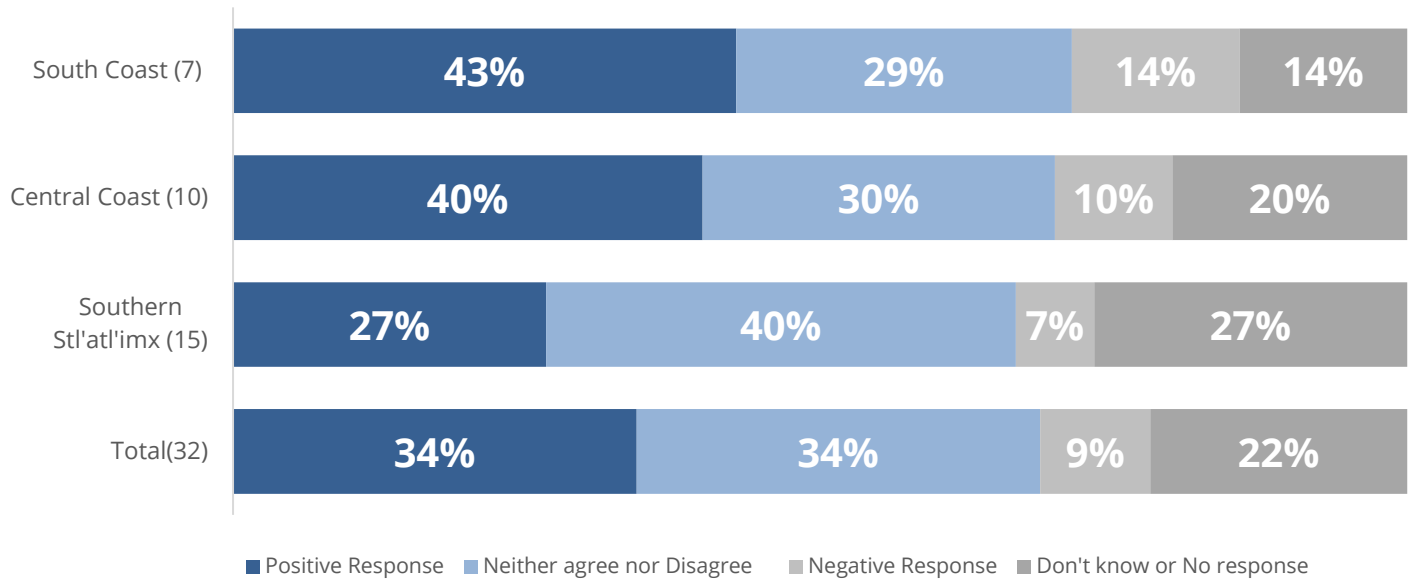Relationships between my Nation and the FNHA have been stregthened

n = 32 participants indicating sub-region

Appendix 4
Figure 7: Q4c) Partnership opportunities with Vancouver Coastal Health have increased (e.g. JPB projects, funding and individual services and related agreements)

Partnership opportunities with Vancouver Coastal Health have increased

	Positive Response	Neither agree nor Disagree	Negative Response	Don't know or No response
South Coast (7)	43%	29%	14%	14%
Central Coast (10)	40%	30%	10%	20%
Southern Stl'atl'imx (15)	27%	40%	7%	27%
Total(32)	34%	34%	9%	22%

■ Positive Response ■ Neither agree nor Disagree ■ Negative Response ■ Don't know or No response

n = 32 participants indicating sub-region

Appendix 5
**Figure 8**: How successful has the PA been at improving communication between partners?

Figure 8: The majority of AHSC members feel the partnership has been at least somewhat succesful in improving communication

40%
Think it has been successful...

20% Feeling Neutral

40%
Think it has been somewhat successful
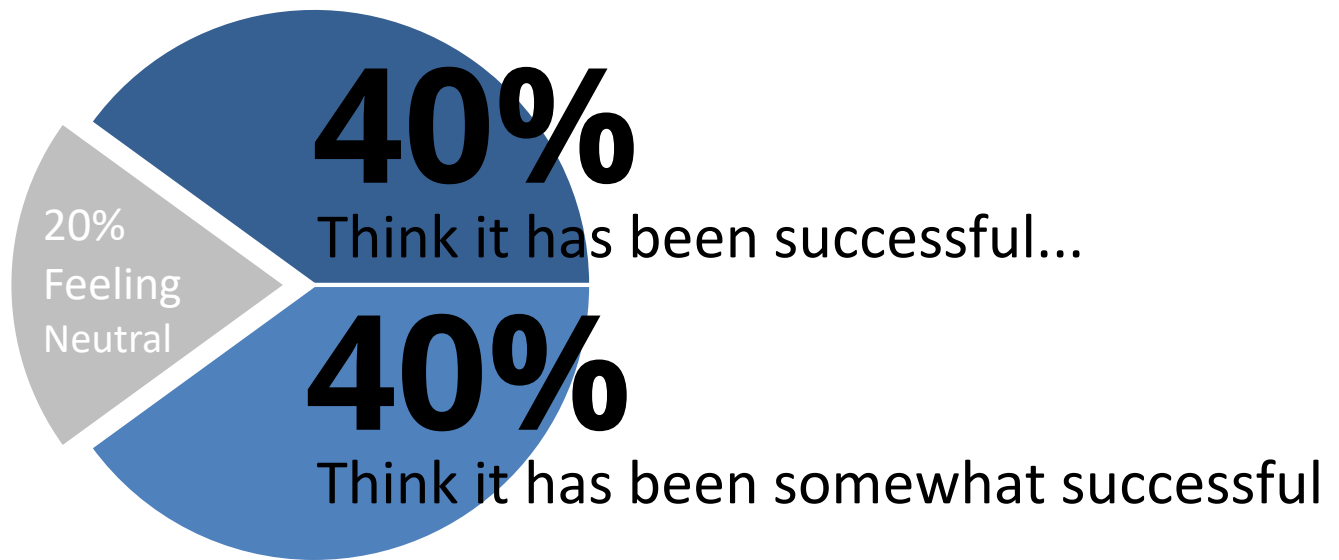
n = 10 AHSC members

Figure 9: How successful do health authority partners think the PA has been at improving their communication with Vancouver Coastal First Nations?
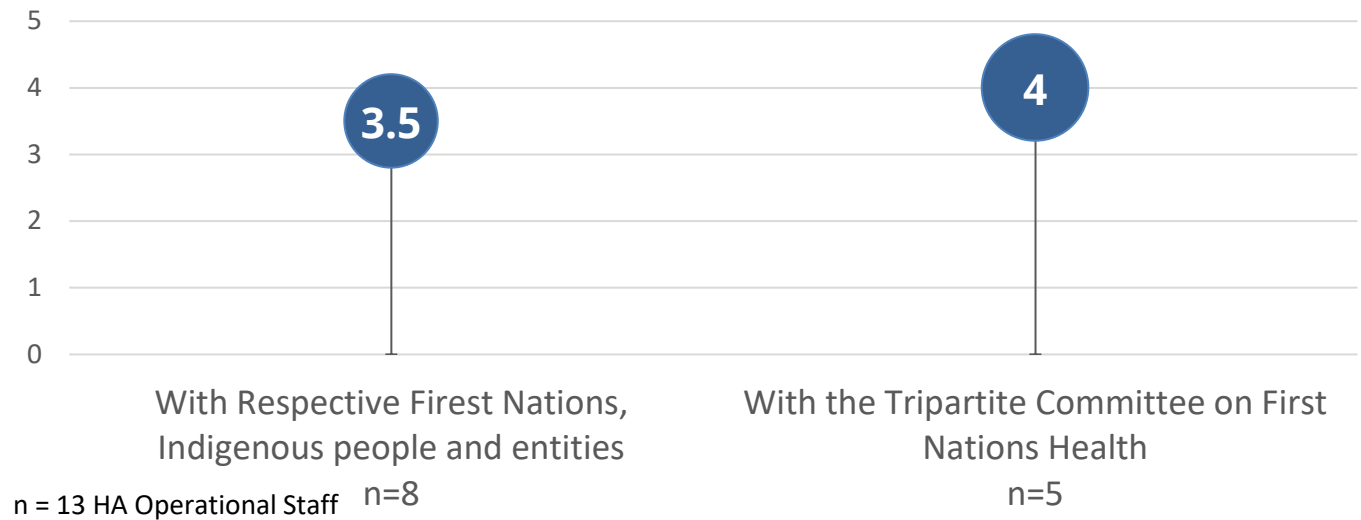
Figure 7: How successful do health authority partners think the PA has been at improving their communication with Vancouver Coastal First Nations(out of 5)?

4.2

3.3

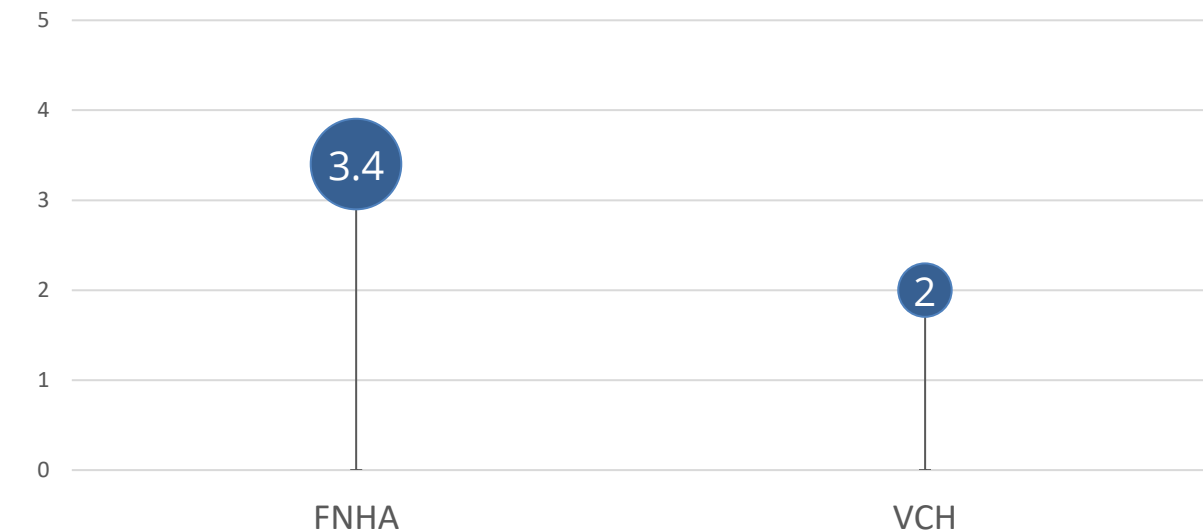FNHA

VCH
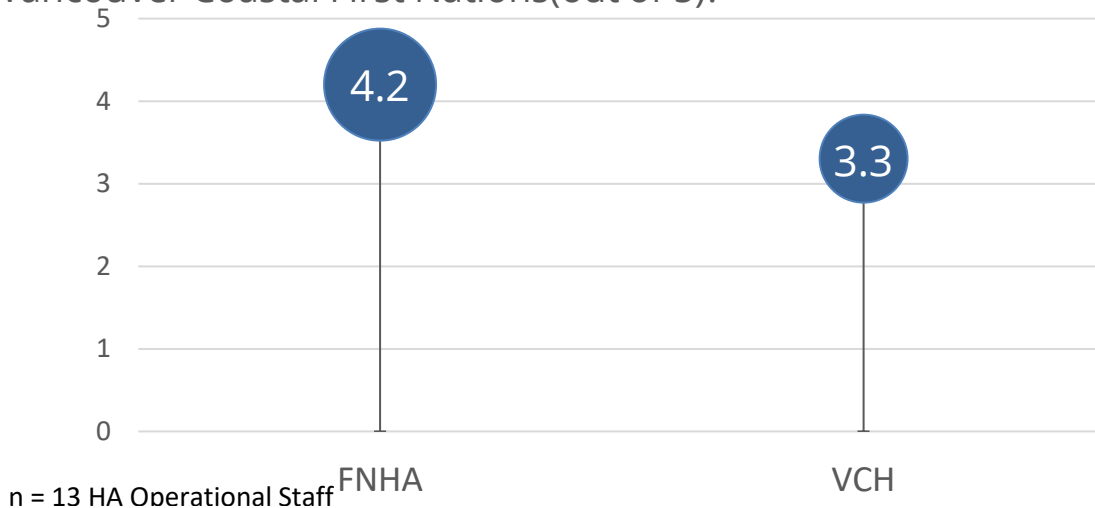
n = 13 HA Operational Staff

Figure 9: To what extent has the Aboriginal Health Steering Committee been successful in facilitating communication and reporting?

Figure 9: To what extent has the Aboriginal Health Steering Committee been successful in facilitating communication and reporting?

With Respective First Nations, Indigenous people and entities
n=8

With the Tripartite Committee on First Nations Health
n=5

n = 13 HA Operational Staff

Figure 10: How successful has the PA been at improving communication between VCH and FNHA?
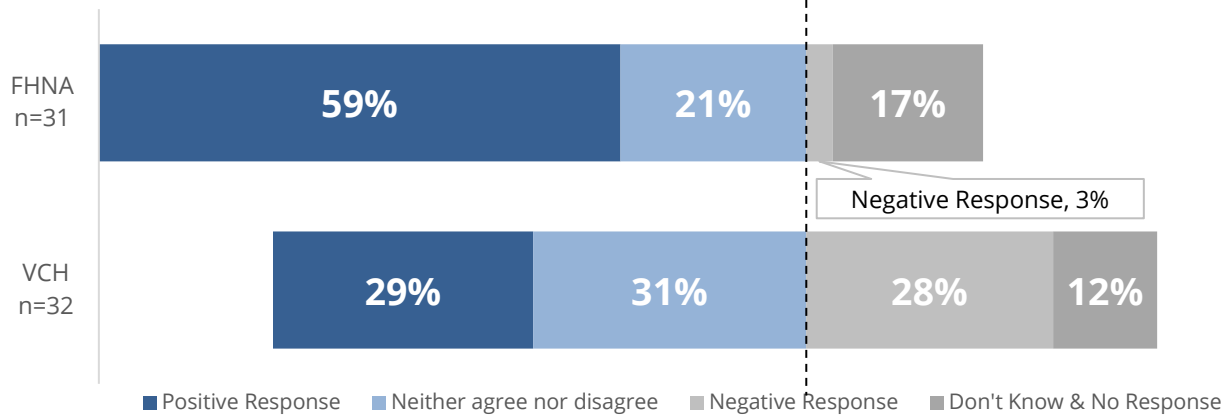
Figure 10: HA operational staff views regarding improved communication between HA partners differed by HA (out of 5)
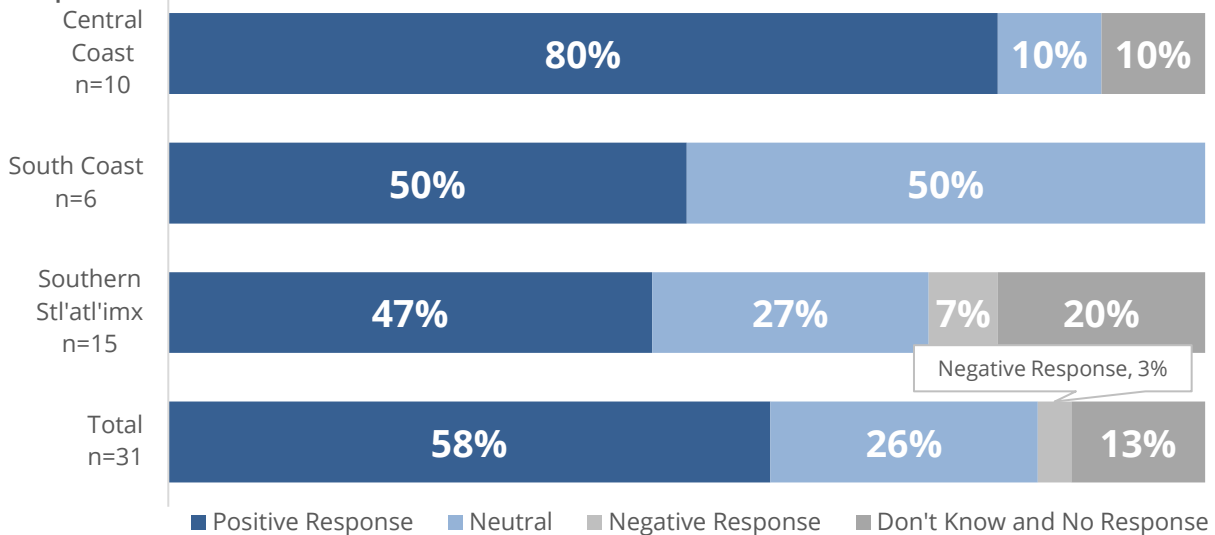

FNHA

VCH

n = 13 HA operational staff

Figure 11: Community leadership' reported agreement that communication with FNHA and VCH has improved

As a result of this partnership f&g) Communication between my Nation and Vancouver Coastal Health/FNHA has improved

FHNA n=31	59%	21%	17%
VCH n=32	29%	31%	28%	12%

Negative Response, 3%

■ Positive Response ■ Neither agree nor disagree ■ Negative Response ■ Don't Know & No Response

Figure 12: Community leadership's reported agreement that communication with FNHA has improved, by sub-region

Communication between my Nation and FNHA has improved

Central Coast n=10	80%	10%	10%
South Coast n=6	50%	50%	
Southern Stl'atl'imx n=15	47%	27%	7%	20%
Total n=31	58%	26%	13%

Negative Response, 3%

■ Positive Response ■ Neutral ■ Negative Response ■ Don't Know and No Response

n = 32 participants indicating sub-region

Figure 13: Community leadership's reported agreement that communication with VCH has improved, by sub-region

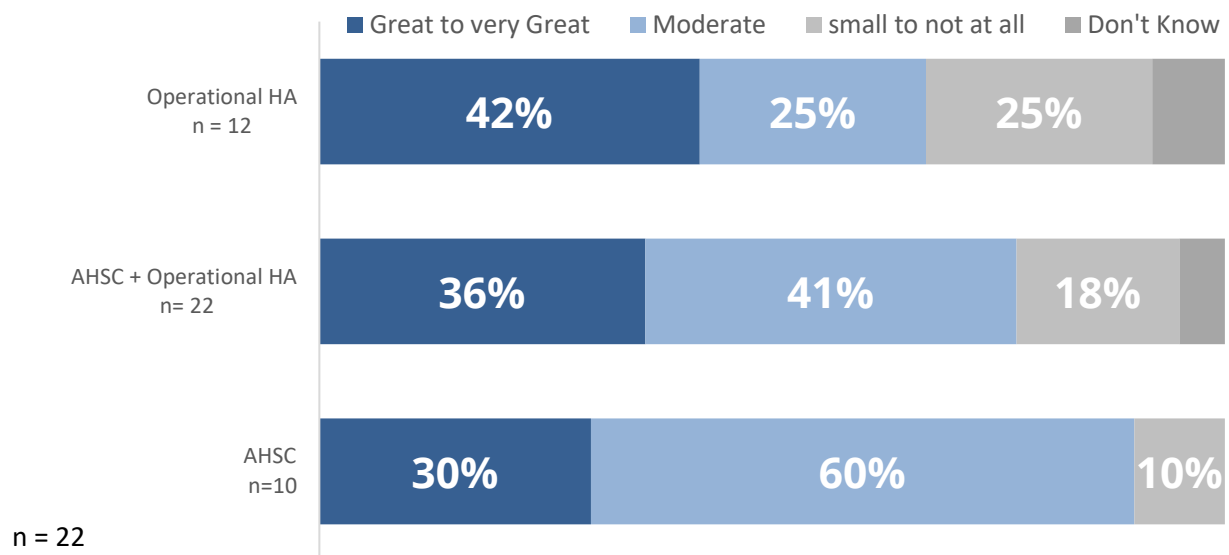## Q4 f) Communication between my Nation and Vancouver Coastal Health has improved

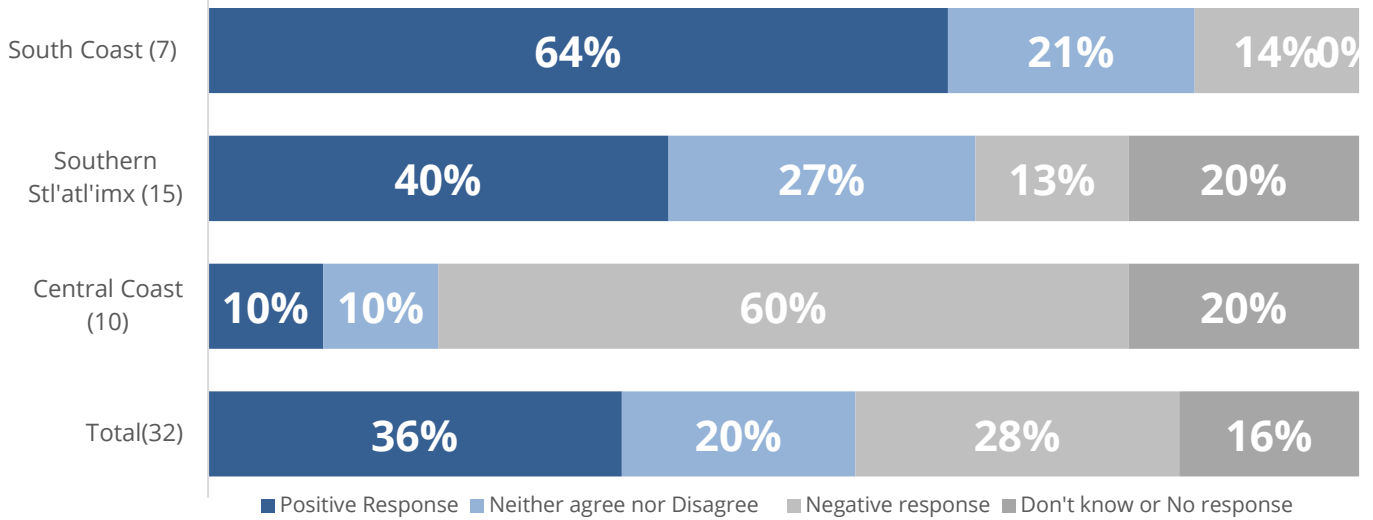|	Positive Response	Neutral	Negative Response	Don't Know and No Response
Southern Stl'atl'imx n=15	40%	40%	13%	7%
South Coast n=7	29%	21%	36%	14%
Central Coast n=10	10%	30%	40%	20%
Total n=32	28%	33%	27%	13%
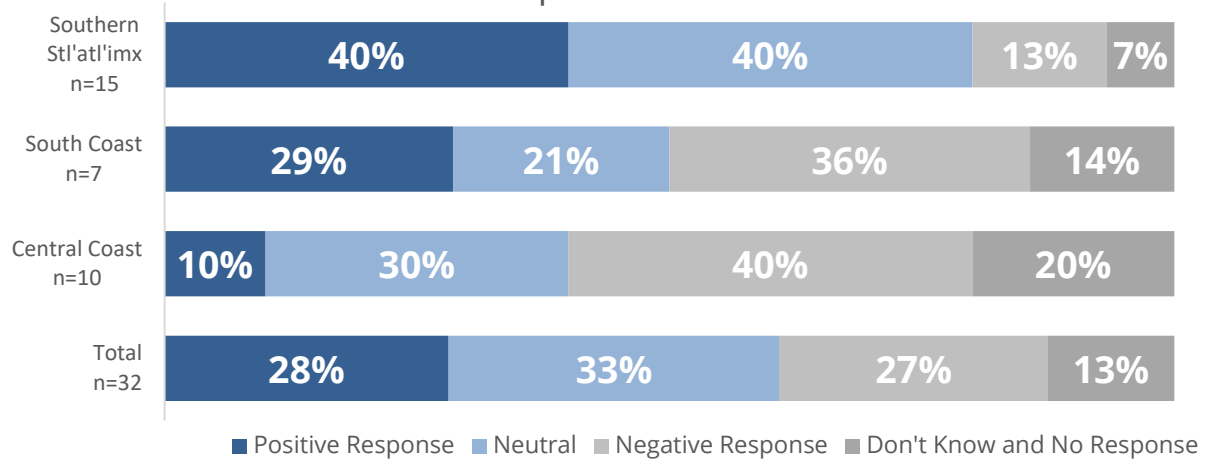
n = 32 participants indicating sub-region

Appendix 6
Figure 14: To what extent has the Partnership Accord contributed to improved engagement of First Nations?

Figure 10: To what extent has the Partnership Accord contributed to improved engagement of First Nations?

	Great to very Great	Moderate	small to not at all	Don't Know
Operational HA n = 12	42%	25%	25%	
AHSC + Operational HA n= 22	36%	41%	18%	
AHSC n=10	30%	60%	10%	

n = 22

Figure 15: Q4i) Meaningful engagement between my Nation and Vancouver Coastal Health has improved (e.g. engagement by VCH service administrators in my area or other VCH staff)
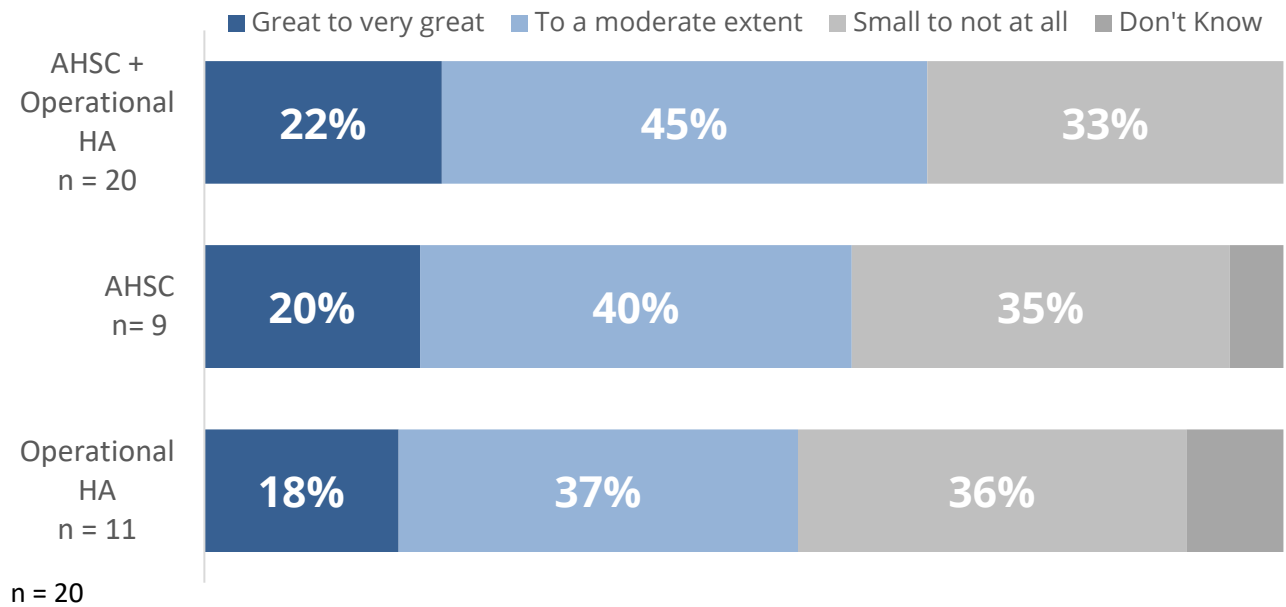
Q4 i) Meaningful engagement between my Nation and Vancouver Coastal Health has improved

	Positive Response	Neither agree nor Disagree	Negative response	Don't know or No response
South Coast (7)	64%	21%	14%	0%
Southern Stl'atl'imx (15)	40%	27%	13%	20%
Central Coast (10)	10%	10%	60%	20%
Total(32)	36%	20%	28%	16%

n = 32 participants indicating sub-region

Figure 16: Has engagement been meaningful, resulting in changes or action?

Figure 16: Has engagement been meaningful, resulting in changes or action?


	Great to very great	To a moderate extent	Small to not at all	Don't Know
AHSC + Operational HA n = 20	22%	45%	33%	
AHSC n= 9	20%	40%	35%	
Operational HA n = 11	18%	37%	36%	

n = 20

Appendix 7

Figure 17: How often is there shared decision-making among the partners with respect to the development and delivery of services?

Always	Often	Sometimes	Rarely	Don't Know
10%	20%	40%	20%	10%
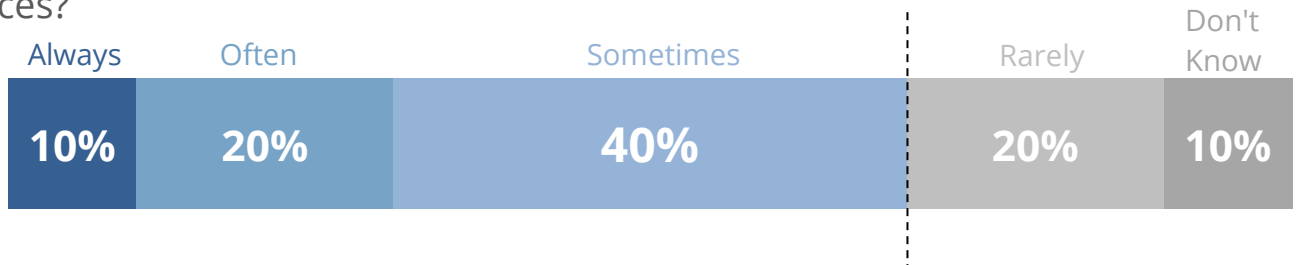
n = 10 AHSC Participants

Figure 18: 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?

To a very great Extent	To a greate extent	To a moderate extent	To a small extent
25%	25%	33%	17%
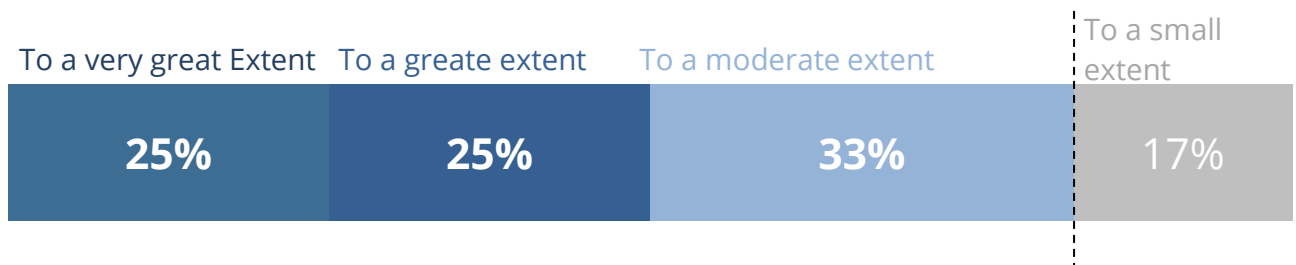
n = 13 Secondary HA participants

Figure 19: To what extent did FNHA and VCH partner with First Nations/Indigenous people to fulfill the commitments?

Figure 19: To what extent did FNHA and VCH partner with First Nations/Indigenous people to fulfill the commitments?

Category	Very great to great	To a moderate extent	Small to not at all	Don't Know
Operational HA n = 12	33%	42%	17%	8%
AHSC + Operational HA n = 22	27%	50%	18%	5%
AHSC n= 10	20%	60%	20%	

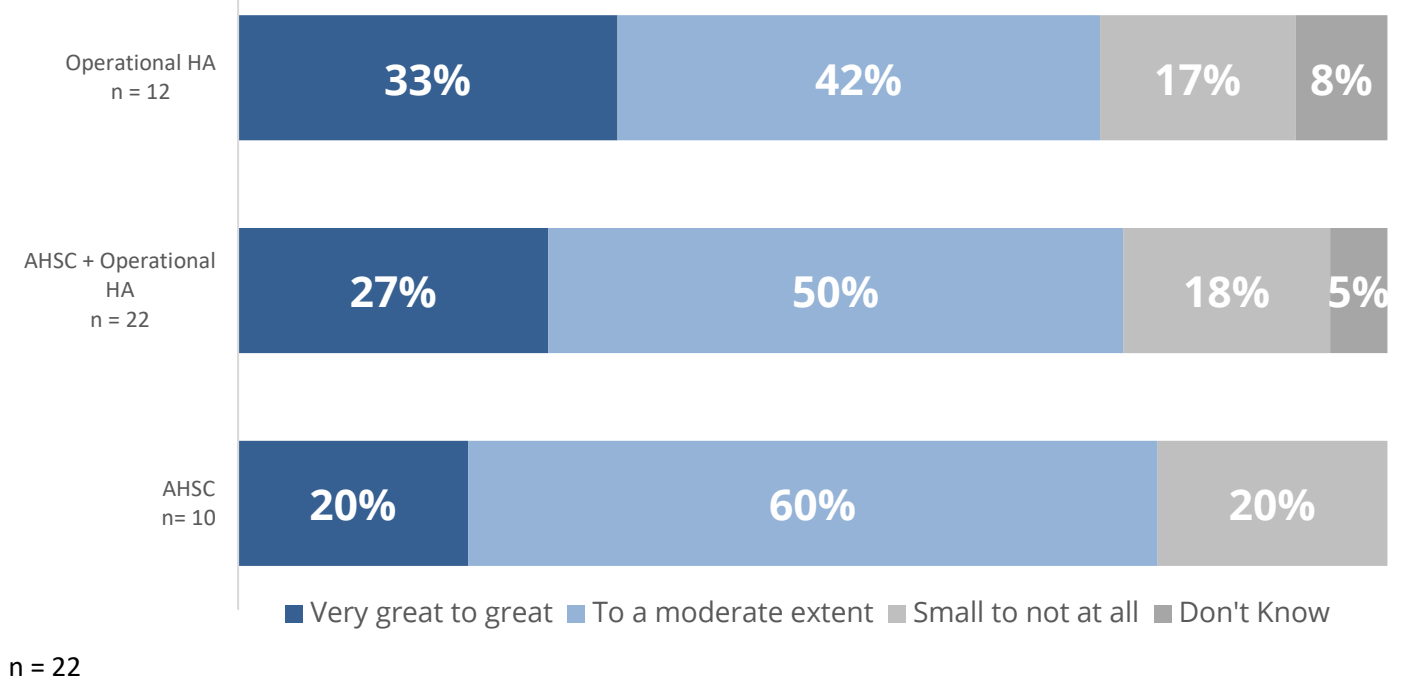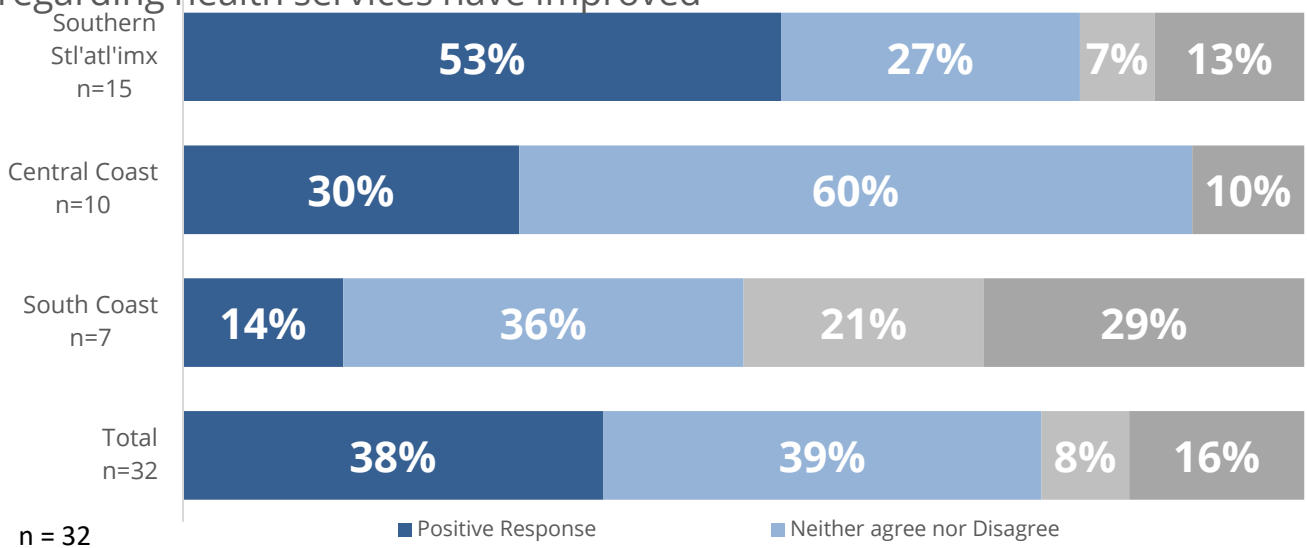■ Very great to great ■ To a moderate extent ■ Small to not at all ■ Don't Know

n = 22

Figure 20: Processes to support decision-making by First Nations regarding health services have improved

Q4 h) Processes to support decision-making by First Nations regarding health services have improved

Category	Positive Response	Neither agree nor Disagree		
Southern Stl'atl'imx n=15	53%	27%	7%	13%
Central Coast n=10	30%	60%		10%
South Coast n=7	14%	36%	21%	29%
Total n=32	38%	39%	8%	16%

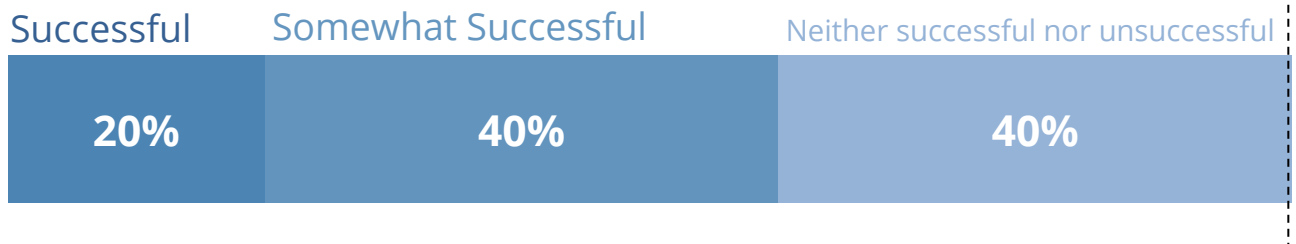■ Positive Response ■ Neither agree nor Disagree

n = 32

Appendix 8

Figure 21: To what extent has the AHSC been successful in strengthening coordination and integration of planning efforts and services?
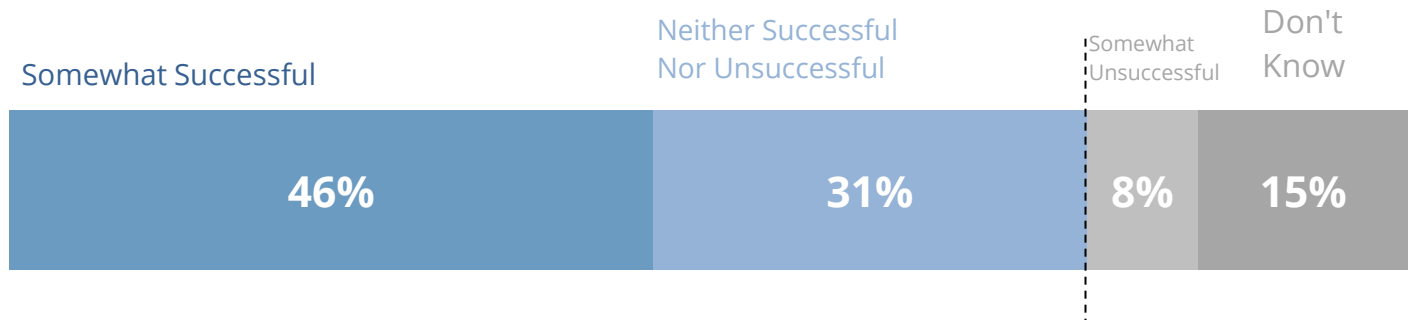
Successful	Somewhat Successful	Neither successful nor unsuccessful
20%	40%	40%

n = 10 AHSC participants

Figure 22: To what extent has the partnership been successful in strengthening coordination and integration of planning efforts and services?

| Somewhat Successful	Neither Successful Nor Unsuccessful	Somewhat Unsuccessful	Don't Know
46%	31%	8%	15%

n = 13 HA operational participants

Appendix 9
Figure 23: How successful has the PA been at improving the cultural safety and humility of health care programs and services?
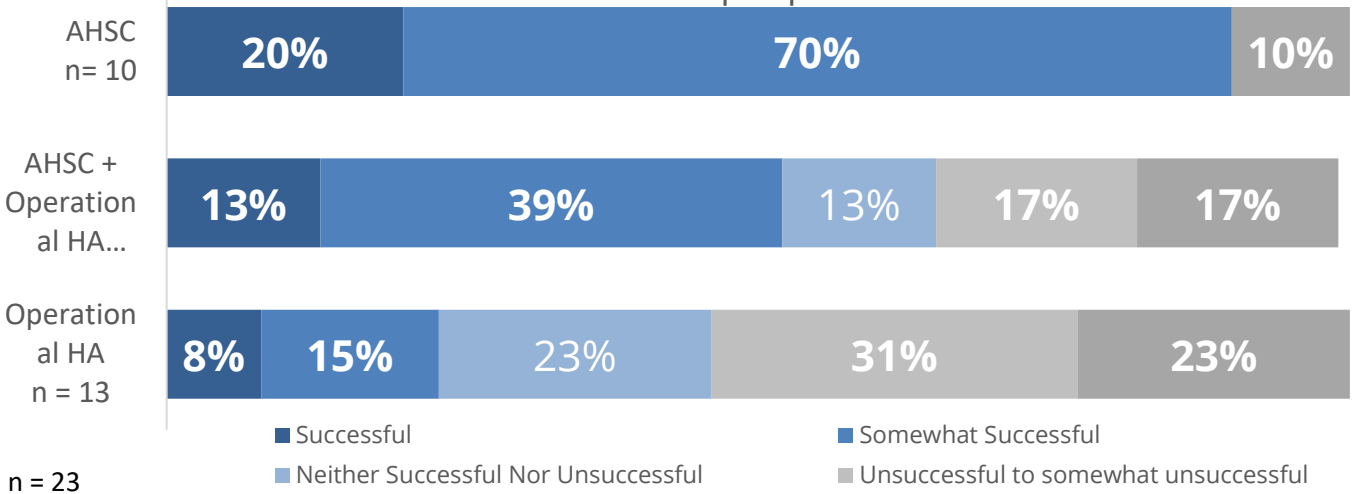
Figure 24: How successful has the PA been at improving the cultural safety and humility of health care programs and services?

	Successful	Somewhat Successful
■ Neither Successful Nor Unsuccessful		■ Negative response
■ Don't Know		

n = 21
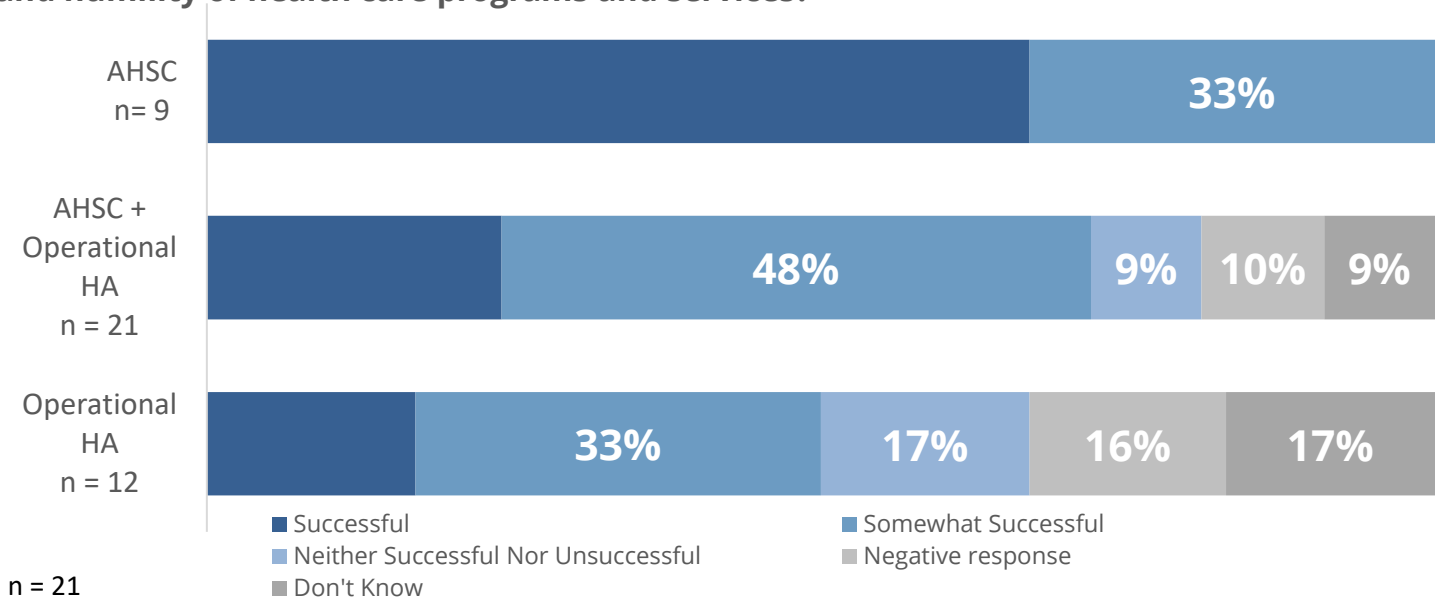
Appendix 10

Figure 24: How successful has the PA been in improving access to health services for First Nations people?

Figure 24: How successful has the PA been in improving access to health services for First Nations people?

■ Successful	■ Somewhat Successful
■ Neither Successful Nor Unsuccessful	■ Unsuccessful to somewhat unsuccessful

n = 23

Appendix 11

Figure 25: How successful has the PA been in creating more responsive regional health care services, programs and policies based on identified health priorities and needs?

Figure 25: How successful has the PA been in creating more responsive regional health care services, programs and policies based on identified health priorities and needs?

n = 23