Vancouver Island Partnership Accord Evaluation Report

November 2019

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Executive Summary

Introduction

The Vancouver Island Partnership Accord is a relationship document intended to strengthen partnership and shared decision-making between the Vancouver Island Regional Caucus, the First Nations Health Authority and Island Health. The first PA was signed in 2012, followed by an addendum to include the FNHA as a Partner in 2014. The PA was refreshed in 2016 after a review of the Accord.

Evaluation Purpose & Methodology

Evaluation of the Vancouver Island PA fulfils the commitment to monitor and report on progress and support the growth of the partnership between Caucus, the FNHA and IH as well as the requirement (Section 39) to review the PA within three years. The PA evaluation methodology was co-created through a collaborative and participatory process led by an evaluation working group composed of FNHA and IH staff. Data was collected from July through December 2018 through surveys, interviews and a focus group with a number of participant groups including: Caucus participants (Health Directors, Health Leads, Chiefs and Proxies), Island Health key informants, Partnership Accord Steering Committee and Executive Committee members and FNHA regional staff. In total the evaluation heard feedback from 117 individuals. Initial findings were presented at the spring 2019 Vancouver Island Caucus. Through the technical advice process, results and draft evaluations were reviewed at Health Director tables in the fall of 2019, presented to the Partnership Accord Executive Committee and Steering Committee, and tabled for endorsement at the Fall 2019 Vancouver Island Caucus.

Key Findings and Suggestions

This evaluation report contains high-level, broadly stated recommendations of a technical and governance nature. These recommendations may need to be further refined to be actionable. The technical suggestions contained in this report defer to the more actionable and tangible Health Forum report recommendations tied to areas of key shared priority.

Celebrating Successes, Evolution and Transformation

Since 2012, there is the perception that relationships, work priorities and methods for approaching PA work have evolved. **Suggestions:** Expand/scale up local wise practices (what works and what doesn't work) that support the objectives of the PA; Challenge systemic structures and policies that impede the objectives and goals of the PA; Management and clinician staffing exchanges

Innovation

Evaluation participants feel the PA has created a learning environment where creative thinking is encouraged. Through the development of relationships and availability of funding, Partners to the accord are able to implement innovative ideas.

Governance

Evidence suggests that Partners to the accord collectively represent an effective structure for helping to ensure accountability to PA commitments, focus and continuity in the approach to PA work. The separation of technical from governance discussions was identified as facilitators to effective PA work. Most groups have a clear understanding of their roles and responsibilities under the PA. There is variation in HD/Chief's understanding of processes for escalating issues. Challenges raised by evaluation participants include turnover in membership, lack of clarity concerning certain roles and responsibilities, and an absence of mechanisms / channels for operationalizing PA objectives for front-line staff or tying local level work to the regional governance structure. **Suggestions**:

- Dedicate one PASC meeting to more governance discussions
- A governance review to enhance clarity on roles and responsibilities
- Develop orientation materials for new HDs, Chiefs, PASC/C and IH leadership
- Develop mechanisms/channels to support progress on solutions, using strength-based approach to the five areas of key shared priority on the ground

Awareness

Awareness of the PA, including commitments and goals, was seen to vary as a function of the relationship to PA work, length of tenure and exposure to PA efforts. There was a general sense that frontline IH staff are not as aware of the PA as those at more senior levels.

Communication

Findings show that multiple modes of formal and informal communication are being employed by Partners to support PA work. **Suggestions:** Support communication between senior tables and First Nations leadership; Develop communication mechanisms and communication materials to share the story of the PA and local wise practices; Share information relating to FNHA and IH services available to communities.

Engagement

There is mixed evidence of engagement and ownership over the PA and its goals. Strong engagement appears to exist in some areas, but not in all. There is evidence that regional structures are being utilized as a joint opportunity to support engagement. **Suggestions**: Meet face-to-face and in community and allow more time for dialogue

Relationships

The development and strengthening of relationships is seen as one of the great accomplishments of the PA. Relationships are valued. While many relationships existed prior to the signing of the PA, there is evidence of improved relationships since 2012 across multiple levels of the partnership, particularly at the PASC / PAEC tables. The PA is seen as a tool to support the dedication of time and effort to building and sustaining relationships.

Collaboration and Partnership

There is evidence of collaboration and partnership at both the senior and local level. Partnership work is being supported through many regional structures and committees, as well as through the localized, organic efforts of Partners. Moving forward there is opportunity to address barriers to collaboration and partnership, including turnover, variations in capacity, organizational size and workload, flexibility and time / resource constraints. **Suggestions**: Further distribute workload of Partnership, including through increased capacity building for First Nations communities to participate in collaboration and partnership initiatives; increase flexibility of funding (dedicated budget within IH).

Integration and Coordination

There is evidence of integration and coordination of health service planning and service delivery at both the strategic and local level. Inclusion of PA goals in strategic documents and the existence of supportive positions (e.g. IH Aboriginal Health Managers; FNHA CECs) were identified as supporting coordination. Impediments identified include a lack of understanding of services provided by each Partner in communities, inability to share patient data, lack of coordination between acute care facilities and communities and lack of alignment between Island Health 'Geos' and cultural family groups. Examining best practices for region-wide application, staffing a coordinator-type position, creating contact lists and coordinating services for First Nations living away-from-home was identified as a potential opportunity. **Suggestions:** Staffing coordinator-type position(s); Coordinating services for First Nations living away-from-home; contact lists and service level/provider descriptions, addressing constraints to information sharing and privacy/confidentiality frameworks/training to support increased care communication and collaboration.

First Nations Decision-Making

There is some indication of increased opportunities for First Nations involvement in decision-making around the design and delivery of some FNHA / Island Health programs.

Cultural Safety and Humility

Evaluation evidence suggests that resources and efforts have been invested into the advancement of cultural safety and humility in relation to health services for First Nations on Vancouver Island. Examples were shared of how cultural safety and humility work has been advanced through focus, communication, training, staffing and resources. These resources and efforts appear to be translating into greater awareness amongst some staff of cultural safety and humility, shifts in language and how and where work takes place (i.e. with First Nations partners, meetings in community, inclusion of Elders). **Suggestion**: Promote CS&H training and integration of CS&H training within health care professional education; Understand the general thought processes of health system staff around CS&H, race and racism; promote better understanding of First Nations people among the general public; Monitor progress and promote patient complaint processes.

First Nations Perspective on Wellness and Social Determinants of Health

Respondents indicate that there have been shifts towards greater awareness, integration and openness to First Nations Perspective on Wellness in programs, policies and spaces; however, changes are not embedded across all areas of the health system. An increased focus on wellness and social determinants of health is valued by participants and seen as an opportunity to address the fundamental determinants of health; however, funding levels and funding silos constrain such an approach.

Access, Availability and Quality of Health Services

A variety of health service delivery arrangements within First Nations communities was described by Caucus participants. A need for greater access to health services and infrastructure was identified. Facilitators to health system access included local service providers and access to telehealth. A variety of barriers were raised, including the impact of historical experiences with the health system that impacts First Nation's community access to health services, the remoteness of communities and program funding arrangements.
Suggestion: The importance of local health services to support access to health services was noted, as was the desire for more local service delivery through more direct funding, collaboration with other First Nations communities and telehealth.

Reporting, Monitoring and Evaluation

Participants noted that joint reporting mechanisms have been developed, however monitoring progress and health outcomes are still in the development stages.
Suggestions: Develop health system performance and health and wellness outcome measurement for each cultural family; Clarify roles and responsibilities for reporting to communities and measuring outcomes and progress; Future evaluation to focus on strategic tables and increase community leadership and technical input into evaluation planning.

Resources

Participants indicated that resources have been expended to advance joint initiatives under the PA however, there is also an acknowledgment of the overall lack of resources with many competing demands, particularly for service delivery in more rural or remote locations.

Introduction

Background

The *Vancouver Island Partnership Accord* (hereafter referred to as the Partnership Accord or PA) is a relationship document intended to strengthen partnership and shared decision-making between the Vancouver Island Regional Caucus (Caucus), the First Nations Health Authority (FNHA) and Island Health (IH) (hereafter referred to as "the Partners"). The PA outlined a shared goal of creating a more integrated, culturally appropriate, safe, and effective health system for First Nations on Vancouver Island and improving the health outcomes of First Nations.

The first PA was signed on May 14, 2012, followed by an addendum to include the FNHA as a Partner in 2014. The PA was refreshed in 2016 after a review of the Accord with the three cultural families and First Nations Service Organizations.

As shown in Figure 1, three cultural families reside within the Vancouver Island Region: (1) the *Coast Salish* Nation on the south and south eastern parts of island; (2) the *Nuu-chah-nulth* Nation, spread along the west coast of the island; and (3) the *Kwakwaka'wakw* Nation, residing in the North eastern parts of Vancouver Island, nearby islands and adjacent mainland. Collectively, these Nations comprise 50 First Nations communities, each with its own set of unique characteristics, strengths, and contexts.

Also depicted in Figure 1 are the locations of four IH "Geos," or health service regions identified by the province. As noted in Table 1, Geos and First Nations cultural family groupings do not fully align. This means that the operational structure of IH spans two or more First Nations cultural family groupings within each distinct Geo, which has implication for coordination and engagement.

Figure 1: First Nations communities in the Vancouver Island region

Table 1: Overlap of Island Health "Geos" and cultural family groupings

	Coast Salish Communities	Nuu-chah-nulth Communities	Kwakwaka'wakw Communities
Geo 1: Comox Valley, Strathcona, North Island	✓	✓	✓
Geo 2: Nanaimo, Oceanside, Alberni-Clayoquot	✓	✓	
Geo 3: Cowichan, Saanich Peninsula and Southern Gulf Islands	✓	✓	
Geo 4: Sooke Region, West Shore & Urban Greater Victoria	✓	✓	

Purpose of the Evaluation

Evaluation of the Vancouver Island PA fulfils the commitment to monitor and report on progress and support the growth of the partnership between Caucus, the FNHA and IH. Findings emerging from the PA evaluation may also inform upcoming renewals of the PA.

In addition, the evaluation of the PA forms part of the commitment to evaluate the British Columbia Tripartite Framework Agreement on First Nations Health Governance (FA), scheduled to be completed in 2019. As a single line of evidence, findings emerging from this PA evaluation will speak to the following areas of the FA evaluation: (1) governance, Tripartite relationships and integration; and (2) health and wellness system transformation.

An evaluation of progress towards the goals identified in the PA annual work plan fall beyond the scope of the current evaluation.

Methods

The PA evaluation methodology was co-created through a collaborative and participatory process led by an evaluation working group composed of FNHA and IH staff. The PA evaluation working group reported to the Partnership Accord Executive Committee (PAEC) (see description of committee in Regional Structure section below).

Evaluation Timeline

Evaluation of the Vancouver Island PA began in May 2018. The major timelines and steps of the evaluation are listed below (*italicized items are validation/endorsement steps as part of the technical advice process*)

May 2018 May – July 2018	FNHA/IH Working group convened - Members appointed by PAEC Development of a regional PA evaluation plan, including evaluation matrix and associated data collection tools (see Appendix C), and identification of key informant groups
July-Dec 2018	Data collection & validation
November 2018	Presentation to ***Caucus*** and PAEC
Nov 2018 - Jan 2019	Transcript and quote validation with respondents
Jan – April 2019	Analysis and writing
May 21, 2019	Update to PASC with draft findings
June 6, 2019	Update to ***Caucus*** with preliminary findings
October 2-3, 2019	Vancouver Island Regional Health Forum
Nov 4, 6, 12, 2019	Review of findings and recommendations through the Technical Advice Process – three presentations at the Coast Salish, Kwakwaka'wakw and Nuu-chah-nulth HD tables and small revisions/additions added to the report,

	most significantly, the deferment of detailed technical suggestions from this report to the Vancouver Island Regional Health Forum report. No significant shifts in findings or suggestions were made based on the technical advice process.
Nov 15, 2019	Presentation of final report and recommendations reviewed through technical advice process to the Partnership Accord Executive Committee.
December 2, 2019	Presentation of final report and recommendations to PASC
Dec 5, 2019	*Endorsement of findings and suggestions at fall 2019 Caucus*
Jan 2020	*Evaluation working group to discuss communication plans*
Jan 2020	*PAEC to discuss any amendments to PA required. Cycle complete. This evaluation report fulfills the commitment to review the PA every three years (Section 39 of the PA).*

**Italicized text denote future work (at the time of the report endorsement at fall 2019 caucus).*

Sample

Perspectives were gathered from a total of 117 individuals through key informant interviews (KIIs) (44 participants), surveys (65 participants) and focus groups (8 participants) (see Table 2 for a breakdown of evaluation participants by participant group).

Table 2: Number of target respondents, evaluation participants and response rate by participant group and data source

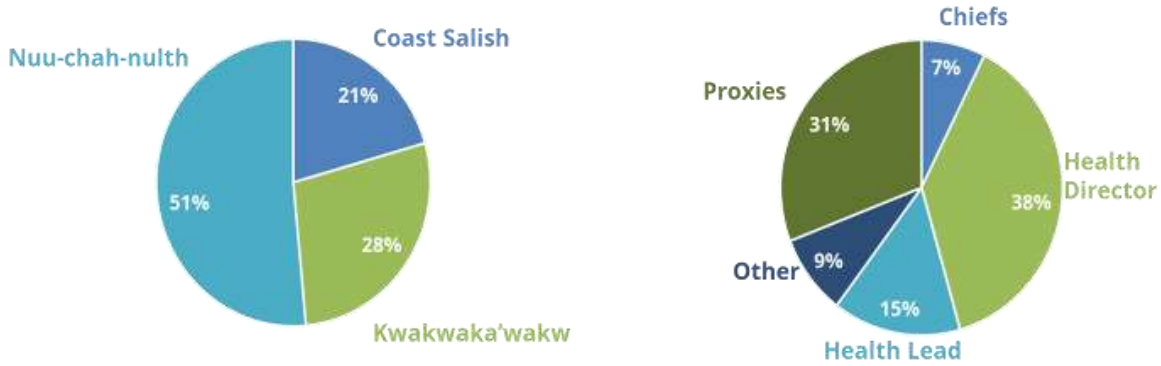
Participant Group	Data Source	Target Participants (n)	Evaluation Participants (n)	Response Rate (%)
Caucus Survey / KIIs (Health Directors (HDs) / Leads, Chief Proxies)	KII	75	20	26%
	Survey		48	64%
PASC and PAEC members (PASC / PAEC)	KII[1]	14	11	79%

[1] Conducted by Ference & Company, a third party consulting firm hired to assist with this evaluation.

IH Directors, Medical Directors, Executive Leads, Vice Presidents (VPs)	KII	12	9	75%
	On-line survey	54	17	32.%
FNHA Community Engagement Coordinators (CECs)	Focus group	NA	8	NA
FNHA Technical Staff	KII[1]	4	4	100%

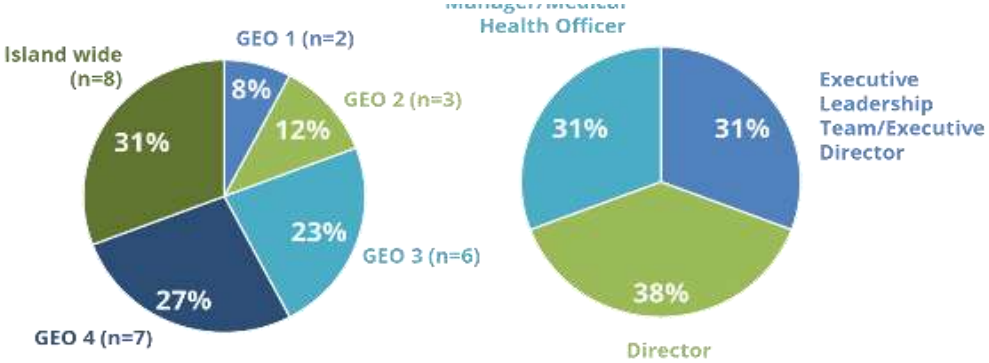
A range of individuals from across different cultural families and roles completed KIIs and a paper survey during the Vancouver Island fall Caucus session (November 6-8, 2018), as illustrated in Figure 2, below.

Figure 2: Percentage of completed Caucus interviews and surveys broken down by cultural family and role (68 participants in total)



IH KIIs and the on-line survey were completed by a range of IH staff whose program area / responsibilities span a variety of geographical areas across the island, as well as roles, as illustrated in Figure 3.

Figure 3: Percentage of Island Health KIIs and surveys broken down by health service region and role (26 participants)



Data Analysis

The qualitative analysis of PASC / PAEC and FNHA technical staff data was completed by Ference & Company, and then synthesized with other data by the FNHA evaluation team. One theme originally included in the evaluation, 'Resources and Prioritization of Share Priority Areas' was removed from the final report because of uncertainty on how to interpret the findings. The contents provided an overview of subjective views regarding the amount of efforts and resources expended to move forward work in the five areas of key shared priority of the PA (Mental health and wellness, Primary Care, Maternal child and family health, traditional wellness and cultural safety & humility). Without more concrete funding information or information on whether participants felt that this level of effort/resourcing was appropriate/or whether efforts should be focused elsewhere, these findings were felt to be of little value, and removed. Future evaluation efforts should consider what type of information would be helpful to measure progress/efforts in key areas of priority.

Analysis of quantitative responses from PASC / PAEC members, IH KIIs and Caucus participants was conducted by the FNHA evaluation team. A sub-working group identified patient experience questions from the Acute Inpatient Patient Reported Experience Measurement Survey (PREMS) of interest from a cultural safety lens

Suggestions

This evaluation report contains high-level, broadly stated recommendations of a technical and governance nature. Feedback from initial presentations at the PASC table in May 2019 suggested the need to further refine the suggestions to make them more specific and actionable.

In October 2019, the first *Vancouver Island Regional Health Forum* was held to bring together Island Health, First Nations and FNHA technical representatives to discuss the five areas of key shared priority from the perspective of both *urban and away-from-home populations* as well as for *rural and remote communities* and delve into great technical detail on matters relating to advancing work in these areas. The Regional Health Forum report will include advice and recommendations that are targeted at specific health topic areas (e.g. Maternal, child health) and for specific target populations (urban and away-from-home populations as well as for rural and remote communities) and thus the high-level, broadly stated technical recommendations contained in this report defer to the more actionable and tangible Health Forum report recommendations tied to areas of key shared priority.

Governance-related suggestions contained in this report may benefit from further refinement.

Evaluation Strengths and Limitations

The strengths of the current evaluation include the use of multiple lines of evidence, co-creation of data collection tools, validation of the transcriptions by participants and

findings/suggestions through the Health Director Table Technical Advice Process, and the use of both quantitative and qualitative data.

Findings from survey questions were integrated with qualitative findings as high-level statements of the results. For reference, complete survey results have been appended to the current report as Appendix B.

The limitations of the evaluation include that data collected for the evaluation were primarily self-reported, collected at a discrete point in time and it is unknown whether the views of those individuals who did not participate or declined to participate may have differed from the views captured in this report. More feedback from community representatives would have been valuable; response rates for Caucus participants varied by cultural family and role. There are some data instrument design limitations; surveys comprised questions that used a 5-point Likert type scale (from "1" "Strongly Disagree" to "5"Strongly Agree"), which may have unintentionally diluted findings. Analysis of findings suggest that providing a single numerical rating for highly complex, multidimensional and evolving PA process was challenging for some participants. Survey data results are to be interpreted with caution.

Opportunities for bias exist during qualitative data analysis due to the unique experiences and perspectives of each analyst. To mitigate the potential impact of this bias the complete technical appendix (containing very granular results) was reviewed by evaluation working group members along with the current evaluation report.

A limitation of the PREMs Acute Inpatient[2] analysis is the limited number of self-reported Aboriginal respondents,[3]as well as perceived (unquantified) barriers for First Nations participation in this survey. PREMs were not created for the purpose of measuring cultural safety & humility, which is a new and emerging topic of measurement. In addition, no statistical tests of significance were able to be conducted due to resource and data access constraints that would indicate whether differences between non-Aboriginal and Aboriginal respondents are significant. Therefore, all results should be interpreted with caution,

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

[3] The analysis includes surveys that contain an ethnicity variable to which respondents select either 'First Nations', 'Inuit', 'Metis' or 'Aboriginal'. Surveys in which individuals selected multiple Aboriginal identifiers (e.g. 'First Nations' and 'Metis') or who selected an Aboriginal identifier (i.e., 'First Nations', 'Inuit', 'Metis' or 'Aboriginal') plus another ethnic identifier (e.g. 'Filipino', 'Chinese') were not included in this data extract. These data will be used for future data analysis.

particularly for questions among subpopulations (maternity patients, pediatric patients, surgical patients, youth patients) where the sample sizes are smaller.

Health Services Matrix data[4] were included in the report to track progress for selected outcomes and to set a baseline. Causal linkages could not be established between these outcomes and the PA[5].

Regional Structure & Processes

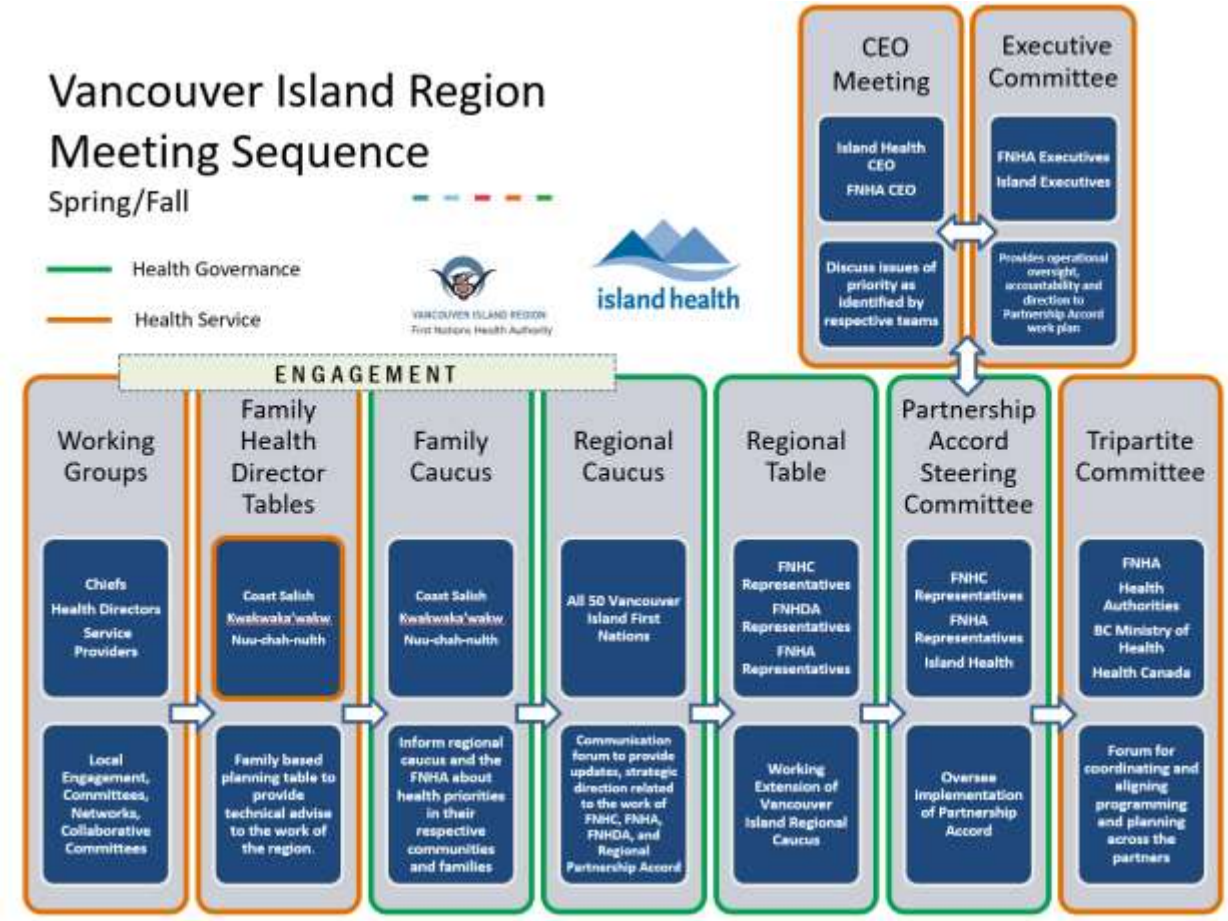
The groups involved in the regional health governance framework in the VI Region are described and illustrated below (see Figure 4), starting with the entities involved in local

Figure 4: Vancouver Island Regional Structure

[4] Health System Matrix (HSM) data contain population-level data on how people use health services (including Doctor visits, hospitals, pharmacies, long-term care facilities and other data sources). HSM data is available broken down by age, gender, residence, population segments (e.g. 'Staying Healthy', 'getting healthy', 'living with illness and chronic conditions' and 'towards end of life') and by First Nations status. First Nations data are available because of a linkage between health services data and the First Nations Client File, a file that enables the identification of individuals likely to be registered under the Indian Act.

[5] PA partners may be interested in establishing a causal linkage between the work of the PA and shifts in health outcomes, however establishing causation is complex, requiring data not available for this evaluation. Analysts may be able to speak to associations between the presence of the PA and shifts in health outcomes, however many health outcomes (e.g. chronic conditions) may take years to develop. *Source: Koepsell (2003). Epidemiological methods: studying the occurrence of illness. Oxford university press.*

level areas of work.



Working Groups – local & technical focus

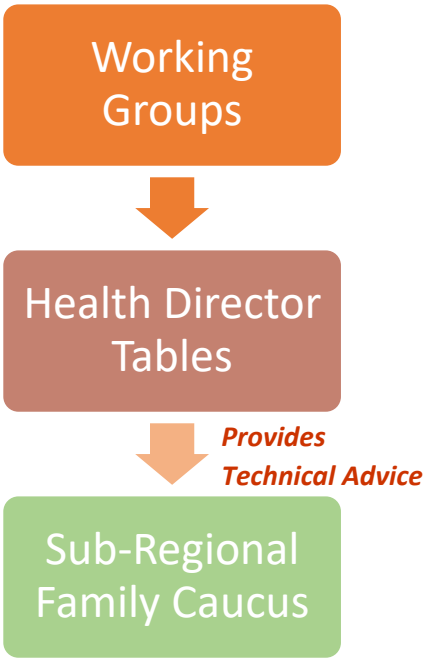
Local level Working Groups are technical in nature and not explicitly tied to the overall governance structure.

Examples include Cultural Safety Committees, a Wellness Table, Collaborative Service Committees, Local Action Teams, as well as numerous IH committees and groups[6]. Membership, structure and nature of these local working groups varies.

[6] The June-November 2014 Island regional update to the Tripartite Committee on First Nations Health mentions numerous working groups and committees, including: 1) Aboriginal Recruitment and Retention Steering Committee 2) Directors Integration Implementation Committee 3) eight (8) Local Area Working Groups these) 4) North Island Hospitals Working Group 5) Mt Waddington Stabilization Committee 6) Perinatal Visioning Committee 7) Dental/Oral Health Committee 8) Pediatrics Planning Committee 9) Mental Wellness and Substance Use Steering Committee & WG 10) NP4BC Implementation WG 11) LHA 70 Review Committee 12) Returning Home Steering Committee 13) Cowichan Attachment/Integration Working Group 14) Mental Health Substance Use ACT Team 15) Cognitive Behaviour Interpersonal Skills Working Group.

Family Health Director Tables – sub-regional & technical focus

The Coast Salish, Nuu-Chah-nulth and Kwakwaka'wakw Family HD Tables are operational in nature and meet as required to discuss issues of concern / shared priority. Partners are invited to these tables to plan, collaborate and learn. Outputs from HD Tables include potential solutions and recommendations for governance tables (Sub-regional Caucus).



Sub-regional Family Caucus – sub-regional & governance focus

The Coast Salish, Nuu-Chah-nulth and Kwakwaka'wakw Sub-Regional Family Caucus each meet biannually to share regional perspectives and information, discuss community-level health concerns, and to support the Regional Caucus process and work. A component of the work completed by the Sub-Regional Family Caucus is informed by and grounded upon the technical advice emerging from their respective Family HD Table.

Each Sub-Regional Family Caucus appoints one governance representative to serve as a member of the First Nations Health Council (FNHC). This individual then serves as the FNHC representative as Chair of the Sub-Regional Family Caucus, as Regional Table member and Partnership Accord Steering Committee member[7].

Evolving engagement structure

In April 2019, the format of Regional Caucus evolved from a biannual joint technical / political forum to a separate event for political vs. technical discussions in the spring. As per the direction of VI Regional Governance and Health Leadership, governance and technical issues are separated to better support the functions of the regional governance processes. Moving forward, the spring Regional Caucus will schedule two separate sessions, one for Chiefs / political leads and one for HDs / technical leads.

Regional Health and Wellness Forum – technical focus

Annual health service focused engagement for HDs / additional attendee. Held in the spring.

Regional Governance Caucus – governance focus

[7] The FNHC seat terms are for varying lengths (Coast Salish and Kwakwaka'wakw FNHC terms are for three-years and Nuu-chah-nulth is for four). Elections for FNHC member occur at Sub-Regional Caucus. All reps will hold their seats until 2021, however election terms are not usually synchronous. FNHDA reps are all two-year terms and elected at the FNHDA AGM. Some individuals may hold positions for more than one term.

Annual political and decision-making forums for Chiefs or political leads. Held in the spring.

Regional Health Assemblies (formerly referred to as Regional Caucus) – regional & technical / governance focus

The Regional Health Assembly will be held in the fall and will bring together FNHA / FNHDA / FNHC to engage and share information on matters that are relevant to both political and technical leads:[8]

- share information related to individual First Nations or groups of First Nations within the Region;
- provide guidance to the Regional Table;
- provide guidance to the implementation of the Regional Partnership Accord;
- approve regional-specific documents such as the Regional Health & Wellness Plan and Regional Caucus Terms of Reference;
- provide direction for any regional-specific initiatives;
- appoint representatives to the FNHC, and nominate individuals for the FNHA Board of Directors;
- participate in consensus-building and engagement processes through the FNHC or FNHDA; and
- participate in processes to solicit regional perspectives and advice.

Annual Partnership Accord Chief's Meeting– **regional governance focus**

The IH and FNHA CEOs attends one of the **Regional Caucus** sessions to report to Chiefs on the progress of the Partnership Accord. The meeting provides Chiefs the opportunity to hear firsthand from those appointed to uphold the PA.

CEO-CEO Meetings – regional technical focus

The IH CEO and FNHA CEO meet twice per year. One meeting coincides with Regional Caucus/Annual Partnership Accord Chief's Meeting.

Regional Table – regional & governance focused

Three appointed FNHC Sub-Regional Cultural Family representatives (political) and three regional representatives from the First Nations Health Director Association (technical) sit at the Regional Table, which functions as a working extension to Caucus to help support and direct work in the region, including:

- Report to and perform work directed by the Regional Caucus
- Engage in strategy development for the work of the Regions
- Lead the development of Regional Health & Wellness Plans

[8] Retrieved online April 26, 2019 at http://www.fnha.ca/Documents/HG_Placemat.pdf

- Lead implementation of Regional Partnership Accord

The Regional Table meets quarterly and also includes senior FNHA Regional leadership.

Partnership Accord Steering Committee (PASC) – regional governance focused

The Partnership Accord Steering Committee oversees the implementation of the Vancouver Island Region Partnership Accord. The Committee represents a senior forum for partnership, collaboration, and joint efforts on First Nations health priorities, policies, budgets, programs and services in the Vancouver Island Region. Members include the IH CEO, and VP of Quality, Safety & Experience, three individuals appointed to the First Nations Health Council by the Vancouver Island Regional Caucus, FNHA's CEO and COO as well as other ex-officio members of IH and FNHA senior staff. The PASC meets twice per year, once to coincide with Regional Caucus.

Partnership Accord Executive Committee (PAEC) – regional technical focus

The Executive Committee was created in mid-2016 and is comprised of a select number of IH and FNHA senior staff. PAEC provides operational oversight, problem-solving, and direction to the Vancouver Island Partnership Accord work plan as directed by PASC.

Tripartite Committee on First Nations Health (TCFNH) – provincial / federal & technical focus

In addition to the regional partnership activities and relationships embodied through the work of the VI Partnership Accord, IH also plays a role as part of the Tripartite Committee on First Nations Health (TCFNH). The TCFNH coordinates and aligns planning and service delivery between the FNHA, IH, the Ministry of Health and Health Canada.

Findings

Several themes emerged over the course of analysis, which are presented below in no particular order of importance, beginning with the evolution / transformation of the regional governance structure and associated work over time.

Celebrating Successes, Evolution and Transformation

There is the perception that since 2012, relationships, work priorities and methods for approaching PA work have evolved.

Examples of transformational shifts include:

- greater awareness of the importance of joint partnership in engagement, planning and decision-making;

> *"[…] we have been doing things the same way for a long time. The PA challenges some long held practices"* Evaluation Participant

- hardwiring of First Nations health priorities into IH work plans
- enhanced availability of technical fora / structures that foster fruitful discussions and decision-making amongst partners (e.g. PAEC table; CEO-to-CEO meetings); and
- shifts in perspectives and in the use of language (e.g. around cultural safety & humility, racism and wellness, importance of involving Elders and meeting in community).

> *"Brought greater awareness of the shared priorities, and the importance of including these in our plans and strategies. No longer an add-on or afterthought to the work - it is imbedded in the work."* Evaluation Participant

Suggestions: Participants see opportunities to expand/scale up local wise practices that support the objectives of the PA (e.g. examining areas of wise practice and translate into region-wide policy and approaches) as well as opportunities to challenge systemic structures and policies that impede the objectives and goals of the PA (e.g. educational requirements that impede First Nations applicants).

> *"Some of these approaches may benefit other areas and should be reviewed as a potential best practice… how do we make this a proactive and regional process?"* Evaluation Participant

A minority of participants indicated that they have not perceived any changes in their work as a direct result of the PA; however, participants expressed recognition of the importance of the work that has been undertaken to date, the understanding that any work flowing from the PA takes time to complete, and of the need to continue with PA work and celebrate successes and key milestones along the way.

Innovation

Evaluation participants feel the PA has created a learning environment where creative thinking is encouraged. Through the development of relationships and availability of funding, Partners have been able to implement innovative ideas, such as joint crisis response protocol, Elders in Residence and multidisciplinary clinical teams.

> *"So as big and challenging and hairy as the problems may seem, we have huge opportunity and willingness from both sides to be bold in our approach to the work"* Evaluation Participant

Innovative PA work that was highlighted by evaluation participants included:

- the development of the Joint Crisis Response Protocol and creation of multi-sector partnerships following community crises
- funding and clinical innovations to support engagement & outreach (e.g. sessional payments for physicians to attend CSC meetings; inclusion of non-clinical supports as part of clinical teams); and
- greater integration of the First Nations Perspective on Wellness into health services (e.g. the creation of Elder-in-Residence in acute care facilities involved complex

issues such as the definition of an 'Elder', as well as criteria to recruit and policies to remunerate such a role)

A suggestion of management and clinician staffing exchanges was identified as a mechanism to support collaboration, partnership, CS&H as well as access is to services. Secondments or interchanges for FNHA / IH management would offer an opportunity to learn about the organizational system, decision-making and service delivery of Partner organizations. Clinician exchanges through secondments, interchanges or practicums was identified as a useful tool for recruitment, relationship building and developing an understanding of First Nation perspectives on wellness and access challenges.

Governance

Evidence suggests that Partners to the accord collectively represent an effective structure for helping to ensure accountability to PA commitments, focus and continuity in the approach to PA work. The separation of technical from governance discussions was identified as facilitators to effective PA work. Most groups have a clear understanding of their roles and responsibilities under the PA. There is variation in HD/Chief's understanding of processes for escalating issues. Challenges raised by evaluation participants include turnover in membership, lack of clarity concerning certain roles and responsibilities, and an absence of mechanisms / channels for operationalizing PA objectives for front-line staff. A governance review was suggested as a means of enhanced clarity.

Governance can be defined in multiple ways, depending on the function and context, and can include:

- First Nations' inherent rights and right to self-government;
- governance of program and service delivery and models;
- FNHA as the BC First Nations "Ministry" (strategy, policy, health governance partnerships, health data governance on behalf of First Nations that collectively established the FNHA); and
- corporate and organizational governance with appropriate authorities, documentation, risk management, planning, controls and decision-making.

Evidence indicates that the PA has helped to guide the establishment of a process and structure for PASC / PAEC members to meet on a regular basis, have in-depth discussions, and communicate and collaborate on PA work. As a result, the Partners have jointly identified areas for further alignment, key priorities and strategic planning opportunities.

Most PASC / PAEC members agree that the current PA structure effectively supports the goals of the accord (see Figure 3.P3 in Appendix A). There is the perception that including the FNHA and IH CEOs at the table is beneficial for advancing PA work. In addition, CEO-to CEO meetings are considered innovative mechanisms for addressing issues in a technical manner, which did not exist prior to the signing of the PA. PASC / PAEC members also feel the Annual Partnership Accord Chief's Meeting is an important accountability mechanism with respect to PA commitments.

> *"Well it makes a difference when you have CEOs on the committee [laughter], as well as the senior leadership in both organizations, you know you make sure things get done"*
>
> Evaluation Participant

The separation of governance and technical discussions through the creation of the PAEC is deemed beneficial by evaluation participants as such separation has helped to operationalize the goals, allowed for a more equitable allocation of PA work amongst FNHA and IH staff, and supported honest and open conversations of a more technical nature. Satisfaction with the PAEC table is supported by survey findings, which indicate that a majority of PASC / PAEC members feel the PAEC is a useful structure for providing operational oversight (see Figure 3.P5 in Appendix A).

Roles and responsibilities. Most participant groups feel they have a clear understanding of their PA roles and responsibilities[9] (see Figures 3.P2 and 2.4 in Appendix A). There is a sense that the joint work of the PA has provided greater clarity on roles and responsibilities, particularly relating to the role of the FNHA, and specifically among those who have become more involved in PA work over time, and those at more senior levels of IH. There was a lack of clarity regarding roles, responsibilities, coordination and service offerings amongst Partner organizations delivering services in First Nations communities.

> "*the services that Island Health provide are probably bought by FNHA to be provided for the community. I'm guessing now, just assuming that there must be some sort of agreement there since FNHA have taken over from Health Canada but still Island Health is providing the services to the FN people.*" Evaluation Participant

A greater awareness of the PA amongst Chiefs and HDs, as well as a greater awareness of the mechanisms and processes for escalating local issues, has helped to move PA work forward. Results from the fall 2018 Caucus survey suggest that there is variation in awareness by Chiefs and HDs of the processes to connect with the FNHA and IH to address local issues (See Figure 1.3.b / 1.3.f in Appendix A). There is work underway to map out the

[9] PASC / PAEC members were asked "In your view, is there a clear understanding by all Partners of the roles and responsibilities as outlined in the PA TOR"? FNHA Technical staff were asked, "How would you rate your understanding of FNHA's roles and responsibilities under the PA?" and IH KIs were asked, "How would you rate your understanding of Island Health's roles and responsibilities under the PA?"

process for escalating issues from local / community-level work up to the PASC that may support this local understanding.

Suggestions: PASC / PAEC meeting logistics. Evaluation participants provided some suggestions for improving the logistics of meetings. Examples include the creation of a regular PASC / PAEC meeting schedule that is booked in advance (e.g. 1 year ahead of time) and that considers strategic meeting sequencing (e.g. aligning Regional Table meetings to support FNHC attendance at PASC meetings; aligning CEO-to-CEO meetings leading up to the TCFNH / Leadership Council). It was also suggested that it may be beneficial for the Partners to come together more often to engage in face-to-face conversations, particularly when there are new members, and that these in-person meetings be held in community whenever possible. Other suggestions include dedicating at least one PASC meeting to a discussion on governance and allowing for more time to engage in dialogue rather than relying on a one-way reporting approach.

Representation of Partners. On the one hand, there is the perception that the right people are sitting at PASC / PAEC tables. On the other, there is a sense that the breadth of representation might be expanded to better influence transformation of the health system. It is recognized that the MOH is not a signatory to the PA. Some feel this lack of MOH representation presents a challenge since the provincial government wields considerable influence over PA work and HA priorities. The MOH mandate letter is a strong tool for advancing shared priorities but other priorities of the MOH can detract from the focus and visibility of the PA key areas of shared work. In addition, it may not be reasonable to expect the three First Nations members sitting at the PASC table to sufficiently represent the diversity of First Nations communities residing across the region. Finally, there may be opportunity to better align the FNHA as an entire organization around regional-level priorities.

> *"HD are changing all the time, our leadership's changing all the time - how do we keep them up to speed? Keep them informed, get them to that level of understanding of the importance of this partnership that FNHA has with Island Health."*
> Evaluation Participant

Overall, turnover in First Nations leadership, technical representation and senior level partnership is a challenge because of the risk of decreased awareness of the significance of the underlying work and commitments that have brought the PA into

> *"Often times, the process by which these agreements are developed, unless you're in the room and part of those discussions, you don't always know the road that was travelled to get there."*
> Evaluation Participant

being[10]. At the fall 2018 VI Caucus, roughly one third of Caucus attendees indicated that they had attended Gathering Wisdom for a Shared Journey in 2011,[11] where the decision to transfer the operations of Health Canada's First Nations and Inuit Health Branch-BC Region to a First Nations Health Authority was endorsed. **Suggestions:** Moving forward, it was suggested that orientation materials for new HDs, Chiefs, PASC / PAEC members and IH leadership, include background context / information on the history of the PA, a description of PA roles and responsibilities, as well as key structures and how these may be utilized to escalate local issues.

> *"*[…] *when the people change, you kind of lose ground. So when leadership changes, or when structures change, you're starting from square one again. And because this work is so dependent on developing trust and some sense of trust over time, when the people change it's not helpful"*
>
> Evaluation Participant

More specific to PASC tables, the turnover of elected FNHC representatives is a challenge in terms of continuity of the work of the PA and in relationships because of the nature of their elected positions. Evaluation findings suggest there is a lack of clarity on whether PA goals and priorities should be revisited when new PASC representatives join the table.

Evaluation participants would like to see enhanced clarity in roles and responsibilities specifically related to:

- the role of the Regional Caucus and of the FNHA in engagement and decision-making;
- the determination of who is accountable for service delivery in communities receiving care through a Health Service Organization;
- the determination of who is responsible for monitoring progress and for following up with Partners on commitments to the PA;

> *"*[…] *we do so much work with the FNHA and the FNHA seems to have representatives that we can call upon at certain points around certain things but I don't see that the Caucus is involved in those discussions at all"* Evaluation Participant

[10] These include the several provincial and regional foundational governance documents including: The Transformative Change Accord: First Nations Health Plan (2006); The Tripartite First Nations Health Plan (2007); The Consensus Papers (2011 and 2012); British Columbia Tripartite Framework Agreement on First Nations Health Governance (2011); Health Partnership Accord (2012); Cultural Safety and Humility Declaration of Commitment (2015); The Island Health Aboriginal Health Plan; Vancouver Island Regional Health and Wellness Plan.

[11] Gathering Wisdom for a Shared Journey is an annual gathering of First Nations leadership, HDs and government partners. The forum provides a key engagement opportunity for Tripartite partners to communicate progress in the implementation of the Tripartite First Nations Health Plan (TFNHP) and to gain additional direction and feedback from BC First Nations to advance the health reform process. See http://www.gathering-wisdom.ca/wp-content/uploads/2015/02/Gathering_Wisdom_IV_Summary_Report.pdf, retrieved online May 3, 2019.

- the determination of who is responsible for reporting back to communities; and
- the role and mandate of IH's Aboriginal Health Committee in relation to the work and structure of the PA.

> *"*[…] *it's our role to provide standard care for everybody regardless of nationhood status or location.* [..I] *don't feel clear on who is overseeing* […] *the services* […] *commissioned through the Band and Chief and Council as well as through the FNHA"* Evaluation Participant

Suggestions: A governance review was also suggested as a way of helping to clarify roles & responsibilities concerning governance, political accountability vs. senior executive accountability and service delivery. Such a review might serve to illustrate concrete examples of what reciprocal accountability looks like in practice across different levels of work.

> *"*[…] *our executive leadership talk about wanting to provide better care for First Nations people but I don't think our Aboriginal health plan actually gives the people on the ground permission or an understanding of how to do this, how to go forward, …[a]nd I don't think we're getting the direction from the FNHA around that either. So from more of a ground level… we find that we're having to lead on that conversation and I wish it was more of a partnership"* Evaluation Participant

Suggestions: Multiple evaluation participants identified the need for mechanisms and / or guidance for linking the strategic goals of the PA to operational work on the ground.

There is the perception that much of the work of the PA takes place at the local level; however, local level work is not explicitly tied to the work of the PA. Moving forward, more explicit linkages may be helpful. The creation of FNHA Manager positions in the four key priority areas was identified as supporting progress. The creation of working groups was raised as an idea to further support this work.

> *"I really think the work is local work."* Evaluation Participant

Finally, there was recognition that the sequencing of community-based feedback through the Regional Structure can be at times a complex and time-consuming process; however, there is recognition of the importance of the process for realizing Community-driven, Nation-based work. Caucus participants identified the difficulty of escalating issues when local level leaders may not be aware of all issues.

"[…] it really can seem complicated, but it's so important to be able to show the pass from the community voice." Evaluation Participant

"*We have a cultural safety committee but I'm not on it so I hear second hand news. Need to have that dialogue…. Depend on leadership but we don't know all the issues"* Evaluation Participant

Awareness

Awareness of the PA, including commitments and goals, was seen to vary as a function of the relationship to PA work, length of tenure and exposure to PA efforts. The majority of PASC / PAEC members (Figure 3.P-1, Appendix A), and Caucus attendees (Figure 1.1, Appendix A) understand the aims of the PA. There was a general sense that frontline IH staff are not as aware of the PA as those at more senior levels (see Figure 2.6 in Appendix A).

Communication

Findings show that multiple modes of formal and informal communication are being employed by Partners to support PA work. Moving forward, further efforts to enhance communication processes and mechanisms may be helpful increase awareness of the PA and support progress towards the PA objectives

"I'm one of those people that I'm not afraid to call it like it is. And people are respectful of that. And I think respect goes both ways." Evaluation Participant

At the PASC / PAEC tables, evaluation participants indicated that communications were being regularly exchanged at formal PA engagement fora / meetings (e.g. Caucus, PASC / PAEC meetings, Annual PA Chief's Meetings, CEO-to-CEO meetings). Frequent informal conversations occur between senior leaders more involved in the work of the PA. Participants feel comfortable engaging in open and honest conversations concerning PA work at PASC / PAEC tables (see Figure 3.P7 in Appendix A).

In the future there is a need to further develop and support messaging and communication between senior tables (PASC / TCFNH) and First Nations leadership within the region. PASC / PAEC members provided suggestions for increasing the frequency and timing of meetings as explored in the Governance section above.

At the local level, evaluation participants referred to multiple fora / tables / structures / mechanisms that had been established since the signing of the PA as a way to foster conversations amongst Partners (see listing in Collaboration & Partnership section). There is the perception that dedicating time for frequent communication helps to move PA work forward.

Some of the challenges that were raised by participants with respect to communication include:

- lack of information relating to FNHA and IH services available to communities;

- the perception that the FNHA is not consistently brought into discussions from the outset (e.g. the Baby Bed program may have benefited from earlier engagement);
- at times there is difficulty knowing who to contact concerning an issue;
- coordinating and scheduling meetings is challenging; and
- lack of alignment between IH Geos and cultural families which adds to the complexity of the conversations taking place between the FNHA and IH concerning service delivery.

> *"I think we need to do a better job at sharing information with communities that is relevant and accessible."*
>
> Evaluation Participant

Suggestions: Moving forward, further efforts to enhance communication processes and mechanisms may increase awareness of the PA and associated work. Specific suggestions for improvement include the development of communication mechanisms (e.g. shared FNHA / IH newsletters; a shared intranet site) and materials (presentations; handouts; 1-pagers; contact lists; roles and responsibilities cheat sheet) to share the story of the PA and local wise practices.

Engagement

There is mixed evidence of engagement and ownership over the PA and its goals. Strong engagement appears to exist in some areas, but not in all. There is evidence that regional structures are being utilized as a joint opportunity to support engagement.

There is evidence of pockets of engagement, champions and 'ownership' of the PA / PA goals in some areas. Many examples of localized innovation, partnerships and collaboration were shared, including a pilot program on the Saanich Peninsula that seeks to integrate First Nations traditions and culture into palliative care services[12]. Another example shared was how IH staff in one area were working to support clinicians in First Nations communities through networking and professional educational opportunities.

> *"I stepped out intentionally how I support advancing the work for our First Nations population."*
>
> Evaluation Participant

[12] Funding for this initiative came from IH and flowed through a local non-profit First Nations home support and home care nursing society, the Saanich First Nations Adult Care Society.

"We have found that in this area that actually the most beneficial way to engage with our First Nations communities and meet with HDs in person. We've learned more about service provision and actual service levels that they're getting within the community by doing that than actually doing that through the FNHA or our external partners" Evaluation Participant

Regional structures are being used by both Partners to meet engagement needs. Meeting in community and/or attending community-driven meetings are seen as supporting engagement, relationship-building and mutual understanding of core issues. Other supports highlighted are staffing & remuneration policies that support engagement (providing supportive reimbursement for engagement of physicians in CS&H committees[13]).

Engagement does not appear to be consistent across the region. Caucus survey results, for example, found that one third of Caucus evaluation participants feel engaged to the PA / PA work (while another third was neutral and one third feels disengaged) (see Figure 1.2 in Appendix A). These findings further vary as a function of cultural family.

"I have been a HD for 5 years and still don't feel engaged on this MOU. Partly due to the work on my plate but also because I have not been asked anything about this." Evaluation Participant

Relationships

The development and strengthening of relationships is seen as one of the great accomplishments of the PA. Relationships are valued. While many relationships existed prior to the signing of the PA, there is evidence of improved relationships since 2012 across multiple levels of the partnership, particularly at the PASC / PAEC tables. The PA is seen as a tool to support the dedication of time and effort to building and sustaining relationships.

The development and strengthening of relationships is seen as one of the greatest accomplishments of the accord.

"The change is very significant in terms of moving from a commitment and a matter of business to actual working relationships. The first meeting that I attended in 2012 was very business-like, very short, very rushed, and very scheduled." Evaluation Participant

[13] Source: Oct 2016-2017 Island Region update to the TCFNH.

There is the perception that relationships more positive, familiar, collaborative and trusting at the PASC / PAEC tables. Partners are making time for the work and shared engagements. PA work is being shared to a greater degree (with some room for further distribution – see Collaboration & Partnership section). Among Caucus participants, results are more varied with respect to relationships with the FNHA and IH over time. Most Caucus participants feel that relationships have improved with the FNHA since the signing of the PA and one third feel that relationships have improved with IH. These results vary by cultural family (see Figure 1.3.a/1.3.e in Appendix A).

> *"A First Nations leader shared with me that the impacts of intergenerational trauma in our relationships go back beyond 150 years, and that it is ok it is going to take time to work through this. It's placed our relationship in a much longer history of time. […] we're actually coming at it from a very different perspective than we did in the past, which was very sequential, logical, rational, European-centric approach to progress where you finish a piece of work and move onto the next piece of work."* Evaluation Participant

> *"Used as a document to rationalize the time, effort and sometimes funding it takes to establish mutually respectful relationships with local First Nations"* Evaluation Participant

There is a growing awareness of the historical context of relations between the health system and First Nations peoples.

Despite resource and time constraints, Partners are becoming more cognizant of the time required, and value of, building partnerships in ways, and at a pace, that meets the needs of all. The PA is seen as a tool that helps to validate the amount of time and effort that may be required to build and sustain strong relationships.

Some evaluation respondents feel that the PA has helped to build relationships with First Nations communities, while others shared that they feel the PA is built upon long-established relationships. As explored in the Engagement section above, Participants shared that they believe partnership efforts and progress in PA work is driven by key individuals rather than the formal structure of the PA.

> *"The outcomes of value are because of relationships between people, not because of ink on paper" Evaluation* Respondent

Collaboration and Partnership

There is evidence of collaboration and partnership at both the senior and local level. Partnership work is being supported through many regional structures and committees, as well as through the localized, organic efforts of Partners. Moving forward there is opportunity to address barriers to collaboration and partnership, including turnover, variations in capacity, organizational size and workload, flexibility and time / resource constraints.

Evidence shows that the PA is an effective mechanism for supporting partnership.

Those who participated in the evaluation feel that the FNHA and IH are working closely and collaboratively, particularly amongst more senior-level staff involved in the work and amongst pockets of front-line staff. Survey findings indicate that the majority of PASC / PAEC and IH respondents feel that the PA has been successful in strengthening partnerships (see Figure 2.8 and 3.P12 in Appendix A). Caucus participants stressed the importance of an equal partnership between IH, FNHA and communities, as well as the need for openness and receptivity to the voices of communities. Caucus participants underlined the importance of being strength-based and solution-oriented in the approach to PA work.

> *"I don't do anything without IH. … I feel as though I can trust them when I need to think through a situation or I need to understand something"*
>
> *Evaluation Participant*

> *"They [communities] all have a vision and an objective in mind on what they want to do but they can't achieve it because they don't have the capacity to do it… the smaller ones for instance, they can't get to that place."* Evaluation Participant
>
> *"at various points in our work it's been hard to find a leader from the local First Nation to participate in the work"* Evaluation Participant
>
> *"Aware there is an FNHA grant due December 19th, sent to administrator to support, too busy to complete. At this moment I do not think anyone worked on the grant application so we have missed out on this opportunity "Evaluation* Participant

Evaluation participants shared a number of different examples of collaboration and partnership fora, including:

- MOH Primary Care Network planning;
- Joint Project Board projects (First Nations Health and Wellness Team; Kwakwaka'wakw Primary Maternal, Child and Family Health; Nurse Navigators; Coast Salish Teamlet; and Hul'qumi'num LPN);
- community visits;
- Regional structure engagements (HD tables, sub-regional Caucus, Regional Caucus);
- Cultural Safety Committees;
- North Island and Cowichan hospital working groups;
- Collaborative Service Committees;
- Joint Crisis Response Protocol development and implementation;
- joint regional leadership of the Opioid crisis response; and
- Environmental Health & Public Health.

Some challenges were identified by evaluation participants in relation to collaboration and partnership.

Staff turnover remains a challenge because of the dependence on established relationships to move PA work forward and maintain positive momentum.

Variation in capacity within First Nations communities was identified as a challenge to partnership. Some communities have greater capacity to partner / are geographically more proximate. Some communities lack capacity to respond to opportunities or have their voices heard.

Unequal organization size across Partners and associated distribution of work was deemed a challenge. There is the perception that FNHA regional staff support a large portion of PA work at both the senior and local level. There is evidence to suggest that the current distribution of work is intentional and serves to ensure work is led by First Nations. More equal distribution of PA work has been noted in some areas; however, moving forward there is further opportunity to distribute PA work more.

> *"We are expected to do and be a counterpart to a system where 10 people on one file whereas we have one person on 20 files."* Evaluation Participant

> "*Starting to work more in partnership– we've agreed with the Cultural Safety Committees that we would support each other - taking turns chairing the meeting ….so far I think it's going really well."* Evaluation Participant

Joint Crises Response Protocol

The FNHA/IH joint crisis response protocol was created in September 2015. The protocol clarifies roles and responsibilities during crises situation in First Nations communities (e.g. cluster of suicides or suicide attempts) in the hopes of ensuring coordinated and culturally appropriate community engagement.

The organizational flexibility of Partners to respond through the Joint Crisis Response Protocol to crises in community was raised as a challenge (see side box for description of the Protocol). Participants acknowledged budgetary realities that affect the ability of each Partner to direct funding and human resources to crises. In some cases, nearby service providers find it challenging to set aside additional time beyond their regular case load to assist with crisis response efforts, and / or transportation to communities poses an added

> "*With many projects, we are under the gun to sprint as fast as we can in order to access one-time resources when they are available or to hit specific target dates. Sometimes that might mean that we don't have the ideal depth and breadth of engagement with every single First Nation community and other non-indigenous stakeholders who may have an interest in that particular project*" Evaluation Participant
>
> *"imposed deadlines are a real tension and stress on our partnership. We want to consult, we want to engage, we want to collaborate but sometimes we have to implement faster than the partnership wants us to."* Evaluation Participant
>
> *"All of this takes time, time to build relationships, time to have the conversation, ask questions, time to say things out loud, have those powerful dialogues and we're not very good at taking time. […] sometimes our actions are a bit clunky because we have a hard time doing the uncomfortable learning*" Evaluation Participant

layer of complexity in terms of being able to direct human resources to communities in crisis. The opportunity of having dedicated budget for the Aboriginal Health team was raised as a suggestion.

Another challenge to partnership are time and resource constraints. There is the perception that imposed deadlines for certain initiatives influence the ability to work together. For instance, timelines associated with the Primary Care Network engagement effort were driven by external MOH deadlines. Another example that was shared pertained to hospital construction projects.

> *"Don't have resources that communities want to see to address the disparities in health system experiences…Sometimes when we can't bring more to table, we frustrate and partnership goes south."*
> Evaluation Participant

> *"Island Health deals with budget cuts and are restrictive. They don't have freedom to direct funding to this work like us. Morally they are very supportive but may not have funding".*
> Evaluation Participant

Finally, participants noted that resource availability within the HA is limited and does not sufficiently cover existing need. Partners expressed the challenge of maintaining partnerships when, in some cases, resources are insufficient.

An idea raised to help support collaboration, partnership, access and supporting management and clinician staffing exchanges. Secondments or interchanges for FNHA / IH management would offer an opportunity to learn about the organizational system, decision-making and service delivery. Clinician exchanges through secondments, interchanges or practicums was mentioned by one respondent as being useful for recruitment, relationship building and developing an understanding of First Nation perspectives on wellness and access challenges.

Suggestions: Further workload distribution between FNHA/IH, including through increased capacity building for First Nations communities to participate in collaboration and partnership initiatives, increased flexibility of funding / clinical staff and staff/management exchanges.

Integration and Coordination

There is evidence of integration and coordination of health service planning and service delivery at both the strategic and local level. Inclusion of PA goals in strategic documents and the existence of supportive positions (e.g. IH Aboriginal Health Managers; FNHA CECs) were identified as supporting coordination. Impediments identified include a lack of understanding of services provided by each Partner in communities, inability to share patient data, lack of coordination between acute care facilities and communities and lack of alignment between Island Health 'Geos' and cultural family groups. Examining best practices for region-wide application, staffing a coordinator-type position, creating contact lists and coordinating services for First Nations living away-from-home was identified as a potential opportunity.

Progress has been observed by evaluation participants with respect to integration and coordination of planning, reporting and in the development of work plans in the region. This finding is supported by survey results, which indicate that most PASC / PAEC members feel that the PA has been successful in creating a more integrated, safe and effective health system for First Nations on Vancouver Island (see Figure 3.P14 in Appendix A).

> *"it's starting to show up, not just in the Aboriginal Health plan which kind of sits on the periphery, but it's more or less embedded across through their annual priorities plan and the IH strategic plan that guides each program area in how they're operationalizing their work plan."* Evaluation Participant

Specific examples of successful coordination were shared by evaluation participants:

- hardwiring the PA into IH's 2018/19-2020/21 Service Plan[14];
- joint hiring panels for new clinicians;
- joint reporting processes; and
- specific situations/ examples of excellence in patient care coordination shared by evaluation participants.

The Aboriginal Health Manager positions at IH and the CEC positions within the FNHA were identified as facilitators to coordination, as was the presence of FNHA on provincial committees.

Evaluation findings also revealed challenges, including:

- the lack of understanding of services provided by different health agencies in First Nations communities. A resource developed by the Divisions of Family Practice called 'Pathways' (https://pathwaysbc.ca/community) maintains a listing of community services available in some areas of the province;

> *"I think at times it muddies the waters in terms of how we go about doing that just because there are three parties to navigate"* Evaluation Participant

[14] Vancouver Island Health Authority (2019). 2018/189-2020/21 Service Plan. Retrieved from the Island Health website: https://www.islandhealth.ca/sites/default/files/2019-01/island-health-service-plan-2018-19-2020-21.pdf

- the inability to share patient records due to privacy legislation and confidentiality concerns
- the lack of information-sharing between hospital staff and local health staff when community members are hospitalized / discharged (particularly those experiencing suicidal ideation / attempts); and
- the lack of geographical alignment between IH Geos and FNHA family groups.

> "*This [geographical] area would really benefit from an Aboriginal coordinator that looked at how to bridge that gap between the HA and all of the FN communities. The challenge with the current structure is there isn't capacity to do that for our area. It's happening but it's not optimal*." Evaluation Participant

Results from the Caucus survey are mixed with respect to views on improved coordination between First Nations, the FNHA and IH. Some participants believe that coordination has improved amongst Partners since the signing of the PA, whereas others do not (see Figure 1.3.d / 1.3.h in Appendix A).

Evaluation evidence suggests that integration and coordination is affected when staff are unavailable (e.g. too busy; staff turnover). On occasion new staff attempt to implement new ideas, which inadvertently creates redundancy or duplication of existing structures.

Suggestions: Consider mechanisms to support coordination between Partners delivering services within First Nations communities and for First Nations living away-from-home, for example:

- 'coordinator' position that might assist in the mapping of needs to services and spearhead the development of processes and policies to support coordinated efforts amongst between First Nations, the FNHA and IH;
- contact lists and service level/provider descriptions; and
- addressing constraints to sharing of patient records (privacy/confidentiality frameworks/training).

FN Decision-Making

There is some indication of increased opportunities for First Nations involvement in decision-making around the design and delivery of FNHA / Island Health programs (see Figure 1.3.c / 1.3.g in Appendix A for Caucus participant's perspectives and Figure 2.9 for the perspectives of IH participants).

Examples of First Nations decision-making include Regional Health & Wellness planning, JPB projects, the North Island hospital design and shared operational decision-making tables at individual health centres. One specific example, following a community crisis, multiple local level agencies, including

> "*I think we still have to remember to consult and collaborate, we're not quite at the 'everything shared' yet.*" Evaluation Participant

the FNHA and IH met over the course of several months at a pace driven by the resources, needs and priorities of the local community.

Participants indicate that First Nations decision-making is not pervasive across the health system and input tends to pertain more to new programs and services. There is a recognition that input into decision-making and prioritization is not equally accessible to all.

> *"The people who are most vulnerable tend to have the quietest voice and not have their voice heard as often as those that are more privileged in society and that's wrong"* Evaluation Participant

Cultural Safety & Humility

Evaluation evidence suggests that resources and efforts have been invested into the advancement of cultural safety and humility in relation to health services for First Nations on Vancouver Island. Examples were shared of how cultural safety and humility work has been advanced through focus, communication, training, and staffing. These resources and efforts appear to be translating into greater awareness amongst some staff of cultural safety and humility, shifts in language and how and where work takes place (i.e. with First Nations partners, meetings in community, inclusion of Elders). There is still a need for further work. Measurement and monitoring of cultural safety & humility is in its early stages of development.

Cultural Safety & Humility (CS&H) is defined as an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care[15]. In July 2015, all Health Authority CEOs signed the Declaration of Commitment on Cultural

About Cultural Safety Committees

Cultural safety committees were created in 2015 for each of the 10 acute care facilities within Island Health.

The Committees provides a forum for FNHA, Island Health staff and local First Nations to come together and provides a safe place for communities to share their experiences with the health system and influence systemic barriers/change.

The role and activities of the cultural safety committees has shifted over time in response to feedback and concerns (e.g. the approaches to the committee (venue shifted from meeting in hospital to meeting in community) and in response to changes in resources and supports (e.g. turnover or vacancy in CEC or Site Director positions, greater co-chairing of the work by FNHA & IH).

[15] FNHA. #itstartswithme Creating a Climate for Change. Retrieved online May 2, 2019 at http://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf.

Safety and Humility[16], which outlines high-level principles to create a climate for change, engage and enable stakeholders, and implement and sustain change. The PA identified CS&H as one of the four areas of key shared priority.

Evaluation participants have observed the investment of resources and efforts into advancing CS&H (see Figure 4.1. in Appendix A). Overall, PASC members perceive strong commitment, support and accountability to advancing CS&H. IH participants feel that the *Declaration on Cultural Safety & Humility* has been championed and / or hardwired into their program area (see Figure 2.6 in Appendix A).

Results from patient experience data collected amongst self-identified Aboriginal inpatients in hospitals across BC in 2016 / 17[17] and self-identified Aboriginal Emergency Department users in early 2018 indicated that:

- 69% of self-identified Aboriginal inpatients felt that their care providers were completely respectful of their culture and traditions (compared to 84% of non Aboriginal patients);
- 77% of self-identified Aboriginal ED users felt that their care providers were completely respectful of their culture and traditions (compared to 91% of non-Aboriginal patients);
- 40% of Aboriginal patients who felt that their spiritual needs were an important part of their care felt that their spiritual needs were met.

Since the signing of the PA, a number of specific mechanisms and structures have been established to support ongoing CS&H work by Partners (see Table 1).

Table 1: Mechanisms identified by Evaluation Respondents for advancing CS&H work

How joint CS&H efforts have been supported	Example
Acknowledgement / focus / emphasis	• The existence of racism in health care has been acknowledged at senior levels • The development of Cultural Safety Committees (CSC) (see text box for a description of these committees) • Inclusion of CS&H as a key strategy within the 2018/19 -2020/21 IH Service Plan[18]

[16] FNHA. Declaration of Commitment on Cultural Safety and Humility in Health Services. Retrieved online May 2, 2019 at http://www.fnha.ca/Documents/Declaration-of-Commitment-on-Cultural-Safety-and-Humility-in-Health-Services.pdf.

[17] See Figure 11 in Appendix A as well as Appendix C for full listing of all patient related experience questions potentially of interest from a CS&H lens. Please note that results should be interpreted with caution due to, in some cases, low sample sizes as well as potential non-response bias

[18] Vancouver Island Health Authority (2019). 2018/189-2020/21 Service Plan. Retrieved from the Island Health website: https://www.islandhealth.ca/sites/default/files/2019-01/island-health-service-plan-2018-19-2020-21.pdf

	• CS&H is a standing agenda item at PASC / PAEC meetings and is a component of each meeting of the Board of IH "[Its starting to be] *ok to look at where Island Health may have some systemic racist practices whereas five years ago people would have felt individually called-out […] I think we're getting mature enough to have those conversations."* Evaluation Participant "[…] *as senior leaders we need to be transparent about culturally unsafe care and acknowledge its existence while demonstrating and championing appropriate care."* Evaluation Participant *"*[…CS&H is] *integrated into everything that these two committees* [PASC / PAEC] *do – constantly on the agenda, constantly monitored and it's part of our quality improvement work we do as an organization. It's very significant."* Evaluation Participant
Leadership	Senior executives are speaking about CS&H through presentations and internal working groups and are setting expectations and encouraging participation in training opportunities
Financial resources	$1 million has been committed in 2018/19 to CS&H training in Emergency Departments
Responsiveness & advocacy	By confronting unsafe language / experiences as they occur "*If I hear it overtly (racism, sexist), there will be an uncomfortable conversation, respectful, but uncomfortable."* Evaluation Participant "*Try to be very responsive to concerns. So if someone from FNHA calls and say 'I don't think this is working very well' I try to make these a high priority*." Evaluation Participant
Staffing	• The creation of three cultural safety training positions within IH, to supplement online training with IH programs / departments / teams • Creation of Elders-in-Residence positions at two acute facility sites to support Aboriginal patients[19] and their families as well as hospital staff. There are plans to roll out to all hospital sites in time. • IH's development of an Aboriginal Employment program aimed at recruiting Indigenous staff members.[20] • Growing recognition of the burden placed upon Indigenous health care providers to support a variety of formal and informal CS&H learning
Training	• San'yas CS&H training is mandatory for senior IH executives and all FNHA staff. The training is also available for any interested Island Health

[19] Source: https://www.mycampbellrivernow.com/39915/elders-support-patients-families-at-north-island-hospitals/

[20] Source: June 2-15-October 2015 Island Region update to TCFNH

	staff.[21] Between 2009 and 2018 / 19 over 4,000 IH staff have completed the San'yas online cultural safety training (358 in 2018 / 19 with a 87% completion rate (54 non-completed seats in 2018/19)). • CS&H information integrated into new employee orientation packages[22]
Interventions and presentations	• Cleansing ceremonies of hospital facilities have been performed[23] • Blanket exercises have been completed[24] • Delivering presentations on CS&H at various committees and meetings
Development of tools and communication materials	• A provincial guide was developed for CS&H, which stakeholders found useful • FNHA material (e.g. Declaration of CS&H, posters, visuals, etc.) • A dementia screening test that was adapted to be more appropriate for First Nations Elders
Utilizing existing processes / supports	• FNHA staff, First Nation communities, IH Aboriginal Health team members and Indigenous health care providers are supporting a variety of formal and informal CS&H work and learning • CS&H considerations were integrated into Primary Care Networks planning • The use of patient quality compliant process to report culturally unsafe care is being encouraged
Acknowledgement, language and mindfulness	• Territorial acknowledgements in meetings • Cultural Safety & Humility language is being increasingly utilized at more senior levels. There is more comfort and willingness to discuss racism. • More awareness of the historical connotation of words and names (e.g. IH's policy for honourarial naming includes an analysis of historical contexts from a First Nations perspective), renaming chapels in hospitals to 'sacred spaces,' using the term 'long-term' care rather than residential care.

[21] There are two online training options within the Island Health region. The first being the PHSA's Sany'as online training, available across the province. Another is an Island specific training cultural safety training module entitled "For the Next Seven Generations - For Our Children" (June 2015-Oct 2015 Island Region update to TCFNH), which includes more regional and community- level content.

[22] Source: June 2015-Oct 2015 Island Region update to TCFNH

[23] Moss, Carla (2018, April 12). A place for healing: Tofino hospital given new Nuu-chah-nulth name. Ha-shilth-Sa. Retrieved from: https://hashilthsa.com/news/2018-04-12/place-healing-tofino-hospital-given-new-nuu-chah-nulth-name

[24] The KAIROS Blanket Exercise program is an interactive and participatory history lesson that covers more than 500 years in a 90-minute experiential workshop that aims to foster understanding about our shared history as Indigenous and non-Indigenous peoples. Source: https://www.kairosblanketexercise.org/

	• Personal reflection "*Fundamentally it is something I have to demonstrate myself in order to affect others*." Evaluation Participant *"I feel it* [the PA] *has made me more reflective of the past and patient with the future. I feel like I am acknowledging the past."* Evaluation Participant
Design innovation	• Creating physical spaces that are welcoming and reflective of local First Nations cultures, values and needs (e.g. involvement in development of North Island and Cowichan hospital designs, All Nations room at West Coast General Hospital[25])

Despite progress and work undertaken to date, there is a recognition that much work remains to support culturally safe health service delivery amongst front-line staff. Evaluation participants shared personal experiences of culturally unsafe health services. Challenges to progress include the large number of staff to train and the nature of CS&H being an individual journey that some may not be ready or willing to embark upon.

"We are still pretty high level … in terms of informing and changing practices at the point of care - still early days". Evaluation Participant

"I feel and hope that Canadian society has come a long way in the last 5 years through the TRC and calls to action. …. As a healthcare system, we need to build on that." Evaluation Participant

[25] Source: https://www.vancouverislandfreedaily.com/community/culturally-safe-space-opens-at-west-coast-general-hospital/

The CS&H of health services is framed within the larger context of Canadian society. Despite increased awareness of harmful policies thanks in part to the work of the Truth & Reconciliation Commission, Canadian society has a long journey of reconciliation ahead. Participants see opportunities for the health system to capitalize on the growing societal awareness to move CS&H work forward, however the challenge of underlying historical and political contexts continue to influence the health system and the health of First Nations people.

Suggestions

- Continue efforts with respect to cultural safety and humility training.
    - Continue to promote CS&H training through online and in-person workshops and explore opportunities to integrate CS&H training in health care professional education.
- Gain greater clarity regarding current understanding of cultural safety and humility, race and racism among health system staff and the general public, so as to target future
- Monitor progress through the creation of indicators and reporting processes.
- Promote the use of the patient complaint process to report instances of unsafe care.

> *"*[…] *we need to work with our teams around their understanding of cultural safety* […]. *If we want to address systemic barriers, the first thing we need to do is understand them. We need to understand our own behaviours and beliefs and how to challenge those."* Evaluation Participant
>
> *"There needs to be a fair and ample opportunity for folks to understand what the expectation is, and then also, what are the tools to support them to be*

First Nations Perspectives on Wellness & Social Determinants of Health

Respondents indicate that there have been shifts towards greater awareness, integration and openness to First Nations Perspective on Wellness in programs, policies and spaces; however, changes are not embedded across all areas of the health system. An increased focus on wellness and social determinants of health is seen as an opportunity to address the fundamental determinants of health; however, funding levels and funding silos constrain such an approach.

Examples of integration of FNPOW provided by respondents include:

- a healing garden, extended family birthing rooms and Kwak'wala signage at the North Island Hospital. The hospital also has policies that allow drumming and smudging;

> *"I'm seeing First Nations Elders being part of and welcomed and actually being part of the work that I'm doing in various places on the island and it really helps."* Evaluation Participant

- through an innovative pilot initiative on the Saanich Peninsula, the design of palliative care spaces has incorporated aspects of importance to First Nations perspectives on death and dying;
- Elders are increasingly included in meetings and committee work; and
- development of traditional wellness committees[26].

However, there is no indication that First Nations perspectives on wellness are being equally integrating into all health services.

> *"On [*medical unit*], if there was a traditional healing practice the family would have to ask. It wouldn't be routine. We'd have to see 'would we allow that' rather than it's just a normal part of practice."* Evaluation Participant

Results from Caucus participants indicate that health programs and initiatives have become more reflective of the culture and traditions of First Nations on Vancouver Island (see Figure 1.3.i in Appendix A). Caucus participants spoke of the importance of traditional teachings, how teachings have been disrupted because of Indian Residential Schools, and that more traditional teachings and medicines need to be integrated into all areas of health services.

Partners are more often considering the social, physical, emotional and spiritual aspects of health and shifting their language away from illness-based to more wellness-based terminology. Respondents also indicated that the concept of FNPOW resonated with their desire for a more wellness-based approach to health services.

> *"Overall, the holistic approach is both timely and reflective of the aspirations of both Aboriginal and non-Aboriginal populations*." Evaluation Participant
>
> *"I would hope that there are as many champions and calls for determinants of health and wellness as there are advocates and calls for improved illness care services. Lead us away from an unsustainable approach to health and health care."* Evaluation Participant

Evaluation participants recognize the importance of the Social Determinants of Health (SDOH) (e.g. housing, food security, income, education, employment, transportation) on individual's health and wellbeing. Participants shared many unmet needs relating to the SDOH in many areas for First Nations on VI.

> *"I would be thrilled if we as a province took more of our resources and invested in those thing that improved the lives of the most vulnerable people in our communities and I am 100% confident that their health would improve. Even if it had nothing to do with health care, just housing, transportation and education and employment."* Evaluation Participant

[26] Source: Nov 2014-May 2015 Island Region update to TCFNH

Evaluation participants noted that the SDOH are outside the purview of the health system and that funding for public health and wellness focused programming in the BC health system has been decreasing over the past few years[27].

Evaluation participants spoke of the 'tyranny of the urgent', that higher profile issues are addressed in lieu of more difficult changes that may have more of an impact on health and wellbeing. Respondents also outlined the constraints that exist (the BC Financial Accountability Act), which prevents the diversion of funds across Ministries.

There were examples shared of work to support the broader determinants of health. One example is IH's ability to award small community grants for cross-sector initiatives[28]. Another is a letter IH wrote to the Ministry of Transportation and Infrastructure advocating for better roads access to a remote First Nation community.

The social determinants of health for First Nations peoples include a complex interaction of many factors, including the past and ongoing impacts of colonialism. Government policies and programs have systematically denied Indigenous people access to the resources and conditions necessary to maximize socioeconomic conditions and health status and suppressed traditional systems of self-governance and self-determination.[29] Over generations, these factors have produced social and material inequalities with compounding effects on well-being that communities continue to experience.[30] Through the creation of the FNHA, First Nations in BC have taken a historic and critical step of self-determination over health services. It has been noted in other jurisdictions that control

[27] 2017 Auditor General's report[27] which showed that funding for public health and wellness programs decreased between 2012/13 and 2015/16 whereas illness-related health spending went up. https://www.bcauditor.com/pubs/2017/health-funding-explained-2

[28] Source: October 2016 – Oct 2017 Island Region update to the TCFNH.

[29] Reading J, Halseth R. Pathways to improving well-being for Indigenous peoples: How living conditions decide health. Prince George: National Collaborating Centre for Aboriginal Health, July 2013; Reading C, Wien F. Health inequalities and social determinants of Aboriginal peoples' health. Prince George (BC): National Collaborating Centre for Aboriginal Health; 2009. p. 36; Reading, C. Structural determinants of Aboriginal peoples' health. In: Greenwood M, De Leeuw S, Lindsay NM, editors. Determinants of Indigenous peoples' health: Beyond the social. Toronto: Canadian Scholars; 2018. p. 3-17.

[30] Reading C, Wien F. Health inequalities and social determinants of Aboriginal peoples' health. Prince George (BC): National Collaborating Centre for Aboriginal Health; 2009. p. 36; Reading, C. Structural determinants of Aboriginal peoples' health. In: Greenwood M, De Leeuw S, Lindsay NM, editors. Determinants of Indigenous peoples' health: Beyond the social. Toronto: Canadian Scholars; 2018. p. 3-17; Czyzewski K. Colonialism as a broader social determinant of health. The Indigenous Policy Journal. 2011; 2(1). Available from: https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1016&context=iipj.

over health services has been seen to have positive effects on health outcomes,[31] community capacity,[32] and health system cost-effectiveness[33].

Access, Availability and Quality of Services

A variety of health service delivery arrangements within First Nations communities was described by Caucus participants. A need for greater access to health services and infrastructure was identified. Facilitators to health system access included local service providers and access to telehealth. A variety of barriers were raised, including the impact of historical experiences with the health system that impacts First Nation's community access to health services, the remoteness of communities and program funding arrangements.

There was a general sense that access to IH health services are lower amongst First Nations community members. As explored in Appendix B, Status First Nations physician utilization, ED usage and GP attachment rates varied from that of other BC residents. For example, Status First Nations had lower usage of surgeon services, higher rates of Anesthesia services and similar rates of GP utilization (both in and out of hospital) (Figure 14), higher ED usage (Figure 15) and lower GP attachment rates (Figure 16). Participants noted the effect of historical experiences with the health system (e.g. Nanaimo Indian Hospital[34]) that affect access for some community members.

[31] Lavoie J, Forget E, Prakash T, et al. Have investments in on-reserve health services and initiatives promoting community control improved First Nations health in Manitoba? Social Science & Medicine. 2010. 71 (4): 717-724. Available from: https://doi.org/10.1016/j.socscimed.2010.04.037

[32] Couzos S, Delaney-Thiele D, Page, P. Primary health networks and Aboriginal and Torres Strait Islander health. 2016. Medical Journal of Australia. 204: 234-237. Available from: https://doi.org/10.5694/mja15.00975; see also Campbell D, Pyett P, McCarthy L. Community development interventions to improve Aboriginal health: Building an evidence base. Health Sociology Review. 2007. 3 (10): 304-314. Available from: https://doi.org/10.5172/hesr.2007.16.3-4.304.

[33] Webster P. Local control over Aboriginal health care improves outcome, study indicates. November 2009. CMAJ 181 (11): E249-250. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2780508/.

[34] Sterritt, Angela (2018, February 1). 'Canadians would be shocked': Survivors, lawyers describe treatment at Nanaimo Indian Hospital. CBC News. Retrieved from: https://www.cbc.ca/news/canada/british-columbia/canadians-would-be-shocked-survivors-lawyers-describe-treatment-at-nanaimo-indian-hospital-1.4513476

Access to health service in community was described by Caucus participants. Some participants noted that services were delivered by FNHA, others by IH, others by a Health Service Organization or a combination of the above.

> *"Not everyone has the confidence to or knows how to get help, and they often reach out to the [x] First Nation office"* Evaluation Participant
>
> *"I think one of our biggest struggles in our community is to get services to the community, whether it's through Island Health or through FNHA*". Evaluation Participant

In some instances, participants shared concerns over service or quality relating to the health services provided by service providers.

The importance of local health services to support access to health services was noted, as was the desire for more services, more direct funding and service delivery by First Nations communities. This sentiment was echoed by other evaluation participants, who noted the opportunity for more focused investments in community-led delivery of health services, both at home and away-from-home as a means of increasing health service utilization by First Nations community members.

> *"How do we work to support further developing the capacity of the Nations that want to deliver that service themselves to their own members?"* Evaluation Participant

Suggestion: Consider exploring service agreement arrangements that enhance the ability for First Nations to deliver services themselves, both at home and away-from-home and in collaboration with other First Nation communities through increased local service delivery, telehealth, and more direct funding.

> *"they all got together and said well this is what we need. And it wasn't an overnight thing, it took a while […] The Elders just love the visits now."* Evaluation Participant

Other caucus participants identified successful efforts to increase access to services (e.g. telehealth, NPs, sessional funding for physicians, additional physician visits). Telehealth was identified as a positive service that reduces travel burden and time spent away from home.

The challenge of delivering services in remote / rural locations was also noted. Several caucus participants described the remoteness of their communities and the challenges to delivering and accessing health services (e.g. single roads that can be cut off due to winter storms, landslides, forest fires, flooding; accessible only by boat or plane; gravel roads that ambulances won't traverse).

"*How do we provide services in a fair and equitable way in remote locations? How do we honor legislative right of our staff being safe while going into unsafe areas - no cell, weather challenges? How do to it without feeling it is too hard to do it at all?*" Evaluation Participant

Other challenges to health service access were raised relating to resource levels and program funding (e.g. access to Aboriginal Liaison Nurses in hospital was perceived to be affected because staff were too busy, the position filled by more than one person (causing coordination challenges) or seen as inaccessible to community members not from the community that housed the contract for the positions[35]).

Reporting, Monitoring & Evaluation

Participants noted that joint reporting mechanisms have been developed, however monitoring progress and health outcomes are still in the development stages. Focused technical efforts & clarity of roles and responsibilities for this area of work may be beneficial.

The development of shared reporting processes (e.g. TCFNH reports, JPB reports and reports to community) was highlighted as an example of coordination between Partners and a mechanism for accountability. Calls for greater clarity on roles and responsibilities as they relate to reporting to community were mentioned earlier in the Governance section.

Evaluation participants indicated that it is too early to see meaningful impacts to health outcomes (see Figure 3.P-13) in Appendix A) and that monitoring performance is also in the early stages of development. More data is available now than in the past (e.g. HSM data, Regional Health Survey data), however the data is now always segregated by cultural family group. There are future opportunities to integrate more data into planning and monitoring.

"defining 'better', 'more responsive' and 'integrated' with metrics would be helpful to understand if we have achieved that or not. I think right now, it would be a qualitative or subjective response." Evaluation Participant

A challenge when it comes to measuring health and wellness is to reconcile the Western desire to measure success with many aspects of wellness that are immeasurable. During the technical advice process, a participant raised the idea that measuring success in a quantifiable sense may be difficult to do for some aspects of Indigenous health and wellbeing, "we don't go to the Big House and measure how it went".

Suggestion: Consider focused technical efforts & clarity of roles and responsibilities for performance and health outcome measurement that allow for reporting and monitoring at

[35] Please note that there have been announcements in late 2018 of increased hours and number of ALN positions

the cultural family level, develop measures to monitor key aspects of the PA (e.g. how to measure an 'integrated health sector') and identify key tables for inclusion in the next evaluation that includes more community-level input.

Resources

Participants indicated that resources have been expended to advance joint initiatives under the PA (see Resources & Prioritization of Shared Priority Areas Section); **however, there is also an acknowledgment of the overall lack of resources with many competing demands, particularly for service delivery in more rural or remote locations.**

Specific community needs were identified by participants relating to services (e.g. clinical counsellors), infrastructure (e.g. clinical space or equipment), and training (e.g. for clinical staff and individual community members to support their health and wellness journeys). Many needs related to mental health services and supports (e.g. immediate access to treatment and detox services, supporting housing and more information on drugs and alcohol).

> *"I think there needs to be better access to human resources. [*would be good to] *visit and speak at colleges and universities, high schools etc. to enter into the health field [..] and say 'This is where you should go. And this is the demand that your People have and we need you.'* Evaluation Participant

Other findings include the need to support the training of more Indigenous health care providers and support community capacity through additional training and supports (as explored in the Collaboration & Partnership section). Applicable training (e.g. webinars) could be made available for anyone to access anytime. Training should be coordinated across communities and funded by FNHA to reduce funding burden on communities.

Discussion

Evaluation of the Vancouver Island PA fulfils the commitment to monitor and report on progress and to support the growth of the Partnership.

The key evaluation questions identified by the VI PA evaluation working group are outlined in table 2 below, along with an overview of findings.

Table 2: Evaluation Questions and findings, VI PA evaluation

Regional Governance Structure	
Has awareness and understanding of the aim of the VI PA increased?	Somewhat - amongst more senior level FNHA and Island Health staff and those more involved in the work. Lower awareness believed to exist at front-line level for IH staff.

To what extent is there understanding of roles and responsibilities	Good understanding of the roles and responsibility of Partners, particularly Island Health and increasingly for the FNHA at the PASC / PAEC tables. Community participants were not as clear on the roles and responsibilities for service delivery. Clarification was suggested, particularly relating to the role of Caucus and for specific functions, such as accountability for progress and reporting to communities.
To what extent are Parties satisfied with the regional structure and processes?	Overall there is satisfaction with the regional structure and processes. Some suggestions for improvement include some alterations to the logistics of PASC / PAEC meetings, increasing HD and Chief's awareness of processes to address local issues, developing mechanisms to linking the goals of the PA more explicitly to work on the ground and developing orientation materials for new Partners to the work.
To what extent have partners demonstrated reciprocal accountability?	Evidence suggests that Partners to the accord collectively represent an effective structure for helping to ensure accountability to PA commitments, focus and continuity of PA work. There is evidence of the integration of shared partnership work into organizational work plans and allocation of human and physical resources to priority areas (e.g. allocation of funds for CS&H training in EDs). There are opportunities to advance the work further by outlining accountability for services in community where there are multiple health provider organizations.
Partnership Success	
To what extent has there been improved communication between the Parties?	In some areas there is evidence of good communication (senior executive levels, particular areas (e.g. planning), and particular local geographical areas). Senior level respondents indicate that they are able to have open and honest conversations. Opportunities to further highlight the work of the PA and to explicitly tie work on the ground was seen as an opportunity. At a local level, where relationships were more key to move work forward rather than through explicit structures from the PA, communications were less consistent, and depended more on individuals. There is an opportunity to increase awareness of the PA and support its work through increased communication channels and increased communication materials.
Have relationships been strengthened and created as a result of the PA?	There is evidence that relationships have been strengthened as a result of the PA. Respondents noted that the development of relationships is the most important outcome of the Accord. It should be noted that many participants felt that their strong relationships predated the signing of the PA and that the PA has simply justified the work that they have already been doing. Participants noted that the PA provides justification for the time

	and efforts expended to nurture and maintain relationships with Partners. Turnover causes disruption of relationships that can be challenges to progress.
To what extent has the partnership continued to grow, mature and enable to resolution of issues?	There is the perception that since 2012, relationships, work priorities and methods for approaching PA work have evolved. There were multiple examples of challenges overcome and innovative solutions to issues relating to service availability (telehealth, GP visits, GP sessional visits, NPs), policies (development of Elder-in-Residence positions required the resolution of complex issues such as the definition of 'Elder' and how to compensate such a role). Partners also referenced the maturation of the partnership to speak of issues that are more difficult, i.e. racism. Participants indicated that relationships are stronger and that Partners are investing time to build relationships (IH Partners are staying for the entire Caucus, IH staff are visiting communities to develop relationships).
To what extent has implementation of the Partnership Accord and reciprocal accountability of the partnership been monitored?	Reciprocal accountability is defined as a coordinated and collaborative way of working together where *"[e]ach partner is accountable to the other for commitments made, and for the effective implementation and operation of their part of the system, recognizing interdependence and interconnectedness."*[36] Participants referenced a number of mechanisms that were important for promoting and support reciprocal accountability, including regular meetings, involvement of senior leadership, the Annual Chief's Meeting, and joint reporting processes. Suggestions that more clarity around what reciprocal accountability looks like for PA, particularly relating to accountabilities for reporting and following up on commitments. The evaluation findings included many perspectives from respondents on their roles & responsibilities (unpublished in findings). This may be helpful contents for such a mapping. There was no evidence that indicated the existence of monitoring tools for reciprocal accountability. The general of such a tool could be considered as a recommendation from this evaluation.
To what extent have partnership opportunities and activities increased?	Many partnerships existed prior to the signing of the PA and so it is difficult to identify the extent to which partnership activities have increased, however many examples of partnership opportunities were referenced by evaluation participants, including formal PA meetings and events, JPB projects,

[36] FNHA (n.d.). Reciprocal Accountability Framework for the Tripartite Health Partnership

	Collaborative Service Committee, Cultural Safety Committees, Wellness Table, joint crises response protocols and visits to community. A wealth of examples of joint partnership work is provided in joint reporting to TCFNH documents. These examples, though not all listed in this report, are inspiring and wide reaching in their coverage of both health system topics and geography.
To what extent do communities have a first round of conversation to develop a plan based on their needs and self-determination of health service provision?	There is some indication of increased opportunities for First Nations involvement in decision-making around the design and delivery of FNHA/Island Health programs. Participants noted that shared decision-making is not yet hard wired into program design and delivery and that contributions predominate more on the 'inform' and 'input' side of the engagement scale, with a few exceptions. Input also tends to relate more to new programs and services. There is a recognition that input into decision-making and prioritization is not equally accessible to all.
Improved services for Vancouver Island First Nations	
To what extent has there been enhanced coordination and alignment of health service planning, design, management and service delivery?	There is evidence of greater alignment of planning, engagement, reporting. There were less examples cited of coordination and alignment of service delivery. Multiple participants noted the need for clarity on accountabilities for service delivery in communities where multiple health providers exist. Little indication of coordination or alignment in terms of management.
To what extent has improved quality and acceptability of health care services been achieved?	Limited mechanisms to measure changes in quality or acceptability of health care services were noted by evaluation participants. Opportunity for further research and/or development may exist.
To what extent have cultural safety and appropriateness of health care programs and services been enhanced?	CS&H is a concept that must be defined by individuals. Results from self-identified Aboriginal patients from the 2016 / 17 Acute inpatient survey suggest that there is room for improvement with respect to some aspects of patient experiences. PREMs surveys are being conducted throughout multiple health sectors. Opportunities to further explore this data source to monitor progress exist. Efforts and inroads have been made in the form of training, communication, prioritization and visibility of CS&H work within

	the health system, however training participation remains low. Roughly 2% of the IH workforce undertook CS&H training in 2018 / 19. It is unknown what percentage of the IH workforce has completed the training since it began in 2009.
To what extent are initiatives, programs, services and policies reflective of First Nations perspectives on wellness?	Participants noted the inroads made in some areas to integrate holistic, culturally-focused and wellness based components/ services. Examples were not pervasive across the health sector and Caucus participants rated the resource and prioritization of traditional wellness highest of all participant groups. Participants identified the importance of the SDOH on health status and some of the challenges faced by First Nations relating to SDOH, in particular food security and housing. Given the importance of wellness to the FNHA, the challenges identified to progress in these areas, including decreased health sector funding for wellness programs and silos of funding imposed by the BC Financial Accountability Act are noteworthy.
To what extent has there been improved access to health care services?	Accessibility challenges were raised by evaluation participants as well as specific examples of work conducted to increase the availability of health services (telehealth, GP visits, GP sessional visits, NPs). No evidence was identified that provided an overview of the extent of improvement in access to health services as a result of the PA.
To what extent have the four key areas of shared interest been advanced?	Respondents indicated that they had observed more efforts and resources put towards CS&H, Maternal Child health and Primary Care. Efforts and resources have been affected by other factors (e.g. emerging opioid crises, MOH priorities). Average ratings varied by participant group and cultural family.
Reduced disparities/ improved health outcomes	
To what extent have health outcomes been improving?	The evaluation lacks data to be able to compare health outcomes since the signing of the PA in 2012. Respondents indicate that it is too early to be able to observe any shifts in health status as a result of the work of the PA.

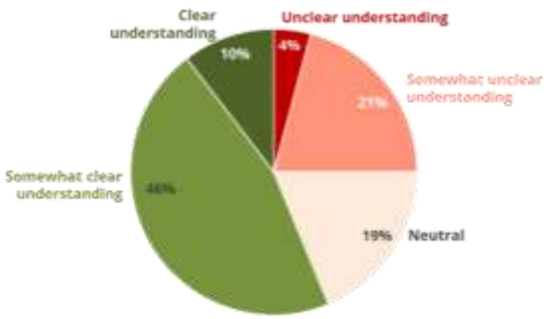
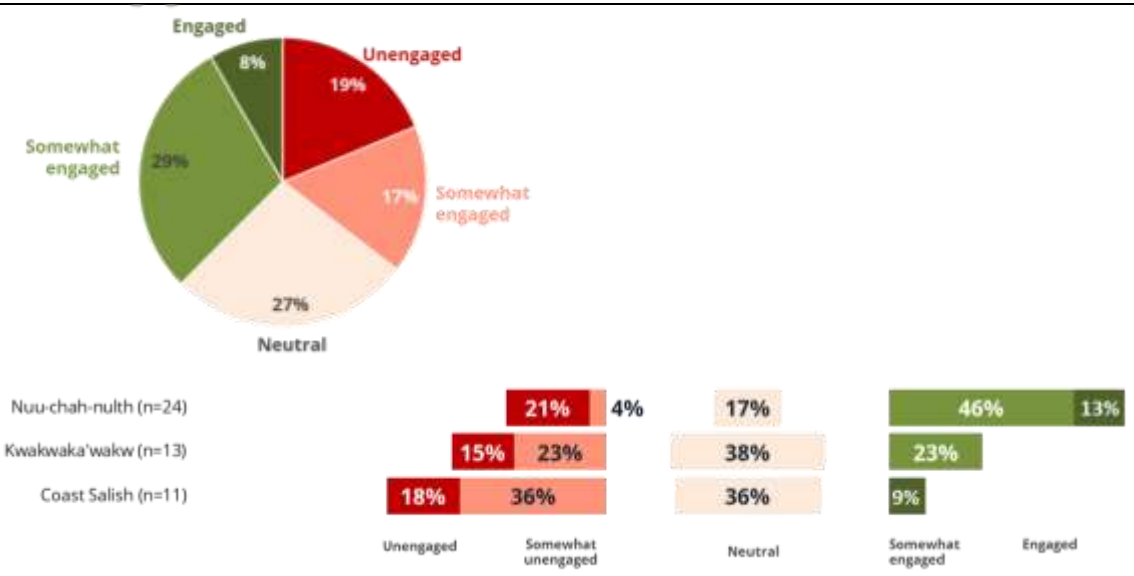
Vancouver Island Partnership Accord Evaluation Report

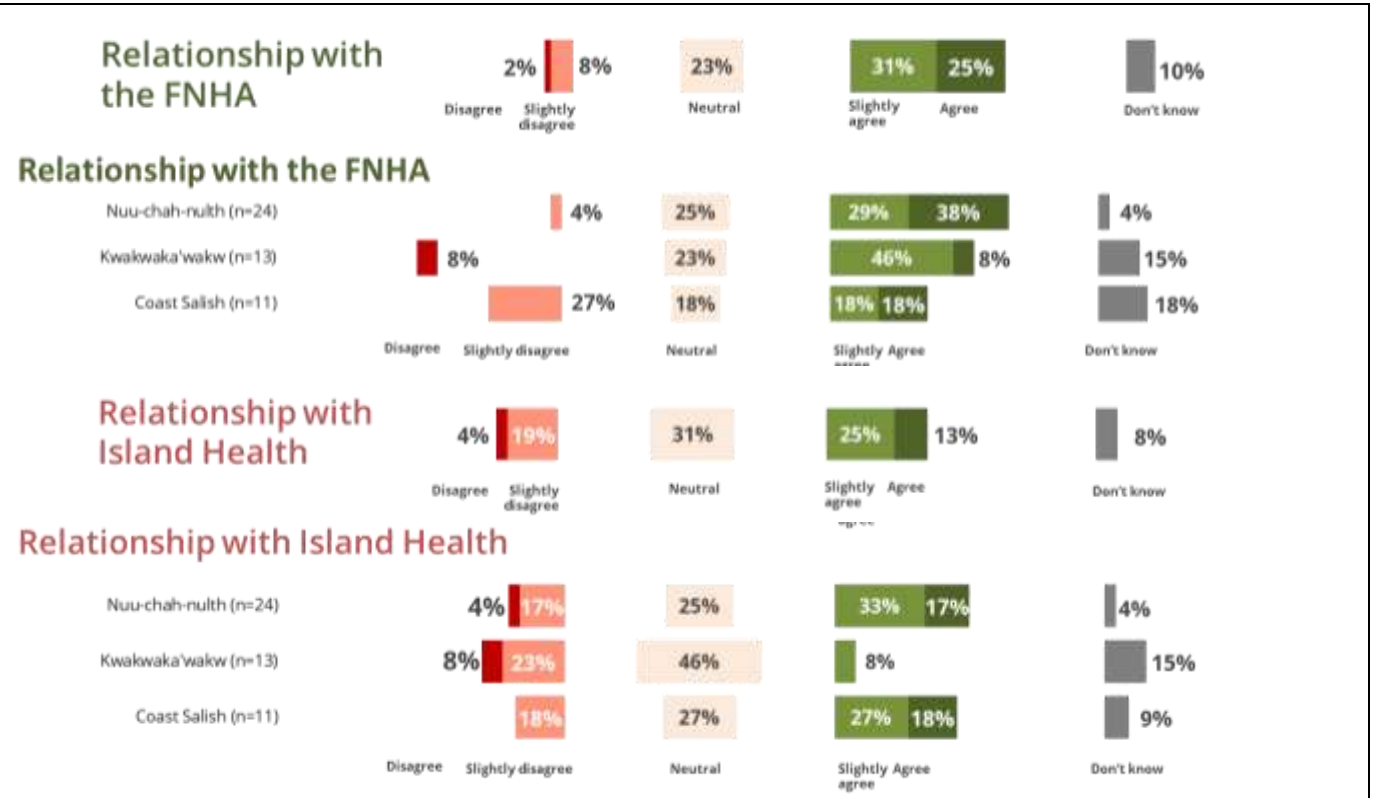
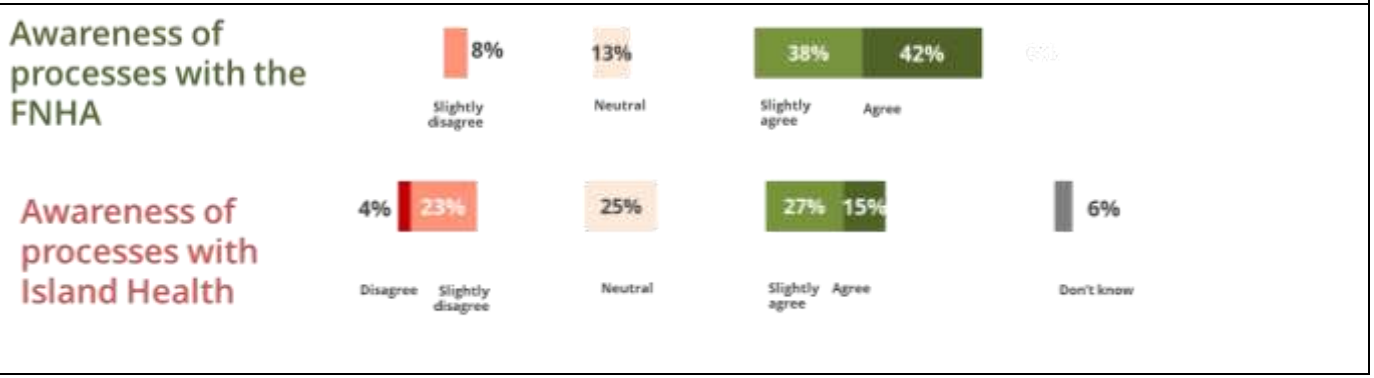
Report Appendices

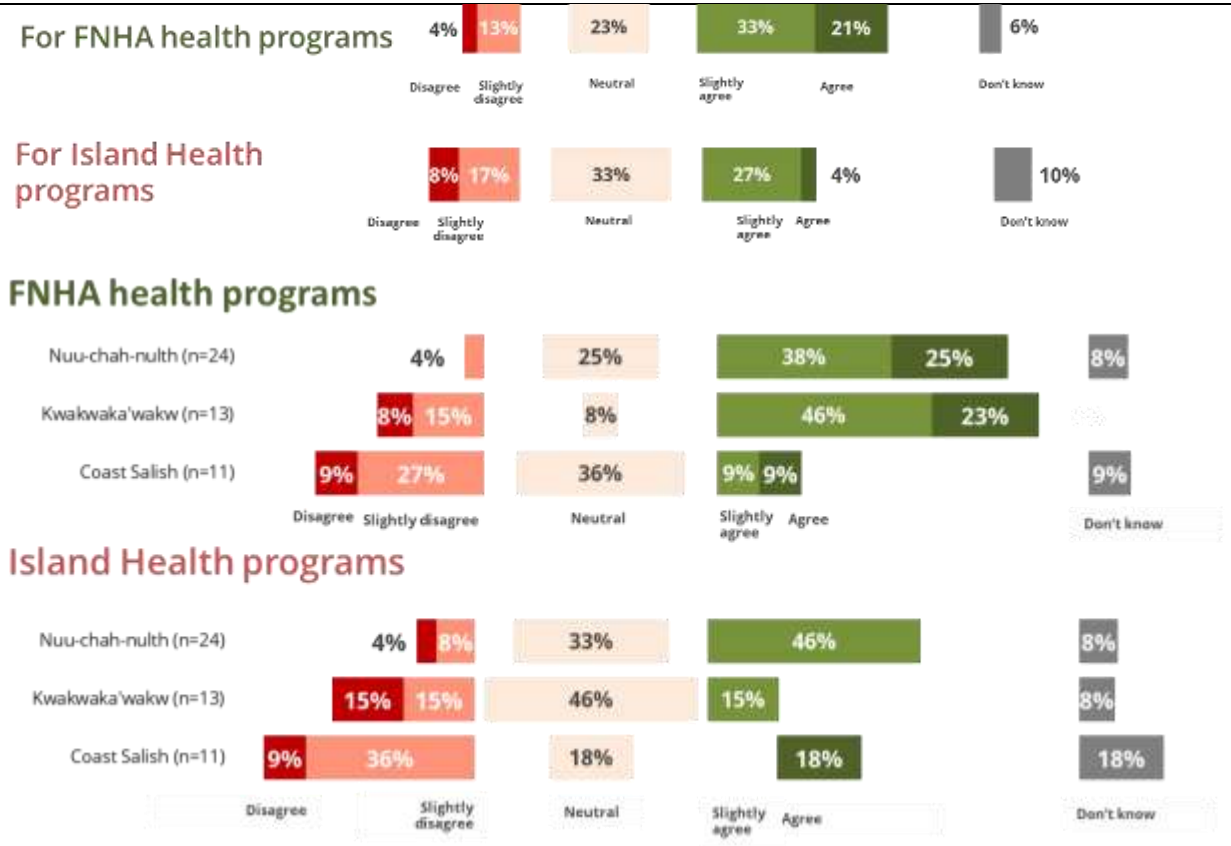
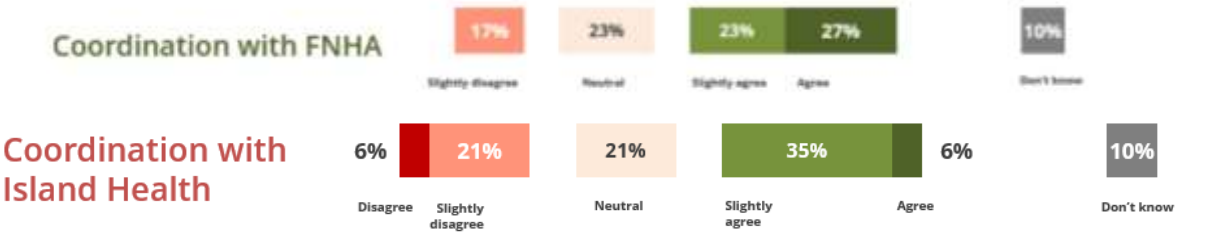
Contents

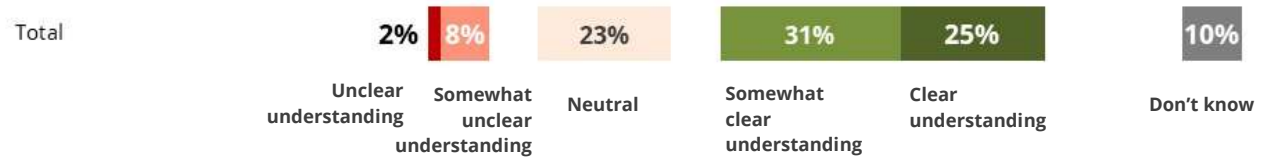
Appendix A: Graphs

1. Caucus survey responses

1.1) How would you rate your understanding of the aim of the Vancouver Island Partnership Accord?	
1.2) How engaged do you feel with the Partnership Accord and its work?	

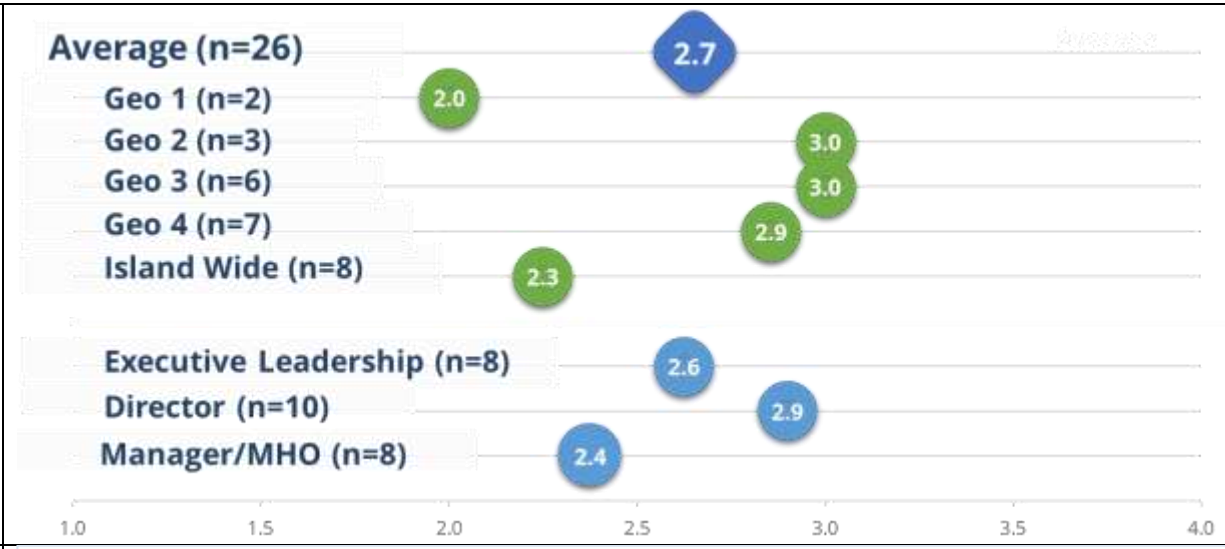
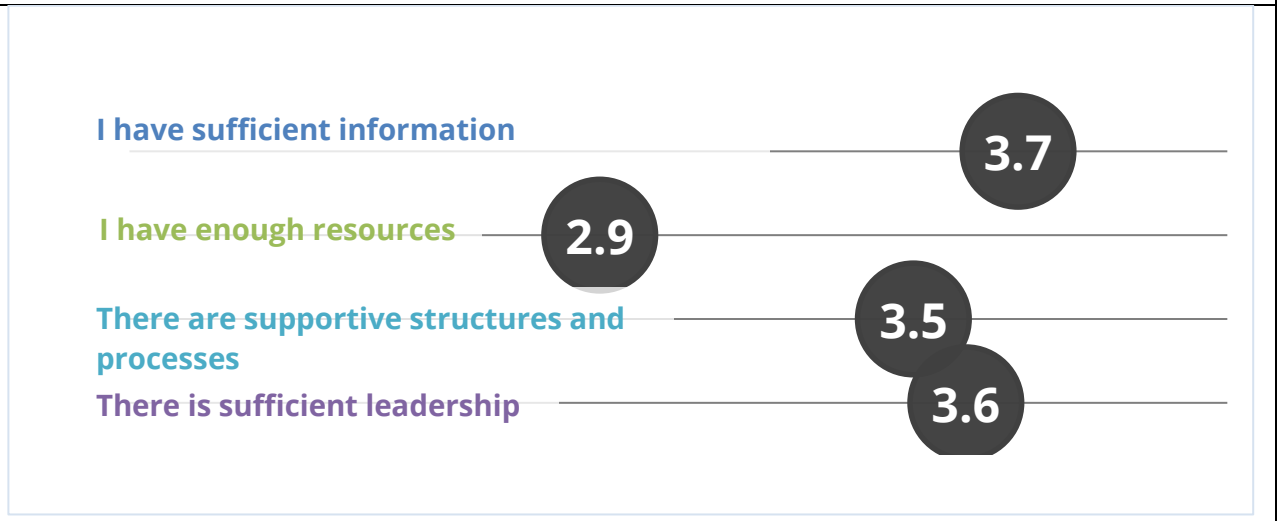
1.3.a/1.3.e) As a result of the partnership, Relationships between my Nation and the FNHA/Island Health have been strengthened	
1.3.b/1.3.f) As a result of the partnership, I know the process to connect with FNHA/Island Health to address issues identified by my Nation	

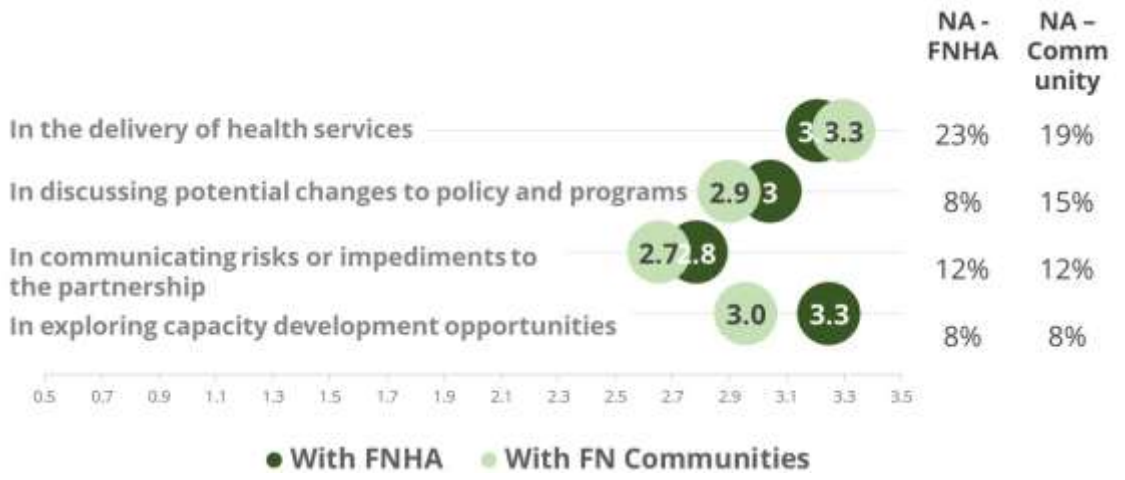
1.3.c/1.3.g) As a result of the partnership, Processes to support decision-making around the design and delivery of FNHA/Island Health programs have improved	
1.3.d/1.3.h) As a result of the partnership, Coordination of services between my Nation and the FNHA/Island Health has increased	

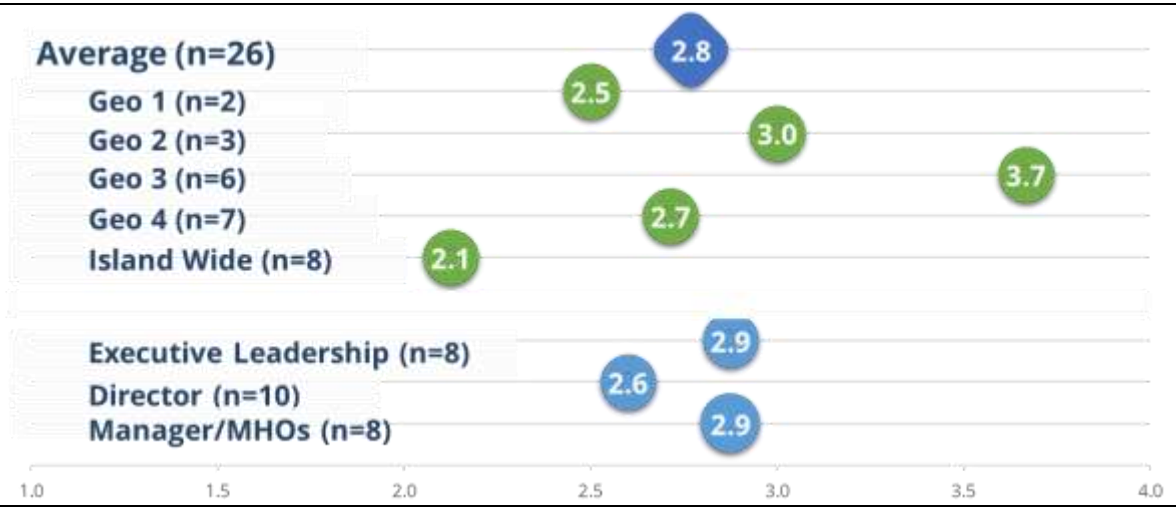
1.3.i) Health programs and initiatives have become more reflective of the culture and traditions of the First Nations on Vancouver Island	

2. Island Health survey responses

2.3) How would you rate your understanding of the aim of the Vancouver Island Partnership Accord?	
2.4) How would you rate your understanding of Island Health's roles and responsibilities under the Partnership Accord?	

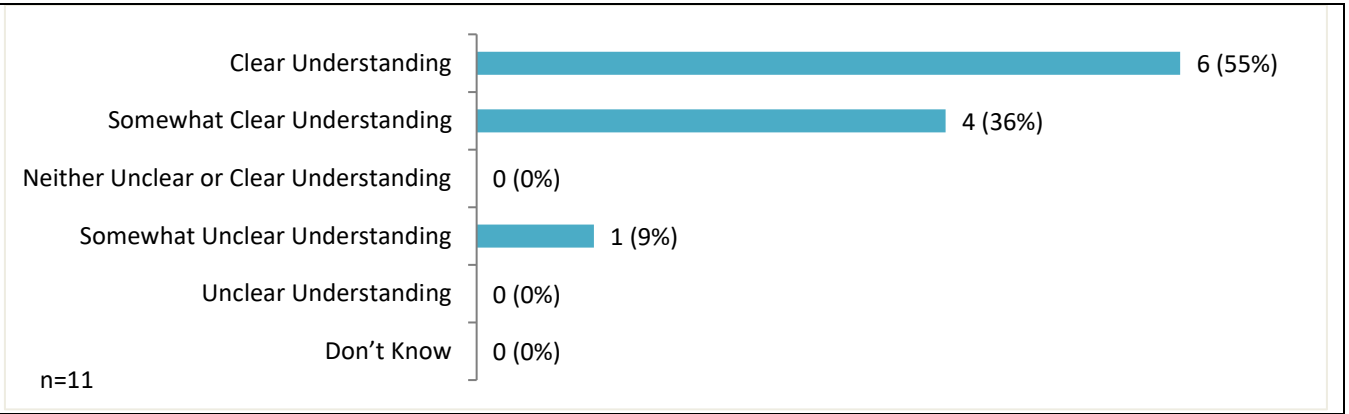
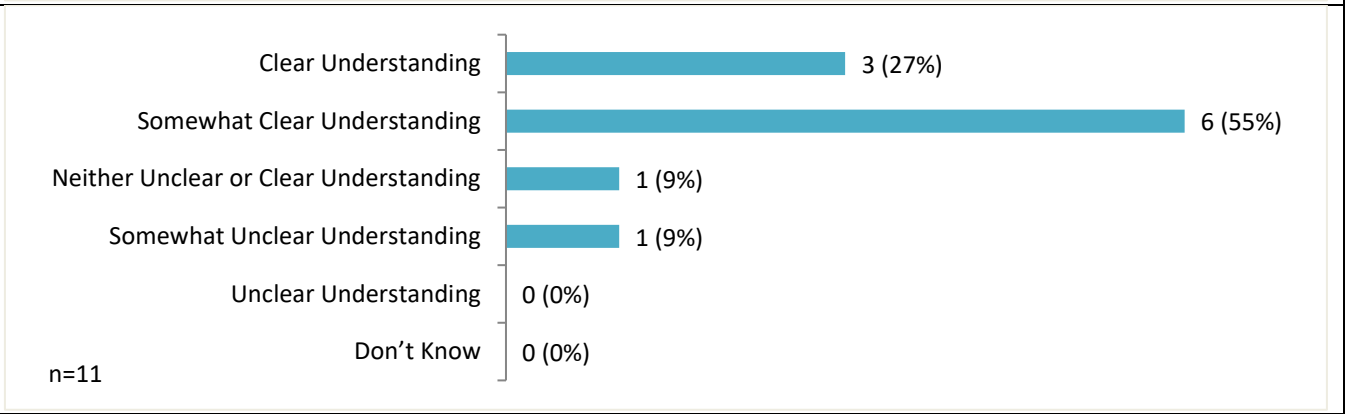
2.6) On a scale of 1 to 5, in your view, how well are the aims and objectives of the Partnership Accord communicated between different levels of Island Health staff, where 1 is not at all and 5 is very well?	
2.7.a) I have sufficient **information** to know how I can support the objectives of the Partnership Accord in my role	
2.7.b) I have enough **resources** (human, financial) to support me in meeting the objectives of the Partnership Accord in my role	
2.7.c) There are **supportive structures and processes** in place to move this work forward	
2.7.d) There is sufficient **leadership** and **direction** from senior levels of Island Health and the FNHA to support this work	

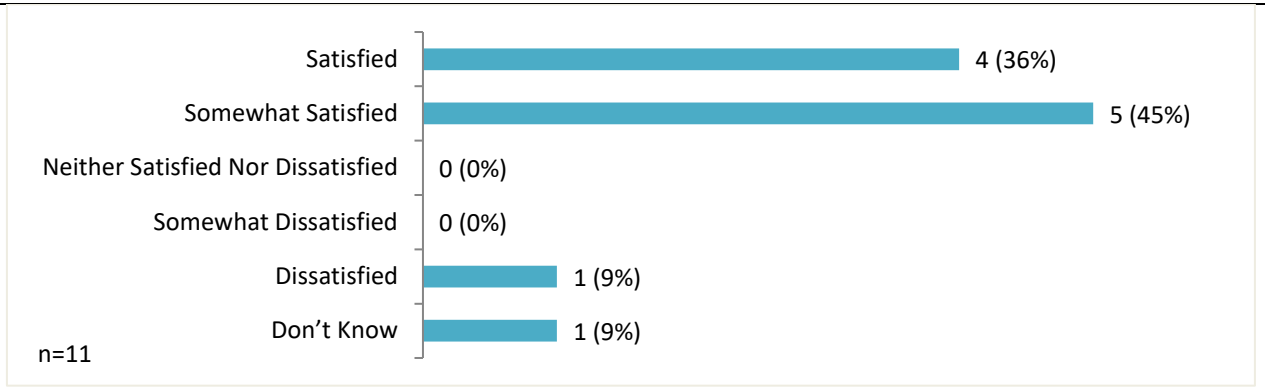
2.8) How successful has the Partnership Accord been in strengthening partnership between Island Health and the First Nations Health Authority?	
2.9) On a scale from 1 to 5, where 1 is not at all and 5 is a great deal, to what extent do you, in your role, currently collaborate with the FNHA/First Nations communities	
in the delivery of health services[1]	
discussing potential changes to policy and programs	
communicating about potential risks or impediments to partnership	
exploring capacity development opportunities	

2.11) In your view, on a scale of 1 to 5, to what degree do you feel First Nations communities share in decisions around the design and delivery of Island Health programs, where 1 is not at all and 5 is a great degree	
2.16) What is your level of agreement with the following statement; "The D*eclaration of Commitment on Cultural Safety and Humility*[37] has been championed and/or hard-wired in my GEO/program"?	

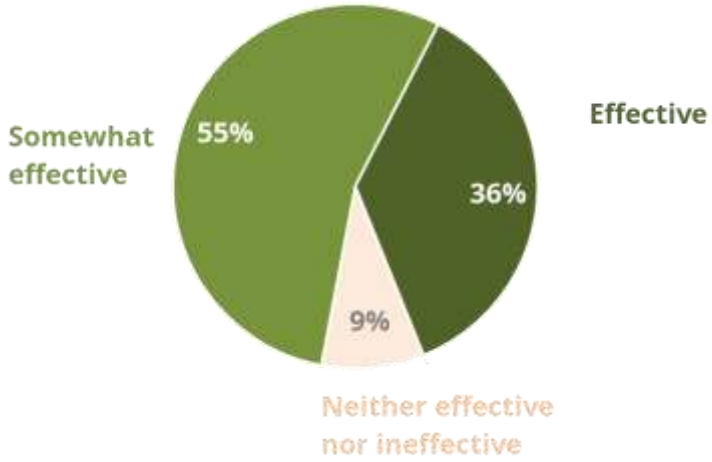
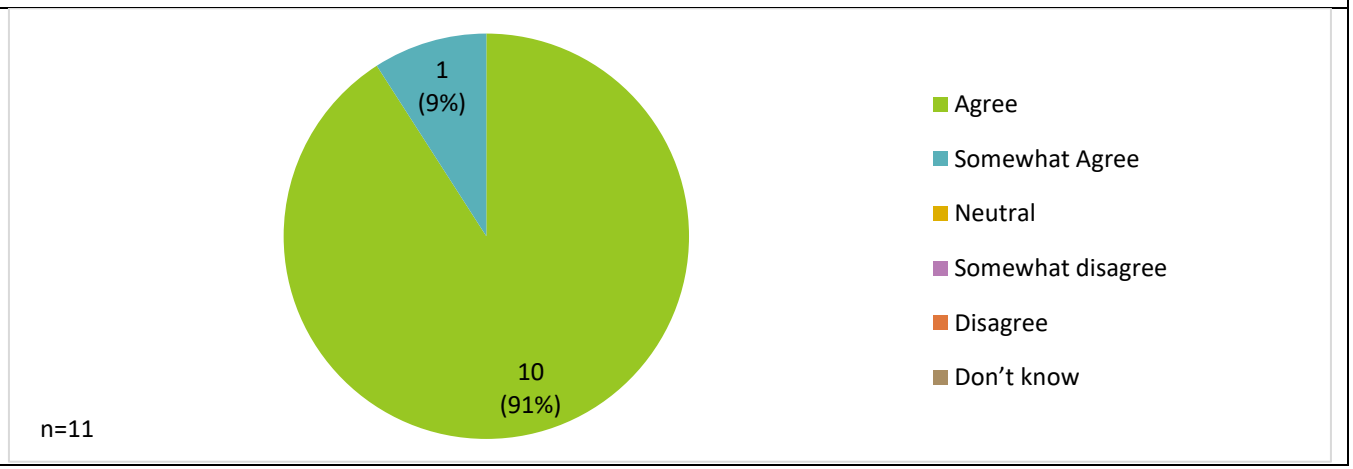
[37] The *Declaration of Commitment on Cultural Safety and Humility* was signed in 2015 and is a component of the priority work area related to cultural safety and humility.

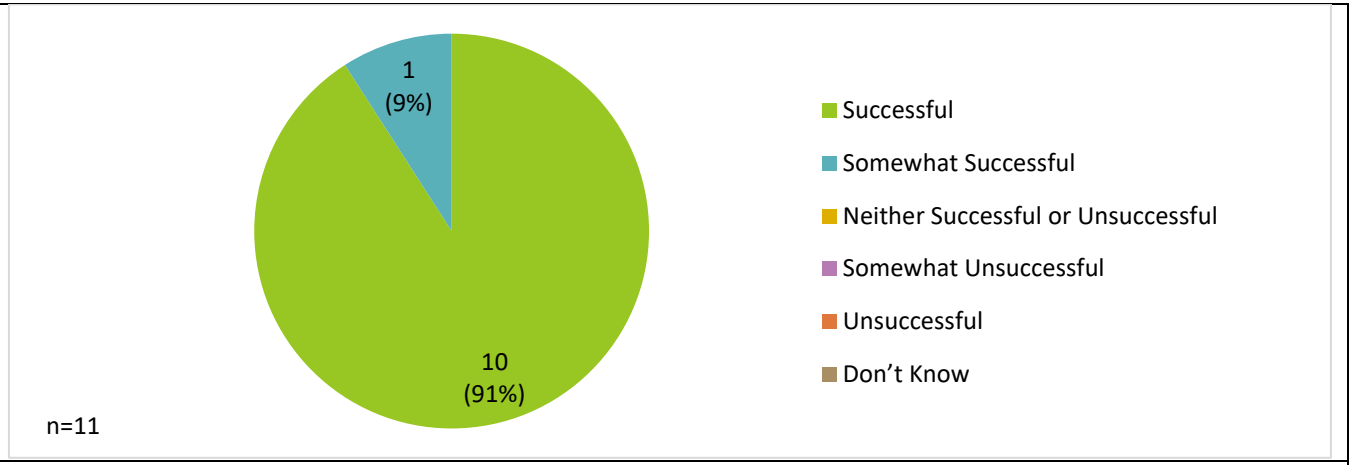
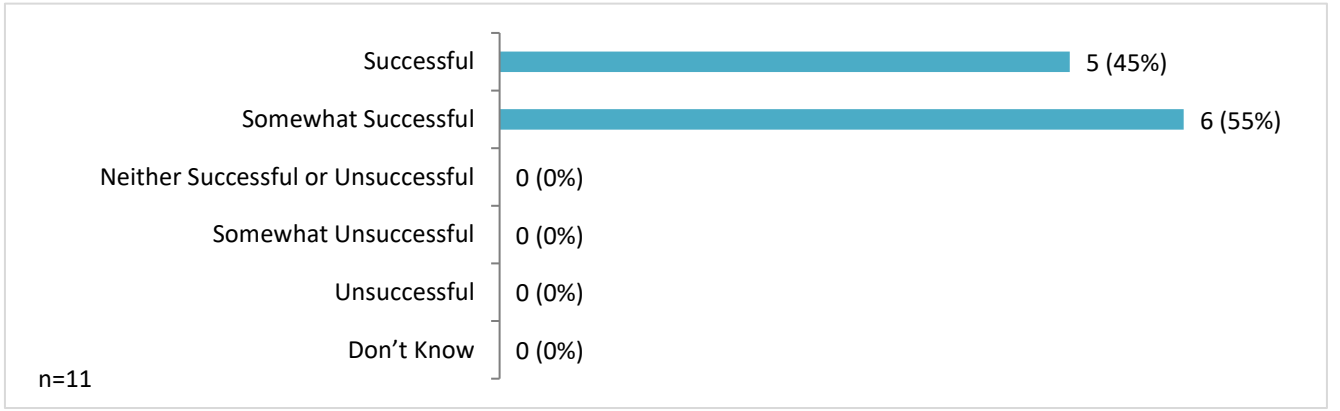
3. PASC / PAEC Survey results

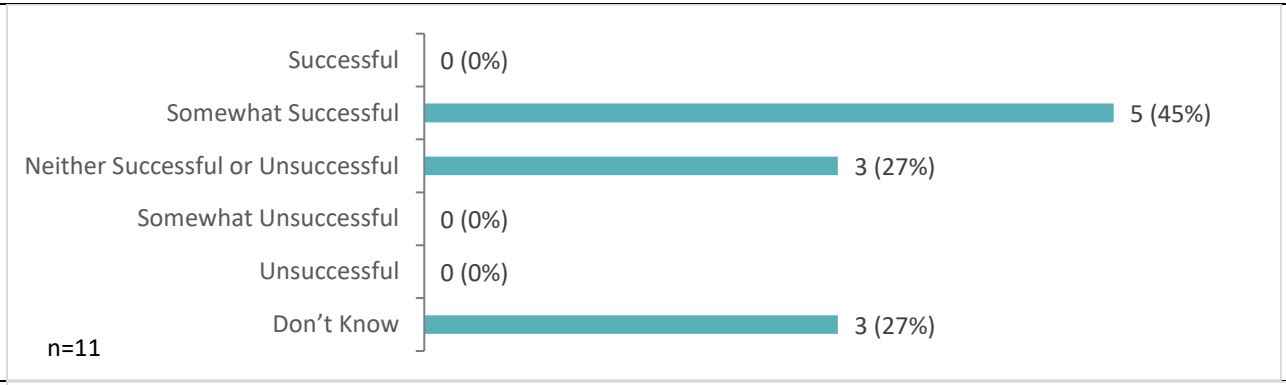
3.P-1) What is the understanding of the aim of the Vancouver Island Partnership Accord within the Partnership Accord Steering Committee/Executive Committee?	
3.P2) Is there a clear understanding by all Partners of the roles and responsibilities as outlined in the Partnership Accord Terms of Reference?	
3.P3) To what extent are you satisfied with how the current structure supports the desired goals of the Partnership?	



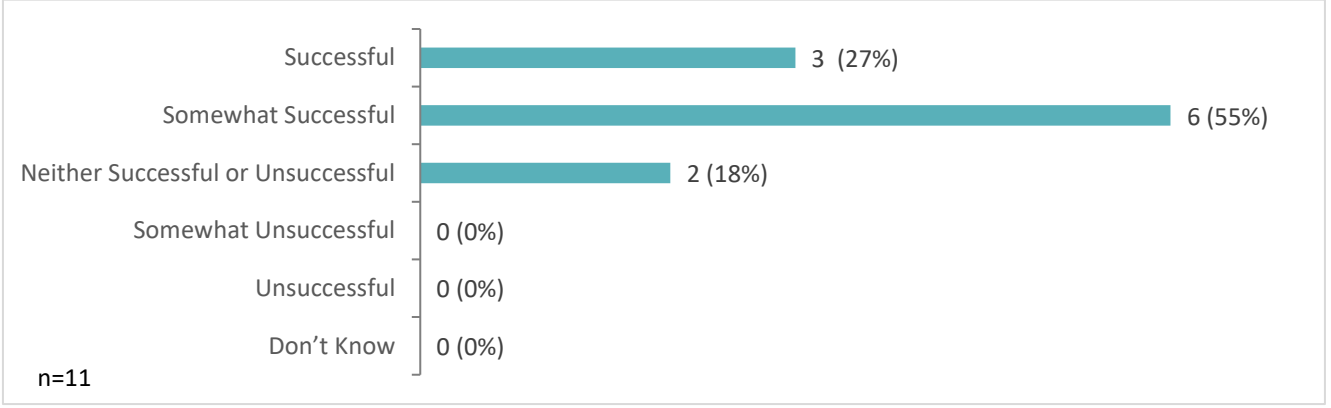
3.P4) In which areas has the PASC been more effective and successful and in which areas have they been less so?	Mean Score* (Scale of 1 to 5) 1 = ineffective; 3 = neither effective nor ineffective; 5 = effective)
Providing oversight and direction to the development and implementation of the Partnership Accord and related plans	**4.7** (range = 4-5, n=10)
Providing a forum for Partners to develop mutual understanding of the problems, strengths and issues supporting a population health approach	**4.5** (range=4-5, n=10)
Aligning and coordinating the participation, messaging and action items relating to the Tripartite Committee on First Nations Health	**4.1** (range=3-5, n=10)
Ensuring mutually agreed First Nations health priorities are incorporated into annual work plans for all Island Health programs	**3.9** (range=2-5, n=10)
Monitoring outcomes of population health approaches that are jointly implemented and evaluated with the Coast Salish, Kwakwaka'wakw and Nuu-chah-nulth First Nations to evaluate progress on closing the health disparity gap between First Nations and non-Aboriginal Vancouver Island residents	**3.7** (range=2-5, n=10)
Jointly monitoring performance indicators and strategic initiatives related to First Nations health	**3.5** (range=1-4, n=9)

3.P5) How effective is the EC in providing operational oversight, problem solving and direction to the Partnership accord work plan and overseeing implementation of the direction provided by the PASC?	
3.P7) Do you feel the PASC / PAEC provides a safe space where you can have open and honest conversations?	

3.P8) How successful has the Partnership Accord been in strengthening partnership between the Vancouver Island Regional Caucus, Island Health and the First Nations Health Authority?	
3.P12) How successful has the Partnership been in advancing shared decision-making between the Vancouver Island Regional Caucus, Island Health and FNHA?	
3.P13) How successful has the Partnership been in: improving health outcomes for First Nations on Vancouver Island?	



3.P-14) How successful has the Partnership been in creating a more integrated, safe and effective health system for First Nations on Vancouver Island?



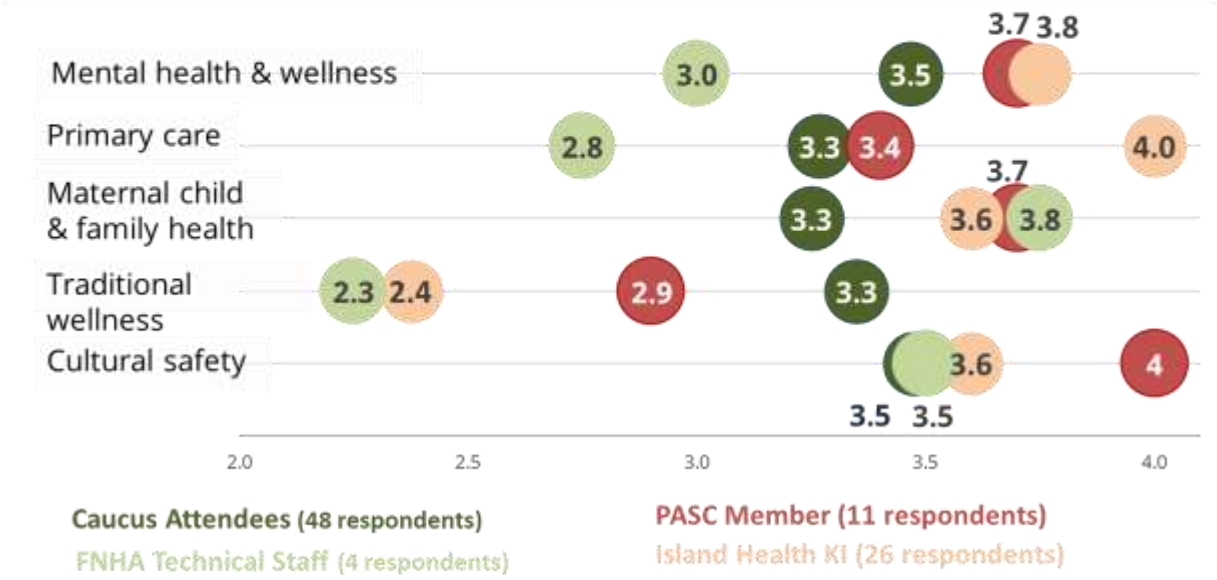
4. Across all surveys (PASC / PAEC, Island Health, FNHA technical staff and Caucus participants)

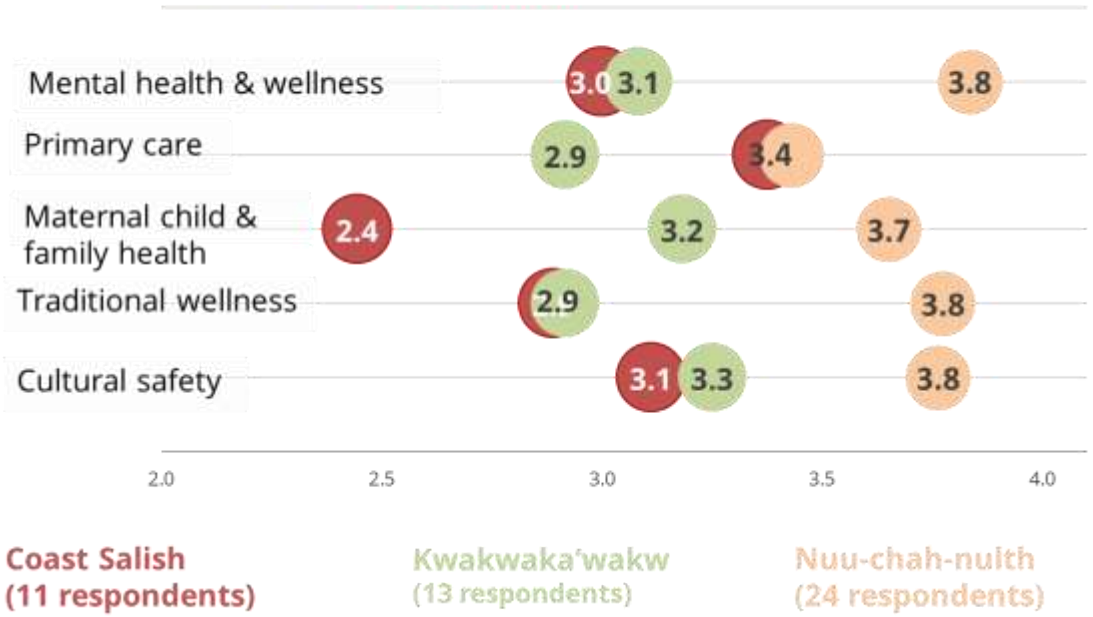
All surveys conducted as part of the evaluation (PASC members, Island Health key informants, caucus attendee survey, FNHC technical staff *(n=89)*) included a question asking respondents to rate, on a scale of 1 to 5, the extent of efforts and resources in the five areas of key shared priority outlined in the Partnership Accord (note that that the fourth area contains two distinct concepts that participants were asked to rate separately).

There were some slight wording differences across the surveys.

- The **PASC** interview guide asked: Q18: To ***what extent have efforts and resources been placed to move forward initiatives in these areas*** (1 to 5, where 5 is every possible resource and priority has been given to a priority area) – how would you rate the level of emphasis and resources put in place to date.
- The Island Health key informant interview guide asks: Q15: ***To what extent have efforts and resources been placed to move these areas forward*** in your program/GEO? One a scale from 1 to 5, where 1 is no resources and prioritization and 5 is every possible resource and prioritization, how would you rate the level of emphasis and resources put in place to date?
- The FNHA Technical staff interview guide asks: Q11: ***To what extent have FNHA and Island Health worked collaboratively in these areas***? On a scale from 1 to 5, where 1 is not yet effectively collaborating and 5 is complete and effective collaboration between FNHA and Island Health?
- Caucus survey: Q3: Please rate your agreement with the following statements regarding the partnership: As a result of the partnership:
    - ***Meaningful efforts have been made to move forward work related to mental health and wellness with my Nation*** *(Disagree, Slightly disagree, Neutral, Slightly Agree, Agree)*

4.1)	**Across all data streams, on a scale of 1 to 5, on average, more collaborative work, efforts and resources have been placed on cultural safety and maternal child & family health and less on traditional wellness** 

4.2)	**The average rating of collaborative efforts, prioritization and resources for the five areas of key shared priority was higher amongst PASC Members / Island Health KIs than amongst Caucus attendees and FNHA technical staff, except for traditional wellness** 

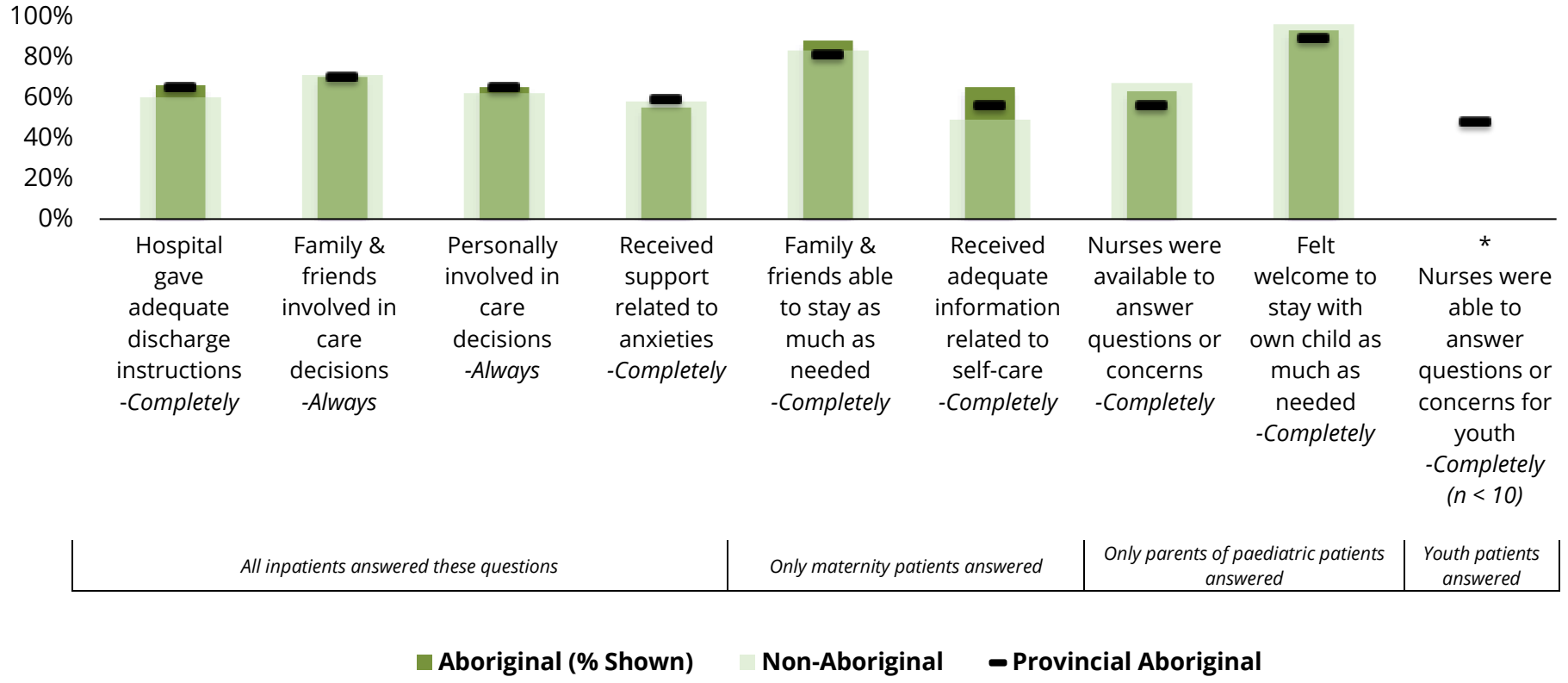
4.3)	**Amongst Caucus attendees, Nuu-chah-nulth attendees reported more meaningful efforts to move forward work in their Nations, on a scale of 1 to 5, than Kwakwaka'wakw and Coast Salish attendees** 

5. FNHA Technical staff

Not reported due to small sample size (n<5).

Self Determination and Equity

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



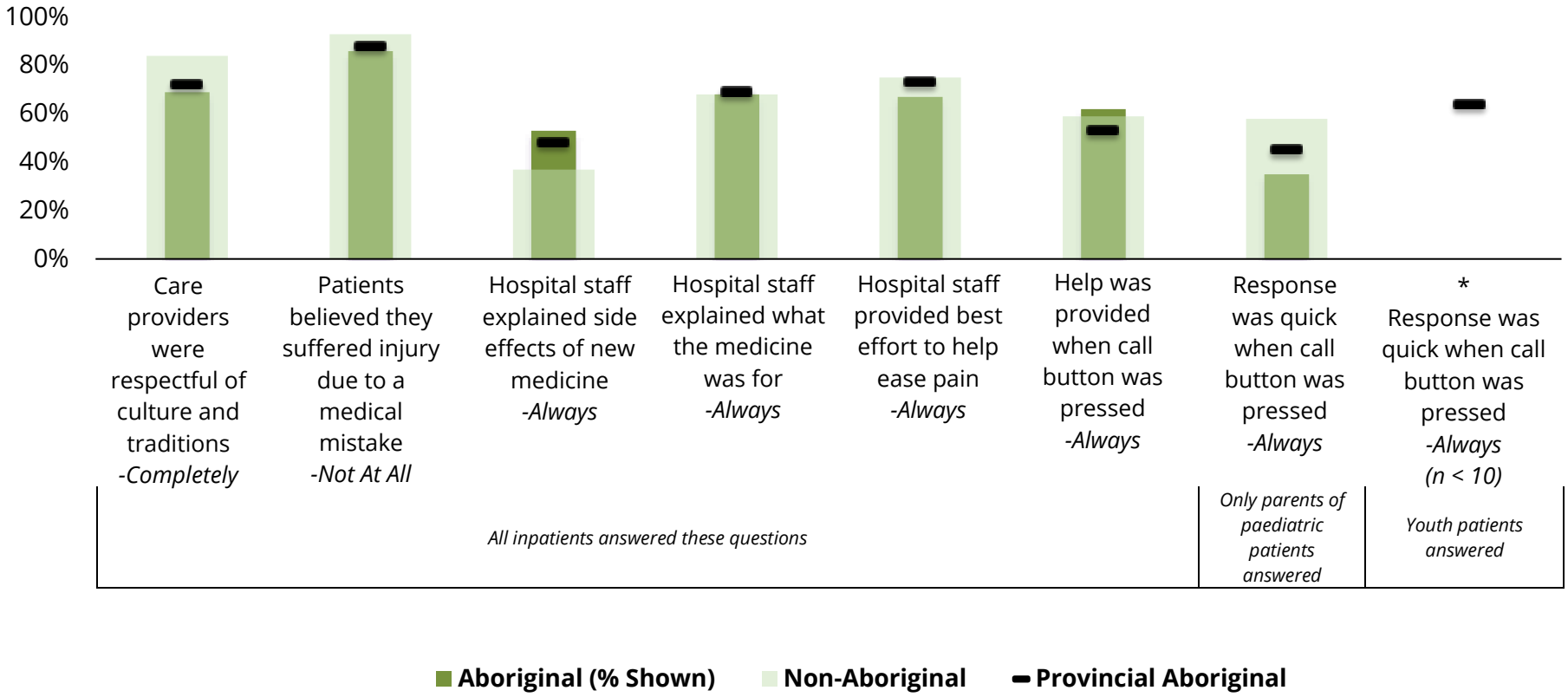
Self Determination and Equity (Data Table)

	Before you left the hospital, did the doctors, nurses or other hospital staff give your family or someone close to you enough information to help care for you? [*Completely*]	During your hospital stay, were your family or friends involved as much as you wanted in decisions about your care and treatment? [*Always*]	Were you involved as much as you wanted to be in decisions about your care and treatment during this hospital stay? [*Always*]	Did you get the support you needed to help with any anxieties, fears, or worries you had during this hospital stay? [*Completely*]	After the birth of your baby, were other family members or those close to you able to stay with you as much as you wanted? [*Completely*]	While in the hospital, did you get enough information about caring for yourself? [*Completely*]	During this hospital stay, were nurses available to answer your questions or concerns when you needed them? [*Completely*]	During this hospital stay, did you feel welcome to stay with your child as much as you wanted? [*Completely*]	During this hospital stay, were the nurses available to answer your questions or concerns when you needed them? [*Completely*]
	Q49	**Q36**	**Q35**	**Q34**	**M14**	**M13**	**P6**	**P2**	**Y6**
Vancouver Island, Aboriginal	66%	70%	65%	55%	88%	65%	63%	93%	*n < 10*
Vancouver Island, Aboriginal (n)	148	165	185	158	18	18	14	15	*n < 10*
Vancouver Island, Non-Aboriginal	60%	71%	62%	58%	83%	49%	67%	96%	*n < 10*
Vancouver Island, Non-Aboriginal (n)	3,101	3,446	4,086	3,109	246	245	102	103	*n < 10*
Provincial Aboriginal	65%	70%	65%	59%	81%	56%	56%	89%	48%
Provincial Aboriginal (n)	654	710	844	679	73	77	55	62	11

Difference between Vancouver Island Aboriginal vs. Non-Aboriginal	6%	-1%	3%	-3%	5%	16%	-4%	-3%	*n < 10*
Difference between Vancouver Island Aboriginal vs. Provincial Aboriginal	1%	equivalent	equivalent	-4%	7%	9%	7%	4%	*n < 10*

Shame, Vulnerability and Empathy

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

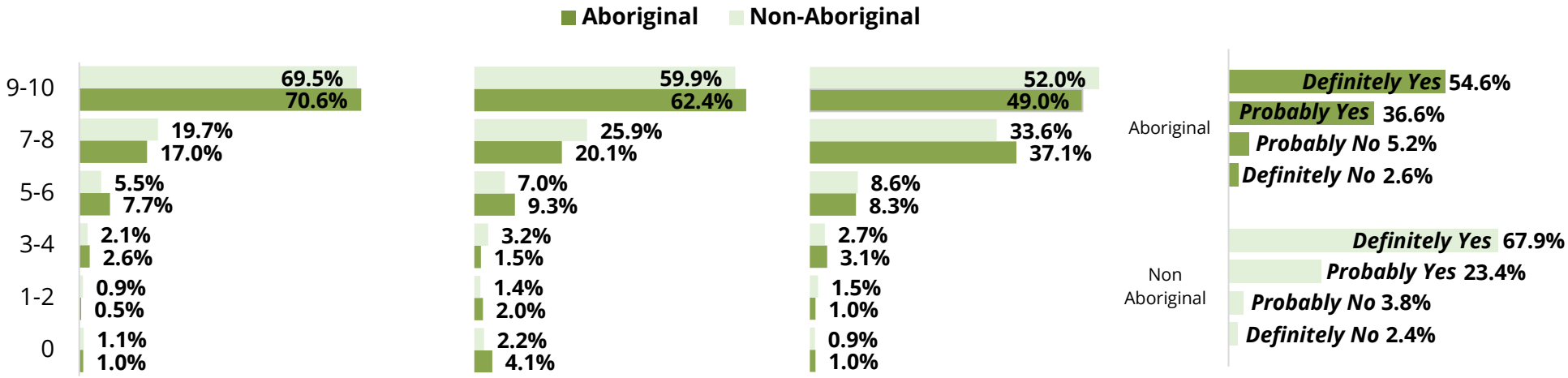


Shame, Vulnerability and Empathy (Data Table)

	During this hospital stay, do you feel that your care providers were respectful of your culture and traditions? [Completely]	During this hospital stay, do you believe you or your family members suffered personal injury or harm, which resulted from a medical error or mistake? [Not at all]	Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? Would you say.... [Always]	Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Would you say.... [Always]	During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? Would you say.... [Always]	During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? [Always]	During this hospital stay, when you or your child used the call button to get help, was the response quick enough? [Always]	During this hospital stay, when you used the call button to get help, was the response quick enough? [Always]
	Q72	**Q68**	**Q17**	**Q16**	**Q14**	**Q4**	**P9**	**Y9**
Vancouver Island, Aboriginal	69%	86%	53%	68%	67%	62%	35%	*n < 10*
Vancouver Island, Aboriginal (n)	179	189	87	88	150	148	12	*n < 10*
Vancouver Island, Non-Aboriginal	84%	93%	37%	68%	75%	59%	58%	*n < 10*
Vancouver Island, Non-Aboriginal (n)	3,464	4,064	2,367	2,471	3,057	3,218	62	*n < 10*
Provincial Aboriginal	72%	88%	48%	69%	73%	53%	45%	64%
Provincial Aboriginal (n)	795	845	392	397	680	863	45	13

Difference between Aboriginal vs. non-Aboriginal	-15%	-7%	16%	equivalent	-8%	3%	-23%	*n < 10*
Difference between Vancouver Island Aboriginal vs. Provincial Aboriginal	-3%	-2%	5%	-1%	-6%	9%	-10%	*n < 10*

Global Rating



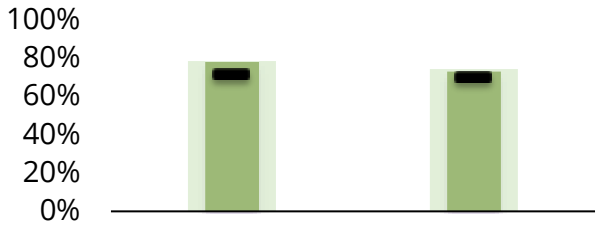
Patients felt they were helped during ED visit

Patients rating of overall experience of the ED visit

Patients rating of care during their ED visit

Patients would recommend ED to friends and family

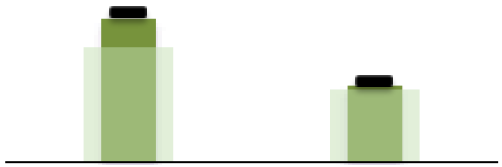
Respect



Doctors treated patients with courtesy and respect
-Always

Nurses treated patients with courtesy and respect
-Always

Identity



Patients felt spiritual needs are important part of overall care
-Always

Patients felt their spiritual needs were met
-Completely

Genuineness

Patients felt they were treated with compassion
-Always

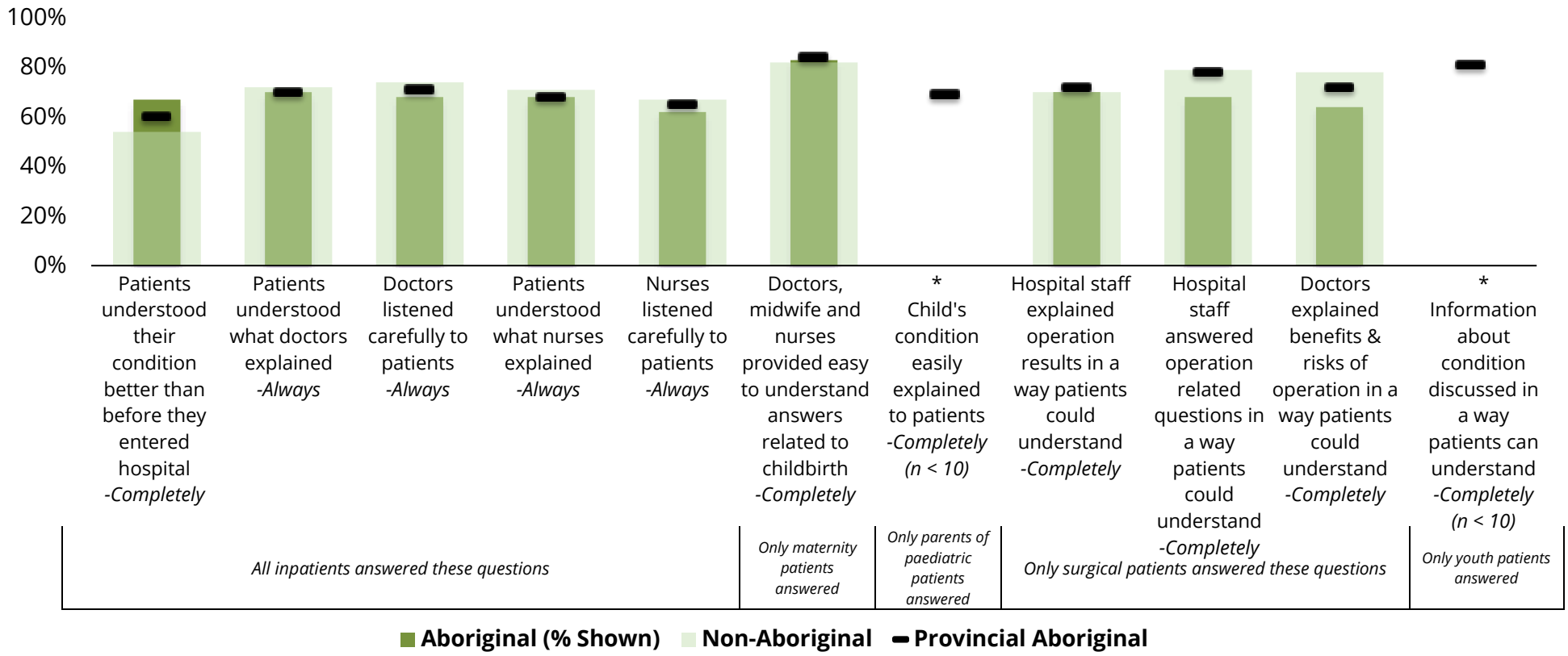
All inpatients answered these questions

Global Rating, Respect, Identity, Genuineness (Data Table)

	During this hospital stay, do you feel you were treated with compassion? [Always]	Do you feel your spiritual needs are an important part of your overall care? [Yes]	During this hospital stay, were your spiritual needs met? [Completely]	During this hospital stay, how often did doctors treat you with courtesy and respect? [Always]	During this hospital stay, how often did nurses treat you with courtesy and respect? [Always]	On a scale of 0 to 10, what was your overall experience with your hospital stay? [9 or 10]	Overall, on a scale of 0 to 10, do you feel you were helped by your hospital stay? [9 or 10]	Would you recommend <INSERT NAME OF HOSP> to your friends and family? [9 or 10]	Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay? [9 or 10]
	Q71	**Q69**	**Q70**	**Q5**	**Q1**	**Q41**	**Q40**	**Q22**	**Q21**
Vancouver Island, Aboriginal	63%	75%	40%	78%	73%	62%	71%	57%	48%
Vancouver Island, Aboriginal (n)	191	140	77	189	194	193	193	192	193
Vancouver Island, Non-Aboriginal	66%	60%	38%	85%	82%	60%	70%	70%	52%
Vancouver Island, Non-Aboriginal (n)	4,170	2,422	960	4,153	4,201	4,193	4,162	4,107	4,184
Provincial Aboriginal	66%	78%	42%	80%	79%	66%	71%	64%	55%
Provincial Aboriginal (n)	857	334	187	853	864	858	860	850	859
Difference between Vancouver Island Aboriginal vs. Non-Aboriginal	-3%	15%	2%	-8%	-9%	2%	1%	-13%	-4%
Difference between Vancouver Island Aboriginal vs. Provincial Aboriginal	-3%	-3%	-2%	-2%	-6%	-4%	equivalent	-0.07	-7%

Relational Care

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



Relational Care (Data Tables)

	When you left the hospital, did you have a better understanding of your condition than when you entered? [Completely]	During this hospital stay, how often did doctors explain things in a way you could understand? [Always]	During this hospital stay, how often did doctors listen carefully to you? [Always]	During this hospital stay, how often did nurses explain things in a way you could understand? [Always]	During this hospital stay, how often did nurses listen carefully to you? [Always]	While in the hospital, did your doctor, midwife or nurse answer your questions about your childbirth in a way you could understand? [Completely]	During this hospital stay, was information about his or her condition discussed with your child in a way he or she could understand? [Completely]	After your operation, did hospital staff explain how the operation had gone in a way you could understand? [Completely]	Before your operation, did hospital staff answer your questions about the operation in a way you could understand? [Completely]	Before your operation, did hospital staff and/or doctors explain the risks and benefits of the operation in a way you could understand? [Completely]	During this hospital stay, was information about your condition discussed with you in a way you could understand? [Completely]
	Q39	**Q7**	**Q6**	**Q3**	**Q2**	**M2**	**P7**	**S5**	**S3**	**S2**	**Y7**
Vancouver Island, Aboriginal	67%	70%	68%	68%	62%	83%	*n < 10*	70%	68%	64%	*n < 10*
Vancouver Island, Aboriginal (n)	191	189	189	191	194	15	*n < 10*	65	58	64	*n < 10*
Vancouver Island, Non-Aboriginal	54%	72%	74%	71%	67%	82%	*n < 10*	70%	79%	78%	*n < 10*
Vancouver Island, Non-Aboriginal (n)	4,007	4,128	4,117	4,169	4,786	238	*n < 10*	2,089	1,875	2,038	*n < 10*
Provincial Aboriginal	60%	70%	71%	68%	65%	84%	69%	72%	78%	72%	81%
Provincial Aboriginal (n)	843	848	845	856	862	64	26	327	280	320	17

Difference between Vancouver Island Aboriginal vs. Non-Aboriginal	13%	-2%	-6%	-3%	-9%	1%	*n < 10*	equivalent	-11%	-14%	*n < 10*
Difference between Vancouver Island Aboriginal vs. Provincial Aboriginal	7%	equivalent	-3%	equivalent	-3%	-1%	*n < 10*	-2%	-10%	-6%	*n < 10*

1. Regional VI Caucus Survey

Vancouver Island Region

Partnership Accord Evaluation Questionnaire

GATHERING FEEDBACK

Please choose one of the below that best describes your role:

Political Leadership	**Technical Leadership**	**Other:**
☐ Chief	☐ Health Director	☐ _____
☐ Proxy	☐ Health Lead	

How long have you been in your role?

Less than 1 year	1 to 2 years	3 to 4 years	5 or more years

Which cultural Family (sub-region) of the Vancouver Island region are you representing?

Coast Salish	Nuu-chah-nulth	Kwakwaka'wakw

1. How would you rate your understanding of the aim of the Vancouver Island Partnership Accord?

Unclear Understanding	Somewhat Unclear Understanding	Neutral	Somewhat Clear Understanding	Clear Understanding	Don't Know

2. How engaged do you feel with the Partnership Accord and its work?

Unengaged	Somewhat Unengaged	Neutral	Somewhat Engaged	Engaged	Don't Know

3. Please rate your agreement with the following statements regarding the partnership:

As a result of the partnership:	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Don't Know
FNHA						
a) Relationships between my Nation and the FNHA have been strengthened						Don't Know
b) I know the process to connect with FNHA to address issues identified by my Nation						Don't Know
c) Processes to support decision-making around the design and delivery of FNHA health programs have improved						Don't Know
d) Coordination of services between my Nation and the FNHA has increased						Don't Know
ISLAND HEALTH						
e) Relationships between my Nation and Island Health have been strengthened						Don't Know
f) I know the process to connect with Island Health to address issues identified by my Nation						Don't Know
g) Processes to support decision-making around the design and delivery of Island Health health programs have improved						Don't Know
h) Coordination of services between my Nation and Island Health has increased						Don't Know
OVERALL						
i) Health programs and initiatives have become more reflective of the culture and traditions of the First Nations on Vancouver Island						Don't Know
PARTNERSHIP ACCORD KEY AREAS OF SHARED WORK						
a) Meaningful efforts have been made to move forward work related to **mental health and wellness** with my Nation						Don't Know

b) Meaningful efforts have been made to move forward work related to **primary care** for with Nation						Don't Know
c) Meaningful efforts have been made to move forward work related to **maternal child and family health** with my Nation						Don't Know
d) Meaningful efforts have been made to move forward work related to **traditional wellness** with my Nation						Don't Know
e) Meaningful efforts have been made to move forward work related to **cultural safety** for my Nation						Don't Know

4. Are there other opportunities for improvement or other recommendations or comments that you would like to add?

2. FNHA Technical Staff Survey

1. In your view, what have been the greatest achievements or outcomes from the Partnership Accord Agreement?

2. How would you rate your understanding of the aim of the Vancouver Island Partnership Accord?

Unclear Understanding	Somewhat Unclear Understanding	Neither Unclear or Clear Understanding	Somewhat Clear Understanding	Clear Understanding	Don't Know

2. a) Please provide an example or rationale for your rating, if appropriate:

3. How would you rate your understanding of FNHA's roles and responsibilities under the Partnership Accord?

Unclear Understanding	Somewhat Unclear Understanding	Neither Unclear or Clear Understanding	Somewhat Clear Understanding	Clear Understanding	Don't Know

3. a) Please provide an example or rationale for your rating, if appropriate:

4. How do you use/draw upon the Partnership Accord in your work?

5. Thinking about the resources, structures and information that you need to work towards the objectives of the Partnership Accord in your role, how would you rate the availability of the following inputs/supports:

5. a) I have sufficient **information** to know how I can support the objectives of the Partnership Accord in my role:

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

5. a) i) Please provide an example or rationale for your rating, if appropriate:

5. b) I have enough **resources** (human, financial) to support me in meeting the objectives of the Partnership Accord in my role:

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

5. b) i) Please provide an example or rationale for your rating, if appropriate:

5. c) There are **supportive structures and processes** in place to move this work forward:

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

5. c) i) Please provide an example or rationale for your rating, if appropriate:

5. d) There is sufficient **leadership** and **direction** from senior levels of the FNHA and Island Health to support this work:

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

5. d) i) Please provide an example or rationale for your rating, if appropriate:

6. How successful has the Partnership Accord been in strengthening partnership between Island Health and the First Nations Health Authority?

Unsuccessful	Somewhat Unsuccessful	Neither Successful or Unsuccessful	Somewhat Successful	Successful	Don't Know

6. a) Please provide an example or rationale for your rating

7. In your role, how do you engage and build relationships[38] with First Nation communities?

8 a) Can you provide an example of **shared decision-making** between First Nations communities, the FNHA and Island Health?

8 a) i. What are the barriers to shared decision-making?

[38] The term 'relationship' differs from the term 'partnership' in that relationships are based on individual connections and communications whereas partnership relates more to organizational alignment and synergies in joint work.

8 b) Can you provide an example of **shared service delivery** between First Nations communities, the FNHA and Island Health?

8 b) i. What are the barriers to shared service delivery?

8 c) Can you provide an example of **changes to policy and programs** between First Nations communities, the FNHA and Island Health to support the work of the PA?

8 d) Can you provide an example of **shared capacity development opportunities** between First Nations communities, the FNHA and Island Health?

9. How has the Partnership Accord enabled innovation and provided opportunities to address challenges?

10. In your view**,** how have Island Health services become more reflective of the First Nations perspectives on wellness?

11. The Partnership Accord identifies the following four key areas of shared priority:

1. mental wellness;
2. primary care:
3. maternal child and family health;
4. cultural safety & humility and traditional wellness

To what extent have FNHA and Island Health worked collaboratively in these areas ? On a scale from 1 to 5, where 1 is not yet effectively collaborating and 5 is complete and effective collaboration between the FNHA and Island Health?

11 a) For work related to mental wellness	1	2	3	4	5	Don't know	Not Applicable
11 b) For work related to primary care	1	2	3	4	5	Don't know	Not Applicable

11 c) For work related to maternal child and family health	1	2	3	4	5	Don't know	Not Applicable
11 d) For work related to cultural safety & humility[39]	1	2	3	4	5	Don't know	Not Applicable
11 e) For work related to traditional wellness[3]	1	2	3	4	5	Don't know	Not Applicable

12. Where are you seeing Island Health championing and/or hardwiring the "The D*eclaration of Commitment on Cultural Safety and Humility*[40]?

12. a) How have you, in your role, worked with Island Health to address systemic barriers related to cultural safety?

12. b) What supports do you use and what additional supports do you need to do this work?

13. Are there other opportunities for improvement or other recommendations or comments that you would like to add?

Thank you for your time,
your input to this evaluation and
your contributions to this work.

[39] Please note that the fourth key priority area "Cultural safety & humility and traditional wellness" is broken out into two sub-components for rating because they represent distinct and separate efforts and initiatives.
[40] The *Declaration of Commitment on Cultural Safety and Humility* was signed in 2015 and is a component of the priority work area related to cultural safety and humility.

3. Island Health Key Informant Survey

Vancouver Island Partnership Accord
GEO Executive Director/Executive Medical Director,
GEO Director/Medical Director,
Program Director,
Aboriginal Health and
Planning Staff
Key Informant Interview Guide

1. Please select your position level from the list below:

- Executive Leadership Team (VP)
- Executive Director
- Director
- Manager
- Medical Health Officer
- Other

2. Please select which Island Health geography or geographies you work in (optional):

- Geo 1
- Geo 2
- Geo 3
- Geo 4

3. How would you rate your understanding of the aim of the Vancouver Island Partnership Accord?

Unclear Understanding	Somewhat Unclear Understanding	Neither Unclear or Clear Understanding	Somewhat Clear Understanding	Clear Understanding	Don't Know

3. a) Please provide an example or rationale for your rating, if appropriate:

4. How would you rate your understanding of Island Health's roles and responsibilities under the Partnership Accord?

Unclear Understanding	Somewhat Unclear Understanding	Neither Unclear or Clear Understanding	Somewhat Clear Understanding	Clear Understanding	Don't Know

5. How has the signing of the Partnership Accord affected your work priorities and how you go about your work (optional)?

6. On a scale of 1 to 5, in your view, how well are the aims and objectives of the Partnership Accord communicated between different levels of Island Health staff, where 1 is not at all and 5 is very well?

The aims and objectives of the Partnership Accord are **not communicated very** well between levels of Island Health staff	1	2	3	4	5	The aims and objectives of the Partnership Accord are **communicated very** well between levels of Island Health staff	Don't Know

6. a) Please provide an example or rationale for your rating, if appropriate:

7. Thinking about the resources, structures and information that you need to work towards the objectives of the Partnership Accord in your role, how would you rate the availability of the following inputs/supports:

7. a) I have sufficient **information** to know how I can support the objectives of the Partnership Accord in my role:

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

7. a) i) Please provide an example or rationale for your rating, if appropriate:

7. b) I have enough **resources** (human, financial) to support me in meeting the objectives of the Partnership Accord in my role:

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

7. b) i) Please provide an example or rationale for your rating, if appropriate:

7. c) There are **supportive structures and processes** in place to move this work forward:

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

7. c) i) Please provide an example or rationale for your rating, if appropriate:

7. d) There is sufficient **leadership** and **direction** from senior levels of Island Health and the FNHA to support this work:

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

7. d) i) Please provide an example or rationale for your rating, if appropriate:

8. How successful has the Partnership Accord been in strengthening partnership between Island Health and the First Nations Health Authority?

Unsuccessful	Somewhat Unsuccessful	Neither Successful or Unsuccessful	Somewhat Successful	Successful	Don't Know

8. a) Please provide an example or rationale for your rating

9. On a scale from 1 to 5, where 1 is not at all and 5 is a great deal, to what extent do you, in your role, currently collaborate with the FNHA and First Nations communities in……

	With FNHA							With First Nation Communities						
9 a) …. the delivery of health services[1]	1	2	3	4	5	DK	NA	1	2	3	4	5	DK	NA
9 b) …..discussing potential changes to policy, programs and services that might impact one another[41]	1	2	3	4	5	DK	NA	1	2	3	4	5	DK	NA
9 c) …. communicating about potential risks or impediments to partnership[42]	1	2	3	4	5	DK	NA	1	2	3	4	5	DK	NA
9 d) … exploring capacity development opportunities[4]	1	2	3	4	5	DK	NA	1	2	3	4	5	DK	NA

9. e) Please provide any examples or rationale for your ratings, if desired

10. In your role, how do you engage and build relationships[43] with First Nations communities?

11. In your view, on a scale of 1 to 5, to what degree do you feel First Nations communities share in decisions around the design and delivery of Island Health programs, where 1 is not at all and 5 is a great degree[44]?

No involvement in decisions relating to the design and delivery of Island health programs	1	2	3	4	5	Great degree of involvement in decisions relating to the design and delivery of Island health programs	Don't Know

[41] Bullet 27 of the VI PA agreement
[42] Bullet 28 of the VI PA agreement
[43] The term 'relationship' differs from the term 'partnership' in that relationships are based on individual connections and communications whereas partnership relates more to organizational alignment and synergies in joint work.
[44] Item 2 in the PA agreement indicates "This Accord is a relationship document intended to strengthen partnership and shared decision-making between the Parties"

11 a) Can you provide an example of shared decision-making between First Nations communities and Island Health?

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

13. How has the Partnership Accord enabled innovation and provided opportunities to address challenges?

14. How have Island Health services become more reflective of the First Nations perspectives on wellness in your GEO/program?

15. The Partnership Accord identifies the following four key areas of shared priority:

5. mental wellness;
6. primary care:
7. maternal child and family health;
8. cultural safety & humility and traditional wellness

To what extent have efforts and resources been made to move these areas forward in your program/GEO? On a scale from 1 to 5, where 1 is no resources and prioritization and 5 is every possible resource and prioritization, how would you rate the level of emphasis and resources put in place to date?

15 a) For work related to mental wellness	1	2	3	4	5	Don't know	Not Applicable
15 b) For work related to primary care	1	2	3	4	5	Don't know	Not Applicable
15 c) For work related to maternal child and family health	1	2	3	4	5	Don't know	Not Applicable
15 d) For work related to cultural safety & humility[45]	1	2	3	4	5	Don't know	Not Applicable

[45] Please note that the fourth key priority area "Cultural safety & humility and traditional wellness" is broken out into two sub-components for rating because they represent distinct and separate efforts and initiatives.

15 e) For work related to traditional wellness[3]	1	2	3	4	5	Don't know	Not Applicable

15. f) What are the barriers to having the necessary resources and focus on these key priority areas, if any?

16. What is your level of agreement with the following statement; "The D*eclaration of Commitment on Cultural Safety and Humility*[46] has been championed and/or hard-wired in my GEO/program"?

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

16. a) How have you, in your role, worked to address systemic barriers related to cultural safety?

16. b) How can you, in your role, address culturally unsafe care and how can the Partnership Accord help support you in this work?

17. How do you see the Partnership Accord influencing your work in the future?

18. Are there other opportunities for improvement or other recommendations or comments that you would like to add?

4. PASC/ PAEC Interview Guide

Vancouver Island Partnership Accord
Partnership Accord Steering Committee
Partnership Accord Executive Committee
Interview Guide

[46] The *Declaration of Commitment on Cultural Safety and Humility* was signed in 2015 and is a component of the priority work area related to cultural safety and humility.

Section 1: Framework Agreement Questions

Section 1 contains questions relating to the **Tripartite Framework Agreement**. These questions are asked across all health authority Partnership Accord evaluations and will only be asked of the following Tripartite key informants:

Note: The term 'Parties' in Section 1 refers to Health Canada, BC Ministry of Health and the FNHA

T-1. How would you assess the first few years of the implementation of the Framework Agreement (the Tripartite transformation journey).

T-1. a) What factors most influenced your assessment?

T-2. The Health Partnership Accord (HPA) signed August 2012 by Health Canada, BC Ministry of Health, and the First Nations Health Council, **describes the broad and enduring relationship amongst the Parties and their political commitment to pursue their shared vision. In your view, is the HPA still relevant in light of changing circumstances and the evolving nature of the partnership or does it need to be updated?**

T-3. In your view, what have been the greatest achievements or outcomes from the Framework Agreement?

T-4. The Parties (Health Canada, BC Ministry of Health and the FNHA) agreed to a shared vision for "a better, more responsive and integrated health system for First Nations in British Columbia". To what degree do you think this has been achieved? Please explain.

T-5. The Framework Agreement committed the Parties to build a new partnership and a new way of working together based on reciprocal accountability.

T-5. a) Is the concept of reciprocal accountability well understood by the Parties?

- Yes

- No
- Don't know

Please indicate the rationale for your response.

T-5. b) If yes, what are some success indicators and/or examples of reciprocal accountability within the partnership?

T-5. c) Are there things that need to be done to strengthen the understanding and application of "reciprocal accountability"?

- Yes
- No
- Don't know

Please indicate the rationale for your response.

T-5. d) In your view how has the partnership evolved since 2013, and what do you think needs to be done to continue to evolve, grow and mature the partnership?

T-6. The FA created a new governance structure (the FNHA, FNHC, FNHDA and the TCFNH) that was intended to support greater involvement and control by First Nations of their health services. How would you assess the overall performance of the new governance structure?

T-7. How well is the regional Vancouver Island structure able to raise issues to the TCFNH?

T-7. a) Is there anything that could make the TCFNH and the Vancouver Island regional structure more coordinated and effective?

T-8. What are the greatest strengths of the Framework Agreement?

T-9. What are the greatest weaknesses, if any, of the Framework Agreement?

T-10. What are the greatest challenges that need to be addressed to ensure the success of the Framework Agreement moving forward?

T-11. What lessons learned from the early years of the partnership are important to consider for moving forward?

T-12. Based on your experience with the Framework Agreement, are there lessons learned that may be important for other jurisdictions to consider when contemplating an agreement similar to the Framework Agreement.

Section 2: Partnership Accord Agreement Questions

In this Section the term "Parties" refers to the Vancouver Island Regional Caucus, Island Health and the First Nations Health Authority.

All members of the PASC/PAEC answer the questions in Section 2.

P-1. In your view, what is the understanding of the aim of the Vancouver Island Partnership Accord within the Partnership Accord Steering Committee/Executive Committee?

Unclear Understanding	Somewhat Unclear Understanding	Neither Unclear or Clear Understanding	Somewhat Clear Understanding	Clear Understanding	Don't Know

P-1. a) Please provide an example or rationale for your rating, if appropriate:

P-1. b) Which aspects of the Partnership Accord are least understood?

P-2. In your view, is there a clear understanding by all Partners of the roles and responsibilities as outlined in the Partnership Accord Terms of Reference (VI Regional Caucus[47], Island Health, and the First Nations Health Authority)?

Unclear Understanding	Somewhat Unclear Understanding	Neither Unclear or Clear Understanding	Somewhat Clear Understanding	Clear Understanding	Don't Know

P-2. a) Please provide an example or rationale for your rating, if appropriate:

P-2. b) Which roles and responsibilities could be clarified?

[47] Note that the VI Regional Caucus is represented by the VI Regional Table, which is in turn comprised of regional First Nations Health Directors Association (FNHDA) and First Nations Health Council (FNHC) representatives.

P-3. The Vancouver Island Region Structure is comprised of the Partnership Accord Steering Committee, Partnership Accord Executive Committee, the VI Regional Caucus, Island Health and the First Nations Health Authority. To what extent are you satisfied with how the current structure supports the desired goals of the Partnership?

Dissatisfied	Somewhat Dissatisfied	Neither Satisfied Nor Dissatisfied	Somewhat Satisfied	Satisfied	Don't Know

P-3. a) Please provide an example or rationale for your rating.

P-3. b) what is working well and are there areas in need of improvement (this could include meeting sequencing, meeting attendance, timing of meetings etc.)?

P-4. The Partnership Accord outlines the following objectives for the PASC. In your view, in which areas has the PASC been more effective and successful and which areas have they been less so?

i. providing a forum for Partners to develop mutual understanding of the problems, strengths and issues supporting a population health approach[48]

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

P-4. i. a) Please provide an example or rationale for your rating, if appropriate

ii. providing oversight and direction to the development and implementation of the Partnership Accord and related plans[49]

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

[48] Article 31 (first sub-bullet) of the Vancouver Island Partnership Accord Agreement
[49] Article 31 (second sub-bullet) of the Vancouver Island Partnership Accord Agreement

P-4. ii. a) Please provide an example or rationale for your rating, if appropriate

iii. jointly monitoring performance indicators and strategic initiatives related to First Nations health[50].

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

P-4. iii. a) Please provide an example or rationale for your rating, if appropriate

iv. monitoring outcomes of population health approaches that are jointly implemented and evaluated with the Coast Salish, Kwakwaka'wakw and Nuu-chah-nulth First Nations to evaluate progress on closing the health disparity gap between First Nations and non-Aboriginal Vancouver Island residents[51]

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

P-4. iv. a) Please provide an example or rationale for your rating, if appropriate

v. aligning and coordinating the participation, messaging and action items relating to the Tripartite Committee on First Nations Health?[52]

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

P-4. v. a) Please provide an example or rationale for your rating, if appropriate

[50] Article 31 (third sub-bullet) of the Vancouver Island Partnership Accord Agreement
[51] Article 31 (fourth sub-bullet) of the Vancouver Island Partnership Accord Agreement
[52] Article 34 of the Vancouver Island Partnership Accord Agreement

vi. ensuring mutually agreed First Nations health priorities are incorporated into annual work plans for all Island Health programs[53]

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

P-4. vi. a) Please provide an example or rationale for your rating, if appropriate

P-5. In your view, how effective is the Partnership Accord **Executive Committee** in providing operational oversight, problem solving and direction to the Partnership accord work plan and overseeing implementation of the direction provided by the PASC[54]?

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

P-5. a) Please provide an example or rationale for your rating, if appropriate:

P-6. To what extent have relationships[55] among the PASC/PAEC members changed as a result of the Partnership Accord?

P-7. Do you feel the PASC/PAEC provides a safe space where you can have open and honest conversations?

Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Don't know

[53] Article 31 (fifth sub-bullet) of the Vancouver Island Partnership Accord Agreement
[54] Article 33 of the Vancouver Island Partnership Accord Agreement
[55] The term 'relationship' differs from the term 'partnership' in that relationships are based on individual connections and communications whereas partnership relates more to organizational alignment and synergies in joint work.

P-7. a) Please provide an example or rationale for your rating, if appropriate:

P-8. How successful has the Partnership Accord been in strengthening partnership[9] between the Vancouver Island Regional Caucus, Island Health and the First Nations Health Authority?

Unsuccessful	Somewhat Unsuccessful	Neither Successful or Unsuccessful	Somewhat Successful	Successful	Don't Know

P-8. a) Please provide an example or rationale for your rating

P-9. To what extent is there alignment of planning, management and service delivery between Partners?

P-9. a) In your view, have the Partners jointly identified/designated resources (time, financial resources, human resources) needed to accomplish the work of the Partnership Accord?

P-10. In your view, what have been the greatest achievements or outcomes from the Partnership Accord Agreement?

P-11. Has the Partnership Accord enabled innovation and provided opportunities to address challenges?

P-11. a) If so, how was that accomplished?

P-11. b) Are there opportunities that the Partnership has missed?

P-12. How successful has the Partnership been in: advancing shared decision-making between the Vancouver Island Regional Caucus, Island Health and the First Nations Health Authority[56]?

Unsuccessful	Somewhat Unsuccessful	Neither Successful or Unsuccessful	Somewhat Successful	Successful	Don't Know

[56] Article 2 of the Vancouver Island Partnership Accord Agreement

P-12. a) Please provide an example or rationale for your rating, if appropriate:

P-13. How successful has the Partnership been in: improving health outcomes for First Nations on Vancouver Island[10]?

Unsuccessful	Somewhat Unsuccessful	Neither Successful or Unsuccessful	Somewhat Successful	Successful	Don't Know

P-13. a) Please provide an example or rationale for your rating, if appropriate:

P-14. How successful has the Partnership been in: creating a more integrated, safe and effective health system for First Nations on Vancouver Island[10]?

Unsuccessful	Somewhat Unsuccessful	Neither Successful or Unsuccessful	Somewhat Successful	Successful	Don't Know

P-14. a) Please provide an example or rationale for your rating, if appropriate:

P-15. How has the PASC/PAEC championed the *declaration of commitment on cultural safety and humility?*

P-16. How does PASC/PAEC support community influence in addressing systemic barriers related to cultural safety and appropriateness of health care programs and services?

P-16. a) Please provide an example or rationale for your answer.

P-16. b) What are the barriers to progress and what would be required to remove or surpass them?

P-17. In your view, what role do you see PASC/PAEC playing in transforming the health system to better reflect First Nations perspectives on wellness?

P-18. The Partnership Accord identifies the following four key areas of shared priority:

9. Mental wellness;
10. Primary Care:
11. Maternal child and family health;
12. Cultural safety & humility and traditional wellness

To what extent have efforts and resources been placed to move initiatives in these areas forward? On a scale from 1 to 5, where 1 is no resources and prioritization being given to a priority area and 5 is every possible resource and priority being given to a priority area, how would you rate the level of emphasis and resources put in place to date?

Note to interviewer: please ensure the respondents rate (rather than rank) resources and prioritization of shared priority areas.

P-18 a) For work related to Mental Wellness	1	2	3	4	5	Don't know
P-18 b) For work related to Primary Care	1	2	3	4	5	Don't know
P-18 c) For work related to Maternal child and family health	1	2	3	4	5	Don't know
P-18 d) For work related to cultural safety & humility[57]	1	2	3	4	5	Don't know
P-18 e) For work related to traditional wellness[11]	1	2	3	4	5	Don't know

P-18. f) What are the barriers to having the necessary resources and focus on these key priority areas, if any?

P-19. Are there additional comments you would like to add?

[57] Please note that the fourth key priority area "Cultural safety & humility and traditional wellness" is broken out into two sub-components for rating because they represent distinct and separate efforts and initiatives.

Appendix D: Demographic, Geography and Health Services Data

Table 3: 2016 First Nations, Status First Nations and Aboriginal Population, geography, health facility and staffing information by region

		Fraser Salish	Interior	Northern	Vancouver Coastal	Vancouver Island
BC Total Population*						
Total Population (4,560,265)(% Prov pop)		**1,695,010 (37.2%)**	722,480 (15.8%)	275,520 (6.0%)	1,110,270 (24.4%)	756,985 (16.6%)
Aboriginal Population±						
Aboriginal population (270,570)(% Abor pop in total pop)		**62,295** (3.7%)	63,845 (8.8%)	56,365 **(20.5%)**	30,850 (2.8%)	57,215 (7.6%)
% of Total BC Aboriginal Pop		23.0%	**23.6%**	20.8%	11.4%	21.2%
First Nations (172,480)(% FN pop in total pop)		35,040 (2.1%)	36,580 (5.1%)	**40,760** (**14.8%)**	22,085 (2.0%)	38,015 (5.0%)
Registered or Treaty Indian Status (70,265)(% Registered/Treaty Indian FN pop)		12,070 (0.7%)	14,860 (2.1%)	**17,935 (6.5%)**	9,410 (0.8%)	15,990 (2.1%)
First Nation communities						
# of First Nation communities		32	52	**53**	14	50
# of communities with <300 people†		29	36	30	6	35
# of fly-in/boat-in communities‡		0	1	**10**	2	**8**
On/off reserve***						
Aboriginal Identity	On-reserve	4660 (7.5%)	11965 (18.9%)	14570 (26.0%)	8040 (26.1%)	12210 (21.4%)
	Off-reserve	57265 (92.5%)	51210 (81.1%)	41530 (74.0%)	22745 (73.9%)	44725 (78.6%)
First Nations	On-reserve	4490 (12.9%)	11105 (31.0%)	14450 (35.7%)	7950 (36.1%)	11995 (31.8%)
	Off-reserve	30225 (87.1%)	24735 (69.0%)	26050 (64.3%)	14070 (63.9%)	25725 (68.2%)
Household Counts****						
Aboriginal households	On-reserve	1,715	5,145	5,075	2,825	3,870

	Off-reserve	28,765	26,565	19,240	13,910	23,835
Registered or Treaty Indian Status households	On-reserve	1,605	4,655	5,055	2,770	3,750
	Off-reserve	9,745	9,220	10,235	6,260	9,820
Health Staff^						
# of Employees		26,000	20,000	7,000	14,000	22,000
# of Physicians		2,900	1,500	375	2,700	1,900
# of FNHA employees (plus 600 Corporate FNHA staff)		36	35	44	17	49
Geographical Area						
Land size (% Prov land mass)		13,362 (1.4%)	215,000 (22.4%)	**617,271 (64.3%)**	58,560 (6.1%)	56,000 (5.8%)
FNHA Health Facility*		17	36	39	10	34
Total Provincial Health Service Facility**						
Large Peer Group		8	2	1	4	3
Medium Peer Group		3	5	4	2	6
Small Peer Group		1	15	9	5	5
Extra-Small Peer Group		0	13	10	2	7
Total		12	35	24	13	21

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

± Statistics Canada, 2016 Census of Population. "Aboriginal identity refers to whether the person identified with the Aboriginal peoples of Canada" (See 'CensusDefinitions2016' tab). As Census 2016 is organized by Community Health Service Areas (CHSAs) and local health areas (LHAs) , it should be noted that three FNHA Vancouver Coastal Region First Nations communities, Samahquam, Skatin and Xa'xtsa, are geographically located in LHA 215 Agassiz/Harrison, which falls within Fraser Health Authority. Fraser Salish Region community, Boothroyd, is geographically located in CHSA 1480, which falls within Interior Health Authority. Two communities, Ulkatcho (Anahim Lake) and Alexandria (?Esdilagh), are part of FNHA Interior Region, but are geographically located in LHAs that are part of the Vancouver Coastal Health and Northern Health Authorities, respectively.

**2018 Emergency Department Patient Reported Experience Measures Survey Technical Report. For definition on peer group see Table 4 below.
† CIRNAC. Data current to December 31, 2018. Based on On Reserve (Own Band) population;

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

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

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

> i) a non-family household in which at least 50 per cent of household members self-identified as Aboriginal/Registered or Treaty Indian Status people; or
> ii) a family household that meets at least one of two criteria:
> a) at least one spouse, common-law partner, or lone parent self-identified as an Aboriginal/Registered or Treaty Indian Status person; or
> b) at least 50 per cent of household members self-identified as Aboriginal/Registered or Treaty Indian Status people.
> An Aboriginal person is anybody identifying as an Aboriginal person (question 18 on 2016 Long-form Census Questionnaire), Treaty Indian or Registered Indian (question 20), or a member of an Indian Band/First Nation (question 21).

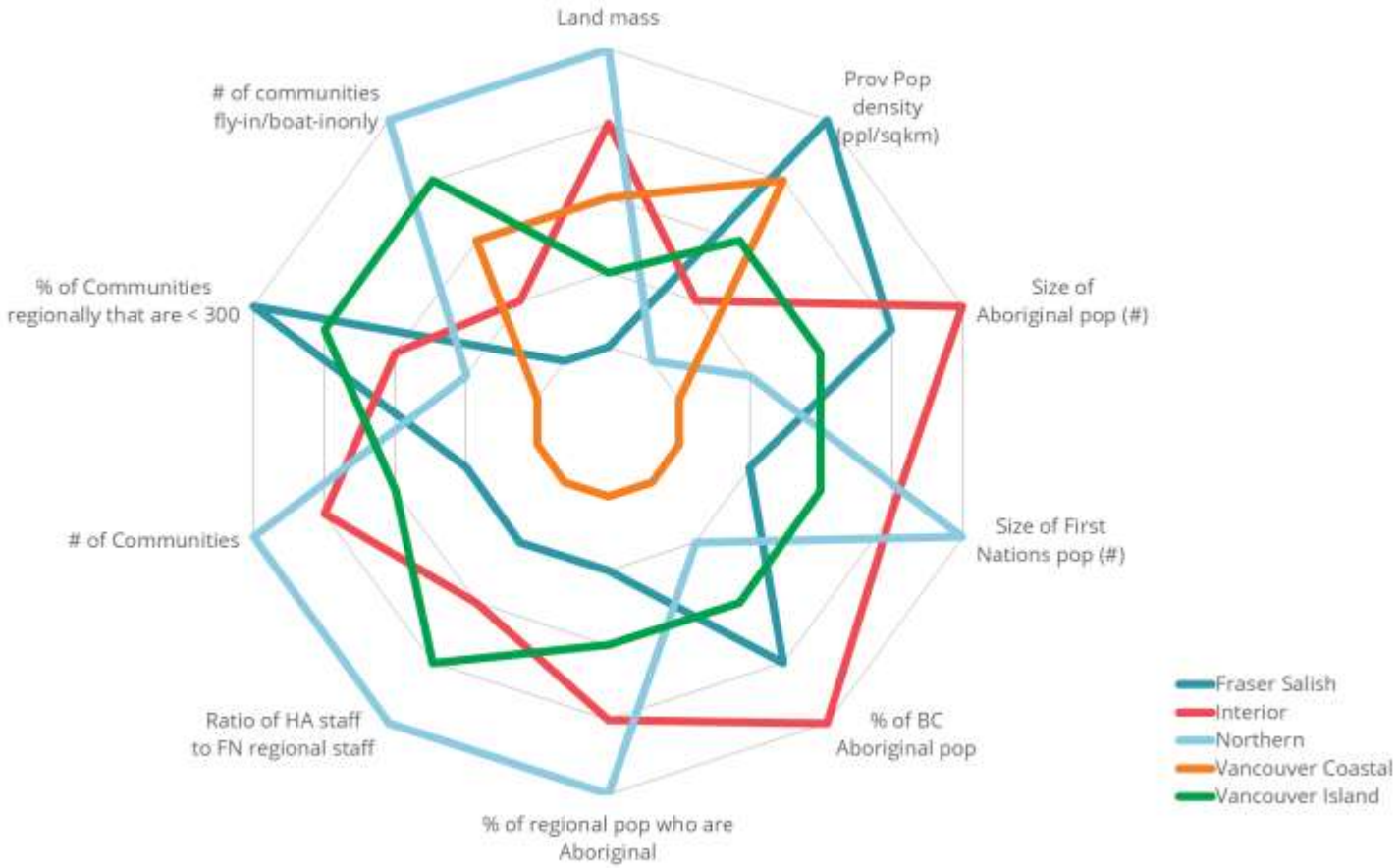
^Factsheet from regional health authorities:

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

Table 4: Regional comparison of select geographic and demographic characteristics

Demographics						Communities and Characteristics			Geography		Staffing
Aboriginal population (#)	% of regional population who are Aboriginal	% of Total BC Aboriginal population	First Nations population (#)	# of First Nations living on-reserve	% of FN living on-reserve	# of First Nation Communities	% of Communities < 300 ppl	# of fly-in/boat-in only Communities	Regional Land mass	Population density (ppl/sqkm)	Ratio of HA staff to FN regional staff
I (63,845)	N (20%)	I (24%)	N (40,760)	N (14,450)	VC (36.1)	N (53)	FS (91%)	N (10)	N (64.29%)	FS (126.85)	N (1:159)
FS (62,295)	I (9%)	FS (23%)	I (36,580)	VI (11,995)	N (35.7%)	I (52)	VI (70%)	VI (8)	I (22.39%)	VC (18.96)	VI (1:449)
VI (57,215)	VI (8%)	VI (21%)	VI (38,015)	I (11,105)	VI (31.8%)	VI (50)	I (69%)	VC (2)	VC (6.10%)	VI (13.52)	I (1:571)
N (56,365)	FS (4%)	N (21%)	FS (35,040)	VC (7,950)	I (31.0%)	FS (32)	N (57%)	I (1)	VI (5.83%)	I (3.36)	FS (1:722)
VC (30,850)	VC (3%)	VC (11%)	VC (22,085)	F (4,490)	F (12.9%)	VC (14)	VC (43%)	FS (0)	FS (1.39%)	N (0.45)	VC (1:823)

Figure 5: Ranked order of regional geographic and demographic characteristics



Note: Each region is represented by a line. Lines that are closest to the edge denote that region has a larger percentage/absolute number of the characteristic labelled on that axis. For example, the Northern region has the largest land mass (see **Error! Not a valid bookmark self-reference.**for the actual number), the next region with the second largest land mass is Interior, followed by VC, VI and FS.

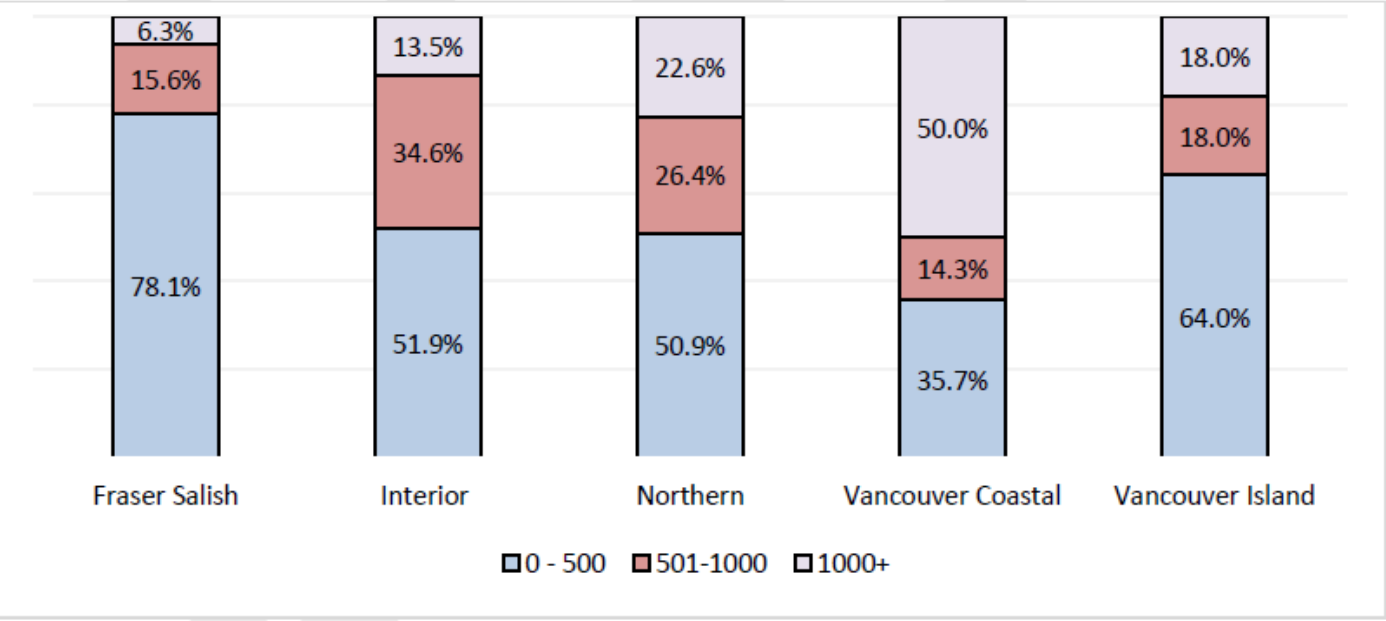
Table 5: 2016 Population size by Census Metropolitan Area

	Total population	Aboriginal Identity	Aboriginal identity, Percent distribution	First Nations	First Nations (North American Indian), Percent distribution
Vancouver	2,426,235	**61,455**	2.5	**35,765**	1.5
Victoria	357,690	**17,245**	4.8	**9,935**	2.8
Prince George	85,135	**12,395**	**14.6**	**7,050**	8.3
Kelowna	190,565	**11,370**	6	5,235	2.7
Kamloops	100,755	10,700	10.6	**6,340**	6.3
Abbotsford - Mission	176,325	9,755	5.5	4,990	2.8
Chilliwack	98,855	9,585	9.7	**6,305**	6.4
Nanaimo	101,985	8,265	8.1	5,145	5
Duncan	43,165	5,775	13.4	4,660	10.8
Prince Rupert	12,515	4,855	**38.8**	4,410	**35.2**
Campbell River	37,105	4,760	12.8	3,420	9.2
Vernon	59,715	4,365	7.3	2,365	4
Port Alberni	24,715	4,210	17	3,035	**12.3**
Terrace	15,460	3,630	**23.5**	2,915	**18.9**
Williams Lake	17,835	3,625	**20.3**	2,800	**15.7**
Penticton	42,105	3,305	7.8	1,695	4

Fort St. John	27,990	3,275	11.7	1,670	6
Quesnel	22,945	3,250	14.2	1,610	7
Courtenay	53,120	3,215	6.1	1,825	3.4
Cranbrook	25,550	2,170	8.5	825	3.2
Dawson Creek	11,785	1,930	16.4	890	7.6
Squamish	19,490	1,275	6.5	870	4.5
Salmon Arm	17,225	1,250	7.3	525	3
Parksville	27,985	1,095	3.9	485	1.7
Powell River	16,360	905	5.5	545	3.3
Nelson	17,960	885	4.9	375	2.1

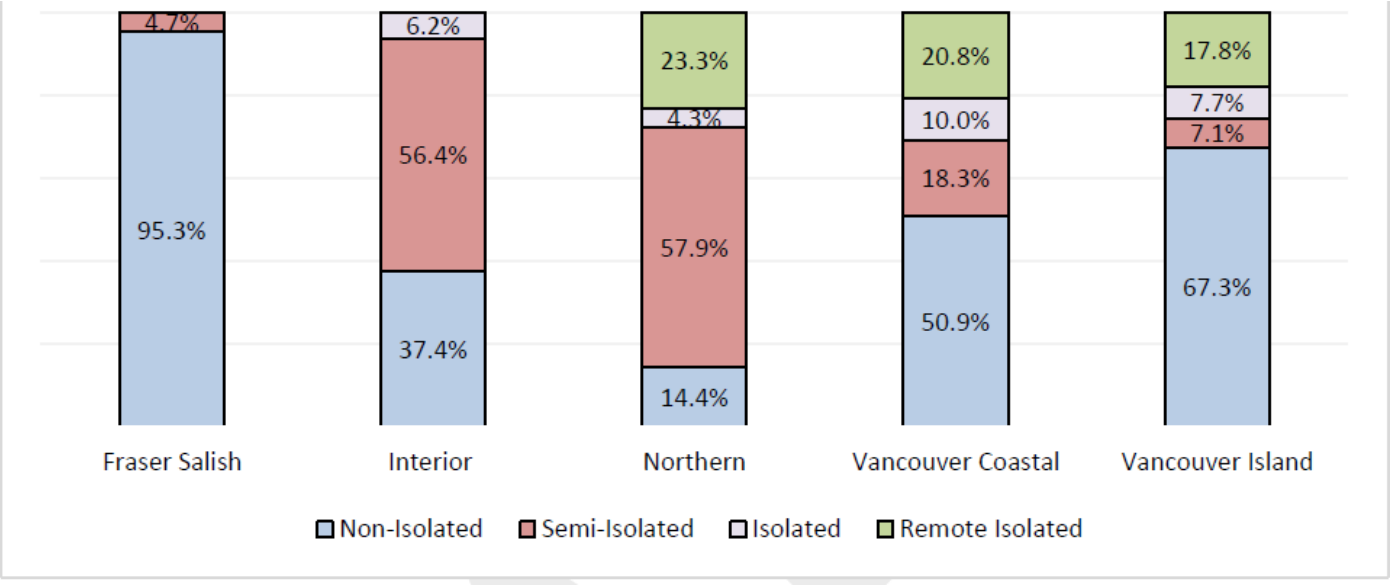
Source: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/abo-aut/Table.cfm?Lang=Eng&T=102&SR=1&S=88&O=A&RPP=9999&PR=0&D1=1&D2=1&D3=1

Figure 6: Proportion of population by community size and region



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

Figure 7: Proportion of population by remoteness and region



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

Table 6: Location and size of acute care facilities by health authority region

	Fraser Salish	Interior	Northern	Vancouver Coastal/PHC†	Vancouver Island	PHSA
Large Peer Group: more than 40,000 annual patient visits n=19	1. Abbotsford Regional General Hospital* 2. Burnaby Hospital* 3. Chilliwack General Hospital* 4. Eagle Ridge Hospital*	1. Kelowna General Hospital* 2. Royal Inland Hospital*	1. University Hospital of Northern British Columbia*	1. Lions Gate Hospital* 2. Richmond Hospital* 3. Vancouver General Hospital* 4. St. Paul's Hospital†*	1. Nanaimo Regional General Hospital* 2. Royal Jubilee Hospital* 3. Victoria General Hospital*	1. BC Children's Hospital*

	Fraser Salish	Interior	Northern	Vancouver Coastal/PHC†	Vancouver Island	PHSA
	5. Langley Memorial Hospital* 6. Peace Arch Hospital* 7. Royal Columbian Hospital* 8. Surrey Memorial Hospital*					
Medium Peer Group: between 20,000 and 39,999 annual patient visits n=20	1. Delta Hospital* 2. Mission Memorial Hospital* 3. Ridge Meadows Hospital*	1. Cariboo Memorial Hospital 2. East Kootenay Regional Hospital 3. Penticton Regional Hospital 4. Shuswap Lake General Hospital 5. Vernon Jubilee Hospital	1. Dawson Creek and District Hospital 2. Fort St. John Hospital 3. Mills Memorial Hospital 4. Prince Rupert Regional Hospital	1. Whistler Health Care Centre 2. Mount Saint Joseph Hospital†*	1. North Island Hospital Campbell River Campus* 2. Cowichan District Hospital* 3. Oceanside Health Centre 4. Saanich Peninsula Hospital* 5. North Island Hospital Comox Valley Campus* 6. West Coast General Hospital	
Small Peer Group: between	1. Fraser Canyon Hospital*	1. 100 Mile District General Hospital	1. Bulkley Valley District Hospital 2. Chetwynd General Hospital 3. Fort Nelson General Hospital	1. Pemberton Health Care Centre	1. Chemainus Health Care Centre	

	Fraser Salish	Interior	Northern	Vancouver Coastal/PHC†	Vancouver Island	PHSA
5,000 and 19,999 annual patient visits n=37		2. Boundary Hospital 3. Castlegar & District Community 4. Chase Health Centre 5. Creston Valley Hospital 6. Elk Valley Hospital 7. Golden and District General 8. Invermere and District Hospital 9. Kootenay Boundary Regional Hospital 10. Kootenay Lake District Hospital 11. Lillooet District Hospital 12. Nicola Valley Health Centre 13. Princeton General Hospital 14. Queen Victoria Hospital 15. South Okanagan	4. Kitimat General Hospital 5. Lakes District Hospital and Health Centre 6. MacKenzie and District Hospital and Health Centre 7. St. John Hospital 8. Stuart Lake Hospital 9. Wrinch Memorial Hospital	2. Powell River General Hospital 3. Sechelt Hospital 4. Squamish General Hospital 5. UBC Hospital*	2. Lady Minto Gulf Islands Hospital 3. Ladysmith Community Health Centre 4. Port Hardy Hospital 5. Tofino General Hospital	

	Fraser Salish	Interior	Northern	Vancouver Coastal/PHC†	Vancouver Island	PHSA
		General Hospital				
Extra-Small Peer Group: fewer than 5,000 annual patient visits n=33		1. Alexis Creek Outpost Hospital 2. Arrow Lakes Hospital 3. Ashcroft and District General Hospital 4. Barriere Health Centre 5. Blue River Outpost Hospital 6. Dr. Helmcken Memorial Hospital 7. Elkford Health Care Centre 8. Slocan Community Health Centre 9. South Similkameen Health Centre 10. Sparwood Health Care Centre 11. St. Bartholomew's Hospital 12. Victorian Community Health Centre	1. Atlin Health Centre 2. Haida Gwaii Hospital and Health Centre – XaaydaGwaayNgaaysdllNaay 3. Houston Health Centre 4. Hudson's Hope Health Centre 5. McBride and District Hospital 6. Northern Haida Gwaii Hospital & Health Centre 7. Stewart Health Centre 8. Stikine Health Centre 9. Tumbler Ridge Community Health Centre 10. Valemount Health Centre	1. Bella Coola General Hospital 2. R.W. Large Memorial Hospital	1. Bamfield Health Centre 2. Cormorant Island Health Centre 3. Gold River Health Centre 4. Kyuquot Health Centre 5. Port Alice Health Centre 6. Port McNeill and District Hospital 7. Tahsis Health Centre	

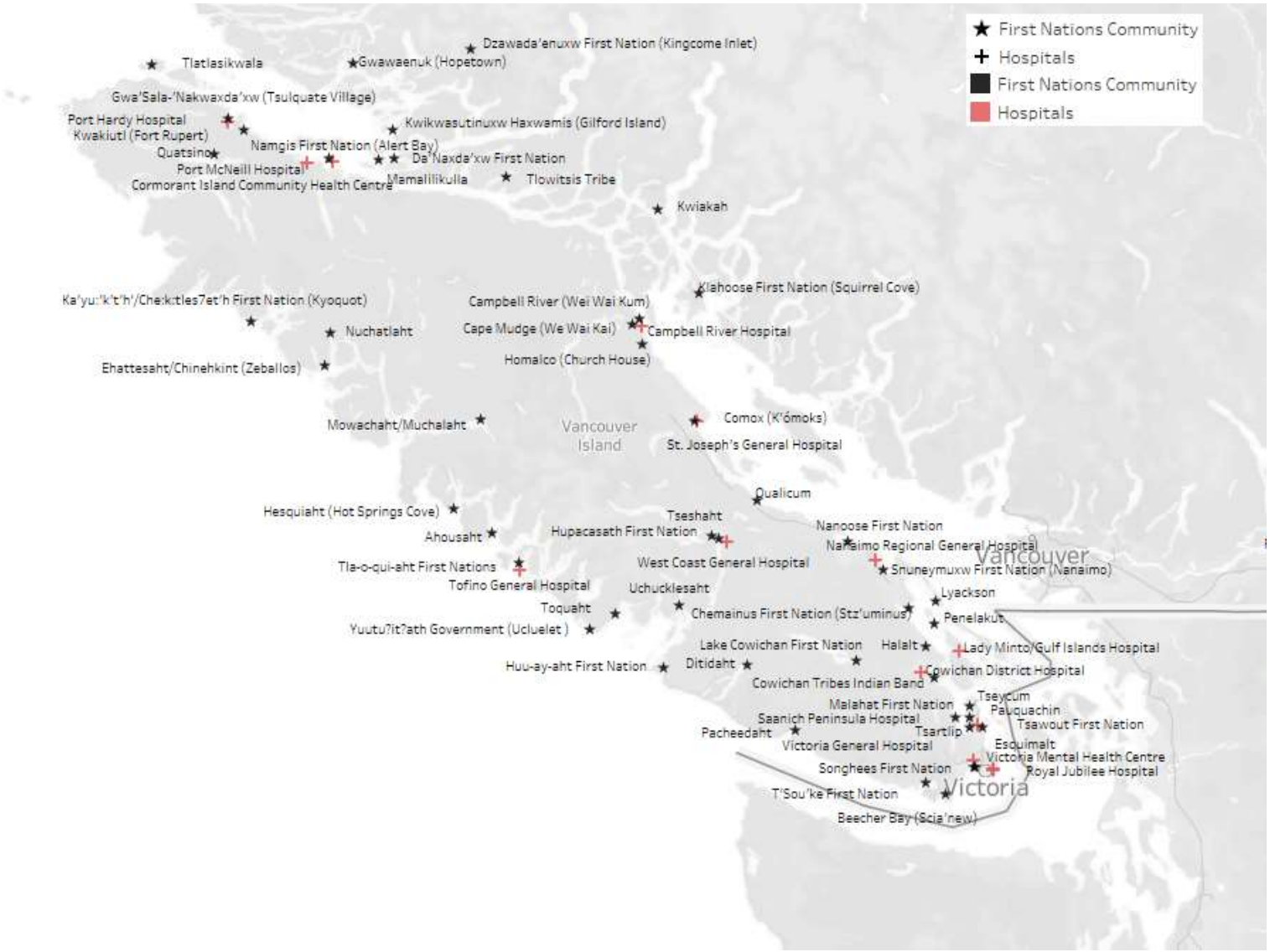
	Fraser Salish	Interior	Northern	Vancouver Coastal/PHC†	Vancouver Island	PHSA
		13. West Chilcotin Health Centre				

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

Figure 8: Location of First Nations communities and First Nations health facilities, Vancouver Island Region

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

Figure 9: Location of First Nations communities and Island Health hospitals, Vancouver Island Region



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

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

Patient Reported Experience Measures

As displayed below in Figure 6, findings from provincial surveys of patient experiences in acute care facilities and Emergency Departments (see Appendix F for more details about these surveys) found that, across all regions and in both hospital and ED settings, self-identified Aboriginal patients reported their care providers were less respectful of their culture and traditions than non-self-identified Aboriginal patients. These differences were significant in both inpatient and ED surveys for all regions expect Fraser. The largest gap between self-identified Aboriginal and non-Aboriginal patient experiences of provider's respect for culture and traditions in EDs were in the North (22% gap), followed by Interior (16%) and the island (13.3%). In Acute care settings, the largest gaps were on the island (15%), followed by the North (12%), Interior (11.9%) and Vancouver Coastal (10.3%).

Figure 10: Experiences of care provider being respectful of culture and traditions among Self-identified Aboriginal Patients vs Non-Aboriginal Patients, 2016/17 Acute Inpatient Patient Reported Experience Measure Survey and 2018 Emergency Department Patient Reported Experience Measure Survey

Experiences of care provider being respectful of culture and traditions among Self-identified Aboriginal Patients vs Non-Aboriginal Patients, 2016/17 Acute Inpatient Patient Reported Experience Measure Survey and 2018 Emergency Department Patient Reported Experience Measure Survey

- AI HA Aboriginal
- AI HA non-Aboriginal
- ED HA Aboriginal
- AI HA non-Aboriginal
- AI BC Aboriginal (n=795): 72.4%
- ED BC Aboriginal (n=1,246): 72.0%
- AI BC non-Aboriginal (17,904): 83.2%
- ED BC non-Aboriginal (12,464): 87.6%

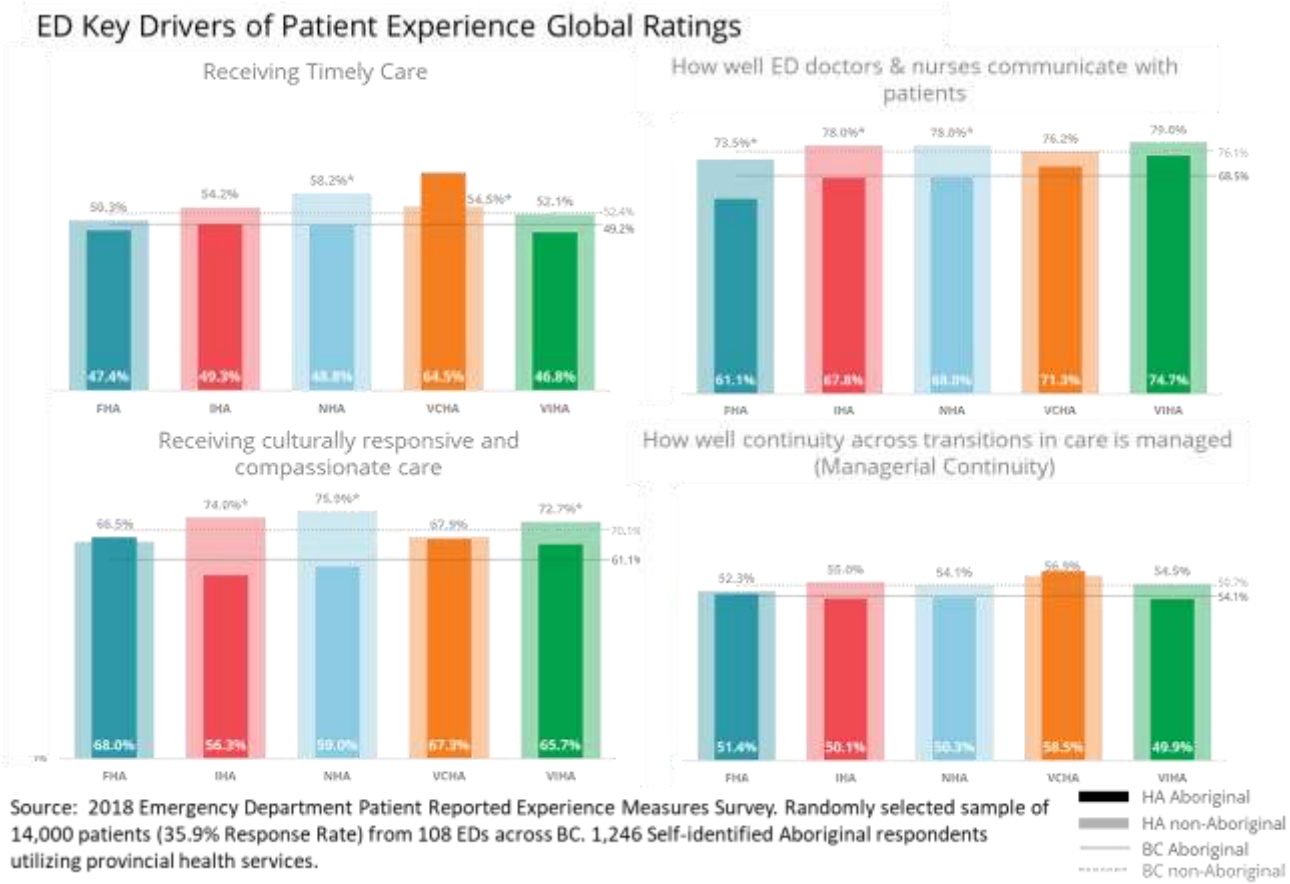
An analysis of factors driving overall rating of patient experience amongst the general department was conducted as part of the Emergency Department patient experience

survey. This analysis found that four areas/dimensions were primarily responsible for the variability in overall ratings of experience[58]: receiving timely care, communications with providers, culturally responsive and compassionate care and how well continuity across transitions in care is managed.

Across all regions and measures self-identified Aboriginal patients tended to rate lower patient experience measures in these dimensions, with some exceptions such as timely care, culturally responsive and compassionate care, and continuity across transitions in VCHA and FHA (see Figure 7 below).

[58] These overall ratings are called 'Global Ratings' and consist of four high-level questions: 1) "ED Rating" (Using any number from 0 to 10, where 0is the worst care possible and10 is the best care possible, what number would you use to rate your care during this emergency department visit?) 2) "ED Visit Helpful" (Overall, on a scale of 0 to 10, do you feel you were helped by your visit to the emergency department? Please answer on a scale where 0 is "not helped at all" and 10 is "helped completely) 3) "ED Experience" (On a scale of 0 to 10, what was your overall experience with your emergency department? Please answer on a scale where 0 is "I had a very poor experience" and 10 is "I had a very good experience.") 4) "Likelihood to Recommend" (Would you recommend this emergency department to your friends and family?)

Figure 11: Key Drivers of Patient Experience Global Ratings



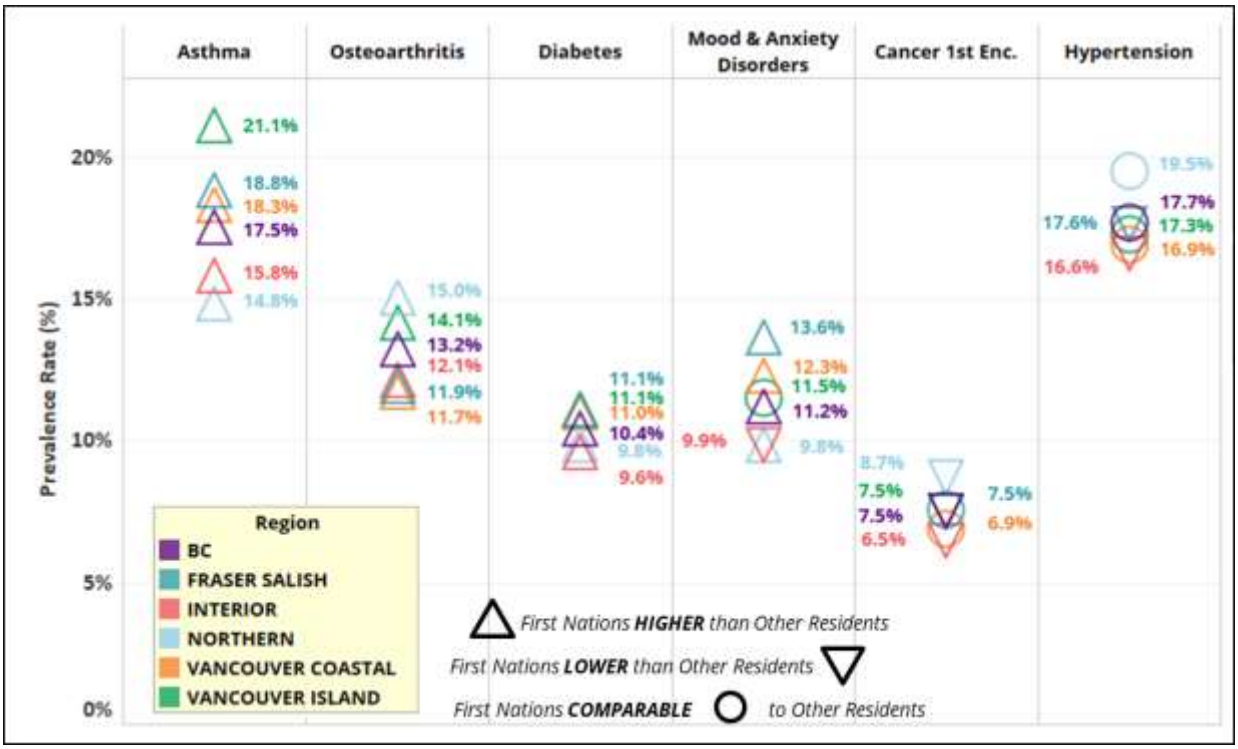
Source: 2018 Emergency Department Patient Reported Experience Measures Survey. Randomly selected sample of 14,000 patients (35.9% Response Rate) from 108 EDs across BC. 1,246 Self-identified Aboriginal respondents utilizing provincial health services.

Chronic Conditions

As depicted in Figure 8 below, the prevalence rates [59]of the top six chronic conditions in the First Nations population were variable by region and in comparison to Other Residents. 'Asthma', 'osteoarthritis', and 'diabetes' rates were higher for "First Nations" relative to "Other Residents" across all regions. Three of the five regions demonstrated higher 'mood and anxiety disorder' rates among "First Nations" compared with "Other Residents" (Fraser Salish, Northern and Vancouver Coastal); the Interior "First Nations" rate was lower than "Other Residents", and Vancouver Island rates were comparable. Three of the five regions demonstrated lower 'first cancer encounter' rates among "First Nations" than "Other Residents" (Interior, Northern, and Vancouver Island). Two of the five regions showed lower 'hypertension rates' among "First Nations" than "Other Residents" (Fraser Salish, Interior).

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

Figure 12: First Nations Chronic Conditions prevalence rate, and comparison with Other Resident rates, 2014/15 by region

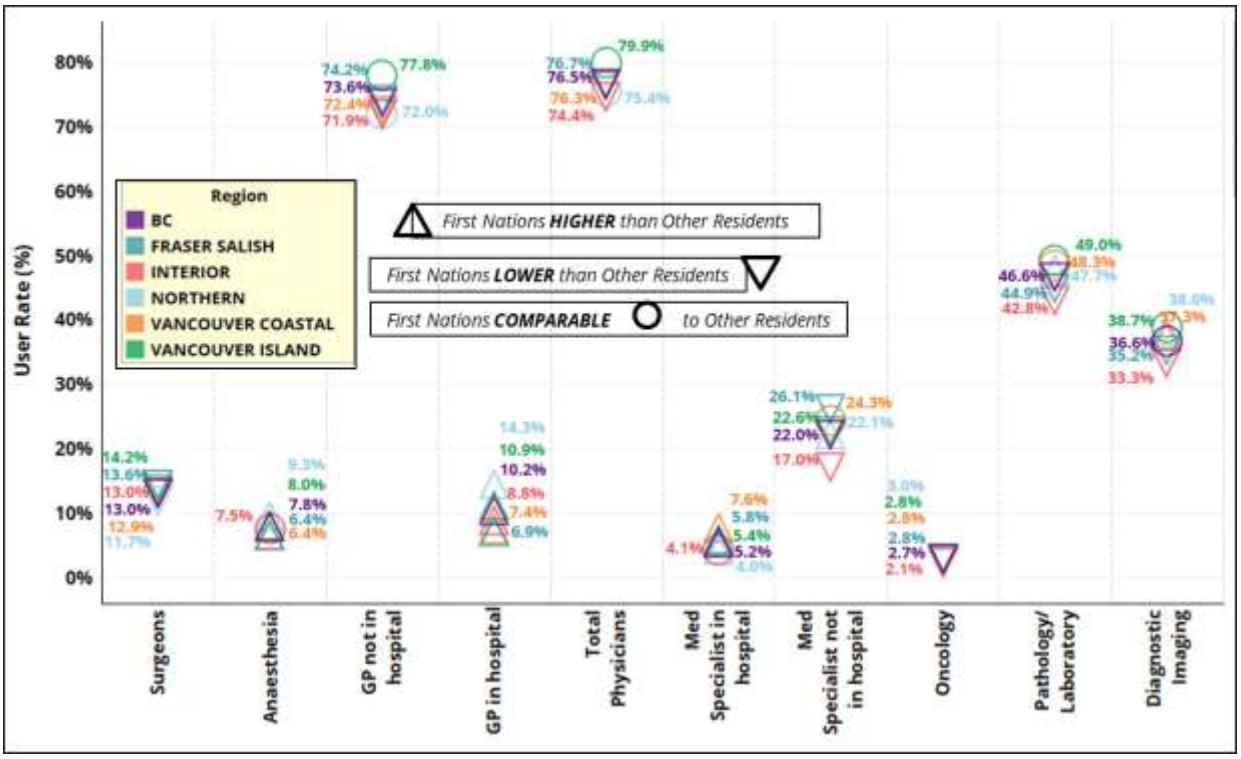


Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Physician Utilization

As depicted in Figure 9 below, regional physician utilization rates were variable across service lines excepting 'General Practitioner in Hospital', where all rates were higher among "First Nations" compared to "Other Residents". Concerning oncologists and surgeons visited outside of the hospital, all rates were lower among "First Nations" compared to "Other Residents", with the exception of Northern Region where the First Nations surgeon rate was higher.

Figure 13: First Nations physician user rate, and comparison with Other Residents, 2014/15 by region



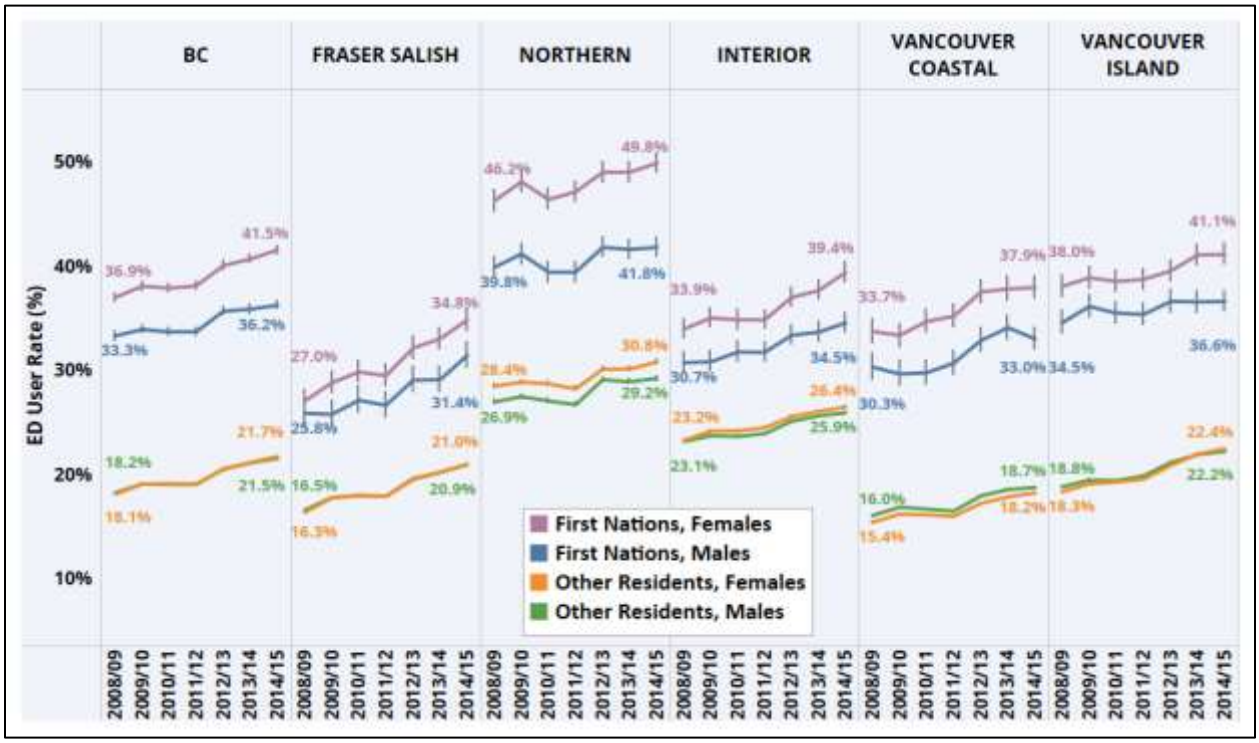
Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Emergency Department (ED) usage rates

As illustrated in Figure 10, regarding emergency department use, First Nations rates were significantly higher than Other Residents in BC and across regions:

- First Nations female rates were significantly higher than First Nations males in BC and across regions;
- There was variability across regions in the magnitude of the rates; and
- First Nations, both females and males had the highest rates in Northern Region.

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



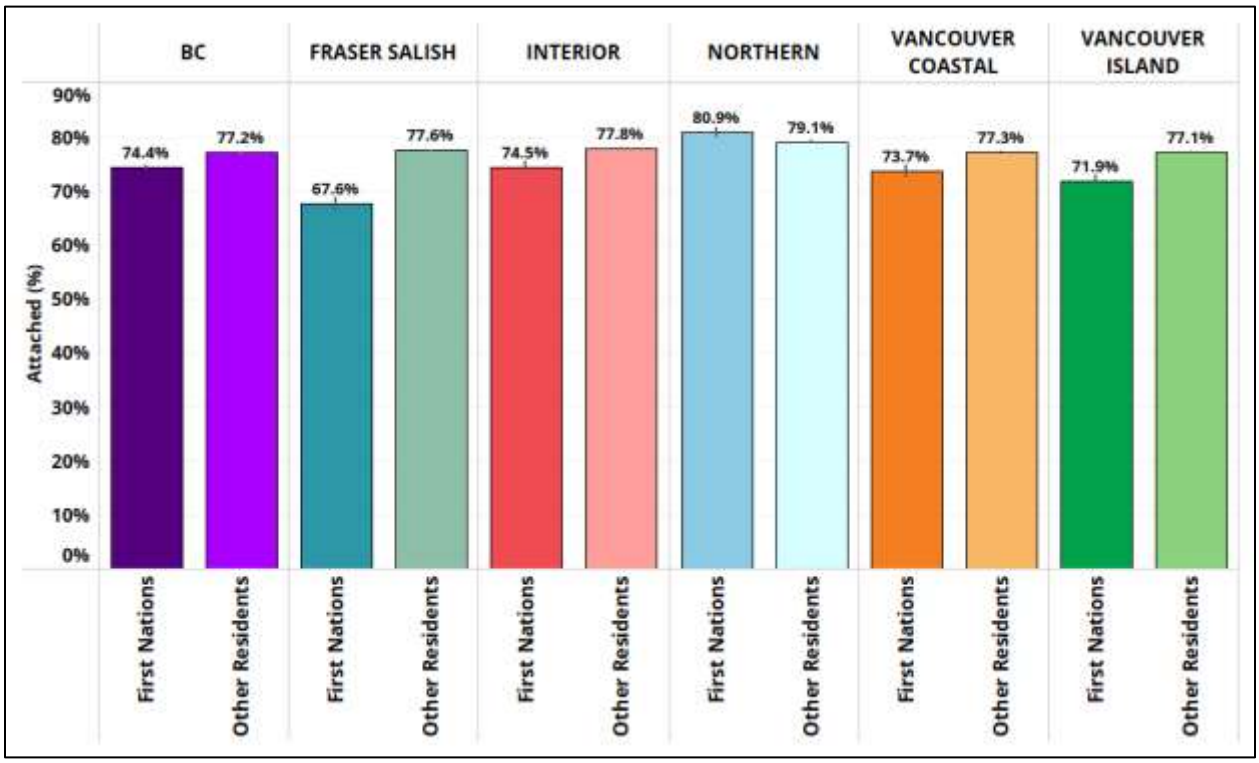
Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

General Practitioner Attachment

As seen in Figure 11, concerning GP attachment[60], attachment rates were significantly lower among First Nations compared to Other Residents provincially and across regions, except Northern Region, where the First Nations rate was higher.

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

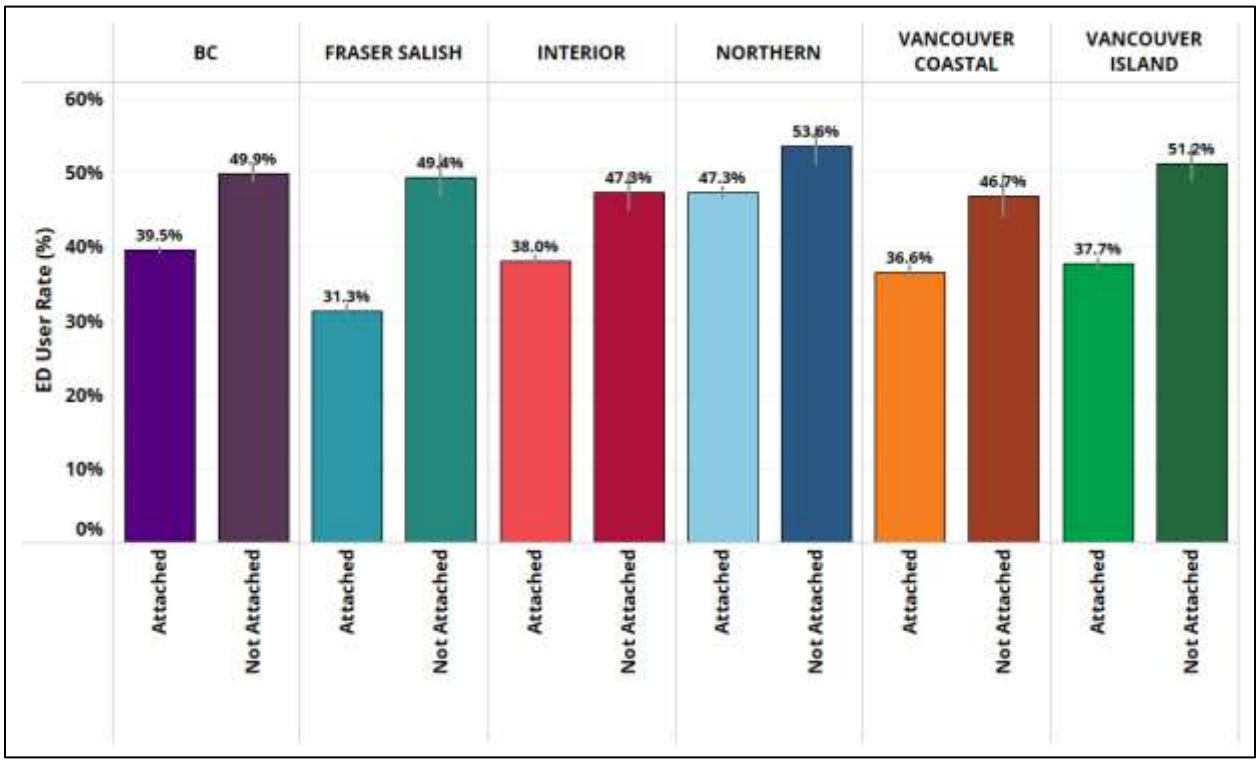
Figure 15: First Nations and Other Residents GP attachment rate, 2014/15, by region



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

Figure 12 below shows that ED user rates were higher in non-attached First Nations than attached across all regions.

Figure 16: First Nations and Other Residents ED user rates, 2014/15 by region

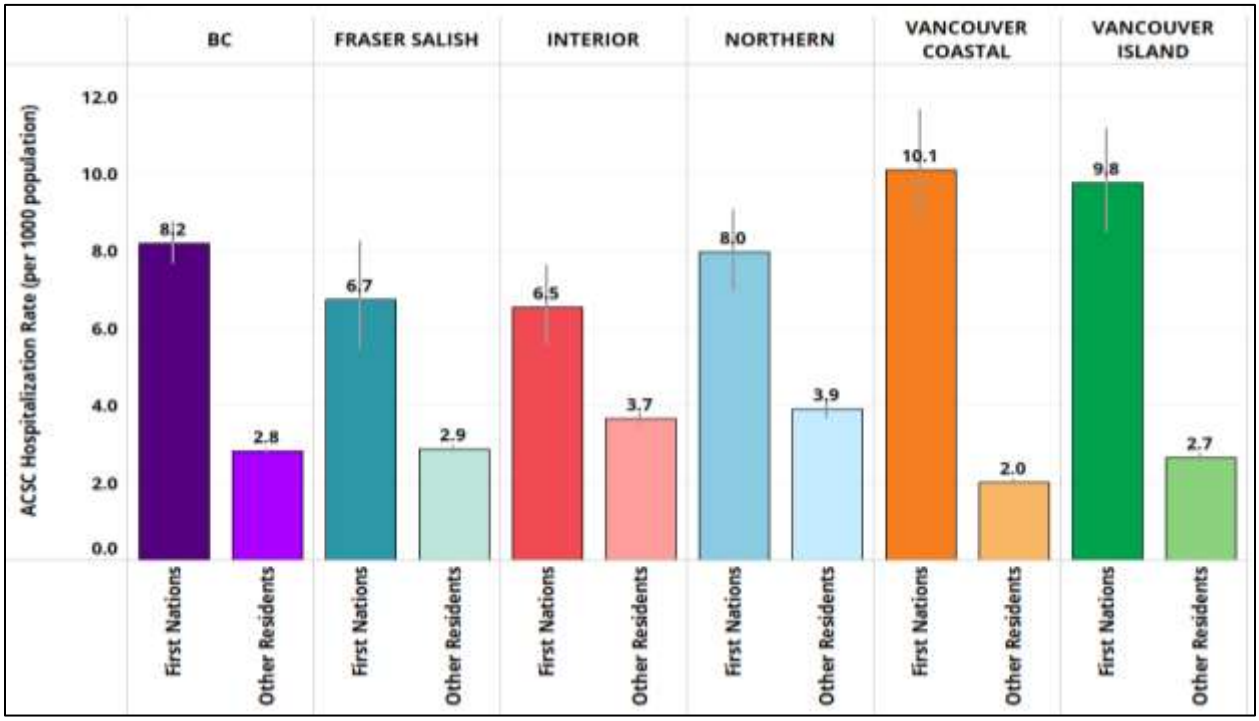


Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Ambulatory Care Sensitive Conditions

With regard to ambulatory care sensitive conditions (ACSC), in all regions, First Nations hospitalization rates for ACSC were higher than Other Residents, across all age groups (exception: 0-17 years olds in Fraser Salish and Interior Regions) (see Figure 13 below).

Figure 17: First Nations and Other Residents Physician and Hospitalization user rates for mental health reasons, 2014/15 by region

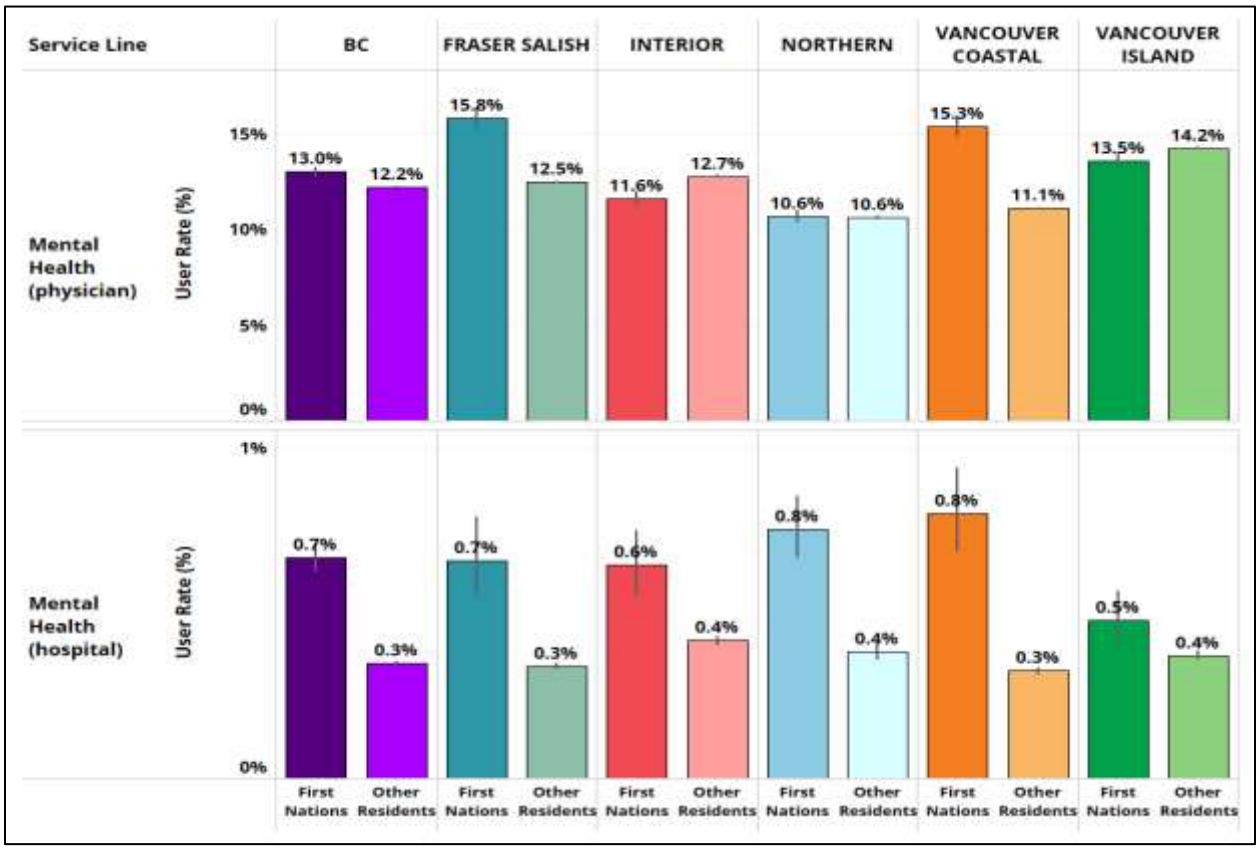


Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Mental Health

As indicated in Figure 14, concerning mental health, physician rates for mental health reasons were variable across regions, with First Nations rates higher than Other Residents in two regions (Fraser Salish and Vancouver Coastal) and comparable in one (Northern). These First Nations rates were lower in Interior and Vancouver Island, with the exception of females in Vancouver Island, were the rate was comparable. Hospitalization rates for mental health reasons were higher in First Nations compared to Other Residents in all Regions.

Figure 18: First Nations and Other Residents physician and hospital substance use user rate, 2014/15 by region



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

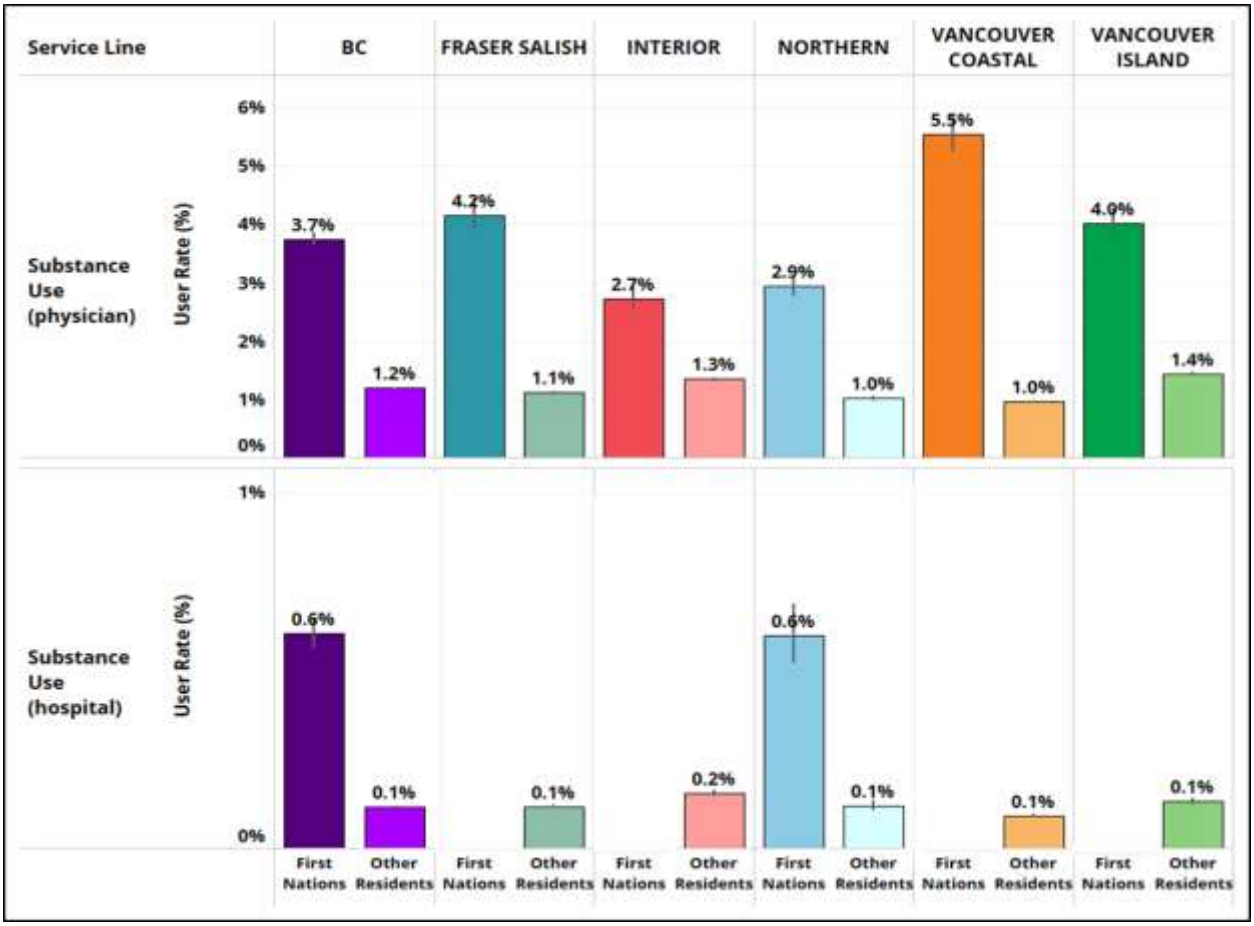
Substance Use

Concerning Figure 15 below:

- Substance use services showed a much greater disparity in rates between populations compared to mental health.
- Physician rates were approximately 3 times higher for First Nations compared to Other Residents.
- Provincial-level hospital user rates were approximately 4 (males) to 7 (females) times higher for First Nations compared to Other Residents; however data were only available for a regional rate calculation in Northern Region (First Nations higher).

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

Figure 19: First Nations and Other Residents physician and hospital substance use user rate, 2014/15 by region

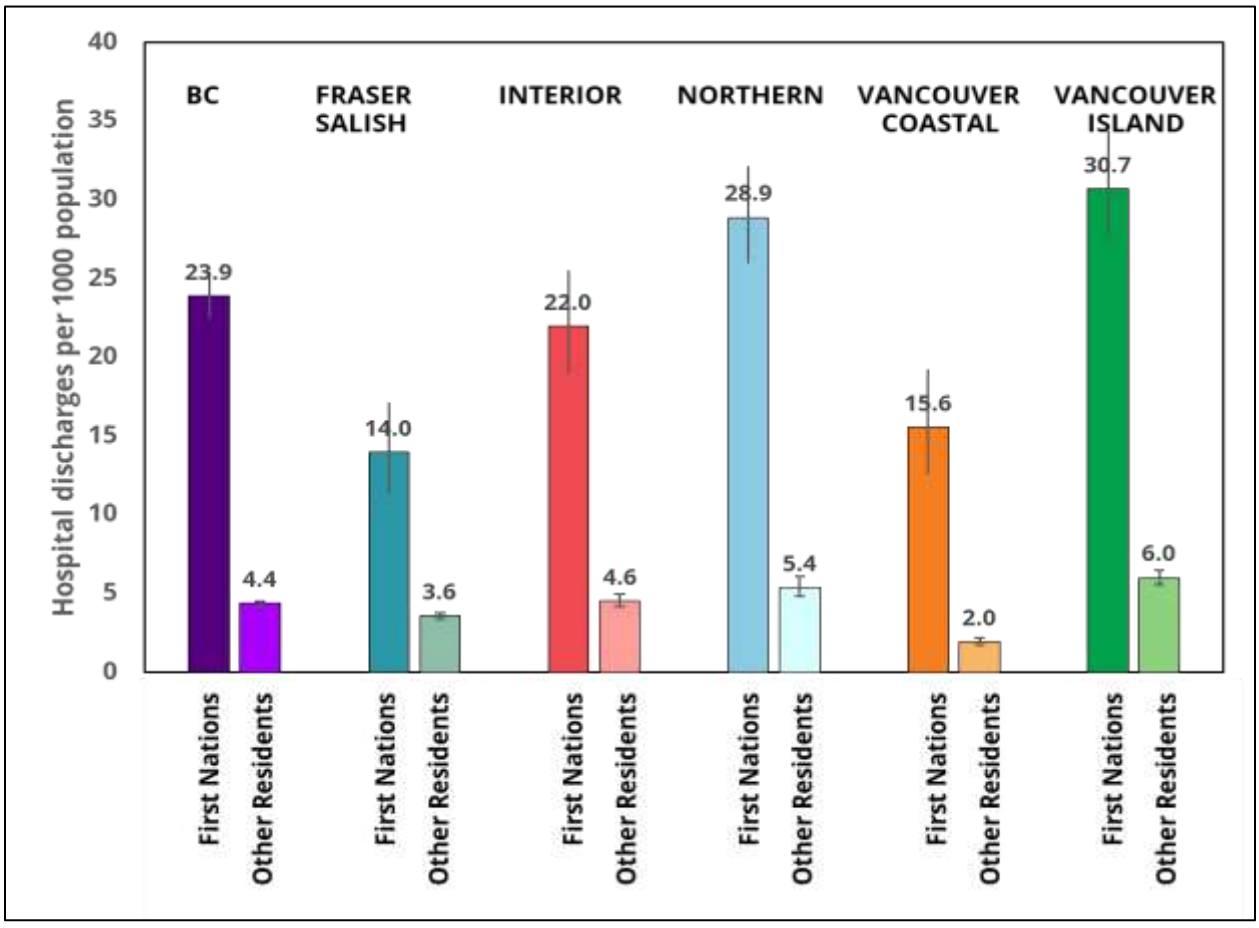


Source: Health System Matrix 2008/09 to 2014/15, Supplemental Region-Specific Slides for the Tripartite Evaluation

Dental Caries Discharge Data

As shown in Figure 16, provincially and regionally, First Nations dental caries hospitalization rates were generally five to six times higher than Other Residents.

Figure 20: First Nations and Other Residents dental caries hospitalization rate, 2014/15 by region



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

Appendix F: Quantitative Data Sources

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

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

Health System Matrix Data

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

Most recently available data	Sampling Framework	Method of identifying First Nation respondents	Limitations
The most recent Health System Matrix (HSM) data is from 2014/15 and therefore does not cover most of the evaluation period (between October	HSM provides an overview of health service utilization of approximately seventy per cent of all provincial health expenditures for individuals who have chosen/been able to access health services.	A deterministic linkage with the First Nation Client File identifies records of individuals who are highly likely to be status First Nations. Does not	Lacking utilization data for First Nation communities, most salaried physicians, Nurse Practitioners may artificially attenuate measures of access to health services. First Nations are believed to be more likely to access health

2013 and December 2018).	Excluded are service utilization from First Nation community health services, JPB projects, as well as the ~ 30 per cent of provincial expenditures such as population health programs, community mental health programs and physician services provided via salaried positions, Nurse Practitioners hired through the NP4BC initiative, sessional employment and incentives encouraging physicians to practice in rural environment, as well as data health BC Cancer Agency, BC Renal Agency and the Ministry of Child and Family Development. The HSM does contain a portion of salaried/alternate payment plan physicians who shadow bill (submit fee codes corresponding to the patient's visit).	capture individuals who are non-Status or Métis.	services through alternative payment plans. Shifts in utilization may indicate shifts in access and/or true shifts in underlying condition being measured.

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

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

Most recently available data	Sampling Framework	Method of identifying First Nation respondents	Limitations
The PREMs sector surveys are completed in various health sectors. The most recent surveys conducted were the Emergency Department survey (conducted between Jan-March, 2018 in 108 ED facilities across the province) and the Sept-December 2017 survey (conducted among 80 acute care hospitals)	Randomly selected sample of individuals who has been discharged from an ED/Acute inpatient facility	Individual self-identify as Aboriginal	As a voluntary sample survey utilizing voluntary self-identification of Aboriginal ethnicity, it is unknown to what extent the survey findings reflect the experiences of all First Nations accessing the health system in BC. The percentage of respondents identifying as Aboriginal varies between sector surveys. The 2018 ED survey, for example, 5.8 per cent of respondents self-identified as Aboriginal vs. the 2016/17 Acute Inpatient survey, in which only 3 per cent of respondents identified as Aboriginal[61].

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