

Evaluation of First Nations Health Authority

Case Study Technical Report

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1. Introduction

1.1. The First Nations Health Authority

In 2013, the First Nations Health Authority (FNHA) assumed responsibility for programs and services formerly held by Health Canada's First Nations and Inuit Health Branch (FNIHB) – Pacific Region and associated headquarter functions, as part of a broader mandate to work with the Province of British Columbia to improve health services accessed by First Nations in British Columbia (BC). The FNHA is the first province-wide First Nations health authority of its kind in Canada. FNHA seeks to improve the health and well-being of BC First Nations through effective health system partnership and integration, as well as management and funding of First Nations health programs. For the FNHA, success is marked not only by how well it has succeeded in fulfilling its commitments under the British Columbia Tripartite Framework Agreement on First Nations Health Governance (Tripartite Framework Agreement) and the Canada Funding Agreement, but also by how well it has advanced First Nations values, perspective and principles in the broader health system through which meaningful partnerships and change in health outcomes can be accomplished.

The FNHA mission is to support BC First Nations individuals, families and communities to achieve and enjoy the highest level of health and wellness by: working with them on their health and wellness journeys; honouring traditions and cultures; and championing First Nations health and wellness within the FNHA organization and with all of our partners.

The FNHA is part of a unique First Nations health governance structure founded on the principle of reciprocal accountability that includes the:

- **FNHA:** responsible for planning, management, service delivery and funding of health programs previously delivered by FNIHB.
- **First Nations Health Council (FNHC):** provides political leadership for implementation of tripartite commitments and supports health priorities for BC First Nations. Additionally, the FNHC members serve a dual role as the Members of the FNHA.
- **First Nations Health Directors Association (FNHDA):** composed of Health Directors and managers working in First Nations communities. The FNHDA supports education, knowledge transfer, professional development and best practices for Health Directors and managers. It acts as a technical advisory body to the FNHC and the FNHA on research, policy, program planning and design and the implementation of the Health Plans.
- **Tripartite Committee on First Nations Health (TCFNH):** forum for coordinating and aligning programming and planning efforts between the FNHA, BC regional and provincial health authorities, the BC Ministry of Health (MoH), the Provincial Health Officer, the Ministry of Mental Health and Addictions (MMHA), and Indigenous Services Canada.

The Shared Vision of the FNHA, FNHC and FNHDA is Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities. The work of the FNHA and its partners is guided by the 7 Directives provided by BC First Nations Chiefs and Leaders¹.

1.2. Purpose of the Evaluation

The purpose of the Evaluation of the FNHA is to tell the story of change resulting from the creation of the FNHA, and the progress that the FNHA has made against its mandate and strategic plan. It does this by telling the story of what existed prior to transfer in the mandate of Health Canada's FNIHB, acknowledging broader mandate that was established for FNHA by BC First Nations Chiefs, and assessing the progress, challenges, constraints in the work of the FNHA to deliver on that mandate as per the goals of its strategic plan.

This is a mandatory evaluation as required under the Tripartite Framework Agreement – Schedule 1 (CF8) and the Canada Funding Agreement – Section 10.1. The evaluation is intended to provide timely information to support results-based decision-making and continuous learning and improvements at the FNHA, as well as support partner efforts in learning, growing and maturing their relationship to advance shared goals. The evaluation will address mandatory requirements (assess FNHA plans and programs, organizational structure and organizational effectiveness, and management of First Nation health provider relationships and health benefit provider relationships) in a manner that has meaning and purpose to the FNHA and BC First Nations while examining more broadly the health system transformation in BC due to the creation of the FNHA.

1.3. Overview of the Case Study Technical Report

This document focuses on the findings from the 11 case studies that were undertaken as part of the broader Evaluation of the FNHA.

The evaluation findings are divided into two parts. Part One reviews the creation of the FNHA including what existed prior to transfer, what FNHA took on at transfer and how the FNHA is meeting its mandate. Part Two provides details of each of the 11 case studies including context, impacts, gaps and challenges as well as lesson learned and opportunities for improvements.

The Evaluation of the FNHA and this Case Study Technical Report can be accessed on the FNHA website at: <https://www.fnha.ca/about/governance-and-accountability/audits-and-evaluations>

¹ <https://www.fnha.ca/about/fnha-overview/directives>

2. Evaluation Methodology

2.1. Evaluation Approach

While seeking to meet mandatory evaluation requirements, the evaluation also aims to understand the broader context, including the FNHA's progress within the surrounding health ecosystem.

2.2. Evaluation Scope

The evaluation covered fiscal years 2013/14 to 2019/20. Pursuant to the requirements set out in the Canada Funding Agreement and the Tripartite Framework Agreement, the evaluation ensured to meet the following lines of inquiry:

- Plans and programs.
- Organizational structure and organizational effectiveness.
- Management of First Nations health provider relationships and health benefit provider relationships.

In addition to addressing these mandatory requirements, a specific focus was placed on assessing the health system transformation in BC due to the creation of the FNHA. This included examining how the FNHA acted as a change catalyst within this health ecosystem, and how its role interfaced with the roles and responsibilities of other partners.

The following areas were excluded from the scope of the evaluation:

- Evaluation issues covered through other FNHA evaluations: Tripartite Framework Agreement Evaluation; FNHA-FNHDA FNHA Relationship Agreement Evaluation; Evaluation of FNHA Health Benefits – Pharmacy Program for BC First Nations (although results of this evaluation are summarized in the Health Benefits case study); and Evaluation of Performance of FNHA Directors.
- Evaluation of the agreements themselves (Tripartite Framework Agreement / Canada Funding Agreement).
- A full in-depth review of all programming areas.

2.3. Evaluation Questions and Issues

A set of evaluation questions related various aspects of the FNHA activities and operations was developed to help guide the evaluation.

Area	Evaluation Question
Context – Pre and Post Transfer	What was the context in which FNHA was created / implemented? What was the mandate of the FNIHB prior to transfer compared to FNHA mandate after transfer? What previously unoccupied space does FNHA now occupy in order to support BC First Nations health?
Alignment with BC First Nations Needs and Priorities	What are BC First Nations needs and priorities related to health? Do FNHA governance and activities align with these priorities? What mandate did BC First Nations create for FNHA? To what degree is FNHA fulfilling this mandate? What are key emerging health needs and priorities?
Relationship with Provincial and Federal partners	What is the role of FNHA related to other jurisdictions and health system(s)? Does FNHA role and current activities duplicate the role of other parts of the health system? Are there any gaps or overlaps? In what ways does the FNHA’s role and current activities complement and/or improve the role of other parts of the health system?
Changes since Transfer and the FNHA as a Change Catalyst	What changes have occurred since transfer? For example, <ul style="list-style-type: none"> • Plans and programs • Priority area for action • Organizational structure • First Nations health provider/health benefit relationships • Relationship with communities • Cultural and traditional approaches • Reciprocal accountability How has FNHA been a catalyst for change in the health system? What is the FNHA value added to the health system? For example: <ul style="list-style-type: none"> • Partnerships • Cultural safety and humility • Economies of scale • Innovation • Leverage funding • First Nations Public Service • Research and data • Urban/Away from Home

Area	Evaluation Question
Organizational Structure	To what extent have the FNHA’s organizational structures supported FNHA in achieving its organizational goals and objectives including regionalization? What are the successes and opportunities to improve effectiveness of FNHA’s organizational structures?
Learning and Measurement	Is there appropriate performance measurement in place? If so, is the information being used to inform senior management decision-makers? How can performance measurement be improved? What lessons learned and best practices have emerged to support the effectiveness of FNHA operations?
Achievement of Goals and Objectives	To what extent have the FNHA goals and objectives been achieved? What has been the impact? Has there been any unexpected impacts (negative/positive)?

2.4. Evaluation Methodologies

The evaluation was undertaken in two phases. The first phase consisted of initial interviews as well as a file and document review leading to the development of a detailed Evaluation Plan and data collection tools and methodologies, which were implemented in the second phase of the evaluation. The field research undertaken in the second phase of the evaluation included:

- A detailed review of documents and files related to the FNHA.** The resources which were reviewed included the background documents (e.g., Tripartite Framework Agreement, Canada Funding Agreement), annual reports, financial statements, strategic plans and Multi-Year Health Plans, policy framework, communication materials, evaluation reports, risk register, briefing notes and other relevant documents and files.
- Interviews with 50 key informants.** The FNHA provided a list of 68 key informants to be interviewed as part of the evaluation. The list included representatives of the federal and provincial governments, senior members of the FNHA staff, members of the FNHA Board of Directors, and representatives of the FNHC and FNHDA. As demonstrated in the following table, a total 50 interviews were completed of which 13 were completed with federal, provincial and TCFNH representatives, 25 interviews with the FNHA senior executive team members, seven with FNHA Board Members, two with FNHC representatives and three with FNHDA representatives. (This does not include the interviews that were conducted as part of the case studies which are described below).

Category	Contacted	Completed	Response Rate
Federal, Provincial TCFNH Representatives	14	13	93%
Senior Executive Team / Executive Directors	28	25	89%
FNHA Board Members	9	7	78%
FNHC Representatives	13	2	15%
FNHDA Representatives	4	3	75%
Total	68	50	74%

Focus groups with FNHA and FNHDA Board of Directors. A focus group discussion was conducted with each of the FNHA Board of Directors and FNHDA Board of Directors. The FNHC was invited to participate in a focus group session in addition to key informant interviews.

Eleven case studies were conducted to explore specific areas of the FNHA operations and activities.

- Organizational Development of the FNHA
- Wellness
- Population and Public Health (Chief Medical Officer) Function
- Client Engagement
- Urban and Away from Home
- Mental Health and Wellness
- Transformation of Health Benefits
- Nursing Service Model Evolution
- Emergency Planning and Response
- New Funding and Funding Relationships
- Changes to FNHA Corporate Services and Functions

The case studies provided an in-depth review of specific areas of the FNHA operations, evolution of these areas over time, impacts of the key changes introduced, and some of the challenges faced and mitigating strategies. The case study methodologies were comprehensive and included a detailed review of the documents and administrative files associated with each area, and a number of interviews with FNHA staff members, provincial and federal partners, community representatives and clients, and representatives of service delivery organizations. A total 110 interviews were conducted to complete the 11 case studies. An open opportunity was provided through the FNHDA for all communities to participate in the case studies.

2.5. Evaluation Considerations and Challenges

The main strategy to achieve high reliability of the findings has been the inclusion of multiple lines of evidence in the methodology. Interviews were conducted with a broad cross-section of stakeholders involved in or affected by the FNHA activities and operations. In addition, an extensive document and administrative data review was conducted. Most representatives of the FNHA who were involved in the transition process or the design and delivery of the FNHA activities and programming were interviewed. Case study methodologies were comprehensive allowing an in-depth assessment of specific areas of the FNHA activities and functions. The key findings and conclusion presented in this report have been triangulated and confirmed with two or more lines of evidence to ensure reliability. As part of this step, the strengths and limitations of each line of inquiry was taken into account.

Despite this, it is important to acknowledge certain limitations. The main limitation is the potential for respondent biases. Many of the respondents are direct beneficiaries of the FNHA activities and programming, which can lead to possible biases in their responses. Several measures were implemented in order to reduce the effect of respondent biases including the following: (i) communicated the purpose of this evaluation, its design and methodology, and strict confidentiality of responses clearly to respondents; (ii) the interviews were conducted by skilled interviewers; and (iii) cross-checked answers from each sample of respondents with the other groups for consistency and validation. For example, findings of the interviews were cross validated by results of case studies and document and file review.

Part One – Creation of the FNHA

3. Pre and Post Transfer

3.1. Pre-Transfer

This evaluation covers the time period from 2013 onwards but given this is the first evaluation of the FNHA, it is important to briefly speak to the context prior to 2013.

Significant and ongoing health disparities between First Nations and other residents of BC led to the decision by the First Nations leadership in BC to gain ownership of the First Nations health care system in BC. A 2001 report entitled, *The Health and Well-being of Aboriginal People in British Columbia* by the Provincial Health Officer drew attention to significant gaps in health outcomes². According to the report, Aboriginal people in BC had a standard of living that was likely to be 20% below the provincial average, lived an average 7.5 years less than other BC residents, significantly more likely to have chronic health conditions (e.g., 3.2 times more likely to suffer from diabetes and 3.4 times more likely to be affected by arthritis) and were less likely (8% below provincial average) to rate their health as excellent or very good. It was evident that existing system of health care delivery did not meet the needs of BC First Nations. Though Health Canada's FNIHB regional office delivered and administered programs and services, strategic direction was set from headquarters in Ottawa which did not allow for the flexibility, relationships or scope required to meet the specific needs of BC First Nations. Jurisdictional disputes between the federal and provincial governments negatively impacted the quality and availability of health care for BC First Nations. This created the context in which BC First Nations and federal and provincial governments created a new health partnership to change the First Nations health care system.

Significant political, bureaucratic and administrative challenges had to be overcome to achieve the transfer. Transfer to BC First Nations the responsibility for design and delivery of health services, was achieved through a series of health plans and agreements between BC First Nations, the provincial government and the federal government. The process took almost a decade, gaining momentum and stakeholder support over time as perceptions and attitudes shifted. The provincial government was an early supporter of transferring control over health programs to First Nations. It took longer to address concerns and build support for the transfer within the federal system. Over a number of years, a comprehensive First Nations health governance structure was established and evolved, including the FNHC, FNHDA, FNHA and TCFNH.

In 2011, 87% of BC First Nations leadership present at Gathering Wisdom IV voted in favour of proposed governance structure and the establishment of a permanent First Nations Health Authority, demonstrating a high level of unity and cooperation in their decision to support the transfer.

² <https://www.health.gov.bc.ca/library/publications/annualrpts/pho/phoannual2001.pdf>

With the Tripartite Framework Agreement finalized and signed and the agreement reached amongst First Nations leadership in 2011 to transition the First Nations Health Society to the FNHA, a complex transfer process required building new systems and structures, assuming assets, taking over programs and services and creating a new shared organizational culture while ensuring no disruptions and minimal adjustments for BC First Nations and program providers. The transfer process included:

- *Finalizing sub-agreements:* Achieving the transfer required a detailed process of analysis, planning and tripartite negotiations that was captured in a set of sub-agreements describing the logistics, parameters and mechanics of transfer.
- *Building the organization:* Balancing efforts to build an organization while maintaining continuity of the programs and services for BC First Nations created administrative and capacity challenges. Creating corporate structures (e.g., corporate services, human resources, finance, Information Management and Information Technology (IMIT) infrastructure) within a two year period required both resources and extensive management efforts.
- *Staffing:* Prior to the transfer, 100 FNHA staff positions were in place, primarily executive, corporate/administration, FNHA/FNHDA Secretariat, and policy and planning staff. During this time, the FNHA worked to develop reasonable job offers to all eligible FNIHB staff to support the transfer as well as built up staff to support corporate functions and infrastructure for which funding was received by Canada (as people and positions were not transferred for these functions).
- *Transitioning infrastructure:* Logistical challenges were addressed through close coordination. For example, joint project management teams and processes were established with FNIHB to oversee the transition of complex areas such as IMIT assets, applications and systems.

Federal transfer to the FNHA successfully took place in two phases: July 2, 2013 (headquarters functions and resources) and October 1, 2013 (regional functions, assets, resources and staff).

3.2. Expanded Mandate

BC First Nations established a much broader mandate for the FNHA, expanding well beyond that of FNIHB. FNIHB's mandate derived from the *1979 Indian Health Policy* and included providing funding to support a range of programming and services on-reserve and providing eligible First Nations and Inuit, regardless of where they live, with supplementary health benefits for certain medically required services. The BC First Nations gave a new mandate to the FNHA through key foundational and governance documents such as Tripartite Framework Agreement, Transformative Change Accord: First Nations Health Plan, Tripartite First Nations Health Plan and the 7 Directives established by BC First Nations through extensive community engagement.

The new mandate included areas that were not part of the FNIHB's mandate. These areas of expanded mandate include:

- Being Community-Driven and Nation-Based, upholding the 7 Directives, and implementing mechanisms to support engagement and decision-making processes among BC First Nations to guide the work.
- Responding in ways that are culturally appropriate and incorporating and promoting First Nations knowledge, beliefs, values, practices, medicines and models of health and healing.
- Representing the interests of all First Nations in BC, regardless of their place of residence, within the health care system, and working with them on their health and wellness journeys as a health and wellness partner.

- Collaborating with the provincial government to coordinate and integrate their respective health programs and services to achieve better health outcomes for BC First Nations.
- Modifying and redesigning existing programs or creating new health programs and services through a collaborative and transparent process with BC First Nations to better meet health and wellness needs - implementing a two-way accountability model of reciprocal accountability between the FNHA and funding arrangement holders.
- Providing population and public health leadership, undertaking First Nations-specific research, health status monitoring, gathering knowledge and collecting and maintaining clinical information and patient records.
- Prioritizing disease and injury prevention and a wellness approach in health, and building multi-sectoral partnerships to better address the social determinants affecting the health status of First Nations.

The new mandate given to the FNHA required the organization to take a more strategic and long-term approach in its activities and focus on transforming the health system for BC First Nations, rather than simply delivering mandated programs and services. To be able to deliver on its new mandate, the FNHA had to focus on:

- Creating a clear vision for the transformation, developing plans and strategies and allocating time and resources to create a new reality.
- Taking a much more strategic/system-wide approach, which meant not just delivering programs and services, but also working to address the root causes of health disparities.
- Developing corporate and strategic planning capacity, including the recruitment of new staff to develop and deliver these functions.
- Focusing on serving the needs of all First Nations, including those living in communities as well as those living in urban areas.
- Creating regional capacity to support communities and clients in their health and wellness journeys.
- Engaging clients and communities as equal partners in the decision-making process and being closely connected to learn about their specific needs.
- Making changes to existing programs and implementing new programming/services/roles to better meet the health and wellness needs of BC First Nations.
- Building partnerships, influencing policies and programs implemented by partners, and coordinating activities with partners for better health outcomes.
- Leveraging additional funding and resources to be able to deliver new programs and address unmet needs.
- Being flexible, agile and innovative in its approach.

The FNHA had to overcome significant issues to be able to build its organizational capacity to implement the expanded mandate. The major issues that the FNHA had to address were related to building infrastructure, recruiting staffing, developing organizational systems and unified organizational culture and overcoming the systems it inherited from FNIHB.

- *A complex transfer process required building new systems and structures, assuming assets, developing organizational and corporate capacity, taking over programs and services and creating a new shared organizational culture. This process needed to take place all the while ensuring no disruptions and minimal adjustments for BC First Nations and program providers.* The most important challenges related to finalizing sub-agreements, building a new organization (recruiting staffing particularly to senior positions and transitioning or obtaining new infrastructure, etc.), within the new realities while maintaining continuity of the programs and services for BC First Nations. Creating organizational structures, systems, policies and corporate structures (e.g., corporate services, human resources,

finance, IMIT infrastructures) within a two year period required both resources and extensive management efforts. There was a plan developed to allow for transfer but within the context that transition be a continuing process to improve and evolve these systems, structures, and policies through time. Cost and complexity of transferring or creating the systems from scratch was significant. The FNHA worked extensively with partners to prepare and address the upcoming challenges associated with the transfer.

- *The FNHA inherited an organizational structure and program delivery system based on colonialism. The health delivery governance was structured by the Indian Act and based on separation of on-reserve and off-reserve activities. The system was under-resourced, largely unresponsive to community needs, bureaucratic and inflexible. Programs were delivered in silos and fractured by partial transfers to communities and Tribal Councils but lacking regional and provincial governance and coordination.* Prior to 2013, First Nations health service delivery was characterized by multiple overlapping jurisdictions. While the province was mandated to provide health services to all BC residents, including First Nations living on- and off-reserve, the provision of services for First Nations on-reserve was seen as the exclusive responsibility of the federal government. As such, provincially funded services were not widely available to this population. The result of this multi-jurisdictional arrangement was a lack of clarity with respect to the responsibility for health services provision for First Nations on- and off-reserve. The lack of coordination between these jurisdictions resulted in service gaps and discontinuity in the continuum of care for First Nations. The federal system, characterized by top-down decision-making included limited input from First Nations political leadership and communities, resulting in services that were perceived as discriminatory and failing to recognize and respect First Nations cultures.
- *The challenge of merging two distinct organizational cultures and subsequently adding new employees that came from different cultural and organizational backgrounds.* The FNHA's new staffing was comprised of former employees of FNIHB; newly recruited members of the First Nation Health Society; and new employees mostly driven to the organization by its mandate (e.g., employees who had a passion to make a difference, but not necessarily adequate understanding of the expected challenges). The FNHA faced challenges to increase its workforce as well as to develop and implement new departments, policies and programs. Additionally, the organization had the unique challenge of needing to merge two distinct organizational worldviews with the on-boarding of FNIHB employees and the hiring of new staff. The FNHA's mandate and philosophy of moving to a culturally informed, community-responsive approach for service delivery was markedly different than FNIHB's top-down bureaucratic approach. Some former FNIHB employees could not adjust to the FNHA. Therefore, many of the previously held FNIHB positions needed to be filled or otherwise restructured. Additionally, new employees recruited to staff up the expanded strategic and corporate responsibilities were neither familiar with the FNHA nor its new organizational culture. Building a unified organizational culture became a central priority for the leadership group assisted by the Knowledge Keepers and the values of the Wolf Clan.
- *The ongoing experiences of health inequities related to a colonial history and specifically the impact of residential schools.* Longstanding differences in health outcomes for Indigenous people are linked directly to broad historical and social inequities such as colonialism, residential schools, poor community infrastructures and a lack of education and employment opportunities. Although fully expected, the extent of health inequities between First Nations and the general BC population meant that the FNHA essentially inherited a failed federal system but was expected to redress these inequities quickly. The FNHA leadership was focused on building an appreciation of these conditions into policies and programs, and continued work in partnership with the provincial health system, recognizing that the FNHA alone could not redress these inequities.

- *A provincial health system that is culturally unsafe for First Nations and which has not historically been well integrated with First Nations health care systems and practices.* The literature makes clear the extent to which the health care system discriminates against Indigenous peoples. Racism is experienced by Indigenous peoples at the point of care as well as at systemic and structural levels. The FNHA had to work cooperatively with a provincial acute-oriented system characterized by a lack of experience cooperating with the on-reserve service environment. The FNHA and the provincial health system were committed to work cooperatively to address both jurisdictional gaps and enhance cultural safety and humility.
- *The FNHA is working with and within a colonial illness-focused model.* The FNIHB system was strongly oriented to responding to sickness, with little in the way of health promotion or strategies for individual and community wellness and healing. The provincial health system is focused on hospital and acute-care and has little dedicated resources for promoting wellness. The new mandate given to the FNHA by the First Nation communities indicated a need for bringing a wellness philosophy into its activities and programming as well as integrating wellness into the provincial system.

3.3. FNHA Fulfilling Mandate

The following section provides a high level summary and some illustrative examples of the FNHA's work to fulfill its mandate, which is elaborated more fulsomely in the case studies that follow.

Staffing

Transitioning federal public service employees to the FNHA involved extensive negotiations with Canada and the federal unions, and a process of extending Reasonable Job Offers to 222 permanent and 18 term federal employees. The accepted Reasonable Job Offers totaled 133, and along with 100 existing FNHA staff, the FNHA's staff complement at transfer totaled 233.

The FNHA utilized funding negotiated in the Canada Funding Agreement to build organizational strategic and corporate capacity; implement new staffing to directly deliver or support administration of new funding in areas such as Primary Health Care and Emergency Management and Response; and as per direction given by First Nations leadership in consensus papers, enhanced the staffing of regional teams to be responsive to regional context.

At the end of the 2018/19 fiscal year, the FNHA employed 748 staff with the majority (67%) being community-facing – supporting direct community engagement, direct service delivery, program and service support services, and funding arrangement relations with First Nations communities and mandated health services.

Engagement

BC First Nations engagement occurs both with community political and health administrative leadership (primarily through fall and spring Regional and Sub-Regional Caucus sessions, Gathering Wisdom for a Shared Journey every 18 months, topic-specific engagements, Regional Health and Wellness Plans, and Regional Partnership Accord tables), and with clients (primarily through Gathering Our Voices for youth, and Elders Gathering events, as well as topic-specific client focus groups and surveys). The FNHA provides funding and staff and participates in these engagement opportunities with governance partners.

Health and Wellness Needs of BC First Nations

Addressing root causes of health disparities (e.g., systemic racism, discrimination and social determinants of health), in part by promoting cultural safety and humility of health care services; championing the BC First Nations Perspective on Health and Wellness; partnering to develop new strategies and policies (e.g. Indigenous Cancer Strategy); enhancing health and wellness data; and supporting community partnerships, such as with the Wellness Grants.

Programs and Services / Roles

Implementing new programming and/or undertaking new roles to better meet health and wellness needs of BC First Nations including:

- Additional programs and services above what was transferred from FNIHB in areas like primary health care, collaborative practice and mental health and wellness.
- Tailoring programs and services that were transferred to better meet the needs of BC First Nations (e.g. bringing health benefits closer to home through partnership with PhamaCare and Pacific Blue Cross).
- Emergency response capacity and engagement in partnership with the provincial government to ensure their emergency response met community needs.
- Crisis response teams to support communities in responding to the mental health crisis.
- Office of the Chief Medical Officer function that provides health and wellness leadership grounded in traditional and western approaches to health, wellness and healing.

Partnership with Provincial and Federal Partners

In 2012, the FNHC and federal and provincial ministers signed a *Health Partnership Accord* that established a vision for an evolving and deepening tripartite health partnership. The Tripartite Committee on First Nations Health continues to evolve as a key forum for health sector leadership and reciprocal accountability. A series of agreements are also finalized each year between the FNHA and relevant federal and provincial departments to articulate principles, collaboration processes and joint annual priorities.

Urban and Away from Home Population

Specific focus has been placed on integrating the interests of the urban population in all program and policy decisions and serving the needs of all First Nations in BC, not just those living on-reserve.

Part Two – Case Study Reports

4. FNHA Organizational Design

There has been extensive transformation in the FNHA organizational structure and processes that have occurred since taking over responsibilities from FNIHB in 2013.

The British Columbia First Nations Health Governance Structure includes four components:

- The First Nations Health Authority (FNHA)
- The First Nations Health Council (FNHC)
- The First Nations Health Directors Association (FNHDA)
- The Tripartite Committee on First Nations Health (TCFNH)

The FNHA is managed by its Board of Directors. The FNHA's Board of Directors is the corporate governance arm of the BC First Nations health governance structure. The Board of Directors provides leadership and oversight for all of the FNHA's corporate activities. It is composed of nine individuals, five selected from nominations made by First Nations in the five regions (Fraser Salish, Interior, North, Vancouver Coastal and Vancouver Island) and four selected at-large through an advertised process.

The FNHA's organizational structure consists of the Chief Executive Office, which provides leadership for the activities and progress of the organization's functional areas including:

- Chief Operating Office (which includes the Regions; Health Benefits; Nursing; Programs and Services; Community Capital)
- Information Management and Information Technology (IMIT)
- The Chief Medical Office
- Human Resources
- Chief Financial Officer and Corporate Services (which includes Policy, Planning and Quality; Communications; Legal; Financial Planning, Accounting Services and Payroll; Procurement; Accommodations and Fleet)
- FNHC and FNHDA Shared Secretariat

4.1. Evolution of the FNHA Over Time

The FNHA has evolved to fulfill its mandate, mature the organization and address challenges. This has included:

- **Building organizational strategic and corporate capability.** As per the Tripartite Framework Agreement and Canada Funding Agreement, funding was provided to the FNHA to build corporate and strategic management capacity (positions and people were not transferred for these functions). Using these resources, the FNHA built strategic planning, headquarters, finance and senior corporate functions within the organization. This new capacity had to be built because: 1) it did not exist under FNIHB, but now it was part of the FNHA's new mandate (e.g., the function of the Chief Medical Officer, research and data and quality assurance); 2) some of this new capacity was undertaken by FNIHB in Ottawa and not in the region (e.g., strategic policy and evaluation); and 3) some of this capability was provided to FNIHB by the broader federal public service and not available to the FNHA post-transfer (e.g., finance, human resources and, information management and technology). The process also included transferring IMIT infrastructure, creating new systems and structures or replacing old infrastructure (e.g., health benefit data warehouse, call center, implementation of PeopleSoft) and developing organizational policies, processes, guidelines and structures.

- **Supporting a governance model that includes political representation and advocacy by the FNHC and technical support and capacity development through the FNHDA.** Both the FNHC and FNHDA are part of the BC First Nations health governance structure. From the beginning, it was agreed that the FNHA would serve as a central administrative body to support the mandates and activities of the FNHC and FNHDA. The FNHA created the FNHC and FNHDA Shared Secretariat led by an Executive Director who is supported by a number of additional staff who provide strategic advice, technical analysis and coordination in support of the FNHC and FNHDA functions. The FNHA also provides corporate services such as finance, human resources, IMIT, community engagement, communications, office accommodations and legal and policy support to the Secretariat.
- **Assuming new roles and undertaking new areas of programming and services.** Prior to transfer, FNIHB's approach was to primarily contract out certain functions, programs and services to partner organizations and to support communities in assuming the direct delivery of their programs and services. Following transfer, the FNHA gradually assumed many of the responsibilities that had been contracted out (examples include conversion of community engagement hub contracts to the FNHA regional staffing, and assuming the tuberculosis program previously administered by the BC Centre for Disease Control). Additionally, over the past five years, the FNHA has taken on new roles and responsibilities to deliver on its expanded mandate, consistent with the mandate provided to the FNHA by First Nations. Some of these new areas of programming and responsibilities include:
 - Implementation of new programs and services in addition to those that were transferred over from FNIHB, such as primary health care and mental health and wellness.
 - Tailoring of programs and services that were transferred to better meet the needs of BC First Nations (e.g., bringing health benefits closer to home through partnership with PhamaCare and Pacific Blue Cross).
 - Development of an emergency response capacity and engagement with the provincial government to meet community needs.
 - Creation of regional crisis response teams to support communities' ability to respond to the mental health crisis.
 - Creation of the Chief Medical Officer function for health and wellness leadership grounded in traditional and western approaches to health, wellness and healing.
 - Creation of Chief Nursing Officer function to represent nurses both at the most senior level within the organization and externally as well as to oversee efforts for transforming nursing and clinical services.
 - Creation of new governance systems for First Nations-specific data, ability to access provincial data sources and capacity to undertake First Nation-specific research.
 - Development of organizational capacity to engage with communities and clients.
 - Creation of organizational capacity to address needs of urban and away from home clients.
 - Engagement in extensive collaboration and partnerships with the provincial health system to achieve significant changes in the BC health care system to contribute to health and wellness of BC First Nations.

In addition, First Nations communities are increasingly asking the FNHA to assume direct service delivery in areas previously provided through community contribution agreements.

- **Leveraging substantial funding from federal and provincial sources to implement new programs and services, which required additional administrative capacity, expanded staffing and contributed to growth of the organization.** Over the five-year period (2013/14 to 2018/19), the FNHA leveraged \$257.6

million in new funds from different sources, accounting for 9.3% of all FNHA’s gross revenues. Sources of new funds included monies provided by the provincial and federal governments as well as leveraging funding opportunities from other national and provincial organizations. These funds were provided to allow the FNHA to administer new programming and services or to take on new roles and responsibilities, which also increased the need for corporate capacity, staffing and contributed to growth of the organization. Examples of new sources of funding to deliver programs and services included significant new investments into mental health and wellness programming, projects supported through Joint Project Board, administration of surveys and funding for the Indigenous Cancer Strategy.

- Recruiting new staff to match growing services and capacity.** By the beginning of the fiscal year 2013/14, the FNHA received funding to create headquarters functions, and had begun a process of building up its staff in anticipation of the transfer of FNIHB-BC Region. Prior to this, the FNHA was composed of an executive team, a small administrative team, the FNHC and FNHDA Shared Secretariat, and policy and planning staff. Leading up to the transfer, the organization brought on enhanced transition and corporate resources to ensure its readiness to assume the operations of FNIHB-BC Region. On October 1, 2013, the FNHA’s size expanded greatly with the welcoming of 133 former federal FNIHB employees to the FNHA. At the time of transfer, FNHA’s staff complement was 233 positions. Over the seven-year period, the employee count has increased to 748 at the end of fiscal year 2018/19. Most noticeable employee growth occurred during first three years after transition, during which time the FNHA transitioned former FNIHB staff, built corporate functions, created a regional presence and established solid organizational systems.

As the organization matured, the growth slowed considerably and was primarily associated with an increased need to undertake additional services, implement new programming and create corporate capacity to be able to deliver on these new roles. To date, the three main areas of staff growth have been associated with nursing services, building regional capacity, and administrative and corporate support services collectively (finance, human resources and IMIT). Some growth was associated with a number of large scale and transformative projects of the FNHA (transitioning IMIT infrastructure, transitioning health benefits, building data warehouse, call center). According to case study participants, many of the positions associated with these large scale projects are temporary and may not be needed once the projects are completed. In 2018/19, 67% of the FNHA’s staff were employed in roles related to delivering programs and services to the communities, supporting direct community engagement, direct service delivery, program and service support services, and funding relations with First Nations communities and mandated health services.

Fiscal Year	Employee Count
2013	100
2014	372
2015	461
2016	587
2017	613
2018	658
2019	748

- Focusing on developing Indigenous capacity.** The FNHA created processes and structures to hire, train and promote Indigenous employees. Human resource systems on hiring, mentoring and capacity building were created to increase Indigenous employment. These processes were clearly articulated and promoted across the organization and First Nations communities. In 2018/19, 35% of the FNHA’s

employees self-identified as First Nations, Inuit or Métis, consistent with the average percentage maintained over the past six years.

Fiscal Year	Total Employees	Self-identified as Indigenous	%
Transfer	100	50	50%
2013/14	372	107	29%
2014/15	461	156	34%
2015/16	587	235	40%
2016/17	613	231	38%
2017/18	658	222	34%
2018/19	748	259	35%

- Implementing leadership strategies to build a strong organizational culture based on First Nation traditions.** Partly in response to the tensions created by the friction between transitioning FNIHB employees and new FNHA employees (particularly Indigenous employees), the FNHA implemented a strategy to build an organizational culture that explicitly expressed the values of the Wolf Clan, a key component of Coast Salish culture. Elder Leonard George and later, Knowledge Keepers Shane Pointe and Syexwalia Ann Whonnock were brought in to work with the FNHA leadership group in an effort to instill First Nations values related to cooperation, mutual respect and responsibility. First Nations values were incorporated throughout all aspects of the organizational activities (e.g., involving Knowledge Keepers, prayers, territorial acknowledgements, organizing family gatherings and ‘Better Together’ ceremonies). Likewise these were promoted across the organizations (e.g., internal communication, booklets, etc.). The FNHA’s organizational mandate, vision and the values are constantly communicated to staff.
- Making changes to its service delivery model and investing in regional capacities.** As part of the consensus development amongst BC First Nations to create a BC First Nations health governance structure, there has been a strong mandate to create and/or redistribute staffing resources to enhance the number of staff working within the five regions. Therefore, the organization created regional teams that did not exist prior to transfer. While staffing and stability of the FNHA’s operations has grown, so too have the number of positions distributed across the regions. As demonstrated in the following table, in 2019, 18% of all FNHA positions were associated with its five regional offices. To reallocate the positions to the regions, the FNHA utilized vacancies and attrition to relocate positions to regions where possible. It also allowed some of the supporting positions to be regionally based even if they perform corporate functions and/or report to centrally based management. At the time of this case study report, all five regions employed a range of senior (e.g., Regional Executive Directors) and service delivery teams (nurse managers, practice consultants, mental health and wellness specialists, crisis response team, emergency coordinators, and engagement teams.). The executive team has approached enhanced regional capacity efforts with the aim to ensure sustainable expansion within the limits of existing resources.

Breakdown of Positions	#	%
Program Teams	350	38%
Corporate Teams	207	22%
Regional teams	163	18%
Surge Capacity	115	12%
Policy, Planning, Quality	61	7%
Governance and Leadership	31	3%
Total	927	100%

- **Promoting Indigenous concepts of wellness within the organization and with employees.** The FNHA has acted as a wellness champion through its commitment to embedding wellness approaches within all of its internal policies and programs (Human Resources, Health Benefits, IMIT strategies, etc.). In the fall of 2019, the FNHA organized the Wellness Summit bringing together all key stakeholders within the organization and from the communities in order to define wellness priorities and to develop a plan of action. The plan of action will help to better coordinate the FNHA's and First Nations communities activities focused on promoting wellness. It will ensure all departments within the organization (e.g., human resources, finance, programs and services, IT, etc.) have a good understanding of the FNHA's wellness philosophy and incorporate wellness into their daily activities and programming.

4.2. Impacts of the FNHA on Service Delivery

The FNHA has set a successful example of a First Nations organization that can deliver effective health and wellness services. Despite many challenges, the FNHA is the first provincial-level First Nations organization in the country and exemplifies building a successful First Nations organization at this level. Case study participants indicated that, in general, there is a sense that ten years of organizational development have been accomplished in five years. The FNHA has become a strong provincial organization that can deliver effective services and respond to emerging needs and challenges of its clients. Increasing numbers of First Nations communities and organizations are requesting the FNHA to share this capacity for their own organizational and administrative needs (e.g., host agency functions, use of organizational policies and procedures as templates, leverage IMIT systems). The development of the FNHA is considered a great achievement and can be used as an example for developing similar First Nations initiatives across the country. As noted by one case study interviewee, “the FNHA has raised the bar for First Nations organizations and that has been reflected in all other areas of our work and work of our partners.” The FNHA can also set an example for Indigenous organizations and communities internationally who are at different stages of developing self-determination in their health systems.

The FNHA has built a sense of ownership of the FNHA among First Nations. In the past, First Nations did not feel ownership over the health infrastructure and programming and services delivered in their communities. Case study interviewees commented that there is a growing sense of ownership among community members. As the services are becoming more community-driven and responsive to community needs, First Nations feel more in charge of their own health system. Case study participants noted that this greater sense of ownership will translate into increased self-confidence and community resilience. It is already leading to some funding recipients seeking to have the FNHA directly deliver services, rather than funding for these services continuing to be provided directly to communities.

The FNHA has developed into a transformative change agent for the entire health care system in BC. By building strong partnerships with the provincial health services, the FNHA has been able to influence provincial policies and services by incorporating First Nations perspectives throughout the health care system. Case study interviewees noted transformative change through: the signing of cultural safety declarations and extensive work undertaken by the provincial service delivery organizations to incorporate cultural safety and humility into their work; the FNHA's active role in the development of the provincial Primary Care Networks and identification of new First Nations-led primary care projects; and the creation of collaborative governance structures with the MoH and MMHA.

4.3. Gaps, Challenges and Issues

The rapid growth of the FNHA has resulted in a number of challenges and issues, some of which continue to affect the activities of the organization.

Effectively operating in a mixed union/non-union environment. The most critical issue of transition related to transferring FNIHB employees who had worked in public sector jobs to employment positions with an organization which was managed and accountable to First Nations. It required extensive negotiations with the unions representing the former FNIHB employees. Four collective agreements were signed prior to transition were consolidated into two bargaining units, however challenges with collective bargaining persist. Case study interviewees noted the existing or potential challenges of unions having limited understanding of organizational culture based on First Nations traditions (e.g., Wolf Clan) which could lead to further disputes and lack of clarity regarding positions that are subject to collective bargaining. Interviewees also noted that there is work to do to ensure that all FNHA managers have an understanding of the FNHA's union partnerships and obligations, particularly in the creation or evolution of new positions and functions.

Ongoing changes within the FNHA's organizational structure and operations created some confusion among staff members with regards to their roles and responsibilities which affected morale. Staff turnover, particularly at the senior level, continues to be an issue. Many of the FNHA staff members expressed that working for a dynamic and growing organization has been a privilege. However, the rapid change has created pressure and tensions within the organization, which has affected staff morale, resulted in burnout and contributed to high staff turnover, particularly at the senior level. Efforts have been made to develop human resources policies and programs to mediate the impacts of this experience. However, according to stakeholders, staff burnout continues to affect the organization and staff turnover. The results of the 2018 and 2019 satisfaction surveys, conducted with the FNHA staff members, confirm these findings. According to the survey, while majority of the employees were proud to work with the FNHA (85% in 2018 and 82% in 2019), overall were satisfied with their employment (80% in 2018 and in 2019), found their workplace energizing, challenging and motivating (80% in 2018) and felt that they belonged to the FNHA family (70% in 2018); a significant proportion also did not feel that they were collaborating with employees from other departments at an adequate level (34% in 2018 and 33% in 2019 reporting collaboration was adequate), and less than half rarely thought about looking for job with another organization (42% in 2018). The other areas where employees provided lowest ratings included trust (43% in 2018 and 42% in 2019), receiving proper communication to perform duties effectively (56% in 2018), and support and recognition for their role in the organization (59% in 2018). Comparative review of the survey results between 2018 and 2019 demonstrated consistent results across two years with some improvements in certain areas (e.g., communication, effective leadership, and work life balance) and slight decline in other areas (e.g., involvement and belonging, focus on customers, professional growth and development).

Challenges with incorporating Indigenous traditions into the organizational culture. During interviews, some staff members noted that the full scale incorporation of First Nations cultures into the organization has experienced certain challenges. The concept of the Wolf Clan, for example, has been difficult to understand and communicate as Wolf Clan teachings vary across First Nations cultural groups, regions and those of other backgrounds. However, efforts to create organizational culture based on First Nations traditions are ongoing and include the involvement of Knowledge Keepers in defining and communicating organizational values (e.g., concept of 'Nuts amaht' which translates into English as 'we are one!'), creating and distributing

booklets and information materials describing the FNHA's organizational culture and values, and prayers, recognition and territorial acknowledgements during events, meetings and ceremonies. There also a recognition that there is a need for a cohesive organizational culture founded in First Nations teachings, while recognizing the diversity of First Nations cultures in BC.

Rapid growth and development has, at times, resulted in a tendency for managers/departments or regions to develop silos in their activities. As new programs and departments have developed, there has been a need for constant administrative change at senior levels. This has resulted in changes in reporting relationships and changes in resources available to different units. These changes and the rapid growth of the organization have affected the level of cooperation within and across the organization. The level of cooperation among members of the senior team have also been affected by differing approaches to work and cooperation and visions for organizational growth. During interviews, case study participants noted that a degree of isolation is expected given the size of the organization and the extent of the geographic area that the FNHA activities cover. The main challenge for the senior management is to find adequate level/model of cooperation across departments/regions to ensure to maintain effective and efficient operations. During interviews, representatives of senior management noted that they have recognized the issue and have taken extensive efforts to maintain adequate level of cooperation across organization and address potential areas of silos that can create inefficiencies. Some of such initiatives implemented by the FNHA senior leadership, include:

- Creation of the corporate Senior Executive Team (cSET) forum, where senior executives from the corporate functions come together regularly to discuss and coordinate the most pressing issues.
- Development of the Strategic Projects Office, which provides process leadership to support improved governance and oversight of strategic projects implemented by the FNHA through regular Strategic Projects Executive Committee meetings, approval processes and development of the project standards and processes.
- Creation of the Architecture Review Committee, a cross departmental committee that provides oversight for key decisions of the FNHA on information management and technology.
- Creation of the Policy Committee that brings together staff members across different departments to coordinate policy development and gathers input on specific policy issues.

Building a new organizational structures and systems required greater involvement by senior management in day-to-day activities of the organization, reducing the time they could allocate to more strategic initiatives. In the early days of the organization, the senior executives were required to be very hands-on due to the relatively small number of staff and the relatively junior level of experience many brought to the organization. New systems and functions had to be built requiring extensive involvement from senior managers. As the organization matured and systems and structures were functional, senior executives were able to move into more strategic and supervisory roles. However, as is common with all rapidly growing organizations, occasionally, members of the senior team are still drawn into day-to-day or project management matters. During case study interviews, members of the leadership team acknowledged that they still allocate time and efforts to day-to-day and/or project management; however, they are also undertaking efforts to delegate more authority to middle management. As the middle management becomes more experienced, their involvement in undertaking major projects and initiatives are increasing. The creation of the Strategic Projects Office have helped better coordinate and manage large scale projects and initiatives, allowing for more efficient use of senior management time.

Evolving identity. Case study participants noted the challenge around finding an organizational identity. FNIHB operated mostly as a funder and was not involved in delivering direct services. In addition to providing funding, First Nations also gave a new mandate for the FNHA to act as a health and wellness partner for all First Nations in BC regardless of their location. The FNHA has also been increasingly involved in delivering services directly to communities. The FNHA's involvement in new areas of programming and taking on new roles creates the potential for duplication and overlap with services provided by other agencies thus creating confusion for some stakeholders.

FNHA's operating model is still evolving and not clearly defined. It has been a challenge to find a strategic vision for an operating model for the FNHA that can effectively function at the provincial, regional and local/community levels, (e.g., operations and services delivered by regions vs. corporate office) and balancing organizational growth at all three levels. The growth of the organization, particularly increase in positions located at headquarters in Vancouver, has created concerns among some First Nations that the FNHA is becoming too centralized and 'top heavy'. More recently, some First Nations have expressed a need for the FNHA to accelerate regionalization processes.

During interviews, all case study participants agreed that regionalization - building a capacity closer to the communities - is one of the top priorities for the FNHA. As per directives given by 2012 Consensus Paper,³ the FNHA was to develop regional offices that would serve central repository and main contact for information within the region and provide technical support for the work of the regions. The paper also indicated that a cost effective approach should be implemented in planning and creating regional offices. According to case study participants, creating a strong capacity in the regions is critical because regional staff members often are better positioned to develop sound understanding of local needs, build closer relationships with communities and deliver more effective services. First Nations communities are also more willing to work with staff member with whom they can meet regularly, communicate directly and build trusted relationships.

According to FNHA corporate documents, a phased approach is being used to implement regionalization. The first phase of the regionalization was the creation of regional offices in 2015/16 and recruitment of Regional Directors (which became Regional Executive Director positions in 2018/19). Efforts have also been undertaken to hire more regional staff, re-assign existing employees to regions (e.g., Nurse Managers, Practice Consultants, Regional Directors of Engagement positions, Network Analyst), allocate more resources and programming to regions (e.g., regional envelopes and Health Actions funding, Environmental Public Health, Aboriginal Head Start On-Reserve and some Primary Care positions) and develop regional infrastructure. To date, increase in regional staffing has been one of the main areas contributing to organizational growth.

For the next phase of the regionalization, the program staff members particularly, regional leadership expects to see a relatively high level of corporate and functional capacity in the regional office (i.e., finance,

³ Consensus Paper 2012: Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure.

human resources, IMIT). Some case study participants recommended functions of FNHA headquarters may need to be downsized in order to adequately support regional capacity. Named as “Corporate Lite,” the plan includes creation of positions in the regions related to human resources generalist, finance (e.g., budget planning, financial consultations, funding arrangements) corporate services (e.g., fleet, accommodations, event planning) and policy/evaluation to support program evaluation and policy development activities in the regions. Regional leadership justifies a need for corporate service function due to a number of reasons, including:

- As the regions have grown in size, their need for administrative and corporate support have grown substantially. The regions' need for corporate supports and functions are quite distinct and difficult to be administrated by those who operate in central office.
- The regions often are not able to receive timely and/or appropriate support from head office, having had to assign corporate duties to existing staff members in the regions increasing work load and creating 'shadow' functions. At the same time, delays in receiving timely approvals, decisions and support from head office affects community satisfaction with the services that they receive from the FNHA and the reputation of the organizations.
- Regional and program staff members feel that some of the corporate policies, structures and systems do not fit their regional specific needs and they need more flexibility around financial, human resources and policy and program decisions. The vision is that the organization should grow from bottom up, instead of based on direction from a senior leadership.

Case study participants also noted an importance of having a strategic approach to regionalization as it is a complex undertaking and should be implemented with proper planning, staff engagement and adequate due diligence. It was mentioned that developing a plan of action and identifying regionalization objectives and priorities and engaging with staff members and governance partners to receive a proper buy-in was necessary. The plan should identify which functions or operations would be more effective or efficient to be implemented from regions or central office, and develop strategies for smooth transition. According to these case study participants, a proper planning and strategic approach will ensure:

- *Maintaining organizational efficiencies and contributing to financial sustainability.* It is necessary to avoid creating parallel structures (e.g., IMIT systems, human resources policies) across regions and programs/departments, which may result in overlap of the services and duplication of efforts.
- *Quality and consistency of the services.* Having proper planning, systems and structures in place will ensure decentralized model has proper quality control over program, policy, planning and financial decisions across departments, regions and/or sub-regions.
- *Maintaining advantages gained from functions of a provincial entity.* Over the past five years, a significant value has been created (e.g., new investments and sources of funding, changing provincial policies and programs) through close cooperation with the provincial government. Maintaining the FNHA's capacity to work with the provincial government will ensure the FNHA continues to leverage provincial funding and influences provincial policies and programs by bringing forward First Nations perspectives.
- *Organizational unity.* Adequate level of cooperation across departments, regions and staff will ensure to avoid creating silos and maintain strong organizational culture, unity, a common voice and shared approaches and principles. It is necessary for the FNHA to continue speaking with one common voice to be able to represent all First Nations in BC and communicate their needs and priorities.
- *Keeping a focus on addressing needs of clients who live in urban areas and away from home.* Ensuring regionalization priorities provides adequate support to programming targeted at urban and away from home clients, given that the current regional model tends to be primarily oriented to the on-reserve population.

Case study participants also noted that it is necessary to conduct a proper review of the activities that were undertaken as part of the Phase I regionalization and identify some of the challenges and lessons learned. These lessons should guide the Phase II implementation.

Complexity of the FNHA design and governance structures requires consistent communication, coordination and alignment of activities. The FNHA operates through a complex health governance structure established by several legal and political agreements, which includes political support provided by the FNHC, technical assistance from FNHDA and involvement by the provincial and federal governments in tripartite processes. The complex structure creates many lines of accountability between partners requiring consistent communication and coordination (e.g., FNHC providing political support and also playing a role in appointing FNHA Board of Directors, FNHDA members providing technical support and also delivering programming at the community level). Case study interviewees mentioned that when coordinated well, these layers of accountability and interactions can create alignments and contribute to the overall success of the FNHA operations. When they are not managed well, which happens at times, the complexity can create impediments and challenges (e.g., political interference, bureaucracy), thus slowing down progress.

Challenges with addressing ever-increasing expectations and requests for services from the communities. Although a greater sense of community ownership over health is a very positive development of the FNHA, it has also led to rising expectations which may be difficult to meet when federal funding plateaus. The FNHA is trying to find strategies to handle increasing expectations while finding cost-efficient ways to address community needs.

Difficulties in recruiting First Nations staff with appropriate training and skill sets. Mentorship and on-going training opportunities for First Nations are available but not sufficient to support the development of adequate capacity, especially for the managerial and leadership positions.

Transferring and building some of the functions and capabilities took longer than anticipated. The FNHA expected to transition the Health Benefit program from FNIHB within the first two to four years of the transition as per the *Health Benefits Service Agreement*. The process, however, took much longer and was only completed in 2019. During the case study interviews, FNHA staff members noted that they did not expect the complexities associated with transferring these systems and/or building those capacities from scratch. These were associated with higher than expected costs, complex and technical change management initiatives, and significant efforts by the leadership team. The FNHA mostly addressed these issues by undertaking buy-back arrangements or other temporary solutions while finding complex solutions to the problems.

4.4. Lessons Learned and Opportunities for Improvement

Leadership development support is needed to build an integrated and collegial leadership team. The pace of growth and development has inevitably challenged the leadership team to remain cohesive and mutually supportive. Although the teachings of the Wolf Clan are important to this process, the complexity and capacity limitations of the FNHA suggest the need for established organizational development. Systems should be built to ensure that BC First Nations leaders can grow within the organization, work in a mutually supportive environment, and lead key strategic areas of the organizational growth and development.

Ongoing organizational support focused on strengthening leadership team may help with the process (e.g., coaching and organizational development consulting).

The degree of staff turnover during the early days of operations was expected. Case study participants noted that staff turnover occurred in the early days of transition. For example, some FNIHB employees left the FNHA because they preferred the federal public service and some new recruits were not a good fit to work under very dynamic and constantly changing work environment. However, it was noted that current employees (including former FNIHB and new employees) are united under one organizational culture. Case study participants commented that not all skills and personalities are suited to work for the FNHA and that is normal given FNHA's unique work culture and environment. Therefore, the FNHA should create recruitment systems to identify employees that can best fit with its organizational culture.

Strengthening supports and enablers for staff at both the central and regional offices should be a priority. Staff turnover due to burnout and morale issues associated with rapid growth and organizational change is an ongoing challenge to the future stability of the organization. The FNHA needs to undertake efforts to reduce staff turnover by hiring people who can operate within a challenging and dynamic work environment, building strong employee communication and transparency, support and mentorship systems, and ensuring that employees feel valued for their contributions to the organizational mission and objectives.

More consistent communication with staff members is needed. Ensuring that staff is constantly informed about changes and events happening within the organization can develop a greater sense of belonging and ownership. Major decisions about the future of the organization need to be transparent to all employees to ensure continued support for leadership.

There is a need to develop strategies to further define regionalization priorities and create an operating model that can function effectively at the provincial, regional and community levels. A strategic approach to finding the most appropriate delivery model for regionalization will require the FNHA to:

- Conduct a proper review of the regionalization activities undertaken in Phase I to identify issues and challenges faced and some of the lessons learned, which can be applied in next phase of the regionalization.
- Review existing operations and functions and engage across the organization (and with health governance partners such as FNHDA and FNHC) to identify most effective and efficient operational model for the organization and identify key areas of organizational structures and functions that should be implemented on a centralized rather than regional basis. As part of the process, identify advantages and disadvantages of different models of operation and determine feasibility (and potential risks and challenges) of transferring each critical function/program to regions.
- Based on findings of previous steps and as per requirement of the Census Paper of 2012, develop and implement a *Regionalization Action Plan*. The Plan should be developed in close coordination and receive buy-in of the FNHA staff, Regional Executive Directors, and governance partners. It should highlight specific phases and steps of the regionalization and clarify timelines.
- Employ some of the best practices implemented in other jurisdictions. It is recommended to explore how other similar organizations (e.g., provincial health authorities) structure and deliver their services and identify some of the key lessons and best practices that can be adapted to operations of the FNHA. For example, as part of the case study an interview was conducted with a representative of provincial regional health authority in charge of the corporate functions and services. According to results of the interview, most administrative functions (e.g., finance, IMIT, payroll) within the provincial health

authorities are centralized and provided from either provincial government or by one of the health authorities. According to a case study participant, by centralizing these services they have gained more concentration of efforts and considerable efficiencies in operations. However, to manage centralized services, the provincial health authorities are engaged in constant communication (e.g., monthly project meetings, ongoing phone and email exchanges) across regions and communities. Building strong partnership and relationships is the key in delivering effective centralized services. At the same time, some of the corporate services and functions delivered are decentralized and implemented by regional health authorities. The decisions over which services should be centralized or decentralized are usually initiated by the leadership from the provincial government or health authorities. Studies and research conducted by staff members or external consultants to determine feasibility of the change, and potential impacts and implications on the operations and services. After thorough research, a plan of implementation is prepared and implemented.

Nation building efforts are necessary to develop appropriate governance structures and mobilize resources at the regional level. The FNHA executive team has been encouraging a Nation-Based approach to service administration and allocation of resources. There is a degree of resistance from some First Nations to embrace this approach due to fear of a loss of resources (i.e., loss of community-level jobs). The communities have thought of themselves as individual Bands for a very long time and changing that mindset to start thinking as a Nation will take some time. While the FNHA encourages Nationhood, unification and joint efforts, case study participants noted that this will take time and extensive efforts.

Maintain the strategic focus on building partnerships with other stakeholders in BC to influence provincial systems. The FNHA has impacted provincial programs and policies by incorporating into them First Nations perspectives. Sustained efforts to influence provincial policies, programs and systems has the potential to achieve system transformation and to generate significant positive health impacts to First Nations and all residents of the BC.

Efforts to build a BC First Nations-oriented organization culture needs to be continued. Case study participants noted that despite challenges, the FNHA organizational culture is strong (compared to other public sector organizations) and that staff dedication to the organizational mission and values is consistent. However, as an organization created with a strong mandate to play a historic role, the FNHA can achieve much stronger organizational unity by using First Nations culture and traditions. The culture can also play an important role in promoting longevity and job satisfaction, particularly among BC First Nations employees. It is critical to continue efforts to strengthen and promote core values, including knowledge of Indigenous communities and culture. Most staff members hired should already have or develop core competencies on working with First Nation clients and communities (e.g., listening to concerns from communities, building positive relationships).

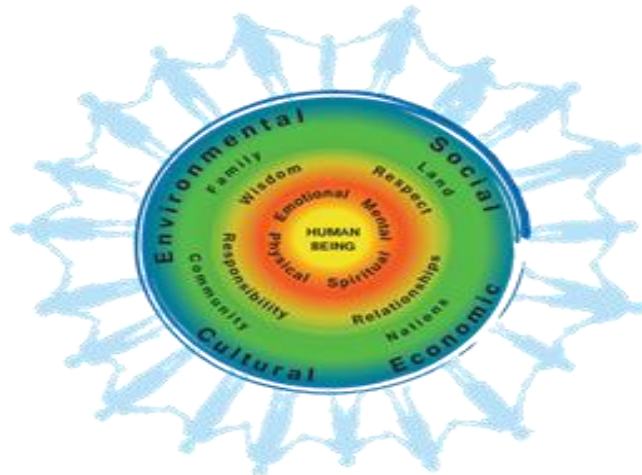
Skills and qualifications of key staff members and the FNHA leadership have been critical to success and have contributed to sustainable growth of the organization. Case study participants noted that most of the transformative change initiatives undertaken by the FNHA have been successful due to skills and capacity of the senior leadership. Senior staff have provided a clear direction, hired qualified staff and been able to coordinate activities and programming. Each major change initiative was well thought out, involved extensive consultation with key stakeholders, and provided enough support and resources. The organization has demonstrated flexibility and agility to make corrective changes and improvements as needed.

5. Wellness

Wellness is at the core of the FNHA’s philosophy, identity and brand. The organization has implemented various initiatives to promote wellness such as working with the MoH in its development of a provincial “Wellness Plan,” supporting the Wellness Grants and active living initiatives, and increasing awareness of topics such as cancer screening and respecting tobacco. The FNHA is shifting more of its resources upstream, from sickness to wellness, and is maintaining a voice of wellness within a sickness-focused system. However, other more immediate priorities can take away from the human and financial resources that can be dedicated to proactively designing and implementing wellness support and promotion initiatives, tools, resources and campaigns.

5.1. First Nations Perspective on Health and Wellness

The First Nations Perspective on Health and Wellness is a shared understanding of the wholistic vision of wellness shared by BC First Nations. It was created through significant engagement with First Nations in BC, including healers and Elders. The basis of this perspective is to achieve health and wellness by taking a look at and nurturing the internal and external factors that affect well-being. As shown in the figure below, the Centre Circle represents individual human beings. Wellness starts with individuals taking responsibility for their own health and wellness. The Second Circle illustrates the importance of Mental, Emotional, Spiritual and Physical facets of a healthy, well, and balanced life. It is critically important that there is balance between these aspects of wellness and that they are all nurtured together to create a wholistic level of well-being in which all four areas are strong and healthy. The Third Circle represents the overarching values that support and uphold wellness: Respect, Wisdom, Responsibility, and Relationships. The Fourth Circle depicts the people that surround individuals and the places from which humans come: Nations, Family, Community and Land are all critical components of a healthy experience as human beings. The Fifth Circle depicts the Social, Cultural, Economic and Environmental determinants of health and well-being. All the words in each circle are interconnected with each other, and with the components of other circles. In addition, all the circles themselves are connected and responsible for each other. Ultimately, all of these factors are important and need balance to achieve wellness.



First Nation Perspective on Health and Wellness

The main difference between the First Nations Perspective on Health and Wellness compared mainstream, western approaches to health is that First Nations perspective is focused on wellness rather than a system focused predominantly on diagnosing and treating illness. The First Nations approach is focused on supporting strengths and resiliency in people. It views the wellness as fundamentally interconnected and aims to create systems that will support individuals and families to heal when they are sick but also support to build on their strengths, to stay well, and to thrive.

The First Nations perspective on health and wellness articulates a wholistic view of health and wellness, and the understanding that the health and wellness journeys are owned by the self-determining individual. The Perspective acknowledges that wellness is intergenerational, meaning that while the wellness of an individual is shaped by that of their ancestors, they also shape the wellness of their descendants and future generations.

Based on the First Nations Perspective on Health and Wellness, the FNHA has prepared its own definition of wellness, which states:

*FNHA understands wellness as a strengths-based and wholistic approach to achieving health and well-being that is identified by self-determining individuals, families, communities, Nations, and organizations. Wellness includes connection and balance within ourselves and with our human and ecological communities, and is directly influenced by: our cultures, teachings and values; the contexts and settings in which we live our lives; our relationships, families, communities and our Nations; the systems we interact with; and, places and lands around us.
Everything is connected.*

5.2. Focus on Wellness Prior to Transition

Prior to transition, FNIHB implemented some programming focused on preventing various diseases. According to case study participants, FNIHB's prevention programming had no specific focus on promoting First Nation perspectives on health and wellness. However, FNIHB exercised a degree of flexibility for communities to use funding to promote health and wellness by way of supporting cultural and traditional activities. The major problem discussed was that the FNIHB programs were implemented in silos and decisions were primarily made in Ottawa with limited engagement from communities. However, the program and policy guidelines (e.g., eligibility rules, funding amounts, etc.) often did not meet health needs and priorities of the communities. Even former FNIHB staff members from the regional office noted that they often lacked authority to make decisions that would benefit specific community needs. The organization also greatly lacked competencies to understand and promote First Nations perspectives on health and wellness.

5.3. FNHA Activities Focused on Promoting Wellness

The main activities undertaken by the FNHA which focus on promoting First Nations perspectives on health and wellness are summarized as follows:

Developed First Nations Perspective on Health and Wellness and identified priorities for the FNHA to advance a wellness approach within the BC health system. Through extensive engagement with First Nation clients, Elders and healers, the FNHA developed a wellness based approach to its work. In particular, the FNHA identified that the existing structures of data in BC and Canada has widely focused on deficits of health including illness, injury and poor health outcomes. Similarly, much work on First Nations health has focused on health deficits and the 'gaps' in health status that exist between the First Nations population and non-First Nations population. Although identifying gaps and health disparities have some value in helping guide program and policy decisions, this approach does not address underlying causes and does not support an individual's wellness journey. As such, it was decided to focus on monitoring and reporting both the impacts of being subject to Canadian colonial practices and policies and monitoring assets and strengths of First Nations individuals and collectives. Taking a strengths-based approach is a deliberate shift away from a deficits-based narrative. It moves towards an approach that promotes and builds on strengths and acknowledges the structures and environments that support First Nations to be healthy and thrive. In

practice, it informs the way that topics and indicators are selected, written about and how recommendations are framed.

Developed a set of indicators to measure First Nations wellness. To advance the First Nations Perspective on Health and Wellness, the Office of the Chief Medical Officer (OCMO) in partnership with the Provincial Health Officer engaged extensively with First Nations stakeholders and the provincial government to develop indicators to measure wellness. The new wellness indicators were based on First Nations ways of knowing, had an available data source, and were reflective of the priorities identified by communities during the engagement sessions. The Population Health & Wellness indicators recognize that achieving a healthy, self-determining, and vibrant BC First Nations population means that the roots of wellness, like self-determination and connection to land, are well nourished. It also requires supportive systems that allow First Nations individuals and communities to lead their health and wellness journeys. Ultimately, roots of wellness and supportive systems are reflected in health outcomes experienced by First Nations people in BC. Thus, the indicators tell the journey through stories and data and are organized into three themes:

- 1) healthy self-determining Nations and communities;
- 2) supportive systems; and
- 3) healthy children and families.

Each data point is honoured as representing a strong, resilient First Nations individual who is a member of a family, community, and a proud Nation. At the time of this evaluation, the indicators were at the final stage of development and the FNHA and the Provincial Health Officer were expected to release a baseline report on the status of these indicators in January 2020.

Championed wellness across the health system in BC through close partnership with provincial and First Nations stakeholders. The FNHA has put a strong emphasis on embedding First Nations perspectives on health and wellness into the provincial health care system over the past five years. The FNHA has engaged at all levels of the provincial government to ensure that First Nations perspectives are reflected in provincial health care from policy and planning to service delivery. The examples of such activities include:

- *Close partnership with the provincial government on strategy development.* This includes working with the MMHA to inform its Mental Health and Addictions strategy and child and youth plan, and with the MoH to inform its primary and community care transformation.
- *Informed revisions to the BC Health Quality Matrix to reflect First Nations perspectives on health and wellness.* The BC Health Quality Matrix is prepared through the collaboration of the BC Health Quality Network (represented by the BC Patient Safety & Quality Council) to provide a common understanding and framework for defining the quality of care. The Matrix is a framework that provides a common language and understanding about health care quality. It is intended to be used by health care delivery organizations, leaders and practitioners for strategic planning, quality improvement, program planning, measurement and evaluation at the program, facility and system-wide levels. In BC, all health care providers, including regional health authorities use the Matrix when making program and policy decisions. Historically, the Matrix has only included quality definitions based on western science and practice. The FNHA has engaged with the BC Patient Safety & Quality Council in the process of producing the next version of the Matrix. Some of the changes involve consideration of the client ecosystem (their family and social and physical environments, and relationships), a focus on wellness, and integration of cultural safety and humility. The new version of the Matrix is expected to be released in the winter of 2019/20. According to case study participants, these changes will affect how the quality of health care is reviewed and assessed in BC and the impacts on the well-being of all clients, including First Nations.
- *Participated at provincial forums and tables to represent First Nations perspectives and to ensure that their perspectives on wellness are included in provincial prevention and promotion priorities and initiatives.* Examples of such forums include:

- *MoH Prevention and Health Promotion Policy Advisory Committee* that provides strategic advice to inform the MoH on health promotion policy and planning.
- *Provincial Injury Prevention Committee* focused on identifying and implementing provincial injury prevention priorities.
- *Injury Prevention Alliance* that represents a range of government agencies, non-profits and service delivery organizations focused on injury prevention.
- *A collaborative Provincial Food Security Committee* of regional health authorities, Provincial Health Services Authority, FNHA and the MoH developed to advance collective interests and provincial priorities related to food security.
- *Healthy Communities Committee* that provides regional and provincial leadership in the implementation, evaluation, and collaborative work of the Healthy Families BC Communities Initiative.

Reviewing and revising the FNHA’s internal policies, programs and operations to focus on wellness and support its wellness agenda. Some of the key activities undertaken by the FNHA, included:

- *Acting as a wellness champion and demonstrating its commitment to the concept* by embracing wellness approaches to its internal policies and programs (Human Resources, Health Benefits, IMIT strategies) as well as its external policies and programs (e.g., funding allocation). For example, the FNHA has assigned specific staff members in its regional offices in charge of promoting traditional wellness and supporting community efforts focused on wellness.
- *Developing the FNHA plan of action on wellness by bringing together all key internal stakeholders.* In the fall of 2019, the FNHA organized a Wellness Forum to gather key stakeholders to reaffirm its identity as a wellness organization, discuss organizational focus on wellness, and lay the groundwork for the development of an FNHA Wellness Action Plan. The forum involved a number of speeches from key FNHA staff members championing the FNHA wellness agenda as well as group work that helped the FNHA to identify key wellness priorities in moving forward. The results of the forum will help the FNHA to prepare a plan of action to better coordinate the FNHA and community activities focused on promoting wellness.
- *Ensuring wellness is part of the key messages that the FNHA communicates to communities, clients and partners.* During the overdose crisis, the FNHA emphasized the social determinants of health and underlying factors (e.g., institutionalized racism embedded in the health care system, intergenerational trauma) in their messaging on the disproportionate effects of the crisis on First Nation individuals. The FNHA’s approach was therefore focused on communicating the root causes of crisis from strength-based perspective.
- *Changing the health benefits available to First Nations individuals to improve their well-being.* A number of changes were made to the Health Benefits program to ensure the benefits supported health promotion, prevention and well-being. Some benefits, such as those for mental health, that were only available at the time of crisis were thereafter made available in order to address issues prior to them reaching a crisis point.
- *Undertaking awareness raising campaigns in different areas of health and wellness.* The FNHA, particularly the OCMO, has undertaken a number of public health campaigns to educate First Nations clients on different issues related to health and healthy lifestyles. Examples of most recent campaigns included "Screen. For Wellness." cancer screening campaign to raise awareness of screening and prevention programs; Coyote's Food Medicines, an innovative storytelling campaign to promote healthy medication use; Cannabis Campaign aimed at reducing cannabis use among Indigenous children and youth; Moose Hide campaign to end violence against Indigenous women and children; and Orange Shirt Day in recognition of the harming impacts of the residential school system on children’s sense of self-esteem and well-being. Each campaign included innovative approaches to inform and educate participants and clients to contribute to improved health and wellness.

- *Developing wellness tools and resources to assist communities.* For example, *Health and Wellness Planning: A Toolkit for BC First Nations* was developed in 2018 to enable First Nations health and wellness planning. It provides a range of templates, instructions and guidance for the Nations to prepare community-based health and wellness plans.

Acted as a wellness partner to First Nations communities, families and individuals by applying a wellness focus on all programs and services. The FNHA is in the process of defining its role in promoting wellness.

According to staff members, the FNHA is striving to:

- Become a wellness partner to First Nations individuals, children, families, communities and Nations by providing initiatives, tools, resources and supports that empower their decision-making in their health and wellness journeys. They do this through promotional public health and wellness campaigns and the development of practical community and individual health and wellness promotion resources. Being a partner means that the FNHA is focused on working with communities and service providers.
- Apply a wellness lens to all areas of the FNHA mandate, services that it delivers or funds, and programs and policies implemented by the federal and provincial system partners.
- Shift the focus on upstream health and wellness by supporting the conditions that create wellness. This means investing in programs and policies to achieve and maintain wholistic well-being such as programming that promotes physical activities, the health and well-being of maternal, children and youth, and improving access to traditional and healthy foods.
- Engage in partnership with key stakeholders to promote and integrate the concept of wellness across the health system.
- Ensure cultural safety and humility of health and wellness programming.

Conducted extensive efforts to support the development of traditional wellness. Traditional wellness is a term that encompasses traditional medicines, practices, approaches and knowledge. At the time of the transition, the FNHA conducted extensive engagement with First Nations communities and clients to learn about their health needs and priorities. During these discussions, traditional wellness was identified as one of the key priorities for stakeholders. All respondents at the Gathering Wisdom for a Shared Journey V, for example, stated that traditional wellness is extremely important to First Nations health. Some of the actions undertaken by the FNHA to support the development of the traditional wellness are summarized as follows:

- *Developing Traditional Wellness Framework to outline key objectives and strategies* for the promotion, incorporation, protection and advancement of traditional medicines and practices. According to the Framework, the main mission of the FNHA's traditional wellness activities is to improve the mental, emotional, spiritual and physical well-being of First Nations while strengthening the traditional health care system through partnership between traditional practitioners and the Western medical system. The Framework outlines five key objectives and number of strategies to achieve each objective. The key objectives include: (1) building an understanding of traditional wellness through bringing healers, practitioners and communities together to share ideas and filling the knowledge gap between western and traditional practices; (2) developing new knowledge resources and combining the existing resources together to benefit the communities; (3) increasing knowledge transfer through involving youth and Elders and documenting and sharing best practices; (4) promoting partnerships with key stakeholders to engage communities, protect intellectual property rights, support policy and protocol development; (5) supporting traditional healers to gain greater recognition for their practice by creating a healer network and advisory body with access to funding and resources.
- *Bringing together over 131 traditional wellness practitioners (Knowledge Keepers, and healers) on October 12-13, 2011, at the Traditional Healers Gathering.* The purpose of the Traditional Healers Gathering was to provide a space for wellness practitioners to meet and find strategies for advancement of traditional wellness (e.g., developing protocols guidelines, increasing awareness) and to make their

services more accessible to First Nations individuals, families and communities. Since then, the FNHA has been supporting traditional wellness gatherings each year so that participants can learn and share their knowledge on land teachings, traditional activities and identify strategies for expanding the practice of traditional wellness.

- *Other actions undertaken by the FNHA to support the Traditional Wellness activities* included: creating the Traditional Wellness Working Group and the Traditional Healers Advisory Committee to coordinate activities; inviting traditional healers and Knowledge Keepers to FNHA events and gatherings; conducting environmental scans for traditional models of wellness practices; and developing resources for communities that provide a traditional and wholistic perspective to health (e.g., Health and Wellness Diary, Corporate Wellness Calendar, Community Toolkit and Facilitator Guide, ADI Resources Booklet, Traditional Approaches Poster and First Nations Traditional Foods Fact Sheets). In addition, the FNHA has hired Traditional Wellness Coordinators as part of their regional teams. The coordinators are responsible for developing, implementing and managing integrated traditional wellness programs.

Dedicated specific funding to support wellness activities on the ground and at the community and service delivery levels. FNHA identified wellness to be a major gap in programming and investment. Some programming to fill this gap included:

- *Delivered Health Actions funding and ensured the program place a larger focus on traditional health and wellness.* Over a five-year period (2014-2019) of the 556 projects funded through the program, over 29% (174 projects with a total funding amount of \$9.5 million) was allocated to Mental Wellness and Substance Use. Almost all of these projects identified First Nations perspectives on health and wellness as their priority. Furthermore, of the \$32.8 million allocated through the program, Traditional Wellness Revitalization received 32% of total funding and Trauma-Informed Health Care received 15% of funding. Examples of projects funded under this category included recovery programs, crisis lines, men and women's circles and skills development seminars on historical trauma and loss of culture.
- *Provided Winter Wellness Grants and Indigenous Peoples Day of Wellness Grants* to support communities, community-based organizations and schools to host community-led wellness events which are grounded in ceremony, traditional practices and incorporate BC First Nations cultures. The grants provide up to \$5000 for innovative and community driven activities which enables communities to celebrate what is important to their well-being in an environment of cultural pride. Wellness events and initiatives supported by the FNHA include change-focused and transformational activities which encourage and sustain wellness in individuals, families and communities. The events are tailored towards promoting one or more of the four wellness streams namely; being active, healthy eating, nurturing spirit and respecting tobacco. Since 2014, the FNHA has invested over \$2.6 million in Winter Wellness and Indigenous Peoples Day of Wellness Grants.
- *The FNHA also implements a number of other programs and services focused on promoting mental health and wellness* of the First Nations communities and individuals, including Healthy Living, National Aboriginal Youth Suicide Prevention Strategy, National Native Alcohol and Drug Addiction Program (currently referred to as Alcohol and Drug Use Services), Maternal and Child Health, Fetal Alcohol Spectrum Disorder, Prenatal Nutrition, Aboriginal Head Start On-Reserve, Brighter Futures and Aboriginal Diabetes Initiative.

Engaged in partnerships to design and deliver programming and services focused on promoting wellness on the ground with First Nation communities, families and individuals. Some examples of such programming and services delivered by partner organizations with support from the FNHA are summarized as follows:

- *Engaged in close partnership with BC Indigenous Sports, Physical Activity and Recreation Council (ISPARC) to deliver culturally safe Indigenous programming focused on healthy living.* The FNHA provides core funding for ISPARC, which often acts as the FNHA's operational arm for physical activities. In particular,

funding from the FNHA has enabled ISPARC to deliver healthy living programming which trains over 350 Healthy Living Leaders every year across the province who then take leadership roles in their communities to deliver healthy living activities focused on healthy eating, physical activity, respecting tobacco and healthy pregnancies. To date, ISPARC Healthy Living has trained over 2,245 healthy living leaders across the province, delivering 1,519 healthy living programs, reaching over 53,000 participants. Through support from the FNHA, ISPARC is also able to provide small funding contributions to enable Healthy Living Leaders to deliver community-based physician activity and healthy living programming and events.

- *Partnered with the First Nations Education Steering Committee (FNESC)* to deliver a number of programs at First Nations schools to support the health and well-being of staff and students. Programs include the Youth Mental Health and Wellness Training focused on equipping teachers to recognize and address youth mental wellness concerns, Get Healthy Stay Healthy Project which promotes physical health within the school system, and programming focused on maternal and child health.
- *Engaged SportMed BC to support their Aboriginal RunWalk Program.* The Aboriginal RunWalk program improves the health and fitness of First Nations by implementing programming consisting of leadership training and province wide RunWalk training opportunities leading up to participation in a run/walk of 10 kilometres. In 2019, with the support of the ISPARC and the FNHA, SportMedBC provided training and support to deliver the 13-week Aboriginal RunWalk Program in eight communities across BC. As of July 2019, the program is being implemented by ISPARC.
- *Engaged Heart and Stroke Foundation to deliver First Nations community gardens* around the province as part of the First Nations Food Systems project.

Facilitated, designed and participated in a number of events and gatherings to support First Nations health and wellness in BC. Examples of such events included:

- *BC Aboriginal Diabetes Conference*, where the FNHA delivered the keynote speech and distributed printed materials in alignment with the priorities of the conference.
- *Annual Gathering our Voices Youth Conference*, organized by the BC Association of Aboriginal Friendship Centres. The FNHA provides funding and participates in the event, which engages over 1000 youth in innovative wellness activities (e.g., information tables, wellness screening, tobacco eater machine, prizes).
- *Gathering Wisdom for a Shared Journey*, held every 18 months by the FNHC/FNHDA/FNHA, where the FNHA offered various health related workshops, health screening and engagement opportunities for BC First Nations.
- *Annual Elders Gathering* to honour the wisdom and contribution of Elders as essential to wellness. As part of the event, the FNHA provides health and wellness screening opportunities, hosts workshops for the Elders and promotes health system literacy to inform Elders of available health services through the FNHA.
- *Numerous other events to support wellness activities* such as Regional Caucus meetings, the FNHDA Health Directors Meetings and AGM, First Nations Quality Improvement and Safety Network Forum, and the Annual Nurses Education Forum. The examples of wellness activities supported in these events included offering classes and providing health screening and tobacco prevention opportunities.

5.4. Impacts of the New Approach to Wellness

First Nations perspectives on wellness has become one of the key components of health planning with the FNHA and at the community levels. In particular, the First Nations health governance structure in BC involved the development of the regional health and wellness plans based on community health priorities. A review of the sample of regional health and wellness plans indicates considerable emphasis across all regions

on the integration of wholistic models of prevention and wellness and traditional wellness activities into regional and community programming.

First Nation perspectives on health and wellness have been incorporated into many provincial programs and policies, affecting key decisions. The FNHA's close partnership with the provincial government representatives has led First Nations perspectives, particularly those associated with mental wellness, to be incorporated into many provincial policies and strategies. For example, the 2019/20 to 2021/22 Service Plan for the MMHA has identified a number of key areas for the province to invest resources to support First Nations health and wellness. In particular, the document recommends the design of a strategy for mental health and addiction services that embodies First Nations perspectives of health and wellness, focuses on the social determinants of health, reflects the connection between the mental, physical, emotional and spiritual dimensions of well-being and ensures that the services are culturally safe and respectful. Similarly, at the time of this evaluation, the MoH was working on a wellness plan, which is expected to include First Nations perspectives on wellness. Case study participants noted that policy and program changes have translated into increased funding for programs and services focused on wellness, which will eventually affect the quality of the services received on the ground by clients.

Increasing funding opportunities for specific projects focused on wellness have had considerable impacts on the well-being of specific individuals and communities. According to case study participants, the FNHA focus on wellness services is making a difference in the lives of clients and within communities. These projects have promoted community events and celebrations and active lifestyles. These have helped communities to come together to celebrate their cultures and traditions, increased community bonds and improved individual self-esteem and confidence. Evaluation of the initiatives funded through the Joint Project Board has shown that almost all funded projects (e.g., 92% in 2017/18) have integrated wellness into the delivery of the health care. Examples of such integration mentioned by project proponents included incorporating social determinants of health approaches, providing wrap around care and integrating traditional wellness practices and approaches. Feeling in control of one's own health can contribute to healing and a strong sense of self determination. Incorporating traditional wellness activities into the health care programming has created welcoming environments and many clients have increased service utilization rates.

Perception that it will take years to achieve the ultimate goal of the FNHA's wellness activities – a shifting of the perceptions from 'curing sickness' to promoting health and wellness and achieve broad and significant improvements in health outcomes. It requires time and consistent efforts to achieve change in perceptions and practices, which will eventually translate into improved quality of the services and health outcomes.

Implementation of the wellness indicators is expected to result in paradigm shift in measuring and reporting on the health status of the First Nations. It will enable reporting on the outcomes that are meaningful to First Nations and reflect community and nation health and well-being. For example, measuring and reporting on indicators related to land, family and community (e.g., community strength and resilience, ecological wellness and connection to land) and health systems (e.g., experience of cultural safety and humility in receiving health care, avoidable hospitalizations) is expected to shift attention and direct resources into areas that help to build individual and community wellness (instead of focusing on addressing gaps or sickness).

There is strong support by the First Nations to advance the development of traditional wellness practices. According to several case study participants, the main factor contributing to the success of the FNHA activities in promoting traditional wellness activities has been the resilience of the First Nations. Despite

colonialism and cultural assimilation, First Nations have preserved their cultural identities, knowledge and practices, and are keen to continue developing their traditional ways of life.

Engagement and partnership with the communities has been critical in defining and promoting First Nations perspective in health and wellness. During these discussions and engagements, communities helped to guide the activities of the FNHA and shape policies and program documents. Key informants noted that, going forward, it is important for the FNHA to continue engaging communities and clients in developing wellness policies, programs and strategies and that it is also important to keep proper records from community and client engagement activities.

At the community level, additional funding flexibilities provided by the FNHA have allowed First Nations to direct resources in the areas that are most critical to them. During interviews, community representatives and service providers noted that flexibility around funding allowed them to target underlying causes of health disparities and to address gaps in services and focus on promoting wellness, which would not have been possible prior to the transition. The examples of wellness areas that they have supported included: hiring traditional healers; undertaking land-based activities; and organizing wellness events and celebrations. In addition, community representatives and service providers noted that they have been able to access more funding opportunities allowing them to strengthen all programming including those focused on wellness. For example, one community noted that they managed to hire a mental wellness clinician, dietician, physiotherapist and a nurse practitioner, which significantly enhanced the types of services that they are able to provide.

Ability of the FNHA staff to think creatively and work with the communities to address their needs have allowed communities to focus on wellness. During interviews, community representatives noted that during earlier stages of the transition, they found the FNHA to be rigid with their rules and guidelines. However, gradually, the FNHA became much more creative and flexible in its approach to working with the communities and First Nations service providers. As a result, First Nations were able to address their most critical wellness needs with the support of the FNHA.

Dedication, skills and competencies of the FNHA staff members in charge of the wellness activities has been critical for the success. Several case study participants, particularly those outside of the FNHA, noted that the staff members employ a professional, respectful, curious and collaborative approach in their work with communities and also with representatives of provincial governments and service delivery organizations. The approach has enabled the organization to gain trust, build partnerships and influence decisions at all levels.

The FNHA's unique role as a provincial health authority has contributed to the success of its efforts. As a provincial health authority, the FNHA is uniquely positioned to attend key provincial tables and to have high level consultation and influence with key decision makers. Prior to the transition, as the representative of the federal government, FNIHB had limited partnership and influence on provincial policies and programs.

The FNHA's focus on wellness is very innovative and unique. The work of the FNHA is significant and impactful. All other health authorities tend to focus their work on diseases and sickness. Focusing on wellness in population and public health will provide more dividends in the future. The challenge with focusing on wellness is to find creative ideas to implement. The concept itself is innovative and it requires constant responsiveness and revision to programs and education.

5.5. Gaps, Challenges and Issues

Wellness is a very new and innovative concept to the mainstream health care system in BC and requires additional efforts and time for implementation and integration. Western approaches to health, as it is currently practiced in the province, is primarily focused on sickness and disease. Having policy-makers, decision-makers, and practitioners change their perspectives towards wellness takes time.

Policy and logistical challenges with incorporating traditional medicine and practices into mainstream health care. As a new area of practice for the mainstream health care system, wellness activities are not clearly defined nor incorporated. For example, creating a system that recognizes the skills and competencies of traditional healers and to accredit and compensate them will take extensive time and efforts. Similar efforts are required to clarify, classify and incorporate traditional medicine into mainstream health care. According to case study participants, the FNHA has been able to overcome these challenges by being agile and proactive in its work, being comfortable and expecting constant change and evolution, and coordinating efforts very closely with team members and partners.

Crises and competing priorities make it difficult for the FNHA to take a proactive approach on wellness. The FNHA and partners have to deal with multiple issues and challenges everyday including crisis situations and emergencies. It is difficult to promote wellness when other partners have differing priorities. Currently, for example, the priority of the BC government is primary care, while health promotion is less of a priority. When there are crises and emergencies, it is difficult to get people's attention to focus on wellness and allocate time and resources. The situation was especially difficult when the FNHA did not allocate dedicated resources to focus on wellness. The hiring of Traditional Wellness Coordinators at regional offices have helped with efforts to promote wellness at regional level and a recent creation of a dedicated wellness team within the OCMO is expected to play a key role in promoting wellness among First Nations at the provincial level. Traditional wellness coordinators, Elders and healers have also been hired by communities and service providers using a range of new funding opportunities (e.g., Health Action funds, Joint Project Board funds, etc.) provided by the FNHA.

Complexity of issues when dealing with wellness. There are a number of complex issues in each area of wellness promotion that the FNHA has to overcome. For example, health and wellness are affected by a range of other conditions and social determinants (e.g., food security, access to housing, poverty, etc.), many of which go well beyond the mandate for which the FNHA receives funding. The issues create challenges for the FNHA to promote a wellness agenda when there are many other issues that affect First Nations individuals and communities. The First Nations Population Health and Wellness Agenda project led by the FNHA and the development of wellness indicators are expected to address some of these challenges by clarifying indicators that contribute to wellness.

Change is slow and requires time and continuous efforts. Case study participants noted that the system level change requires a long time and extensive efforts. Despite significant progress, it may take years before the health delivery partners are able to achieve a significant shift in their perceptions from sickness to wellness.

Promoting wellness requires support and participation by all departments within the FNHA. Given the size and differing priorities of the organization, it is difficult to bring FNHA staff members around the same table and coordinate activities to promote wellness.

5.6. Lessons Learned and Opportunities for Improvement

Proactive and dedicated resources and efforts are needed to promote FNHA’s wellness agenda. Promoting the First Nation perspective on health and wellness is a key priority for the First Nations and for the FNHA. However, competing priorities makes it difficult for the FNHA staff and partners to allocate time on wellness. It is necessary to dedicate specific resources, staffing and efforts to consistently promote wellness across FNHA activities, and with provincial and service delivery partners.

More comprehensive support is needed to develop traditional wellness practices. The FNHA needs to support the development of traditional wellness resources, guidebooks, instructional videos and other materials to support the advancement of traditional practices. Standards of practice, accreditation and certification systems are necessary to ensure traditional healers can be integrated into mainstream health care.

Including traditional healers as part of the Health Benefits program can help to support the development and utilization of the practice. Several case study participants noted that support for the development of traditional wellness practices can be enhanced by including traditional healers as part of the mental health and wellness support provided through Health Benefits program.

Finalize FNHA Policy on Wellness. The FNHA Policy on Wellness has been drafted and is in process of being reviewed. Once finalized it will help to guide the FNHA efforts to promote wellness. This includes ensuring FNHA staff members and First Nations have a clear understanding of the concept of wellness. Wellness may mean different things for First Nations depending on their backgrounds, and cultural and geographical circumstances. While recognizing cultural diversity and uniqueness of a definition of wellness, it is also important to develop common understanding and parameters. The First Nations Perspective on Health and Wellness has provided a common definition of wellness. However, more work will be required to ensure that FNHA staff and stakeholders develop a clear understanding of the concept. Without a clear understanding, there is room for interpretation and therefore staff may promote wellness differently.

Continue working with community leadership to gain their support in promoting wellness. Chief and council make critical decisions with regards to community health programming and services. When community and health leadership understand the importance of promoting wellness, it can make a significant difference in how community focuses its health programming and resources. The FNHA should be supporting the communities and engaging with leadership to help them with implementing wellness activities and programming.

6. Population and Public Health (Chief Medical Officer) Function

After the transition of programs and services from FNIHB to the FNHA in October 2013, the FNHA substantially revised its organizational design to increase the profile of First Nations physician leadership through the development of the Chief Medical Officer role. This was designed to use physician expertise in public health and make this expertise more accessible to BC First Nations, position the role as a health and wellness partner, and to create a clear and trusted voice for the health and wellness of the First Nations population in BC. The Office provides public health and wellness reporting and championship for First Nations.

6.1. Public Health with First Nations

Population and public health activities provided to First Nations communities prior to the transition were associated with a range of challenges and shortcomings. Prior to the transition, FNIHB implemented a range of programs and services focused on population and public health such as Communicable Disease Control, Environmental Public Health, Environmental Health Research, and Primary Health Care. According to case study participants, FNIHB's approach to public and population health had a number of critical challenges, including:

- FNIHB's approach was top down and often did not adequately represent the interests of the First Nation clients and communities. Communities had little ownership and/or control over FNIHB's programming and did not feel well represented by the organization.
- Public health programming delivered by the FNIHB were mostly focused on program administration and service delivery (internally facing) and lacked public physician services targeted at community and client needs.
- Most population and public health data collected and reported by FNIHB helped to create an overall negative image (e.g., highlighting health disparities) of First Nations without paying adequate attention to underlying causes of the health disparities (e.g., colonialism, racism).
- The programming and services implemented by FNIHB were mostly implemented in silos and the communities had little opportunity to integrate funding and services to be able to meet their unique needs. Programs often required extensive reporting and most of the information reported on by the communities was not shared back to them in a useful format.
- FNIHB's approach to public health was based on western principles of public health and therefore did not incorporate traditional and cultural practices.
- FNIHB programming was often understaffed and lacked necessary resources to address growing and complex public health needs of the communities.

6.2. FNHA Approach to Population and Public Health

Focus on development of the First Nations public health function was a critical part of the tripartite negotiation processes. The transformative Change Accord signed in November 2006 between the Province of BC and the First Nations Leadership Council recognized that First Nations needed to be involved in decision-making regarding their health and well-being, including the monitoring of health outcomes. The Accord also committed the Provincial Health Officer to appoint an Indigenous physician to advise on First Nations health issues and to issue First Nations health status reports every five years. Consequently:

- *As part of the tripartite negotiation process, a specific position was created within the BC Government to monitor and report on First Nations health outcomes.* In 2007, the position of Aboriginal Health Advisor, later changed to Indigenous Health Physician Advisor, was created within the MoH. The role of the advisor was to provide advice to the MoH on public health issues specific to First Nations. The position had specific responsibilities for monitoring and reporting on the health and well-being of First Nations people in BC and for tracking the progress of these performance measures.
- *After signing of the Tripartite Framework Agreement, the roles and responsibilities of the Aboriginal Health Advisor was expanded.* The Tripartite Framework Agreement outlined commitments for the First Nations and the provincial health system to collaborate in the monitoring of health status. It also changed the role of the Aboriginal physician advisor to a Deputy Provincial Health Officer so as to work with the FNHA to improve the quality of data being collected and health indicators available for First Nations health and wellness.
- *In 2014, the relationship with the FNHA and the province with regards to population and public health activities was formalized by the signing of Memorandum of Understanding.* As part of the Memorandum of Understanding, parties committed to maintaining a collaborative relationship based on principles of reciprocal accountability and respect, and designating a Deputy Provincial Health Officer position within the Office of the Provincial Health Officer to work closely with the FNHA. In addition, it required the Provincial Health Officer and Chief Medical Officer to develop and implement a joint work plan as well as hold quarterly meetings to review and update the plan and organize annual meeting between the Chief Medical Officer of the FNHA and Provincial Health Officer.

The need for the creation of the Chief Medical Officer Office within the FNHA became evident soon after the FNHA took responsibility for the delivery of programs and services for First Nations in BC. All other health authorities in BC have a position for a Chief Medical Health Officer. This position oversees population and public health activities. The FNHA needed a similar public health physician to provide health and wellness leadership and to promote both traditional First Nations and Western approaches to health, wellness, medicines, and healing. The key difference between the FNHA Chief Medical Officer role and Chief Medical Health Officer function within other provincial health authorities were related to accountability. According to provincial legislation, Chief Medical Health Officers are to follow recommendations of the Minister of Health. In particular, *Public Health Act* provides legislative powers to Chief Medical Officers and the MoH through Order of Council to impose decisions. However, exercising such powers (e.g., health inspections, shutting down operations, etc.) would go against the FNHA’s mandate, working philosophy (i.e., health and wellness partner to First Nations communities and individuals), and 7 Directives. The FNHA wanted to be able to respond to the needs and priorities of the First Nations in an autonomous way (as a health and wellness partner) and to bring their voice into the provincial health care system. Consequently, the FNHA created the new Chief Medical Officer role which is significantly different than the role of provincial Chief Medical Health Officer. The FNHA Chief Medical Officer acts as a partner and does not have legislative authority to impose programs or services (e.g., shut down operations, etc.). Instead, the Office of Chief Medical Officer (OCMO) provides expert advice and physician leadership from a First Nations perspective to support First Nations individuals and communities, and to help achieve a paradigm shift within the provincial health system.

The OCMO acts as the FNHA’s representative on public health matters and builds strong relationships with First Nations communities and other partners to advance high-quality and culturally safe clinical care, programs, services and policies for First Nations peoples in BC. The mandate of the FNHA OCMO is to:

- Monitor and report on the health and wellness of the First Nations population in BC
- Lead population health and wellness innovation

- Advance quality (e.g. complaints)
- Ensure appropriate data governance
- Support the regions
- Monitor and identify priorities and reports on First Nations health and wellness by establishing a “Watchmon” role that integrates Indigenous stories, knowledge and health data, and is responsive to community and client needs. Watchmon is a traditional concept across a number of First Nations cultures, related to watching over a population to keep them safe.

The new mandate of the OCMO expanded the types of activities that the FNHA can deliver. In addition to western public health functions, the OCMO is able to engage public health activities that are specific to First Nations. For example, the Chief Medical Health Officer at the provincial health authorities can only speak about public health issues and concerns that have western evidence and scientific backing. While, the OCMO within the FNHA is able to engage and promote traditional foods, medicines, healing practices, as well as issues that are related to the social determinants of health (e.g., the intergenerational effects of trauma and colonialism). The FNHA has adopted an approach called “Two-Eyed Seeing” where one eye is focused on western evidence while the other is focused on the strengths of Indigenous knowledge and ways of knowing. When both eyes are used together it creates strong benefits to achieve common objectives for health and wellness of First Nations communities and individuals. This was concept was developed by Mi'kmaw Elder Albert Marshall.

In close collaboration and partnership with other departments within the FNHA, the OCMO has taken extensive efforts to provide public health leadership and address public health needs and concerns of First Nations communities and individuals. In particular OCMO and/or the broader FNHA in collaboration with OCMO:

- *Developed indicators to measure wellness.* To advance the First Nations’ perspective on health and wellness, the FNHA has engaged in a process of developing indicators that can measure wellness. It launched a joint initiative between the OCMO and the Office of the Provincial Health Officer of BC called the Population Health and Wellness Agenda. The project developed a set of indicators to be tracked and measured on a regular basis. Through extensive engagement with clients and stakeholders and using an iterative prioritization process, the FNHA prepared 15 new indicators to measure wellness. The process of selection was guided by the Project Steering Committee which included members from both the Office of the Provincial Health Officer and the FNHA. The Population Health & Wellness indicators recognize that achieving a healthy, self-determining, and vibrant BC First Nations population means that the roots of wellness, like self-determination and connection to land, are well nourished. It also requires supportive systems that allow First Nations individuals and communities to lead their health and wellness journeys. Ultimately, roots of wellness and supportive systems are reflected in health outcomes experienced by First Nations people in BC. Thus, the indicators tell the journey through stories and data and are organized into three themes:
 1. healthy self-determining Nations and communities;
 2. supportive systems; and
 3. healthy children and families.

Each data point is honoured as representing a strong, resilient First Nations individual who is a member of a family, community, and a proud Nation. At the time of this evaluation, the indicators were in the final stage of development and the FNHA was expected to finalize a baseline report on the status of these indicators in January 2020.

- *Undertook a range of activities to promote health and well-being of First Nations clients and communities.* As Watchmon, one of the critical roles of the OCMO is to communicate with people and guide them through challenges. This involves transmitting knowledge and communicating with First Nations clients and communities in a way that is the most comfortable to them (e.g., face-to-face communications, posters). It also includes listening to their perspectives and needs. Some support and educational activities implemented by the OCMO, in close collaboration with the FNHA communication department, include:
 - Organized or supported campaigns targeted at specific events (e.g., World Breastfeeding Week, International Day of the World’s Indigenous People, International Youth Day, International Overdose Awareness Day, World Suicide Prevention Day, World Environmental Health Day, World Heart Day, Orange Shirt Day). To support these events, the FNHA has used social media to share critical knowledge and information, published and distributed posters, information materials, and fact sheets.
 - Organized lifestyle campaigns and challenges to promote physical activity and sports (e.g., 30x30 Active Challenge, which encourages First Nations peoples to come together and commit to the goal of doing 30 minutes of physical activity each day).
 - Activities focused on promoting First Nations strength and resilience (e.g., linkages between language and traditions and wellness, celebrating and honoring stories - intergenerational resilience and progress).
 - Educational campaigns to encourage healthy behaviours (e.g., risks and benefits of cannabis use among First Nations youth, silver ribbon events to raise awareness of the overdose crisis, importance of peer involvement in harm reduction, recognizing the signs of suicide).
 - Responded to extensive inquires from clients and communities. The OCMO has received extensive inquires from community leaders and individuals who face specific challenges related to their health and well-being. Each inquiry involves assessing the specific need and taking actions to address the issues or referrals. Examples of such inquires that the OCMO had to address, included:
 - Provincial public health officers trying to impede the serving of traditional food at community events, as the event did not follow the provincial food safety rules. The community was very upset with their involvement as it was in violation of their community traditions. The FNHA was able to solve the issue by communicating the community perspectives to the provincial health officers.
 - Involvement in Mount Polley mine disaster. In 2014, Mount Polley copper and gold mine tailings pond collapsed releasing contaminated water into Polley Lake. The initial reaction from the provincial government was that the disaster did not create significant public health concern. However, as per request from the communities, the FNHA engaged in partnership with representatives of affected communities and helped with communicating their voice who could no longer use the lake as a source of food.
- *Improved how First Nation-specific population and public health data is collected, managed, and reported.* Some examples of these improvements include:
 - Played a role in changing the approach to data governance and management. Some of the key changes to data governance happened prior to the creation of the OCMO function within the FNHA. In 2010, as part of the transition, the FNHA signed the Tripartite Data Quality Sharing Agreement with the MoH and have jointly created the Data and Information Planning Committee. The Committee consists of representatives from the FNHA, the MoH, and FNIHB. It has developed the processes, evaluation criteria and policies required to adjudicate the First Nations Client File Data Access Requests. The First Nations Client File allows the FNHA to obtain First Nations-specific population and public health data from the provincial health databases through creating a linkage

between the federal government database (Indian Register), the MoH Client Roster, and BC Vital Statistics birth and death records. The MoH links the First Nations Client File with numerous health-related databases that exist within the Ministry to identify and extract First Nations-specific data (e.g., hospital or physician databases). The FNHA, particularly the OCMO, is the data steward for the First Nations Client File, which is in the custody of the MoH. The access to First Nations-specific files is provided by the Data and Information Planning Committee, which meets to review First Nations Client File data access requests and to ensure that the data linkage process operates smoothly. The Committee has established processes and procedures for the submission and review of these data access requests, balancing the need for high-quality First Nations health data with the need to protect individual and community privacy while respecting the principles of First Nations health information governance. Access to additional data through the First Nations Client File has helped the FNHA obtain First Nations-specific data which is critical for shaping programs and policies. The examples of such data include access to data on the cancer patient journey and outcomes for First Nations clients, data on prevalence of chronic conditions, and data on rates of hospitalization and physician utilization.

- Increased access to data from other sources. As a First Nations organization, the FNHA administers surveys led by the First Nations Information Governance Centre (e.g., Regional Health Survey, First Nations Labour and Economic Development Survey, and First Nations Regional Early Childhood, Education and Employment Survey). The FNHA is able to store and analyze the results of these surveys and return the data to the communities, thus respecting the OCAP® Principles. Starting with transfer in 2013, FNHA assumed responsibility for the delivery of the Non-Insured Health Benefits (NIHB) Program (called simply Health Benefits in FNHA), which has meant that the organization stores and/or has access to pharmacy, dental, vision, medical transportation and mental health crisis response data. Although the administration of much of these benefits has now devolved to third party management (e.g. Pharmacare at MoH; and residual pharmacy, medical equipment and supplies, dental and vision services at Pacific Blue Cross), all benefit associated data is still accessible by the FNHA. The data is used to make important program specific decisions.
- The FNHA, through its data governance committees, has developed processes and procedures of sharing First Nations-specific data based on OCAP® Principles. Protecting privacy and confidentiality of the First Nations-specific data is directly related to the OCMO's Watchmon role. As there are no standard guidelines to follow to govern community-level data release, the FNHA has developed its own procedures. Some of the procedures include: working with specific regions/communities to manage their specific data; sharing the data with regions, Nations or communities and obtaining their approvals before the data is shared with others; and reporting back the data in aggregate formats to protect confidentiality and client privacy. Currently, the organization is working to prepare a data strategy that will govern all aspects of data governance, stewardship and custodianship.
- The FNHA is also playing a critical role in how the First Nations-specific data is governed and reported at the provincial and national levels. For many years, various stakeholders in BC have collected, interpreted and reported First Nations-specific data which often did not serve the interests of the communities and clients (e.g., focusing on negative outcomes, ignoring root causes of disparities). As a steward for First Nations data, the FNHA is advocating for a system at the provincial level which requires pre-approval by the FNHA for data that is being collected, analyzed and reported on by partners. The *Joint Statement on First Nations Data Governance*, still in draft, is an FNHA initiative with two external partners: Canadian Institute for Health Information and MoH. Through adoption of this joint statement by external partners, First Nations interests and perspectives will be protected when partner organizations prepare and report data on First Nation health indicators. At the national level, the FNHA has provided an Indigenous perspective

to the *Tri-Party Research Data Management Policy* authored by Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada and the Social Sciences and Humanities Research Council. The policy will govern and guide how researchers use Indigenous-specific data that has been generated through government funding, including meaningful involvement by the Indigenous population reflected in the data, and upholding of OCAP® Principles.

- Reporting data back to the communities. FNIHB had a strong mechanism for collecting data from the communities (e.g., through community based reporting templates), but had very limited systems to return the data to the communities in usable formats. As the FNHA is an organization governed by First Nations, it prioritizes the interests of the communities and clients in collecting and on reporting data. Examples of changes in how the FNHA collects and reports data included putting an emphasis on returning the data back to regions and communities in a format that is useful to them and not collecting the data that has only limited use or an unclear purpose.
- *Played a key role in development and implementation of the Indigenous Cancer Strategy to facilitate the cancer journey for First Nations clients and communities.* The FNHA, in partnership with BC Cancer, identified that First Nations clients in BC experience the cancer journey differently compared to non-First Nations people in BC and that there were significant disparities in cancer outcomes between these populations. To address this issue, the FNHA undertook a number of key actions:
 - Over a three-year period (2013-2016), they partnered with Métis Nation BC, BC Association of Aboriginal Friendship Centres, and BC Cancer to engage extensively (e.g., in-person forums, roundtable community discussions and online and in-person questionnaires) with Indigenous clients and families to learn about the Indigenous cancer journey. In 2017, these partners created an Indigenous Cancer Strategy intended to support all First Nations (status and non-status, living at home or away from home), Métis (citizens and self-identified) and Inuit living in BC. This strategy provides a road map to improve the Indigenous cancer journey and includes the following six key areas of action: (1) partnerships among all stakeholders involved in the delivery of cancer services to Indigenous clients in BC; (2) wellness and cancer prevention, including screening; (3) culturally safe cancer programs and services to overcome impacts of colonialism and trauma; (4) support for cancer survivors; (5) support the end-of-life journeys for patients who can not be treated; and (6) knowledge development.
 - Facilitated ongoing partnership with agencies involved in the development and implementation of the Indigenous Cancer Strategy. As part of the partnership, representatives from the four partner organizations come together every quarter to develop and implement a plan of action.
 - Conducted an internal review of the Health Benefit program to identify potential benefits that could encourage and facilitate more frequent cancer screening.
 - Supported BC Cancer to improve cultural humility within their organization and cultural care at their centers. For example, regional cancer centers were made more welcoming by including First Nations-specific art and delivering welcoming messages (e.g., recognizing traditional territories).
 - Engaged in partnership with the University of British Columbia to establish a new faculty position focused on improving cancer outcomes and wellness among First Nations and Indigenous peoples. The chair collects and analyzes epidemiological data from First Nations communities, creates systems for health monitoring and chronicles relevant oral traditions and community practices related to cancer. The position also provides training and mentorship to faculty, students and staff to promote provincial and national partnerships to advance First Nations and Indigenous health.
 - Developed and implemented cancer awareness and screening campaigns. As part of implementing the cancer strategy, the FNHA developed and disseminated posters, booklets and other information materials (e.g., cervical screening for women between 25–69 through a Pap test every three years, *Community Resource: Cancer and First Nations Peoples in BC, Living with*

Cancer: Everyone Deserves Support). The FNHA organized campaigns dedicated to raise awareness about specific cancers (e.g., Prostate Cancer Awareness Month, Breast Cancer Awareness Month), as well as campaigns to promote screening (e.g., Screen For Wellness campaign specifically targeted increased awareness of BC's colon, cervical and breast cancer screening programs). The FNHA used social media, its website, in-person meetings and presentations, and the distribution of materials to implement the campaigns. In addition, the FNHA supported community champions who delivered key messages to promote screening among community members. As part of the campaign, the FNHA established a mobile mammogram service allowing community members to receive screening within their communities.

- Supported First Nation cancer survivors to come together to support each other and to share stories of their journey and survivorship.
- *Provided support to frontline staff members (e.g., Communicable Disease Population and Public Health Nursing team) in delivering population and public health activities on the ground with the communities.* During the case study interviews, frontline staff members noted that when working under FNIHB, they mostly received guidance and support from the provincial health authorities. The situation changed through the establishment of the OCMO. The OCMO has created a strong support system that is made available to frontline staff members (e.g., community health nurses) to access when they need help.
- *Established close collaboration and partnership with the Provincial Health Officer ensuring the interests and perspectives of the First Nations clients and communities are represented at levels within the provincial population and public health activities.* The *Transformative Change Accord: First Nations Health Plan*, released in 2006, set out seven specific health outcomes (life expectancy, mortality rate, youth suicide rate, infant mortality rate, diabetes prevalence, childhood obesity, and practising, certified First Nations health care professionals) that had to be monitored by the provincial government (the Provincial Health Officer and Deputy Provincial Health Officer /Aboriginal Health Physician Advisor). The monitoring of these outcomes was continued in partnership with the FNHA, particularly by OCMO after the office was created. At the time of this report, the partnership was further expanded to include monitoring and reporting on 15 additional indicators focused on First Nations wellness. In addition, the FNHA (OCMO and also other organizational staff members) sit on tables and committees within the provincial system. The province also partners with the FNHA at multiple levels to ensure the interests of the First Nations clients and communities are respected. During interviews, case study participants noted that the partnership between the OCMO and the province is based on a true and equal partnership, sincere collaboration, mutual trust and reciprocal accountability. This partnership has led to a number of new initiatives and innovative projects, such as the creation of the First Nations Client File, the development of wellness indicators, the development of the *Indigenous Women Health Report* (forthcoming), and the *Population Health and Wellness Agenda* baseline report. All of the projects undertaken by the OCMO and the province are respectful to the interests of both parties. Joint reports integrate information that is not only useful to leadership in both government and First Nations communities, it also reflects the knowledge and lived experiences of First Nations people in BC.

The FNHA also implements a number of programming and services (not directly part of the OCMO) that are focused on promoting population and public health. Many of these programs and services have been inherited from FNIHB and some were created after the transition. These programs and services include:

- The Environmental Health Program is focused on ensuring healthy home environments for First Nations families in BC. The program includes a number of components such as Environmental Contaminants, Drinking Water Safety Program and Advisories and Wildfire Information.

- The Health Protection (i.e., Communicable Disease Control) program is part of the FNHA’s Nursing team, and works with health care providers to deliver Communicable Disease Control programs in First Nations communities. The program increases awareness and builds capacity around communicable disease programming with education, training and resources. This supports community programming related to tuberculosis, immunization, blood borne infections, communicable disease management, including vaccine preventable diseases.
- Healthy Living identifies, develops and supports strategic methodologies which allow for the greatest degree of systemic changes and improvements for BC First Nations communities. The program includes chronic disease prevention and management, injury prevention and control, Elder abuse awareness, and cancer prevention.

The types of activities and services delivered through these programs are similar in some ways to programming offered by the provincial health authorities, in that FNHA staff work with communities in identifying and advising on environmental hazards, communicable diseases and making recommendations to promote healthy communities. A key difference of this programming compared to similar programs offered by the provincial health authorities is that the FNHA does not act as a regulator and does not have a legislative mandate to impose decisions (e.g., order in council). Instead, the FNHA acts as a community partner in health providing advice, guidance, and capacity development to support communities to address their population and public health concerns. Most of the FNHA staff members who deliver these programs are located in the regions and work in close partnership with the communities. Furthermore, the FNHA has been implementing a range of innovative initiatives as part of these programs. For example, it supports communities in: cultivating horticultural gardens and using traditional foods; assessing the effects of climate change on communities and helping communities to prepare and address these effects; recruiting nutrition and healthy eating specialists to assist communities with their healthy food choices; training nurses on trauma and incorporating trauma informed treatment practices; inviting Elders and involving them in story-telling sessions as part of the nurse community training; and incorporating cultural humility in all aspects of the service delivery.

6.3. Impacts of the New Approach

The creation of the OCMO and population and public health activities undertaken by the FNHA has created a range of impacts. These impacts are summarized as follows:

Provided a stronger voice for First Nations communities and clients. The creation of the OCMO role has been critical in creating a high-level platform and voice that can speak on behalf of First Nations clients reflecting their perspectives and interests. It has created a greater sense of ownership of the health care system overall. The Chief Medical Officer is able to speak on behalf of the First Nations using culturally appropriate language while communicating the root causes of health problems and disparities. Compared to FNIHB and other provincial health authorities, the FNHA has a strong relationship with communities which has enabled them to better serve the communities. Over the past few years, the FNHA and particularly the OMCO have developed strong capacity to engage communities, to listen to their perspectives and to develop programs and campaigns that reflect their needs. Consequently, as noted by case study participants, there is a greater buy-in among First Nations clients and communities to participate in the FNHA programming.

Improved quality and availability of the First Nations-specific health data, which has helped to make important policy and program decisions affecting client and community well-being. Through partnership

with the provincial government, and First Nations organizations and communities, the FNHA has improved the quality and accessibility of First Nations-specific data. The data has been used by the FNHA and partners to make better informed policy and program decisions, and to advocate for more funding and resources. For example, in 2017, the data on the opioid crisis demonstrated that First Nations individuals were more likely to be affected by the crisis. Consequently, the decision was made to allocate additional resources (\$20 million in provincial funding) for crisis response efforts specific to First Nations clients and communities. The funding enabled the FNHA to address the needs of First Nations clients and communities affected by the crisis in a culturally responsive and appropriate manner.

The information campaigns have affected client attitudes and behaviours empowering them to make healthy lifestyle choices. During interviews, case study participants noted that health promotion campaigns undertaken by the FNHA, particularly by the OCMO, have had some initial impacts on the attitudes and beliefs of clients and communities. Examples of change in attitudes and beliefs, mentioned by case study participants included: feeling in control of one's own health and increase in self-esteem and a sense of self-determination, a decrease in stigma around mental health and addictions challenges (e.g., acknowledging the issue and talking about it), an openness to use harm reduction techniques, and screening for cancer. Due to trust that the FNHA has been able to build with communities, the campaigns have been more effective in empowering clients and communities and resulting in change in attitudes and beliefs. Integrating First Nations approaches and placing an emphasis on wellness have contributed to the success of the information campaigns undertaken by the FNHA.

Improved coordination of the activities with provincial partners and regional health authorities in the delivery of the population and public health programming. Through close collaboration, the FNHA has ensured that population and public health activities delivered by the province (e.g., environmental health programs) were better coordinated and delivered and many of the jurisdictional issues were addressed.

Impacts of some activities undertaken by the OCMO will be known in the future. During interviews case study participants noted that some of the activities undertaken by the OCMO will have positive impacts in the future. In particular, the indicators of wellness will help to report on First Nation health status using culturally appropriate approaches, increase First Nation ownership of the data and contribute to move the FNHA wellness agenda forward.

6.4. Gaps, Challenges and Issues

The OCMO has experienced significant issues with resources and capacity to deliver on its commitments. The OCMO was created with a small number of physicians who are expected to work with First Nations communities and individuals to promote wellness and well-being. This meant that other departments within the FNHA had to provide necessary support (e.g., research, administrative) to ensure public health physicians can deliver best on their roles and responsibilities. However, during case study interviews, members of the OCMO staff noted that although they are passionate about their job and feel privileged to work for the FNHA, they often have to work 60 to 80 hours per week, which can create mental and emotional challenges and may lead to burnout. Members of the OCMO undertake extensive list of responsibilities (e.g., serve on executive team, represent the FNHA at provincial meetings, act as Watchmon, review data reports, respond to community and client inquiries) despite limited staffing and support that they receive. Some of the challenges mentioned by case study participants included delay in producing results and outputs (e.g., all reports and data that the FNHA and partner organizations publish have to be reviewed and endorsed by the Chief Medical Officer which has burdened staffing), and staff turnover due to burnout. Case study

participants noted a need for the FNHA to provide more support (e.g., admin, research, etc.) and better alignment to ensure OCMO can deliver on its mandate.

Coordination of the activities may become challenge. The FNHA has grown to become a large organization with various departments and officers, each performing important functions with respect to population and public health. For example, research, surveillance and environmental and public health officers all operate under different departments. Bringing these different functionalities under one umbrella to coordinate activities can be a challenge. The issue is further complicated by the fact that most population and public health activities undertaken by the FNHA also need close coordination with the provincial health authorities. When, for example, immunization requirements are changed for school children, it requires not only instructions with nursing staff within the FNHA, but also close coordination of the immunization activities with provincial government. Although the OCMO was created to bridge this gap, it will require time and effort, and additional resources, to address the coordination challenges and achieve full scale integration of the activities within the FNHA as well as with stakeholders outside of the organization. The FNHA may need to re-design workflows and undertake a review of internal communications to ensure full alignment of the activities of OCMO with other departments within the organization.

Despite positive improvements over the past few years, public and population health work undertaken by the provincial health authorities has many challenges in their approaches to work with First Nations communities. Population and public health activities delivered by partners (reflective of broader health system) are usually underfunded (only about 4% to 5% of health budget spend on public health) affecting quality of their work. Provincial health authorities often lack capacity, resources and commitment to undertake large scale improvements in addressing the needs of the First Nations communities.

Despite significant improvements in recent years, the availability and quality of the First Nations-specific health data continues to be a challenge. With the exception of data on the overdose crisis, the FNHA does not have access to raw data collected by the MoH within various databases. Due to privacy constraints, the FNHA has to submit requests for the MoH to provide aggregate level First Nations-specific data. This process has multiple challenges. Often the MoH lacks the capacity to provide a timely response to the FNHA's requests for data linkages that can identify First Nations-specific data. Furthermore, limited access to raw data constrains the FNHA's ability to analyze data and report back to the communities in the format that is useful to them.

Balancing differing priorities can become a challenge. The FNHA (as well as provincial health authorities to a certain extent) is often busy with addressing multiple critical issues and priorities. It is difficult to allocate time, resources and staffing into population and public health activities when there are many other key issues and crises occurring (e.g., overdose, suicide). At the same time, population and public health programming is critical to community and client wellness. When neglected, it can result in significant public health crisis and emergencies, such as outbreaks, at a later date.

Lack of established infrastructure and systems and past experience. The FNHA did not inherit the Chief Medical Officer function from FNIHB. This function was created after transfer requiring extensive administrative efforts (e.g., creating new policies, procedure and working standards, establishing governance and reporting structures, recruiting staff).

It has been a challenge for the FNHA to work actively with partners to ensure they follow OCAP® Principles and/or obtain pre-approvals prior to reporting data on First Nations health indicators. Implementing pre-

approvals by partners required extensive efforts by the FNHA and the challenge was ongoing at the time of this evaluation.

Growing expectations may become difficult to address, requiring extensive communication. As the FNHA has been successful in improving the quality of the services and programming delivered to clients and communities, their expectations of the organization have increased. The FNHA staff, particularly the OCMO, has had to communicate extensively with clients and communities to address expectations. Case study interviewees mentioned that higher expectations included clients and communities asking for a team of psychiatrists to be sent to a community to address one client who experienced psychiatric difficulties, requesting coverage for items not listed as health benefits, and extensive requests to assist with securing traditional foods at the community level.

Creative approaches to the work require constant change in programs and activities and flexibility in operations. Many of the public health activities and initiatives undertaken by the FNHA and the OCMO have never been previously implemented. Consequently, greater efforts and resources are required to explore and initiate various ideas, as well as the flexibility to change and adjust them quickly and as needed.

6.5. Lessons Learned and Opportunities for Improvement

Increase the level of coordination, alignment and communication among various departments and regions within the FNHA involved in population and public health. To be able to perform its functions in the most effective way, the OCMO needs to have strong support and coordination within all FNHA departments and functions. That may require more planning and sharing of knowledge, best practices and lessons learned among FNHA staff to keep lines of communication open in order to increase the level of engagement and outreach within the FNHA departments and regions. For example, during interviews Communicable Disease Population and Public Health and environmental health staff mentioned that their activities and functions would be more effective if they received consistent guidance and support from the OCMO. As part of these efforts, it is important to keep administrative burden on OCMO to minimum and improve resourcing to allow Chief Medical Officer to focus on most critical public health priorities.

Increase focus on urban and away from home clients. The largest population of First Nations people, both in Canada and in BC, do not live on-reserve. Going forward, it will be important to acknowledge this and develop and implement programming targeted to all First Nations clients, particularly those who live in urban areas. It will also be vital that the FNHA make the distinction between First Nations people living in communities and those living away from home when collecting and reporting on their population and public health data.

The unique role of the FNHA's OCMO requires constant communication and coordination to clarify roles and responsibilities with other service providers. As noted earlier, the FNHA decided not to assume legislative powers for the OCMO under the *Public Health Act* and have acted as a partner to First Nations by providing expert advice and physician leadership from a First Nations perspective. However, the challenge with this role is that some partners, particularly other provincial health authorities, often do not understand FNHA's unique role and assume that it is the FNHA responsibility to carry out public health activities performed by provincial health authorities (e.g., health compliance, health inspections for public health safety at restaurants, stores and other locations operated on-reserve or undertake communicable disease management services). There is a constant need for the FNHA public health officers to closely coordinate

their activities with those from other provincial public health authorities and educate them on the FNHA's unique role and align activities.

The FNHA should continue to enhance its efforts to represent the interests of the First Nations at key provincial tables. It is critical to have representation at key tables to share perspectives of First Nations and who can proactively advocate for First Nations interests. A large share of support and resources to address First Nations needs should come from the provincial government and particularly through other health authorities. For this to happen, proper advocacy work needs to be conducted at the provincial levels. As part of this work, the FNHA needs to work with provincial health authorities to ensure their services are culturally safe for First Nations. Proactive advocacy and coordination are necessary to achieve cultural safety of their services. There is a need to strategically identify the right tables to participate in, given the limited resources of the FNHA to participate everywhere.

Continue efforts to improve First Nation specific data collection and reporting practices. According to case study participants, more work needs to be done on how the First Nation data is collected and reported. Areas of improvement mentioned by case study participants included:

- *Finding ways to make the data useful at the regional and community level*, which should help the organization to build strong relationships with communities and gain their trust. Reciprocal accountability means that every time the FNHA asks communities to provide information, it should also report back to them on how the information was used and how it can be made more useful for communities.
- *Integrating the data that the FNHA and partners collect from different sources* to (e.g., health benefit data, surveillance, surveys) in order to tell the full story of the BC First Nations health journey.
- *Working with provincial partners to facilitate easier access to First Nation specific data* collected by the provincial partners while maintaining client privacy and confidentiality.

Creativity and innovative ideas are a key part of the OCMO's role and should be continued. During interviews, case study participants noted that most activities undertaken by the OCMO have been innovative and unique in Canada. OCMO should continue finding and implementing such innovative concepts and ideas in order to create a significant impact. Working in constant communication and coordination with communities and frontline staff members will help to identify such ideas to be implemented at a broader scale.

7. Client Engagement

As per the 7 Directives and foundational governance documents, the FNHA's activities and operations should be Community-Driven, Nation-Based and the program, service and policy development must be informed at the grassroots level. Guided by this Directive, the FNHA has undertaken extensive efforts to engage with First Nations communities and individuals to govern its activities and make strategic program and policy decisions.

7.1. The FNHA Approach to Client and Community Engagement

The FNHA did not inherit community and client engagement practices from FNIHB. FNIHB rarely did engagement with clients and occasionally conducted engagement with community health staff members and leadership.

The process of engaging First Nation communities in health governance was started as part of the tripartite process. At the time of the tripartite discussions (2007/08), the FNHC recognized a need for a more coordinated community engagement processes. Consequently, the organization created 32 community engagement hubs where community representatives (e.g., health staff and leadership) could come to talk about and discuss issues related to their health and wellness. By 2013, 180 communities had participated in the community hub process. The hubs continued to 2014, until engagement activities were transitioned to the FNHA. The FNHA built on the engagement capacity developed by the hubs and later transitioned some of the staff to become Community Engagement Coordinators employed by the FNHA.

Once the FNHA took responsibility for the provision of the programs and services, in 2013/14, it continued with ongoing community engagement efforts. As per the 7 Directives and required by Directive #1, the FNHA ensured that all programming and major decisions were Community-Driven and Nation-Based. Some of the methods used by the FNHA to engage with First Nations communities included:

- *Extensive consultations with the FNHDA and FNHC.* As per the First Nations Health Governance Structure, both the FNHDA and FNHC are critical in the decision-making processes.
- *Participation in Regional Caucus meetings and Gathering Wisdom for a Shared Journey conferences.* The Regional Caucuses are composed of First Nations leaders and health professional representatives in each region. Through Caucus sessions, the regions approve action plans which serve as the basis of the FNHA plan of action. Gathering Wisdom for a Shared Journey is a forum held approximately every 18 months that include First Nations leadership, Health Directors, wellness leads and governance partners. The forum provides a key engagement opportunity for tripartite partners to communicate progress on the implementation of the Tripartite First Nations Health Plan and to gain additional direction and feedback from BC First Nations to advance the health reform process.
- *Through Regional Community Engagement Coordinators.* In 2014, the FNHA created Regional Community Engagement Coordinator positions across BC to help support with community engagement and communication efforts. The coordinators play a critical role in engaging with community members and in keeping the lines of communication open with community leadership and health staff members.

The role of the FNHA in engaging with First Nation clients and interacting and communicating with them directly has evolved and increased over time. At the initial stages following transfer, the FNHA largely did not engage or communicate with clients directly as it did not have a service delivery role (with the exception of nursing stations run by the FNHA, and some components of the Health Benefits program). The direct interaction between First Nation clients and the FNHA was relatively limited. However, gradually the FNHA increased its efforts to engage and communicate directly with clients and to learn their perspectives on specific issues and needs. The level of the FNHA's direct interaction and engagement with clients often depends on the purpose and nature of the initiatives that require engagement. Often the range of engagement and communication activities included one-way communication that is focused on informing clients on specific issues (e.g., educational and informational campaigns), one-way communication to gather client feedback (e.g., surveys), interaction over social media or call center to help with client navigation and also two-way interaction where the FNHA learns client perspectives on specific issues, changes or design of programming and then reports back to communities (e.g., client journey mapping, Health Benefits program redesign). At the time of this evaluation, the FNHA was engaging and/or communicating with clients through a number of approaches, most notably:

- *The FNHA uses its website and social media channels to interact with all stakeholders including First Nation community representatives and clients.* The organization is actively engaged on most available social media channels (e.g., Facebook, LinkedIn, Instagram, Snapchat, Twitter) with considerable followers. According to the FNHA staff members, a large proportion of the communication received through social media (1,500 to 2,000 communications per year) is related to client complaints, and issues related to client navigation in accessing the health care system. After undertaking client privacy protection measures, members of the FNHA communication team often refer these clients to appropriate departments for assistance.

Social Media	Following
• Facebook	• 23,312
• Twitter	• 9,993
• LinkedIn	• 5,454
• Instagram	• 855

- *Undertaking client surveys.* In 2017, the FNHA administered a *Health Attitudes and Beliefs Survey* with over 2000 Indigenous residents of BC with a focus on their views, attitudes and beliefs on health. This survey was a critical step for the organization to learn directly from clients (who live in communities as well as in urban areas and away from home) on their health issues instead of through consultations with community representatives such as Health Directors and community leaders. The survey collected information specific to clients’ health attitudes towards cancer screening, opioids and legalization of cannabis. In addition, the FNHA administered several health surveys with clients on-reserve organized by the First Nations Information Governance Centre including the *Regional Health Survey*, the *First Nations Labour and Economic Development Survey*, and the *First Nations Regional Early Childhood, Education and Employment Survey*. The data helped the FNHA to better understand the health needs and priorities of its clients and to make informed policy and program decisions.
- *The FNHA uses a number of innovative approaches to reach out to its client base as part of educational and awareness raising campaigns.* Some of the methods used include: extensive communication and interaction through social media; posters at bus stations, transit homes, shelters, community health stations (or Aboriginal Friendship Centers) and band offices; paid advertisements on Google to draw attention to the FNHA campaign sites; creative radio advertisements targeted to those who drive; creative video content distributed through social media; and in-person discussions at various gatherings and events (e.g., innovative “Make Your Own Poster” on cannabis use at youth gathering).

- *Participation in the Patient Voices Network.* Created in 2009, Patient Voices Network is a program administered by the MoH as part of its Patients as Partners strategy. The network works to match volunteer patients with health care partners who are seeking to engage patients in their efforts to improve quality of care. The FNHA has used the network to connect with First Nation clients, particularly those living in urban areas, as part of transitioning health benefits. At the time of the evaluation, the FNHA was planning to expand on this cooperation and use the network to undertake more client engagements.
- *Participation at various events and gatherings to connect with and listen to the perspectives of client groups.* Over the past five years, the FNHA has organized, supported and/or participated in a number of events and gatherings that brought together different groups of clients from across BC, including:
 - BC Elders Gatherings. The FNHA regularly participates in the annual BC Elders Gatherings. For example, in July 10 – 12, 2018, the FNHA attended the 42st Annual Elders Gathering. During the event, the FNHA and Cowichan Elders collaborated on a number of workshops including managing pain in arthritis care, forgiveness and healing and healthy cooking.
 - Gathering Our Voices Youth Conference is an annual event that brings Indigenous youth together. Over the course of four days, up to 1,000 delegates gather from across Canada to participate in ceremonies, workshops and engaging, informative and educational experiences on health and wellness. The FNHA supports the event by providing \$375,000 through a contribution agreement and participates at the conference every year. The FNHA uses multiple approaches to engage youth at this event. For example, in 2019, the FNHA organized workshops on cannabis use (each attended by approximately 12-15 youth), created a wellness area, set up an information and health careers booth, and provided an innovative and fun game named the Tobacco Eating Machine (a vending machine that gives prizes for those who give their cigarettes away). By participating at the event, the FNHA was able to reach over 400 youth on tobacco with over 70 making pledges not to use cannabis, commercial tobacco and vaping.
- *FNHA regional staff members interact with clients through service delivery, community discussions and gatherings.* During the case study interviews, regional staff members, particularly those in charge of community engagement, indicated that they interact and engage with clients directly as part of their activities. In particular, the FNHA regional team members often participate at various community events, gatherings and special occasions, where they directly interact with clients and community members to learn about their needs and priorities. For example, in 2019, Fraser Salish region set up community barbeques and breakfasts sessions with community members and most recently with urban members via homeless shelters to develop relationships with individuals, discuss access to health care, and help navigate the health system and identify any issues or barriers they are facing in the health care system. In addition, regional crisis team members are often involved in responding to crisis situations and emergencies, which involves direct interaction with clients. Similarly, the members of the FNHA nursing team and environmental health officers regularly travel to communities, interact with community members, and provide advice and services to primarily on-reserve clients.
- *Client journey mapping.* The FNHA has partnered with the BC Patient Safety & Quality Council to understand the client journey through the health care system in key priority areas. For example, journey mapping was conducted with Indigenous cancer survivors and their families which informed the Indigenous Cancer Strategy, as well as with patients/peers and health care providers as part of improving substance use treatment.⁴

⁴ <https://bcpsqc.ca/resource/journey-mapping-in-cancer-care-maps/>

- *Extensive interaction, communication and engagement were undertaken through the Health Benefits program.* Health Benefits is the main program area where the FNHA comes into direct contact with its clients. Therefore, extensive communication and engagement has been conducted as part of the program, particularly through the transition of health benefits from FNIHB's the NIHB program. The main examples of client interaction, communication and engagement activities undertaken through the Health Benefits program include:
 - Client Satisfaction Surveys. In 2016, the FNHA launched the *Health Benefits Client Satisfaction Survey* to collect client perspectives on their experience with the Health Benefits program. By October 2018, a total of 551 clients had participated in the survey. The FNHA used the survey results as a means for monitoring the effectiveness of its programming in addressing clients' needs and identified recommendations for improvements.
 - Extensive information campaigns as part of the Phase I transition of Pharmacy Benefits. As part of the transition, the FNHA created a Working Group on Communications and Engagement and conducted extensive communications campaigns. In particular, the FNHA organized two mail outs targeted at all its client base, extensively used social media to spread the message about upcoming changes (e.g., 134 social media posts related to the transition were shared, and YouTube videos garnered over 32,700 views), and 418 radio announcements were made through three major radio stations during the three-week period prior to the transition. However, the campaigns experienced a number of challenges with reaching out to clients and communities and educating them about upcoming changes.
 - Extensive in-person group discussions organized with clients (mostly who live in communities) as part of the Phase II transition of other health benefits. Learning from the experience of Phase I transition, as part of the Phase II transition, the FNHA engaged directly with clients and communities across the province. With the assistance from the Regional Community Engagement Coordinators, the FNHA Health Benefits team organized over 51 group sessions across the region which included representatives from 97 First Nations communities. During the discussions, the FNHA collected their recommendations on how the Health Benefits program could be improved. Based on these recommendations, the FNHA created the design of the new program. In 2019, the FNHA organized group discussions again in the same communities and reported back to them how the design of the new Health Benefits program would address their community recommendations.
 - Interaction with customers through call center and appeal processes. Prior to the transition, the NIHB program did not have a call centre where clients and service providers could phone. In 2017, the FNHA created a call center to provide assistance to Health Benefits program clients and service providers. At the time of Phase I of the transition of Pharmacy benefits, the call center played a critical role in addressing client and service provider inquiries. Notably, the day following the transition the number of calls received by the center peaked at 444. The numbers gradually declined and by the end of October 2017, just over 100 phone calls were received by the center every day.
 - The Health Benefits program also has a 3-stage appeal process that allows clients to appeal the decisions when their health benefits are declined. In 2018/19 fiscal year, the FNHA received a total 32 appeals that required a review and decision by staff members.
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7.2. Impacts of Client and Community Engagement

Case study participants identified a number of positive impacts generated by the FNHA's client and community engagement activities.

The primary impacts of the FNHA efforts to engage with clients and communities have been improved understanding of clients' needs and priorities. The results of the engagement activities are used to bridge the gap between clients and the organization and to bring clients' voices into decision-making. The new knowledge is used to shape the FNHA's activities and/or information campaigns to better target client needs. For example, the information obtained through the *Health Attitudes and Beliefs Survey* was critical for designing the FNHA's public health campaigns and educational materials. The survey identified that Indigenous youth were misinformed about the harmful effects of cannabis use on brain development. Consequently, a strengths-based education campaign called *Indigenous Strength* was launched which provided accurate information on cannabis use amongst youth. The campaign included digital advertising on multiple social media platforms, radio spots, and transit shelter advertisements strategically selected locations to direct people to a cannabis web portal for information and resources. According to case study participants, the campaign was highly successful and won an award from the British Columbia Communication Association. Contributing to the success of this campaign was the knowledge gap that the FNHA gained through the *Health Attitudes and Beliefs Survey*.

The FNHA's client and community engagement activities have helped the organization to build a positive reputation and gain trust of some communities and clients. For example, as part of the Phase II Health Benefits transition, the FNHA consulted with communities to get their recommendation on the design of the Health Benefits program. The in-person discussions included participants from 97 of the 201 First Nations communities in BC. The representatives of the FNHA then went back to the same communities to inform them how their recommendations were used in the process. It also has helped to improve clients' self-esteem and create sense of control over decisions affecting their lives.

Supporting clients to navigate and improve their experience with the health system. The FNHA's social media is often the first point-of contact for many clients. Clients approach the FNHA through social media and the website to request assistance with accessing the services. Through this contact, the FNHA helps clients to navigate the system and improves their experience. Similarly, the Health Benefits call center has supported many clients in accessing pharmacy benefits and navigating the system.

Engaging and communicating with communities and clients have been an important factor that has allowed the FNHA to continuously learn and grow. Through constant communication and engagement, the FNHA is ensuring that it does not repeat the mistakes of the past. The enthusiasm and dedication of the staff members have been important aspects of the success. As a new area of practice, engagement and communication activities also involved lots of learning. Case study interviewees mentioned that lessons learned included: changing approaches to engagement and communication as part of the Health Benefits transition; using the results of the client surveys to identify how clients describe certain terminology (e.g., those related to addictions) and then using it as part of the information campaigns; using Google and social media analytics to place proper advertisements; and reporting back to the communities on how the results of the engagement was used in decision-making.

Creating capacity at the regions have contributed to the success of engagement efforts and helped the FNHA to build better relationships with the communities and connect with clients. The regional staff are much closer to the communities with most of the clients that are being engaged with by the regional teams are on-reserve. Given that they are in constant communication with communities, regional teams are able to build direct relationships with them. In particular, hiring/transitioning Community Engagement Coordinators was a best practice and it allowed the FNHA to establish direct connections with the communities.

In terms of negative impacts, it was mentioned that extensive communication, interaction and engagement with communities can create engagement fatigue therefore discouraging some people from participating. Communities are often willing to participate in the engagement activities, however continuous engagement can drain their resources and time away from other priorities.

7.3. Gaps, Challenges and Issues

Client awareness of the FNHA is still low. During interviews, case study participants indicated that despite increasing communication and engagement efforts, client awareness of the FNHA and its services and programs is still low. The FNHA communication activities only reaches a small fraction of its client base. The organization also lacks client contact information and a proper mechanism for reaching them. For example, of the approximately 150,000 letters sent out to clients as part of the Phase I transition of Pharmacy Benefits, 10-15% (an estimated 15,000 letters) were undelivered due to incorrect addresses. Similarly, despite extensive communication campaigns undertaken by the FNHA at the time of the transition, only 20% (or 16 of 79) eligible clients who responded to the survey, indicated that they were familiar with Plan W.

The FNHA lacks a dedicated strategy and systematic processes focused on client communication and engagement. Without a proper strategy, clear targets, processes and action plans, the engagement and communication activities may not produce effective results. Undertaking communication and engagement without clear purpose may affect the success of the efforts and result in a waste of limited resources. Furthermore, a few case study participants noted issues with properly documenting the results of the client and community engagement activities and sharing them through central repository, which often results in loss of corporate memory.

The FNHA lacks a mechanism to reach out to and engage First Nation clients living away from home. With exception of a few activities (e.g., customer survey, health attitude survey, journey mapping and social media), the FNHA does not have a proper mechanism to communicate and collect the perspectives from the urban population. The issue is further constrained by the lack of an organization/body that represents this group of clients. Furthermore, according to a few case study participants, the FNHA's Community Engagement Coordinators mostly work with communities and they lack focus on engaging with clients who live in urban areas and away from home. This is mostly because the coordinators role in engaging with clients, particularly with those who live in urban areas, is not clearly defined.

Resource challenges and balancing priorities. Engagement and communication activities, particularly those conducted in-person, are very resource and time intensive. The FNHA often has to balance priorities when allocating resources to engagement activities because the organization constantly faces many other pressing health needs and issues. Staff members often find it to be challenging to perform their duties while also

undertaking extensive engagement, which may result in burn out. The decisions may also get delayed because it requires proper engagement, affecting the outcomes of the work.

7.4. Lessons Learned and Opportunities for Improvement

Despite challenges, the FNHA should continue the engagement and communication activities with communities and directly with clients. Engagement and communication are one of the most important aspects of the FNHA activities that helps the organization be connected with its clients and to address their needs. It is an historic opportunity, and whose success will depend upon the extent to which the FNHA understands client and community needs and priorities. Ongoing engagement and communication activities have made the FNHA agile and flexible so that it can make quick decisions and adapt to community and client needs.

Develop a strategy and/or systematic processes focused on client engagement. Having clear target, processes and plans of actions would ensure the engagement and communication activities are undertaken more systemically with clear purpose (rather than an ad-hoc approach). As part of the strategy, it is important to develop mechanisms specifically dedicated to reaching out and engaging clients living in urban areas and away from home. Some of the strategies to be considered in engaging urban and away from home clients include allocating specific resources/staffing for engagement and/or involving Community Engagement Coordinators and building partnerships with provincial Patient Voices Network and using the Network's resources.

The BC First Nations health governance structure has been critical in supporting the FNHA engagement activities. However, opportunities exist to improve the level of communication and engagement within the structure. The existing structure requires close involvement of the FNHDA and FNHC. The 7 Directives require the FNHA to be Community-Driven and Nation-Based. However, the recent evaluation of the FNHA, FNHDA and FNHC relationship agreement demonstrated that shared engagement mechanisms were not being leveraged as much as they could and there were a range of opportunities to improve existing engagement activities, including: need for creation of the FNHA engagement platform and more investments on engagements, particularly those directed at First Nations leadership, clients and service providers; involvement of the Chiefs in Regional Caucus meetings; and the development of shared and coordinated external messaging targeted at different stakeholder groups (e.g., First Nations leadership, community members, and stakeholders and partners).⁵ Community leadership can help the FNHA set client engagement priorities. Similarly, findings of client engagement should help the FNHA to identify key issues and needs and help to guide community engagement and decision-making processes.

It is important to properly document the results of each engagement activity and make results accessible to other staff members. Prior to transfer, the FNHA had a centralized mechanism and process to document community engagement, particularly that carried out through Regional Caucuses. Through time, however, this centralized mechanism has not been maintained and there is currently no repository. Case study

⁵ FNHA-FNHC-FNHDA Relationship Agreement Evaluation 2019

participants mentioned examples of when the FNHA engaged communities however, because they did not produce a summary document of the results, was not able to follow through on commitments discussed in the engagement process. Documenting results properly and making them accessible to staff members would maintain corporate memory, and help build more systematic approaches to engagements and support follow through on the issues that were raised during engagements.

The engagement activities should align with community traditions and cultural practices to succeed. In accordance with partnership accord principles to 'lead with culture' the FNHA incorporates cultural practices its activities and demonstrate respect to community traditions, which contributed to the success of its engagement efforts.

Ensure engagement priorities and processes are genuine and meaningful. The engagement should start as early in the process as possible. Communities and clients should decide the terms of engagement and importantly the engagement should benefit them. Communities and clients prefer in-person meetings where they can ask questions and build trust. It is important to report back to the clients and communities how their opinions were used to make decisions and how those decisions will affect their lives.

It is important to hire and train staff members who can undertake culturally appropriate engagements and interactions with clients and communities. When engagement activities are not properly implemented, they may create negative consequences for both the FNHA and the communities and clients. Therefore, it is important for the FNHA to ensure its staff members have proper skills to undertake communication, interaction and engagement. The FNHA should also develop training curriculum, policy, and manuals for staff members to help guide them during engagement activities.

8. Urban and Away from Home

Through adopting Consensus Papers and the Tripartite Framework Agreement, BC First Nations have provided a mandate to FNHA to support the health and well-being of all First Nations in BC, including those living in urban areas/away from home. The FNHA has worked to increase access to health benefits, supported overdose emergency, facilitated integration of services for all BC First Nations regardless of residence, service providers and agencies and undertook joint planning and funding of some service delivery projects. As well, the FNHA regularly produces data and reports reflective of the entire population and works with provincial government to influence provincial policies (e.g., BC's Guiding Framework for Public Health, primary care policies) and services to reflect perspectives and interests of First Nations regardless of their residence.

8.1. Health Needs and Priorities of the Urban and Away from Home Population

The First Nations and Indigenous population in BC has been steadily growing. Between 2006 and 2016, the Indigenous population in BC grew 39% - from 195,400 to 270,585. The First Nations population, specifically, increased by 34%. As of 2016 BC is home to 172,520 First Nations people, 89,405 Métis people, and 1,615 Inuit.

The Urban and Away From Home population has been growing at a faster rate than the First Nations population living in communities. Between 2006 and 2016 the urban and away from home population grew 49%, from 61,735 to 120,815. In the same time period the on-reserve population also grew, but by a factor of 5.6%, from 48,810 to 51,710.

The majority of the BC First Nations live away from home. The percentage of status First Nations people living away from home in 2016 was 60%. The urban and away from home population nearly doubled between 2006 and 2016.

Most of those who live away from home are young. BC First Nations youth are more likely to live away from home than middle aged First Nations people, with 73% of the population aged 0-24 living away from home, compared to 69% for those aged 25-64.

Many First Nation clients face a number of challenges when they move to urban areas away from the communities. These challenges include issues related to living expenses and accommodation, lack of access to support network (family and friends) that they had in the community, and racism and cultural barriers in accessing health care services (e.g., primary care, mental health and wellness support). Navigating the system to access care can become difficult for some clients, particularly when many do not trust that the health care system adequately represents their interests. The journey often creates a feeling of isolation and contributes to depression and anxiety.

A clear gap in the health system for First Nations in BC is illustrated by the over-utilization of emergency departments, and associated under-utilization of physician services. First Nations people (including those who live in urban areas and away from home) in BC are more likely to use emergency departments than

other residents in BC, which corresponds to the lower utilization rate of physician services (e.g., general practitioners outside of hospitals, medical specialists or surgeons). The data shows that First Nations females were almost two times more likely to visit the emergency room than non-First Nations women, and First Nations males were approximately 70% more likely to visit the emergency room than non-First Nations men.

Historically, the federal government provided some support to First Nations people living away from home. This support was mostly around funding allocation to Aboriginal Friendship Centers as well as access to health benefits to all First Nations including those who lived in urban areas. More recently, federal government has started implementing an Urban Aboriginal Strategy and Urban Programming for Indigenous Peoples both of which provide short term and application based-funding (and which is not health-specific).

Jurisdictional ambiguity exists around accountability for urban and away from home populations, which has created gaps and issues with service delivery. The division of powers in the Constitution of Canada has led to jurisdictional wrangling between provincial and federal governments for First Nations (both home and away from home populations), resulting in people falling through the gaps and not receiving adequate services. Addressing jurisdictional disputes have been a key part of the tripartite negotiations processes. For example, the 2006 *Transformative Change Accord: First Nations Health Plan* noted that the province was responsible for providing services to all British Columbians, regardless of residence and the *Tripartite First Nations Health Plan* in 2007 brought the federal government to discussion table to ensure work can be conducted on a tripartite basis to resolve jurisdictional issues.

The availability of the health care services in urban areas does not often translate into accessibility. Institutionalized racism within the health system and lack of culturally safe and appropriate services are the main barriers for First Nation clients in accessing services.

8.2. The FNHA Mandate to Service the Urban and Away from Home Population

Aspects of the FNHA's mandate extend to all First Nations living in BC including to the urban and away from home populations. The FNHA inherited a service-delivery mandate from FNIHB that was limited to on-reserve health services only (the exception being the NIHB program which is available to all Status Indians irrespective of residence). Foundational governance documents (e.g., Tripartite First Nations Health Plan) and tripartite agreements on First Nations health, however, provided a clear mandate for the FNHA to represent interests of all First Nations in BC regardless of their residence and act as a health and wellness partner. The new mandate includes areas of program and service delivery as well as collaborative work and partnership to address jurisdictional issues, and program and service gaps by achieving integrated services. For example:

- *Tripartite First Nations Health Plan* indicated that health services in BC will be delivered in manner to effectively meet needs and priorities of all First Nations regardless of their residency and First Nations individuals will have access to quality health services comparable to those available to other Canadians living in the same regions, and health services will be integrated with provincially-funded services such as those provided to the regional health authorities.
- *Health Partnership Accord* indicated that parties will work together to remove jurisdictional impediments, and support collaboration, and create integrated health systems which will serve all First Nations and ensure that First Nations in all regions of BC will have equitable access to quality health services.
- *Tripartite Framework Agreement* indicated that the FNHA should work collaboratively with the MoH and

BC Health Authorities on the design and delivery of provincial health services available to First Nations in BC, to address gaps in health services and to better coordinate such services with First Nations health programs so as to improve efficiency and effectiveness of health care for First Nations in BC; and work with the MoH and BC health authorities to integrate First Nation models of wellness into the health care system, to improve health outcomes and wellness for First Nations in BC.

Continuous support was expressed by First Nations leadership at various meetings for the FNHA to undertake activities to support urban and away from home populations. At various meetings and gatherings, it has been acknowledged that there is a duty to support those living in urban areas and away from home. For example, at various Regional Caucus meetings, 93% to 100% of the participants indicated that they wanted the FNHA to support programming that was targeted at away from home population.

8.3. FNHA's Efforts to Target Urban and Away from Home Clients

Since transfer, the FNHA has undertaken a number of steps to improve programming and services addressing the needs of clients living in urban areas and away from home. These efforts are summarized as follows:

Hired dedicated staff members (two full-time equivalent positions) to coordinate the FNHA activities targeted at clients living away from home and begin developing a strategic framework to set strategic objectives and guide the FNHA work targeted at First Nation peoples living away from home. Through extensive engagement with First Nation stakeholders (e.g., Regional Caucus meetings), provincial service providers and other partners (Aboriginal Friendship Centers), the FNHA learned the needs and priorities of the urban and away from home population. Stemming from these engagements, the FNHA started developing a strategic framework to guide its activities targeted at this population. At the time of this evaluation, the framework was in development stage.

Integrated the interests and perspectives of urban and away from home population in all its activities, programming and policy decisions. The FNHA's internal philosophy and policy work considers the needs of all clients including those who live away from home. For example, policies and strategies such as the Indigenous Cancer Strategy, the opioid response, and the Cultural Safety and Humility Standard, include urban and away from home interests and perspectives.

Facilitated transformation of the health care system in BC by integrating First Nations perspectives for the benefit of all First Nations people including those who live in urban areas and away from home. According to stakeholders interviewed, the most important aspect of the work that the FNHA is doing targeted at all First Nations including the urban and away from home population is achieving the change in the BC health care system overall. In particular, the FNHA is working towards 'hardwiring' First Nations perspectives into the provincial health care system. The FNHA has been acting as a leader and champion to influence health ecosystem transformation, affecting all residents of BC, including First Nation clients living in urban areas. The FNHA is achieving these changes by representing the interests of First Nations at all health tables and forums from the most senior levels (e.g., Chief Executive Officer to Deputy Minister) to service delivery levels (e.g., direct engagement with health authorities, service delivery agencies, and providing tools and guidelines on First Nations approaches to health). These efforts help provincial services to become more responsive to the needs of First Nations clients, including those who live in urban areas, away from home. Stakeholders mentioned a number of systemic changes that had occurred, including:

- Establishing Collaborative Governance Structure with the MMHA and incorporating First Nation perspectives into provincial mental health policies.
- Working together with provincial government to respond to the Overdose Public Health Emergency for First Nations and supporting the social determinants of health initiative.
- Influencing how the First Nation specific population and public health data is collected, analyzed and reported ensuring a greater access to data, and proper reporting of the data that benefits First Nations.
- Working directly with regional health authorities to make their services more culturally safe for First Nations clients (e.g., organizing regular meetings to discuss the needs of First Nations clients, hiring of First Nations members to regional health authority boards, hiring Aboriginal Navigators and serving traditional foods at provincial hospitals).
- Signing of cultural safety and humility declarations by BC service providers and creating cultural safety forums and task forces at the regional levels to address systemic racism within emergency rooms and hospitals and other health facilities.

Engaged in partnerships with First Nations organizations that represent the interests or deliver services to First Nations living in urban areas. In particular, the FNHA has engaged with:

- *The BC Association of Aboriginal Friendship Centres.* In 2015, the FNHA signed a Memorandum of Understanding with the BC Association of Aboriginal Friendship Centres, an umbrella association representing 25 Friendship Centres located throughout the province. The Memorandum of Understanding formalized a working partnership between the FNHA and the BC Association of Aboriginal Friendship Centres and considered a number of actions to advance interests and support those living in urban areas. They also implemented a number of joint initiatives, including: grant funding to support doula programming for First Nations families; support for the annual Gathering Our Voices Youth Conference; partnership in implementing the Indigenous Cancer Strategy and support for the Moose Hide Campaign. In addition to the work with the BC Association of Aboriginal Friendship Centres, the FNHA also works with individual friendship centers to support programming and services as listed below.
- *Aboriginal Friendship Centers* to support programming and services targeted at urban and home away clients. Programming and initiatives supported by the FNHA include: supports to recruit and retain health and wellness navigators to assist clients while accessing the services in urban areas; funding for Elder circles; financial support to expand primary care (e.g., creation of the Indigenous Primary Care Team in Fraser Region) and mental health and addiction services available in urban areas (e.g., access to Wellness Grants, hiring of psychiatric nurse by Quesnel Tillicum Society); and other supports and programming needed in each region (e.g., organizing support for wildfire evacuees, hiring of home care liaison, creating access to occupational therapy and speech therapy services).
- *Indigenous Sport, Physical Activity & Recreation Council (ISPARC)* to support healthy living programming. The ISPARC has trained over 350 Healthy Living Leaders every year to deliver healthy living activities focused on healthy eating, physical activity, respecting tobacco and healthy pregnancies. To date, the ISPARC has trained 2,245 healthy living leaders who have delivered 1,519 healthy living programs to over 53,000 participants across the province, many of whom represented urban and away from home population. Through support from the FNHA, the ISPARC also engages in delivering all types of other physical activities programming (e.g., Indigenous RunWalk Program).

Worked with service delivery and provincial government partners to improve quality of primary care services available for all First Nation clients in BC, particularly, those who live in urban areas. Some of these activities are summarized as follows:

- *Studied models such as Southcentral Foundation in Alaska and the Aboriginal Health Access Centres in Ontario* and currently working with the province to develop similar primary care centres in BC.
- *Played a significant role in the development of the Primary Care Networks policies and processes to*

ensure that First Nations are included and full partners in the process. Through reviewing policies and engaging in service planning, the FNHA is working to ensure that this process benefits First Nations.

- *Supported investments in primary care clinics for First Nation clients through Joint Project Board funding.* About half of the projects supported by the Joint Project Board provide some support to urban and away from home.
- *Developed a partnership with Lu'ma Medical Services* and provided funding support in an effort to support the health journey of the First Nations population living in Vancouver.
- *Co-led the development of the a new primary care clinic in Surrey* (i.e., Indigenous Primary Health and Wellness Home) in partnership with the Fraser Health Authority. The clinic offers “culturally safe” and wholistic health care to 17,000 First Nations, Métis and Inuit people in Surrey. The clinic delivers a team-based ‘circle of care’ approach that addresses the physical, mental and social needs, as well as spiritual wellness of clients.

Provide support to First Nations clients, particularly those who leave their communities to access services in urban settings, to navigate the health care system. Aboriginal Navigators have been hired to work at major provincial hospitals and service delivery locations, as well as navigators who help all clients with accessing health benefits under the Health Benefits program. In addition, the FNHA regional offices and program staff help clients navigate the system. The FNHA receives an average 1,500 to 2,000 communications per year through social media and the website related to client complaints, and issues related to client navigation in accessing the health care system. Many of these communications are from clients who live in urban areas and away from home. After undertaking a privacy check, the communication department connects these requests with appropriate program staff who assist clients with navigation. Toll free number created as part of the Health Benefits program provides customer support to clients in accessing health benefits and health benefit appeal processes are open to all clients regardless of their residence.

Assisted in the development of regional strategies in areas with the highest concentration of urban and away from home clients. In 2018, given the high number of urban First Nations clients, the FNHA Vancouver Coastal Region partnered with provincial and First Nations organizations to develop a Urban Aboriginal Health Strategy for North Shore, Vancouver and Richmond. The strategy was developed through extensive engagement with First Nations stakeholders in the region and lays out the health priorities for the First Nations and Aboriginal population and identifies key areas of action to address these needs and priorities.

Played an active role in addressing emerging crises affecting the urban and away from home population. In 2016, the provincial government declared a state of emergency due to high levels of opioid overdose in the province. The FNHA was extensively involved in the provincial efforts to respond to the crisis, representing the interests of the First Nation clients across the province. In 2017, the FNHA released a report, in collaboration with health system partners, that found that Status First Nations peoples were five times more likely to experience an overdose, and three times more likely to die from an overdose. Most of these cases were reported from urban areas. The FNHA created a Senior Overdose Response Team as a response to the crisis. The FNHA collaborated extensively with all stakeholders, including the province, involved in the crisis and influenced the response to crisis. Specifically, the FNHA was involved in coordinating services, ensuring provincial services were culturally responsive, undertaking awareness-raising programming, conducting research and data collection, distributing emergency supplies and medication, organizing direct interventions in the high incidence areas (e.g., sending regional crisis response team), and delivering other preventative services and programming.

Obtaining new sources of funding targeted at all First Nations regardless of their residence. Case study participants noted that a significant share of funding that the FNHA obtained from FNIHB through the Canada Funding Agreement was specifically dedicated to supporting services in communities (on-reserve). However, most of the new funding secured by the FNHA can be used to deliver services for all First Nations throughout BC, including those living away from home. A 2018/19 review of the FNHA financial documents indicated that approximately 42% of all expenses were allocated to programs and services to support on-reserve activities. The remaining expenses were allocated to the Health Benefits program and other health services and programs targeted at all First Nation clients, including those who live in urban areas. However, a few case study participants, particularly those who provide services targeted at urban and away from home clients, indicated that other provincial and federal funding (that had broader eligibility rules) that the FNHA received were disproportionately allocated to support activities and programming targeted at clients living in communities (on-reserve). For example, according to these key informants, \$20 million funding to support Opioid Public Health Emergency and \$30 million Mental Health and Wellness Fund as well as projects funded through Joint Project Board and Tripartite First Nations Health Plan have broader eligibility rules (not restricted to serve clients on-reserve), but have mostly been allocated to support projects and initiatives in communities. According to these key informants, a number of challenges affect the FNHA's ability to allocate resources and deliver programming targeted at urban and home away clients, including: lack of data and research to identify needs and priorities of the urban and home away client base, lack of existing mechanism to reach out to urban clients and deliver services and programming (governance and engagement processes are focused in the on-reserve context), and lack of a consistent partnership practices with umbrella organizations that serve this group of clients.

Undertook significant efforts to transition the Health Benefits program to a BC-based provider to improve the program for all BC First Nations, particularly those who live in urban areas. The first phase of the transition integrated the delivery of the pharmacy benefits into provincial PharmaCare program. The change improved access to pharmacy benefits for all First Nations, particularly those living in urban areas. As part of the transition, the FNHA engaged extensively with the urban and away from home population through social media, and in-person group discussions to learn their perspectives and incorporate them in the delivery of the Health Benefits programming. Phase II of the transition is expected to improve vision, mental health and dental care that all First Nation clients will receive in BC, including those who live in urban areas.

Developed and implemented initiatives focused on all First Nations including those who live in urban areas and away from home. For example:

- *In 2017, the FNHA created an Indigenous Cancer Strategy intended to support all First Nations (status and non-status, living at home and away from home), Métis (citizens and self-identified) and Inuit living in BC. This strategy provides a road map to improve the Indigenous cancer journey and is part of an ongoing commitment by the FNHA, BC Cancer, Métis Nation British Columbia, and the BC Association of Aboriginal Friendship Centres. Between 2013 and 2016, these partners held in-person forums, roundtable community discussions, and online and in-person questionnaires as part of their consultations with Indigenous stakeholders to develop the strategy. This strategy includes the following six key areas of action: 1) partnerships among all stakeholders involved in the delivery of cancer services to Indigenous clients in BC; 2) wellness and cancer prevention, including screening; 3) culturally safe cancer programs and services to overcome impacts of colonialism and trauma; 4) support for cancer survivors; 5) support the end-of-life journeys for patients who cannot be treated; and 6) knowledge development.*
- *Played a key role in the Overdose/Opioid Public Health Emergency response and ensured that the*

provincial overdose response met the specific needs of the First Nation clients. As part of the initiative, the FNHA created a Senior Overdose Response Team, developed the *Framework for Action: Responding of the Overdose/Opioid Public Health Emergency for First Nations*, represented First Nations at provincial overdose tables, helped to distribute over 3,655 naloxone kits through First Nations distribution sites, added intranasal naloxone spray as a drug benefit as part of the Health Benefits program, and helped to build community and service provider capacity to address overdose incidents.

- *Enhanced availability and delivery of Mental Health and Wellness crisis support for First Nations.* In 2016, the FNHA engaged in partnership with the KUU-US Crisis Line Society to provide crisis response services to First Nations clients across BC.
- *Supported development of the traditional wellness practices* to support mental, emotional, spiritual and physical well-being of First Nations individuals and communities.

8.4. Impacts of the FNHA Approach

Case study interviews and review of the documents and files identified a range of impacts resulting from the changes implemented by the FNHA, summarized as follows:

Health care providers are more aware of the need for cultural safety and humility and some have taken concrete steps to improve cultural safety and humility of their services. The signing of declarations of commitment to cultural safety and humility by service delivery organizations have increased health professionals' and administrators' awareness of the barriers faced by First Nation clients when accessing health care. Some health care organizations have taken concrete steps to address these barriers by offering staff training on cultural safety and humility, creating welcoming environments (e.g., including First Nations art work in the facilities) and offering culturally appropriate programming (e.g., traditional healers) as part of their services.

The quality and availability of the primary care services have improved for some urban and away from home clients. The FNHA support for the Aboriginal Friendship Centers and service delivery organizations such as the Lu'ma Medical Services and the Surrey Medical home, have had significant impacts for improving the quality of the care that clients receive. The Lu'Ma Medical Centre for example, has been able to increase the patient roster, and provide wrap-around care (i.e., integrated and coordinated services) in a culturally safe and appropriate environment. Similarly, the clinic in Surrey is able to provide culturally appropriate services for urban and away from home populations, which was not available before. These clinics often employ Indigenous staff and physicians, include support from Elders as part of the services, and provide holistic and culturally safe services.

Increased sense of control and awareness. A number of case study participants noted that the FNHA activities lend to First Nations having a greater sense of control over decisions that affect their health and wellness. Having a voice in the provincial health care system through the FNHA, and feeling part of the governance system, helps to empower individuals and communities. Nevertheless, case study participants noted that overall awareness of the FNHA activities among First Nations individuals, particularly those living in urban areas, remains low. They also indicated that it will require many years to achieve full scale system transformation with noticeable impacts on their health outcomes and health behaviours.

The impacts of the FNHA activities will only become apparent in the future. According to case study participants, most of the activities implemented by the FNHA that are focused on the urban and the away

from home populations are still at the policy stage. The impact of these will only become apparent in the future. For example, the FNHA's role in the provincial Primary Care Network is expected to have a significant impact in the transformation of the primary health care delivery in BC and increase access primary care services for First Nations clients, including those who live in urban areas.

8.5. Gaps, Challenges and Issues

The FNHA's mandate to serve First Nations clients living away from home is evolving and not fully defined.

It is unclear if the FNHA is a partner, direct service provider or funder in providing services to urban and away from home clients. The FNHA's role is especially unclear as it relates to its role as a provider of primary care services. For example, getting involved directly in the delivery of primary care services may create overlap or confusion as primary care (except for the nursing services delivered by FNIHB/FNHA) has traditionally been the responsibility of the provincial system. Case study participants noted that they expect the problem with clarity of mandate to be resolved once the FNHA finalizes its Urban and Away from Home Framework.

The existing mechanism that is used by the FNHA to distribute funds to First Nations does not adequately reflect the interests of the urban population.

While a majority of the First Nations live in urban areas, most of the FNHA funding is directed at First Nations on-reserve. Furthermore, the amount of funding allocated to communities has increased significantly, due in part to the FNHA's own efforts. However, it is not clear if similar patterns have been observed for organizations that serve First Nation clients in urban areas. Going forward it is critical to ensure that organizations serving urban populations have equal opportunities to access new sources of funding that they are eligible for, to sustain and expand their services.

Lack of mechanisms to reach and engage First Nations clients living away from home.

Although the FNHA has strong mechanisms to engage and learn perspectives of First Nations communities through its governance system (e.g., Regional Caucuses, Gathering Wisdom for a Shared Journey forums, and through FNHC and FNHDA), it lacks an established mechanism to learn perspectives from urban and away from home clients. With the exception of a few activities (e.g., customer survey, health attitudes and beliefs survey, and social media), the FNHA does not collect the voices and perspectives from the urban population and it lacks a communication strategy specifically targeted at urban and away from home clients. The issue is further constrained by the lack of a single organization/body that represents this group of clients, although there is opportunity to continue to partner with the organizations that exist in urban settings.

Embedded racism and lack of cultural safety is still a critical issue affecting First Nations.

First Nations clients experience bias and discrimination which results in a different standard of care. Many do not trust the health care system, which affects utilization. Racism and cultural barriers particularly affect First Nation clients living in urban areas due to lack of access to support networks and community based health services that they had in the community. These factors contribute to inequitable health outcomes for First Nations.

8.6. Lessons Learned and Opportunities for Improvement

Define the FNHA's policy and service delivery mandate, objective, funding frameworks and roles and responsibilities with regards to urban and away from home populations and communicate it clearly to all stakeholders and clients.

Create strategies to engage and develop programming to address the needs of clients who live in urban areas and away from home. Systems and processes need to be created to ensure the FNHA can constantly identify needs and develop programs and influence policies targeted at urban and away from home clients. Some of the recommendations with this regards, mentioned by case study participants, included:

- Establishing a system to engage clients living in urban areas and away from home, learn their perspectives and incorporate it into the FNHA decision-making processes.
- Developing systems to distinguish urban and away from home populations in collecting and reporting population and public health data and conducting more research to identify specific needs of urban and away from home populations.
- Building close relationships with First Nations organizations (e.g., Aboriginal Friendship Centers) that represent interest of the urban and away from home clients and ensuring that the services and activities are aligned and avoid potential areas of conflict and unnecessary competition for resources between organizations.
- Mapping of existing services available for urban and away from home populations to identify gaps in the services and programming available to them.
- Recognizing that the needs and challenges faced by urban and away from home populations are different across the province, thus allowing flexibilities in developing plans and strategies and delivering the services to urban and away from home populations across the regions.
- Improving coordination and communication within the FNHA to ensure concentrated efforts can be implemented in addressing the needs of urban and away from home populations.

Update funding formulae and allocation mechanisms to ensure urban and away from home clients receive an appropriate share of resources and programming based on their needs and eligibility. Existing mechanisms used by the FNHA to allocate resources do not consider priorities and needs of urban and away from home populations.⁶ The funding mechanism can be improved by:

- Examining on-reserve contribution agreements to identify ways for communities to support their members who live away from home, or other guests on their territory.
- Ensuring that the FNHA's Strategic Financial Framework identifies which streams of funding support eligibility for urban and away from home clients, and reviewing eligibility criteria for different sources/streams of funding that the FNHA receives and ensuring proportionate share of the funds are allocated to support programming and services for urban and away from home clients.
- Focusing on a 'need-based' funding formulae where a higher proportion of the FNHA funds that support eligibility of all First Nations, regardless of residence, are allocated to areas of the greatest need. This may also require an access to strong research and data to ensure the FNHA can effectively identify areas of need on a timely manner and make quick decisions to allocate resources.

Continue building close working relationships with the provincial government to influence provincial policies and programs by bringing forward First Nation perspectives. By influencing provincial policies and programs, the FNHA can create tangible benefits to all First Nations in BC, particularly those who live in urban areas. For example, the FNHA should continue efforts to partner with the provincial government through the

⁶ The existing funding model is based on historic formulae developed by FNIHB that take into account the community population size (as registered with the band and resident on reserve) and the degree of remoteness or isolation.

Primary Care Network process. It will ensure that First Nations continue to be full partners in the design and delivery of primary care services in urban areas and that those services are culturally safe.

9. Mental Health and Wellness

First Nations peoples and communities had a rich history of land-based health and wellness, which included hunting, fishing and the gathering of traditional foods and medicines. These activities, which required an active lifestyle, were further enhanced by ceremonial and spiritual practices for well-being. Contact with European settlers marked a significant change in BC First Nations health and wellness. Colonialism and colonial policies devastated First Nations peoples' health through the forced displacement from their traditional territories and disconnection from cultures, families and communities, ceremonies, languages, knowledge and traditions. The resulting losses have caused intergenerational trauma and internalized racism. These effects continue to be experienced today through symptoms such as substance use and harmful behaviours, resulting in lower life expectancies and health disparities experienced by First Nations peoples in BC.

Addressing mental health and wellness (MHW) (which includes addressing the opioid crisis) has been identified as a major priority by the First Nations communities in BC and in Regional and Community Health and Wellness Plans. Towards that end, the FNHA has undertaken extensive efforts to support First Nations communities and clients to address MHW issues and challenges and support for building wellness and resilience.

9.1. Mental Wellness Services Provided Prior to Transition

Prior to transition, FNIHB delivered six major programs that together formed its Mental Wellness Program portfolio. These included (1) Brighter Futures Program, (2) Building Healthy Communities Program, (3) National Aboriginal Youth Suicide Prevention Strategy, (4) National Native Alcohol and Drug Abuse Program, (5) National Youth Solvent Abuse Program, and (6) Indian Residential Schools Resolution Health Support Program. In addition, some counselling support was available to BC First Nations through the NIHB program. These MHW programs funded community-based programs and services that aimed to provide treatment, reduce risk factors, promote protective factors and improve health outcomes for clients. In addition, a number of MHW initiatives were undertaken by the First Nations Health Society and tripartite partners prior to transfer. Examples of such initiatives included the development of *A Path Forward*, which identified a shared vision and provided guiding principles and strategic directions to address MHW challenges, and the development of the *Hope, Help, and Healing: A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide*.

According to case study participants, the Mental Wellness programs provided by FNIHB were mostly prescriptive, colonial and delivered according to policies and programs set from Ottawa and did not reflect community interests and priorities. MHW programs were implemented in silos and without adequate coordination with provincially funded services, which created gaps in the availability and accessibility of the services. Communities received insufficient coordination, communication and support from FNIHB in delivering MHW services and programs. The programs were not designed to address root causes of MHW problems experienced by clients such as systemic racism and the intergenerational effects of colonialism.

9.2. The FNHA Actions to Address Mental Health and Wellness Issues

The FNHA undertook extensive engagement with communities to identify their MHW needs and priorities.

The FNHA undertook the delivery of the MHW programming for BC First Nation communities in 2013 with the transfer of the services from FNIHB. Case study interviewees commented that after transition the FNHA continued implementing the same set of programs that it inherited from FNIHB⁷. At the same time, the FNHA undertook reviews of the existing MHW programs and services available to First Nations in BC and conducted extensive engagements with First Nations stakeholders (e.g., through regional mental health and wellness forums, regional health and wellness plans, journey mapping and surveys). Through these engagements, it was identified that issues related to MHW and addictions were very important priorities for BC First Nations and led to key areas in shaping the FNHA's MHW strategies:

- Promotion of resiliency and wellness should be a key component of MHW programming (instead of focusing only on the treatment of illness).
- Mental health and wellness approaches must be designed with an understanding of the deep and ongoing impacts of colonialism, including experiences of intergenerational trauma and racism.
- First Nations' self-determination is a critical determinant of mental health and wellness and needs to be at the foundation of all work aimed at improving well-being.
- There is a need for better access to a full continuum of supports from mental health and wellness literacy and promotion through to acute care.
- All mental health and wellness services, whether delivered by health system partners or First Nations communities and organizations, need to be culturally safe and trauma-informed, free of all forms of racism and stigma, and must include cultural supports and interventions.
- The communities and service delivery organizations need a wide range of service delivery and planning supports, including more capacity building and care for the mental health and wellness workforce.

Based on the findings of engagements, in 2018 the FNHA released a Policy on Mental Health and Wellness.

According to the *FNHA's Policy on Mental Health and Wellness*, a systems-wide paradigm shift was required for significant progress to be made toward a vision where all First Nations experience support for positive mental health and wellness and have access to a full continuum of wholistic and culturally safe programs and services. Key to this model was the application of the First Nations Perspective on Health and Wellness across the entire continuum. This meant working towards approaches that were centered on First Nations ways of knowing and being.

The policy identified five key areas of action for the FNHA to focus its efforts to achieve this paradigm shift. These areas included:

1. Shifting focus from looking to “cure” mental “diseases” to addressing root causes of mental health and enhancing the conditions for mental health and wellness. This required finding ways to build on

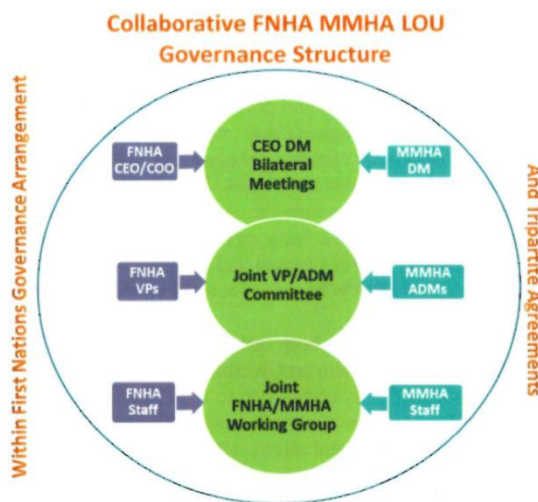
⁷ As per request from the communities, at the time of the transfer, the agreements with communities included requirements for the FNHA not to change the existing programming, funding amounts and distribution processes and procedures for at least two years after the transition. Consequently, the FNHA kept its Funding Agreements/Contribution Agreements the same until 2015/16, with the exception of increasing the annual escalator.

strengths and meet the needs of the whole person, in both their family and community contexts.

2. Using a "two-eyed seeing" approach, which incorporates the best of western and First Nations traditional healing and wellness approaches. This concept was developed by Mi'kmaw Elder Albert Marshall. This includes making concerted efforts to eliminate all regulatory barriers and ensuring that Elders and traditional healers are included and compensated as part of the circle of care.
3. Improving the quality of programs and services by adhering to principles such as being person-family-and community centred, wellness-focused and recovery-oriented, trauma-informed and responsive, and culturally safe and humble.
4. Integrative system design and service delivery, which includes shifting to a mental health and wellness perspective that works to address and prevent the root causes of mental health and substance use together.
5. Using First Nations self-determination and Nation-based and Nation-rebuilding approaches. This means ensuring the First Nations individuals and communities are directly engaged in, and leading and planning around mental health and wellness in a manner consistent with their cultural and Nation identity, and in a way that supports Nation-based and Nation rebuilding models of care.

Engaged in partnerships with representatives of the provincial government to ‘hardwire’ First Nations’ perspectives on health and wellness into the provincial MHW policies and programs. The FNHA represented the interests and perspectives of the BC First Nations at a wide range of provincial and federal tables and advocated on behalf of First Nations. Some of these activities are summarized as follows:

- In 2017, the FNHA established a Collaborative Governance Structure with the MMHA by signing a Letter of Understanding. The objective of the structure was to work jointly to improve the mental health and wellness of First Nations in BC. The Collaborative Governance Structure enabled two organizations to closely coordinate activities from the most senior level to the operational level. As demonstrated in the following diagram, the Chief Executive Officer/Chief Operating Officer of the FNHA and Deputy Minister from MMHA organize bilateral meetings at least once every two months. The FNHA Vice Presidents meet with MMHA Assistant Deputy Minister) every two months to coordinate and implement decisions made at the Chief Executive Officer/Chief Operating Officer and Deputy Minister at bilateral meetings. The FNHA staff members in charge of mental health and wellness meet with MMHA staff regularly as part of the Joint Working Group to implement joint initiatives and activities.



- The Letter of Understanding signed between MMHA and the FNHA also ensures that the FNHA is engaged in all key initiatives undertaken by MMHA early in the process to have adequate input. The MMHA also signed a Declaration of Commitment to cultural safety and humility. It described a commitment to collaborate on the development of the provincial Mental Health and Addictions strategy reflecting the First Nation perspectives and support for development of the mental health and addiction-related labour force capable of working with First Nations. In 2019, the Letter of Understanding between the FNHA and MMHA was updated with a new set of shared commitments for 2019/20. These included partnering to support the integration of planning across primary care and mental health and wellness to ensure that the benefits from available funding is maximized, working together to respond to the Overdose Public Health Emergency for First Nations and supporting the social determinants of health initiative led by the FNHC.
 - Case study participants mentioned examples of other partnership activities and collaborative efforts with representatives of MMHA focused on incorporating the First Nations' perspectives into provincial mental health policies. Examples of such efforts mentioned include working closely with the provincial health authorities at the regional levels to ensure their MHW programming is able to address community and client needs, and participation at numerous initiatives supported through the Joint Project Board and membership in many other collaborative partnership committees at the provincial level (e.g., bilateral MHW Committees between the FNHA and regional health authorities, the Standing Committee on Health Services and Population Health with MoH, the Provincial Mental Health and Substance Use Working Group, and the Joint Steering Committee on BC's Overdose Response).

- **Through collaboration with the provincial and federal partners, the FNHA obtained significant new sources of funding to support Mental Health and Wellness programming and services.** The FNHA's extensive partnership with the provincial and federal governments helped the organization to obtain additional resources and funding to support MHW programming and services. The most significant examples of these new areas of funding and programming are summarized as follows:
 - The FNHA played a critical role in creating and administering the \$30 million Mental Health and Wellness Fund. The fund was created in January 2019 through a partnership between the Government of Canada, the Province of BC and the FNHC. The Fund supports First Nations in planning, designing and delivering a full continuum of culture and strengths-based mental health and wellness services, including prevention and early intervention, over two years (2019-2021). It provides support for culture as a social determinant of health, mental health as a building block for Nation re-building, integration in service design and delivery, and activities that address root causes of MHW. The funding is distributed under flexible arrangements to allow communities and service delivery organizations to align the resources with their unique mental health and wellness plans and the priorities.
 - Supported MHW projects through the Joint Project Board. The Joint Project Board is a forum between the FNHA and the MoH that supports new primary health care and mental health and wellness projects jointly developed by First Nations and health authorities. A total of 27 projects with \$15.3 million in funding are supported through this envelope, of which 42% are focused on primary health care and 58% are focused on mental health and wellness. Twenty-six projects are spread across the five regions, and one project is provincial in scope and is being implemented by the Provincial Health Services Authority.
 - Increased health benefits coverage to provide better mental health services for short-term mental health crisis intervention and counselling. For mental health services, clients require prior approval and may be eligible to receive two sessions for initial assessment, a maximum of 15 sessions in a treatment plan and an additional five sessions for transitional services. In 2015/16, health benefits

- provided 1,674 crisis intervention and counselling sessions to 268 clients, at an expenditure of \$144,822.
- Delivered Health Actions funding and ensured the program places a larger focus on supporting MHW projects and initiatives. Over the five-year period from 2014 to 2019, of the 556 projects funded through the program, over 29% (174 projects with a total funding amount of \$9.5 million) fell under the Mental Wellness and Substance Use category. Examples of projects funded under the program include helping recovery programs, crisis lines, men and women’s circles, and skills development seminars on historical trauma and loss of culture.
 - Secured additional funds to support revitalization of treatment centers. In July 2018, a Memorandum of Understanding between the FNHC and the provincial and federal governments was signed, outlining commitments to Nation rebuilding and planning in mental health and wellness as well as to building, repairing and renovating FNHA-funded treatment centres. The FNHA, the Province of BC and Canada each contributed \$10 million towards Nation planning, and the FNHA and the Province of BC contributed \$20 million each towards treatment centre revitalization. The funding commitment of \$20 million by the federal government was pending at the time of this evaluation.
 - Obtained new funds to support land-based treatment and healing. In 2018/19, the FNHA confirmed a commitment to land-based healing by allocating funding across three years. The funding, which was provided by the Province of BC, will begin at \$2.5 million in the first year and increase by \$2.5 million increments up to \$7.5 million in the third year. Nine land-based healing initiatives were supported, including on-the-land men's groups, a Visiting Ancestors initiative, wellness campouts and community engagement to develop an equine therapy program.
- **Played a key role in the overdose/opioid public health emergency response and ensured that the provincial overdose response met the specific needs of the First Nations clients.** In 2016, the opioid emergency was declared a public health emergency by the BC Provincial Health Officer under the *Public Health Act* due to the unprecedented increase in overdoses and deaths in the province. In the summer of 2017, a joint report from the B.C. Coroners Service and the FNHA found Status First Nations people were five times more likely to experience an overdose, and three times more likely to die from one. In response to the crisis:
 - The FNHA created an Senior Overdose Response Team to facilitate the FNHA’s response to the crisis including engagement in provincial strategies and committees. In June 2016, the FNHA developed the *Framework for Action: Responding of the Overdose/Opioid Public Health Emergency for First Nations*. The Framework for Action described a set of shared cross-system goals and recommended associated activities for addressing the overdose/opioid public health emergency.
 - Represented First Nations at provincial overdose tables. In particular, the FNHA was a critical part of the Provincial Overdose Emergency Response and Overdose Emergency Response Centre, which played an important role in coordinating the regional response to the crisis. In addition, the FNHA worked closely with Regional Response Teams by the provincial health authorities as well as the Community Action Teams to identify gaps in the available services and ensure the needs of First Nations clients were adequately addressed by the provincial service providers.
 - Helped to distribute over 3655 naloxone kits through First Nations distribution sites, reached out to 126 First Nations communities to deliver Indigenous Harm Reduction training and expanded access to naloxone to First Responders in First Nations and raised awareness of no-cost access to naloxone kits through pharmacies.
 - In April 2018, the FNHA added intranasal naloxone spray as a drug benefit as part of the Health Benefits program. In addition to the naloxone spray, it also increased accessibility of the naloxone for those who did not want to administer naloxone by injection.

- Helped to build community capacity to address overdose incidents. The capacity-building activities included hosting a workshop called 'Not Just Naloxone: Talking about Substance Use in Indigenous Communities' to support community champions by building a greater understanding of addiction, substance use, and harm reduction at the community level; equipping all eight of its nursing stations with the capacity to provide suboxone and a type of opioid agonist therapy; and providing over 2,430 community members from 175 First Nations communities with the training and skills to prevent overdose deaths.
- Other initiatives supported by the FNHA as part of the response included increasing supports for opioid agonist therapy at treatment centres funded by the FNHA, implementing an Intensive Case Management initiative (implemented jointly with provincial health authorities in some regions and supported communities and service delivery organizations to develop their own case management in other regions) to ensure culturally safe system navigation and case management supports for clients at risk of overdose, developing an information portal at www.fnha.ca/harmreduction and a series of resources for overdose prevention and harm reduction, introducing Peer Health Monitoring to support clients at high risk for overdose who discharged from prison with integrating into the communities, assisting with creation of the First Nations Addictions Care Coordinator position within the BC Centre on Substance to strengthen partnerships within the health care system and implementing innovative responses to substance use disorders and associated harms.

Hosted events, gatherings and conferences to raise awareness of the MHW issues faced by First Nations, bringing together MHW staff members, specialists, community representatives and others to share knowledge and learn from each others' experience. Some of these events included:

- The Mental Health and Wellness Summit. From February 7-8, 2018, the FNHA organized the first Mental Health & Wellness Summit in Vancouver. The event was attended by 538 participants (presenters, Elders, youth, community leaders and health staff and representatives of service providers) from across BC and Canada. The Summit covered a range of key topics focused on pressing MHW priorities. It also provided an opportunity for participants to share and learn from each others' knowledge and experience and discuss challenges and best practices in the field. The event was considered successful in meeting its objectives, as 92% of participants who completed the survey indicated that the event was a productive use of their time and 96% indicated a need to continue the event in the future.
- The First Nation Addictions Forum was held from March 12-13, 2019. The event brought together 97 addictions workers from across the province to share knowledge and learn from each others' experience. The forum was organized in response to community addictions workers' request for a gathering, for training, and for an opportunity to support each other. The key subjects that were addressed as part of the forum included transforming the National Native Alcohol and Drug Abuse Program to ensure that the program is strengths-based and supporting clients' healing journey through a full continuum of services and programs (e.g., land-based healing, residential treatment for adults and families, trauma, mobile detox, as well as supportive aftercare).

Enhanced availability and delivery of MHW crisis support for First Nations communities and individuals.

The key FNHA's activities to support First Nations communities, families and individuals in addressing the MHW crisis are summarized as follows:

- The FNHA has created capacities at the regional offices to support communities during MHW related crises. In particular, positions have been created in three regions (Vancouver Island, Northern and Interior) to respond to MHW. The regional Crisis Response Manager (Coordinator) positions (as well as regional addiction specialists in some regions) have been created to provide oversight to emergency response activities, and new staff have been hired to provide support to communities to address MHW crises. The regional team members assist communities to address MHW crises by providing a range of

support services (e.g., mental health counselling, traditional healers, etc.). The services are community directed and driven, and the FNHA sends support only when requested by the communities. During interviews, MHW regional staff members indicated that the FNHA team members try to take wholistic approaches, address causes of problems and build community capacity to prevent such crises in future.

- Formalized crisis response protocols between the FNHA and provincial health authorities to leverage supports and resources and coordinate activities at the time of crisis.
- In 2016, the FNHA engaged in partnership with the KUU-US Crisis Line Society to provide Crisis Response Services to First Nations clients across BC. KUU-US provides a 24-hour crisis line for adults, seniors and youth. In addition to the 24-hour support line, KUU-US also provides risk assessment (mediating, de-escalating or intervening based on the level of risk) and safety monitoring (phone support and establishing coping mechanisms by doing safety monitoring calls) services. Services are culturally safe, and all crisis response personnel are certified and trained in First Nations cultural safety. In 2018, KUU-US supported over 27,000 individuals who were struggling with mental health issues and crises related to residential schools, child welfare, addictions, health concerns, divorce/separation, suicide ideation/survivorship, grief/loss, crime, abuse, peer pressure, and financial distress.

Delivered MHW training and capacity development support to front-line workers. Some of the MHW-related training and capacity development support delivered by the FNHA included:

- **Healing Complex Trauma Training.** A strong need for training on complex trauma was expressed by community MHW workers during the FNHA’s initial engagement processes with First Nations stakeholders. As a result, the FNHA developed the Healing Complex Trauma 1 curriculum and training model in 2017/18 in consultation with leaders in the field of trauma (e.g., Dr. Bessel van der Kolk, Dr. Gabor Maté, and Dr. Ruth Lanius). Once developed, the FNHA implemented the curriculum through a 3-week training program accredited by the First Nations Certification Board of Canada. The program is the first stage in addressing complex /intergenerational trauma. The goal of the program is to help participants to articulate their internal reality and to understand individual trauma as it relates to the collective reality. In 2018/19, the training was offered to First Nations communities and organizations in the Interior and Northern regions. According to the results of the survey conducted at the end of the training, participants were more comfortable and open about vocalizing their suffering and healing.
- Other training and capacity development support provided by the FNHA included training on trauma and trauma-informed services; chemical addictions; Indigenous tools for healing; cultural safety and humility; and the development of toolkits (e.g., wholistic approach to planning for mental health and wellness), guides, frameworks, and handbooks to support service delivery partners and community staff.

Engaged in activities to support harm reduction. FNIHB provided limited support for harm reduction. The federal mandate on harm reduction was “abstinence-only” and provided no coordination of services or central support. After transfer, the FNHA engaged in discussions around how to best approach the topic of harm reduction with First Nations, recognizing their inherent autonomy and self-determination. The organization ensured the right of Nations to choose how they wanted to approach harm reduction. The FNHA is in the process of drafting a Harm Reduction Policy Statement based on the results of the discussions. Other activities and programming undertaken by the FNHA to support harm reduction are summarized as follows:

- The FNHA and Vancouver Coastal Health worked with filmmaker Asia Youngman to create the ‘Taking Care of Each Other’ Indigenous harm reduction video series. These videos are a teaching tool to help start discussions in First Nations about harm reduction, substance use and stigma.
- Developed ‘Indigenous Harm Reduction’ principles and practices as a learning tool to facilitate conversations on addictions and harm reduction. Indigenous Harm Reduction was defined as a process of integrating cultural knowledge and values into the strategies and services associated with the work of

harm reduction.

- In 2017, secured a \$2.5 million grant from the Canadian Institutes of Health Research to identify promising models for harm reduction services for opioid use in First Nations communities across the province.
- In 2017, FNHA also announced \$2.4 million investment in 55 Indigenous harm reduction projects to support innovative and culturally relevant responses to the opioid public health emergency, both on-and off-reserve.

Implemented a new programming on prescription and non-prescription drug misuse. In 2014, the FNHA entered into a funding agreement with the Government of Canada to deliver approximately \$1.7 million over five years, starting in 2014/15, as part of the National Anti-Drug Strategy. Through this funding, the FNHA is implementing a suite of complementary activities to address prescription and non-prescription misuse by First Nation communities and clients, and has:

- Provided funding to support all First Nations communities and service delivery organizations in BC that want to organize a Medication Return-it event in their community. Partners joined forces for 'Med Return-it' events and collected unused or expired prescription (or non-prescription) drugs from clients and communities. As of June 2018, three Med Return-it events have been held and 27 grant applications have been received.
- Naloxone train-the-trainer sessions were organized in partnership with the BC Centre for Disease Control, Provincial Health Services Authority and regional health authorities. The sessions included in-person sessions to train nurses and community health care workers to provide naloxone to those at risk of opioid overdoses.
- Compassion, inclusion and engagement sessions were organized for health care workers who provide harm reduction services or have roles related to substance misuse to promote culturally safe interactions with clients.
- Awareness campaigns were organized to promote awareness of safe medication storage and disposal.
- Cultural safety and humility training was offered to targeted pharmacists and technicians to improve their skills, knowledge and behaviours to deliver services in a culturally safe way.

Continued support for a range of MHW programs and services inherited from FNIHB. These programs include:

- The National Aboriginal Youth Suicide Prevention Strategy - As a program, it targets resources that support a range of community-based solutions and activities that contribute to improved mental health and wellness among Aboriginal youth between the ages of 10 and 30 years, as well as their families and communities.
- The National Native Alcohol and Drug Addiction Program (currently referred to as Alcohol and Drug Use Services)- Substance Use Prevention and Treatment programming provides a range of community-based prevention and treatment services and supports. Programs include prevention, health promotion, early identification and intervention, referral, aftercare and follow-up services. These services are integrated with a network of addiction treatment centres which provide culturally relevant in-patient, outpatient and day or evening programs for alcohol, solvents and other drug addictions.
- There are currently ten treatment centres funded by the FNHA. Services are offered to all genders, youth and families. Programs vary, but overall include services for individuals with physical disabilities, concurrent disorders, clients on methadone or suboxone and pregnant women. All centres also offer a variety of cultural and clinical interventions in support of First Nations individuals and families.
- The Indian Residential Schools Resolution Health Support Program seek to ensure that eligible former students of residential schools and their families have access to appropriate and safe mental health,

emotional and cultural supports.

- Substance use prevention and treatment include a range of community-based services and supports such as prevention, health promotion, early identification and intervention, referral, aftercare and follow-up services.

9.3. Impacts of the New Approach to Mental Wellness

A system is being created that is more responsive to First Nations MHW needs and priorities. Case study participants noted that the FNHA's current system of MHW planning and design is more inclusive of First Nations perspectives and needs. Through engagement with communities at Regional Caucus meetings and regional health planning processes, the FNHA is able to identify community and client MHW needs and priorities. This allowed the FNHA to make its operations, programs and services more responsive to community and client needs. Furthermore, by working closely with provincial partners, the FNHA has been able to influence provincial MHW programs and policies and incorporate First Nations perspectives. The changes at the policy level will gradually affect the quality and accessibility of the MHW services delivered by the provincial government.

New funding opportunities and funding flexibilities have improved the quality of services delivered by the communities and service providers. Case study participants noted that increased funding for MHW and greater flexibility provided to funding recipients over program decisions have enabled communities and service delivery organizations to use incoming resources for addressing their most important needs and priorities. Most often the communities and service providers have used additional funds to recruit mental health professionals (e.g., counsellors, psychiatrists, mental health workers), which have improved the quality of the services that they can deliver. Focus on building regional capacity has also helped to bring more support (e.g., crisis response teams), coordination (e.g., cooperation with regional health authorities), and resources into the regions. These all led to improving capacity to deliver effective MHW programs and services. Growing interest in learning about and practicing First Nations cultures and traditions, also contributes to improved self-esteem and confidence.

The long-term health impacts and outcomes of MHW activities will only become known in the future. There is anecdotal evidence from the communities and service providers that there are changing attitudes towards trauma and stigma. In particular, case study participants noted that there is a growing understanding that violence and substance abuse are not happening in isolation, and that they are rooted in intergenerational trauma. First Nations individuals and communities are more willing to talk about their trauma and suffering and how they have affected their lives. By doing this, they are able to begin their healing journey.

Finding innovative approaches to address MHW issues and challenges has been successful. Case study participants noted that the FNHA has been successful in coming up with innovative solutions to address the multiple and complex challenges related to MHW. They mentioned the FNHA's support for community-driven projects (e.g., Mobile Support Teams, land-based feeling in wellness), addressing root causes of trauma (e.g., colonialism), using traditional approaches to health and wellness (e.g., traditional healers, traditional medicine), and using approaches that are based on strengths and resiliency of client base (e.g., focus on wellness and culture).

Building partnerships slowly over time while gaining trust and commitment from partners. Some communities and service providers, particularly at the initial stage of the transition, were slow in trusting the FNHA and engaging in partnership with them. A respectful, curious and collaborative approach, and consistent efforts by the FNHA staff members, helped the organization gain the trust from the communities. Case study participants noted that the FNHA's proactive approach for partnership building and its demonstrated commitment to First Nations values and principles. The FNHA was responsive to community and stakeholder inquiries and delivered on promises, which helped to build positive relationships with communities and other First Nations organizations. Case study participants noted that the FNHA needs to continue its approach to coordination and partnership with communities and provincial partners. More work needs to be done around improving the quality and accessibility of the MHW services, which can only be achieved through coordinating activities with a wide range of partners (e.g., service providers, Indigenous organizations, non-profits, Aboriginal Friendship Centres, health authorities, school districts).

The role of the FNHA in providing mental health services has been shifting. Initially, the FNHA primarily focused only on supporting communities and service providers to build their capacity. However, gradually FNHA's role has shifted to become more hands-on. For example, the FNHA maintains crisis teams who assist communities and clients at the time of crisis by providing a range of support services including counselling, integrated through crisis response protocols with the regional health authorities.

9.4. Gaps, Challenges and Issues

Challenges with delivering quality MHW services and programming. Communities and service providers often face difficulty with recruiting and retaining qualified staff members, which creates challenges in their ability to design, plan and deliver effective mental health and substance use services and programming.

A lack of long-term funding commitments creates challenges with the sustainability of MHW services and staff. Despite efforts made by the FNHA to improve resource and funding allocations to MHW programming at the community and service delivery level, some of the new funding sources are short-term and/or temporary. As a result, service delivery organizations and communities struggle to hire permanent staff members and undertake long-term planning.

Challenges associated with delivering a full continuum of MHW services. The availability and accessibility of the MHW services is inconsistent across the regions, particularly in remote and isolated areas. Access to certain services (e.g., detox, clinical supervision, aftercare) is an ongoing challenge. A lack of continuity of care creates many challenges for clients. For example, the lack of aftercare for those who are discharged from treatment centers which can slow their recovery or contribute to relapse remains a critical challenge for many individuals and communities. In 2018, the FNHA increased investments in treatment centers and provided additional supports to communities to recruit Alcohol and Drug Use Services addiction workers. This is expected to address some of these issues related to the continuum of care.

Access to MHW and addictions services provided by the province is low due to racism and stigma. The provincial government provides many MHW and addiction services. Despite efforts to increase the cultural competency of the provincial service providers, First Nations clients still experience cultural barriers when accessing the services. Change in attitudes and behaviours takes time and requires more extensive efforts for cultural safety and humility to become fully integrated into the MHW services provided by the provincial government.

The existing mechanism that is used by the FNHA to fund MHW programming does not adequately reflect the needs of client population. According to case study participants, although most new MHW funding obtained by the FNHA has broader eligibility rules, programming that provide MHW services to urban and away from home populations have not received adequate share of funding. For example, although First Nations clients living in urban areas were disproportionately affected by the opioid crisis, the larger share of new opioid funding was distributed to support programming on-reserve.

First Nations clients and communities experience difficulties navigating the MHW services. The availability and delivery of mental health and substance use programs and services are fragmented and complex. There are multiple federal, provincial and First Nations agencies responsible for mental health and substance abuse services in BC. The practical challenge for clients and communities is to navigate this complex network of programs, services and funding opportunities.

Despite many changes and improvements, the design and delivery of the core MHW programs (e.g., National Native Alcohol and Drug Abuse Program, National Aboriginal Youth Suicide Prevention Strategy) have not changed in all areas of the province. Although the FNHA has provided flexibilities in funding agreements allowing First Nations to adjust MHW programming to their specific needs, there are limits the extent to which the FNHA is able to influence the delivery of MHW programming at the community level. In particular, the programs are often operated in silos, which create inefficiencies in program delivery and gaps in the continuum of care. Case study interviewees identified gaps related to early identification, access to detox, access to specialized/professional services and aftercare services.

Isolation and remoteness create many challenges related to service accessibility. Many of the First Nations communities served by the FNHA are located in remote and isolated areas. The geographical conditions create challenges with travel when accessing services, and difficulty in recruiting and retaining qualified staff.

9.5. Lessons Learned and Opportunities for Improvement

Need to continue leveraging funding for MHW programming and ensure sustainability of the funding. Historically, governments lacked the capacity to work with First Nations organizations and communities in delivering MHW services. The FNHA was largely successful in bridging this gap by building equal partnerships. The provincial and federal governments are more willing to invest in MHW programming through the FNHA. Case study interviews with representatives of the provincial government highlighted their strong focus on increasing MHW funding and services available for First Nations clients and communities and a willingness to work with the FNHA to achieve this.

Incorporating traditional approaches to MHW has been successful and should be continued. Case study participants indicated that incorporating traditional practices into MHW services has been successful. This has made care more relevant to First Nations needs and should be continued and enhanced. The FNHA should ensure that Elders, Traditional Healers, traditional medicines and other traditional practices are part of MHW and addiction programming and services.

The flexibility and agility of the FNHA activities have been critical to its success. Members of the FNHA regional staff mentioned that they constantly search for unmet needs and gaps in the availability and quality of the MHW services and find innovative approaches to address them. The regional staff also noted that the

FNHA's leadership has provided regional offices with adequate flexibility to be able to make quick decisions, use best practices, hire staff/professionals that they need (e.g., mental health professionals, nurse practitioners), and tailor the operations to address unmet needs. Case study participants noted that this flexibility and agility has been critical to success and should be continued.

Strong leadership, commitment to the cause and focus on underlying causes. During interviews, several case study participants indicated that the FNHA leadership has focused on the 'big picture' of MHW (rather than focusing on details) and thus have allocated resources and time to address root causes of MHW (e.g., systemic racism, discrimination, and social determinants of health). These activities should be continued and enhanced to support resilience, self-reliance and self-esteem, which are important for MHW.

Improve the mechanisms and formulae used to allocate resources into MHW programming and services to ensure the resources are mainly distributed based on needs and so that clients can receive adequate services regardless of their location. Particular focus should be placed on addressing inequalities in supporting programming targeted at urban and away from home clients.

Continue working with provincial and service delivery partners to address gaps in MHW programs and services. The FNHA should ensure the full continuum of culturally appropriate MHW care is available for all First Nations across the province. Working closely with provincial partners and service delivery organizations and coordinating activities closely and aligning services and resources with them may help to close service gaps more efficiently and effectively. The partnerships and coordination are especially important given the increasing pressure on the system due to growing demand for MHW services.

Support First Nations communities and service delivery organizations to develop strong capacity in delivering quality MHW services and programming. Building capacity and relationships takes a long time and requires understanding client needs and gaining trust. Building internal capacity to deliver quality MHW programming usually produces better results than using outside expertise. Therefore, there is a need to invest in staffing and capacity that already exists at the community (or service delivery) level.

Continue giving flexibility to communities, service delivery organizations and regional staff to use creative approaches to address MHW needs. Ensuring program descriptions and guidelines describe flexibilities that are provided, educating First Nations about them and supporting them to adjust their programming will ensure MHW programming are tailored to the specific needs of the communities and clients.

The fast growth of the FNHA has at times resulted in some staff members working in silos or not enough communication between the head office and regional offices. More communication on shared work plans and activities can help with MHW efforts.

Focus on resilience/wellness, land-based activities and strong cultural identity to support self-esteem and self-reliance among First Nations and support healing from intergenerational trauma. In the long-term, focusing on wellness and prevention will help to improve First Nations well-being and reduce prevalence of MHW issues and challenges.

10. Transformation of Health Benefits

Under the terms of Tripartite Framework Agreement, the FNHA was expected to design, plan, manage and deliver a Health Benefits program that would replace the Non-Insured Health Benefit (NIHB) Program in BC previously delivered to First Nations through the FNIHB. In 2013, when the FNHA assumed responsibility for delivery of the NIHB program in BC, it entered into a buy-back arrangement with FNIHB. As a result, FNIHB continued to provide health benefits to FNHA clients on a cost recovery basis. The objective of the transition was to bring the decision-making close to home and ensure the programming and services can be adjusted to better meet the specific needs of BC First Nations. The FNHA transitioned pharmacy benefits on October 1, 2017 to be managed by PharmaCare, BC's public drug insurance program; and transitioned dental, vision and medical supplies and equipment benefits on September 16, 2019 to be managed by Pacific Blue Cross a BC-based not-for-profit health benefits society based out of Vancouver. The FNHA continues providing medical transportation, and short-term crisis intervention and mental health counselling benefits directly to clients.

10.1. The Non-Insured Health Benefit Program

The NIHB program is a long-established national health benefits program administered through FNIHB. The NIHB program provides eligible registered First Nations people (both on and off-reserve) and recognized Inuit residents in Canada with supplemental health benefits.

The NIHB program provides access to a range of medically necessary, health-related goods and services when these benefits are not otherwise provided to eligible clients through private or provincial/territorial insurance programs. The components of the NIHB program include pharmacy, medical supplies and equipment, dental care, vision care, short-term crisis intervention mental health counselling, and medical transportation to access medically required health services not available on-reserve or in the community of residence. The NIHB program does not provide direct services to clients but instead relies on service providers (e.g., pharmacists) to deliver them.

Extensive consultations with First Nations at the time of tripartite negotiations demonstrated critical issues related to coverage rules and appeals procedures with the NIHB program. As the program rules were set from Ottawa, it often did not meet specific needs of BC communities. Consequently, a provision was included in the Tripartite Framework Agreement that facilitated the transition of the delivery of health benefits from the NIHB program to the FNHA. In 2013, the FNHA began receiving transfer payments from FNIHB and assumed responsibility for the provision of health benefits to BC First Nations. As a temporary measure, the FNHA entered into a buy-back arrangement with Health Canada and FNIHB continued to provide health benefits to FNHA clients on a cost recovery basis.

10.2. Phase I: Transitioning of the Pharmacy Benefits

Transition Process

In 2014, the decision was made to transition the Pharmacy Program, the largest component of the NIHB program to a BC-based service-provider, PharmaCare.

It was determined that PharmaCare, a program by the provincial government, was best suited to deliver pharmacy benefits to First Nation clients on behalf of the FNHA. In 2014, the FNHA issued the Request for Expressions of Interest to solicit services from a third-party insurance provider that could assist in delivering pharmacy benefits. Based in part on the results of this request and the FNHA's internal analysis, it was determined that PharmaCare, a program administered by the provincial government, was best positioned to deliver pharmacy benefits. PharmaCare had a number of advantages such as: an extensive infrastructure (including PharmaNet, the province-wide network that links all BC pharmacies to a central data system); well established processes for managing the formulary (e.g. scientific and evidence-based procedures for selecting effective therapies); strong links with service providers (e.g., BC pharmacists and physicians work closely with PharmaCare); and better integration with the provincial health care system and alignment with provincial standards (e.g., provincial priorities and service delivery systems are reflected in PharmaCare formularies). Furthermore, PharmaCare offered easier access to pharmacy benefits (e.g., First Nation clients can access the services by BC Service Card only) and access to additional services and programming provided by provincial agencies.

To facilitate the transition to the PharmaCare, the FNHA set up effective internal governance structure. The governance structure included an Executive Committee and five working groups. The Executive Committee was created to provide oversight to project implementation and high-level vision and guidance. The Executive Committee was chaired by the FNHA Chief Executive Officer and included other senior staff members such as the Chief Operating Officer, and the Vice President of Health Benefits as well as the Chairs of the five working groups. Working groups were established to undertake various aspects of the transition including communications and engagement, finance, organizational changes, information management and privacy, and design of the new plan.

The transition to PharmaCare was implemented under very tight deadlines and involved extensive project management efforts. The transition process involved extensive work between January and October 2017. The first step included the signing of a high-level Framework Agreement with the MoH to create Plan W within PharmaCare, a program specifically dedicated to First Nation clients. The funding mechanism for Plan W was created through the FNHA-PharmaCare Financial Framework Agreement with the BC MOH. This led to legislative changes being introduced to the *Pharmaceutical Service Act*. The Drug Plans Regulation was developed to enable BC First Nations participate in PharmaCare, processes and procedures for data sharing and protecting client confidentiality. Over 110,000 transitional special authorities were issued to grandfather existing coverage under the NIHB into the new plan. A cross-border program was established to ensure that clients living in border regions could continue accessing benefits through the NIHB program. A call centre was created to respond to inquiries from clients, service providers, and other stakeholders. A data warehouse was built and populated with large volumes of client data taken from the old system. Finally, the FNHA undertook an extensive communications program including mail outs, social media, radio advertisements, webinars, and in-person meetings and presentations designed to inform First Nations and service providers about the upcoming changes.

Impacts of the Phase I Transition

Launched in October 2017, the new program created a significant shift in how the services were provided to First Nations.

- **The transition resulted in greater utilization of the pharmacy benefits and reduced administrative expenditures.** The shift from the NIHB program to Plan W involved changes related to formularies, pricing, position of the first payer, dispensing fees, special authority and appeal procedures, coverage

rules, and access to emergency supplies. The change has resulted in a significant increase in pharmacy benefits delivered to BC First Nations across a range of key metrics and a reduction in administration costs. In particular, the rate of growth in the number of claimants, claims, and claims per claimant, claims expenditures, expenditure per claim, expenditure per claimant in the first-year post-transition all exceeded the annual percentage increase the four years prior to the transition.

- **The transition has placed the FNHA in a much better position to affect improvement in pharmacy benefits going forward.** The transition helped the FNHA gain a greater role in the decisions related to the delivery of pharmacy benefits to First Nation clients in BC. The FNHA has developed a strong partnership with the provincial government that should enable it to influence Plan W formularies in the future.

The transition has generated a range of positive and some negative impacts on both clients and service providers.

- **The transition enabled First Nations clients to gain access to the same care as other BC residents** (e.g., accessing additional services provided by PharmaCare and provincial agencies), streamlined some processes, improved access to benefits for clients who live away from home, enabled clients to access more benefits initiated by pharmacists, and enabled some clients to shift to more effective therapies.
- **The transition generated negative impacts on clients, at least in the short-term.** Differences in the formulary between the NIHB program and Plan W resulted in many clients, including those with diabetes, experiencing a change in therapies which created confusion, increased anxiety and, for some, reportedly, poorer health outcomes. One survey with Health Directors, pharmacists, physicians and nurses estimated that up to half of their clients were negatively impacted in some way by the transition. Some clients reported having to go back to their health care providers to obtain special authorities to be able to continue with their previous therapies or paying out-of-pocket, at least temporarily, for their medication. Many clients and service providers viewed the transition to Plan W as resulting in more limited access to pharmacy benefits.
- **The transition created criticism by First Nation leaders, Health Directors and community members** with regards to how the FNHA handled the transition process and its engagement efforts with First Nation representatives.
- **The FNHA undertook extensive efforts to address the negative impacts of the transition.** At the time of this evaluation, most issues and challenges of the transition had been successfully addressed by the FNHA. The organization was working on addressing other issues that were still affecting clients. Some of these issues include: limited knowledge of prescribers of the Plan W formularies, combined with restricted formularies under PharmaCare which affects client access to benefits; client access to benefits outside of the province; and technical issues associated with access (e.g., denial for services due to outdated status card, being taken off Plan W list without the person's prior knowledge). There are also challenges regarding the limited knowledge among clients regarding generic drugs and the procedures to appeal decisions as well as limited knowledge by some pharmacists to address community and client concerns in culturally safe manner.

Gaps, Challenges and Issues

Lack of experience in delivering health benefits programming and working with insurance providers. While the FNHA management included senior people with extensive work experience in the health system, the organization itself was only newly created. It was also at the early stage of hiring staff and creating an organizational structure and culture. As a new organization, the FNHA did not have experience in working with other insurance companies, PharmaCare or the provincial government in the delivery of health benefits. As a result, various partners including the federal and provincial governments were reluctant to start working with the FNHA until it could determine a course of action to make progress towards implementation.

Lack of experience and communication channels to inform clients and service providers of changes. The introduction of Plan W represented the first attempt by the FNHA to undertake an information campaign targeted at all First Nations clients across BC. The FNHA did not have up-to-date client contact information and lacked proper communication channels to effectively inform and prepare clients about the transition and subsequent changes. In particular, clients living in urban areas were the most difficult to reach as there were no effective mechanisms to collect their contact information. Furthermore, the communication activities had to be designed and implemented within a very short period which did not allow adequate time for planning, testing and improving the communication tools and resources. Awareness raising activities were also affected by miscommunication between the FNHA and FNHDA. While the FNHA expected the FNHDA to take a greater role in communicating with and preparing the communities for the transition, Health Directors did not feel they were adequately engaged or prepared to respond to questions received from the community.

Challenges with setting up proper governance and project management structures. An initial attempt to establish an effective governance structure and to put processes in place to manage planning and implementation of the transition was not successful. At that time, the project was managed by the Information Management Information Technology (IMIT) Enterprise Project Management Office within the FNHA. IMIT took a more traditional IT project management approach as part of this process. The result was that the transition activities were slowed down in 2014 while the FNHA created new governance and project implementation structures. In 2015, the FNHA created and launched a more formal and broad-based governance structure. This governance structure was more effective in bringing together the range of capabilities, functions, and skills needed to plan and successfully complete the transition.

10.3. Phase II: Transitioning of Other Health Benefits

Transition Process

The transition of other health benefits started immediately after the Phase I transition was completed. The FNHA started the transitioning of other health benefits (e.g., medical supplies and equipment, dental care, vision care) immediately after Phase I was completed in October 2017.

Through a competitive bidding process, Pacific Blue Cross was identified as the most qualified organization to deliver the health benefits to First Nations communities in BC. A first step in the transition process was to identify a BC-based third-party provider to deliver other health benefits to First Nations communities. Learning from the experience of Phase I, the FNHA decided to employ a more collaborative approach for selecting a partner. First, it issued a request for proposal, requesting third party providers submit proposals. A multidisciplinary selection committee was created to review proposals, interview candidates and make the final decision on the provider. The committee included members from the FNHA, Elders, and representatives of the FNHC and FNHDA. Through this process, Pacific Blue Cross, a BC-based not-for-profit health benefits society based out of Vancouver, was identified as a potential partner. Other positive characteristics of the organization was that as one of BC's largest benefits organizations, it provides fast claims processing, reimbursement, as well as electronic coordination of benefits and has a strong relationships and fast payment systems established with health care providers. Also it was viewed as the only capable bidder that could deliver services in a culturally appropriate manner and who could work in close partnership with the FNHA. Pacific Blue Cross demonstrated a strong understanding of the project requirements, shared similar

values with the FNHA, demonstrated a commitment to cultural safety, and a willingness to work with the FNHA to engage with clients and communities as part of the design phase of the transition. As such, in January 2018, the decision was made to select Pacific Blue Cross as a third-party provider to deliver the other health benefits.

It was decided that the FNHA would continue providing some of the health benefits, while most would be transferred to Pacific Blue Cross. The range of benefits delivered by the Pacific Blue Cross would include dental and vision care, medical supplies and equipment, and pharmacy benefits in addition to those covered by PharmaCare and those obtained outside of the province or by those not yet enrolled in Plan W. The FNHA would continue to provide medical transportation services and short-term crisis and mental health counselling.

PharmaCare	Pacific Blue Cross	FNHA
<ul style="list-style-type: none"> ✓ Pharmacy Benefits ✓ Some over-the-counter items 	<ul style="list-style-type: none"> ✓ Dental services; ✓ Vision care aids & services; ✓ Medical supplies & equipment; ✓ Some additional pharmaceutical benefits not available through Pharmacare and pharmaceutical benefits for those not accessing (or not enrolled) in Plan W; and ✓ Reimbursement for eligible benefits obtained outside of BC. 	<ul style="list-style-type: none"> ✓ Medical transportation, ✓ Short-term crisis intervention & mental health counselling

In Phase II, the FNHA implemented a number of key lessons that it learned as part of Phase I transition of the Pharmacy Benefits. In particular, the FNHA allocated greater time period (from October 2017 to September 2019) for planning and implementing the transition, created Community Relations Representatives positions (one position in each region was created in the spring of 2018 and all were filled by the summer of 2018) and Regional Community Relations Representative positions across BC to help support the FNHA community engagement and communication efforts. These representatives played a key role in undertaking the groundwork to support Phase 2 of the transition. They were involved in organizing community meetings, and face-to-face and telephone discussions with service providers and community representatives to support the transition process.

The FNHA conducted extensive in-person engagement with First Nations clients and communities as part of the Phase II transition to learn their needs and perspectives on the design of the new program. The contract with Pacific Blue Cross was signed in September 2018 and immediately after, the FNHA and Pacific Blue Cross started extensive in-person engagement, communications and information campaigns across BC. Over a one-year period, in partnership with the Community Relations Representatives, the members of the Health Benefits team and Pacific Blue Cross traveled across all regions of BC to deliver over 51 focus group sessions (involving mostly First Nations who live in communities/on-reserve). The focus groups included participants from 97 of the 200 First Nations communities in BC. During these discussions, the members of the FNHA Health Benefits team were able to identify critical issues and challenges with the existing health benefits delivery and collected a list of recommendations on how to improve the services.

The FNHA engaged extensively with existing service providers to hear their perspectives on the design of the new program. As Pacific Blue Cross had existing relationships with the service providers, the FNHA engaged Pacific Blue Cross to lead these discussions. During the discussion the FNHA Health Benefit team

members learned the provider perspectives and concerns on the former NIHB program and collected recommendations how the new program could be improved to address those concerns. The FNHA used the Pacific Blue Cross network (and also Association and Colleges representing service providers) to reach out to service providers through webinars, fax machines, conferences and events and make them aware of the changes.

The new plan is expected to improve coverage and delivery of the health benefits to First Nation clients.

According to the case study participants, the new Health Benefit plan launched in September 2019 will substantially improve the coverage, design and delivery of the benefits to First Nation clients. During discussions with community representatives, coverage, rigid rules, and the speed of services received from NIHB were the most critical issues faced by clients when using the NIHB program. The new plan was designed to address these issues and to improve the experience for clients and service providers when accessing services. Some of the critical improvements made to the new plan include:

- Extensive cultural safety training to Pacific Blue Cross staff members to ensure they can work appropriately with First Nation clients.
- Improved coverage rates (e.g., eye exams will be reimbursed up to \$100 every two calendar years, standard prescription eyewear will be reimbursed up to \$275 every two calendar years).
- Removal of the requirement for pre-approvals (under the new program pre-approvals are only required for exceptional client needs beyond the coverage limits).
- Increased flexibility in the coverage rules allowing clients to choose the types of the benefits that they require at any time. For example, instead of assigned benefit value for each specific item, the clients are provided a fixed limit within the category.

According to the case study participants, the removal of pre-approvals will increase speed of services substantially, and accessibility to the program will improve because any providers that have existing enrollment with Pacific Blue Cross will be able to serve First Nation clients.

The FNHA made sure to report back to the communities and clients on the improvements that it made to the coverage, design and delivery of the new program. Once the decision on the design of the new plan was made, the FNHA community engagement team started scheduling more in-person meetings and group sessions to report back to clients and communities on the design of the new program. At the time of this evaluation, over 50 such information sessions were either planned or already delivered.

Impacts of the Phase II Transition

Case study participants noted that it is too early to identify the impact of the Phase II transition as the transition only happened on September 16, 2019. However, they identified a key impact that has been generated through the transition process itself – increased trust of the clients and communities. Phase I transition was associated with a number of challenges which affected the reputation of the FNHA. The major concerns were that the FNHA did not adequately engage nor inform clients and communities about upcoming changes. However, the approach undertaken by the FNHA in Phase II was very participatory and involved extensive in-person engagements. Consequently, many clients and community representatives were satisfied how the organization handled the process.

Key informants noted a number of expected impacts of the Phase II transition. In terms of anticipated positive impacts, it was mentioned that:

The transition is expected to improve the coverage, delivery and access to health benefits affecting health and well-being of the First Nation clients. Pacific Blue Cross is one of the largest third-party providers in BC and most service providers accept their benefits. The organization also has streamlined processes (e.g., online systems of submitting claims) and clarity with regards to claims processing. It is expected that more providers will join to deliver health benefits to First Nation communities and that First Nation clients will have easier and streamlined access to health benefits (e.g., use of smartphone apps, less paper work, no need for pre-approvals, clarity with regards to eligibility). For example, during first two weeks of the transition, of the 33,000 claims submitted to Pacific Blue Cross, 85% were submitted electronically and only 15% were submitted manually, indicating a huge increase in electronic transitions. The following table illustrates how the FNHA was able to address specific design priorities for the Phase II transition.

Plan Design Priorities	How delivered
<ul style="list-style-type: none"> • Create a plan that is easier to understand 	<ul style="list-style-type: none"> • Simplified plan • Tools available to increase access to information
<ul style="list-style-type: none"> • Improve access to services and reduce administrative barriers 	<ul style="list-style-type: none"> • Large number of items no longer require prior approvals • Pay direct to providers • 48-hour turnaround for client reimbursements submitted electronically
<ul style="list-style-type: none"> • Minimize client out of pocket expenses 	<ul style="list-style-type: none"> • Fee guide increases • Flexibility in coverage • Pay direct to providers
<ul style="list-style-type: none"> • Ensure plan is financially sustainable 	<ul style="list-style-type: none"> • Detailed actuarial analysis completed • Risk mitigations on high cost items

Gaining full control over the Health Benefit program decisions, the FNHA will be able to eliminate inefficiencies in the program and continuously improve the quality of the services. It will also allow the FNHA to align the program with other programs and the services that it provides. For example, it was mentioned that the FNHA will be able to allocate resources into more preventative care (e.g., more focus on regular dental cleaning rather than spending resources on fillings and dentures) that are consistent with its wellness agenda and incorporate benefits that are aligned with First Nations traditional and cultural practices.

In terms of potential negative impacts:

The new Health Benefit program is expected to increase program expenditures, which can affect sustainability of the program in the future. Due to streamlined services, it is expected that the utilization of the health benefits will increase.

Gaps, Challenges and Issues

The increased cost of the new program may affect the availability of resources that the FNHA can allocate into other areas of its programming. Going forward, the FNHA will have to balance between Health Benefit program priorities with other pressing issues that it has to handle. Utilization rates for some health benefits by First Nation clients have been low (e.g., 39% for dental benefits) most likely due to difficulties associated with access. The new program will provide more streamlined services, which may increase access and

utilization rates, putting extra pressure on the budget. The issue is further complicated by growing expectations of the program by clients and the communities.

The FNHA's ability to reach out to and communicate with clients, particularly with those who live in urban areas and away from home, continues to be a major challenge. The organization lacks a proper database of contact information that would enable it to communicate with clients. Although hiring of Community Relations Representatives have helped with reaching out to clients who live in communities, little progress has been made in terms of finding effective communication strategies targeted at clients who live in urban areas and away from home. Constant travel to regions and communities is costly and does not allow reaching the larger client base. Use of social media is not effective in reaching remote regions due to connectivity and access issues.

Some technical gaps within the Pacific Blue Cross system and provider network did not enable electronic adjudication of some medical supply and equipment benefits. Case study participants did not see the issue as a major challenge. At the time of this evaluation, Pacific Blue Cross and the FNHA were working on addressing the issue.

Geographical barriers, isolation and remoteness of some communities is an issue in delivering health benefit services and reaching out to and communicating with clients and communities.

Limited clarity regarding the decision-making framework. As noted by case study participants and documented in the project reports, the challenges were experienced with clarity around how the decisions were made and who were to be consulted in making critical decisions. At times it slowed the decision-making processes. The issue with clarity around decisions making was identified as a challenge during both Phase I and Phase II transition processes.

Ending the contracts of external consultants in charge of the transition resulted in loss of some corporate knowledge. Project Team composed of external consultants in place for over three years. The team operated alongside the Health Benefits team, connecting in as needed with staff. Ending the contracts resulted in some corporate knowledge leaving the organization.

10.4. Lessons Learned and Opportunities for Improvement

Focus on ensuring sustainability of the Health Benefit program. The improved accessibility and utilization is expected to increase the cost of the Health Benefit program. Regular cost monitoring and forecasting will be necessary to help the leadership with planning and finding effective solutions.

The FNHA approach for learning and incorporating lessons from Phase I transition has been successful. The organization demonstrated a willingness to learn from mistakes and incorporate these lessons in Phase II transition. Examples of such actions undertaken by the FNHA as a result of Phase I learnings included the creation of Community Relations Representatives in charge of communications with communities, allocating more time for engagement, reporting back to the communities on how their suggestions were used in designing the new program. The FNHA demonstrated flexibility and agility in its approach and was quick and effective in addressing mistakes of the Phase I transition.

Involving partners early was the critical factor that contributed to the success of the Phase II transition. The FNHA involved Pacific Blue Cross at the time when it did not have concrete ideas on the design of the new Health Benefit program. Instead, using the participatory approach, it made sure that Pacific Blue Cross participated in community and client engagements, learned their needs and priorities and helped to design the new program.

Continuously learning client need and involving clients and communities in all aspects of the program design and implementation will support effective decision-making. All major changes in the program should be informed by engagement with clients and communities. Client focus is the most important aspect of the success. All planning, analysis, recommendations, decisions should consider their impact on clients. Clients should be at the center of all work when undertaking similar projects. It is also critical to ensure to learn and incorporate perspectives of clients from various backgrounds (e.g., geographical regions, age groups, in-community and urban/away from home, isolated and remote) and identify potential impacts of changes on these client groups. While considerable progress was made to engage with representatives of communities (including leadership and community members) as part of Phase II transition, communication and consultations with urban and away from home clients were still limited. Going forward, the FNHA will have to find ways to increase communication with urban and away from home clients and learn and address their needs and priorities.

Using community-based information materials such as newspapers and newsletters is an effective approach to reach out to community members. As part of the Phase II transition, the FNHA Health Benefits team members partnered with community newspapers and newsletters to distribute materials and to inform community members about upcoming changes, which was well received by community members and was effective in raising awareness of the changes.

Support from FNHA senior management was critical in implementing the Phase II transition. The senior management were willing to listen to recommendations and make decisions, which facilitated the transition process.

Use of skilled staff and consultants. The FNHA used highly experienced staff and consultants to undertake the Phase II transition. When problems arose, they were resolved quickly. Experienced and skilled contractors, while often more expensive, are also more effective in delivering quality results.

The FNHA approach to involve Pacific Blue Cross to engage and inform providers through its network was successful. Pacific Blue Cross effectively worked with the FNHA to inform and guide the service providers through the transition processes. When service provider complaints were received, they were addressed by finding solutions and change in processes and procedures.

Effective partnership is critical when undertaking large scale transformative change initiatives. Most of the failures during Phase I transition were created due to a lack of effective partnership with the FNHDA, FNIHB, service providers etc. In Phase II transition, the FNHA was able to build effective partnerships with:

- Communities through large scale, in-person consultation processes
- Health Directors by creating FNHDA advisory committee and involving it in most critical aspects of the transition from early stages of implementation
- FNIHB through early involvement and ongoing communication
- Other departments within the FNHA

- Pacific Blue Cross through early engagement and constant communication

Having clarity with regards to project objectives, vision and guiding principles was critical. During Phase I transition, lack of clarity required most critical decisions to be consulted with the senior management. As part of the Phase II transition, multiple, early sessions were held with the FNHA executive team, which led to the definition of project guiding principles. This minimized the need for executive management involvement in day to day project decisions and allowed the project team to proceed with the detailed work. When difficult decisions were required, or conflicting opinions arose on how to proceed, the project team could validate against the guiding principles and keep moving forward.

Incorporating lessons learned from Phase I transition ensured that Phase II was implemented smoothly without significant issues and challenges. While Phase II required a number of change orders and went significantly over budget, Phase II transition was implemented without a change in the project scope and the transition was completed within the original scope.

A separate review may need to be conducted to assess effectiveness of the processes involved in delivering other health benefits. Some health benefits delivered directly by the FNHA (medical transportation, and short-term crisis intervention and mental health counselling benefits directly to clients) were excluded from scope of this case study review. A separate review may be warranted in the future to assess effectiveness of processes and procedures involved in delivering those benefits.

11. Nursing Service Model Evolution

The FNHA has set a path to address the health inequities of BC's First Nations peoples, and this vision aligns with the enhancement of integrating culturally safe services with its key stakeholders and community health nurses who deliver health services to some of BC's most rural and remote First Nations communities.

Nursing Services is the FNHA's largest direct patient care portfolio spanning across the province within its five defined regions. Nursing is an essential contributor to the health and wellness of BC First Nations' peoples, to the overall transformation of health services for the organization, to fostering internal and external partnerships focused on cultural safety and humility, and equity as foundational to Nursing Services' work. The Office of the Chief Nursing Officer is a team based in Vancouver that serves the entire province, working in partnership with regional teams in Prince George, Kelowna and Matsqui (Mission) as well as three locations on Vancouver Island. FNHA Nursing Services operates directly in 12 hub health centres (serving many surrounding First Nation communities) and eight nursing stations, together serving 42 BC First Nations communities. Nursing and interprofessional practice consultation and support (advanced practice, regulatory practice, clinical education, quality and client experience) is provided in partnership with regional teams for all communities in the province.

Due to global nursing shortages, FNHA Nursing Services experience challenges with recruitment and retention of qualified nurses. Due to the high vacancy rates in nursing stations, the organization maintains hiring of permanent full-time, part-time and casual staff as well a Provincial Resource Team of 18 full-time equivalent positions to support temporary staffing requirements. The Office of the Chief Nursing Officer also partners with two agencies to fill vacancies on an ongoing basis.

The FNHA nursing stations employ between two to four community health nurses depending on population size and who work in an expanded scope of practice to provide primary care, public health, health promotion and emergency care for First Nations individuals, families and communities (from newborn to the elderly), including after-hours on-call care. Mandatory primary services (those that have a direct impact on the health and safety of community members and the population) is a significant part of services to communities. These services have a strong public health and/or clinical component and require that staff have certain competencies/credentials/certification/licensing and meet practice standards to ensure quality and safe public health and client care provision. Individual and community-level health assessment for the purpose of prevention, promotion, diagnosis and treatment is the foundation of all care. All actions are predicated on the provider to be supported to have knowledge, skills and abilities (competencies) to carry out required care, including the ability to conduct a thorough and accurate health assessment in all program domains. This includes but is not limited to the mandatory programs of immunization and communicable disease control, as well as services such as maternal and infant health, preschool, school beginners and school aged children/youth, adult health, monitoring of stable chronic conditions in all age groups, palliative care and end of life support, opioid agonist therapy; and assessment related to non-nursing services such as oral health and environmental health. Nursing Services also collaborates with the BC Emergency Health Services and Patient Transport Network to medivac clients safely to higher levels of care. In addition to post-secondary training and education, community health nurses are required to have a designated Remote Certification,

obtained through the British Columbia College of Nursing Professionals as well extensive emergency, cardiac, and trauma training, which allows them to work in an expanded scope.

Community health nurses provide a comprehensive range of nursing services to First Nation communities including public health, health promotion and disease prevention. These primary care services are part of the continuum of care in rural/remote First Nations communities and are often interconnected and integrated with other health programs and services. They work in partnership with the community to develop and implement relevant, culturally safe, culturally competent and culturally sensitive interventions, providing services in a clinic, home and community settings. Community health nurses in this setting are not on call and do not provide emergency services.

Standard Essential Primary Care Services within FNHA nursing operations, include:

- Health assessment in all domains required in the nurse's practice environment, including mandatory and non-mandatory programs
- Immunizations
- Communicable diseases outbreak management and treatment
- Management of minor and complex episodic illness and injuries
- Initial identification and management of chronic disease
- Monitoring of stable chronic conditions
- Coordination and referral to health services not offered in the community, with provincial services (e.g., rehab, palliative care); coordination of access to diagnostics (lab, diagnostic imaging); access to invasive or specialized diagnostic procedures (biopsies, imaging, pulmonary function tests, etc.)
- Discharge planning: Coordination and collaboration with provincial services of return for patients who were hospitalized or treated outside the community across the spectrum of care complexity

Nursing Services also includes Clinical and Client Care and Home and Community Care services offered by First Nations communities. Clinical and Client care provide essential health care to community members who live primarily in remote and isolated communities. The Clinical and Client care include essential health care services such as coordination and case management and other health-related services such as access to supplies, equipment and pharmaceutical, health records and diagnostic services. The home and community care include services that enables First Nations people to receive needed care for chronic or acute illness closer to home. Essential services include client assessment, home care nursing, case management, palliative and end of life care, home support, in-home respite, linkages and referrals to other health and social services, provision of and access to specialized medical equipment and supplies, record keeping and data collection.

Clinical and client care is provided by nurses and specialized care professionals employed by the FNHA or by the community. Home and community care is provided primarily through contribution agreements with First Nation communities and aims to equal services offered to other Canadians in similar geographical areas. Care is delivered primarily by home care registered nurses, licensed practical nurses and trained, certified personal care workers.

11.1. Nursing Services Prior to the Transition

The major concerns related to nursing services structure prior to the transition identified in the interviews include:

- **Less flexibility around program and policy decisions.** Case study participants noted that at the time of the FNIHB, First Nations, particularly those who received funding under the Block Funding Model, had a degree of flexibility to design and deliver community-based nursing services. However, the policies, structures and types of programs and services were designed from Ottawa, which made it more difficult for First Nations in BC to adjust the programming to their community needs and priorities.
- **Limited access to nursing support.** The support services offered by FNIHB to community-based nurses was mostly inadequate to ensure effective programming. Case study participants noted that FNIHB had limited staffing and practice specialists who could support building capacities of community-based nurses involved in service delivery.
- **Issues related to the quality of services** particularly with respect to inadequate emphasis on cultural awareness and sensitivity and FNIHB's challenges to recruit and retain nurses (large turn-over levels, lack of infrastructure and support for nurses).
- **Limited integration of services and continuity of care** as programs largely operated in silos with minimal information sharing and collaboration. The particular areas of silos mentioned by case study participants included silos between FNIHB-employed (non transfer) nurses and the community-employed (transfer), silos in delivering health programs and services (e.g., nursing, home and community care, and communicable disease and public health) as well as disconnect between programming and services delivered by the regional health authorities, communities and FNIHB.

11.2. The FNHA Approach to the Nursing Services

Smooth transition of the nursing services, recruitment and retention of qualified nurses, nurse education and training and continuous quality improvement were the key priorities of the nursing services at the time of the transition from FNIHB. In October 2013, the FNHA took on the responsibility for the design and delivery of health programs and services, including Nursing Services, for BC First Nations, formerly delivered by FNIHB. The transition priorities for the FNHA Nursing Services included:

- Continued collaboration to support a smooth transition of nursing services
- Recruitment and retention of qualified health care providers for primary care, public health, home and community care
- Nursing education, practice and research: review and improve training and education programs; ongoing commitment to best practice, nursing education, including remote certified practice, cultural competency and mandatory training
- Health service delivery models in remote communities
- Enhanced services to First Nations communities
- Integration of a wellness approach

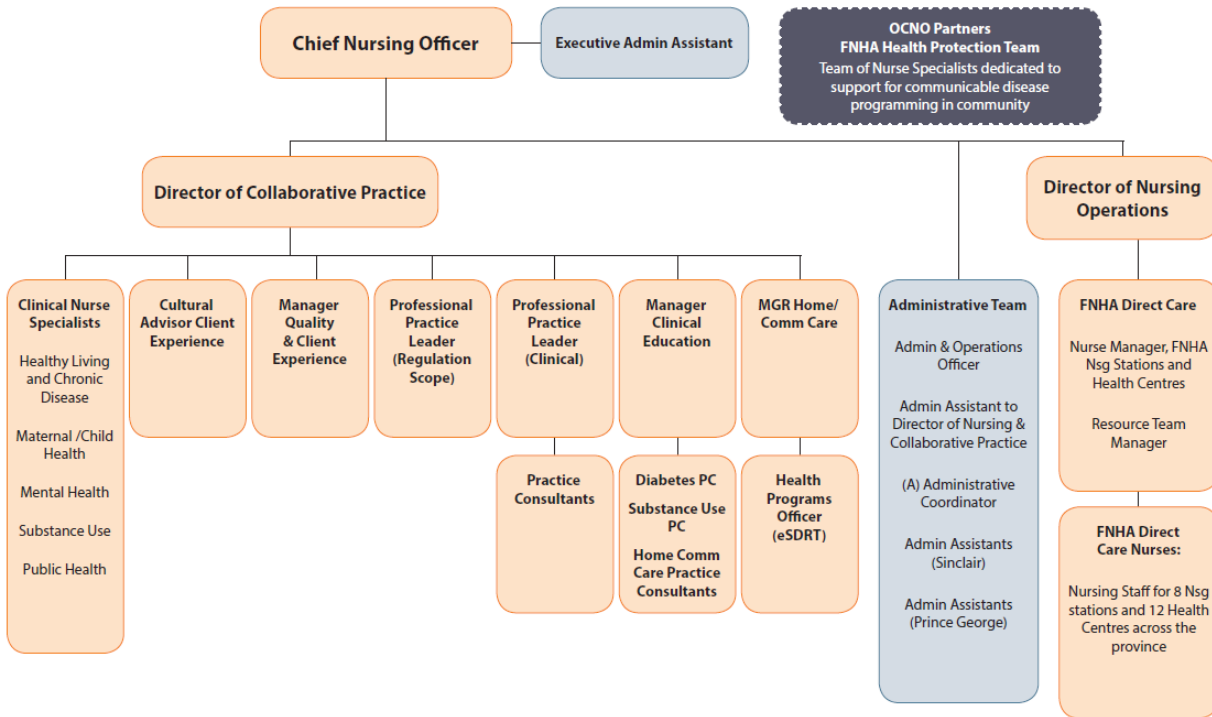
To ensure continuous improvement, in 2015, the FNHA conducted a review of its Nursing Services. The findings of the review identified a number of issues and gaps and provided a range of recommendations for improvement. In particular, the review identified that there were overlaps between nursing services and programming offered by other departments, nurses in some communities were not well supported by the FNHA, nurse turnover and use of agency nurses were high, and relationships between the regional health authorities, communities and the FNHA were not formalized to support nurses. The review also provided a range of recommendations for the FNHA to improve nursing services. These recommendations included:

- A need for a shift to a patient-centered and interdisciplinary model of care integrating primary care and public health in communities.
- Strengthening the nursing leadership team by hiring a Chief Nursing Officer reporting to the FNHA Chief Operating Officer.
- Changing the structure of the Nursing Services Department to include Regional Nurse Managers and recruiting/reassigning practice support consultants at regions/communities (Community Health Practice Consultants).
- Supporting nurse capacity through training, standardized tools and resources and mentorship supports.
- Addressing wage disparities for community-employed nurses and creating a career laddering program to support professional advancement and reduce turnover.
- Promoting nursing as a career of choice for First Nations.
- Implementing eHealth and health-related technologies at remote and isolated communities.
- Developing performance measurement.

Following the report, the FNHA undertook a number of actions to implement recommendations identified in the report, summarized as follows:

- *The FNHA restructured the nursing services through recruitment of a Chief Nursing Officer to lead both nursing operations and collaborative practice portfolios.* The Chief Nursing Officer is responsible for direct care programs supporting public health mandate in the First Nations communities and nursing operations standards and quality delivery, clinical education and advance practice. Two additional director positions were created who report directly to the Chief Nursing Officer and include Director of Nursing Operations overseeing operations of the FNHA nursing stations and health centers and manages resource teams, and Director of Collaborative Practice ensuring that nurses and clinicians who provide care for the communities have the knowledge, supportive structure in place, access to educational opportunities, professional practice quality and safety. The new structure of the FNHA Nursing Services is provided in the following diagram.

The FNHA Nursing Services Structure



- Initiated regionalization of Nursing Services.* As part of the restructuring, the FNHA has hired Regional Nurse Managers in four regions (Vancouver Coastal and Fraser Salish were combined to form one region). The former Home and Community Nursing Practice Advisors and Transfer Nursing Practice consultants were reassigned to each region and started reporting to their respective Regional Nurse Managers in new roles titled Community Health Practice Consultants. The Regional Nurse Managers now report to Regional Executive Directors and Community Health Practice Consultants to Regional Nurse Managers and are often first point of contact for community health nurses and home care nurses working in the community and provide a range of support to nurses on delivering their and professional development assistance. Regional Nurse Managers and Home, Community and Preventative Care teams also work on adjusting and improving policies and protocols, and standards with the support of the office of the Chief Nursing Officer.
- Enhanced the availability of the professional support for all community-based nurses.* Efforts were undertaken to build and strengthen the FNHA capacity to support community-based (i.e., both community-employed and FNHA-employed) nurses and interprofessional practice. To implement the capacity building efforts, in June 2017, a new position of Director of Collaborative Practice was created. The position is responsible for leadership for advanced nursing practice, implementation of best practice and research, professional practice, point of care practice consultation and support, clinical education, clinical quality, safety and client experience, and home and community care consultation. During interviews, the intent to build a center of excellence in clinical education and learning, which can provide a full range of support to community-based nurses is being considered. A range of positions have been created as part of the Director of Collaborative Practice to support nurse capacity, including: Clinical Nurse Specialists (e.g., healthy living and chronic disease, maternal/child health, mental health, substance use, public health), Cultural Advisor, Clinical and Regulation Professional Practice Leaders, Clinical Education Manager, Diabetes Practice Consultant, Substance Use Practice Consultant, Home and

Community Care Practice Consultant, Manager of Home and Community Care, and Health Programs Officer. The role of the office of Collaborative Practice is to ensure there is adequate support for nurses and also other clinicians who work in communities. The range of support provided includes educational opportunities, clinical practice consultation, professional practice, and quality and safety standards.

- *Shifted nature of relationships with the community-based nurses to a system based on reciprocal accountability, collaboration and partnership.* During interviews, case study participants noted that the FNHIB used to implement nursing services through the highly structured national system. The community-based nurses had to follow protocols, policies, and directions and clinical guidelines, often directed from Ottawa with little flexibilities and limited support. A review of the nursing services conducted in 2015, identified issues with regards to limited supports that the nurses received and existence of culture where the nurses were afraid to report on incidents (and near incidents). The report also recommended creating a “no blame” culture where nurses are supported in dealing with practice issues. Consequently, the FNHA Nursing Services shifted its approach to working with nurses into a community-driven and partnership-based model. In particular, the FNHA is trying to evolve its Nursing Services continuously and adjust to the specific needs and circumstances of each community. As a result, community-based nurses (i.e., both community-employed and FNHA employed) went from working under very strict system into having much flexibility to decide on the program design and how to improve their services. The partnership model used by the FNHA is focused on defining priorities together with communities while respecting their right to self-determination and control over delivery of health services and ensuring quality of care. A program of clinical quality and client experience is evolving with a current focus on incident reporting and follow up for quality improvement, data informed quality improvement initiatives, establishment of performance metrics. The Manager for Quality and Client Experience, reporting to the Director of Collaborative Practice, is responsible to lead the work in partnership with regions and communities.
- *Implemented steps to integrate activities of nurses employed by communities (transfer) and those employed by the FNHA (non-transfer).* Nursing services are currently provided to First Nations communities in three primary ways: by nurses employed by the FNHA; by nurses employed by the community; and/or by nurses employed by regional health authorities. Case study participants noted that the FNHA Nursing Services considers community-employed nurses as part of the ‘family’ and extends all its programming, services, and supports to all nurses including to those hired by communities. The FNHA has also changed the terminology used to describe nurses and is no longer uses ‘transfer nurse’ referring to nurses employed by the communities. The nurses who work with First Nation clients from all backgrounds are invited to attend FNHA events (e.g., Nursing Education Forum) and use its capacity-building support and services. At the time of the evaluation, the FNHA Nursing Services were also working to engage with nurses who primarily serve First Nation clients in urban areas. To further integrate nurses from different backgrounds, the FNHA has established an online community of practice for nurses focused on different areas of practice (e.g., mental health) and nurses from all backgrounds (including transfer and non-transfer) have been encouraged to participate. Similarly, the annual Nursing Education Forum includes representation from nurses of all backgrounds.
- *Implemented efforts to build nurse capacity and improve standards of care.* Some of these efforts are summarized as follows:
 - Improved nurse orientation processes by increasing time allocated to the orientation of newly hired nurses from two weeks to six weeks, using more creative and engaging orientation activities and using community trials (e.g. sending a nurse to a community as a trial before being placed in the community).

- Developed a nurse preceptorship program as part of orientation. The FNHA offers 6-week preceptorship experiences (i.e., time-limited, education-focused model for teaching and learning within a clinical environment) in nursing stations and health centres. This has led to more nurses available to work in nursing stations.
 - Developed standards and best practices for nursing education and capacity building. The FNHA nursing services provides consultation and support for standards of practice to be applied across different communities and service delivery locations to ensure adequate quality of the nursing services. For example, in 2018/19, the FNHA initiated work with the BC College of Nursing Professionals to harmonize practice standards and integrate Accreditation Canada standards into quality initiatives and work plans.
 - Delivered training and developed tools and resources to support nurses working in the communities. Examples of tools identified through case study included: breastfeeding toolkit – *Breastmilk, First Traditional Food, Tuberculosis Services Community Programming Guide* (which provides direction on how to create and launch tuberculosis services in community), practice competencies for all areas of specialty practice, personal privacy tool, safety in the workplace, and cancer awareness resources, symptom management guidelines, and guidelines on professional consultation nurse-to-nurse, after-hours, support for families, advance care planning/serious illness conversation guide education, and palliative benefit forms. Examples of training and workshops included a new training and clinical program guidance aimed at community health nurses and home community care nurses, training on trauma-informed practice and cultural humility, training on Indigenous Perspectives on Harm Reduction and mandatory training on basic safety, information security and occupation health and safety, advanced training online, basic palliative care education for nurses, Licensing, Education, Advocacy and Practice Program, W'Sanec Indigenous Licensing, Education, Advocacy and Practice; Licensing, Education, Advocacy and Practice for First Responders. During interviews, the FNHA nursing service leaders noted that they will continue enhancing the training and capacity building support to the nurses through creating a center of excellence in clinical education and learning. The center will provide a full range of education and best practice to support excellence in nurse education and promote high standard of practice.
 - Worked with academic partners to enhance nurse education. The FNHA nursing team is working with a number of academic partners across BC to support Indigenous students in their journey to obtain an education in nursing. The examples of such activities include designing curriculum jointly to ensure it includes knowledge and skills in cultural safety and humility and incorporating First Nations ways of learning, establishing credential recognition programs (e.g., Remote Nursing Certification program was established with the University of Northern BC).
 - Implemented a clinical quality and client experience initiatives such as incident reporting and follow up for quality improvement, data informed quality improvement initiatives, and establishment of performance metrics. The Manager for Quality and Client Experience, reporting to the Director of Collaborative Practice, is responsible for implementation of quality improvement initiatives in partnership with regions and communities.
- *Implemented interprofessional team-based and wholistic circle of care approach*, which brings together community nurses and other care professionals including traditional Knowledge Keepers. The FNHA Nursing Services has taken steps to adopt a wholistic circle of care approach which is centered on wellness for people, families and communities and is based on culturally safe, trauma-informed practices. This approach is appreciative and strength-based, supported by inter-professional teams embedded in communities, offers care plans that are person-centered and connected and integrated with all care providers partnering in the care experience, embraces traditional approaches to health,

healing and wellness and integrates alternative levels of care. An interdisciplinary model of care integrates both primary care and public health in communities. This model focuses on a patient-centred approach which enables patients to actively participate in their own decision-making and care planning. The model also integrates health services at the community level and combines health services with other services available in the community, including traditional wellness, and provides links to available health services outside of the community. Director of Collaborative Practice is responsible for broader interdisciplinary approach within the nursing services as well as integration of nursing with other programs and services. To implement this interdisciplinary strategy the FNHA has:

- Further defined roles and responsibilities for team disciplines, as well as guidelines and tools to support safe and effective practices to integrate nursing with other community health care providers.
 - Concentrated efforts on health prevention and health promotion for patient self-management.
 - Identified governance roles to enable teamwork, as the composition of the teams involves staff employed by the FNHA, communities, regional health authorities and private practitioners (e.g. physicians).
 - Engaged with key stakeholders (e.g., communities, regional health authorities, MoH) to outline community resources, pinpoint disparities and align the interdisciplinary model and relationships with key initiatives to deliver services in each community in a hub and spoke model.
 - Formed relationships between each community with acute, specialist and other health services not available within the communities.
 - Developed a nursing resource mix model in alignment with the interdisciplinary model to provide quality care by enhancing the current nursing resources [e.g., allowing nurses to work to their full scope of practice by choosing nursing categories (e.g., nurse practitioner, registered nurse, licensed practical nurse) that match the scope of practices and types of services offered, and tailored to the specific needs of health care providers available in each community]
 - In addition, the FNHA Nursing Services team has introduced nurse practitioner and midwifery models of care; established an inter-professional medication quality and safety committee.
- *Expanded scope of practice and areas of focus for nursing professionals.* The FNHA Nursing Services have included a number of new areas of focus for nursing professionals. New clinical areas of focus included end of life support, palliative care, opioid response, substance use, cannabis, mental health, community care, wound care, etc. At the time of this evaluation, the Nursing Services were working on a number of other projects focused on expanding nursing care to other clinical areas.

The FNHA also implemented a range of other activities and initiatives to improve the quality of the nursing services, summarized as follows:

- *Organized events, gatherings and forums to facilitate knowledge exchange among nurses.* Examples of such events organized by the FNHA nursing team include:
 - Annual Nursing Education Forum to support and recognize the value and impact of the service provided by nurses. In 2018, the event brought over 250 FNHA nurses and community-based nurses who serve First Nations communities across BC and provides an opportunity to learn best practices, innovative approaches and network and learn from each other's experience.
 - Regional nursing forums are organized periodically to bring nurses from each region together. For example, a Northern Nursing Conference was held in April 2018, which brought nurses from the Northern Region to discuss improvements to quality of services in geriatric outreach, palliative care, maternal and child health, remote pharmacy delivery, and HPV self-screening.

- Education support for regional interprofessional events (e.g., Clinical Nurse Specialists Substance Use and Primary Care Substance Use supporting regionally based opioid agonist therapy training).
- *Engaged in partnership with provincial health authorities and service providers to improve quality and coordination of care.* Examples of such partnerships identified through interviews and document and file review included partnerships by the FNHA Northern Region Nursing team with the Northern Health Palliative Care Consultation team to expand palliative care consultation services to rural and remote First Nations communities and partnerships with University of British Columbia to deliver an HPV self-screening pilot project in three communities in the Northeast sub-region.
- *Increased focus on wellness and prevention and addressing a full spectrum of determinants of health.* The FNHA has been given a strong mandate by communities to shift the paradigm from focusing on sickness and deficits to an approach focused on wellness. As such, Nursing Services have been exploring and identifying sources of strength and adjusting its services to base on community resilience.
- *Increased funding allocated to Nursing Services through provincial partnerships.* In 2017/18, the FNHA announced shared investment with Interior Health of \$3 million to bring Elder care closer to home, including a nursing enhancement to support First Nations Elders and those living with chronic conditions and to support community preparedness. This joint investment is expected to support about 4,450 Elders in the Interior Region. The investment was driven by collaboration and leadership from seven Nations of the Interior. The nursing enhancement (i.e. new and enhanced nursing roles and broader scope of practice), is expected to improve access to culturally safe, wholistic and quality health care services for Elders living in community, including those living with chronic conditions, by allowing nurses to work more collaboratively with Elders, their families and interdisciplinary care teams.
- *Undertook efforts to improve nurse recruitment.* Joint efforts were implemented between Nursing Services, Human Resources and Communication department within the FNHA to promote the organization as an attractive employer of choice for all qualified nurses, and particularly those from Indigenous background. Many complexities around nurse salaries and benefits have been addressed to ensure nurses working in communities (e.g., community-employed, FNHA employed, and union / non-union) have the similar wages and benefits.
- *Participated in collective bargaining processes.* Nursing Services played an important role in collective bargaining process with unions. The negotiations resulted in signing of two collective bargaining agreements in 2015 and renewed agreements again in 2018.
- *Created better alignment in the activities of nurses working in public health and communicable diseases with nurses delivering other types of services.* In 2018, public health nurses were transferred to report to the office of Chief Nursing Officer to create more consistency in nursing service delivery.

11.3. Impacts of the New Approach

Case study interviews and review of the documents and files identified a range of impacts resulting from the changes implemented by the FNHA, including:

- **Building regional capacity increased support for nurses working in the communities and improved services provided to communities.** Hiring of regional Nurse Managers and Practice Consultants in the

regions have brought services closer to the communities, making them more responsive to the needs of communities. A regional focus helped communities and health providers to focus on new areas of health that are driven by community needs. Examples included the development of new programs such as end of life and reproductive health, agility of programming, increased community engagement in implementation and ownership of services, priority setting, and easier and faster access to resources. Having capacity in the regions also have helped to create more accessible support for community nurses through regional resource teams. However, building regional capacity also increased the need for more efforts to coordinate activities across regions and ensure consistency of services, programming and sharing of knowledge and practice.

- **Nursing Services became more responsive to community needs and priorities.** During interviews, case study participants noted that Nursing Services have become more community-driven enabling the program to better address community health needs and priorities. For example, one community nurse mentioned that the reproductive health prevention program was developed and implemented in collaboration with the community and the home care nurses. They noted that the community members identified the need for the program, the community health team then worked collaboratively to develop the services and the funding was quickly made available to implement it.
- **Focus on wholistic and integrative care is expected to improve the quality of the care and health outcomes.** The new nursing service delivery model that will integrate nursing services with primary care and other services (e.g., traditional healing) will improve quality of care received by patients at nursing stations, reduce rates of hospitalization and improve health outcomes.
- **Increased nurse capacity.** More opportunities for training, mentorship and orientation have helped to improve the capacity of nurses working in the communities. Nurses interviewed as part of the case study reported being supported by the FNHA to undertake their responsibilities and new opportunities to advance their professional careers.
- **Increased access to services** through close alignment and collaboration with the provincial partners and regional health authorities. New programs and services are being developed which have increased access to areas such as maternal health, cancer care and palliative care, which is delivered by the provincial service providers.
- **Increased visibility of the nursing services within the FNHA.** The transition resulted in the creation of the Chief Nursing Officer to represent Nursing Services at the most senior level within the FNHA, which helped to increase visibility of nursing services within the FNHA. Nurses are more involved in design and delivery of the FNHA programs and are able to contribute to program and policy decisions.
- **Made Nursing Services more culturally responsive.** Training on cultural safety and humility and trauma-informed treatment have helped nurses to provide culturally responsive services.
- **Facilitated recruiting qualified nurses.** According to case study participants, extensive efforts by Human Resources, Nursing and Communication departments have helped to improve the FNHA's ability to recruit qualified nurses. At the time of the evaluation, the efforts to improve recruitment and retaining the nurses were ongoing.
- **The FNHA's nursing leadership philosophy implemented through community-driven and guided model of care have been proven to be successful.** The FNHA nursing team has strictly followed the 7 Directives

to guide their work with communities. The approach has included setting priorities based on community needs, honoring and respecting community perspectives, and being responsive to community inquiries. The team has also followed the vision for regionalization of the Nursing Services, bringing services and program decisions close to the communities. The approach has focused on respecting community-self determination while providing them with all necessary support and care to improve quality of the nursing services.

- **Focusing on client experience to determine the quality of nursing services.** The FNHA nursing team has taken efforts to improve and measure quality and safety and client experience with the services. The efforts have included development of new quality and safety standards, development and implementation of an online incident reporting tool, recruitment of Manager of Quality and Client Experience, communication with clients and regular feedbacks to measure their level of satisfaction with the services provided.
- **Flexibility and the agility of the FNHA programming.** During interviews, members of the FNHA nursing team mentioned that the organization has become agile and flexible in its approach working with nurses. It is quick to make decisions and provide help when requested.
- **Focus on cultural safety and trauma-informed services have been proven effective.** The FNHA nursing team has taken efforts to deliver training on trauma-informed treatment and support for cultural safety of the nursing services. According to staff members, the approach has made nursing services more relevant to the communities and thus has improved effectiveness of nursing. Recruitment of a Cultural Advisor for Client Experience has been critical in enhancing cultural appropriateness of the nursing services.
- **Staff, capacity, dedication and competencies have played a key role in success.** Transformative work is exciting and attracts creative people. Despite heavy workload and critical challenges, many staff members feel privileged to be involved in the transformative work and are dedicated to making a positive change. Qualification, dedication and commitment of the staff members supported by the leadership have been the key factor facilitating the critical improvements.
- **Recruitment of the Chief Nursing Officer and their involvement at the Senior Leadership Team has been critical.** The Chief Nursing Officer was able to lead the transformative change and represent the nurses at the FNHA Senior Executive Team meetings.

11.4. Gaps, Challenges and Issues

While progress has been made in many areas of Nursing Services, there are some remaining gaps, challenges and issues.

The change takes time. It will require time for the extensive efforts undertaken by the FNHA (e.g. interdisciplinary practice, wholistic approach, capacity building) to generate substantial impacts on the service quality and affect the service delivery model at the community level. Many of the changes and improvements in delivery models (e.g., interdisciplinary practices, training, support) were newly implemented with the impacts on service quality becoming apparent in the future. For example, at the time of the evaluation, the FNHA nursing team was working to create new systems that would allow the nursing stations to recruit other health care professionals, which will substantially enhance quality of the services

and support wholistic and interdisciplinary approaches. Limited access to wholistic primary care (e.g. physicians, nurse practitioners, healers) creates health complications affecting nursing care.

Evolving Nursing Service delivery model. The Nursing Service delivery model is still in the process of evolution and constant change. Regionalization of nursing services is not complete and regionalization objectives and priorities (e.g., services and operations to be delivered regionally or centrally) are not clearly defined. It will require time to find an operational model that can function well at provincial, regional and community levels. For example, hiring regional Nurse Managers and Practice Consultants has increased support for nurses working in the communities and ensured that the services better reflect community needs. However, it also increased potential for development of silos and need for a concerted effort to ensure seamless coordination of services across regions. Changes in direct reporting relationships also required the Nursing Services to improve efforts to provide professional support and ensure consistency of the services across regions.

Nursing shortages. Following the transition, nurse turnover and vacancies increased due to various reasons (e.g., change of employer, changes in unions). Since that time, the FNHA nursing team has been working diligently to improve the situation and reduce turnover and vacancies. Over the past few years, progress has been made in recruiting nursing staff. Despite this, the issues of high turnover, vacancies, use of overtime and agency nurses continue affecting the nursing program. The FNHA's ability to recruit experienced nurses is further complicated with the fact that the FNHA nursing is not represented by the same unions that represent nurses employed by the provincial health authorities. This limits the FNHA's ability to recruit nurses from provincial health authorities as nurses are more reluctant to change unions as it often results in loss of accumulated vacation and sick days.

Communities experience challenges with hiring qualified nurses and delivering effective nursing services. Some communities face serious challenges with recruiting and retaining qualified nurses. During interviews, some representatives of communities mentioned that the demand for qualified nurses are high and they often have to compete with large service providers (e.g., provincial health authorities, the FNHA) when recruiting nurses. Over the past few years, increasing number of communities have asked for the FNHA's assistance with recruitment of nurses or delivery of the nursing services. While feasible, such requests increase administrative work for the FNHA and create resource and financial challenges.

Challenge with engaging community-employed nurses. The nurses employed by communities, report directly to community leaders, primarily to Health Directors. Therefore, community hired nurses access the FNHA supports and resources by choice. The FNHA has taken innovative approaches to engage community-employed nurses, such as building partnerships, providing support, organizing nurse events and creating community of practice where nurses from the same discipline come together and discuss issues affecting them. Furthermore, the FNHA has worked with provincial partners to improve nursing practice standards to ensure minimum quality of care across communities. The nurses who are not able to meet the standards can receive support and assistance from the FNHA nursing team.

The potential of telehealth and technology has not been fully utilized in accessing specialized services. During interviews, community representatives noted that they feel the technology remains largely underutilized, particularly with respect to bringing specialized services to the communities. For example, one representative noted that having access to psychiatrists through telehealth would be very beneficial for the

community. Case study participants noted that the telehealth expansion project did not result in any significant changes at the clinical practice level.

The nursing program faces challenges with collecting and using quality data to facilitate decisions making.

Tools for data collection are not standardized and reporting remains an administrative burden for nurses. In the fall of 2019, a new online incident reporting system was implemented in all nursing stations, allowing for standardized and timely reporting and follow-up, and tracking of progress and incidents. There is a need for Nursing Services to optimize the use of data collected for decision making purposes and to better understand and track health outcomes. The provincial data collection and reporting systems are not integrated to be used in First Nation communities due to issues associated with client privacy.

Lack of organizational systems and infrastructure. As a new organization, the FNHA had to create infrastructure and organizational systems to facilitate the delivery of the nursing program. Some of the challenges mentioned by the members of the FNHA nursing team included using paper-based scheduling for nurses (instead of electronic), manual system for incidence reporting (which was recently upgraded to online) and limited use of other technological tools and equipment.

Staff burnout. During interviews, members of the FNHA nursing team reported that as much as they feel excited to be part of the dynamic team and transformative work environment, they often feel overworked which can result in staff burnout.

The complexity of the health problems faced by communities and challenges related to health outcomes are significant, which requires systemic approach, collaborative efforts, and focus on underlying causes and social determinants of health (e.g., environmental, housing, food security etc.) to actually generate positive impact on health outcomes. The issues are significant and complex, and services by the FNHA nursing team is too limited in the scope to generate significant positive impacts.

The FNHA has grown into a large organization quickly and has gone through major restructuring which carries a risk of becoming too bureaucratic and creates confusion about various roles and responsibilities. Changes, such as regionalization and restructuring, affects organizational culture and staff morale and requires time for staff to adjust to new culture, roles and responsibilities. The new positions created across regions within the Nursing Services at times gets confusing for staff. Potential for new barriers and silos in the activities is increasing which requires more efforts to coordinate services and share knowledge and resources.

11.5. Lessons Learned and Opportunities for Improvement

Nurses should be involved in all levels of planning and administering clinical care. It is important that the voices of nurses be heard and included in the discussions in all stages of the processes affecting clinical care. For example, nurses/nursing leadership needs to be a critical part of the discussions around transformation of primary care since they play an important role in delivery of primary care services.

Focus on Nursing Service delivery model evolution, until the model is created that best fits the needs of the communities and the FNHA. The model of Nursing Services is still in the process of change and improvement. It may be beneficial to assess success of the changes that have been implemented to date and

identify lessons learned that can guide the next phase of evolution. The main challenge for the FNHA is to identify an operational model that can function effectively and efficiently at the provincial, regional and community levels, while ensuring suitability of the services. More strategic approach to regionalization of the Nursing Services (i.e., services and operations to be delivered regionally and centrally) will help to improve effectiveness and efficiency of the services in the long-term.

Some of the lessons learned from Nursing Services evolution can also be applied in other areas of the FNHA operations. Since transition, the Nursing Services have gone through significant restructuring and reorganization (e.g., regionalization of some functions), and many innovative new approaches have been implemented. Identifying key learnings and incorporating them in other areas of the FNHA operations will ensure more effective transformation.

Nursing Services need more support with data and information management. The support is necessary to improve data collection, analysis and reporting, which are very critical for continuous improvement.

Focus on nurse recruitment and retention. Continue efforts is required to explore and find innovative approaches to reduce nurse turnover and vacancies and improve recruitment and retention of nurses. Reducing overtime hours and use of agency nurses will contribute to significant cost savings for the FNHA and communities.

Ensure focus on community remains a key driver of the nursing services delivered to First Nation communities. The community-driven model has been the key factor that differentiates the work of the FNHA nursing compared to activities of other health authorities. Going forward, it remains critical to ensure communities are in the center of all decision-making processes.

Expand efforts to support nurses who primarily provide services to First Nation clients in urban areas. Supporting nurses in urban areas will contribute to quality of the services that urban and away from home clients receive. The FNHA's active participation in the provincial Primary Care Network will increase a need for more extensive work with nurses who mainly provide services to First Nation clients in urban areas.

Support greater utilization of the telehealth to improve access to specialized services. Efforts should be undertaken to utilize full potential of the telehealth services. This will require collaboration across nursing, IMIT, regions, communities, and others to enhance alignment of clinical practice and available technology, to contribute to greater utilization of the telehealth assets.

12. Emergency Planning and Response

The purpose of health emergency management programming is to ensure that the health system maintains a state of readiness to respond to and recover from operational disruptions or disaster events. In British Columbia, Emergency Management BC (EMBC) provides provincial leadership to emergency management and disaster response and Health Emergency Management BC (HEMBC), leads all health emergency response efforts with the province and provides emergency management leadership and support to the BC health system, including regional health authorities, the FNHA, Provincial Health Services Authority and the MoH.

The FNHA has been part of the provincial health emergency management system and has fulfilled a role of assisting communities and health system partners to respond to crisis/disaster events ranging from public health emergencies (e.g. potential communicable disease outbreaks) to natural disasters (e.g. wildfire and flooding emergencies). This role can include supporting the coordination of activities and services, working to resolve barriers and issues, providing financial support, and acting as a trusted source of information. The FNHA's health emergency management objectives include:

- Ensuring that communities are effectively linked within the provincial emergency response structure and receive support for emergency preparedness and management at a level equivalent to non-First Nations.
- Ensure an effective FNHA response during the response and recovery stages of an emergency.

During emergencies, the FNHA works in partnership with numerous agencies at the local, provincial and federal levels, to ensure that First Nations communities are effectively incorporated into emergency preparedness, prevention, response and recovery activities. These partnerships are essential to the FNHA and the communities they support. The FNHA coordinates events and activities with HEMBC, EMBC and the regional health authorities.

12.1. The FNHA Involvement in Emergency Response

As part of transfer, the FNHA inherited no emergency management structure and very limited emergency response programming. Prior to transition, emergency response work delivered in First Nations communities involved multiple jurisdictions and lacked proper resourcing and coordination. Prior to transition, as a requirement of the federal *Emergency Management Act*, the emergency response in First Nations communities fell under the jurisdictions of both Indigenous and Northern Affairs Canada⁸ and FNIHB. Indigenous and Northern Affairs Canada took the main role in delivering emergency management support, which included prevention and mitigation, preparedness, response and recovery. In BC, Indigenous and Northern Affairs Canada funded the First Nations' Emergency Services Society to support First Nations in

⁸ On April 1, 2017, Indigenous and Northern Affairs Canada signed an agreement with the provincial government and Emergency Management BC (EMBC) assumed responsibility for the delivery of the emergency management support to First Nations in BC. The agreement is to run for 10 year period, during which the province will receive \$30 million to provide emergency management services such as mitigation, preparedness, response and recovery programming on-reserve.

preparing for emergencies by providing training and developing emergency plans. FNIHB's role was limited to providing support and health care services for health-related emergencies such as disease outbreaks and mental health crises. Specifically, FNIHB worked with First Nations to create plans to prepare for potential pandemics. FNIHB also employed a Manager of Environmental Health and several regional Environmental Health Officers who supported communities with environmental health issues (e.g., drinking water safety, food safety, healthy housing, wastewater, solid food disposal, facilities inspections, communicable disease control, risk assessment) some of which were related to emergencies. According to case study participants, FNIHB's work often lacked resources and proper coordination while providing limited representation at the provincial and national emergency tables. Furthermore, the services provided in the past were not community-driven and neither FNIHB nor Indigenous and Northern Affairs Canada had proper mechanisms to learn about and communicate community needs and prepare strategies to address them. This 'top-down' approach often did not serve community priorities in emergency situations.

First Nations requested the FNHA involvement in environmental emergencies as early as 2014 as part of the Mount Polley mine disaster. In 2014, First Nations communities requested that the FNHA support communities and communicate their voices as part of the Mount Polley mine disaster. When the Mount Polley copper and gold mine tailings pond collapsed, releasing mining waste-contaminated water into Polley Lake, the initial reaction from the provincial government was that the disaster did not create significant public health concerns. At the request of the First Nations, the FNHA worked in partnership with the First Nations affected by the disaster and helped to communicate their perspectives about such matters as impact on traditional food supply.

A need for greater involvement became evident in 2017 when wildfires impacted First Nations communities in the BC interior and the services provided did not meet First Nations needs. The wildfires demonstrated a strong need for a coordinated emergency response to First Nations communities. British Columbians experienced unprecedented impacts from the 2017 flood and wildfire season. The events were among the worst in the province's history, prompting a 10-week provincial state of emergency. More than 65,000 residents were displaced, with flood response costs estimated at more than \$73 million and direct fire suppression costs estimated at more than \$568 million. The impact on First Nations was particularly harsh and disproportionate. More than half of the First Nations in the Interior Region were either evacuated or put on alert. When the wildfires started, the FNHA expected the province and/or Indigenous and Northern Affairs Canada to take the lead role in responding to the emergency and delivering services. However, the responsibility for the delivery of the emergency management services in First Nation communities were only recently transferred from Indigenous and Northern Affairs Canada to EMBC and the provincial government did not have a chance to develop capacity to serve First Nation communities in adequate level. Therefore, soon it became necessary for the FNHA to take more proactive role due to the following reasons:

- *A communication gap between the province and communities was evident.* The province did not know with whom and how to communicate and communities did not get timely communication and regular updates on the emergency situation. For example, while an agreement between Indigenous and Northern Affairs Canada and the province authorizes the Chief and Council to oversee alerts and evacuations, the provincial response system did not have information, knowledge and capacity to respect and uphold the governance rights of Chiefs and Councils to issue alerts and orders. This led to miscommunications and misunderstandings between the province and the communities (e.g., late or premature evacuations, not communicating when evacuation orders were lifted, hostile communications). Provincial evacuation processes did not adequately meet First Nations challenges and First Nations were not aware of the evacuation protocols and procedures.
- *The provincial emergency management had limited knowledge and capacity to support communities*

during the emergencies. At the time of 2017 wildfires, as newly assigned area of responsibility, key staff members at the EMBC did not have a chance to learn and gain adequate knowledge of the communities that they were to serve. They were not provided sufficient information about the community names, locations, housing and infrastructure and emergency contacts.

- *There were many gaps in the quality and adequacy of the services delivered to First Nations clients.* Emergency Social Service programming provided to First Nations evacuees mostly lacked culturally safe approaches. As a result, the processes reflected similar experiences to the residential schools (e.g., large public buildings like high school gyms with many beds next to each other, requirement for registration with two pieces of ID, email, and online banking information). Displacement from communities and temporary shelters in urban environments lacked cultural safety. Most staff members serving clients were of a non-Indigenous background and further traumatizing clients (in particular the elderly and sick) as they were not trained in providing culturally appropriate work. Many community members with chronic and life-threatening conditions arrived at evacuation centres without care plans or medications. They often were afraid or embarrassed to ask for help from health authority care teams, and meal vouchers were not enough to help them maintain a healthy diet and did not include access to traditional meals.

Given the circumstances, the FNHA played a critical role in bridging the communication gaps and unmet needs between the province and the residents of the communities affected by the wildfires. In particular, the FNHA's role involved:

- *Bridging the communication gap between the communities and provincial authorities in charge of emergency (i.e., EMBC, BC Wildfire Service and MoH) management (e.g., providing regular information and guidance on air quality and indoor and outdoor instructions and information, providing other evacuation information and instructions).* Due to existing relationships and trust, the FNHA regional office became the key point of contact for most communities. For example, during the first ten days of the 2017 wildfire emergency, the FNHA regional office in the Interior Region received over 3,200 emails, many of which came from community members seeking assistance.
- *Ensuring the services were culturally safe and met First Nations' needs and priorities and coordinating a delivery of emotional, spiritual, traditional, and mental health and wellness supports.* The FNHA assigned culturally competent staff members to the regions and made resources available 24/7 per week facilitating access to services, organizing and delivering new services or products, and coordinating activities. The FNHA deployed both internal and contracted counsellors and traditional wellness supports (e.g., traditional healers, ceremonies) for First Nations at reception centres. Case study participants spoke of activities related directly to assisting clients at emergency shelters with their individual needs (e.g., obtaining identification cards, finding relatives, providing access to online banking); distributing gas cards, meal vouchers, laundry vouchers, personal hygiene materials and clothing to those who had to be evacuated; distributing air filters to those under evacuation alert; addressing language barriers; organizing traditional and mental wellness activities; serving traditional foods; and organizing funerals and/or ceremonies for those who died at the evacuation shelters.
- *Identifying key service gaps and advocating for service providers to deliver appropriate services (e.g., mental health support, crisis support, emergency air filters, food, shelter), covering the gaps in emergency response funding from internal resources and helping clients to navigate the system to access the services.* The FNHA was quick to allocate funding and instruct staff members to address key service gaps.
- *Coordinating the activities (e.g., creating and attending interagency meetings) of key service delivery partners (e.g., EMBC, First Nation Emergency Services Society and service delivery organizations, Red Cross) and advocating on behalf of communities to ensure that adequate support is provided and that provincial service delivery organizations perform their roles and responsibilities.*

- *Providing recovery support once the emergency was over.* The FNHA coordinated the re-entry of the evacuees back to their communities and delivered health and wellness support to assist community well-being. The range of services supported included safety inspections, damage assessments, insurance, ongoing air quality issues from smoke, mental wellness services (including trauma and services for children) and health benefit information. Funding was also provided for community events to strengthen community ties and provide additional comfort.

After the wildfires, the FNHA created an internal Emergency Command Structure and emergency response policies and procedures. In December 2017, a project was initiated to assess the effectiveness of the FNHA's existing structure to respond to emergencies and provide recommendations for improvement. The results of the review demonstrated that as the FNHA inherited no emergency response structure, the response capacity was limited, that decisions were not supported sufficiently, that the FNHA's emergency response portfolio lacked dedicated leadership, and that the FNHA lacked a formalized Emergency Response Structure.

Consequently, in 2018, the FNHA created the Emergency Response Structure Project Working Group and initiated a project called the Emergency Response Structure Implementation Project. The goal of the project was to develop efficient and effective the FNHA Emergency Response Command Structure, engage staff across the organization who play a role in the FNHA emergency response, and develop and advance an Implementation Plan to respond to emergencies. As part of the project, the FNHA undertook an extensive range of activities to improve health emergency preparedness for the organization and to create an emergency governance structure. These actions are summarized as follows:

- *Created a Director of Emergency Management* (one full-time equivalent position) in charge of the emergency management portfolio (planning emergency management activities and representing First Nations' perspectives at provincial tables) and reporting directly to the Chief Operating Officer.
- *Created regional Crisis Response Manager (Coordinator)* positions in three regions (Vancouver Island, Northern and Interior) to provide oversight for emergency response activities in the regions. The FNHA staff members in these positions liaise between communities and provincial emergency management services to make sure the services provided align well with community needs and priorities, participate in the activities of the provincial emergency operations centres, gather information from partners involved in emergency response and communicate this information to communities and individuals, provide them with information and guidance on air quality and indoor and outdoor instructions and information, and provide evacuation information and support to communities when needed.
- *Developed an Operational Guide detailing the FNHA's Health Emergency Operations Centre (Health EOC).* The Guide details the FNHA's Health EOC structure as well as the mechanism to activate it and identifies the key responsibilities within the structure. The Guide will later be transitioned into the FNHA Emergency Response Framework and will be reviewed at regular intervals with teams to ensure accurate descriptions of respective roles and responsibilities. The Guide provides a decision-making pathway and instructions to coordinate activities at the time of the emergencies and the role of the FNHA within provincial emergency operations. At the time of this evaluation, the Guide was in the final stage of development.
- *Created the Emergency Response Operational Work Plan*, which provides a detailed plan of action to operationalize the emergency management structure. A select group of key stakeholders will need to become subject matter experts (trainer level) and be empowered to make decisions.
- *Prepared the FNHA Health EOC Toolkit* to support effective implementation of the FNHA's Health EOC. The range of resources included in the toolkit includes an emergency contact list, FNHA situation reports, the Health EOC Action Plan, communication tools (BigHouse/Gathering Space, Common Operating Picture, Event Status), logistics management (tracking, finance), human resources (scheduling, staff

check-in protocol, occupational health and safety resources, wellness kits/plans), an emergency management portal, alert notification implementation, and an evacuation planning template and processes.

As part of the Emergency Response Structure Implementation Project, the FNHA also prepared the FNHA Emergency Response Training Plan and is in the process of delivering a range of training and skills-building opportunities for staff members who will be involved in emergency response. The following table provides a list of training and skills building opportunities planned to be delivered for the FNHA staff members in 2019, grouped into three major phases of the emergency response, including:

- *Phase I – Introduction to Emergency Management* training is delivered to all staff members (including front line and senior management) who are involved (even as back-ups) in the FNHA emergency response. These training programs include online sessions, in-person workshops and discussions.
- *Phase II - Specialized Emergency Operations Centre (EOC) Training* involves in-person workshops and a training session for key FNHA staff members. The training helps the staff to understand their roles and responsibilities within EOC functions, key internal and external interactions, communications, the EOC activation process, EOC staffing considerations, tools and processes, etc.
- *Phase III - Table Top Exercises*, which include discussion-based sessions where team members meet in an informal, classroom setting to discuss their roles during an emergency and their responses to a particular emergency situation.

At the time of this evaluation, the FNHA was in the process of implementing the training plan. For example, Phase 1 Online Training launched in May 2019 and already had over 90 staff members registered to participate.

Type of Training	Description	Target Participants
PHASE 1 Training		
Online Training (3 Courses) (17 Hours Total)	1. EMRG-1100: Introduction to Emergency Management in Canada (7 Hours) 2. EMRG-1200: Incident Command System Level 100 (7 Hours) 3. EMRG-1600*: Introduction to Emergency Social Services (3 Hours) <i>*Optional</i>	Regional and central FNHA managers and staff who are tasked with working (even as back-up) in a regional or central FNHA EOC or working with external partners in the emergency management arena. SET members can choose if they wish to take the online training.
BCEM Orientation (1-3 Hour Information Session)	Tailored orientation course provided by EMBC that emphasizes learning modules for Emergency Management Programs. (1-3 hours)	Staff across the organization who are part of the FNHA’s emergency response activities.
Guided Dialogue	Guided discussion regarding FNHA Health EOC structure and on team respective roles and responsibilities.	FNHA teams across the organization.
ESET Work Shop (3 Hours)	An orientation workshop on EOC Essentials and roles and responsibilities delivered to the ESET by JIBC.	Extended SET members
FNHA Board Work Shop	An orientation workshop on EOC Essentials and roles and responsibilities delivered to the FNHA Board by JIBC.	Board Members and FNHA Executive representatives (CEO and COO)
PHASE 2 Training		
EOC Essentials Classroom Training (2 days)	EMRG-1320: EOC Essentials. Details roles and responsibilities of the primary EOC functions, key internal and external interactions, communications, EOC activation process, EOC staffing considerations, tools and processes, EOC action planning process, effective worker care, and demobilization of the EOC. (Tailored to FNHA – 2 days)	Regional Exec. Director; Directors of Engagement (regional), Program Managers; Corporate Services; Communications; & admin support staff.

Type of Training	Description	Target Participants
Intro to EOC (Classroom) (1 day) (max 24 people)	EMRG-1300: EOC Essentials (tailored to FNHA – 1 day)	Staff across the organization who are part of FNHA emergency response activities.
PHASE 3 Training		
Internal Table Top Exercise	Internal Table Top Exercise at central FNHA for those who support the central FNHA EOC	SET, departmental managers and other staff
Table Top Exercises in all five FNHA regions	Table Top Exercises in all five FNHA regions for those who support the regional EOC (it is anticipated that not all regions may focus on an exercise within their regions at this time)	regional managers and staff

The FNHA was more prepared when First Nations communities were affected by 2018 wildfires. During interviews, FNHA staff members involved in emergency support during 2018 wildfires noted that they either were involved or directly administered the following activities:

- *Supporting activities at a larger scale.* Five evacuation centres were set up in the Northern Region and the FNHA was involved in the activities of these centres. The FNHA assigned over 50 staff members across the organization (some flown to the region) to assist with the efforts. Sufficient administrative support and staff time was allocated to coordinate activities and avoid staff burnout.
- *Coordinating activities between different service providers* by attending inter-agency meetings (First Nations service delivery organizations, documenting information about evacuees)
- *Supporting people at the time of disaster* (e.g., opening bank accounts, obtaining status cards, checking emails, accessing food and shelter, addressing language barriers at evacuation centres, serving traditional food, supporting cultural and wellness activities, distributing gas and laundry vouchers, access to medical prescriptions)
- *Delivering support services* (e.g., nursing, access to medication, and other health services) and delivering traditional wellness and cultural support activities (e.g., establishing traditional wellness centres at evacuation centres)
- *Communicating messages between the provincial authorities and communities* (e.g., daily calls, email updates, situational awareness reports, information dissemination to communities, and emergency event debriefs)
- *Providing follow-up care* after the residents returned to the communities.

Undertook extensive efforts to ensure the services provided by the provincial emergency response partners were able to meet the needs of First Nation communities and individuals. Using the lessons learned from the 2017 wildfires, the FNHA has taken a number of steps to ensure that the emergency response services provided by the provincial partners can address the needs of First Nations clients and communities. For example:

- *Participated in the development of the Provincial Disaster Recovery Framework* to ensure that integrated disaster recovery efforts by the province reflected First Nations perspectives and needs.
- *Participated in provincial efforts to modernize the Emergency Program Act, BC’s primary legislation for managing emergencies.* Modernized *Emergency Program Act* is expected to support First Nations as partners in the governance and operations of emergency management in BC.
- *Engaged with EMBC to ensure their services can address the needs of First Nations communities and clients.* In May 2019, the FNHA and EMBC signed a Letter of Understanding to clarify roles and responsibilities and coordinate operational activities in responding to emergencies in First Nations communities. It was to define and promote a positive and cooperative working relationship between the

FNHA and EMBC at the service planning and operational levels. As part of the Letter of Understanding, the FNHA and EMBC agreed on a number of mutual commitments, including:

- Embedding cultural safety and humility in emergency management operations in BC by signing a Declaration of Commitment to cultural safety and humility and sharing information and progress on this commitment each year.
- Improving and streamlining communications and engagement between EMBC and the FNHA and with First Nations, particularly in preparation for and during emergency response.
- Sharing information and collaborating on responding to First Nations' training needs and integrating training materials, including participating in training exercises together to improve collective preparedness.
- Working together to incorporate First Nations perspectives into provincial emergency management legislation, strategies, policies and actions.
- Developing joint planning, monitoring and reporting mechanisms to measure progress towards the goals.

Once implemented, these requirements are expected to have considerable impact on the quality and adequacy of the emergency response services that First Nations communities receive from the provincial government.

12.2. Impacts of the FNHA Emergency Response Efforts

Interviews with case study participants combined with the findings from the document and file review identified a number of positive and negative impacts of the FNHA emergency response efforts. In terms of positive impacts, it was identified that the FNHA activities:

- **Ensured hundreds of First Nations clients received proper emergency support** (e.g., food, shelter, mental health) at the time when they needed the support the most. These services helped to support their health and well-being, contributing to improved health outcomes.
- **Helped to build the FNHA capacity and preparedness to address emergency response in future.** Throughout the process, the FNHA grew its capacity in emergency response, developed emergency response planning, and built relationships with provincial and non-profit emergency service providers. These activities have helped the organization to improve its emergency preparedness to address similar emergency situations in the future.
- **Increased the reputation of the FNHA as a First Nations organization that can adequately support the interests of the First Nations at the time of the emergencies.** According to case study participants, the FNHA's willingness to go above and beyond its mandate and support the First Nations at the time of disasters was an unprecedented example of dedication to those affected by the events. This was a role model for government agencies and First Nations organizations and helped to build the positive reputation of the FNHA.

In terms of negative impacts, it was identified that:

- **The FNHA took resources away from other areas of programming** to address emergency situations, which may have affected the quality of the services in other areas. As the organization had no dedicated resources for emergency management, and limited partnership with provincial emergency services (to coordinate activities and obtain resources), resources had to be drawn from other areas of operations.
- **The disaster in 2017 and 2018 made many First Nations to feel abandoned as they did not receive timely and appropriate support and assistance.** Systemic impact of the disproportionate experiences of the wildfire season on First Nations communities and a lack of cohesive regional and provincial level support resulted in displacement, evacuation and living at evacuation centres, which have created

further trauma for some clients, particularly for elderly and sick who have experienced the residential school system.

12.3. Gaps, Challenges and Issues

Funding constraints to support emergency management activities. The FNHA lacks a funded mandate to undertake emergency response work. It often has to take funds from other areas of operations to fund emergency management. Most of the emergency preparedness work is undertaken by existing staff members, increasing the workload for those who are already overwhelmed with their responsibilities. It is difficult to take staff members' time away from their day-to-day responsibilities to participate in emergency preparedness work.

Resource challenges at the time of emergencies. Despite significant success in supporting communities and clients at the time of the wildfires, the FNHA encountered staffing shortages and resource challenges. In particular, during the 2017 wildfires, the Interior region experienced challenges with allocating sufficient mental wellness resources. The situation was further challenged due to staff burnout and lack of clarity with regards to staff roles and responsibilities during emergencies. For example, the Mental Wellness Advisor resigned at the time when wildfires were continuing.

Lack of clarity with regards to the FNHA's role and responsibilities for disaster and emergency response. The FNHA did not have a proper strategy/structure that outlined its mandate and clarified its operational roles and responsibilities for emergency management and preparedness. Within the organizational structure, at the time of emergencies, often the decisions were made at last minute or rushed and staff members were assigned to tasks without advance planning or proper training resulting in confusion and lack of proper coordination. At the time of this evaluation, the FNHA was in the process of creating structures and putting together processes to clarify its role and responsibilities with regards to emergency management. The effort also included addressing the internal structure of response and providing training and clarifying roles and responsibilities of staff members during emergencies.

As the FNHA did not inherit emergency management structures from FNIHB, it required extensive efforts and additional resources to build a command structure from scratch. During interviews, case study participants noted that the FNHA's unique organizational structure required a new system to be designed to address its specific emergency management needs. The task required extensive review of the existing roles and responsibilities within the organization, assessment of similar emergency management services delivered by other partners and the creation of a structure that would work for the FNHA. Changing roles had to be agreed upon with key staff members within the organization, which required additional time.

Provincial emergency management policies do not acknowledge specific needs of the First Nations, and provincial staff often lack training and capacity to deliver culturally safe services and engagement during emergencies. Despite some progress that has been achieved by the FNHA in coordinating activities with the provincial emergency management organizations, more work needs to be done to ensure that the provincial health services can address the specific needs of the First Nations clients and communities. The FNHA often lacks staff time and resources to adequately represent and advance First Nations interests at the provincial emergency management tables. It is important to have a strong First Nations voice to ensure that they receive adequate services in future emergencies.

Communication failures affected the success of the coordination activities. For example, in Williams Lake, the emergency officials did not notify the FNHA and the Interior Health Authority in advance regarding the timing of when the evacuation order was lifted. The FNHA received the notification only when it was announced to the public, which did not give enough time for the organization to do preparation work.

Increased intensity and frequency of the natural disasters requires focus on preparedness and planning. Over the past two decades, the consequences of climate change on BC have become much more apparent. The unprecedented impacts of 2017 and 2018 disasters demonstrated a strong need for proper planning and preparedness to address consequences of raising frequency and severity of natural disasters (e.g., related to heat, drought, lightning and intense rains, snow melt).

First Nation communities are disproportionately affected by the natural disasters. The First Nation communities are disproportionately affected by natural disasters and environmental emergencies due to a range of reasons, such as those associated with their locations, and the consequences of colonialism (e.g., systemic racism during evacuations). In addition, First Nations have deeper connectedness and relationship with the land and natural resources, thus the changes in environmental conditions may affect them differently compared to other residents of BC.

12.4. Lessons Learned and Opportunities for Improvement

The FNHA's focus on putting client needs as a top priority at the time of the 2017 and 2018 natural disasters contributed to success of the emergency management efforts. The FNHA went above and beyond the accepted mandate and responsibilities at the time of the disasters. During interviews, case study participants noted that the FNHA demonstrated a great degree of agility and flexibility in its work during the disasters in 2017 and 2018. It was able to respond when the population that it serves was in need, conduct a quick assessment of the situation, allocate resources, and undertake extensive measures to address the gaps and bridge communication challenges. The FNHA staff responded to the emergency by showing commitment, ingenuity and hard work. As a result, the FNHA was able to respond more effectively and efficiently compared to responses from other emergency agencies. Nevertheless, case study participants also noted that going forward, the FNHA needs to coordinate its emergency management activities with partners closely, to ensure that partners can deliver on their roles and responsibilities and the FNHA does not have to undertake programming that goes beyond its mandate.

Having support from the most senior level and hiring qualified staff members who have adequate understanding of health emergency management work was critical. As the need for the emergency response work was evident, the FNHA senior team dedicated their own time, allocated resources and provided all necessary support and guidance for the development of the structure. The staff members hired to lead the emergency management work had necessary qualifications and skills, which facilitated the process.

The FNHA regional presence and connections to communities contributed to the success of the FNHA efforts during 2017 and 2018 emergencies. The members of the FNHA regional team already had established close relationships with the communities, which played a vital role bridging the communication gap with provincial partners.

The approach of “With Us, Not for Us” and cultural awareness and sensitivity should be a key part of the all emergency response efforts. First Nations communities should become partners in emergency management by being involved in all levels of planning, decision-making and implementation.

Traditional wellness activities and traditional food should be made available at the time of similar emergencies as it supports building community and client strength and resilience during difficult times.

It is important to plan for emergencies and increase preparedness during non-emergency times. However, it is always a challenge to bring emergency management to the attention of authorities until an emergency happens.

The FNHA should finalize the creation of the Emergency Command Structure to clarify its mandate, governance model and approach to emergency management and create systems to strategically and operationally address all areas of health emergency management that falls within its mandate. The establishment and implementation of a FNHA emergency response structure will ensure that the FNHA has an internal pathway for efficient and effective decision-making, mobilizing services and supports during times of emergency response. It will provide the escalation pathway, promote accountability, and ensure that responsibilities are clearly understood through the different levels of emergency response. Key members of the FNHA staff need to receive training and communication on how the FNHA Emergency Response Structure will work when activated and the tools, resources and work practices to be followed. All FNHA teams engaged in emergency response activities need to have proper instructions on what activities and events will be activated within their teams when an emergency is declared. These instructions and guidance need to be readily available for all staff engaged in emergency response activities.

Strengthen coordination and collaboration efforts with the provincial and federal partners in delivering emergency management programming. In particular, the FNHA in collaboration with provincial partners, should:

- *Balance growing expectations with availability of the resources and its mandate.* Although the efforts by the FNHA to intervene at the time of the emergency were necessary, they create a challenge for the organization in the future. As the expectations of the organization are growing, there is an increasing risk of being continuously involved in activities that go far beyond its health care mandate.
- *Clarify and communicate its mandate with regards to emergency management* and work with provincial and federal partners to ensure that the partners are aware of the FNHA’s mandate and can deliver on their own responsibilities. Coordinating activities closely and keeping the lines of communication open will be critical in this process.
- *Continue and strengthen its role as a strong point of connection between communities and service delivery partners* and represent interests of First Nations in the provincial decision-making process. There is a keen interest from the provincial government in working with the FNHA to improve their emergency response programming. There is a need to establish a strong presence for the FNHA at the HEMBC tables to ensure that First Nations interests are adequately represented. As part of these efforts, the FNHA should enhance its advocacy and coordination efforts to bridge the gaps between communities and service delivery organizations and improve accessibility and quality of the services that the communities are getting.
- *Facilitate working partnerships between First Nations communities and provincial emergency response partners to build community emergency management capacity.* There is a need to ensure provincial

partners allocate additional time, efforts and resources to fulfill their roles with regards to First Nations communities. For example, building emergency response capacity and preparedness (including health emergency management) for First Nations communities fall under the provincial mandate. There is the need to work with the provincial government to ensure they can support communities and that their capacity to address emergencies are at the same level as municipalities and regional districts. This can be achieved through close coordination, intensive work and additional resources. As part of this work, it is necessary to help communities to develop emergency response plans, toolkits and resources, emergency communications materials and systems to appropriately exercise leadership responsibilities and authorities at the time of disasters.

- *Collaborate and partner with representatives of provincial government to develop evacuation systems that are aligned with the needs of the rural First Nations communities and individuals.* The experience of the 2017 wildfires demonstrated that evacuations are particularly hard on First Nations who live in rural and remote communities. The institutional style of evacuations and service delivery creates many challenges for community members who often struggle to adjust to urban reception centres. Therefore, there is a need to develop evacuation services that can address the unique needs of remote and rural First Nations. Best practices identified by the case study interviewees included evacuating remote and rural First Nations to neighboring First Nations communities (instead of urban areas), allocating campgrounds to extended families to stay together to avoid family separation, and focusing on keeping elderly, families and other community members together.
- *Continue working with provincial partners to affect provincial emergency management policies, and legislative frameworks (e.g., Emergency Program Act) to reflect First Nations perspectives.* Many of the provincial policies, acts, and legislations are outdated and do not reflect interests and perspectives of First Nations to an adequate level.

Develop strategies to maintain access to primary care services during emergencies. At the time of the evacuations, many community members arrive to evacuation centres without a care plan or medication. To address these issues, the FNHA should help the communities to develop Health Emergency Management Plans as part of their overall Emergency Response Plans. The plans should include a list of clients who need extra care (e.g., chronic care clients), outline how such clients will be supported at the time of the emergencies, and identify roles for existing community health teams in implementing the plan when needed.

Develop strategies to deliver sufficient mental wellness support at the time of a disaster. At the time of the wildfires, the FNHA mental wellness support team (internal and external counsellors) and cultural and traditional wellness activities played a critical role in supporting community well-being. However, challenges were encountered because the amount of services deployed was insufficient to meet the needs on the ground. It is necessary for the FNHA to determine the standards for providing mental wellness support during evacuations and emergencies and apply them consistently in similar situations in the future.

Work with emergency management organization to streamline registrations at the time of the evacuations. Registration is necessary to receive food and services and is undertaken by provincial emergency management organizations. During the wildfires many clients suffered because registration requirements were extensive (e.g., need to register several times and the requirement for an extensive list of information during the time of the registration such as IDs, emails).

It is necessary to allocate proper/dedicated funding and resources to the FNHA's emergency management programming. According to case study participants, the FNHA needs to allocate pre-defined budget for the operations necessary to build emergency preparedness and capacity. The funding for emergency response

and recovery efforts can be obtained from federal (Indigenous Services Canada) and provincial sources (EMBC or HEMBC) based on cost recovery.

13. New Funding and Funding Relationships

Funding shortages have been one of the critical challenges faced by First Nations. The FNHA has undertaken extensive efforts to leverage additional sources of funding from provincial and federal sources and use innovative approaches (e.g. regional envelopes) to distribute the funds to incentivize governance and partnership, address the most pressing needs and eliminate competition for funding. The FNHA has also been working to transform the funding agreements system by adjusting funding, restructuring staffing, improving community planning (e.g. development of a health and wellness planning toolkit), establishing community development teams, and revising funding arrangement templates, including streamlining reporting requirements.

13.1. Funding Prior to the Transfer

Prior to the transfer of services in 2013, FNIHB designed, managed, and delivered First Nations health programming in BC. Many population health programs were delivered by the communities under contribution agreements with FNIHB. In addition, some communities had transferred nursing services while in others, FNIHB continued to employ nurses and delivered nursing services directly.

FNIHB had signed 140 Contribution Agreements with First Nations health service providers to deliver health programs across First Nations communities. The health programs were organized and reported on by activity, sub-activity and sub-sub activity. At the activity level the programs were divided into:

- Primary health care, which included the sub-activities on health promotion and disease prevention, public health protection and primary care. Under each sub-activities there were specific sub-sub-activities and health programs/services. For example, clinical and client care and home and community care fell under primary care.
- Health infrastructure support, which included health system capacity and health system transformation.
- Supplementary health benefits, which included NIHB.

Funds were allocated under three types of agreements: Set, Flexible and Block Funding. The funding models varied in:

- The type of plan required.
- Program management and administration (transferred/non-transferred communities).
- Flexibility to move funding within and among Program Authorities.
- Ability to use a surplus and/or to carry forward unspent funds from one fiscal year to the next.
- Duration of the contribution agreement.
- Financial and activity reporting requirements.

The following table describes each funding model:

Type of Funding Model	Description of Funding Model
Flexible Funding Model	Recipients must establish a Multi-Year Work Plan, including a health management structure. Recipients have the flexibility to reallocate funds within the same Program Authority and are allowed to carry forward program funding (with written approval from the Minister) for reinvestment in the following fiscal year within the same Program Authority. Annual reports, including year-end audit reports, are mandatory. Duration of the agreements is two (2) to five (5) years.
Set Funding Model	FNIHB designs the programs. Recipients are able to redirect resources within the same sub-sub activity (with the written approval of the Minister). Interim and year-end reports are required. Duration of the agreements is up to three (3) years.
Block Funding Model	Recipients determine their health priorities, prepare a Health Plan (HP) accordingly, and establish their health management structure. Recipients are able to reallocate funds across all authorities and are allowed to retain surpluses for reinvestment in priorities (listed in the approved HP). Annual reports and year-end audit reports are mandatory as well as an evaluation report every five (5) years. Duration of agreements is five (5) to ten (10) years

The following are reporting requirements associated with FNIHB Contribution Agreements in 2012/13 for each type of funding provided.

FNIHB Reporting Requirements

Type of Reports	Funding
Financial Reporting – Annual Audit report	All levels of funding
Program Reporting – Annual (Community-based reporting template)	All levels of funding
Financial Interim Report (Apr-Sep due Nov 15 th)	Set Funding/Indian Residential Schools Resolution Health Support Program
Two financial interim reports (Oct 15 th and Jan 15 th)	First Nations Health Benefit Program
Two Interim Program Activity Reports (Oct 15 th and Jan 15 th)	First Nations Health Benefit Program
Four Program Activity Reports (quarterly)	Indian Residential Schools Resolution Health Support Program

In addition to funding provided by FNIHB, the communities were also able to obtain funding from other sources or invest their own resources to deliver health care services. However, according to case study participants, with exception of a few communities with higher capacity (which could leverage resources from other sources), prior to the transition, FNIHB’s funding was the main source of monies to deliver health care programming. Ongoing shortage of funding and competition for resources were key factors affecting health care delivery for First Nation communities.

Key informants interviewed noted the following challenges regarding the funding relationship with FNIHB:

- Significant reporting burden under different agreements.

- Focus on financial accountability. As an organization reporting to the Crown, financial accountability (rather than shared approach and commitment to quality of services and programming based on community needs) was a key priority for FNIHB.
- A more directive relationship rather than one built on partnership. FNIHB designed and managed programs that communities then implemented. There was some but not enough communication and engagement with the communities, leaving them without a voice in designing the programs and allocating resources.
- Rigid funding arrangements that were difficult to adapt to community needs and priorities.
- Communities were required to submit proposals in response to a request for proposal and compete for funding for small projects. This resulted in the unequal distribution of funding across communities since those that had more capacity were more successful in writing proposals. Some programs (e.g. Maternal Child Health and Fetal Alcohol Spectrum Disorder) were not resourced adequately when established, to provide services in all communities.

13.2. New Funding and Funding Models

The FNHA was able to leverage significant amounts of new funding from provincial and federal sources and distribute the funds through new allocation mechanisms. The new approaches to funding distribution have helped to increase collaboration, reduce competition for resources and address most pressing health needs by supporting innovative projects and initiatives.

Funding shortages were one of the key challenges affecting First Nations health care delivery prior to the transition. At the time of the tripartite negotiations, one of the major issues expressed by First Nations was a concern that by transferring the responsibilities of health programming, the federal government will abandon its fiduciary duty of supporting First Nation health. Based on the experience of the past, First Nations were concerned that the federal government would transfer responsibilities to the FNHA without adequate funding and resources. To address these concerns, transfer of administrative responsibilities (as opposed to fiduciary duty) were key part of the tripartite negotiation processes. Furthermore, through extensive negotiations, Canada Funding Agreement included an Annual Escalator of 5.5%. Finally, the Canada Funding Agreement included a commitment that the FNHA will continue to receive new monies that the FNIHB-BC Region would have received in the absence of the FNHA.

The FNHA also worked to develop new programs and services and leverage additional funding from different sources that were not available for First Nations prior to the transition. The following table provides the amount of new funds that the FNHA has leveraged from different sources over the six-year period, since the transfer. From 2013/14 to 2018/19, the FNHA has leveraged a total \$257.6 million new funds from different sources, which accounted for 9.3% of all the FNHA's gross revenues. These funds are attributed to the creation of the FNHA as they would not have been available for FNIHB-BC Region.

New Funding Leveraged by the FNHA from 2013/14 to 2018/2019

Source of Revenue	Amount	Percent
New sources of funding leveraged by the FNHA ⁹	\$257,623,076	9.3%
Continuing or customary funding	\$2,502,440,002	90.7%
Total Revenue	\$2,760,063,078	100%

Source FNHA Finance Department

The sources of new funds leveraged by the FNHA were primarily from the provincial government, although other sources included other national and provincial health organizations and research organizations. The new funds leveraged by the FNHA have increased its revenues significantly. As demonstrated in the following table, over the most recent four-year period, FNHA's gross revenues have increased 40% from \$429.6 million in 2014/15 to \$599.6 million in 2018/19.

FNHA Revenues and Expenses, 2013/14 to 2018/2019 (,000)

FY	2013/14 ¹⁰	2014/15	2015/16	2016/17	2017/18	2018/19
Revenues						
Health Canada	\$248,781	\$ 413,771	\$433,603	\$465,354	\$498,655	\$532,737
Province of BC	\$8,545	\$12,353	\$15,576	\$17,669	\$25,256	\$60,351
Interest and Miscellaneous Income	\$1,619	\$2,325	\$2,915	\$3,263	\$5,178	\$5868
Health Authorities	\$458	\$660	\$707	\$795	\$812	\$661
First Nations Information Governance Centre	\$6	\$491	\$665	\$812	\$178	0
Total Revenues	\$259,409	\$429,600	\$453,466	\$487,893	\$530,079	\$599,612
Change in Revenues Year over Year		-	5.6%	7.6%	8.6%	13.1%
Expenses						
Corporate Operations	\$21,834	\$31,378	\$34,569	\$34,350	\$37,069	\$42295
Governance and Community Engagement	\$4,601	\$5,749	\$9,414	\$8,680	\$8,811	\$10573
<i>Program Services</i>	<i>\$203,109</i>	<i>\$357,800</i>	<i>\$393,089</i>	<i>\$418,601</i>	<i>\$446,163</i>	<i>\$507,263</i>
Total Expenses	\$229,544	\$394,927	\$437,072	\$461,631	\$492,043	\$560,131
Change in Program Services Spending Year over Year		-	9.9%	6.5%	6.6%	13.7%

Source: Annual Financial Statements (2014-2018)

The FNHA has directed most increase in revenues to support programs and deliver health services for First Nations across the province. As demonstrated in the table above, spending for program services has

⁹ Includes only funding that can be attributed to the creation of the FNHA and excludes new funding that the FNIHB-BC Region would have received in the absence of the FNHA. As such, only half of the increase in funding (\$43,039,112) due to 5% annual escalator negotiated with Health Canada have been included. The assumption is that FNIHB-BC region would have received increase in funding around 2.5% per year if the FNHA was not created.

¹⁰ 2013/14 was a partial year

increased by 42% over the most recent four year period from \$357.8 million in 2014/15 to \$507.3 million in 2018/19. Similarly, spending on direct community services funding has increased by 39% during the same period, from \$168.5 million in 2014/15 to \$234 million in 2018/19.

FNHA Spending on Programs and Services, 2013/14 to 2018/2019 (,000)

Fiscal Year	2013/14 ¹¹	2014/15	2015/16	2016/17	2017/18	2018/19
Program Services						
Health Benefits	\$96,298	\$137,699	\$148,612	\$153,853	\$158,836	\$168,723
Direct Community Services Funding	\$80,772	\$168,481	\$183,606	\$201,083	\$211,729	\$234,247
Health Services and Programs	\$26,039	\$51,620	\$60,871	\$63,665	\$75,598	\$91,289
Total Program Services	\$203,109	\$357,800	\$393,089	\$418,601	\$446,163	\$507,263
<i>Change in Direct Community funding year over year</i>		-	9%	10%	5%	11%

Source: Annual Financial Statements (2014-2018)

The FNHA has developed many innovative mechanisms to distribute new funds to First Nation communities and service providers. The new mechanisms were developed to eliminate competition for funding, encourage and support collaboration and partnership, and identify innovative concepts that can address root causes of health issues and problems. Examples of new programs and initiatives implemented by the FNHA that leveraged significant amounts of new funding and allocated to programming and services through new mechanisms, are summarized as follows:

- *Over \$15 million in ongoing funding to support a wide range of new and innovative projects (“Joint Project Board” projects).* Since the 1980s, FNIHB and the Province of BC had a bilateral agreement with respect to the payment of Medical Service Plan premiums for status First Nations in BC. Through this agreement, FNIHB transferred \$20 million per year to the Province of BC. Effective July 2, 2013 FNIHB transferred the funds they had historically used to pay the Medical Service Plan premiums on behalf of First Nations residents in BC to the FNHA. The FNHA and MoH agreed to set aside 25% of the annual payment over three years to establish new primary care and mental health projects across BC, with the provincial government assuming responsibility for the ongoing operational costs of these projects. The range of projects includes initiatives related to improving access to health services, increasing service delivery by regulated health professionals, increasing the sustainability of services, collaboration and innovation in services and supporting regional health priorities. Importantly, the process to distribute funding required partnership between First Nations in each region and the Regional Health Authority, supporting partnership development, First Nations decision-making, and full transparency of funding decisions. As of 2020, BC will be eliminating Medical Service Plan premiums, which frees up the FNHA’s annual payment to invest in new primary care projects in partnership with the MoH.
- *Over \$30 million has been leveraged to address mental health and wellness (MHW) issues faced by First Nations and allocated through a new model of funding.* A new Mental Health and Wellness Fund (\$30 million) has been created by the Province of BC, the Government of Canada and the FNHC. The fund offers a flexible funding arrangement that supports First Nations unique mental health and wellness plans and priorities. There has been new matching funding for Mental Health and Wellness programs (a \$10 million investment from the FNHA, Canada and the Province) as well as recent investment in

¹¹ 2013/14 was a partial year

treatment centers (\$20 million from the FNHA and \$20 million from the Province). In 2018, the FNHA announced specific funding procedures to administer a \$30 million mental health and wellness fund obtained through a partnership with the provincial and federal governments. The fund supports First Nation communities and aggregations of First Nations to come together to plan, design and deliver a full continuum of culture and strengths-based mental health and wellness services over two years (2019-2021). The FNHA regional teams work closely with First Nations to prepare a Statement of Readiness that outlines the activities and outcomes that the funding will support. The communities are supported by the FNHA at all stages of accessing funds, including “Pre-Plan or Plan” stage to development of partnerships, project design and demonstration of the project results. The Mental Health and Wellness Table is in charge of reviewing Statements of Readiness from a wholistic, strengths-based, family-focused and Nation-Based perspective. The advantage of the system is that it is streamlined, requires less administration and the First Nations are supported by the FNHA throughout the development and implementation of the projects.

- *Regional envelopes for supporting smaller projects was created to remove competition over funds, provide greater flexibility in accessing funds, and allow more targeted investments in specific areas of need.* The FNHA has created a regional envelope funding process to provide streamlined access to new funding opportunities. The approach allows First Nations to access new and more targeted sources of funding in addition to that received through contribution agreements. Using the sources of new funding (e.g. provincial funding, and new federal funding streams), the FNHA has allocated dedicated funding envelopes for the regions. The regions are in charge of developing a transparent way to equitably and collectively make decisions around funding distribution. Regional teams work closely with First Nations and health providers to secure funding for specific needs and priorities or for project ideas that communities have identified. Provided that proposed project/initiative fits within the funding criteria, regional teams work with the community to develop a project proposal. The proposals are developed not to compete for funding but rather serve to articulate community-driven ideas around health priorities and needs and request the grant money. Regional envelopes support about 10-20% of funding. The FNHA’s regional envelopes are allocated based on a formula (% regional allocation). A within-region budget is allocated based on three variables: number of communities, population size and remoteness. There has been some discussion about how to incorporate other information and health outcomes in the funding allocation, but to date there have been no changes. Most of the regional funds are targeted at the specific issues identified in the community health plans such as opioid use, mental wellness, health transformation, and enhancing the health system). Regional envelopes also fund smaller, innovative and community relevant projects. They are also used to advocate for and access new funding from regional health authorities or other sources (e.g., non-profits).

13.3. Changes in Funding Arrangements

The transfer of health services and programs to the FNHA, in 2013, included 140 Contribution Agreements with First Nations Health Service providers. Since the transition, the FNHA has been working to transform funding arrangement supports by streamlining and improving supports to community health and wellness planning, reporting, evaluation and agreement management. The following changes have been reported:

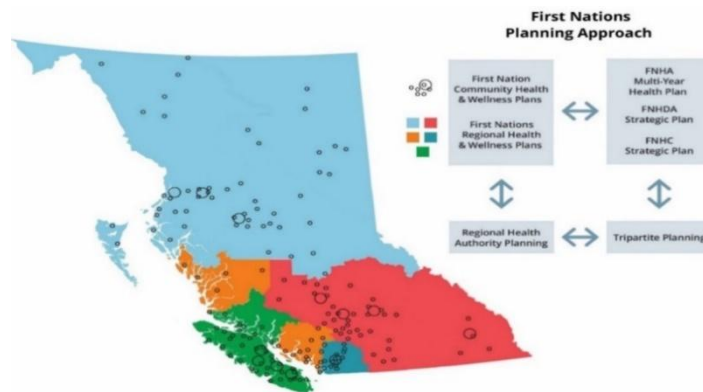
There has been an increased focus on health and wellness planning within the FNHA at the organizational and community levels. First Nations Community Health and Wellness Plans are at the heart of the planning approach and investments.

The FNHA is leading or supporting planning processes at the organizational level as well as at regional and community levels. Major planning documents that drive all planning and investment strategies include:

- The Multi-Year Health Plan - a five-year organizational strategic plan.
- The Summary Service Plan - an annual plan derived from Multi-Year Health Plan that sets out the overall annual FNHA direction.
- Regional Health and Wellness Plans - developed by First Nations within each region who are supported by the FNHA Regional Teams.

The BC First Nations approach to planning is a ground up approach which ensures that regional and community priorities, goals and perspectives guide planning and investments. The planning approach ensures that the health system and services are integrated and consistent with the 7 Directives.

The FNHA updates the Multi-Year Health Plan and Summary Service Plan on an annual basis. The FNHA planning occurs in a larger planning ecosystem, which includes plans developed by First Nations governance, the tripartite partners and others. The following diagram depicts the planning approach within the First Nations health governance structure. Community Health and Wellness Plans inform Regional Health and Wellness Plans, which in turn inform the FNHA Multi-Year Health Plan and operational plans as well as governance partner plans¹².



First Nations Community Health and Wellness Plans are at the heart of the planning approach. The FNHA is supporting and funding First Nations communities and health providers (communities, Tribal Councils, or First Nations organizations funded to provide First Nations health programs) in developing, implementing and evaluating their health and wellness plans.

To assist First Nations communities with health and wellness planning, the FNHA provides assistance for building community planning capacity. In 2019, the FNHA prepared the *Health and Wellness Planning: A Toolkit for BC First Nations*.¹³ The document provides foundational information on health and wellness planning, explains planning, reporting and evaluation standards, provides tips and content for the plans and

¹² FNHA Planning Framework, March 31, 2017

¹³ <https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-Health-and-Wellness-Planning-A-Toolkit-for-BC-First-Nations.pdf>

includes a wide range of templates and tools that communities can use in health and wellness planning process. The purpose of the toolkit is to:

- support the development of Health and Wellness Plans.
- introduce planning, reporting and evaluation standards.
- share planning tools, templates, resources and stories.
- support alignment in First Nations health and wellness plans to enable greater collaboration, coordination and quality of services.

The FNHA has made some improvements to the contribution agreement format. Although funding flexibility has increased, a few communities still receive funding through set funding agreements, which are more restrictive. At the time of the evaluation, the FNHA was working with some of these communities to transition them to more flexible funding arrangements.

At the time of transfer, the FNHA signed Novation agreements with First Nation communities and other funding recipients. The agreements outlined the funding processes during the time of the transition and ensured continuity of services. As per request from the communities, the Novation agreements included requirements for the FNHA not to change the funding amounts and distribution processes and procedures for at least two years after the transition. Consequently, the FNHA kept funding agreement and amounts the same until 2015/16.

The FNHA has used annual escalator negotiated in the Canada Funding Agreement and escalator in increasing funding to communities and their health service organizations. The escalator on the Canada Funding Agreement has been important for determining the escalator that the FNHA will apply to community agreements in the coming years. Key informants noted that there has been a full application of the 5.5% annual increase to base funding in community agreements for at least several years after the transition, however, since 2017/18, a portion of these funds were targeted to areas of inequity or high need in communities. In 2017/18, 3.0% was applied as a one-time increase to targeted programs, with the 2.0% more generally distributed to the majority of programs as an ongoing increase. The following year, 2.4% was applied as an ongoing increase to targeted programs, and the balance was distributed to the majority of programs on an ongoing basis.

According to the FNHA website “Summary of Improvements to Contribution Agreements,” a number of changes and improvements were implemented, including:

- Reporting schedules have been combined and reporting requirements streamlined.
- Annual reporting dates were aligned across all agreements.
- A simplified financial schedule. An adjusted financial schedule includes the current year cash flow only.
- References to federal government were removed.
- A notice of budget adjustment can be used to add any new programs and services or activities (it was previously only used for adjustment of existing programs).
- More flexibility in the submission of the agreements.

More recently, summary of improvements to Health Funding Agreements also include:

- Shared commitment to the provision of health programs and services.
- Agreement holder’s authority to act on behalf of its members and member First Nations.
- Clarity on the FNHA audits.
- Further information on core program requirements and evaluations.

- Further information on the requirements to opt out.
- Additional details on systems of accountability to members and default provisions and default terminology.
- Further clarity on process for termination of agreement.
- Align dispute resolution provisions across all funding agreement types.

Twenty-three First Nations communities continue to have set funding agreements. During one interview, a representative from a community funded under a set model noted that this does not align with the needs of the community and is inadequate to hire qualified staff and undertake long term planning. During interviews, representatives of the FNHA mentioned that the organization is actively working with some of these communities to develop health and wellness plans and to transition them into more flexible funding arrangements.

Communities Under Different Funding Arrangements Across Regions

Region	Block Arrangements	Transitional/Flexible Arrangements	SET Arrangements
North	12	20	6
Interior	19	19	8
Fraser	4	8	2
Vancouver Coastal	6	2	2
Vancouver Island	10	18	5
Total	51	67	23

Source: FNHA - as of December 2019

The FNHA is undertaking a reporting transformation initiative to streamline the reporting requirements and make reporting more meaningful for the communities.

The following table provides a description of the FNHA’s reporting requirements. During the initial stages of the transition, the reporting requirements remained largely the same as they were prior to transition. Gradually, the FNHA allowed for more flexibility and offered more reporting support to the communities.

FNHA Reporting Requirements

Type of Reports	Funding
Financial Reporting – Annual Audit report	All levels of funding
Program Reporting – Annual (Community-based reporting template) – not required as of 2017)	All levels of funding
Financial Interim Report (Apr-Sep due Nov 15 th)	Set Funding/Indian Residential Schools Resolution Health Support Program
Two financial interim reports (Oct 15 th and Jan 15 th)	First Nations Health Benefit
Two Interim Program Activity Reports (Oct 15 th and Jan 15 th)	First Nations Health Benefit
Four Program Activity Reports (quarterly)	Indian Residential Schools Resolution Health Support Program

As of 2017, the FNHA no longer requires the submission of the Community-Based Reporting Template describing program activities. Instead, it accepts financial reports as well as annual reports that are from the community to its own people (based on what matters to the communities). The FNHA is currently working

with communities to develop indicators/reporting that reflects areas that matters to them the most, based on which the FNHA can develop province-wide indicators for aggregation and reporting.

In addition, the FNHA introduced a Surplus Reinvestment Plan to allow communities new flexibility in retaining and reinvesting unspent funding. The Surplus Reinvestment Plan provides communities with an opportunity to communicate the pace of their spending and spending priorities. As well, it will provide the FNHA with current, concrete data related to: the long-term goals of First Nations health provider partners, resource gaps in programs and services (as illustrated by low/no carry over), surplus programs and opportunities for new funding models.

Nevertheless, reporting continues to be a challenge for many communities due to various reasons (e.g., busy workloads, competing priorities). Funding arrangement holders provide an annual narrative and financial reporting to the FNHA. In 2018/19, only 11% of arrangement holders submitted financial reports and 10% submitted narrative reports by the submission deadline of July 29, 2019. At the time of assessment (August 20, 2019) a total of 18% of 2018/19 financial reports and 18% of 2018/19 narrative reports had been submitted. According to case study participants, busy work schedules and competing priorities affect the ability of the communities to undertake timely reporting.

The FNHA is undertaking several initiatives to support community reporting. Examples of such initiatives mentioned by case study participants included developing reporting and evaluation toolkits to provide instructions and guidance on reporting, and program advisory services and individual assistance with report preparation. During interviews, one community representative noted that she received an in-person assistance from a representative of the FNHA who visited the community to help her with preparing narrative and financial reports.

13.4. Impacts of the New System

According to case study participants, the FNHA's efforts to leverage new funds, create innovative models of funding distribution and changes to funding arrangements, have resulted in a number of positive impacts, summarized as follows:

- **An increase in funding amounts has improved First Nations capacity to hire qualified health professionals and deliver better health care services.** Communities have access to more and better services and the quality of services has improved.
- **More sustainable funding has enabled communities to engage in long-term planning** and create more creative and unique projects to meet their needs and priorities. Communities have more time to test and implement their initiatives.
- **Easier access to new funding opportunities lead to more responsive services** and to the development of new and innovative services driven by the communities and service providers and utilized by community members.
- **Collaborative initiatives and integrated services.** New funding opportunities (e.g., regional envelopes, and Joint Project Board projects) have facilitated partnership-based initiatives and projects (e.g., joint

projects with other service delivery organizations and provincial health authorities) and helped to integrate services at the community level.

- **An increased focus on partnership and collaboration** has created opportunities for communities and various partners to engage in issues beyond direct health services and to address other social determinants of health.

13.5. Gaps, Challenges and Issues

The following are some of the challenges identified by interviewees and through a review of the case study files and documents:

Challenges with identifying and implementing appropriate funding formulae. During the two years following the transition, the FNHA's ability to change funding formulae and amounts was restricted due to Novation agreements. The Novation agreements signed with First Nations communities, at the time of transfer, required the FNHA to keep funding amounts and systems the same for at least until 2015/16. As described in the previous section, since 2015/16, the FNHA have implemented some improvements in funding allocation processes. However, case study participants noted that the existing funding model is based on historic formulae developed by FNIHB that take into account the community population size (as registered with the band and resident on-reserve) and the degree of remoteness or isolation. The fact that health care providers are also servicing residents who are not registered (or their members who live away from home) and that needs for health programs/services and resources vary across communities does not factor into the allocation. There is a large urban and away from home population that is not currently being served in culturally appropriate ways because of the existing funding formulas.

The existing mechanism that is used by the FNHA to distribute funds to communities does not adequately reflect the interests of the urban population. Most of the funding that the FNHA has obtained through tripartite negotiations and the Canada Funding Agreement is specifically designated at First Nations communities. New sources of funding obtained, however, particularly those from the provincial government, tend to have broader eligibility rules. Nevertheless, according to case study participants, the FNHA lacks funding and program delivery mechanisms to target urban and away from home populations in adequate levels. Consequently, disproportionately high shares of the new funds have been allocated to communities (verses addressing the needs of urban and away from home clients).

Some of the new funds allocated are temporary, creating sustainability challenges. During interviews, community representatives noted that some of the new funds that the FNHA has leveraged are allocated on a temporary basis, which creates challenges for long-term planning.

Community challenges with hiring qualified staff. The FNHA's regional staff members and community representatives noted that they often face challenges with spending available funds due to limited human resources for project management and implementation. There has been significant competition for human resources. For example, some staff left the positions in the communities to work for regional offices, thus increasing the pressure on communities to find new employees.

Limited investment in infrastructure. The increase in funding amounts has not been matched with a focus on developing community infrastructure. Limited infrastructure has affected the extent to which communities can use funds to deliver effective programming and services.

There has been some disengagement as some communities want to develop their own specific strategies or implement programming. Disengagement refers to the process by which a community voluntarily chooses to withdraw from a multi-community agreement to deliver services directly to its members or enters into a different multi-community agreement. There are various reasons for disengagement including changes in organizational structures, organizational or community maturity (e.g., when a community has enough capacity to deliver services by own), mutually agreed upon reasons, or due to the relationship challenges that the FNHA inherited from FNIHB. At the time of this case study, up to ten communities had requested disengagement from multi-community agreements that they had with service delivery organizations or tribal councils. In addition, the FNHA terminated two agreements with the Inter Tribal Health Authority, a decision that impacted 31 communities. Disengagements and reengagements usually increase administrative efforts that the FNHA has to invest to ensure continuity of the services and occasionally results in legal costs.

Requirements for set funding are too restrictive. At the time of this evaluation, 25 communities were still receiving their funds through set funding agreements. During interviews representatives of such communities mentioned that under such arrangements they face challenges with being able to use funds in other areas of operations. For example, they are not able to use the funds to purchase equipment or transportation, even when that is what they need to be able deliver effective services.

Reporting remains a burden for some communities, particularly those that face challenges with recruiting qualified human resources. During interviews, communities reported challenges with reporting. The examples of challenges mentioned included complex and burdensome reporting requirements as they receive funding from different sources, each having their own requirements (e.g., projects under the Joint Project Board have very complicated reporting requirements). One community representative mentioned that the community experienced such difficulty that they requested help from the FNHA to assist them with reporting. An FNHA representative visited the community and trained the community representative in reporting. The challenge with reporting is reflected in a number of narrative and fiscal reports submitted to the FNHA each year. For example, in 2018/19 only 11% of arrangement holders submitted financial reports and 10% submitted narrative reports by the submission deadline of July 29, 2019.

Challenges with the funding model (regional envelopes). The FNHA adopted health authority boundaries so that they operate under a regional approach. There are communities that belong to two regional authorities. During interviews, representatives of such communities noted that they face challenges with identifying the region from which they should receive support and direction.

13.6. Lessons Learned and Opportunities for Improvement

The FNHA needs to revise and improve funding allocation formulae and processes. The timing of the funding agreement transition has been affected by Novation agreements. As per requirements of the agreements, the FNHA was not allowed to change funding agreement provisions until 2015/16. Most of the changes implemented since have been effective, including the introduction of new methodologies like regional envelopes. However, the efforts should be continued to further improve funding allocation

processes, including regional envelope allocation formulae, taking into account some of the gaps and issues (e.g., equitable allocation of funds for the population at home and away from home) identified in this report.

The FNHA's ability to bridge the communication and capacity gap between governments and First Nations have played a key role in enabling the organization to leverage additional sources of funding. Historically, governments lacked capacity to work with the communities in delivering effective programs and services. During interviews, representatives of provincial governments noted that in the past they lacked ability to support effective programming at the First Nations communities. The FNHA was largely successful in bridging this gap by building equal partnerships with First Nations and governments. The federal and provincial governments are willing to work with the FNHA, which can deliver effective programming.

Shift from accountability/oversight to a partnership-based model is an effective approach. According to case study participants, the shift from an approach focused on fiscal accountability (under FNIHB) to a new approach based on partnership and advisory (under the FNHA) has been successful in supporting the First Nations communities with accessing funding, and implementing innovative projects and initiatives that are designed to meet their specific needs. Similar approaches should be continued in supporting First Nations with fulfilling reporting requirements.

Continue efforts to support communities with reporting. The efforts should be continued to transform reporting requirements, streamline reporting procedures, and ensure reporting is meaningful to communities.

There is a need to develop disengagement protocols and processes. Standard procedures will ensure consistent approaches of disengagement are implemented with different Nations.

There are risks associated with asking newly established organizations, particularly community organizations or new entities, to manage and implement health services and large projects. As part of the transition, the FNHA has engaged many newly established organizations to deliver programs and services. Case study participants noted that when newly established organizations are given an opportunity to undertake large-scale projects, proper support should be provided to ensure successful implementation of both project management as well as good governance practices (policies, incorporation documents, etc.).

14. Changes to FNHA Corporate Services and Functions

FNIHB did not hold significant corporate capacity in BC region as many corporate functions were provided from FNIHB's office in Ottawa (e.g., strategic policy and evaluation), or through the broader federal public service (e.g., finance, human resources and IMIT). The Tripartite Framework Agreement required the FNHA to develop corporate functions and capacities to support the delivery of effective programming and fulfill its broader mandate and contractual and legal obligations. The Canada Funding Agreement allocated funding for the FNHA to develop these corporate functions and infrastructure. Since then, the FNHA has undertaken extensive efforts to set up corporate services and functions to enable effective operations and programming.

14.1. Creation of the Corporate Services and Functions

A review of the FNHA files and documents combined with interviews with case study participants, identified that:

The FNHA inherited very limited administrative and corporate capacity from FNIHB. FNIHB's regional office had limited in-house corporate capacity as most corporate services and administrative functions were provided from FNIHB's office in Ottawa (e.g., strategic policy and evaluation), or through the broader federal public service (e.g., finance, human resources and IMIT).

The FNHA needed much stronger corporate services due to its expanded mandate, new roles and responsibilities in delivering programs that included representing interests of all First Nations in BC, and requirement to uphold the 7 Directives (including Directive #7 – Function at a High Operational Standard). The new mandate provided to the FNHA by First Nations was much broader compared to that of FNIHB and included new areas of responsibilities (e.g., the function of the Chief Medical Officer, research and data, and quality assurance) that required additional administrative and corporate support functionalities. Furthermore, additional corporate capacity was required for the FNHA to be able to fulfill the requirements of the 7 Directives provided by the BC First Nations. In particular, Directive #7 that requires the FNHA to operate at a high operational standard: Be accountable, including through clear, regular and transparent reporting; Make best and prudent use of available resources; Implement appropriate competencies for key roles and responsibilities at all levels; and Operate with clear governance documents, policies, and procedures.

The Tripartite Framework Agreement allocated significant funds for the FNHA to build corporate functionalities. As it was indicated in the Tripartite Framework Agreement, the Canada Funding Agreement allocated dedicated funding and resources to build corporate and management capacity within the FNHA to fulfill its commitments to deliver on programs and services. As demonstrated in the following table, from 2008/09 to 2013/14, the Tripartite Framework Agreement allocated a total \$42.7 million to build and support the FNHA's corporate and management services, \$23.9 million to support employee benefits and \$9.2 million for accommodations.

**Canada Funding to Administrative and Corporate Expenses
2008/09 to 2013/14 (millions)**

Funding Areas	2008/09	2010/11	2011/12	2012/13	2013/14	Total
Corporate and Management Services	\$8,301.70	\$8,451.50	\$8,528.00	\$8,642.20	\$8,745.20	\$42,668.60
Employee Benefit Plan	\$4,538	\$4,702.80	\$4,787.20	\$4,872.80	\$4,960.20	\$23,861.20
FNIHB HQ Policy and Programs	\$7,819	\$7,928.40	\$7,984.20	\$8,040.80	\$8,098.30	\$39,871.00
Accommodations	\$1,847	\$1,847.10	\$1,847.10	\$1,847.10	\$1,847.10	\$9,235.50
Total	\$22,506.30	\$22,929.80	\$23,146.50	\$23,402.90	\$23,650.80	\$115,636.30

Source: Tripartite Framework Agreement

Using the funds provided through the Framework Agreement, the FNHA built corporate capacity and functionalities. In 2012, in anticipation of transfer, the FNHA started building corporate functions and services. The process was implemented under tight deadlines to ensure adequate support services were in place prior to the transfer of FNIHB BC region staff. The FNHA built strategic planning, headquarters, finance and senior corporate functions within the organization. Despite challenges, most corporate functions were built on time facilitating the overall transfer process and ensuring the FNHA was able to deliver on its programs and services. The process also included transferring IMIT infrastructure (e.g., the FNHA hired IMIT professionals and created the Joint Project Management Office with FNIHB to transition IMIT assets, applications and systems), creating new systems and structures or replacing old infrastructure (e.g., health benefit data warehouse, call center, implementation of PeopleSoft) and developing organizational policies, processes, guidelines and structures.

14.2. Existing Structure of the Corporate Services and Functions

The FNHA corporate services and functions, include the following major components:

- **Policy, Planning and Quality (PPQ) function**, which includes areas related to health economics and analytics, corporate policy, strategic policy, quality agenda (including cultural safety and humility), planning and evaluation, strategic projects office and central administration. Some of these functions can be considered corporate services while others are more strategic and external-facing in nature. The activities of the PPQ are delivered with the help of approximately 50 full-time equivalent positions (note: approximately 10% of these positions in PPQ are funded through externally-leveraged opportunities and are not funded through the Canada Funding Agreement).
- **Information Management, Information Technology (IMIT) office.** Lead by the Chief Information Officer the office includes functionalities around innovation and information management services, analytics, project and risk management services, core technology and user support services, network architecture and information security. Activities of the IMIT are delivered by approximately 80 full-time equivalent positions, most whom are based in Vancouver and some are assigned to regions to support IMIT needs of regional offices.
- **Office of Chief Financial Officer and Corporate Services.** The office of the Chief Financial Officer controls the largest area of enabling functions and services, including financial planning and analysis, accounting,

legal, procurement and contracting, travel and events, reception, risk management, office accommodations, fleet services, privacy, and communications. The operations are supported by a total 88 full-time equivalent positions.

- **Human Resources Office, led by Vice President of Human Resources**, the office includes functionalities around staff recruiting, employee and labour relations, compensation and benefits, talent management, learning and development, human resource information systems, organizational development, employee health and safety, and disability support. The activities of the Human Resources are delivered by a total of 40 full-time equivalent positions.

14.3. Progress in Building Corporate Services and Functions

The FNHA undertook a number of steps to build corporate services and functions within a relatively short period of time. Some of the key areas of progress are summarized as follows.

Human Resources

Activities undertaken by the FNHA to improve HR functions within the organization are summarized as follows:

Implementing the new Human Resources Information System called the Technology and Resources Enabling Employees (TREE) Project to support organizational HR service delivery, enhance the candidate and employee experience, and to provide business insight and inform strategy. TREE is an integrated and modern platform that enables recruitment operations to streamline processes, reduce manual activities, enhance the applicant/candidate experience, improve reporting on key business performance metrics, and improve overall recruitment service delivery. It provides an automatic system for posting jobs, short listing applicants, scoring their qualifications, scheduling interviews and evaluating applicants. It also provides candidate database search capabilities and automated recruitment reporting on standard metrics. For example, it allows an employee to have an easy online access to his/her personal information such as viewing details of benefits, and pay advices through “My FNHA.” According to case study participants, it helps the FNHA to increase its operational standards. The following table provides stages and timelines for implementing Project TREE and a short description of each stage.

Stages	Timelines	Description
Basic Employee Self-Serve	November 2019	Real-time access to personal information online: pay advices, benefits details, and more
Recruiting Solutions	November 2019	Improved experience and greater visibility into recruitment activities for new and existing employees and hiring managers
Enhanced Employee Self-Serve	June 2020	Real-time management of timesheets, leave and overtime requests and more
Learning Management	October 2020	Access learning courses online in one place
Performance Partnerships	December 2020	Set, track and measure employee goals online
Career & Succession Planning	December 2020	Plan career development online

Creating Compensation Framework, which helps the FNHA to identify compensation and pay rate based on potential employee background and knowledge. During interviews case study participants noted that the Framework is very useful in helping the FNHA to quickly screen and select potential candidates and

determine compensation rates. For example, adding points to previous experience of working within First Nations context helps to focus on hiring employees who can better succeed within the FNHA.

Launching HOWL Employee Engagement Survey. The survey helps the FNHA to identify staff's levels of satisfaction with the FNHA in a number of key areas including, employee engagement with the work, trust, collaboration and support from leadership. The survey helps the leadership to benchmark staff members' level of engagement and enablement, and compare it to other organizations and/or national rates and track changes over time. This helps management to identify and undertake areas of action to improve levels of engagement and satisfaction.

Formalizing processes, created HR policies and quality standards. Consistent processes and structures have been implemented pertaining to different areas of HR management, including disability management, collective bargaining, identifying candidate qualification and recruiting.

Negotiating and signing two collective bargaining agreements. After extensive negotiations, in 2018, the FNHA signed collective bargaining agreements with two different unions that represented its employees. It was a lengthy process as one agreement took three years to negotiate.

Collaborating with the communication department to brand the FNHA as an employer of choice for potential employees. The activities included branding and differentiation exercises to identify areas of strength (and also weakness) for the FNHA and promoting them through different communication channels. Communication specialists were engaged to create the FNHA brand, creative and communication materials, and conducted extensive outreach to educate and promote the FNHA among potential employees.

Information Management, Information Technology

Activities undertaken by the FNHA to improve information management and information technology functions within the organization are summarized as follows:

Transferring IMIT assets and infrastructure from FNIHB. At the time of the transfer, the IMIT team worked with FNIHB to transfer IT assets (e.g., health legacy systems) and set up basic IT services (e.g., desktops, computer systems, network and basic people soft) within the FNHA. The process was started in October 2013 and completed by March 2015 – ahead of schedule and under budget. Extensive efforts were undertaken to ensure the transitions were implemented in the background and did not affect activities of programs and front line staff members.

Creating a data warehouse to manage FNHA's growing needs for high quality data. Once the transfer of the IT assets was completed and basic IT systems were created, the FNHA created a data warehouse to manage all corporate data. The warehouse contains a large amount of corporate and program data in one location allowing easier access and integrated analysis and reporting. Additional data related to HR and payroll is extracted directly from PeopleSoft for desktop data analysis using Excel or other reporting tools. The FNHA also relies significantly on external data from government partners and future initiatives are in discussion to acquire additional client health and/or administrative data in order to further enable population health analysis.

Helping to deploy eHealth infrastructure. In 2015, the FNHA installed telehealth units across remote regions and communities. Telehealth allows using videoconferencing (live video) to deliver health and wellness

services over long distances. IMIT department worked very closely with communities and other departments within the FNHA to coordinate the activities, and ensured installation of other supporting systems and health grade internet connectivity. In 2016, once established and functioning, eHealth was transitioned to operate under the FNHA programs and services.

Creating helpdesk management system and escalation pathway to address technical challenges. The helpdesk system ensures a one-window approach to submit tickets for IMIT support. The escalation pathway ensures that basic technical support requests (e.g., assistance with logging in, email or connectivity problems, etc.) can be addressed at Level 1, while more complicated technical challenges (e.g., software implementation) can be escalated to level 2 and level 3, which requires greater technical expertise and more complex intervention.

Creating and implementing Information Security Three Year Strategy and Plan, which establishes a roadmap for improving cyber security at the First Nations Health Authority over the next three years. The plan described how FNHA will move towards a defensible level of security ensuring information is protected and supports the development of guidance to effectively and seamlessly integrate security into everyday operations. The Strategy has four hierarchical objectives, ranging from achieving minimum/basic security controls to a defensible security environment within three years. To create the strategy the FNHA IMIT team have conducted an assessment of the current state of cyber security within the FNHA, identified gaps between current state and three year objectives and created a road map to achieve those objectives.

Extensive efforts to ensure information security and manage and mitigate IT risks. The efforts have been concentrated in establishing policies, standards and procedures for managing risks, and building staff knowledge and capacity. Some of the steps undertaken to ensure information security includes offering mandatory information security training for staff members, issuing regular alerts and notifications to staff on emerging risks (e.g., phishing campaigns), preparing an approved list of applications that staff can use on their devices, and conducting cyber security audits to identify and address vulnerabilities.

Developing and implementing the Enterprise Information Management Strategy Framework and Enabling Infrastructure. Enterprise information management is an integrative discipline for structuring and governing information assets across the organization to improve efficiency, promote transparency and enable business insight. It specializes in finding the optimum use of information assets to support decision-making. The need for development of the enterprise information management strategy was identified in the FNHA Data Analytics Recommendations report prepared in 2018. The objective of the strategy was to help the FNHA to better manage its growing information needs and priorities to support its decision-making processes, and mission and mandate. The strategy mapped the types of information available through various data sources in the FNHA, identified the flow of information across the FNHA, created a data life cycle (i.e., mapping how the information flows through various departments and systems within the FNHA), created existing and potential future/needed metrics to measure various aspects of enterprise information management, and prepared a data management governance framework that clarified responsibility and accountability for data management and maintenance (i.e., through a committee infrastructure). The FNHA developed the strategy in 2019 and at the time of this evaluation was in the process of implementation.

Creating the Architecture Review Committee. The purpose of Architecture Review Committee is to provide organizational-level oversight for FNHA information management and technology decisions. It was created to

provide consistency with regards to information management decisions and technologies across the organization. The committee reviews and endorses information management and technology initiatives within the FNHA that have organizational implications. It ensures new technologies and information management applications implemented within the FNHA are consistent and aligned. The committee is comprised of representatives of various departments across the FNHA.

Efforts to develop operational excellence within the IMIT team. Efforts have been invested to ensure quality and stability of IMIT services and infrastructure to maintain and support operations of the FNHA. The IMIT team consistently scans areas of the organization's operations to identify efficiencies that can be achieved by applying effective technologies. Efforts are also undertaken by management to ensure quality of the IMIT services are improved continuously, including developing quality metrics and applying benchmarks.

Implementing a wide range of IMIT projects to improve technological capabilities of the organizations. IMIT manages a three-year IMIT plan approved by the FNHA Board of Directors that outlines the approved organization's technology projects and ensures that these projects are governed within established budget. This IMIT plan is overseen by the FNHA's Strategic Projects Office and the Strategic Projects Executive Committee. According to the most recent three-year plan, approved by the Board on May 2018, the IMIT is undertaking 37 major projects from 2018/19 to 2020/21 with estimated total budget of \$14 million. Examples of projects in the action plan include:

- Moving crisis intervention counselling benefits from the legacy FNIHB system to the newer Sohema system which supports IRS Counselling claims.
- Upgrading windows servers to align with industry best practices.
- Identifying a system(s) to manage complaints, incidents, and feedback.
- Replacing the system that supports the management of contribution agreements .
- Upgrading SharePoint.
- Reconfiguring primary and secondary data centers.
- Continued implementation of electronic content management.

Created Change Advisory Board to oversee changes in the technical and technological environment within the FNHA. The Change Advisory Board regularly reviews and approves technological changes (e.g., software updates, hardware installations, purchase of new software) and ensures that those changes can be introduced without negatively affecting the operations (i.e., production environment) of the FNHA.

Created the IMIT Policy Committee. In collaboration with the FNHA policy team, IMIT have created an internal policy committee dedicated to developing and implementing IMIT policies and procedures.

Engaged in developing Digital Strategy to better coordinate the digital activities within the FNHA and align them with organizational priorities and the FNHA's Multi-Year Health Plan. At the time of the evaluation, the Strategy was under development and expected completion date was March 2020.

Policy, Planning and Quality (PPQ)

Activities undertaken by the FNHA to improve the corporate services functions within PPQ are summarized as follows:

Created capacity to conduct program evaluations and prepare high quality plans and reports to fulfill the FNHA's legal and contractual commitments. As per provisions of the Canada Funding Agreement and the

Tripartite Framework Agreement, the FNHA is required to undertake regular evaluations, prepare annual reports and draft sound policies and procedures. In addition, the Chief Executive Officer is required to report to the FNHA Board of Directors on the performance of the organization in a quarterly and annual basis, which requires regular efforts to measure and monitor performance of the organization. The evaluation and planning unit was created within PPQ to prepare multi-year plans, annual/quarterly reports and undertake program evaluations. Skilled staff members were recruited. Uniting evaluation and planning within a single unit helped to ensure evaluation results were used in planning and contributed to more integrative planning and reporting. The reporting cycle was revised to better align with organizational priorities and the quality and consistency of annual and quarterly reports were improved. New and revised performance measures for the organization was developed and efforts were undertaken to improve quality and consistency of the data collected to measure performance in different areas of operations. Performance measures reports were initiated to regularly summarize and report on findings of performance indicators. A Performance Measurement and Evaluation Framework has been drafted to enhance consistency, transparency, and strategic connection.

Created capacity to develop high quality policies to govern the organization. The FNHA holds a full spectrum of policy leadership responsibilities ranging from public policy development (as an organization and in partnership with federal and provincial partners), to program policy development (as applied to the programs the FNHA is responsible for designing and delivering) to corporate policy development (as applied to the operations of the FNHA as a health authority). The FNHA's four key policy areas are: Strategic Policy, Program Policy, Clinical-Practice Policy, and Corporate Policy. During the early days of the operations, the FNHA did not have sound systems and procedures for policy development. Policies were developed by departmental staff, were often delayed, and sometimes lacked necessary rigour and quality. Initially, the policy work was undertaken under the corporate policy department. In 2017, PPQ was created and staff members in charge of corporate policy were reassigned to PPQ. Some of the key areas of accomplishments by the FNHA's policy team, included:

- *Prepared policy frameworks to guide the policy development activities.* The FNHA developed an FNHA Policy Framework approved by the Board of Directors. The Framework defines four policy areas (strategic, program, clinical and corporate), establishes high-level responsibilities for each policy area, and provides direction for the development of policies in each area. The frameworks set a strong policy foundation for the organization. It outlines accountabilities within the FNHA for developing, approving and using organizational policies, directives and procedures, and outlines the organizational policy development cycle. At the time of this evaluation, the FNHA was also working to develop sub-frameworks to further elaborate the process for policy development in each of the four policy areas.
- *Systems and procedures were created to streamline policy development, review and approval processes.* A qualified team was recruited to coordinate policy development processes. The first area of improvement for the team was to meet the commitments to the FNHA Board of Directors by providing timely and high quality corporate policies for their reviews and approvals. An annual corporate policy review cycle was created in 2017 to conduct a full corporate policy suite review each year. In 2019, once the existing corporate policies were of satisfactory quality, the policy was changed to a less frequent, three-year review cycle. This annual cycle ensured a base level of quality across all corporate policies, and now the three-year cycle allows meaningful engagement on those policies, for the development of policy documents that address gaps in existing inventories, and for more comprehensive implementation

of policies. A Corporate Policy Calendar and the Corporate Policy Development Schedule were created and are carefully monitored to ensure timely review of all policies.

- Developed an extensive list of organizational policies, frameworks, procedures and executive directives.* As demonstrated in the following table, from 2013 to 2019, the FNHA policy team completed the drafting or review of 138 organizational policies, 49 executive directives, and 16 procedures and frameworks. Development of each policy or procedure required engagement and a review process by the FNHA Board of Directors. At the time of this evaluation, the FNHA was in process of similarly developing or reviewing clinical and program policies to improve governance in those areas of its operations.

Year	Corporate Policy Document			Total
	Policies	Executive Directives	Procedures & Frameworks	
2013	24	0	0	24
2014	3	1	0	4
2015	15	5	3	23
2016	18	0	0	18
2017	26	6	1	33
2018	35	18	10	63
2019	17	19	2	38
Total	138	49	16	203

Created Strategic Projects Office and Strategic Projects Executive Committee to improve governance for projects that have organizational significance. The Strategic Project Office was created to provide consistency and structure for supporting the success of strategic projects by ensuring such projects receive adequate authorization, coordination and support from the senior management team. This ensures strategic monitoring of the projects’ scope, schedule, and budget. An intake and phase-gating system was created to identify strategic projects, and ensure that their planning, budgeting, and implementation meets established standards of quality. Strategic projects are those that have cross-organizational impact and which are of significant cost; as such, these need to be managed carefully to ensure coordination and that the budget is adhered to. Examples of strategic projects that are or were supported by the Strategic Project Office at the time of this evaluation include: transition of health benefits, Project TREE, Metro Vancouver Office Project, Cultural Safety and Humility Standard, the 3-year IMIT strategic plan. Decisions are made, and progress overseen, by the Strategic Projects Executive Committee which is composed of all FNHA Senior Executive Team members which meets monthly to review project status reports, and provide advice and guidance on all matters pertaining to the management of project scope, cost, schedule and risk.

Developed tools and templates for First Nations, and the FNHA departments and regions to support the development and implementation of plans, policies and evaluations. Some of the resources and tools include templates for policy implementation and issues tracking, a policy register and dashboard for full transparency of all policy work in progress, regularly providing policy templates and examples to communities and First Nations organizations, and a Health and Wellness Planning Toolkit to assist communities with health planning.

Corporate Services

Activities undertaken by the FNHA to improve corporate services and functions within the organization are summarized as follows:

Developing sound processes, procedures and policies for each area of the corporate services. Some of the areas included: fleet (e.g., enhancing processes for authorizing drivers, recording mileage); procurement (e.g., tender and awarding processes etc.); event planning and management (e.g., booking venues,); staff travel (e.g., booking flights, using personal vehicles); establishing accommodations plans across the province; and enhancing the FNHA’s risk management.

Developing corporate infrastructure and assets to support service delivery. For example, fleet size was increased from 80 to 100 vehicles across the province, systems were created to manage the fleet and provide easier staff access to corporate cars when needed (e.g., booking and accessing processes, use of credit cards for gas, fleet maintenance, log book for mileage). Office spaces have been procured for central office and also to five regional offices and sufficiently supplied with equipment, infrastructure etc. necessary for effective functioning.

Developed communication team within the corporate services to inform, increase awareness and help building relationships with First Nations, governments and service delivery partners. The communication team consisting of 12 staff established culturally safe communication policy and procedures and provides centralized communications support for the FNHA, FNHC and FNHDA. The team established close working relationships with the communication department within the provincial government which gave access to the provincial media monitoring system and supports alignment of initiatives and messaging. The team has supported organizational efforts to communicate with its client base, build positive reputation of the FNHA and has implemented a number of successful information campaigns to raise First Nation awareness of healthy lifestyles and support them in their health and wellness journey. The team established strong social media and online presence (e.g., the FNHA website that receives over 40,000 visits per quarter) for the FNHA.

Social Media	Following
Facebook	23,312
Twitter	9993
LinkedIn	5,454
Instagram	855

The communication team also built the FNHA internal communication systems, including daily news stories, to inform staff members around the FNHA activities and successes, and developed service request processes to review, process and support program staff with their information and communication needs. Through the system, the communication team is able to review information and communication needs and support staff members by developing communication materials, work plans, and other resources and undertake communication activities on their behalf. The team has also undertaken extensive outreach and communication activities to engage First Nation clients and communities. These activities, and their impact are summarized and further described in the Client Engagement Case Study Report.

Finance

Activities undertaken by the FNHA to improve financial management practices within the organization are summarized as follows:

Developed Strategic Financial Framework, which brought clarity to inflow and outflow of funds to the FNHA facilitating financial decision-making. The framework mapped different sources of funds that the FNHA receives against intended purpose and eligibility, and identified financial authority over the funds. It divided funds into sources (e.g., provincial, federal), purposes (e.g., salary, contribution, base funds), and other sub categories (e.g., permanent vs. temporary, base vs. program specific) which are important in decision-making. The framework provided structure and strategy within which to make financial decisions and to ensure sustainability. It helped the FNHA better manage its resources and predict how spending decisions affect financial position of the organization. It was a significant undertaking and will facilitate the next round of funding agreement negotiations.

A number of financial reviews and internal audits were undertaken for different areas of the FNHA operations and programming. The purpose of the reviews were to inform the Senior Executive Team of current FNHA operations, costs, and potential issues, and to provide additional information to support a discussion and decision-making around challenges and improvements. The results of the reviews were summarized into a number of reports, which provided a range of recommendations for the FNHA to undertake to improve efficiency and effectiveness of its operations. Some of the FNHA areas of operations covered by the review process, included office accommodation, fleet services, deferred investment funds and health action funding.

Created long term and strategic financial planning processes. To support a fiscally prudent and sustainable strategic approach to financial planning, the FNHA has started developing five-year budget forecasts. Five-year budgets were developed for each area of FNHA funding, including: Base Funding (Canada Funding Agreement), Deferred Investment Funding, and Specified Purpose Funding. During interviews case study participants noted that long term budget forecasts were necessary to undertake proper program planning and make informed decisions. It was a critical part of ensuring long term sustainability of the FNHA activities.

Established systems, structures and processes for effective and efficient financial management. Some of the new strategies and systems created include: reporting strategy to provide improved and timely financial information aligned with the Financial Strategy; a range of tools and resources to support budgeting, forecasting, and funding arrangement support services; and agreement monitoring support and reconciliation to provide a more efficient way to support funding arrangements, recipient relationships, and timely information supports. The finance team also developed internal capacity and staff qualification to meet service expectations.

14.4. Impacts

The development of the FNHA corporate services and capacity have generated a number of impacts, in terms of:

The FNHA has built a strong corporate infrastructure and capacity. During interviews, case study participants noted that the FNHA corporate services and functions are of high quality, comparable and even better in many areas compared to other similar organizations. In particular, according to case study participants, compared to other health authorities, the FNHA corporate services and functions are much

smaller, more nimble and less bureaucratic. As a new organization, it has been able to incorporate some of the most advanced technologies and infrastructure, which function better compared to software and technologies used by other health authorities. However, it was also noted that other health authorities are much larger, have more staffing, and more resources. Their corporate services are also centralized to a certain degree (e.g., provided by the provincial government and/or one health authority), helping them to gain significant economy of scales and efficiencies. In addition, other health authorities are more established and have more procedures in different areas of operations and their policies are more functional due to a long history of implementation. In terms of the FNHA's corporate functions and capacity, case study participants noted that:

- *FNHA has a solid IMIT structure, which functions effectively and can address growing organizational needs.* Over 80% of the IT service needs are addressed immediately (at Level 1) and IMIT is integrated with other key parts of the organization, corporate planning, operations and policy development. Organizational data infrastructure helps the FNHA to access more quality data on its activities and operations, which facilitates effective decision-making.
- *Solid financial planning and informed decision-making process have been built, helping the FNHA to predict and identify critical issues when they arise and to support sound decision-making.* The FNHA is better able to support communities with financial planning and reporting (e.g., timely and appropriate guidance in reinvesting surplus funds, financial reporting). First Nations, funding recipients and the FNHA program staff are able to receive timely information, advice and support with regards to funding allocation and reporting. The FNHA is able to provide support and a high degree of assurance that funding is utilized to ensure prudent use of resources and sustainability of funding to communities and service delivery organizations.
- *Corporate policies, structures and systems have helped to create consistencies in FNHA activities, save costs, and create efficiencies.* Case study participants noted that having policies and procedures in place have created more consistency across the organization and increased effectiveness and efficiency of operations. Examples of impacts mentioned by case study participants included: procurement policies ensured a proper due diligence and finding best deals for the organization, and fleet guidelines ensured a proper sign off procedures in place for staff who want to borrow a company car.

Case study participants also noted that there are spin-off benefits from the creation of the FNHA corporate capacity. Due to high quality of the corporate services, some First Nation organizations and communities are requesting the help from the FNHA, for example when hosting gatherings or developing organizational policies, systems and procedures.

During interviews, case study participants noted that FNHA's corporate functions and services do not usually have direct impacts on First Nation clients. However, these functions are critical in enabling the organization to function more effectively and efficiently to deliver on its roles, achieve its mandate and produce expected outcomes. Some of the positive impacts in improving the organizational effectiveness mentioned by case study participants are summarized as follows:

- **More coordination and alignment of the major projects implemented by the FNHA.** According to case study participants, creation of the Strategic Projects Office has ensured that enterprise-wide implications of new projects are assessed and understood prior to implementation. It also facilitates a greater level of collaboration among departments affected by major initiatives, and greater awareness of initiatives undertaken within the organization. The Strategic Projects Office also helped to create consistency

across the organization's major projects, reducing silos and contributing to the quality and outcomes of those projects.

- **Proper planning and reporting have made it possible for the FNHA to meet its contractual and legal requirements.** Regular and timely planning, reporting and evaluations have enabled the FNHA to make more informed decisions and demonstrate success of its activities to stakeholders. High quality, and engaging reports helped First Nations and governments better understand accomplishments of the FNHA and challenges that it faces, improving the reputation of the organization. All of the FNHA's legal and contractual requirements under the Tripartite Framework Agreement and Canada Funding Agreement have been consistently met, to a high quality standard.
- **Enabled the FNHA to become more responsive to client needs.** Case study participants noted that corporate services have enabled the organization to better identify (e.g., through surveys, online activities and in-person engagements undertaken by the communication department) and address client needs (e.g., through coordinated supports, more strategic approach, policies, systems new technologies and better systems and processes.)

In terms of negative impacts:

A few case study participants noted that too much focus on developing strong corporate functions may at times take away focus of the programs and services. Especially, when the organization does not have a clear strategy or structure for corporate services, there is a risk that growing size of the services does not match with growth in regional and community capacity. In addition, case study participants also noted that implementing many policies and procedures, if not managed well, may create extra layers of bureaucracy, affecting agility of the organization and restricting the staff to deliver on their roles and responsibilities.

14.5. Gaps, Challenges and Issues

The development of the FNHA corporate services and capacity was associated with a number of challenges and issues, some of which are summarized as follows:

Building systems from scratch took extra efforts. As a new organization, FNHA did not have existing corporate services infrastructure, processes, policies and systems. For example:

- The organization did not have a process for developing and approving policies, which had to be created. Challenges were encountered in the ability of the policy team to develop timely policies given the volume of the work and ambiguity of the cycle and process. As a result, policy documents often were delayed, did not have adequate rigour, and were not developed with adequate engagement from staff. These challenges were addressed significantly in 2017 and 2018 as the corporate policy team was placed within PPQ and a focused improvement effort was made to create a new Policy Framework, and corporate policy calendar and process.
- Challenges were encountered with aligning IT equipment and application with organizational priorities and needs. Extensive discussions and reviews had to be conducted to determine the types of technology, equipment etc. required and ensure those technologies were in line with the organizational vision and strategies.
- During the time of transfer from FNIHB, challenges were encountered with hiring new staff members or contractors and getting them to work because the organization did not have established HR systems in place. Systems for developing job descriptions, advertising, recruiting, identifying benefits and pay grades etc., had to be created within very short period of time.

Evolving mandate, operating model and activities of the FNHA affected the design and delivery of corporate functions and activities. As the organization has been growing and its identity and operating model been evolving, the requirement for corporate functions have also been shifting. During early stages of the transition, the FNHA mostly operated as funder and also partner to First Nations. Gradually, however, the FNHA has been involved in delivering services directly to communities. The FNHA's involvement in new areas of programming and taking on new roles shifted the nature and type of corporate services and functions that it needs. For example, the FNHA's involvement in delivering primary care, may require a new systems of IT and HR functionalities. Each time there is a change in nature of operations and activities, the corporate policies, procedures, progress reports, performance measures, IT systems have to be changed and adapted. Constant change takes away staff time and sometimes makes it difficult to adjust. Furthermore, lack of clarity around the organization's operating model makes it difficult for the FNHA to determine proper size, and structure of the corporate services. Under continuous change, opinions and visions differ across the organization's Senior Executive Team in terms of the size, structure and type of corporate services and functions that the organization needs.

Balancing speed and agility with a proper due diligence and checks and balances. According to case study participants, the main advantage of the FNHA has been its agility in identifying needs and taking action to address them. At the same time, having necessary checks and balances, and processes and procedures to ensure legal and policy compliance, and quality and effectiveness of the activities have been critical. Maintaining balance between quality and effectiveness while ensuring timely response has created difficulties. For example, the organization has to balance reviewing continuous requests for new positions against available funding, the organization's purpose and identity, and its commitments under collective agreements. Similarly, constant program and funding requests have to be weighed against funding availability and long-term sustainability of the organization. At times balancing such priorities have slowed decision-making and resulted in internal complaints around levels of bureaucracy created at the central office and/or in corporate services.

Conducting adequate level of engagement and buy-in on developing organizational policies, procedures and systems has been a challenge. The FNHA has struggled to find a right balance for engaging staff members in developing policies, frameworks and procedures. There is no single agreement among senior executives with regards to engagement processes, timing and involvement of key staff members. While more extensive engagement often produces greater buy-in and participation, it is also associated with greater administrative work and delays in producing outputs, as well as implications for time available for other strategic discussions. Finding a right balance for ensuring engagement while also meeting the Board's expectations and timelines has been a challenge. Similarly, busy schedules and competing priorities have made it difficult for program staff members to discuss development of new corporate policies and procedures and provide adequate and timely feedback.

Staff turnover, particularly among senior leadership in charge of the corporate services and functions, is an issue. The FNHA have had several Vice Presidents of HR and IMIT over the last few years. Each time a senior staff member leaves the organization, it creates an issue with employee morale and contributes to turnover of other staff members. In some departments, turnover rates have been at 20% which is relatively high by the standards of the industry. According to case study participants, high turnover also affects the reputation of the organization and its ability to attract qualified employees.

Insufficient collaboration between corporate services and program staff has affected the operations of the FNHA. During interviews, case study representatives involved in delivering corporate services and functions indicated a high degree of collaboration and partnership among staff and departments (i.e., IMIT, PPQ, HR and Finance). In particular, leaders of IMIT, PPQ, HR and Finance come together quarterly to coordinate activities, improve communication and avoid potential areas of overlap or duplication. They also work extensively on joint initiatives and projects. For example, IMIT, HR and Corporate Services work together with on-boarding new staff members (e.g., setting up office space, IT equipment), PPQ works with other departments in developing HR, IMIT or financial policies, procedures and systems as well as in implementation of strategic projects. Case study participants noted that the same level of collaboration, partnership and trust has not been built between the corporate services and other departments. Particular challenges noted by case study participants included: limited understanding of the value that corporate services and functions provide in ensuring sustainability and effectiveness of the organization; busy schedules and limited time for program staff to attend cross departmental meetings or provide feedback on key documents; differing views on the level of engagement and participation required in developing organizational policies and procedures; differing philosophical views on role of corporate services and vision for the organizational growth; differing views on the value of corporate policies and procedures; and difficulties for corporate teams working directly with regional teams to better understand their needs and preferences. Case study participants also noted that the senior leadership at the FNHA is aware of the issue and are undertaking efforts to create greater cooperation among all departments within the FNHA. Some of these efforts have included creating Strategic Projects Executive Committee to coordinate strategic projects across departments, Architecture Review Committee, a cross departmental committee to coordinate activities around the information management, and Policy Committee to coordinate policy development across the organization.

Limited benchmarks to measure and communicate success of the corporate services. A few case study participants noted that the corporate services and functions have not measured and reported consistently on the outcomes of their work. For example, measuring some of the basic indicators around activities and success (e.g., time it takes to respond to emails, percentage of technical issues that gets resolved, staff satisfaction with the response) and comparing those indicators against industry benchmarks, would help with continuous improvement and create awareness around the quality and success of the services provided.

Challenges around meeting the needs of regions. Case study participants noted that as the regional offices have grown in size, their need for administrative and corporate support has grown substantially. Regional staff members interviewed as part of the case study noted that regions need for corporate supports and functions are quite distinct and difficult to administrated by those who operate in central office. They often cannot receive timely and/or appropriate support from head office, having to assign corporate duties to existing staff members in the regions increasing workload and creating 'shadow' functions. According to these case study participants, more corporate services and functions have to be transferred to the regions. At the same time, case study participants noted that more strategic approach to creating corporate capacity in the regions was necessary. The approach should ensure maintaining efficiencies and avoid creating parallel structures (e.g., IT systems, HR policies) across regions and programs/departments. Case study participants also noted that often regional staff do not have adequate understanding of the capacity and resources that corporate services can offer to them and, thus they do not to use the services in adequate level. Initial efforts to build direct communication between corporate offices and regional team have not been successful. A

more detailed description of potential approaches to regionalization is provided in Case Study on Organizational Design.

Busy schedules that do not allow adequate time to be allocated into corporate functions and activities and to build collaboration between corporate functions and other teams. FNHA staff members, particularly program staff, are busy with their schedules and are constantly dealing with emergencies and other issues of high priority. They often lack time to attend meetings or coordinate activities with corporate services unless it becomes necessary to perform their duties. Members of the corporate services team noted that they often find it difficult to get attention or time from program staff or approval from senior management to engage directly with regional staff over their needs for corporate services. Members of the corporate service team expressed a need for developing effective and efficient systems so they can learn service needs from regions (and also program staff) quickly to be able to address the needs on timely manner.

14.6. Lessons Learned and Opportunities for Improvement

Case study participants provided a range of recommendations on how the FNHA corporate services and functions can be improved in the future. These recommendations and some of the lessons learned mentioned during interviews are summarized as follows:

Decide on the approach to deliver corporate functions and services that will fit the FNHA’s organizational needs the best. To have a strategic approach to corporate services and functions, the FNHA needs to:

- Finalize the FNHA's organizational identity and operating model and identify the type, nature and structure of the corporate services and functions that is needed to support most effective and efficient operations. As part of this step it may become important to review corporate services delivered by similar organizations (e.g., provincial health authorities) to identify and adopt some of their best practices and lessons learned.
- Define and agree the size, nature and structure of the FNHA corporate services. As part of the steps, identify which services will be most effectively delivered centrally (rather than regionally) to create efficiencies and maintain the FNHA's long term sustainability. Ensure, the size and structure is clearly articulated, understood and supported by staff members.
- Regardless of the model used, ensure certain operational rules and standard of the quality backed by measurable metrics are maintained throughout the organization. Having proper systems and structures in place across the organization will ensure the services have a proper quality control and consistency across departments, regions and/or sub-regions.
- Ensure the growth of the corporate services are aligned with growth of programming and community capacity.

Develop metrics to measure effectiveness and efficiency of the corporate services and functions against industry benchmarks. Case study participants noted that to ensure to maintain quality and consistency of the corporate functions and services, the FNHA needs to develop metrics to regularly measure and monitor how the corporate services and functions are delivered. Learning experience of similar organizations and incorporating some of the lessons learned in other jurisdictions into the activities of the FNHA should be beneficial. Some of the performance metrics may include timeliness of response (e.g., time it takes to respond to a request, solve issue or make a decision), effectiveness in solving issues (e.g., through satisfaction survey) and other metrics that will help to benchmark and constantly improve the performance.

The benchmarks should be reviewed and updated regularly to make sure they are aligned with organizational strategic goals and are able to provide sufficient evidence for continuous quality improvement.

Continuously improve quality and consistency of the corporate services and ensure they can address the needs of the organization in adequate level. The FNHA should take steps to address some of the issues with the quality of the corporate services (e.g., slow response, ongoing need for approvals, rejections) mentioned in the previous sections and ensure the services can adequately address needs of the regions and communities. Working closely with representatives of programs and regional staff to find solutions jointly will facilitate the success of efforts.

Continue efforts to improve collaboration and coordination within the FNHA across departments and regions. As the organization grows, finding a right balance of collaboration and partnership will be critical to ensure effective and efficient operations. Focusing collaboration efforts on building positive working relationships based on shared organizational values and mutual trust will help to produce strong team environment, facilitate joint decision-making and contribute to positive results.

Find a right balance for staff engagement in developing policies and procedures to ensure buy-in from staff members while maintaining quality and timeliness of the policies and FNHA's compliance with its legal and contractual arrangements. Clear guidelines and procedures should be developed and agreed within the senior team and staff with regards to requirement for staff engagement in policy development processes. Finding a right balance of engagement and participation will be critical to maintain efficient use of staff time while ensuring that staff have necessary understanding and buy-in of the new policies and procedures. Staff support is critical to ensure the policies and procedures are adequately followed and implemented (and not viewed as an additional layer of bureaucracy).

Continue sharing corporate capacities for the advancement of First Nations and First Nations organizations. A few case study participants noted that the FNHA has developed a strong corporate capacity and infrastructure, which can be used to assist BC First Nations and other First Nation organizations in developing their capacities or supporting their activities. Examples of such opportunities mentioned by case study participants included sharing of software (e.g., Project TREE), office spaces, policies, communication expertise, etc.

Create a greater visibility and awareness of the FNHA corporate services within the organization. According to case study participants, raising awareness of the corporate services (availability, quality, etc.) and functions may help to improve visibility, gain greater support and improve utilization. Ensuring corporate services have strong focus on 'customer satisfaction' will help with continuous improvement and contribute to improved profile among staff members.

There are opportunities to improve efficiency of the FNHA operations through a greater integration of the technology. Case study participants noted there were opportunities to further utilize the FNHA's IMIT and HR infrastructure and capabilities to create efficiencies. This can be achieved by reviewing the FNHA operations and its digital strategy for better alignment and finding opportunities to achieve a greater use of technology and IT infrastructure.

Capacity, skills and dedication of the FNHA staff members involved in corporate services and functions have been critical for the success. While maintaining high quality more alignment of the activities with regional and program needs will contribute to success in the future. The FNHA have hired the most qualified staff members to lead activities of the corporate services. The staff have provided necessary leadership, and demonstrated passion and commitment to develop and grow the corporate functions. Case study participants also noted that the FNHA staff members were able to use strategic approach in developing corporate services, which included focusing on process and systems improvement and proper planning and necessary alignment with the organizational objectives. Going forward, it is important to maintain the existing capacity with a greater recognition of the need for better alignment of the activities with the regional priorities and program needs. While maintaining high service quality, it will become necessary to ensure adequate level of flexibility and support is provided to program/regional staff in making decisions. Developing organizational procedures, policies and systems in close coordination with program staff will ensure greater buy-in and success in implementation.

Annex A: Glossary of Acronyms

BC	British Columbia
EMBC	Emergency Management BC
EOC	Emergency Operations Centre
FNHA	First Nations Health Authority
FNHC	First Nations Health Council
FNHDA	First Nations Health Directors Association
FNIHB	First Nations and Inuit Health Branch
HEMBC	Health Emergency Management BC
IMIT	Information Management and Information Technology
ISPARC	Indigenous Sports, Physical Activity and Recreation Council
MHW	Mental Health and Wellness
MMHA	Ministry of Mental Health and Addictions
MoH	BC Ministry of Health
NIHB	Non-Insured Health Benefits
OCMO	Office of the Chief Medical Officer
PPQ	Policy, Planning and Quality
SET	Senior Executive Team
TCFNH	Tripartite Committee on First Nations Health
TREE	Technology and Resources Enabling Employees Project