Implementation of the Integrated System of Primary and Community Care:

Team-based care through Primary Care Networks
Guidance to Collaborative Services Committees

December 2017

General Practice Services Committee

Contents

Context

This guidance document covers the implementation of team based care through Primary Care Networks in support of an Integrated System of Primary and Community Care. The first phase of implementation will occur over the next 12-18 months of a three year period, with the recognition that primary and community care integration and redesign is a long term endeavor and system outcomes will take longer to achieve. The overall objective of health system transformation is to deliver care that is accessible, person and family-centered, culturally safe, effective in meeting population and patients' needs, coordinated, seamless and easy to understand for patients, family members and care providers, and that has appropriate access and support from hospital and diagnostic services (this system is referred to as the Target Operating Model as set out in policy direction).

Background

Primary and community care is a major component of the British Columbia health system, delivering over thirty million health care services each year to B.C.'s 4.6 million residents, with a total expenditure of approximately $5.4 billion. Nearly every British Columbian has contact with this part of the health care system each year.

Results of previous patient attachment and service integration efforts achieved a number of improvements to primary care access provincially, including over one hundred thousand previously unattached British Columbians gaining access to a family physician. Despite these efforts, patient access to primary care and community care across the province is still a challenge and the demand for primary and community care services is exceeding current capacity.

The formation of divisions of family practice throughout the province has enabled better intra-professional support, and the opportunity to partner with health authority and community organizations to identify and address health care needs within the community. Furthermore, national and international evidence indicates the addition of interdisciplinary team members to the primary care team, along with supports that enable those teams to design and deliver optimal care, is a means to improve both patient access to primary care and overall quality of care.

The Ministry of Health, Doctors of BC and Health Authorities are committed to a vision that enables access to quality primary health care, including Urgent Family Care Centres, that effectively meets the needs of patients and populations in BC, using the Patient Medical Home and Primary Care Network to form the foundation for care delivery within a broader, Integrated System of Primary and Community Care. Additionally, within this system of care, it will be important to consider how best to coordinate care with specialist physicians to effectively meet patient needs.

Objective

To substantively implement team-based primary and community care through the Integrated System of Primary and Community Care (see Ministry of Health draft policy direction) across all 89 Local Health Areas (LHAs) and their constituent communities over the next three years, built on:

- Increasing the availability of primary care teams through Patient Medical Homes (PMH) and Urgent Family Care Centres. Teams will include doctors, nurse practitioners and nurses, and other health professionals linked to primary care networks, to ensure there

are enough of the right type of services for the people who need them, and that they are available when they need them.
- Establishing new Urgent Family Care Centres in communities of greatest need with the full support of a medical team linked to lab and diagnostic services as part of the integrated system of care.
- Supporting GP practices to attain the attributes of the PMH, including a clear understanding of their patient panel, the ability to use practice level data to inform practice improvements, and the commitment to provide access to comprehensive care using team based care and networking to care for the community.
- Developing health authority delivered or contracted 1. Mental Health and Substance Use Services, 2. Older Adult, Complex Medical and Frailty Services, 3. Cancer Care Services, and, 4. Scheduled Surgical Services into four integrated specialized programs effectively linked to PMHs/PCNs (which include Urgent Family Care Centres).

Primary Care Networks, Patient Medical Homes, Urgent Family Care Centres and their Role in the Integrated System of Primary and Community Care

As outlined in the Ministry of Health (the Ministry) policy papers, Primary Care Networks (PCNs) will be established across BC to provide quality team based primary care services to the population of local communities, coordinating access to health authority specialized services through integration and service redesign.

A PCN is a network of family practices (including traditional GP owned family practices, community governed health centres, and health authority delivered family practices) in a defined geography linked with each other and with other primary care services delivered by the health authority and other community-based organizations. Patient Medical Homes (PMHs) are advanced primary care clinics that are defined by 12 attributes. Key attributes of PMHs include the provision of timely access to comprehensive, coordinated primary care which will require a focus on the following building blocks: engaged leadership, data-driven quality improvement, panel assessment and management, and team-based care.

Where established, Urgent Family Care Centres may act as a key hub within a PCN to provide access to urgent care, extended hours and cover off for other practices, and access to a wider range of health care professionals

While PMH and PCN, are the foundation of the integrated system, true integration between primary care and health authority specialized services is essential to meet the needs of British Columbians and deliver the Triple Aim: improved patient and provider experience, improved population health, and reduced per capita cost of health care (also known as the Quadruple Aim).

The objective of the first phase of primary and community care implementation is to increase the number of British Columbians who have access to quality primary care and are attached to a primary care provider and establish formal linkages to efficient health authority managed, population based specialized services. Four components of this integrated system are: 1. development of PCN among primary care providers currently working in community and around a defined population, which may include an urgent family care centre or services and community governed primary health centres; 2. use of interdisciplinary teams to deliver care; 3. redesign of community specialized services to meet the health needs of a geographical community; and 4. integration with community specialists. These components will enable the PCN to deliver the PCN Core Attributes,

associated Measurable Outcomes, and the Patient and Provider Value Propositions supported by the PMH Commitments (see Appendices A, B and C).

Community Readiness and Prototype Selection Criteria

As we move forward with implementing an integrated system, including defined PCNs, we will work in a focused fashion starting with, at a minimum, five to eight early adopter communities beginning in February with a representative sample of metro, urban and rural areas, then spreading to other communities over the next 12 to 18 months with an objective of substantive implementation of this model over the coming three years.

The following readiness criteria will be used for selecting the first and subsequent communities:

Community Readiness Criteria

1. Population based analysis which shows patient and population needs across defined geographic areas (*i.e. attachment, access and care gaps*)
2. High functioning local partnership between the division and health authority with a commitment to jointly work toward the Integrated System of Primary and Community Care (Target Operating Model), proceed to next steps (Memorandum of Understanding and Service Plan) and to inform provincial processes (*see appendix D*)
3. First Nations, in-community and within urban centres are engaged and invited to participate as full partners (or in another agreed upon capacity) in the development of the PCN
4. Divisional board leadership, readiness, engagement and capacity
5. Physician readiness (*PMH foundational work, demonstrated high level of member engagement and capacity to participate in PCN, use of EMR in the community*)
6. Health authority readiness, engagement and capacity (*CEO endorsement*)
7. Partners are willing to provide evaluation data to inform refinement of strategies regarding interdisciplinary practice, including measurement of attached patients, access and quality impacts
8. Partners are willing to participate in an attachment process including a centralized waitlist and to attach patients off the waitlist as available

The following steps will be required for communities through existing or establishment of Collaborative Services Committees (CSC), to indicate their **readiness and interest:**

1. CSC indicates Community Readiness and Interest (see appendix D) which requires sign-off from the health authority CEO and division board chair.
2. CSC submits Community Readiness and Interest to the GPSC co-chairs, copying the Interdivisional Collaborative Services Committee (ISC) co-chairs. For the first wave, submissions must be received by February 1, 2018. Communities will be confirmed within 10 working days.
3. GPSC co-chairs (supported by staff) review submissions in consultation with the associated GPSC regional representatives, and health authority representatives.
4. Approved communities are provided initial change management funding to support rethinking service delivery, and the rapid development of a primary care service plan.
5. From the date change management funding is received, the CSC is given 60 days to develop a primary care service plan, supported by the Ministry and the Doctors of BC through the GPSC, that includes a gap analysis of primary and community care needs against the PCN Focus Areas, giving particular attention to access and attachment.

6. The CSC submits the service plan for review. Responses will be provided within 15 working days.
7. Once the plan receives sign off, a Memorandum of Understanding is signed and resources are provided to the community.

Community Readiness and Interest intakes for 2018 will occur as follows: February 1, May 1, August 1, and November 1. Note that in each wave, consideration will be given to geographic distribution and size for the selection of communities. Communities not selected in the first wave will be supported to submit in subsequent intake periods.

Resources

New resources will be provided for planning, development and supporting change, to increase primary care teams and to develop and enhance networks that meet the PCN core attributes.

Available Resources

- Community Profile Data
- Primary Care Network Incentive (*under development)*
- Funding for net new team-based care providers
- Practice Support Program resources including coaching and change management supports to improve understanding and management of patient panels, support for practice efficiency, and effective implementation of team based care
- Funding for PCN change management

Additional resources may be made available in response to community needs and realities including: digitally enabled primary and community care services; resources to develop urgent family care centres or services; resources to develop community governed primary health care centres, or strengthen services in, and linkages with, existing community health centres; and specialist integration resources.

Note, communities may not require all of the above resources to identify and close the primary and community care gaps in their respective geographies. These resources are intended to support divisions, or groups of family physicians where divisions do not exist, health authorities and patient partners to co-design and develop local solutions to implement PCNs. A provincially resourced external awareness and communications campaign for patients and families will further support community engagement. See Appendix E for further description of resources.

Compensation Options Supporting Team Based Care

The Ministry and Doctors of BC are working together in the development and implementation of a suite of compensation models/options for physicians, nurses and other health care providers that support team based primary care and that demonstrate clear value to British Columbians. The following options are available initially on a limited basis as part of the implementation of the integrated system:

Compensation Options Supporting Team-based Care

- Population Based Funding
- Value Based Compensation
- Fee for Service Plus options: Nurse in Practice

See Appendix F for further description of funding models/options.

Approach and Process

Current collaborative structures will be used to establish the key components of PCNs. New funding will be targeted to deliver the PCN Core Attributes, with initial focus on access and attachment. Initial governance should be designed to directly enable/oversee achieving these deliverables.

The CSC will assess the gaps in comprehensive care (including the need in their community for establishing an Urgent Family Care Centre as part of the PCN), jointly decide the health professionals required (RNs, NPs, social workers, health coaches, team based clinical pharmacists, etc.) to meet the PCN Core Attributes, and submit this assessment in a PCN service plan as set out above. The CSC will jointly agree on the fund holder among participating members and will share accountability for planning and implementation, with fiscal accountability restricted initially to the funding of new resources for team based care, Urgent Family Care Centres and PCN development.

With the approval of the service plan, a Memorandum of Understanding (MOU) between the PCN partners (the division (or group of early adopting PMH physicians), the health authority, First Nations and other partners, Doctors of BC and the Ministry) will formalize the PCN. Prior to completion of the MOU, it is expected that the division and health authority will meaningfully engage First Nations with Nation based health services[1] and Indigenous health services organizations and invite them to participate as either stakeholders or full partners in the development of the PCN. PCN partners will sign-on the MOU, stating its role, responsibilities and commitment to joint decision making and accountability for a shared PCN service plan and resources. Once PCNs are demonstrating effective partnerships, expansion could occur and local, regional and provincial governance structures would evolve to meet changing needs, in the medium to long term.

Summary of Next Steps

- Working with Collaborative Services Committees, the Ministry, Doctors of BC and Health Authorities, through the GPSC, identify the first wave of five to eight communities (February 2018)
- First wave of communities receive initial change management funding to develop service plans; available budget for action/hiring is identified (February 2018)
- Service plans approved, partners sign Memorandum of Understanding and required resources identified in the plan are provided to communities (April-May 2018)
- Local governance structure, roles and accountabilities incrementally established (December – June)
- Companion guidance documents for specialized community services programs, including core attributes, to support the broader system of care developed and shared (February 2018)
- Subsequent intakes for Community Readiness and Interest occur: May 1, August 1, and November 1, 2018
- Subsequent communities identified by May, August and November 2018
- Patients, families and caregivers will be engaged on services and activities throughout the implementation phases.
- Develop shared learning systems and feedback loops to encourage cross-provincial and system learning (January and ongoing)

[1] First Nation health service organizations who deliver health and wellness services at the Nation level, in village health centres and/or across clusters of communities.

Appendix A: Primary Care Network Core Attributes

Primary Care Network Core Attributes
1. Process for ensuring all people in a community have access to quality primary care, and are attached within a PCN.
2. Provision of extended hours of care including early mornings, evenings and weekends.
3. Provision of same day access for urgently needed care through the PCN or an Urgent Family Care Centre.
4. Access to advice and information virtually (e.g. online, text, e-mail) and face to face.
5. Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.
6. Care is culturally safe.
7. Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community.
8. Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.

Proposed Measurable Outcomes

Accessibility:

- Percentage of population attached to a practice or primary care provider [▲]
- Number of patients on a centralized waitlist for attachment to a primary care provider [initially: ▲; once established: ▼]

Appropriateness:

- Attached patients utilizing Emergency Departments (EDs) during working hours classified as Canadian Triage and Acuity Scale (CTAS) Level 4 or 5 [▼]

Acceptability:

- Percentage of patients who are satisfied with their ability to access a practice (same day/extended hours) [▲]

Efficiency:

- Number of primary care providers in clinical networks that provide comprehensive service (convert to proportional measure) [▲]

Appendix B: Patient and Provider Value Proposition

Patient Value Proposition	Provider Value Proposition
I am cared for in my community. I have an ongoing relationship with my GP or NP who knows me, my needs, and my preferences. If my GP or NP retires, I am still able to get care.	I am supported by other doctors and providers in my community as we collectively provide care for patients in our community. I am supported by the network to develop my new practice (e.g. new docs) or leave my practice (e.g. retiring docs).
I am able to receive care during the day and on weekends when I need it. I do not have to wait at a walk-in clinic for many hours to get care.	I am able to share the workload and coverage of non-traditional hours with other providers, and get time off when I need it.
When I need urgent care, I do not go and wait in the emergency department because my PCN has designated places where I can receive same-day service that links back with my regular care provider.	My patients are able to receive urgent care in the community because I'm connected to and supported by other providers within my PCN. I can do the necessary follow up because information is shared appropriately.
I am able to communicate with my regular care provider in a way that works for me. The key information is all available to me (online, if I wish).	I am able to communicate with my patients more effectively and efficiently. A website helps my patients find information easily, which reduces unnecessary calls to my clinic.
I receive care tailored to my medical needs throughout my life (whether having a baby, reminders for screenings, or end of life care).	I am trusted to provide personalized care to my patients within a team, which enables me to provide care consistent with my training.
I am treated with dignity and respect; I don't experience shame or intimidation and feel my health concerns are addressed without racial or other discrimination.	I am given the training and supports to provide my patients with care that respects their culture and history.
My care is coordinated. I don't have to worry about advocating for my needs because my regular practice has helped me make the connections I need to get surgery, manage my depression and receive the home care I need.	I am easily able to connect my patients to the services they need inside and outside my clinic – the silos between health authority and GP services are gone. I am connected to other GPs and providers in my community so my patients have all the care they need. I use a payment mechanism that is simple to administer.
I know how to get good advice 24/7. I know what office close to me is open in the early morning, evenings and weekends. I know where in my community to get care for a minor illness or injury so I that I can avoid going to the hospital emergency department.	I have a clear picture of the comprehensive services available in the PCN, providers and locations in the network, and all the necessary contact information. I am provided with a variety of communication materials that are patient-friendly to help my panel understand where best to receive a range of care within the PCN, e.g. advice, prevention, minor illnesses, or care that is urgently required.
Where my condition requires care from one or more specialist physicians, I know that all of my physicians are working together to help me achieve the best outcome possible	I am in communication with specialist colleagues, and we work together to build appropriate, comprehensive shared care plans for my patients.

Appendix C: PMH Commitments in Support of PCN

As a foundation for an effective PCN, practices in the community need to be committed and supported to adopt the PMH attributes, with a focus on understanding and updating their patient panel, using practice data from their EMR to inform practice improvements, providing access and comprehensive care and preparing to implement team based care within the practice and/or as part of the primary care network supporting the practice.

PMH Commitments
Complete PMH Assessment
Commitment and demonstrated progress to moving along the levels of the Practice Characteristics Matrix, to enable PCN Core Attributes, for: - Networks - Empanelment (panel clean up, maintenance, and review) - Team-based Care

Appendix D: Community Readiness and Interest

PARTNERS

The initial partners committing to become part of the PCN must include the local division of family practice, local regional health authority and patients and families. Where First Nations with Nation based health services and/or Indigenous health service organization fall within a planning region, it is expected that they will be engaged and invited to participate as full partners (or in another agreed upon capacity) in the development of the PCN. Refer to Appendix G for an overview of First Nations/Indigenous engagement considerations. Other partners may be included at this time, or brought onto the PCN Committee as it matures.

Division of Family Practice

Name of Division:

	Name	Phone Number	Email Address
Division Lead			
Division Executive Director			

Total Division members actively practicing in community:
Total Division members willing to participate in PCN:
Approximate number of patients currently cared for by willing members:

Regional Health Authority

Name of Regional Health Authority:

	Name	Phone Number	Email Address
PCN Lead			
PCN Support			

Patients and Families

Organization Identified to Engage Patient Participation:

Other Partners*

Partner organization:

	Name	Phone Number	Email Address
First Nations Partner			
Organization Director			
PCN Lead			

*Partners may continue to onboard to the PCN as it matures.

Primary Contact and Fund Holder

	Name	Phone Number	Email Address
Primary Contact for			

Submission			
Fund Holding Organization			

PARTNERSHIP OPERATIONAL OVERSIGHT
Is there an existing body that can serve as the PCN Committee (e.g., Collaborative Services Committee)?
Yes/No :
If Yes, what body:

Impact Funding

Has your community received Impact Funding in 2017/18?
If yes, briefly indicate how projects will be supported through the PCN:

GEOGRAPHY
Please provide the names and population numbers of the communities that will make up the geography of your PCN. Ensure First Nation communities are included, where they exist within your area:

1.
2.
3.

ELIGIBILITY CRITERIA
Please tick the following criteria to indicate your eligibility to participate in forming a PCN.

- ☐ Partners are willing to jointly work toward the Integrated System of Primary and Community Care, proceed to next steps (Service Plan and Memorandum of Understanding) and to inform provincial processes
- ☐ The division of family practice and the regional health authority both commit to forming and actively participating in the PCN
- ☐ Reasonable proportion of physicians are willing to participate in the PCN
- ☐ Physicians have been using an EMR for at least 12 months
- ☐ Physicians have completed Understanding Your Patient Panel PSP process or have plans to do so (engaged with PSP and booked time)
- ☐ First Nations with Nation based health services and/or Indigenous health service organizations have been invited to participate as full partners
- ☐ General understanding of patient and population needs across defined geographic areas (i.e. attachment, access and care gaps) that will be further developed as part of the Service Plan process
- ☐ Partners are willing to provide evaluation data to inform refinement of strategies regarding interdisciplinary practice, including measurement of attached patients, access and quality impacts. Partners are willing to participate in an attachment process including a centralized waitlist and to attach patients off the waitlist as available
- ☐ Division board chair has indicated support via email to CSC co-chairs
- ☐ Health authority CEO has indicated support via email to CSC co-chairs

INTEREST IN ALTERNATE FUNDING MODELS AND SUPPORTS
Please indicate if any practices in your region are interested in pursuing the following enhanced funding models and/or supports:

Funding Model (mutually exclusive)	Number of Clinics/Group Practices Interested. Please identify for each the number of physicians and total number of patients served.
Population-Based Funding	
Value-Based Compensation	
Nurse in Practice	

Please indicate community interest in the following supports by community:

Additional Support	Community
Urgent Family Care Centre	
Digitally Enabled Primary Care	
Team Based Clinical Pharmacist	
Specialist Integration	

Note: *the Ministry of Health currently has limited capacity to onboard practices to new funding models. The Ministry will make every effort to accommodate requests but as it will take time to develop full capacity an indication of interest will not guarantee immediate availability.*

SUBMISSION CONTACT INFORMATION
Please submit your interest to the GPSC co-chairs Ted Patterson and Dr Shelley Ross and with a copy to your ISC co-chairs and to the MoHStrategicManagementOffice@gov.bc.ca.

If you do not feel ready to submit a proposal, but are interested to explore this initiative further, you are invited to contact Joanna Richards or Afsaneh Moradi, who will put you in touch with a member of the team who can answer your questions. We would be happy to meet with your stakeholders to explain the agreement in greater detail.

Appendix E: Description of Resources Available

Placeholder for information to come in January.

Appendix F: Definition of Funding Models

Population Based Funding (PBF)

Population Based Funding (PBF) is an established patient-based funding model that compensates group practices (clinics), based on panel complexity. This model allows the sites the discretion to determine the appropriate services, how they are delivered (i.e., in person, telephone, etc.) and by which team member to improve quality of care, increase patient attachment and improve access for registered patients.

The Ministry of Health makes payment at the clinic level. The clinic determines the compensation paid to individual physicians and nurse practitioners, as well as their staff nurses, and other health providers, and administrative support.
Funded services relate to a defined set of 'core' primary care services, with the flexibility to provide extended services. There is greater flexibility to deliver virtual care, deal with multiple conditions in a single visit, and to put emphasis on preventative services.

Program Components

1. *Registered Patient Panel* – PBF clinics receive payments based on the complexity of the panel for registered patients within a defined area. The complexity of each patient is calculated using the diagnostic coding submitted on FFS and PBF encounter claims. Using the Adjusted Clinical Grouping® (ACG) model, patients are assigned to categories based on the combination of patient age, gender, and all diagnoses submitted through MSP.
2. *Fee-for-Service* - for services outside the 'core basket' for paneled patients, and all services for non-paneled patients.
3. *Outflows* - payment deductions when a paneled patient receives core primary care services from another General Practitioner within the clinic's catchment area.

Electronic Medical Record (EMR) Requirement:
- Enhanced EMR: Telus Wolf; IntraHealth Profile; and, Telus Med-Access

Value Based Compensation (VBC)

Value-Based Compensation is a capitation model that compensates primary care teams based on panel size and complexity and quality improvement indicators. It supports the delivery of high-quality integrated and coordinated health services that are team-based.

The services covered by VBC funding relate to a defined set of 'core basket' primary care services. Like PBF, there is greater flexibility to deliver virtual care, deal with multiple conditions in a single visit, and greater emphasis on preventative-type services.

Program Components

1. *Base Core Payment* – based on the number of patients attached to the clinic. Funding is intended to be used to cover a significant portion of overhead expenses, professional fees, and the hiring of other health professionals to care for patients.
2. *Pay for Panel Care* - based on a unique complexity index derived from the EMR problem list and patient encounter information.
3. *Quality Payment* – a quality improvement and activity payment to the clinic based on proscribed targets.

4. *Fee-For-Service* - for services outside the 'core basket' for paneled patients, and all services for non-paneled patients.
5. *Outflows* - Payment deductions when a paneled patient receives primary care services (including emergency visits) from another Practitioner within the clinic's catchment area.

EMR Requirement:
- Currently MOIS only.

Nurse in Practice

The Nurse in Practice initiative expands a Fee-For-Service family practitioner's (FP) capacity through a team-based care approach where a nurse practitioner (NP), registered nurse (RN) and/or licensed practical nurse (LPN) function in a complementary and collaborative role in the FP's office. Under the current iteration of this program family practices sign a contract with the Ministry of Health and receive block funding to cover the salary, benefits and overhead costs associated with the nurse. The nurse is an employee of the practice and employment terms are determined by the FPs.

Program Components:

1. *Letter of Intent (LOI)*: FPs/practices are required to sign a LOI outlining the overall principles, objectives, and requirements (e.g. determining current practice panel, developing net new patient attachment target, etc.).
2. *Contract*: Funding is provided under a contract with a practice or group of physicians. Block funding is to cover a nurses' salary, benefits, and other associated costs (e.g. overhead). Payments will be made based on one FTE (minimum 1631 hours).
3. *Start-up funding* - One-time funding for start-up costs.
4. *Shadow billing* - Nurses are required to shadow bill electronically using the Teleplan system for all patient services provided.

EMR Requirement:
- Practice must be using an EMR for a minimum of 12 months.

Appendix G: Roles of Partner Organizations

Placeholder for information to come in January.

Appendix H: Engaging with First Nations / Indigenous Communities

The intention of engaging First Nations and Indigenous partners in the development of primary care networks (PCNs) is to ensure:

a. First Nations and Indigenous stakeholders, including patients, families, caregivers, Elders, Traditional Healers, community leaders, etc., are able to collaborate with and contribute information, advice, and guidance to PCN planning, operations and evaluation;
b. PCN services are culturally safe and meet the needs of the community population; and,
c. First Nations and Indigenous health care organizations that deliver components of comprehensive primary care services within the geographic service area of the PCN have the opportunity to participate in developing the PCN service plan, contributing to the PCN operations, and receive resources as part of the PCN.

It is the expectation that First Nations and Indigenous health service organizations will be engaged and invited to participate as full partners (or in another agreed upon capacity) in the development of the PCN.

BC Indigenous population

For many thousands of years, First Nations in BC enjoyed good health and wellness . Due to the historic and ongoing impacts of colonialism and racism, including residential schools and intergenerational trauma, the health and wellness of First Nations in BC has been disrupted. This has resulted in substantial health disparities between First Nations and non-First Nations people and distrust in BC's health system and its associated governance structures. In order to ensure success of the implementation of BC's Integrated System of Primary and Community Care, meaningful engagement and collaboration must occur with First Nations and Indigenous partners.

Collaboration and Engagement

There is not a one-size-fits-all approach to relationship building and meaningful engagement with First Nations and Indigenous peoples in BC[2]. Meaningful connection is often best achieved through direct relationship building with community representatives, including Health Directors, administrators and/or Chief and Council. The following organizations may be able to facilitate introductions or provide information on engagement considerations and protocols: First Nations Health Authority, Regional Health Authorities, Nation satellite offices, Métis Nation BC, and Indigenous health service organizations such as BC Association of Aboriginal Friendship Centres.

Engagement Process Considerations

- Prior to connecting with community leaders, seek to understand the local First Nation/Indigenous community's governance, partnerships and perspectives on health, healing and wellness.
- Focus on relationship-building as a starting point and engaging in-person when possible.
- Consider cultural safety and protocol. Meet with First Nations/Indigenous representatives on their territory, co-developing documentation (agendas, proposals, etc.) and respecting protocol for First Nations/Indigenous community members to open and attend meetings.
- Seek information from relevant partners on positive or existing engagement processes.
- Respect the Nation/community's right to self-determination, as reflected in their right to determine the degree to which they wish to be involved.

[2] There are approximately 270,000 Aboriginal citizens in BC, making up about 6% of the population, with approximately 70% living off-reserve (or away from home).