

HEARING FROM FIRST NATIONS IN BC

FNHA AND BC TRIPARTITE
FRAMEWORK AGREEMENT
EVALUATIONS

**What We Heard Report,
Fraser Salish Region, June 2024**



1. INTRODUCTION

PURPOSE OF THIS REPORT

This report summarizes input received during the Fraser Salish community engagement sessions held on June 4th, 2024 (10:00 am -12:00 pm), and June 6th, 2024 (1:30 pm – 3:30 pm). A total of 23 Chiefs, Health Directors, and Health Leads participated in the two sessions. See Appendix A for the list of communities that were present. The list reflects all communities that were present for any portion of the sessions.

During the sessions, the following issues were discussed:

- Improvements in programs and services over the past five years and the impact of these improvements on health outcomes
- Constraining factors and challenges related to the delivery of community health services
- Recommendations for improvement

This report is intended to provide an opportunity for validation from participating Chiefs, Health Directors, and Health Leads, serve as a reference for those unable to attend, and outline additional opportunities to provide input.

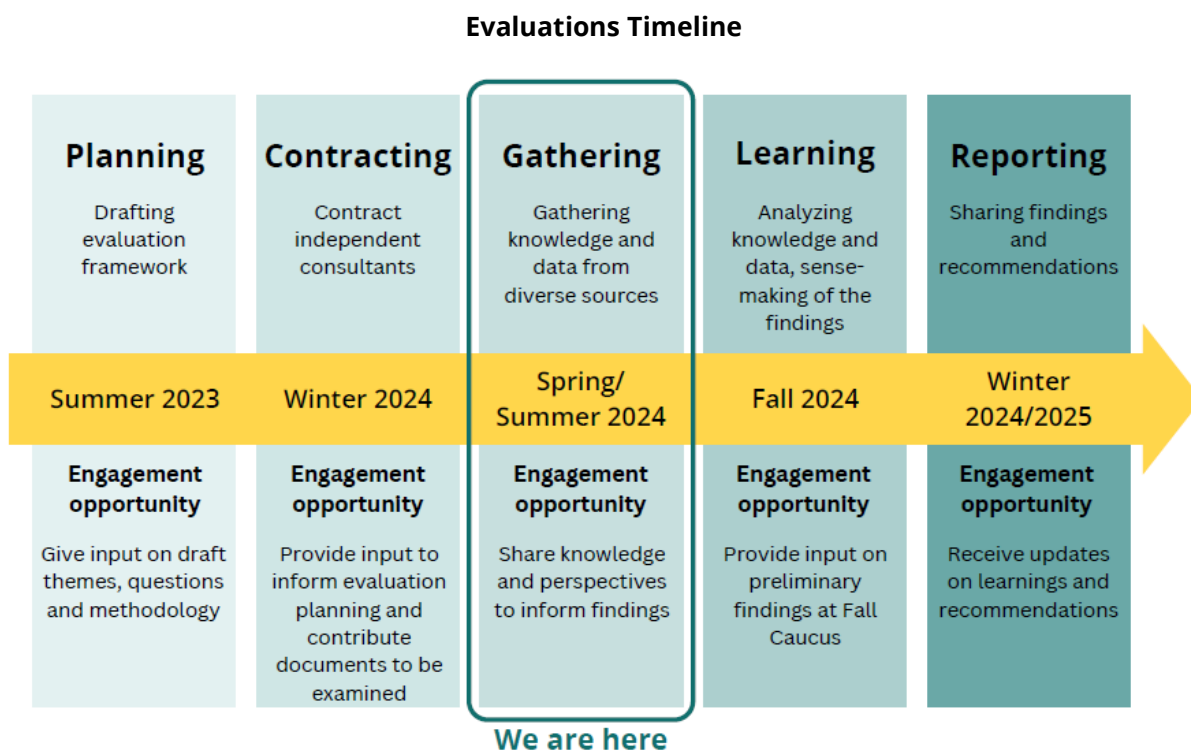
CONTEXT

The two evaluations are a mandatory requirement under the British Columbia Tripartite Framework Agreement on First Nations Health Governance ([Tripartite Framework Agreement](#)). The scope of the evaluations also reflects the strategic priority areas identified by First Nations and Health Governance Partners.

- **Evaluation of the BC Tripartite Framework Agreement (BC TFA).** The BC TFA Evaluation tells the story of the Health Governance Partnership’s progress over the past five years. It aims to support the Partners in their decision-making, continuous learning, and improvement to serve First Nations in BC.
- **Evaluation of the First Nations Health Authority (FNHA).** The FNHA evaluation tells the story of the FNHA’s progress against its mission, goals, and strategies over the past five years, including aligning its health programs with First Nations perspectives and ways of knowing and being. It is intended to provide timely information to support results-based decision making and continuous learning and improvements at the FNHA, as well as support partner efforts in learning, growing, and maturing their relationship to advance shared goals.

Since the two evaluations address interrelated issues and engage with many of the same people and organizations, an integrated evaluation approach was developed to reduce the burden on the communities and organizations.

Evaluation planning started in the summer of 2023 with a review of engagements and priorities identified over the previous two years, and by obtaining input on the draft frameworks from First Nations Chiefs, Health Directors, Health Leads, First Nations Health Council (FNHC), First Nations Health Directors Association (FNHDA), Canada, the province, and regional health authorities.



OPPORTUNITIES TO PARTICIPATE IN THE EVALUATIONS

Feedback from community leaders is a critical line of evidence to inform both evaluations. We invite you to remain engaged in the evaluation by visiting the webpage below for updates and additional engagement opportunities. At this time, you are welcome to provide additional input through the online survey or a 1:1 phone or video conversation. Preliminary findings will be shared back for information and validation in fall 2024. Additional opportunities to gather input from community members will be made available during summer 2024.

**Online survey
via the
evaluation
website**



[www.Qatalyst.ca/
FNHAevaluations](http://www.Qatalyst.ca/FNHAevaluations)

**Schedule a
personalized
engagement**



evaluation@fnha.ca

2. SUMMARY OF WHAT WE HEARD

FNHA-FUNDED AND DELIVERED PROGRAMS AND SERVICES

Funding Agreements and Funder-Provider Relationship

- More flexible community funding models (e.g., options for block, set, and flex) were highlighted, as was the ability for communities to achieve greater self-determination, if desired.
 - Increased flexibility in funding distribution by communities and health service organizations.
 - Greater flexibility in the FNHA's community and health service organization annual narrative reporting requirements.
 - There is an opportunity for interested communities (e.g., Boston Bar First Nation and Spuzzum First Nation) to disengage from health service organizations with FNHA support.
- Better communication and strengthened relationships between communities and service agencies led to more localized decision-making and increased flexibility in the use of funds.
- Some communities reported increased FNHA support for human resources, (e.g. hired a full-time nurse, care aids, and a weekend nurse position).
- Concerns were raised about the level of funding allocated to the region, given the size and population. There were concerns about inconsistent funding and support, particularly for smaller programs and older funding models that have not been updated.
- There is a need for clarity on the evolution of the FNHA's roles and responsibilities in relation to direct service delivery.
 - There are concerns that the FNHA has not sufficiently evolved its inherited top-heavy bureaucratic structure to become a community-driven organization.
 - There are concerns that the FNHA is moving into direct service delivery, rather than funding communities and Nations for service delivery.
 - FNHA overextending itself into social determinants of health may hinder its focus on health services and programs.
- There are calls for the FNHA to adopt more community-driven approaches and to ensure funding is directed towards organizations that serve First Nations people effectively.

Mental Health and Wellness Programs and Services

- FNHA successfully increased access to counsellors during and after the COVID-19 pandemic to accommodate growing demand.

- FNHA's new Healing Houses initiative to create a provincial network of 5 healing centres to support mental health and wellness and address grief and trauma is a positive step towards meeting demand.
- FNHA's holistic wellness model and provision of new community funding streams to support cultural and traditional wellness and harm reduction programs and initiatives have been very positive. Examples of initiatives/programs undertaken:
 - Group programming for women, men, and Elders.
 - Naloxone and overdose prevention training and youth-focused life promotion training for staff and community members.
 - Mobile overdose prevention sites to improve accessibility and build trust within communities.
- Concerns about the approved list of counsellors and psychologists for FNHA direct billing, which limits member access to other qualified and preferred counselling supports¹.
- Need for after-hours mental health and wellness counselling and crisis support in addition to the FNHA-funded grief and healing services and supports offered by Tsow-Tun Le Lum.
- There is a need for increased flexibility to support the provision of community-based traditional and cultural healing practices. It was suggested that FNHA fund different modalities for traditional wellness and holistic medicine to meet the need for immediate supports and a space for healing that is easily accessible to community members.
- Communities would benefit from additional FNHA support in developing strategic plans to address the mental health crisis.
- There is a lack of growth or evolution amongst smaller wellness programs (e.g. Brighter Futures) and uncertainty around how funding models, ratios of clients to providers, and requirements for these programs have evolved over the years. For example, The NNADAP (National Native Alcohol and Drug Abuse Program) funding model for addiction care has not significantly changed since being funded under Health Canada, leading to concerns about its adequacy.

FNHA-Funded Treatment Centres

- There are challenges with the accessibility and quality of FNHA-funded treatment centres.
 - 10 FNHA-funded treatment centres are insufficient to meet demand, and waitlists are very long. Some communities spend large amounts of funding for members to attend private treatment centres.
 - The quality and consistency of care across FNHA-funded treatment centres varies. FNHA should play a stronger role in enforcing quality and program standards

¹ Funded by Health Benefit program

including a harm reduction approach and monitoring accessibility, quality of care, and client outcomes.

- Suggestion that new treatment centres should be built based on the design and intentions of First Nation long houses that can offer both separation and communal gathering spaces for those in need of healing rather than having to respond to very expensive provincial requirements that are not culturally aligned with First Nations.
- Challenges with inadequate transitional housing and reintegration and aftercare supports for clients leaving treatment centres.

Health Emergency Management and Support

- The creation of the FNHA's permanent Health Emergency Management structure and quick response during recent floods and wildfires, ensuring culturally appropriate support was available to communities, was very positive.
- Concerns that the diversion of FNHA and Fraser Health Authority attention and resources from the toxic drug supply crisis to COVID-19 response efforts may have impacted the adequacy of resources and attention to preventing overdoses and toxic drug poisonings.
- Improvements were noted in FNHA's health surveillance and availability of data on toxic drug poisonings.

BC TRIPARTITE FRAMEWORK AGREEMENT

Partner Mandates, Roles, and Responsibilities

- There have been some improvements in the accessibility and quality of Fraser Health Authority services and supports.
 - Some communities reported greater accessibility and financial support from Fraser Health Authority.
 - Fraser Health Authority's Aboriginal Patient Liaisons or Navigators are valued and important supports.
- Need for compatible electronic medical record systems to support continuity of care and ensure patient care teams are adequately informed.
- There are some issues with an ongoing lack of clarity on the division of roles and responsibilities among Tripartite partners, leading to confusion over who is responsible for funding certain programs and positions. For example:
 - Confusion about contracts and funding for nurse practitioners.

- The status and funding of community health representatives and various small programs such as the Building Healthy Communities program and the Mental Health Workers program.
- Concerns were noted regarding community health representatives, with no clear updates on their roles or funding.
- There are concerns First Nation communities are being excluded or not meaningfully engaged in harm reduction strategies. There is a need for more education and information sessions for communities on harm reduction programs and services. The education and awareness campaign for mobile overdose prevention sites was cited as a positive example to follow.
- Need for more clarity and direction on Tripartite partner roles and responsibilities for implementing the 10-Year Strategy on Social Determinants of Health.
 - There are concerns the FNHA's expanding role in implementing the 10-Year Strategy on Social Determinants of Health may reduce the focus and hinder progress on delivering community health programs.
 - There are concerns that Canada provides inadequate funding to address social determinants of health that impact First Nation members' wellness and longevity (e.g., adequate housing), impeding the ability of FNHA and FNHC to impart progress.
- There are concerns regarding political interference from organizations like the Union of British Columbia Indian Chiefs (UBCIC) and British Columbia Assembly of First Nations (BCAFN) engaging Tripartite partners on areas within the First Nations Health Council's jurisdiction.
 - For example, transfer of Indigenous Services Canada (ISC) funding to the province for emergency response for First Nations without proper consultations with communities. Concerns were raised that communities are not receiving appropriate compensation or that funding is denied after an emergency.
 - Need for ongoing education for newly appointed Chiefs on the health governance structure and mandates to avoid confusion and political interference.

Cultural Safety and Humility

- Communities continue to face challenges with the cultural safety and humility of health system partners' services.
 - There is evidence of some health system partner staff having taken cultural humility and sensitivity (CHS) training and wearing CHS pins, which has been beneficial.
 - Many community members continue to choose not to access Westernized health care due to ongoing discrimination, racism, and a lack of cultural safety in the health system. Some Elders and community leaders shared personal stories of experiences of discrimination and unsafe care.

- Need for greater accountability and reflection on the behaviors and attitudes of staff among health partners and documentation of how cultural safety and humility is being implemented and how complaints are being resolved.
- Ongoing difficulties with late-night discharges from hospitals, leaving community members in vulnerable situations without transportation options.
- Need for more Aboriginal Patient Liaisons or Navigators to meet demand (at least one per region, if not one per community).

Health Human Resources

- Communities face significant challenges in hiring nurses and specialized positions due to burnout and differences in compensation and benefits between the FNHA and health system partners. Healthcare staff frequently face burnout due to the constant need to manage crises, which impacts their retention.
- Need for more upstream recruitment and education/training to encourage First Nations people to fill key service and community leadership positions. This might include youth mentorship and greater training and support for new Health Directors.

Data Sharing and Sovereignty

- Need for more education and awareness-building among community health leadership of opportunities to access community-level health data to support community planning and reporting.
- Opportunity for the FNHA and BC to create knowledge-sharing products highlighting improvements in health outcomes for First Nations people in BC related to substance use and mental health.

APPENDIX A - FOCUS GROUP METHODOLOGY

This engagement session was conducted virtually over Zoom. The engagement was facilitated by the Qatalyst Research Group consultants.

Nations and Families or Organizations Represented

Stó:lō Nation Matsqui Skawahlook Skowkale Tzeachten Yakwekwioose	Independent Boston Bar Kwi'Kwetlem Skwah Spuzzum Sts'ailes Tsawwassen Yale
Stó:lō Tribal Council Cheam Seabird Island Shxw'ōwhámel	