

# JPB Projects 2017/18 Provincial Analysis Report

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## EXECUTIVE SUMMARY

### Background

The Joint Project Board (JPB) was established in 2012 and is a senior bilateral forum between the Assistant Deputy Ministers of the BC Ministry of Health, and the First Nation Health Authority's (FNHA) Chief Operating Officer and its Vice Presidents.

A total of 27 JPB projects have been approved, with 26 spread across the five regions, and one project that is provincial in scope implemented by the Provincial Health Services Authority. Each of the projects are different in scope and complexity; they are based on the realities and interests within each region, on different care models and are at different stages of development and implementation.

The JPB projects evaluation approach has evolved over time. The evaluation approach has been adapted to balance high-level data collection from all JPB projects to gauge overall trends, successes and lessons learned, while enabling a comprehensive evaluation of a subset of projects. A JPB Projects Evaluation Framework document describes how the JPB annual report and additional prototype evaluations will feed into the overall JPB evaluation.

### Methods

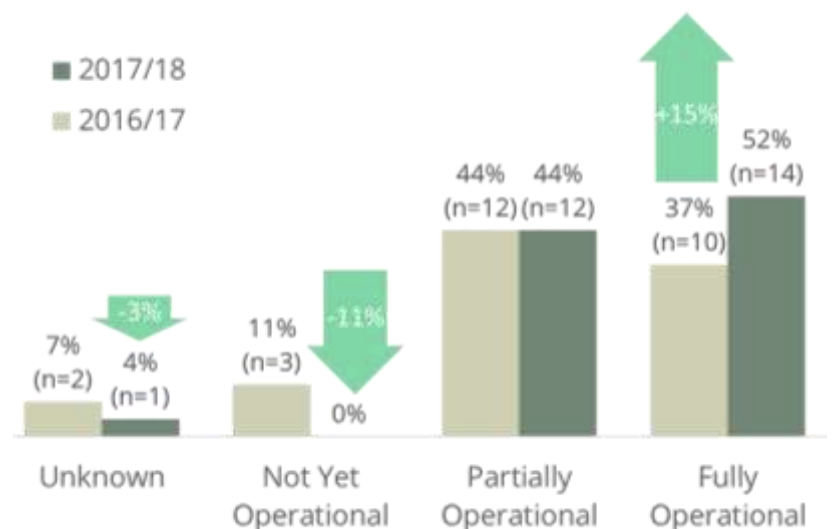
JPB project annual narrative report templates were the main information source for this report, with some supplementary information gathered from funding arrangements documentation, tracking and summary reports. Overall, narrative report submissions have increased: two additional projects submitted reports in 2017/18 compared to 2016/17. At the time of analysis, annual narrative reports had been received from a total of 24 out of 27 projects. Reports were missing for more than half of the Vancouver Coastal projects; and so, values presented for Vancouver Coastal Region in this report should not be taken as representative of all projects in the region. Additionally, for some projects, separate reports are submitted for project sub-components based on different implementation sites or funding recipients. Four projects were missing reporting for one or more project sub-components.

## PROJECT IMPLEMENTATION

### Implementation progress

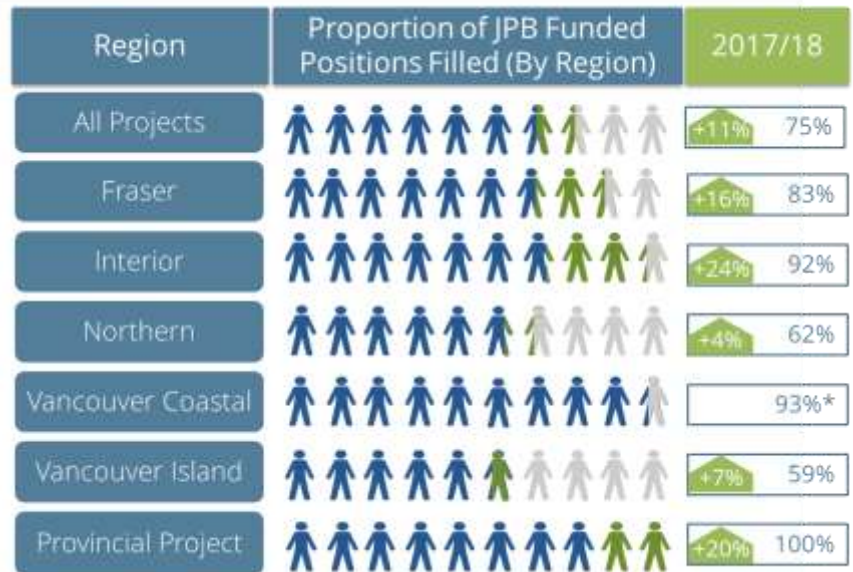
#### Implementation status

Overall, the proportion of projects that are operational increased by 11% (n=3) and the proportion of projects that are fully operational has increased by 15% (n=4) 2016/17 to 2017/18. Aside from one project with unknown implementation status, all projects were either partially or fully operational as of July 2018: 44% (n=12) of projects were partially operational (some clinicians hired and seeing patients, but not the entire project team) and over half [52% (n=14)] of the projects were fully operational (all clinicians hired and seeing clients).



## Recruitment and retention

Recruitment and retention challenges were among the top barriers reported by projects in both 2016/17 and 2017/18. Although recruitment and retention challenges persist, projects described a number of efforts and strategies to address this, resulting in an 11% increase in filled JPB-funded positions in 2017/18. The proportion of filled JPB-funded positions has increased or been maintained in every region and across every health care professional group.



Projects shared strategies used to expand recruitment efforts, prevent provider burnout and improve staff retention. Suggestions to support recruitment and retention included: increasing flexibility in position qualification requirements/criteria and improving access to professional training opportunities for project staff/providers as a factor supporting retention.

Overall, projects reported 9% of JPB funded positions as actively recruiting; 2% of positions as vacant due to turnover; 2% of positions were closed after unsuccessful recruitment for one year or more; and 13% of positions did not have a clear status reported for 2017/18.

## Implementation challenges

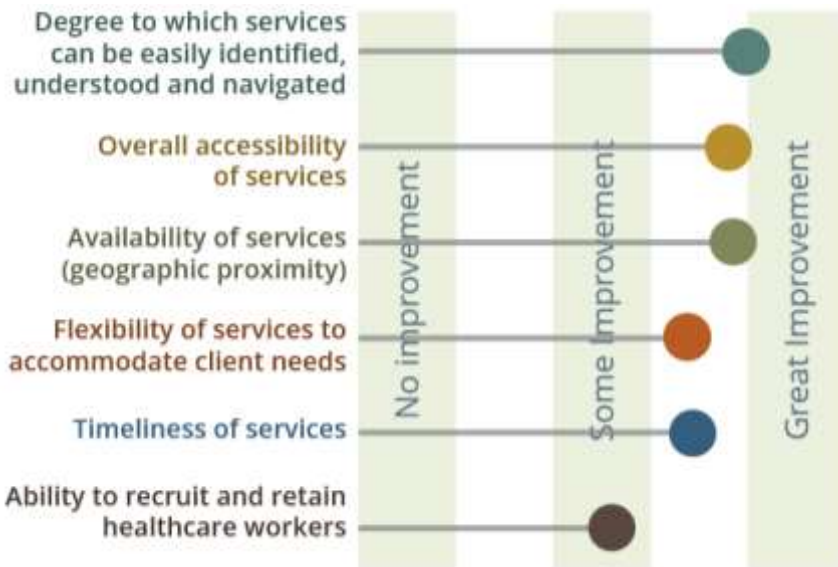
The top three most commonly reported implementation barriers in 2017/18 included: “lack of trained candidates in the area”; “information and technology (IT) issues”; and “barriers related to funding conditions”.

Recruitment & Retention	Infrastructure	Funding Conditions
Lack of trained candidates in the area (54%)	IT issues (e.g. Bandwidth, EMR) (50%)	Barriers related to funding conditions (42%)
Lack of short-term housing/accommodation (38%)	Lack of physical office space (42%)	Lack of clarity on funding usage, eligible activities, and available resources
Unable to attract local qualified candidates (33%)	Lack of confidential clinical space (42%)	
Length of time to hire (e.g. developing job description, posting job, signing contract, setting up workspace) (25%)	Lack of spaces where clients feel comfortable and safe accessing care	
Finding candidates who are an appropriate fit and culturally safe and humble		

# ACCESS TO HEALTH SERVICES

## Overview

Overall, Joint Project Board projects reported improvements across several dimensions of service accessibility and availability since project initiation including: overall accessibility; availability of services;

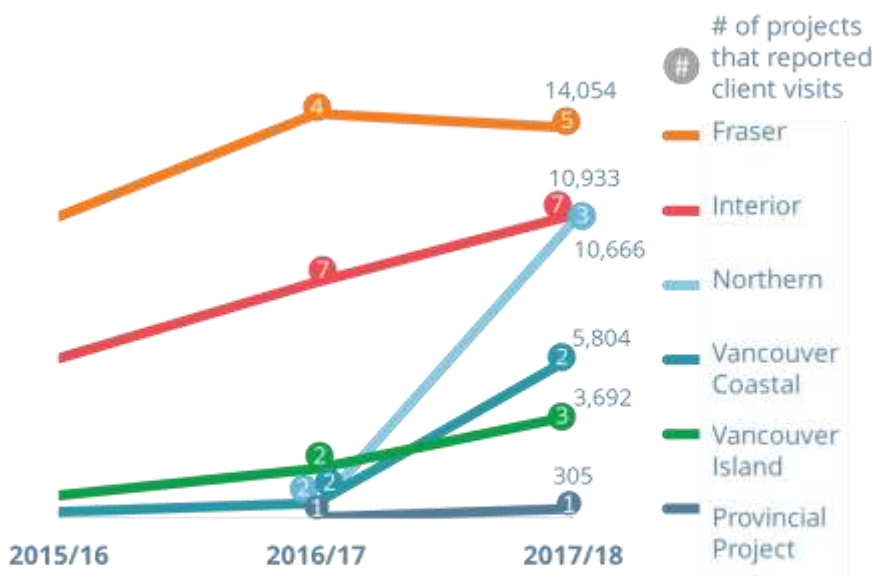


ability to recruit and retain health care workers; flexibility and timeliness of services; and degree to which services can be easily identified, understood and navigated.

On average, projects reported the greatest improvement in service identification and navigation and the least improvement in ability to recruit and retain healthcare workers. 71% of projects reported considerable or great improvement in overall accessibility of services since project initiation.

## Service utilization

Project impact on improving accessibility and availability of services, combined with steady implementation progress, is reflected in increased utilization of project services in all regions over the past three years. Total client visits increased by 77% (1.77 times higher) from 2016/17 to 2017/18.



## Service utilization barriers

The top service utilization-related barriers reported were “client unaware of services” and “restricted provider hours/availability”, reported by 50% of projects. Other service utilization barriers reported included “clients don’t trust/know the providers yet”, reported by 39% of projects, and “location of services difficult for clients to get to,” reported by 29% of projects. The proportion of projects reporting these service utilization barriers remained roughly the same from 2016/17 to 2018/19, except for “location of services difficult for clients to get to” which increased from 19% in 2016/17 to 29% of projects in 2017/18.

## Approachability of services

**96%** of projects agreed that as a result of the project, **cultural safety and humility** of care has improved.

Projects shared efforts to improve approachability of services through working with clients and communities to increase awareness of services and build relationships and trust between project staff/service providers and clients/communities.

## Availability of services

Several projects described strategies to improve access to care/services by bringing services closer to clients and communities; adapting the physical spaces and locations of service delivery/care provision; offering flexible hours and scheduling; and leveraging partnerships to increase the availability of care providers delivering services in-community.

**63%** of projects reported considerable or great improvement in the **availability of services (geographic proximity)** since project initiation.

## Coordination of care and integration of services

**79%** of projects reported considerable or great improvement in the **degree to which services can be easily identified, understood, and navigated** since project initiation.

Several projects are playing a unique role in the health system to improve coordination of care, continuity of care, discharge planning, and complex care management through strengthening linkages among provincial and regional health services and providers, community-based providers, and clients and communities. Integration of care was described as a priority by several projects, particularly for client populations with complex care needs and those who face barriers to accessing care.

Partnerships and collaboration have been a key cross-cutting strategy leveraged by projects to improve availability, access, and quality of care; address challenges and service gaps; and reduce service delivery and implementation barriers. Several projects have highlighted partnership as a key enabler of impact and success.

Projects described strengthening relationships with health system and community partners to improve linkages between internal and external care providers, teams and organizations including allied health and social services.

Of the JPB funded positions reported on this year, **over one fifth (21%)** included **systems navigation** as a primary role.

Many projects are using integrated multi-disciplinary team-based approaches to improve integration of care including linkages to specialty services. In some cases, this was done through a primary care/wellness/medical home model of care; co-locating multi-disciplinary providers/services in one location. In cases where a full complement of multi-disciplinary care team was not housed under one project or in one location, some projects are establishing teams/care providers that work collaboratively with other health service providers and teams from various specialties and organizations.



## Coordination of care barriers

The top reported coordination of care barriers were “clients difficult to reach for follow up, reported by 54% of projects; “client record/charting issues (other than lack of EMR)”, reported by 42% of projects; and “lack of communication between service delivery organizations”, reported by 38% of projects.

## Appropriateness, responsiveness and quality of services

### Integrating a wellness approach

Reports were overflowing with examples of projects integrating wellness into care delivery including incorporating social determinants of health approaches, providing wrap around care and integrating traditional wellness practices and approaches.

**92%** of projects agreed that as a result of the project, **wellness is integrated into delivery of care.**

### Responsiveness

Projects shared examples of centering community needs, priorities and input throughout project planning, operations and monitoring to ensure responsiveness to community needs and expectations. Some projects are also well positioned to respond and adapt to unique and acute community needs. Participation and collaboration with community and Nation members has been attributed as an enabler of project success and facilitator of ongoing quality improvement and responsiveness to community/client needs, priorities and expectations.

### Quality improvement

#### Knowledge exchange, collaboration and innovation

Partnerships and collaboration were highlighted as a facilitator of innovation and quality improvement. Some projects described establishment of research and practice partnerships to collectively identify, advocate and address service barriers and gaps. Others described collaborative planning of quality initiatives ranging from provincial to community levels. Some projects are also generating and sharing knowledge through research and publication. Collaboration among projects, health service delivery departments and organizations was highlighted as an opportunity for capacity development and knowledge exchange, including sharing promising practices, models and approaches.

#### Monitoring, evaluation and learning

Many projects described monitoring, evaluation and reporting activities including conducting program evaluations, establishing informal and formal client feedback and data collection mechanisms, and developing tools to standardize data collection and reporting. Findings from monitoring and evaluation activities are being used to inform planning and decision-making; improvements to programs, policies and practice; and staff training/development.

## BACKGROUND

### Joint Project Board Evaluation

The Joint Project Board (JPB) projects evaluation approach has evolved over time. The evaluation approach has been adapted to balance high-level data collection from all JPB projects to gauge overall trends, successes and lessons learned, while enabling a comprehensive evaluation of a subset of projects.

Finding this balance has led to the development of a multi-streamed approach to the JPB Projects Evaluation consisting of:

- 1) Stream 1: A provincial analysis stream utilizing the JPB Project Annual Report for all 27 projects and prototype evaluation data (this report is fulfilling this evaluation component for 2017/18 – a similar report was completed for 2016/17);
- 2) Stream 2: A focused exploration of facilitators and constraints to full implementation of five prototype projects (prototype project gap analysis and process evaluation); and
- 3) Stream 3: Full evaluations of the five prototype projects (or a project of the region's choosing) to assess early project outcomes. Streams 2 and 3 are often conducted simultaneously to increase efficiencies.

The purpose of the JPB Projects Provincial Analysis stream is to:

- Identify models and supports that are working well;
- Identify implementation issues that the JPB is in a position to address;
- Share innovations or lessons learned across other JPB Projects; and
- Measure outcomes across projects such as access to culturally safe care and availability of services provided by regulated health care professionals.

### Joint Project Board

The Joint Project Board (JPB) was established in 2012 and is a senior bilateral forum between the Assistant Deputy Ministers of the BC Ministry of Health, and the First Nation Health Authority's (FNHA) Chief Operating Officer and its Vice Presidents.

Effective July 2, 2013, Health Canada transferred the funds it had historically used to pay Medical Services Plan (MSP) premiums on behalf of First Nations residents in BC to the FNHA. A portion of these funds were set aside by the FNHA to support JPB projects and initiatives related to MSP services.

A key focus of the JPB is to enhance services and delivery through:

- Advancing strategic priorities;
- Overcoming policy barriers;
- Supporting priorities and initiatives of the regions; and,
- Supporting integration of services and initiatives of the province and FNHA.

The JPB projects must improve one or more of the following for First Nations people:

- Improve *access* to health services;
- Increase service delivery by *regulated health professionals*;



- Increase *sustainability*<sup>1</sup> of services;
- Be *collaborative* and *innovative*; and
- Support regional priorities.

JPB projects must provide direct service delivery to First Nations people in one of the following areas: primary care, mental wellness and substance use, maternal and child health and oral health services.

### Joint Project Board Projects

A total of 27 JPB projects have been approved, with 26 spread across the five regions, and one project that is provincial in scope implemented by the Provincial Health Services Authority. Each of the projects are different in scope and complexity; they are based on the realities and interests within each region, on different care models and are at different stages of development and implementation.

## METHODS

### Annual narrative reporting coverage

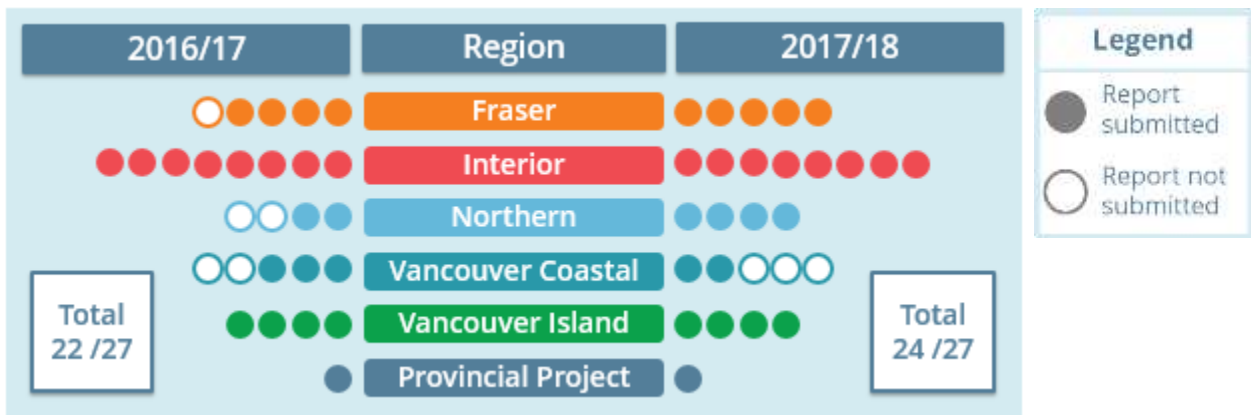


Figure 1. JPB projects with at least one annual narrative report submitted in 2017/18 compared to 2016/17. 24 out of 27 projects submitted annual narrative reporting.

Overall, there has been an increase in narrative report submissions: two additional projects submitted reports in 2017/18 compared to 2016/17. At the time of analysis, annual narrative reports had been received from a total of 24 out of 27 projects. Reports were missing for more than half of the Vancouver Coastal projects; and so, values presented for Vancouver Coastal Region in this report should not be taken as representative of all projects in the region. Additionally, for some projects, separate reports are submitted for project sub-components based on different implementation sites or funding recipients. Four projects were missing reporting for one or more project sub-components: two Interior Region projects and two Vancouver Coastal Region projects. The numbers above reflect projects with at least one annual narrative report submitted.

<sup>1</sup> The investment enables continuous service delivery over time.

## Data collection and analysis approach

JPB project annual narrative report templates were the main information source for this report, with some supplementary information gathered from funding arrangements documentation, tracking and summary reports.

An annual JPB report template has been collected since 2015/16 but was adapted in May 2017 and continues to evolve over time to ensure relevance, clarity and utility of information requested. The annual report template aims to collect an overview of project implementation, services delivered, accessibility and availability of services provided, challenges and successes. The template attempts to balance the need for collecting high-level information of an evaluative nature while managing the reporting and evaluation burden for projects and JPB.

An annual report template is the only source of information of an evaluative nature being collected for the majority of JPB projects. Additional evaluation work will be conducted for select 'prototype' JPB projects. A JPB Projects Evaluation Framework document describes how the JPB annual report and additional prototype evaluations will feed into the overall JPB evaluation.

## Limitations

This report draws on the information, discussions and stories that 24 of the 27 JPB projects shared in 2017/18 annual narrative reports. As such, any missing reports, data or lack of clarity in responses may affect the interpretation and summarization of the submitted data. Quantitative findings were compiled based on data submitted which included omissions and approximations. As a result, quantitative questions relating to the number of services delivered and recruitment and retention are an approximation.

## PROJECT IMPLEMENTATION

### Implementation progress

#### Implementation status

When examined at a high-level in terms of staffing, projects can be roughly categorized as not yet operational (no clinicians hired and no patients being seen); partially operational (some clinicians hired and seeing patients, but not the entire project team); and fully operational (all clinicians on the team hired and seeing patients).

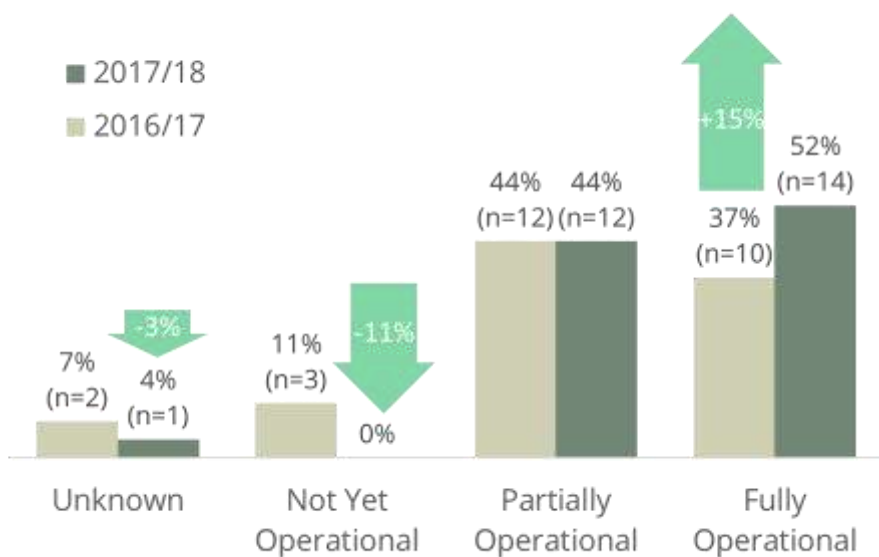


Figure 2. Project implementation status in 2017/18 compared to 2016/17.

Overall, the proportion of projects that are operational has increased by 11% (n=3) from 2016/17 to 2017/18 and the proportion of projects that are fully operational has increased by 15% (n=4).

Aside from one project with unknown<sup>2</sup> implementation status, all projects were either partially or fully operational as of July 2018: 44% (n=12) of projects were partially operational (some clinicians hired and seeing patients, but not the entire project team) and over half of the projects [52% (n=14)] were fully operational (all clinicians hired and seeing clients).

Three projects that were not yet operational by the end of the 2016/17 fiscal year are now operational. Additionally, three projects went from partially operational to fully operational.

Barriers for projects moving from partially/mostly operational to fully operational are mostly recruitment and retention (since “fully operational” defined as all clinician positions filled). This and other implementation barriers, challenges and mitigation strategies are discussed in subsequent sections of this report.

#### Recruitment and retention

Recruitment and retention challenges were among the top barriers reported by projects in 2016/17 and 2017/18. Although recruitment and retention challenges persist, projects described a number of efforts and strategies to address this, resulting in an 11% increase in filled JPB-funded positions in 2017/18. The

<sup>2</sup> Note: number of “not known” status projects does not correspond with number of projects with no 2017/18 reports because information on implementation progress has been supplemented with info from funding arrangements’ project tracking documents (which draw on other data sources including quarterly reports and financial reports).

proportion of filled JPB-funded positions has increased or been maintained in every region and across every health care professional group.

Projects have expanded recruitment efforts by:

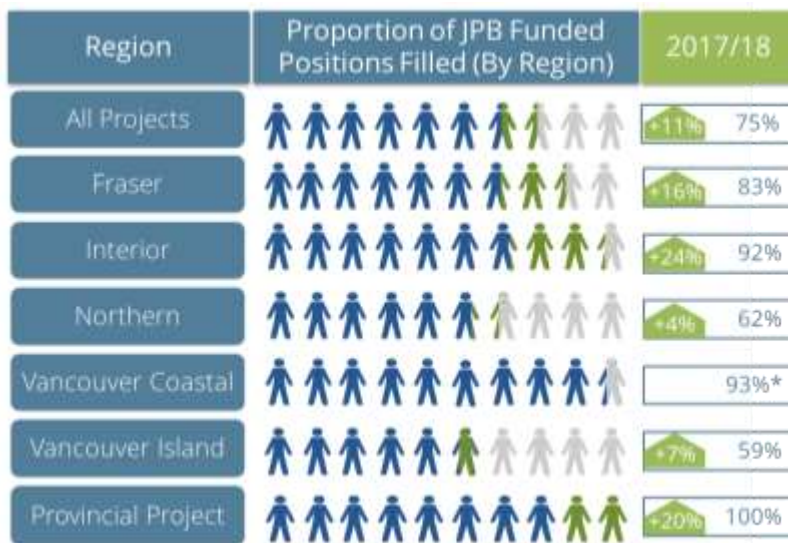
- Networking with partner organizations and communities to reach a larger pool of candidates;
- Partnering with health authorities to support advertising of positions; and
- Use of creative recruitment incentives including flexibility in home location and interchange agreements with health authorities.

Projects have been working to prevent provider burnout and improve staff retention by:

- Staffing full-time positions with multiple part-time individuals; and
- Hiring casual staff to support leaves and fill staffing gaps (to reduce burden on permanent staff/providers).

Suggestions to support recruitment and retention included:

- Increasing flexibility in position qualification requirements/criteria (e.g. experience/education requirements); and
- Improving access to professional training opportunities for project staff/providers as a factor supporting staff retention.



In 2016/17, approximately 64% (102 out of 159) of JPB funded positions were filled. In 2017/18, 75% (121 out of 162) of JPB funded positions were filled – an 11% increase from the previous year. The proportion of positions filled has increased or been maintained across all regions.

Both Fraser Salish and Interior Regions are close to having fully staffed projects with only three positions (in each region) remaining to be filled. Nineteen out of 22 of unfilled positions from Northern Region are from one project. The majority of these vacancies are due to implementation phase versus recruitment and retention challenges. The majority (11 out of 13) of unfilled positions in the Vancouver Island Region are from one project. Half of these positions have been recruiting for one year or more. The length of the recruitment and hiring process/ steps has contributed to attrition of potential candidates.

Figure 3. Proportion of JPB funded positions filled by Region including % change from 2017/18 to 2016/17.  
 \*These values only include funded positions from 2 out of the 5 projects in the Vancouver Coastal Region.

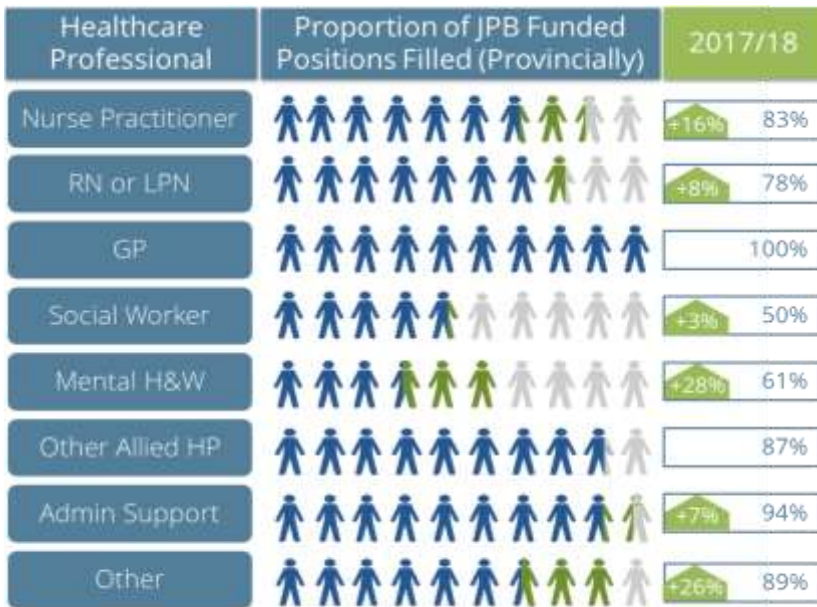


Figure 4. Proportion of JPB funded positions filled by health care professional type including % change from 2017/18 to 2016/17.

Mental Health & Wellness (H&W) includes: Registered Clinical Counsellor, Mental Health Clinician, Psychologist, Addictions & Mental Health Counsellor. Other Allied Healthcare Provider includes: Dietician, Naturopathic Doctor, Traditional Chinese Medical Practitioner, OT, PT, Podiatrist, Pharmacist. Other: Project Lead, Primary Care Coordinator, Wellness System Navigator.

Overall, the proportion of JPB funded positions filled have increased or been maintained across every healthcare professional group. Among JPB funded positions, the healthcare professional groups with the highest proportion of positions filled include: general practitioners, with 100% of positions filled; admin support, with 94% of positions filled; “other” group (which includes a project lead, primary care coordinator and wellness system navigators) with 89% of positions filled; and other allied healthcare professionals (which include dieticians, naturopathic doctors, traditional chinese medical practitioners, occupational therapists and physiotherapists), with 87% of positions are filled.

Registered social workers and mental health and wellness professionals (which include

registered clinical counsellors, mental health clinicians, psychologists, and other counsellors) have the lowest proportion of positions filled, with 50% and 61% of funded positions filled, respectively. However, the proportion of mental health and wellness clinician positions filled increased by the largest margin (28%) from 2016/17 to 2017/18 compared with any other healthcare professional group.

### Mental Health and Wellness Clinicians

61% (19 out of 31) of funded positions filled.

Unfilled Position Status	#
Recruiting	7
Vacant due to turnover	1
Closed after >1yr recruiting	2
Not reported	2

### Social Workers

50% (17 out of 34) of funded positions filled.

Unfilled Position Status	#
Recruiting	4
Vacant due to turnover	2
Not reported	11

Seven out of 12 unfilled mental health and wellness clinician positions are in the recruitment stage; one is vacant due to turnover; and two positions closed after remaining unfilled for over a year of recruitment.

Four out of 17 unfilled social worker positions are in the recruitment stage (all from one project in Vancouver Island Region). Three out of four of these positions have been recruiting for 7-10 months. Eleven out of 17 unfilled social worker positions are not reported: the majority (10 out of 11) of these not reported positions are from one project which has project components/sites that have not yet been implemented.



Overall, 9% of JPB funded positions are actively recruiting; 2% of JPB funded positions are vacant due to turnover; 2% of JPB funded positions were closed after unsuccessful recruitment for one year or more; and the status of 13% of JPB funded positions for the 2017/18 fiscal year is not clear or was not reported on. Eighteen out of 21 of the positions with unknown status<sup>3</sup> are from one project that is not yet fully implemented; and therefore, it is likely that these positions are pre-recruitment stage.

### Recruitment and retention challenges

Recruitment and retention challenges have consistently been among the top reported implementation barriers.

Specific challenges include:

- Uncompetitive salaries, hiring incentives insufficient for recruitment and retention;
- Lack of portability between FNHA and health authority nurses (i.e. transferability of seniority, benefits and vacation);
- Restrictive hiring criteria (e.g. rigid education and experience criteria and a requirement for registered Nation members); and
- Nursing union seniority requirements (a barrier for hiring First Nations candidates).



Figure 5. Detailed status of unfilled JPB funded positions by region.

### Implementation challenges and mitigation strategies

The top three most commonly reported implementation barriers in 2017/18 included: “lack of trained candidates in the area”; “information and technology (IT) issues”; and “barriers related to funding conditions”. All regions except Vancouver Coastal reported “lack of trained candidates in the area” and “IT issues” as one of their top three implementation barriers. “Barriers related to funding conditions” was among the top three barriers in all regions except Fraser Salish Region.

“Lack of trained candidates in the area” and “IT issues” were also among the top three most commonly reported barriers in 2016/17 and the proportion of projects reporting “lack of trained candidates in the area” as an implementation barrier increased by 17% from 2016/17 to 2017/18. The proportion of projects reporting “barriers related to funding conditions” increased by 16% from 2016/17 to 2017/18. The proportion of projects reporting “length of time to hire” as an implementation barrier decreased by 16% from 2016/17 to 2017/18.

<sup>3</sup> “Unknown positions” do not include positions from projects with no 2017/18 annual narrative report received.



Recruitment & Retention	Infrastructure	Funding Conditions
Lack of trained candidates in the area (54%)	IT issues (e.g. Bandwidth, EMR) (50%)	Barriers related to funding conditions (42%)
Lack of short-term housing/accommodation (38%)	Lack of physical office space (42%)	Lack of clarity on funding usage, eligible activities, and available resources
Unable to attract local qualified candidates (33%)	Lack of confidential clinical space (42%)	
Length of time to hire (e.g. developing job description, posting job, signing contract, setting up workspace) (25%)	Lack of spaces where clients feel comfortable and safe accessing care	
Finding candidates who are an appropriate fit and culturally safe and humble		

Top three **most commonly reported** implementation barriers in 2017/18

Figure 6. Most commonly reported implementation barriers in 2017/18.

Strategies used by projects to address infrastructure barriers and recruitment and retention challenges are covered in other sections of the report (for recruitment and retention see *implementation progress > [recruitment and retention](#)* section; for infrastructure see *access to health services > [availability of services](#) and [coordination of care and integration of services](#) sections).*

### Funding conditions

Projects shared approaches to mitigating challenges related to funding conditions, including:

- Mobilizing funding from additional sources; and
- Initiating/participating in discussions among partners (FNHA, regional health authorities, health service delivery organizations and Nations/host communities) about managing operational demands with financial constraints.

Some projects also requested more clarity and flexibility in funding coverage and criteria, including:

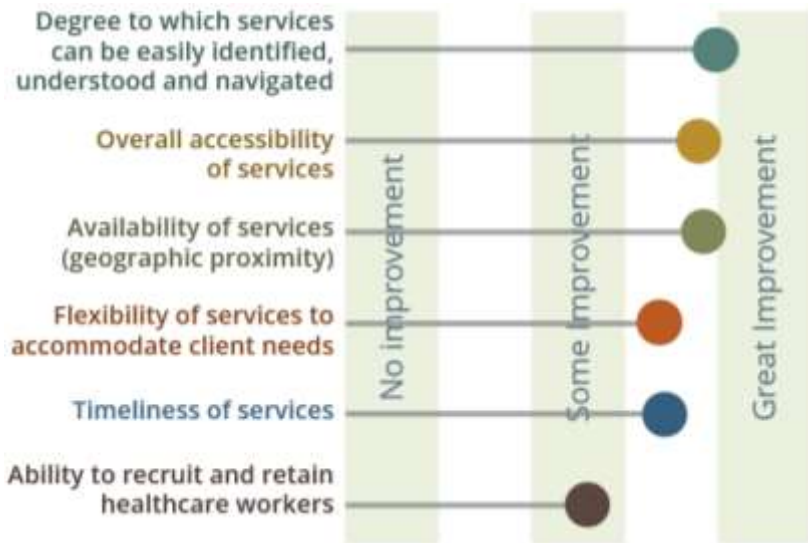
- Clarity and flexibility on what activities fall within criteria of what funding can be used for; and
- Flexibility of funding for projects to support social determinants of health.

## ACCESS TO HEALTH SERVICES

### Overview

On average, JPB projects reported improvements across several dimensions of service accessibility and availability since project initiation including: overall accessibility; availability of services; ability to recruit and retain health care workers; flexibility and timeliness of services; and degree to which services can be easily identified, understood and navigated.

On average, projects reported the greatest improvement in service identification and navigation and the least improvement in ability to recruit and retain healthcare workers. 71% of projects reported considerable or great improvement in overall accessibility of services since project initiation.



79% of projects reported considerable or great improvement in the degree to which services can be easily identified, understood and navigated; 63% of projects reported considerable or great improvement in the availability of services (geographic proximity) since project initiation; 50% of projects reported considerable or great improvement in the flexibility of services to accommodate client needs since project initiation; 50% of projects reported considerable or great improvement in timeliness of services since project initiation; and 17% of projects reported considerable or great improvement in the ability to recruit and

Figure 7. Projects reported on improvements (on a scale of no improvement to great improvement) in dimensions of health care accessibility and availability since project initiation. Ratings/scorings shown are averages.

retain health care workers since project initiation (25% of projects reported there had been limited or no improvement).

### Service utilization

Project impact on improving accessibility and availability of services, combined with steady implementation progress, is reflected in increased utilization of project services in all regions over the past three years. Total client visits<sup>4</sup> increased by 77% (1.77 times higher) from 2016/17 to 2017/18.

Fraser Salish Region has consistently had the highest number of total client visits. Fraser Salish Region projects collectively have the highest number of filled physician and nurse practitioner (NP) positions of any

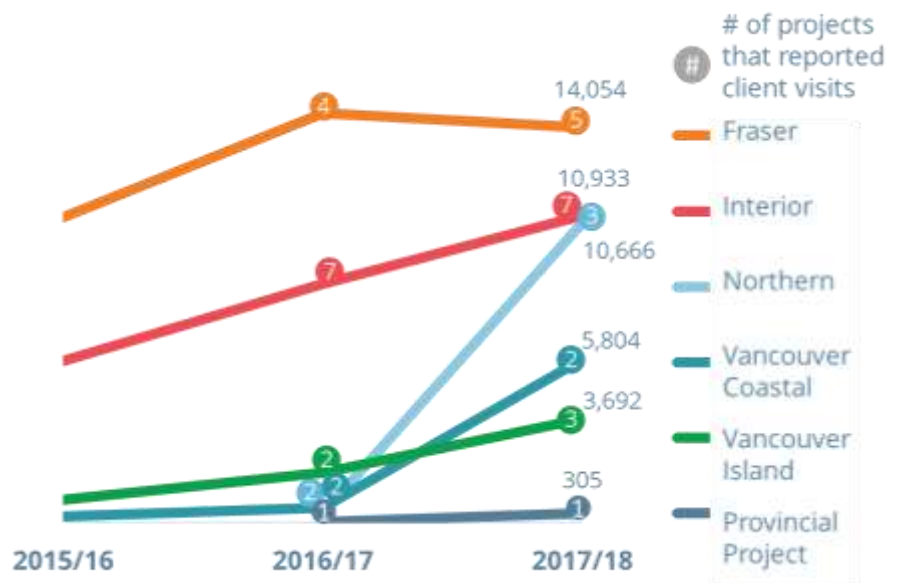


Figure 8. Total number of client visits reported by projects from 2015/16 to 2017/18. Note that values are an approximation and do not include reporting from all projects or providers.

<sup>4</sup> Values reflect **total** number of client visits not the number of **unique** clients

region. On average, physicians and NPs have substantially more total client visits per year compared with other provider groups. Additionally, aside from Interior Region, more projects from Fraser Salish Region reported total client visits than other regions.

Northern Region had the most substantial increase in total client visits reported from 2016/17 to 2017/18. One project in this region went from not yet operational in 2016/17 to operational in 2017/18 – contributing to the increase. There was also one additional Northern Region project that reported total client visits in 2017/18 compared to previous years.

### Service utilization barriers

The top service utilization-related barriers reported were “client unaware of services” and “restricted provider hours/availability”, each reported by 50% of projects. Other service utilization barriers reported included “clients don’t trust/know the providers yet”, reported by 39% of projects, and “location of services difficult for clients to get to,” reported by 29% of projects. The proportion of projects reporting these service utilization challenges remained roughly the same from 2016/17 to 2018/19, except for “location of services difficult for clients to get to” which increased from 19% in 2016/17 to 29% in 2017/18.

Aside from “client unaware of services”, these barriers were not commonly reported by Interior Region projects. “Client unaware of services” was among the top three barriers reported by projects across all regions except Vancouver Island. “Restricted provider hours/availability” and “clients don’t trust/know providers yet” were among the top three barriers in Fraser Salish, Northern and Vancouver Coastal Regions. “Location of services difficult for clients to get to” was among the top barriers in Fraser Salish and Northern Regions only.

### Service utilization barriers

Client unaware of services (50%)

Restricted provider hours/availability (50%)

Clients don’t trust/know the providers yet (38%)

Location of service difficult for clients to get to (29%)

### Approachability of services

Projects shared efforts to improve approachability of services through working with clients and communities to increase awareness of services and build relationships and trust between project staff/service providers and clients and communities. 50% of projects reported “client unaware of services” and 38% of projects reported “clients don’t trust/know the providers yet” as service delivery challenges.

**96%** of projects agreed that as a result of the project, **cultural safety and humility of care** has improved.

Strategies and activities used by projects to improve these areas included:

- Project staff/providers visit communities, participate in community and Nation events, engage with Health Directors;
- Promote project services in communities (e.g. information booths at events, distribution of promotional materials); and
- Email and text notifications about project services, visits and sessions.

## Availability of services

**63%** of projects reported considerable or great improvement in the availability of services (geographic proximity) since project initiation.

Several projects described strategies to improve access to care/services by bringing services closer to clients and communities; adapting the physical spaces and locations of service delivery/care provision; and offering flexible hours and scheduling. Projects are working to reduce service delivery and utilization challenges that include: the location of services being difficult for clients to reach (reported by 29% of projects) and restricted provider hours/availability (reported by 50% of projects).

### Location and flexibility of services

Projects described the following strategies for making it easier for individuals and families to access services, particularly in-community:

- Delivering care or meeting clients in community spaces;
- Increasing the availability of drop-in timeslots for more flexible scheduling;
- Using telehealth to deliver the following activities: primary care appointments, specialist consultations, follow-up appointments and delivering training and workshops; and
- Combining in-person and virtual service delivery.

**50%** of projects reported considerable or great improvement in the flexibility of services to accommodate client needs since project initiation.

Availability of physical office space and confidential spaces to work and provide care were challenges reported by 42% of projects. Project staff and care providers continue to accommodate client and community needs and strive to deliver person-centred care under these constraints. Examples of this adaptability and resourcefulness include:

- Flexibility and willingness of providers to work effectively in whatever spaces may be available for care delivery/ meeting with clients in communities;
- Sharing health authority office space/co-locating with other care providers;
- Staggering provider schedules to share available office space; and
- Establishing partnerships to share office spaces and service delivery locations.

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*"We often go where the clients we work with go. We attend soup kitchens, community meals, pancake breakfasts and the harm reduction bus."*

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### Availability of providers

One strategy used to increase the availability of care providers in-community, was to establish partnerships to create provider-sharing agreements where care providers work out of multiple locations, including splitting time between community-based and clinic-based care delivery. Establishment of a partnership agreement with the Divisions of Family Practice to employ clinicians/service providers is an illustrative example of this.

## Coordination of care and integration of services

Several projects are playing a unique role in the health system to improve coordination of care, continuity of care, discharge planning and complex care management by strengthening linkages among provincial and regional health services and providers, community-based providers, and clients and communities. Integration of care was described as a priority by several projects, particularly for client populations with complex care needs and those who face barriers to accessing care.

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*"The current [provincial] system did not support coordinated discharge planning, appropriate linkages with community-based providers and systematic follow-up with patients/families in the community after discharge. The goal of the [project] is to prevent similar occurrences in the future."*

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## Partnerships and collaboration

Partnerships and collaboration have been a key cross-cutting strategy leveraged by projects to improve availability, access and quality of care; address challenges and service gaps; and reduce service delivery and implementation barriers. Several projects have highlighted partnership as a key enabler of impact and success.

### Strengthening linkages between internal and external care providers, teams and organizations

Projects described strengthening relationships with health system and community partners to improve linkages between internal and external care providers, teams and organizations including allied health and social services. This included strengthening connections between centrally-based care teams and community-based care providers to support coordination and quality of care.

**79%** of projects reported considerable or great improvement in the **degree to which services can be easily identified, understood, and navigated** since project initiation.

To lay the groundwork for better collaboration, coordination and communication, projects are fostering relationships with local health and social service providers/staff. This included initiating introductions, raising awareness of project services and inviting other providers/staff for project site visits.

Of the JPB-funded positions reported on this year, **over one fifth (21%)** included **systems navigation** as a primary role.

Improving communication and referral processes with local health service providers/organizations is another strategy used. One project described establishing intake and referral processes with external service partners to better position communities as active and equitable partners within larger systems.

Other projects are supporting coordination and transitions in care by establishing roles specific to service coordination and navigation. Another strategy used is establishing consistent care providers for clients/families to support and facilitate transitions in care.

Participation and collaboration with community and Nation members has been attributed as an enabler of project success and facilitator of ongoing quality improvement and

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*"Having a [care provider] in the hospital to provide support to families as they are traveling down to [city] has been very helpful. This provides a linkage for families when they are waiting [...] and knowing that there is a support person available has significantly reduced anxiety for some families"*

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responsiveness to community/client needs, priorities and expectations.

### **Integrated multi-disciplinary team-based care**

Many projects are using integrated multi-disciplinary team-based approaches to improve integration of care including linkages to specialty services. In some cases, this was done through a primary care/wellness/medical home model of care; co-locating multi-disciplinary providers/services in one location. One project described an extension of this model; housing multiple stages of a care pathway in one location to support a full continuum of care (e.g. detox, treatment, recovery and after care services all in one location). Projects highlighted the need to increase the number/availability of traditional wellness practitioners to enable expansion of integrated care teams/approaches.

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*“Our focus on integration has resulted in improved care to patients, particularly for patients who are difficult to track down or have complex care issues.”*

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In cases where a full complement of multi-disciplinary care team was not housed under one project or in one location, some projects are establishing teams/care providers that work collaboratively with other health service providers and teams/units from various specialties and organizations. In some instances, employing care providers that work across

multiple teams or out of more than one service delivery location was an applied solution. Telehealth is also being used by some projects as a tool for collaboration and coordination including hosting interdisciplinary care team meetings.

### **Technology and electronic medical records integration**

Projects described efforts to improve communication and information flow between partners as an enabler of service integration. Technology and emergency medical records (EMR) system integration among health system partners is a core component of this.

EMR access/integration challenges were reported as a delivery of care barrier by close to half (46%) of projects: “lack of access to health authority EMR” was among the top three delivery of care barriers in all regions except Fraser Salish and “multiple EMRs that aren’t integrated” was among the top three delivery of care barriers in Northern and Fraser Salish Regions.

#### **Technology integration barriers**

Lack of access to health authority EMR (46%)

Multiple EMRs that aren’t integrated (46%)

Projects have been working to improve technology integration and reduce technology infrastructure barriers by:

- Exploring other options for charting/medical records management (e.g. purchasing access to MedAccess);
- Developing centralized document/data collection tools; and
- Project host/health centre’s IT department conducting site visits and consulting with IT services in other communities.



## Coordination of care barriers

The top reported coordination of care barriers were “clients difficult to reach for follow up”, reported by 54% of projects; “client record/charting issues (other than lack of EMR)”, reported by 42% of projects; and “lack of communication between service delivery organizations”, reported by 38% of projects. Other coordination of care barriers reported included “confusion over coordination of services or resources among multiple funding recipients” and “perceived privacy barrier to sharing information”, each reported as a barrier by 29% of projects.

Overall, coordination of care barriers were rated disproportionately high by Northern Region projects. “Clients difficult to reach for follow-up” was among the top ranked barriers in all regions except Fraser Salish. “Client record/charting issues (other than lack of EMR)” was among top three barriers in Northern and Vancouver Island Regions and top five in the Interior Region. “Lack of communication between service delivery organizations” and “confusion over coordination of services or resources among multiple funding recipients” were among the top three barriers in Northern Region and top five in Interior Region. “Perceived privacy barrier to sharing information” was among the top three barriers in Northern Region and top five in Vancouver Island Region.

### Coordination of care barriers

Clients difficult to reach for follow-up (54%)

Client record/charting issues (other than lack of EMR) (42%)

Lack of communication between service delivery organizations (38%)

Confusion over coordination of services or resources among multiple funding recipients (29%)

Perceived privacy barrier to sharing information (29%)

## Appropriateness, responsiveness and quality of services

### Integrating a wellness approach

Reports were overflowing with examples of projects integrating wellness into care delivery.

### Integrating traditional wellness practices and approaches

Projects described the value of adopting two-eyed seeing approaches to wellness that draw on strength, wisdom and value from both traditional and western health and wellness knowledge and practices. Projects described this as an active process of knowledge sharing and exchange. Several projects are working with traditional knowledge keepers including Elders and traditional wellness practitioners.

**92%** of projects agreed that as a result of the project, **wellness is integrated into delivery of care.**

### Wrap around care

Projects described a strong emphasis on providing wrap around care, characterized by wholistic, person-centred and family-centred care. This is supported by integrated care teams, partnerships and communication with other health providers and organizations to support transitions in care.

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*“Providing holistic and wrap around support is key to working with families in a culturally mindful and supportive manner.”*

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## Social determinants of health approaches

Projects are incorporating social determinants of health into their services by:

- Integrating social and environmental factors, for example housing and food security, into their wellness assessments and discussions with clients;
- Introducing roles such as navigators and wellness coordinators that support navigation and coordination of both health and social services/resources; and
- Building partnerships with other organizations that provide services beyond the health sector; for example, one project is partnering with a non-profit housing society.

Some projects identified a need for funding to cover a broader range of costs related to wellness and health and social services such as food security, transportation, and identification card application fees.

## Responsiveness

### Community-driven and Nation-based project models and practices

Many projects are designed as client and community-centred care delivery models. Projects shared examples of centering community needs, priorities and input throughout project planning, operations and monitoring to ensure responsiveness to community needs and expectations.

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*“During each engagement with each community, we always respectfully ask ‘How would you like services to be provided?’ as services and needs vary from each community.”*

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Examples of this include:

- Modelling community-driven project priority-setting, planning, design, implementation and quality improvement including establishing “Nation-Owned Models of project delivery”;
- Collaborating with communities to develop community-specific wellness programming;
- Ongoing collection of feedback from community-members and services users;
- Changing the scope of JPB funded positions/roles in direct response to community feedback such as shifting a family support role to a child and youth-oriented role; and
- Facilitating collaboration between/among host communities.

Some projects are also well positioned to respond and adapt to unique and acute community needs. For example, one project’s flexible service delivery model was well suited to respond to remote communities with at-home disaster-specific counselling during the 2018 wildfires.

## Quality improvement

### Knowledge exchange, collaboration and innovation

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*“The innovation opportunities presented as a result of all the partners engaged in these projects, and underway at each [advisory committee] has been remarkable. [...] at several junctures in the [advisory committee] process various barriers and challenges for [projects] have been identified – for example, adequate clinical and accommodation space in isolated communities. Each partner has gone away from [advisory committee] meetings and advocated for resources or changes required to try and bridge these challenges.”*

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Partnerships and collaboration were highlighted as a facilitator of innovation and quality improvement. Some projects described establishment of research and practice partnerships to collectively identify, advocate, and address service barriers and gaps. Others described collaborative planning of quality

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*“We will continue to be open to change as we work towards understanding the needs of our communities.”*

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initiatives ranging from provincial to community levels. Some projects emphasized how integration of community and Nation member collaboration and guidance into project planning, implementation and monitoring processes enables quality improvement and responsiveness of project programming to community and client needs.

Collaboration among projects, health service delivery departments and organizations was highlighted as an opportunity for capacity development and knowledge exchange, including sharing promising practices, models and approaches. A couple of projects had identified a need or interest in replicating the project/similar service in another sub-region or region. One example of collaborative capacity development shared is a project equipped to support communities in setting up telehealth.

Sharing learnings and capacity building is also occurring within project teams. For staff/providers that are supported to obtain specialized training or professional development, projects described this as benefitting the team as staff share learnings and practices.

Some projects are also generating and sharing knowledge through research and publication. Examples of this include: publication on a project’s primary care model in a BC Medical Journal; a collaborative cultural safety and humility research project; a research project to identify and address program and service barriers and gaps; and development of revised chronic disease indicators.

### **Monitoring, evaluation and learning**

Many projects described monitoring, evaluation, and reporting activities. Some projects are conducting program evaluations including process, outcome and impact evaluations. Projects have established informal and formal processes for client feedback including client feedback surveys. Other projects are collecting data and reporting on areas including client outcomes and quality improvement progress. One project developed an electronic incident reporting tool to streamline and standardize incident data collection and reporting. Other quality assessment practices include peer-to-peer clinical supervision and chart audits. Findings from monitoring and evaluation activities are being used to inform planning and decision-making; improvements to programs, policies and practice; and staff training/development.

## **RECOMMENDATIONS**

### **Collaboration and knowledge exchange**

JPB projects are health system leaders and innovators, particularly in improving coordination and integration of services, models of flexible and person/community-centred care, and service innovation and quality. Collaboration and knowledge exchange of project teachings would benefit and improve the broader health system. Recommendations to promote collaboration and knowledge exchange include:

- Sharing and disseminating project learnings and success stories;
- Creating platforms and opportunities for collaboration and sharing of promising practices and strategies between projects, communities/Nations and health service delivery organizations; and
- Facilitating connections and mobilizing resources to support scale up or replication of project service delivery models.

## Human health resources

Recruitment and retention of health human resources remains a top reported implementation challenge. The most commonly reported recruitment and retention barrier was “lack of trained candidates in the area”. Recommendations to support improved availability of appropriate human health resources, particularly in remote and rural areas, include:

- Explore opportunities to share/replicate promising strategies for rural and remote recruitment and retention between/among projects and partners;
- Increase the flexibility of position qualification requirements;
- Support professional training opportunities for project staff/providers; and
- Explore strategies to increase the number/availability of traditional wellness practitioners to enable expansion of integrated care teams/approaches.

## Electronic medical records access and integration

Electronic medical records (EMR) access/integration challenges remain a top reported barrier.

Recommendation:

- Explore/analyze opportunities to address EMR integration issues.

## Funding conditions

Barriers related to funding conditions were among the top three reported barriers in 2017/18; the proportion of projects reporting “barriers related to funding conditions” increased by 16% from 2016/17 to 2017/18. Suggestions from projects to reduce these barriers included:

- Explore flexible funding criteria that cover a broader range of costs related to wellness including social determinants of health; and
- Clarify what activities fall within criteria of what funding can be used for.