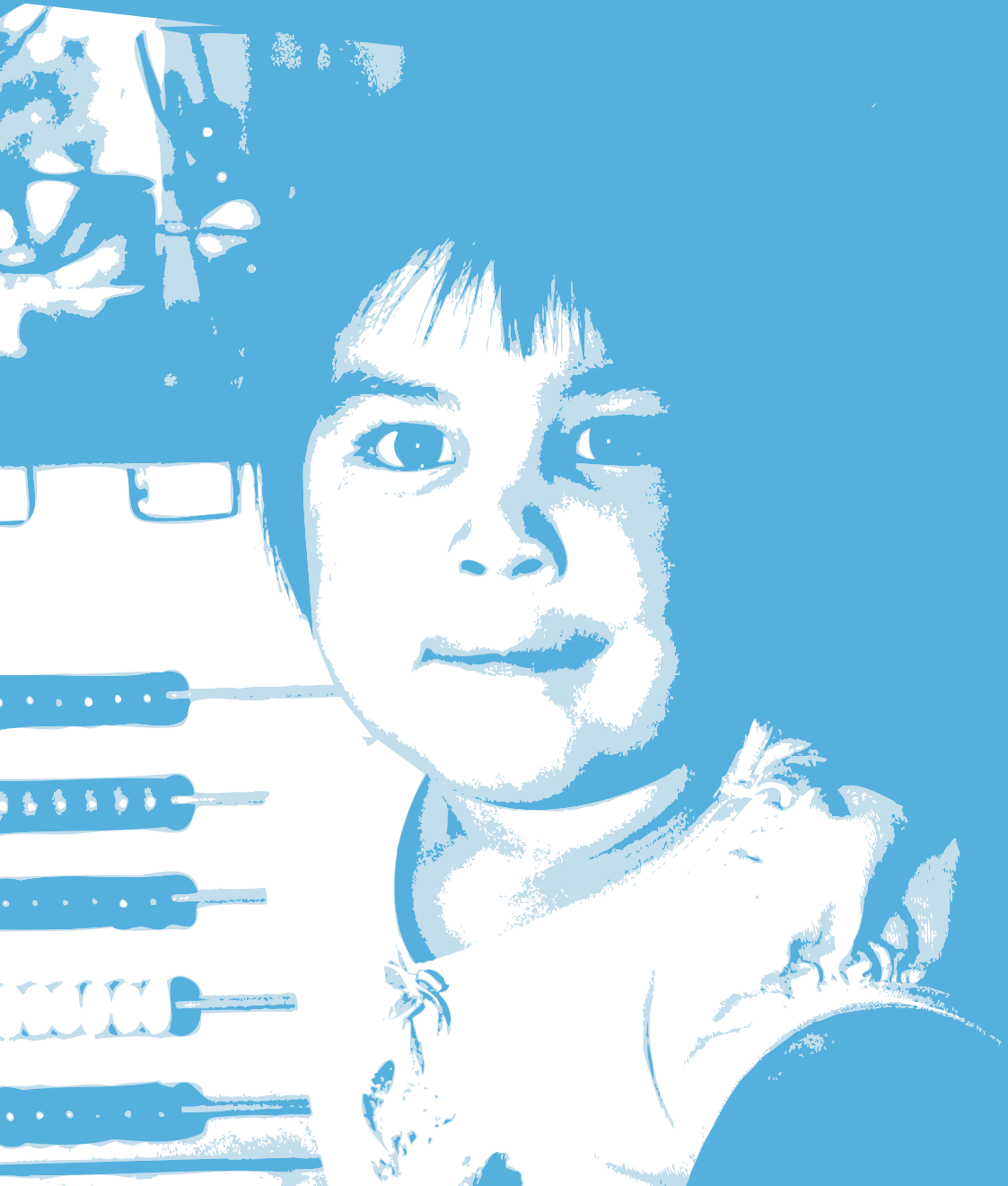


Regional Summary of Governance Discussions

2011

Summary of Feedback from the Fraser Regional Caucus
and Health Partnership Workbook



Fraser

Thank you to all Fraser region Chiefs, leaders, health professionals, and community members who took the time to attend regional caucus sessions and provide feedback through the Health Partnership Workbook.

This draft report summarizes your feedback to date – we look forward to incorporating further wisdom and direction from Fraser Region First Nations into future drafts.

Published May 2011

CONTENTS

1

INTRODUCTION p. 4

2

FRASER REGION SNAPSHOT p. 5

3

DETAILED FEEDBACK FROM FRASER REGION p. 7

07 Health Partnership Workbook Feedback
19 Other Feedback

4

KEY THEMES & SUMMARY OF FEEDBACK p. 26

26 Community Principles and Involvement
26 Regional Caucuses
26 Relationship with Fraser Health Authority
26 First Nations Health Council
27 First Nations Health Directors Association
27 First Nations Health Authority

A

APPENDIX - METHODOLOGY p. 29

1. INTRODUCTION

The First Nations Health Council (FNHC) launched a 'Health Partnership Workbook' in January 2011, and made the Workbook available online and was the focus of a series of First Nations regional caucus sessions across the province. The Health Partnership Workbook summarized the discussions about health governance held at more than 100 First Nations regional caucus meetings over the past three years. It asked First Nations Chiefs, leaders and senior health professionals in BC to confirm this summary of feedback gathered. They were also asked to share new thoughts and perspectives. The results will inform further discussions, negotiations and relationship-building towards the establishment of a new health governance arrangement for First Nations health services in BC.

The feedback provided by First Nations through the regional caucus sessions and the Health Partnership Workbook has been rolled into 5 summary documents – one for each region in BC. The regional reports will be provided to each region for review, discussion and further amendment; revised versions of these draft reports will be provided again to each region in May 2011. The five regional summary documents will also be merged into a province-wide consensus document. This consensus document will be put forward for review and consideration for approval at the 4th Annual Gathering Wisdom Forum to be held in May 2011 and will chart a path forward for the establishment of a new health governance arrangement for First Nations health services in BC.

This summary report collates all of the feedback from the **FRASER** region - as provided at Fraser Regional Caucus sessions and through Fraser region participation in the Health Partnership Workbook. This document is only a **draft** – as more feedback is provided by First Nations in the Fraser region to the Workbook and at regional caucus sessions, this report will be further developed and refined. This report begins with a short snapshot profile of the Fraser region. It then provides a detailed accounting of all feedback provided by First Nations in the Fraser region to this health governance process (through regional caucuses and workbooks). The key themes of the feedback provided by Fraser region First Nations are then summarized. Finally, an appendix provides a description of the 'Health Partnership Workbook' process and methodology.



2. FRASER REGION SNAPSHOT

The territorial land base of the Fraser region is 15,735 square kilometres – 1.7% of the provincial total. The total population of the Fraser region (2006) is 1,501,6838, and the Aboriginal population is 2.5% at 38,105.

There are 32 First Nations Bands within the Fraser Region (three Bands physically located in Fraser Health—Samahquam, Skatin and Douglas—are served by Vancouver Coastal Health Authority because washed out bridges result in their only access being through Pemberton):

- | | |
|-------------------------------|--------------------------------|
| 1. Aitchelitz Band | 17. Seabird Island Band |
| 2. Boothroyd Band | 18. Semiahmoo First Nation |
| 3. Boston Bar First Nation | 19. Shxw'ow'hamel First Nation |
| 4. Chawathil | 20. Shxwha':y Village |
| 5. Cheam | 21. Skawahlook First Nation |
| 6. Chehalis Indian Band | 22. Skowkale First Nation |
| 7. Katzie First Nation | 23. Skwah First Nation |
| 8. Kwantlen First Nation | 24. Soowahlie |
| 9. Kwaw-Kwaw-Apilt | 25. Spuzzum First Nation |
| 10. Kwikwetlem First Nation | 26. Squiala First Nation |
| 11. Leq'á:mel First Nation | 27. Sumas First Nation |
| 12. Matsqui First Nation | 28. Tsawwassen First Nation |
| 13. Peters Indian Band | 29. Tzeachten First Nation |
| 14. Popkum | 30. Union Bar Band |
| 15. Qayqayt (New Westminster) | 31. Yakwekwioose |
| 16. Scowlitz | 32. Yale First Nation |

Four Tribal Councils exist within this region, although a number of these Tribal Councils operate also in other regions (Vancouver Island and the Interior):

1. Nlaka'pamux Nation Tribal Council
2. Sto:lo Nation Chiefs Council
3. Sto:lo Tribal Council Member Bands
4. Naut'sa Mawt Tribal Council

There are 5 First Nations umbrella health organizations within the Fraser Region (note that a number of these also operate in other regions):

1. Sto:lo Nation Health Services
2. Seabird Island Health Services
3. Chehalis Health Services
4. Southern St'at'imx Health Society
5. Nlaka'pamux Fraser Thompson Indian Society

78.79% of First Nations in the Fraser region are involved in Community Engagement Hubs, as follows:

SEABIRD ISLAND

- o Seabird Island First Nation
- o Scowlitz
- o Soowahlie
- o Kwaw'Kwaw'Apilt
- o Kwantlen
- o Shxw'ow'hamel
- o Chawathil
- o Cheam
- o Union Bar
- o Chehalis
- o Skwah

STO:LO NATION

- o Aitchelitz
- o Leq'á:mel
- o Matsqui
- o Popkum
- o Skawahlook
- o Skowkale
- o Shxwhà:y Village
- o Squiala
- o Sumas
- o Tzeachten
- o Yakweakwioose

FRASER CANYON

(Fraser Thompson Indian Services Society)

- o Boston Bar (Fraser Health)
- o Boothroyd (Fraser Health)
- o Spuzzum (Fraser Health)
- o Oregon Jack Creek

UNREPRESENTED COMMUNITIES

- o Yale
- o Tsawwassen
- o Semiahmoo
- o New Westminster
- o Peters
- o Katzie
- o Kwikwethlem



3. DETAILED FEEDBACK FROM FRASER REGION

Health Partnership Workbook Feedback

This section summarizes feedback from the completion of Health Partnership Workbooks by First Nations from the Fraser Region and from the minutes of meetings of Fraser regional and sub-regional caucus meetings.

This section of the report summarizes feedback about First Nations health governance at a community level, at the regional level and at the provincial level.

Community Level

'Community level' refers to the 203 First Nations in BC and the 130 First Nations community health centers in BC. At this level First Nations and their health technicians deliver health programs and services to their local populations.

The workbook summarized the principles and requirements identified by First Nations health governance at a community level, as stated by First Nations at regional caucus sessions over the past several years. Specifically First Nations have stated that a regional health transfer process must:

- Increase and support First Nations decision-making over the health of their peoples;
- Ensure the transfer results in opportunities to leverage more funding for community-level programs and the reinvestment of current resources to improve health at the community level; and
- Enable collaboration with other First Nations and local and regional health program and service providers.

First Nations in the Fraser region responded to these principles as follows:

Answer Options	Response Percent	Response Count
Strongly Disagree	12.5%	2
Disagree	6.3%	1
Agree	25%	4
Moderately Agree	12.5	2
Strongly Agree	43.8%	7
<i>answered question</i>		16
<i>skipped question</i>		2

First Nations in the Fraser region identified additional principles and requirements:

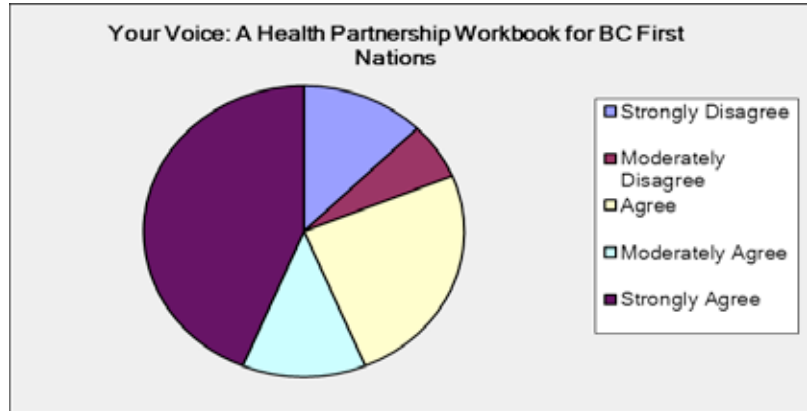
- **Community Participation and Involvement** - Strong community engagement built upon trust, regular conferences; inclusion of youth, Elders, and off reserve members; link with Community Engagement Hubs to share information with their representative Bands; ensure input from

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DETAILED FEEDBACK FROM FRASER REGION

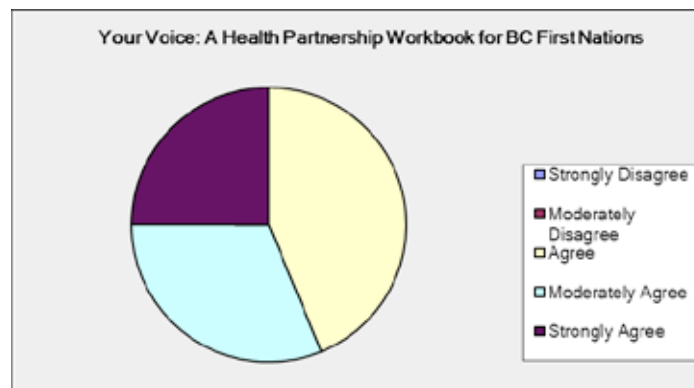
frontline workers;

- **Traditional Values, Practices and Holistic Wellness** - Recognize and integrate traditional practices as the cornerstone of this whole process; follow medicine wheel approach; service integration and breaking down barriers; strong interface on social determinants;
- **Funding** – Leverage additional resources to meet the mandate to improve health;
- **Workforce Development** - Increased access to education of First Nations students wanting to enter health care;
- **Building Trust** - transparency to ensure all people can see what is happening; need to build and maintain trust in each other, the process, partners, decision-makers, communications and reciprocal accountability; and
- **Flexibility** - communities need flexibility to deliver services according to local community needs; there needs to be adaptability; individual communities do not want to lose their own autonomy as they work collaboratively so the principles of community level control need to be adaptable and organic.



The workbook also asked First Nations to indicate their level of support for the following statement:
“A Regional Health Transfer process would support the greater local control over health services and the development of local health program and service delivery models”

Answer Options	Response Percent	Response Count
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Agree	43.8%	7
Moderately Agree	31.3%	5
Strongly Agree	25.0%	4
answered question		16
skipped question		2



DETAILED FEEDBACK FROM FRASER REGION

3

Fraser region First Nation participants provided the following additional comments:

- **Expanding services and economic opportunities:** Increasing access should include contracting with First Nations to provide services to non-First Nations; First Nations need to look for opportunities to extend health care medical insurance rather than relying on non-insured benefits;
- **Relationships with the Regional Health Authority (RHA):** RHA to work with First Nations with open minds and willingness to listen;
- **Recruitment:** People in control need to ensure people are doing the jobs they are hired to do;
- **Philosophy:** Focus on wellness, not on illness, including a much stronger focus on Health Promotion activities;
- **Data:** Capture existing baseline data so that First Nations can track what were things like before the transition took place;
- **Off-Reserve Focus:** Greater control for First Nations must include representatives from the off reserve members;
- **Impact of Bill C3:** Have to keep in mind that Bill C-3 has the inclusion of many additional First Nations people who will become eligible for health benefits and funding has to be considered for these people.

Others comments made regarding the community level control of health services:

- **Political and Technical Expertise:** separate political level; need a Regional Hubs meeting bringing together the Hubs from the Fraser Region to meet and discuss regional issues;
- **Service Design and Delivery:** share models of community services that people can learn from; ensure health services are accessible for all members as many have transportation problems; First Nations must be adequately and realistically funded in order to meet goals and objectives; respect and recognize the traditional healers in the territory that they reside in;
- **Workforce Development:** increase access to health education by funding seats in local college and university programs; and,
- **Standards:** First Nations should develop standards with cultural perspectives.

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DETAILED FEEDBACK FROM FRASER REGION

Regional Level

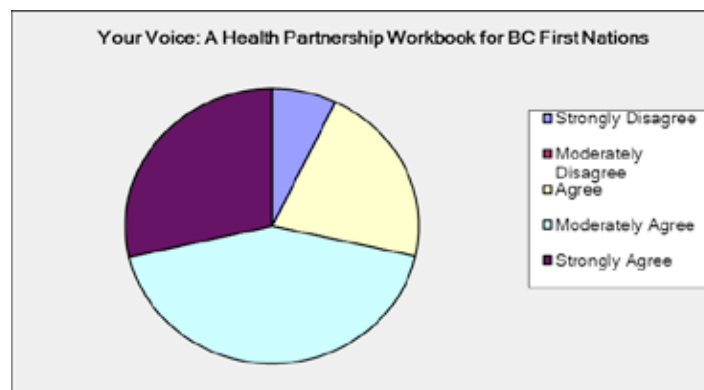
'Regional level' refers to the five regions in BC – Fraser, Interior, North, Vancouver Island and Vancouver Coastal. Within regions, First Nations collaborate on shared health issues of relevance and develop regional perspectives on First Nations health and wellness amongst themselves. They also collaborate with the Regional Health Authority on regional First Nations health issues.

Through regional caucus sessions over the past several years, First Nations have formed key principles and requirements for health governance as it relates to the regional level including:

- Maintenance of Regional Caucuses to reflect collective authority and to enter into partnerships and agreements with Health Authorities;
- Continuing to support collaborations and relationship building among First Nations;
- Supporting the development of First Nation health programs, services and initiatives which can be delivered by and serve the needs of the region;
- Supporting the development of regional perspectives on health and wellness;
- Increasing collaborations with RHAs to leverage provincial resources;
- Enabling First Nations to have a greater influence over services provided by RHAs to First Nations;
- Supporting regional and sub-regional planning; and,
- Improving communication based on regional expectations, including accountability and reporting.

First Nations completing the workbook were asked how they felt about these principles and whether any were missing – the results from Fraser region respondents were as follows:

Answer Options	Response Percent	Response Count
Strongly Disagree	7.1%	1
Disagree	0.0%	0
Agree	21.4%	3
Moderately Agree	42.9%	6
Strongly Agree	28.6%	4
answered question		14
skipped question		4



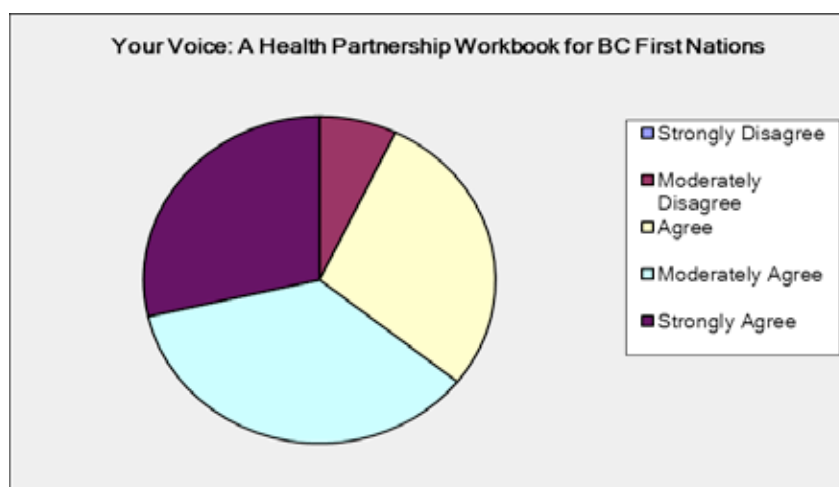
DETAILED FEEDBACK FROM FRASER REGION

Fraser region First Nation participants also identified the following additional principles and requirements:

- **Cultural Competency:** professionals involved in the health system need to learn about First Nations as people and their background, including recognizing the impact of historical experiences of First Nations;
- **Role of Caucus:** be clear about the structure, roles and responsibilities of Caucuses; an accountability and transparency statement should be added; Caucuses don't just want to influence – they want decision-making; inclusive participation, including robust communications;
- **Health Planning:** support regional and sub-regional planning, including capacity building in order to progress at all levels; developing case law and other legislative precedents that will inform policy and program development

The workbook also asked participants to indicate their level of support for the following statement:
“First Nations have stated that they would like to see the regional caucus structure continue as part of the new regional health transfer process with the purpose described above”

Answer Options	Response Percent	Response Count
Strongly Disagree	0.0%	0
Disagree	7.1%	1
Agree	28.6%	4
Moderately Agree	35.7%	5
Strongly Agree	28.6%	4
answered question		14
skipped question		4



3

DETAILED FEEDBACK FROM FRASER REGION

Participants were asked to state what they believed Caucuses were doing well and what additional things they thought the Caucuses could improve on – the results from the Fraser region are as follows:

WHAT CAUCUSES ARE DOING WELL	WHAT CAUCUSES NEED TO IMPROVE
<ul style="list-style-type: none"> Communication and Information Sharing: Persistence, keeping all informed; openness, inclusiveness (invitations always go out to all Bands), pulling all the communities together; looking at inclusive economy of scale projects; bringing communities and region together providing a forum to brainstorm, give input and raise concerns; inclusion of Health Directors representatives is a positive; been very helpful in distributing information; maintaining an inclusive and participatory spirit; <p><i>“Caucuses are a positive thingthere is a need to recognize that Caucuses are only in early stages of development so things are still building up”</i></p>	<ul style="list-style-type: none"> Increase participation and information: Involve a wider range of participants into the meeting forums including elders, frontline workers and youth; get information to all communities as well as ensuring that all bands are represented; create more awareness across all nations and generate greater involvement; provide all publications and material to the communities. Accountability and transparency - on all levels. Promote importance of health – advertise to communities the importance of their health and why they need to get involved

DETAILED FEEDBACK FROM FRASER REGION

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Provincial Level

'Provincial level' refers to the full geography of the Province of BC. At this level, health programs and services that serve all First Nations and First Nations individuals in BC are designed and delivered, and other population health issues are addressed. First Nations engage at a senior level with federal and provincial governments on strategic-level health issues.

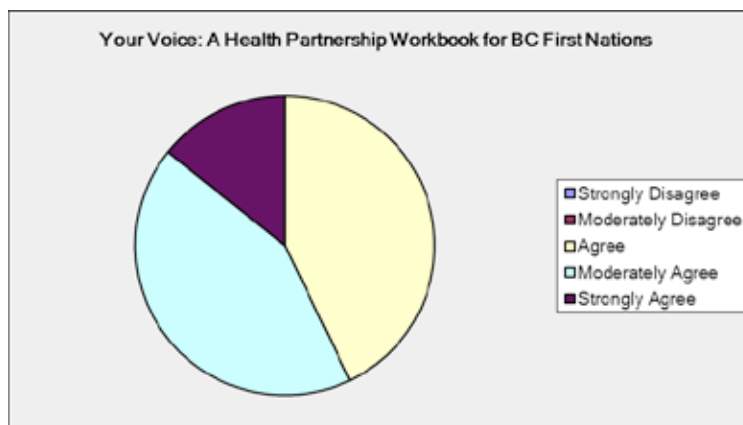
Principles of the Structure

The workbook outlined a number of key principles and requirements for the structure that needs to be in place to support the regional health transfer process at the provincial level. First Nations have stated that the regional health transfer process must:

- Increase First Nations decision-making, control and flexibility in health program and service philosophy, design and delivery;
- Foster collaborations and partnerships;
- Function at a high operational standard;
- Not impact on Aboriginal title and rights or the Treaty rights of Nations; and,
- Not impact on the Crown's fiduciary duty – including ability for First Nations to transfer responsibility back to the federal government if the arrangement does not work for First Nations.

First Nations completing the workbook were asked how they felt about these principles and whether any were missing – the results for the Fraser region are as follows:

Answer Options	Response Percent	Response Count
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Agree	42.9%	6
Moderately Agree	42.9%	6
Strongly Agree	14.3%	2
<i>answered question</i>		14
<i>skipped question</i>		4



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DETAILED FEEDBACK FROM FRASER REGION

Participants also added the following provincial level principles:

- **Wording of the Principles:** Need to strengthen wording 'increase decision-making'. Should be decision-making guaranteed – no sense in moving forward if this is not guaranteed;
- **Managing Change:** Identify drivers and inputs to change so it can be managed well;
- **Workforce Development:** Human Resource plans should include mentorship and succession plans;
- **Efficiencies:** Need to ensure that First Nations maximize financial resources which includes minimizing operational & administrative costs; focus on improving technology, infrastructure, safety and standards of buildings as well as processes and research – regions need support for this sort of thing;
- **Contingency Plan:** There needs to be reassurance that First Nations and Inuit Health (FNIH) would always be in the background and exist, even after this process is effected;
- **Health Directors:** need active and direct involvement.

Future Mandate for the First Nations Health Council (FNHC)

The workbook summarized that, based on feedback from Regional Caucus sessions, the mandate for the First Nations Health Council (FNHC) from 2012 and beyond should include:

- Continued leadership for implementation of the Transformative Change Accord: First Nations Health Plan and Tripartite First Nations Health Plan (TCA: TFNHP)
- Providing support to First Nations in achieving their health priorities and building relationships at local and regional levels
- Health advocacy with government partners and others at the highest levels
- Overseeing and advocating for service improvements for First Nations
- Overseeing the transition of FNIH to a new First Nations Health Authority.

Participants were asked if any key principles for this mandate were missing – Fraser region First Nations identified the following:

- **Workforce Development:** Need to ensure that promotion of youth into health careers is a key priority; and
- **Philosophy and Values:** Being culturally appropriate, and be respectful and listen; key principles for the FNHC moving forward must be trust, unity, honesty, humbleness, and healthy living.

Future Structure and Composition of the First Nations Health Council

The workbook stated that since the regional health transfer process will strive to devolve services to the local and regional levels as much as possible, and include representation of First Nations in regional caucuses and the new First Nations Health Authority – some First Nations have stated that the future FNHC should be a smaller group – with perhaps 1-2 representatives appointed per region. Respondents were asked if they had any comments about the future structure and composition of the FNHC and the responses were as follows:

DETAILED FEEDBACK FROM FRASER REGION

- Need a greater statement for the inclusion of off reserve members, the elders, and youth;
- 3 – 4 representatives would be good but 3 seems to be working – the idea of 1 representative would not work;
- We need to look at criteria for the nomination process to ensure diverse skills and background;
- Do not agree with only having 1-2 representatives per region;
- Need to ensure representation from all communities and that the FNHC remain community driven and focused on coordinating effort; and
- Believe that there needs to be broader representation than just 2-3 reps per region.

First Nations Health Directors Association (FNHDA)

The workbook summarized that First Nations have stated that the FNHDA should play a key role in providing technical advice and guidance to the FNHC and the First Nations Health Authority. Participants were asked if they supported this statement and responded as follows:

Answer Options	Response Percent	Response Count
Strongly Disagree	0.0%	0
Disagree	15.4%	2
Agree	23.1%	3
Moderately Agree	46.2%	6
Strongly Agree	15.4%	2
answered question		13
skipped question		5



First Nations Health Authority

The workbook summarized that First Nations have clearly stated some principles for the activities and operations of the First Nations Health Authority (FNHA). Specifically these principles require that the new FNHA must:

- Recognize the authority of individual BC Nations in their governance of health services in their communities;
- Protect, incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into the health programs and services in BC First Nations;

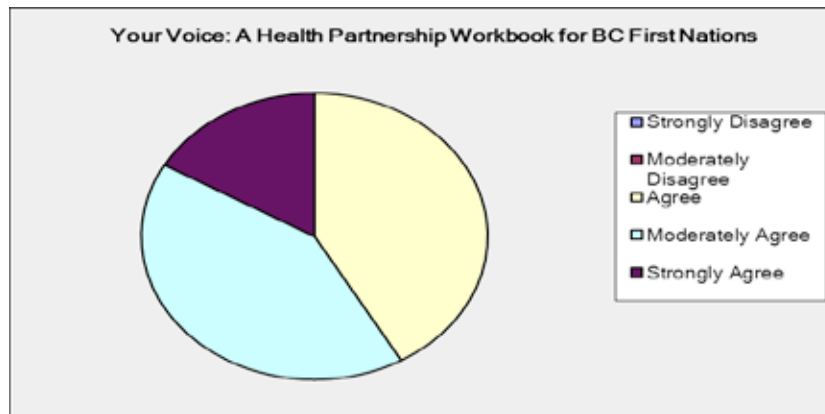
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DETAILED FEEDBACK FROM FRASER REGION

- Enhance collaborations and relationships that impact on First Nations health;
- Uphold reciprocal accountability particularly in their relationship with First Nations;
- Uphold professional standards and ethics;
- Uphold the highest standards in order to avoid conflict of interest;
- Have a transparent and manageable appointment process; and,
- Have a Board of Directors with relevant experience and expertise with respect to First Nations health programs and services and successfully running a large organization.

Participants were asked if they supported these principles for the activities and operations of the FNHA and if any were missing – the results are as follows:

Answer Options	Response Percent	Response Count
Strongly Disagree	0.0%	0
Disagree	0.0%	0
Agree	41.7%	5
Moderately Agree	41.7%	6
Strongly Agree	16.7%	2
<i>answered question</i>		12
<i>skipped question</i>		6



Participants were asked if any further key principles for the FNHA should be adopted – the results from this region are as follows:

- **Unity:** Need to promote unity which will have a key emphasis on getting the Chiefs more involved;
- **Representation:** Like other areas the FNHA will need to directly include the Elders and the Youth; and,
- **Capacity Building:** The FNHA must assist First Nations with capacity in the short term so that communities will be ready for takeover in the longer term.

DETAILED FEEDBACK FROM FRASER REGION

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While not suggesting additional principles, one participant said:

'I think there should be a review of other models. When you adopt the language of a culture (health has a culture) you also adopt their underlying beliefs and behaviours. I get concerned when people talk about creating something new but use all the same language and structures [as the current system].'



Reciprocal Accountability

Reciprocal accountability is acknowledged as a key part of the regional health transfer process. Reciprocal accountability means shared responsibility – amongst the Federal Government, Provincial Government, the Health Authorities, the First Nations Health Council (FNHC), the First Nations Health Directors Association (FNHDA) and in future the First Nations Health Authority (FNHA). It also includes First Nations themselves who have primary responsibility to look after themselves first and foremost and to work with partners to improve health outcomes for First Nations populations.

Principles for Reciprocal Accountability

The workbook set out the following principles that were shaped by First Nations input and dialogue over the past several years:

- Clear roles and responsibilities;
- Clear performance expectations;
- Balanced expectations and capacities;
- Credible reporting; and,
- Reasonable review and adjustment.

Fraser region First Nations who responded to the workbook added the following principles:

- Chiefs and Councils must be committed and accountable to the Health process;
- First Nations must not lose sight that individuals also have a responsibility to improve their own health and wellbeing; and,
- Include a shared accountability amongst all parties to our Elders and Youth, as well as off reserve members.

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DETAILED FEEDBACK FROM FRASER REGION

Processes for Reciprocal Accountability

The workbook outlined a number of processes for reciprocal accountability that First Nations have developed including:

- Regional Caucus sessions including all BC First Nations and their health organizations;
- Regular meetings of the Provincial [now Tripartite] Committee on First Nations Health;
- Regular reciprocal accountability and health partnership meetings between the partners to measure progress and discuss potential changes to roles, powers or funding that may be required; and,
- Regular senior political and technical meetings with key decision-makers at national and provincial levels to focus on BC First Nations health priorities and plans.

First Nations from this region who responded to the workbook added the following processes:

- **Reporting and Planning:** focus reports on long term health; need to be outcomes focused; resources need to be available to address long term strategic planning balancing health needs and health resources; continuous feedback/input with community members, including follow-ups with changes in health issues; need to undertake a comprehensive survey of the population to establish baselines and reporting;
- **Funding:** Funding is a key priority and there should be a commitment to carry over any surplus funding to the next fiscal year; and
- **Accountability:** must be from the top - down to Bands, Tribes, Hubs, etc.



OTHER FEEDBACK

Fraser Salish Regional Caucus

Several comments were made at the Fraser Region Caucus relating to the operation of the Caucus and the need for this forum to be inclusive of both on and off-reserve participants, including other urban Aboriginal groups. It was stressed that there was a need for more methods of communication to get more people and communities involved since many still were not attending the Caucus meetings despite notices being sent to all areas. In the earlier meetings of the Caucus (January – February 2011) there was concern that the Sto:lo Nation did not have someone appointed to occupy the 3rd seat for the Fraser Region on the FNHC. However by April 2011 after positive communications and relationship building between the Caucus representatives and Sto:lo Nation, a new appointment was made and the 3rd seat was filled. Fraser Region now has 3 representatives on the FNHC.

The development of a communications plan was seen as essential which incorporated a variety of methods to reach the leaders of all of the communities to encourage stronger participation.

First Nations Health Directors Association

Representatives from the First Nations Health Directors Association (FNHDA) board attended the Fraser Region Caucus and stated that they were developing a communications plan to identify how they intended to reach Health Directors and hubs. They expressed concern about communities that were not in the Community Engagement Hubs and therefore potentially missing out on crucial support and information. There was also mention that the Health Directors in the Fraser Region were required to notify the FNHDA Board of the process they intend to use to elect their two representatives on to the Board of the FNHDA.

Tripartite First Nations Health Plan Implementation

A brief discussion was held at the Fraser Salish Regional Caucus on the Tripartite First Nations Health Plan (TNFHP) Health Actions implementation. It was recommended that all of the work done to implement the Health Actions from the Plan be evaluated to ensure that identified action items were being addressed and to measure their effectiveness.

There was also a discussion on health planning, with some communities indicating that they wanted a process which allowed their community health plans to fully represent their uniqueness and not to be a 'tick the box' process to access Federal Government funding.

Relationship with the Fraser Health Authority

The Fraser Region Caucus involved a lengthy discussion on the relationship of Fraser region First Nations communities with the local regional health authority (RHA) - Fraser Health. During the March to May 2011 period the Fraser Region Caucus began a process of developing a Health Partnership Accord with Fraser Health. A draft was developed and at the time of completing this report, this document was still in development between the partners.

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DETAILED FEEDBACK FROM FRASER REGION

One of the suggestions arising from discussions on this Accord was to establish a youth assembly / conference for youth to talk about the Tripartite Health Plan and contribute ideas to the relationship with Fraser Health.

Some of the issues raised by the participants included the need for First Nations patients in the RHA to be identified in the system and not be included in the overall Aboriginal patient numbers.

There was also discussion on the methods used for First Nations to have influence on RHA plans and decisions and how the Caucus might provide the vehicle to do this. The RHA has its own methods for gathering advice and information and the session discussed the benefits of both the Caucus and the RHA methods and which would provide more value. Regional caucus participants want to see an equal partnership with the Fraser RHA which is based on the RHA respecting and recognizing their culture, mandate and role in the region.

As part of this relationship and partnership the participants sought mutual respect, reciprocal accountability, consistent communication and full engagement in needs-based service planning and decision making with the Fraser RHA. Participants also want to see the Fraser RHA become fully transparent with its budget and expenditures on Aboriginal / First Nations programs within its overall budget and to increase the number of Aboriginal / First Nations people employed at all levels of its organization. It was noted however that due to the evolving nature of the relationship this might be a longer term goal that the parties work toward rather than implement immediately.

In assessing the evolving relationship, participants wanted it recognized that the communities in the Fraser region are very diverse – developmentally, geographically, socially and culturally. This diversity would present challenges but these should not hinder progress continuing to move forward – but it stresses that a ‘one size fits all’ approach will not work. Some of this diversity also relates to choices that people make in terms of accessing traditional as well as modern medicines and services.

A discussion on the Aboriginal Health Plan which is prepared by the RHA was held which indicates that First Nations want to have significant input to this plan and how it is formulated.



First Nations Health Authority (FNHA) and Framework Agreement

A number of themes and comments emerged from the discussion on a new First Nations Health Authority (FNHA) which would be established to assume control of the current functions delivered by First Nations and Inuit Health (FNIH) – BC Region, and the draft Tripartite Framework Agreement on First Nation Health Governance which describes legal commitments for the transfer of FNIH.

Draft Framework Agreement Considerations

The following key points and queries were raised to clarify certain aspects of the Agreement:

- It was confirmed that fundamentally the Agreement is not changing programs on day one - it is just changing who is administering/managing them;
- There was a query as to why the FNHA is not described in the Agreement in detail. It was clarified that the FNHA is not set up yet and therefore there is a reluctance to add language that may sound too prescriptive about what this body might look like and do – that is up to First Nations to determine;
- One participant asked how First Nations are involved in the development and review of Aboriginal Health Plans of RHAs. It was noted that currently a Partnership Agreement was being worked on which would create space to work out the nature of the relationship and how First Nations will be involved with the Fraser Health Authority. The Framework Agreement requires that all Regional Health Authorities enter into Agreements with Regional Caucus Tables;
- There are concerns around capacity of the new FNHA to undertake policy analysis and development of all programs that are being transferred, and how to manage the change process in this environment. It was stated that the FNHC has been conscious of this issue, and that the Implementation Committee would have a lead role in helping to coordinate the transfer process. The Interim Management Committee will also play a big part while the transition is being planned and implemented;
- One participant asked about funding for remote communities and how First Nations access to health services would be dealt with. It was noted that there will be a need to work with the Federal Government around a funding policy – once transfer of programs has started, First Nations will determine this for themselves. Also there is a need to work with the Provincial government around access issues. A partnership will ensure that there is a forum for raising issues.

Capacity to Operate the FNHA

At the Fraser Region Caucus some participants expressed concern about whether First Nations had the capacity to take over the current Health Canada First Nations and Inuit Health (FNIH) operation from the Federal Government. Specifically, they wondered whether there was sufficient capacity at a management level to assume oversight of financial and human resources for instances. They felt it was vital that senior personnel from FNIH were encouraged to continue working for the new First Nations Health Authority to ensure these functions continued without problems. Participants were assured that this was part of the negotiations with the Federal Government that were continuing and that transfer of human resources from FNIH was a top priority.

3

DETAILED FEEDBACK FROM FRASER REGION

Name of the new FNHA

There was a suggestion that the new First Nations Health Authority have a name which was community-centred and did not represent yet another 'authority' over communities. They felt that the word 'authority' interfered with individual First Nations authority and an alternative name would be preferable.

What Decision-Making by First Nations looks like in the FNHA

First Nations decision-making and participation was a critical factor for the new FNHA. Participants at the Fraser Region Caucus identified that this meant citizens were actively engaged, connected and had confidence in the leadership of the new FNHA. They expected that decisions and influence would be localized where decisions were not all made at the center. It was stated that the FNHA needed to be inclusive and ensure it incorporated equal influence of First Nations communities across the Province and not just in specific areas or from those who were highly vocal. The structure of the new FNHA must have a clear mandate and Terms of Reference and be accountable to First Nations communities. The organization must not be overly bureaucratic but nimble enough to adapt and respond to needs quickly.

It was also considered that the new FNHA needed to work collaboratively with other agencies (e.g. Fraser RHA) to help coordinate services for a continuum of care for citizens and to build meaningful relationships. An organization with integrity and transparency were key characteristics identified which would build trust and confidence among the communities.

First Nations' Needs & Aspirations Drive Planning and Decisions

Participants felt that individual health plans for citizens and community health plans needed to be encouraged which could be rolled up into Regional health plans that could be used to engage with Health Authorities. Community needs assessments which supported plans should be done by communities and resources targeted at needs (not centrally-designed initiatives), with strategies being comprehensive, holistic and integrated. Plans should also be adaptive and able to respond quickly to needs without getting caught up in bureaucratic processes which are slow at responding to crises or opportunities.

Service and Program Design

Comments received indicated that service and program design by the new FNHA needed to be re-oriented to help build independence and strength among First Nations communities and not create cycles of dependency (e.g. addiction treatment programs). The new FNHA needs to focus more on prevention and supporting people on a journey to wellness by designing and funding initiatives that support this direction. Programs need to remove current barriers and 'fear' of the system (including helping people to navigate the system). Traditional and cultural practices are seen as an inherent and necessary part of the bigger system and the new FNHA needs to take cognisance of incorporating and recognising these practices as essential components. To complement effective services and programs the participants also considered that more needed to be done to increase the First Nations health workforce as well as ensuring they are culturally competent.

DETAILED FEEDBACK FROM FRASER REGION

3

Economic Benefits from a new FNHA

Participants spent time considering the economic benefits that may arise from having a First Nations Health Authority. There was unanimous agreement that working together in a unified and collective way would benefit everyone and offer several potential opportunities such as:

- Consolidating pharmacy purchasing and provision for communities;
- Using their collective buying power to purchase commodities (e.g. cleaning supplies);
- Utilizing the management of the First Nations and Inuit Health (FNIH) funds to leverage more resources from the federal and provincial government (including the local health authority) to manage a wider array of programs and services for First Nations communities; and,
- Offering services of the First Nations Health Centres to the wider community to create choice for the BC population.

Some methods for implementing efficiencies to generate savings and income were also discussed which could generate funds for investing in other strategies including:

- Restructuring INAC and Health Canada approvals processes for items funded by both Federal agencies;
- Maximising use of all forms of transport (e.g. school buses) for medical transportation to generate efficiencies and savings under the Non-Insured Health Benefits (NIHB);
- Reviewing current FNIH processes and structures that are tied to national requirements to remove un-necessary bureaucracy and 'red tape' that will not be necessary when First Nations assume management and do not have to conform to all of the national processes;
- Leasing out free space in First Nations health center buildings to generate revenue (including identifying alternative uses for space which complement health services);
- Moving away from Fee for Service payment systems for dentists and physicians to salaried positions; and,
- Working with the Health Authority to establish clinical centers for minor surgeries to reduce wait times in large hospitals and negotiating for anticipated savings to be shared (while increasing access to specialist surgery for other First Nations families).

Another theme of the discussions on economic benefits also listed several entrepreneurial options and investments that might support and benefit First Nations citizens:

- Investigating the benefits of a First Nations Health insurance plan;
- Learning from other models e.g. Alaska Native Health System and how they have generated alternative revenue streams;
- Increasing the availability of dental service at FNIH rates - rather than market rates;
- Investing in hostel / hotel accommodation in city centers for those travelling for treatment and reinvesting profits in the First Nations health system;
- Analysing current services / suppliers to First Nations communities and health centers and see what could be delivered by First Nations at a better cost;
- Identifying opportunities to bill other health plans (e.g. employer plans);

3

DETAILED FEEDBACK FROM FRASER REGION

- Creating a Charitable Foundation to help fund-raise to improve access primary health care services for all First Nations (e.g. helicopter / ambulatory transport for remote areas in the province or other areas) and identifying how this can generate revenue while meeting health needs;
- ‘Thinking outside the box’ to be creative and use the freedoms and flexibility that a FNHA would have to completely rethink how things are done and to get the best ‘bang for the buck’; and,
- Identifying opportunities for “preferred” service provider status and negotiating package deals which benefit citizens and reduce costs.

The final theme to emerge from considering economic benefits was to develop First Nations Health Human Resources. Specifically it was felt that by encouraging young people at an early age to look at opportunities to work in health this would in itself create economic opportunities for themselves and their families and communities. These opportunities would come from children who earned a better income and who could better take care of themselves. It was noted that in order to attract young people into health careers within First Nations health centers, communities would need to create a positive working environment in the health centers and communities.



Improving Health Literacy among First Nations Citizens

Another subject canvassed within the Fraser Region Caucus was how to improve health literacy among First Nations citizens. It was considered that by doing this, then people would be able to access and understand services a lot better and also be more confident to advocate for themselves if services were deficient.

Educating citizens on their rights when using health services was a key theme to emerge. By encouraging and supporting our citizens to be able to speak up, make complaints and know their rights it was felt that many benefits would accrue both to improving services as well as improving their experience of service delivery. This needed to include encouraging citizens to get prompt resolution to their issues with service delivery.

It was also felt that citizens who were more confident in themselves, would be in a stronger position to advocate to the system. It was considered that instilling pride in people so that they can advocate for themselves included building pride of their identity through cultural and traditional teachings.

More education on maintaining personal wellbeing through individual wellness plans for people to maintain health and for people with chronic disease or addictions was suggested as a means to achieve good health and to prevent further complications (e.g. community workshops; use of technology; think tanks; traditional leaders and healers). Promoting individual responsibility could be achieved through focusing on young people and community leaders as role models (e.g. wellness plan “books” into every school).

Ensuring traditional healing and medicines was available to all citizens as well as conventional medicines were seen as strategies that not only provided choice but built confidence in people.

4

KEY THEMES & SUMMARY OF FEEDBACK

4. KEY THEMES & SUMMARY OF FEEDBACK

Community Principles and Involvement

Of the responses received to the Workbook, 81.3% of Fraser region participants agreed with the community level principles that were expressed in the Health Partnership Workbook. All of the participants agreed that a Regional Health Transfer process would support the greater local control over health services and the development of local health program and service delivery models. Some further considerations put forward included the need to be inclusive of all First Nation members, particularly the Elders, the young as well as off-reserve members; inclusion of traditional practices and holistic models of wellness; ensuring sound First Nations values underpin the way that leadership operates; effective use of funding; workforce development; building trust; applying flexibility and making sure that benefits reached the intended target populations.

Of the responses received, 100% agreed that a regional transfer process should support greater local control over health services and the development of local program and service delivery models. Participants also wanted to see the expansion of services to non-First Nations incorporated, along with creating economic opportunities; building relationships with Fraser Health; and ensuring funding, data and philosophical approaches included off-reserve members.

Regional Caucuses

From the workbook feedback, 92.9% agreed with the regional level principles that were expressed in the Health Partnership Workbook. Further, 92.9% of participants agreed that they would like to see the regional caucus structure continue as part of the new regional health transfer process.

A number of other issues that were important to the participants at the Fraser Region Caucus arose. The structure, roles and responsibilities of Regional Caucuses needed to be refined and clarified. There was a need to have a clear statement that the role of Regional Caucuses went beyond influencing but to decision-making. There was also an urgent need to create and implement a Communications Plan that would encourage greater involvement and participation by other communities who are not attending the meetings. Cultural competency; accountability of roles and health planning were also considered important considerations for Regional Caucuses.

Relationship with Fraser Health Authority (FHA)

The relationship with, and expectations of, the Fraser Region Health Authority were also discussed extensively at the Fraser Region Caucus. There was support for a partnership relationship with the RHA which allowed for mutual respect; shared decision-making; reciprocal accountability; budget and service transparency by the RHA; acknowledgment of traditions, culture and mandate of First Nations by the RHA and improved cultural competency of the RHA across a range of areas.

First Nations Health Council

All of the responses agreed or strongly agreed with the provincial level principles expressed in the Health Partnership Workbook and added further principles including managing change well; workforce development; driving for efficiencies and having a contingency plan (for First Nations and Inuit Health [FNIH] to remain in the picture during and after the transfer of FNIH programs and administrative management).

KEY THEMES & SUMMARY OF FEEDBACK

4

Participants agreed with the proposed mandate for the FNHC, and added workforce development and values / philosophy as an important focus. Some participants believed that the composition of the FNHC needed to be broader than just 2-3 members per region and that suitable criteria for nominations, diverse skills and representation were vital to success.

First Nations Health Directors Association

Nearly 85% of participants agreed that the FNHDA should play a key role in providing technical advice and guidance to the FNHC and the First Nations Health Authority. A number of other issues that were important to the participants at the Fraser Region Caucus related to the need for the First Nations Health Directors Association to engage with Health Directors and involve the voice of Fraser Region Health Directors.

First Nations Health Authority

All 100% of the responses were supportive of the principles relating to the FNHA expressed in the Health Partnership Workbook.

Three main areas of discussion emerged from the discussions on the new FNHA – the first related to the actual transfer itself from FNIH; the second related to key aspects that participants felt were important once a FNHA was designed and operating; and the third related to the benefits that could be gained from operating the FNHA once it was up and running.

On the issue of the FNIH transfer, it was stressed that acquiring expertise from the current FNIH operation was important to maintain effective oversight of the operation particularly in the area of financial management. Negotiators were encouraged to try and retain as many FNIH staff and experts as possible. Several queries were raised about the draft Framework Agreement which were responded to also.



4

KEY THEMES & SUMMARY OF FEEDBACK

On the matter of the FNHA operation once it is designed and established, participants felt that key issues related to First Nations decision-making and involvement in planning, program and service design. In this area the important principles were integrity, transparency, accountability, flexibility, adaptability, decentralization, reduced bureaucracy and strong integration with other systems (including First Nations health center systems). Decisions also needed to be based on community needs and ability to respond to those needs as quickly as possible.

There were considerable economic benefits anticipated from the new FNHA once it was operationalized in terms of returns for individuals as well as communities. The main theme of the benefits was ability to use the collective 'buying power' and influence of all First Nations communities who would be part of the FNHA, to achieve gains. This would include benefits in combined purchasing of a range of products and commodities as well as streamlining processes in the current system. There were also a number of investment opportunities identified by the participants which would seek to look outside the FNHA and into a broader range of strategies that involved serving non-First Nation citizens in BC as well.

Reciprocal Accountability

Participants agreed with the proposed principles for reciprocal accountability and added the need for Chief and Councils to be committed and accountable to the health process; promoting self-care as part of accountability for health and including elders, youth and off-reserve members in shared accountability.

Participants agreed with the proposed processes for reciprocal accountability and added standards and long term outcomes; funding and flow through of accountability to Bands, Tribes and Hubs within communities.

General Issues

Several other issues were raised and discussed during the various Caucus sessions including the development of the Health Partnership Accord between the Caucus and Fraser Health; ensuring the Fraser Region Caucus maintained its 3 members on the FNHC; and addressing queries with the Framework Agreement draft document.

APPENDIX - METHODOLOGY



5. METHODOLOGY

The Health Partnership Workbook was developed by the FNHC in late 2010, and rolled out to First Nations across BC in January 2011. The Workbook summarized the feedback from more than 90 regional caucus sessions held over the past three years, and posed key questions to confirm this summary, and solicit further wisdom and advice.

There were two main methods of collecting feedback from First Nations communities, Chiefs, leaders and health professionals, into the Health Partnership Workbook:

- 1) Conducting Regional Caucus meetings in each of the five regions in BC and inviting all Chiefs, leaders and health workers to attend, and:
 - a. asking participants to complete workbooks at the sessions (or to send them in after the session) so that the FNHC had completed hard copy workbooks to contribute to these regional summary reports; and
 - b. taking notes at regional and Vancouver Coastal Regional Caucus of discussions and questions which could also add additional value to the information contained in the workbooks or complement the workbook information; and
- 2) Making the workbook document available on-line through surveymonkey.com which is an on-line survey tool and encouraging community representatives to respond using this method if they could not attend the engagement sessions.

The regional sessions were organized in accordance with the needs and priorities of each region. Therefore, the regional sessions included a variety of approaches, such as: convening sub-regional sessions in some of the larger areas; conducting one on one sessions with some Nations who wanted their Tribal Council to hear the information at a Council meeting; conducting presentations at other gatherings and holding sessions over two days instead of one where there were a larger regional attendance requiring significant travel time. This report includes workbook feedback and meeting feedback from the following meetings:

- 8 and 9 February 2011, Chilliwack
- 22 March 2011, Agassiz
- 4 April 2011, Seabird Island
- 28 April 2011, Sumas

Facilitators, presenters and note-takers attended every meeting to present prepared information such as PowerPoints and hand-outs; hear questions and issues; and record the proceedings. Hard copy workbooks were handed out at the sessions and some participants completed these at the meetings while others agreed to complete them later and send them in. On some occasions, smaller work groups convened at the sessions and notes on flipcharts were also incorporated into the notes of the session to be included in the regional summary reports. All information gathered from all sessions and methods (notes, completed workbooks, flipcharts, on-line workbooks) has been incorporated into this report.