

**First Nations Health Governance in British Columbia:
Strategic Planning and Performance Reporting in the First Nations Health Authority**

By

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B.A., University of Victoria, 2018

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF PUBLIC ADMINISTRATION

in the School of Public Administration

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First Nations Health Governance in BC:
An Organizational Analysis of the First Nations Health Authority

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Abstract

The low health status of First Nations people in the Province of British Columbia and persistent gaps in health outcomes as compared with other provincial residents led to the founding of the First Nations Health Authority (FNHA) in 2013. With less than a decade of operations, there have been limited evaluative studies assessing performance of this unique first-of-its-kind health authority in Canada that is run by and for First Nations. An in-depth document analysis of all FNHA service plans and annual reports to date shows the development of strategic planning and performance reporting processes in the context of a new and growing organization. A detailed analysis into this type of organizational literature is helpful in highlighting areas of misalignment and improving planning and reporting processes. In a public sector context, analysis of service plans and annual reports is particularly useful in assessing performance and accountability where the metric of profitability is not a consideration as it is with private-sector organizations.

Keywords: First Nations; strategic planning; performance reporting; FNHA; health outcomes; annual reports

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Acknowledgements

I would like to take this opportunity to thank my supervisor Dr. Kimberly Speers for her ongoing support and encouragement throughout the thesis process. Your feedback, guidance, and patience have been instrumental and highly appreciated.

Also, many thanks to Dr. Susanne Thiessen for your insightful comments informed by your expertise in this area of research. Your notes and remarks strengthened my understanding of the topic and pushed my analysis further.

To my family and friends, your constant love and support has meant the world to me. Thank you for everything!

Most of all, I dedicate this thesis to my Mom without whom this work would not have been possible.

Chapter 1: Introduction

This thesis examines the First Nations Health Authority (FNHA) service plans and annual reports to identify component changes and assess the level of alignment between plan goals and performance reporting. The relatively new organization, with less than a decade of operations, has been the subject of evaluative processes; however, an in-depth content analysis of its service plans and annual reports is missing from this evaluation literature. This research effort is intended to help inform recommendations for the FNHA illustrating opportunities for strategic planning and performance reporting improvements. A detailed analysis into this type of organizational literature is helpful in highlighting areas of misalignment and improving planning and reporting processes. In a public sector context, analysis of service plans and annual reports is particularly useful in assessing performance and accountability where the metric of profitability is not a consideration as it is with private-sector organizations.

In particular, the exercise of evaluating FNHA service plans and annual reports matters and is important because it reveals whether organizational goals, objectives, strategies, targets, and performance measures are aligned with the overall mission of the organization to improve the health and wellness of First Nations people in BC. However, it is important to note that traditional western approaches to strategic planning and performance reporting may not always align with Indigenous worldviews and cultural values. It may therefore be challenging for Indigenous-led organizations to adopt and implement these processes in ways that are relevant and meaningful to the communities they serve. A key takeaway from this research is that it is essential to develop planning and reporting literature that takes into account the unique needs of Indigenous-led organizations and is tailored to their cultural context.

1.1 Defining the Issue and Context

Defining the Issue

This thesis aims to address the gap in the literature regarding strategic planning and performance reporting that is specific to Indigenous-led organizations. The problem identified is that the current literature in these areas is generally rooted in western perspectives and lacks an Indigenous-specific focus and applicability. This issue of a lack of Indigenous-specific planning and reporting literature can make it challenging for Indigenous-led organizations to adopt and implement these processes and difficult to assess their effectiveness. Without Indigenous-specific planning and reporting literature to serve as a reference point, implementation and evaluation of these processes can be problematic. This gap in the literature is a complex issue that is partially attributable to practices of colonization that often emphasize assimilation and western-based systems of governance and accountability which may not align with traditional Indigenous values and ways of knowing. As such, this study supports the efforts of Indigenous-led organizations to adapt western-based strategic-planning and performance reporting frameworks to be more culturally

relevant while also including several recommendations for the FNHA should it choose to amend plans and annual reports to better align with provincial and federal government reporting requirements as part of the *Tripartite Framework Agreement* that established the FNHA. This thesis intends to provide a more comprehensive understanding of how strategic planning and performance reporting processes can be tailored to meet the needs of Indigenous-led organizations. This involves exploring approaches that are more culturally appropriate and sensitive to the needs and values of the Indigenous communities the FNHA serves.

As a relatively new organization, limited evaluative studies have been conducted in terms of assessing performance in the FNHA. The 2019 study entitled *Evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance* assessed the effectiveness of the FNHA's regional partnership accords and various health initiatives; however the scope of the report did not include an evaluation of FNHA strategic plans or annual reports. There is a gap in the literature on the FNHA or any First Nations health organizations that focuses on organizational assessment, strategic planning, and performance measurement. A lack of targeted research in these areas leaves Indigenous organizations without meaningful, representative, and applicable data by which to inform and guide their own strategic planning and reporting processes. The purpose of this qualitative study is to help address this gap in the literature by analyzing the FNHA's strategic plans and annual reports from its inception in 2013 to the most recent year of reporting in the 2021/22 fiscal year.

The founding of the First Nations Health Authority represents a significant step towards the recognition of Indigenous sovereignty and the right to self-determination for First Nations people in BC. Decision-making authority over matters impacting First Nations communities including control over the sphere of healthcare is based on a legal, constitutional foundation of rights that uphold and affirm Indigenous self-determination. While self-government provides opportunities for Indigenous communities to exercise their inherent rights, it also poses challenges, particularly around the issue of governance. As the FNHA is a relatively new organization, many of the Indigenous communities it serves are also new to the process of self-governance and may need support in building their governance capacity to exercise their right to self-determination effectively. A further challenge is that FNHA staff may have limited experience with various management processes such as strategic planning and annual reporting and require additional resources to fulfill these reporting requirements.

While governance and management related challenges are significant, so too are the opportunities that stem from the founding of a First Nations health authority developed to address the specific needs of this population. The FNHA is the first province-wide health authority in Canada governed by and for First Nations that aims to deliver programs and services that are culturally appropriate and specifically designed to promote and benefit First Nations' health and wellness (<https://www.fnha.ca>). The FNHA mission statement reflects this mandate to transform healthcare

for First Nations people in BC: “The FNHA supports BC First Nations individuals, families, and communities to achieve and enjoy the highest level of health and wellness by: working with them on their health and wellness journeys; honouring traditions and cultures; and championing First Nations health and wellness within the FNHA organization and with all of our partners” (FNHA, 2023).

Besides self-government, one of the overarching reasons leading to the founding of the FNHA is the low health status of First Nations people in BC as compared to other provincial residents (Gallagher, Mendez, & Kehoe, 2015). For example, First Nations health outcomes across major health indicators lag significantly behind those of the non-Indigenous population in British Columbia (FNHA/PHO Indigenous Health and Wellness Report, 2018, pp. 7-18). Closing these health gaps is the main goal guiding and influencing the work of the FNHA.

Defining the Context

Ill health among Indigenous people in Canada is a critical and persistent problem that has required government attention and innovative policy solutions for the last several decades. Across all major health indicators including life expectancy, infant mortality, and rates of chronic disease, Indigenous peoples fare far worse in terms of health outcomes than their Canadian counterparts (Auger, Howell, Gomes, 2016, p.e393; Allen *et al.*, 2020). It is important to note that any discussion of the health inequalities between Indigenous and non-Indigenous people must be contextualized within the historical, political, social, and economic conditions that have influenced Indigenous health. By addressing these broader contributing factors, this research incorporates a culturally-sensitive and trauma-informed perspective that takes into account the varied structural and social determinants of health. Indigenous health inequities attributable to Canada’s colonial legacy, social exclusion, and racism can be seen across all major health indicators (Ray, Wylie, Corrado, 2022). According to recent Statistics Canada data, Indigenous people showed higher age-standardized mortality rates (ASMRs) compared with the non-Indigenous population, and on-reserve Indigenous people showed higher ASMRs than off-reserve Indigenous people (Park, 2021, p. 3). Indigenous people’s excess mortality as compared to their non-Indigenous counterparts was caused by an increased rate of death from diabetes, chronic liver disease and cirrhosis, unintentional injuries, and intentional injuries (suicide and assault) (Park, 2021, p. 3).

The historical context of colonization and practices of forced assimilation are key determinants in Indigenous health status today (Lavoie, Forget, & Browne, 2010). Allen *et al.* (2020) have argued that the reservation system, residential schools, the criminal justice system, welfare, the Indian Act, and decades of ineffective and inappropriate health policies and practices have contributed to residual and compounding harm to Indigenous communities. The effects of these colonial processes that led to the loss of land, language, and culture continue well into the present day and

research has demonstrated that these processes have had lasting, deeply internalized, and multi-generational impacts on Indigenous peoples (Allan & Smylie, 2015, pp. 2-10).

Further contributing to the low health status of Indigenous people are the layers of jurisdictional ambiguity for healthcare service delivery between the federal and provincial governments. Unlike other Canadians who benefit from health services provided by provincial health systems, Indigenous healthcare for on-reserve communities has historically been the responsibility of the federal government (Gouldhawke, 2021). This bifurcated system of health service delivery has placed Indigenous people at a significant disadvantage in terms of accessing health services and receiving quality care. Related, the federal provision of health services through Health Canada's First Nations and Inuit Health Branch has been highly problematic in several key areas including funding, regulation, program clarity, and local service delivery (Office of the Auditor General, 2015). These areas of concern, particularly inequitable funding, compounded by "...complex, ambiguous, and fragmented jurisdictional issues, has resulted in confusion, frustration, and unmet healthcare needs. This has in turn led to higher mortality and morbidity rates among Indigenous Peoples" (Halseth & Murdock, 2020, p. 13). Belying the universality of Canada's healthcare, Halseth and Murdock argue that this two-tiered service delivery system is unequal and discriminatory as Indigenous people do not experience the same quality of care and access to services as other Canadians (2020, p. 13).

1.2 Significance of the Study

As the First Nations Health Authority is a relatively new public health institution established only in 2013, there have been limited studies conducted thus far that assess the work of the health authority and determine to what extent it aligns with its founding goals and principles. In accordance with the Tripartite Framework Agreement between First Nations leadership, the Province of BC, and the federal government, all Parties agreed that a joint evaluative process would be conducted every five years and offer a comprehensive review of Indigenous health indicators and an assessment of the effectiveness of the Tripartite structure of governance (British Columbia Tripartite Framework Agreement on First Nation Health Governance, 2011). The first of these five-year evaluation studies was published in 2019 and focused on several key areas including the Tripartite relationship, the FNHA governance structure, the integration of the FNHA into the broader provincial system of health authorities, and Indigenous health and wellness outcomes (Evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance, 2019).

The present study differs from this prior evaluation in that the focus in this thesis will be a narrow, highly specified assessment of the FNHA's summary service plans and annual reports. The originality offered by this research is in its organization-level analysis of strategic planning processes and performance measurement indicators. This type of analysis is missing from the literature on the FNHA and its contribution is valuable in addressing this gap regarding strategic planning and performance reporting research that is specific to Indigenous-led organizations. This

research is intended to benefit First Nations people in BC through the improvement of FNHA planning and reporting processes that may result in more effective organizational outcomes in terms of program design and service delivery. While strategic planning and performance measurement are key concepts within the field of public administration and the vast majority of private and public sector organizations undertake these planning and measuring exercises, there appears to be a gap in this literature that does not include a commensurate level of analysis that assesses the quality of strategic plans and the suitability of chosen performance indicators.

1.3 Thesis Objectives, Scope, and Research Questions

The objective of this research study is to analyze the strategic plans and annual reports of the FNHA. The findings from this research effort is intended to help inform recommendations for the FNHA illustrating opportunities for strategic planning and performance reporting improvements.

This research will be guided by the following objectives and tasks:

- Highlight the ongoing Indigenous health crisis and draw attention to the persistent gaps in health outcomes between Indigenous and non-Indigenous people in BC.
- Explore the work of the First Nations Health Authority through an assessment of its strategic summary plans, five-year plans, and annual reports.
- Determine the extent to which there is alignment between the strategic direction of the FNHA and its overarching mission to close persistent health gaps between Indigenous and non-Indigenous people in BC.
- Evaluate First Nations governance through a culturally sensitive lens and explore the interplay between Indigenous community wellness values and Western practices for public sector organizations such as strategic planning and performance measurement.

These objectives will be guided by the following research questions:

Primary research question: How have the FNHA annual reports, five-year plan, and service plans changed in content since their inception?

To support answering the above research question, the following supplementary questions will be explored:

- To what extent is there congruency between the FNHA service plans and annual reports such that plan goals align with organizational outcomes?
- What are the changes in the components of the annual reports from when they began to the most recent version?
- What are the changes in the components of the service plans from when they began to the most recent version?
- In focusing on performance, to what extent does the FNHA focus on inputs, outputs, outcomes, and impacts in their annual reports and plans?

The scope of this thesis has set boundaries and focuses exclusively on an organization-level analysis of the FNHA through an assessment of strategic plans and annual reports spanning nearly a decade of operations. This evaluative process does not include an analysis of the various FNHA health promotion policies and programs to determine the impact of these initiatives on specific health outcomes and indicators.

Based on the research questions, the main terms and concepts used in this thesis are the following:

Annual reports: The FNHA publishes annual reports that include vision, mission, and values statements and provide messages from the board chair and CEO that detail the previous year's operational successes and challenges, and discuss the future direction of the organization. FNHA annual reports include information outlining the specifics of program implementation and service delivery and provide financial and performance reporting.

Five-year plans: The FNHA implemented a five-year plan that would encompass annual service plans and corresponding annual reports starting with the 2016/17 fiscal year and ending in 2020/21. This inaugural five-year plan was extended by a year to include planning and reporting information for the 2021/22 fiscal year due to a number of delays and disruptions caused by the Covid-19 pandemic.

Service plans: The FNHA publishes annual service plans which include the organization's vision mission, and values statements and outline the intended direction of the organization over the course of the year. Operational objectives are outlined along with strategies, key priorities, outcome statements, performance measures, and organization-wide goals. FNHA service plans, annual reports, and the five-year plan are discussed in detail in chapters five and six.

1.4 Positionality Statement

In relation to studying the work of the First Nations Health Authority, I recognize my position as an outside researcher. As I am not a member of a First Nations or Indigenous community, I realize the importance of remaining aware of the unintentional tendency towards both conscious and unconscious bias. My position as a non-Indigenous researcher says who I am not, but who I am is a woman of a visible minority group that has an awareness through lived experience of the relationship between dominant and marginalized cultures. Racism and a palpable sense of being other, different, and excluded at times have been part of this lived experience.

I also remain aware of the fact that the vast majority of studies conducted on Indigenous issues has been by non-Indigenous researchers and this work has oftentimes been perceived by Indigenous people as culturally insensitive. This problem of outsider, western-centric subjectivity colouring the research is one I hope to avoid through conscious self-monitoring, although eliminating all vestiges of researcher subjectivity may not be possible.

Some of the subject matter of this thesis is of a sensitive nature. Topics such as chronic disease and youth suicide rates in Indigenous communities have often been deeply misunderstood and over-represented by non-Indigenous researchers. This points to a painful history that is disrespectful to Indigenous ways of knowing and understanding these complex issues. Mainstream Indigenous health research tends to be reductionist in that participants become mere numbers and statistics, or worse still are portrayed as victims. It is my hope and sincere effort to counter such mistaken and reductionist tropes and centre this research from the perspective of Indigenous strength and self-determination. Although Indigenous health outcomes and statistics are included in this research, this data is used in accordance with the Indigenous principle of *two-eyed seeing*. This key concept refers to research that is informed through “...one eye of Indigenous ways of knowing and from the other eye of Western ways of knowing, and using the strengths, gifts, and insights from both together to gain a more well-rounded perspective” (PHO & FNHA Annual Report, p.7, 2021). This study incorporates the principle of two-eyed seeing by drawing from Indigenous and non-Indigenous scholarship and utilizing statistics that were produced through the inter-office partnership and collaborative effort of the BC Public Health Officer and the Chief Medical Officer of the FNHA.

By including Indigenous voices and Indigenous-led research in this thesis, a more robust and authentic analysis of the issues becomes possible. The creation of the FNHA is a hopeful story demonstrating Indigenous resilience and the power of advocacy and community. I was motivated and drawn to this research as it covers a unique moment and milestone in Canadian history with the founding of the first ever province-wide Indigenous-led health authority in Canada that is supporting the health and wellness of Indigenous people in BC and making a real difference in First Nations communities throughout the Province. This is a success story and I recognize the privilege of a non-Indigenous researcher such as myself in being able to tell it.

1.5 Structure of Thesis

Chapter one provides a brief introduction to the persistent problem of poor health outcomes for Indigenous people in Canada and outlines the significance of the research, project objectives and questions, and positionality statement. Chapter two provides background information that delves further into the nature of the problem introduced in the first section and discusses the persistent health gaps between Indigenous and non-Indigenous people in BC. This discussion is grounded within the broader context of Canada’s history of colonization and draws a line connecting this painful past to the present-day low health status of Indigenous people. This background includes a look at the founding of the First Nations Health Authority (FNHA) and shows the significance of this milestone achievement for the self determination of First Nations people in BC.

The literature review in Chapter three explores the foundational work of scholars researching key concepts in public administration relevant to this study such as strategic planning and organizational performance measurement. This chapter will explore the relationship between strategic planning and organizational performance and draw on several studies to demonstrate how

the former has been shown to impact the latter in important ways. This chapter also discusses the defining qualities and characteristics of Indigenous health governance models and how these systems are poised to overcome the problems of mainstream health systems in countries with a settler/colonial history similar to Canada. This section takes a close look at the health governance model of the First Nations Health Authority to assess what makes it different from the mainstream healthcare system in BC and how these distinct differences can improve the health and wellness of First Nations people in British Columbia. Chapter four on methods and methodology covers the research approach of this study including the strengths and limitations of the selected study design. Chapter five discusses the findings of this research from an in-depth content/document analysis of the FNHA's strategic summary plans and annual reports. Chapter six answers the main research questions and provides an analysis of FNHA strategic planning and performance reporting practices. Chapter seven details strategic implications of the research and includes limitations of the study and avenues for further research and concludes with final thoughts.

Chapter 2: Background

This chapter discusses how top-down approaches by the federal government for the provision of healthcare services to Indigenous communities across the country have failed to address the growing health disparities between Indigenous and non-Indigenous Canadians. As will be shown, a great deal of confusion accompanied critical aspects of conventional forms of Indigenous health services with regard to service delivery, funding arrangements, and accountability. This approach that has prevailed for decades has created barriers for effective service delivery, which has in turn negatively affected Indigenous health outcomes.

The chapter concludes with a look at the founding of the FNHA, which represents a move away from the status quo towards a new approach to Indigenous healthcare that incorporates innovation, collaboration, improved services, and Indigenous self-determination.

2.1 Jurisdictional Gaps for Indigenous Health Services

This section explores the problematic governance framework and issues that undermined the effectiveness of Indigenous healthcare services. A patchwork type approach to Indigenous health services in Canada has led to jurisdictional gaps and an unclear line of accountability for service delivery, implementation, and outcomes (Gallagher, Mendez, & Kehoe, 2015, pg. 255). Up until 2013, these healthcare services were the shared responsibility of the federal and provincial governments in British Columbia. The provision of health services for First Nations communities on-reserve fell under the purview of the federal government through the *Indian Act*; however, under the *Canada Health Act*, each province is required by law to provide healthcare services to all residents within its provincial boundaries including Indigenous people living on and off-reserve (Gallagher, Mendez, & Kehoe, p.255, 2015).

Inadvertently, these pieces of legislation created an overlapping and ambiguous mandate for health service delivery to on-reserve First Nations communities, which at times have created "...gaps, discontinuities, and inadequacies in service. Programs to address health problems are often developed independently by one or more of the provincial, federal, or First Nations partners, so that well intentioned initiatives may create overlaps or duplication" (Transformative Change Accord: First Nations Health Plan, p. 4, 2006). Another critical problem in this multi-jurisdictional healthcare approach was the lack of information sharing and access to data that would allow for programs and services delivered by the differing partners to be seamlessly tracked, analyzed, and assessed for their degree of efficiency and effectiveness. This lack of data sharing hindered the ability to identify emerging issues and led to an evaluation failure regarding which services achieved their outcomes (Transformative Change Accord: First Nations Health Plan, p. 3, 2006).

A landmark report issued in 2001 by the BC Provincial Health Officer signaled a sea change in the decades-long indifference and defeatist position towards the status of Indigenous health in the

province (PHO Annual Report: The Health and Well-being of Aboriginal People in BC, 2001). The extensive annual report dedicated to detailing the health challenges faced by Indigenous communities and the causes of poorer health status officially recognized the jurisdictional and funding flaws in the federal/provincial healthcare systems and the tendencies of this multi-governance framework to produce gaps and inadequacies of services for Indigenous people. The report went further to discuss key measures in improving the delivery of healthcare to Indigenous people in the province including “[g]reater Aboriginal control and involvement in decisions about health services; and improved working relationships with health authorities and service providers” (Office of the Provincial Health Officer, 2002).

2.1 Indigenous Health Outcomes

This section provides a brief overview of the health disparities experienced by Indigenous people as compared with non-Indigenous Canadians. The research included below points to a direct causal link between poorer Indigenous health outcomes and the historical context of colonization. Colonial processes in Canada have led to long-term impacts on Indigenous communities which continue to affect Indigenous health outcomes today. Across major health indicators including life expectancy, infant mortality, and rate of chronic disease, Indigenous peoples fare far worse in terms of health outcomes than their Canadian counterparts (Office of the Provincial Health Officer, 2007). Lavoie, Forget, & Browne (2010) argue that the historical context of colonization and practices of forced assimilation are key determinants in Indigenous health status today. The reservation system, residential schools, the criminal justice system, welfare, the Indian Act, and decades of ineffective and inappropriate health policies and practices have contributed to residual and compounding harm to Indigenous communities (Allen et al., 2020). The effects of these colonial processes that led to the loss of land, language, and culture continue well into the present day and have lasting, deeply internalized, and multi-generational impacts (Jacklin & Warry, 2012).

The link between Canada’s colonial history and present-day effects can be seen in the difference of health outcomes between First Nations and non-First Nations people in the province of BC (O’Neil *et al.*, 2016, p. 230). A joint study by the Government of BC and First Nations leadership in the Province called the *Transformative Change Accord: First Nations Health Plan* found several key concerns relating to the delivery and access of health services for First Nations people. The report was an important initial step forward in recognizing and studying the problems faced by Indigenous people within the Province in terms of accessing the care they need. The report found a critical lack of access to healthcare services for First Nations communities in rural areas, limited general access for First Nations women, and an overall crisis of care in the areas of dental health and mental health and addictions (Transformative Change Accord: First Nations Health Plan, p. 2, 2006). Further the report found significant life expectancy gaps and rates of disease where status First Nations live seven years less than other British Columbians and have a diabetes rate that is 40% higher than the general population (Transformative Change Accord: First Nations Health Plan, p. 3, 2006).

Although these health statistics represent a snapshot in time from over a decade ago, the health status of First Nations people continues to lag across several key indicators. While the joint report set an ambitious agenda to significantly narrow health disparities between First Nations people and other BC residents by 2015, a progress update on the selected indicators showed some improvement, however, five of the seven indicators did not meet their set targets (Office of the Provincial Health Officer & First Nations Health Authority, 2018). The gap reduction target for life expectancy at birth and the mortality rate (deaths due to all causes) aimed towards a 35% reduction; however, while both indicators saw some improvement since the baseline year of 2005, the overall gaps increased as the wider provincial population also made statistical gains in these health outcomes (PHO & FNHA, pp.7-10, 2018). Conversely, the diabetes prevalence rate (per 100 population) worsened for non-First Nations BC residents and thereby artificially narrowed the gap temporarily (PHO & FNHA Annual Report, p.93, 2021). Yet as recent provincial health statistics from 2017/18 show, First Nations people experienced a greater increase in the rate of diabetes than other residents causing the gap to widen once again (PHO & FNHA Annual Report, p.93, 2021).

The progress update showed significant improvement in the youth suicide rate (age 15-24) indicator, which demonstrated a 38% gap reduction between First Nations youth and other young people in the province (PHO & FNHA, p.21, 2018). While the target of a 50% gap reduction was not achieved, meaningful change in the right direction signals progress being made. Another key indicator that is used to assess the broader health of a given population is the infant mortality rate which refers to the number of infants who die during the first year of life, per 1,000 births (PHO & FNHA, p.13, 2018). The gap reduction target for 2015 was 50% between First Nations people and the wider provincial population; however, the gap continued to persist and widened at a rate of 13% (PHO & FNHA, p.21, 2018). Recent data from 2017/18 show that although there has been a successful reduction in infant mortality among First Nations in BC, the overall gap still grew due to a slow reduction of infant deaths in the wider provincial population (PHO & FNHA Annual Report, p.70, 2021).

2.2 Barriers to Effective Service Delivery

There are numerous barriers to effective service delivery in Indigenous healthcare services. Principal among these are government policies and interventions rooted in colonial beliefs and processes (Allan & Smylie, 2015, pp. 5-8). Flawed and inappropriate policies have led to serious deficiencies in the delivery of Indigenous healthcare and have also created structural impediments such as inadequate funding mechanisms (Jacklin & Warry, 2012; Office of the Auditor General, 2015). The 2015 Truth and Reconciliation Commission devotes several of its Calls to Action to address the issue of ineffective government policies and mitigate the health disparities between Indigenous and non-Indigenous people across Canada (Truth and Reconciliation Commission of Canada: Calls to Action, 2015). These recommendations highlight a key feature of the nature of

the problem, which is a lack of recognition in the mainstream health sector of poor Indigenous health outcomes and their causes. The report calls on all levels of government to “...acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties” (Truth and Reconciliation Commission of Canada: Calls to Action, p.2, 2015). Although policy priorities within the BC government began to shift in the late 1990s to formally recognize the problem of chronically poor Indigenous health status in the province, high rates of disease, infant mortality, and the prevalence of accidental injuries continued to persist.

A long history of paternalistic governmental policies has often placed Indigenous peoples in a position of dependency (Jacklin & Warry, 2012). This reliance on a range of federal programs and services in areas such as education, health, water quality, housing, and child and family services has often left Indigenous communities in an even greater state of need and dependence due to an ineffective and inefficient allocation of resources and inherently flawed policies (Wilmot, 2018). Audits of federal programs conducted by the Office of the Auditor General have found serious and persistent deficiencies in the delivery of these services to Indigenous communities (Office of the Auditor General, 2015). The 2011 June Status Report of the Auditor General of Canada highlighted four structural impediments that hindered the delivery of federal programs and services to on-reserve Indigenous communities. These overarching barriers preventing the efficient and effective delivery of public services include lack of clarity about the type and level of services the federal government supports; the absence of a legislative or regulatory framework for programs to support First Nations communities; lack of an appropriate funding mechanism; and the absence of organizations to support local service delivery (Office of the Auditor General, 2015).

The finding by the Auditor General regarding the federal government’s lack of clarity for the type and level of services under its mandate is not surprising in the area of healthcare given that in the province of BC alone, health programs were governed by more than 50 agreements involving 150 First Nations communities (Canadian Medical Association Journal, p.E1228, 2011). Further complicating this haphazard service delivery approach was the added layer of perpetual healthcare pilot projects that rarely developed into long-term, stable, funded programs (Katz, Enns & Kinew, p.E1006, 2017).

2.3 Lack of Indigenous Healthcare Rights

The lack of Indigenous healthcare right within the Canadian legal landscape serves to reinforce and strengthen barriers to effective service delivery in Indigenous healthcare. The absence of a legislative or regulatory framework for Indigenous healthcare rights have led to not only a considerable level of uncertainty regarding the provision of services, but also legal challenges by Indigenous communities claiming healthcare as a fundamental right as enshrined within treaty rights. The Medicine Chest clause in Treaty 6 which stipulates the federal government’s obligation

to protect First Nations people from pestilence and famine and to provide a “medicine chest” is interpreted by Indigenous groups as representing a legal federal responsibility for the provision of healthcare services (Lavoie et al., p.68, 2016). Yet the federal government has argued against this line of reasoning and instead maintained “...the position that the provision of medical care is a matter of policy and not of right. This position is based on the 1966 Supreme Court of Saskatchewan, known as the Johnston appeal, which stated that ‘the [medicine chest] clause itself does not give to the Indians the unrestricted right to the use and benefit of the medicine chest’...Therefore, according to this interpretation, the federal government determines the legitimacy of...the request for healthcare and to allocate it free of charge or at a cost” (Lavoie et al., p.68, 2016).

A corollary to the absence of a legislative framework for Indigenous healthcare rights is the lack of an appropriate funding mechanism for health programs and services. For instance, the federal government through the First Nations and Inuit Health Branch of Health Canada provided a range of health services to Status First Nations on-reserve in BC; however, it became evident that these services lacked the breadth and quality of provincial healthcare services available to off-reserve First Nations people and other BC residents (Office of the Auditor General, 2015). This disparity between federal and provincial healthcare services for First Nations people prompted questions and concerns of equity and fair treatment. Off-reserve First Nations people in BC benefited from higher quality healthcare than First Nations living on-reserve primarily because of the absence of a stable funding mechanism at the federal level. Rather than support long-term funding that would allow for long-term planning, the federal government’s preference was for varied contribution agreements with First Nations that typically had to be renewed yearly and left little room for future healthcare considerations (Office of the Auditor General, 2015).

Given this growing recognition of the problem of persistently poor health status of First Nations in BC as compared to the wider provincial population, representatives of the federal and provincial governments came to the negotiating table along with First Nations leadership to begin the process of repatriating healthcare back into the control of First Nations communities. The tripartite partners found common ground in their shared aim to improve the health and wellness of First Nations people in the province and overcome structural barriers preventing the efficient and effective allocation of services (Evaluation Tripartite Framework, 2019, pp. 18-27). The status quo was seen as no longer acceptable and there was a shared understanding that the solution to the health challenges faced by First Nations communities across the province lay in large part with a new health governance model that would allow First Nations people more control over their own healthcare (Evaluation Tripartite Framework, 2019, pp. 18-27). Working towards this common vision of healthy and vibrant First Nations children, families, and communities facilitated a high degree of collaboration between the tripartite partners and led to an historic achievement with the founding of the First Nations Health Authority, the first province-wide health authority of its kind in Canada.

2.4 Founding of the FNHA

The founding of the FNHA represents a decades-long collaborative effort between key government and Indigenous leaders to create an innovative and novel solution to the persistent problem of alarming health inequalities between Indigenous people in BC and other residents (O’Neil *et al.*, 2016, p. 242). Glaring disparities in health outcomes helped to foment a sustained effort and advocacy movement by First Nations leadership to compel government to act and improve First Nations’ health by closing the gap in outcomes and more broadly to implement systemic changes that would lead to a new governance system for health services that would be inclusive of First Nations’ voices, input, and decision-making (Levesque, 2017). This lobbying campaign to better the health and well-being of First Nations in BC resulted in a high degree of collaboration between the tripartite partners of the Government of Canada, the Government of British Columbia, and the First Nations Leadership Council that represented the BC Assembly of First Nations, the First Nations Summit, and the Union of BC Indian Chiefs (Levesque, 2017).

The period between 2005 and 2011 saw the relatively quick succession of key guiding documents and agreements that committed each party to working together to better the lives of First Nations people in BC (Gallagher, Mendez, & Kehoe, 2015). This period of collaboration marked a turning point and signified a new understanding that the gaps in health outcomes between First Nations and other British Columbians were unacceptable and had to be addressed. There were a number of important steps leading up to the creation of the FNHA including in March 2005 when the Province of British Columbia and the First Nations Leadership Council (FNLC) agree to *The New Relationship* which would be “...guided by principles of trust, recognition, and respect for Aboriginal rights and title. The New Relationship focuses on closing the gaps in quality of life between First Nations and other British Columbians” (Transformative Change Accord: First Nations Health Plan, 2006).

Later that same year, another critical step was taken at the First Ministers’ Meeting on Aboriginal Issues in Kelowna, BC where national Indigenous leaders and First Ministers committed to improving the lives of Indigenous people in Canada in what became known as the Kelowna Accord (Levesque, 2017). Significantly, at this same meeting, the BC government, the Canadian government, and the FNLC take a historic step of their own and sign the *Transformative Change Accord* (TCA) (Levesque, 2017) which puts into place certain goals and indicators of success and sketches the practical outlines of the *New Relationship*. The TCA highlighted three main priorities in a 10-year plan which include closing the gaps between First Nations and other British Columbians in areas of education, health, housing, and economic opportunities; reconciling Aboriginal rights and title with those of the Crown, and remaining committed to the principles of mutual respect and recognition that were established in the *New Relationship* (Transformative Change Accord: First Nations Health Plan, 2006).

Another key milestone in the development of the FNHA came in November 2006 when the BC government and the FNLC agree to the *Transformative Change Accord: First Nations Health Plan* (TCA:FNHP) which identifies twenty-nine actions intended to improve the health status of BC First Nations (Tripartite First Nations Health Plan, 2007). This step was significant for the commitment it created but also because it signaled that First Nations voices were being heard and their authority over Indigenous healthcare was being respected. The TCA:FNHP was based on an earlier document published by the FNLC called *First Nations Health Blueprint for British Columbia* which outlined what the FNLC thought needed to change in the First Nations health sector (Tripartite First Nations Health Plan, 2007).

In June 2007, the FNLC along with the governments of BC and Canada negotiated the *Tripartite First Nations Health Plan* that reaffirmed the commitment of all parties to improving First Nations' health in BC and "...broadly outlines a new health governance system that is intended to promote First Nations involvement and calls for the creation of an autonomous body to run First Nations health programs" (Levesque, p. 5 2017). This visionary agreement that saw the repatriation of healthcare to BC First Nations came to fruition in October 2011 when the Tripartite partners signed the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (BCTFA on FNHG) that formally established the First Nations Health Authority to be part of a new First Nations Health Governance structure "...created by and for First Nations people" (Gallagher, p. 5, 2011). This agreement represents a landmark achievement in Indigenous self-determination. The following two years since the signing of this agreement saw the federal government undergoing a process to transfer its responsibilities, resources, and infrastructure for Indigenous health in BC to the new First Nations health authority (Canadian Medical Association Journal, 2011). Included in this transfer was Ottawa's budget for BC First Nations health which amounted to roughly \$380 million per year to start along with approximately \$83 million in provincial funding (Canadian Medical Association Journal, 2011).

Against this trajectory of collaboration and progress that repatriated healthcare back to First Nations in BC and led to the creation of the FNHA is the backdrop of colonization in Canada. A common point of agreement in the literature is that colonialism is a key contributing factor in the health status of Indigenous peoples in Canada. There is also consensus on the idea that colonialism is not limited to its historical legacy but rather continues to exert its influence through present day Indigenous health policymaking which has evolved from and remains entrenched in colonial systems (Jacklin & Warry, 2012). Far from the distant past, "...traumatizing colonial practices continued well into the 'postcolonial' period. The last residential school continued to operate into the 1990s in Yellowknife, Northwest Territories" (Jacklin & Warry, 2012). This idea of colonialism as an ongoing process helps to explain why various efforts at the provincial and federal levels of government to address Indigenous health disparities have not worked. Building a new nursing station or providing funding for health programs are inherently limited efforts at addressing the crisis of Indigenous ill health because these and other such initiatives fail to address

the underlying root cause of the crisis which is “...systemic racism within health care” (Gouldhawke, p. 1, 2021).

Chapter 3: Literature Review

To ground the primary research conducted for this thesis, a literature review was conducted to provide an overview on strategic planning, organizational performance, and Indigenous health governance systems and characteristics. This foundational information has been drawn upon to discuss major themes, ongoing debates, gaps within the scholarship, and highlight the various connections, comparisons, and contrasts between key researchers. This chapter also explores scholarly literature to assess how strategy and performance concepts are applied to public-sector organizations. The research conducted for this thesis contributes to this broader academic literature with its unique application of traditional management concepts such as strategic planning and performance assessment to the analysis of a newer type of organization, the Indigenous-led health governance model.

As will be shown in this chapter, there is empirical validity underpinning the idea that strategic planning is positively correlated with improved organizational performance. Moreover, this chapter highlights recent efforts within the literature to broaden the concept of performance and move performance reporting beyond the traditional markers of efficiency and effectiveness to include other indicators of success such as democratic outcomes, namely equity and responsiveness to citizen concerns. Following this analysis is an examination of the defining qualities and characteristics of Indigenous health governance models and how these systems are poised to overcome the problems of mainstream health systems in countries with a settler/colonial history similar to Canada. These problems of anti-Indigenous racism, discrimination, poor quality of care, undertreatment, and overtreatment within mainstream healthcare systems are well documented and have fomented a global movement of Indigenous groups reclaiming their health rights by repatriating healthcare back under the management and control of Indigenous communities. The First Nations Health Authority is a prime example of the repatriation of Indigenous healthcare and demonstrates the possibilities for First Nations health and wellness that can be realized through a community-led healthcare model that incorporates traditional healing practices and does not discount Indigenous ways of knowing as is the tendency of mainstream health systems.

The research consolidated in this literature review was collected using two databases: the University of Victoria Summons 2.0 portal and Google Scholar. Search terms and key phrases used to locate scholarly, peer-reviewed sources included: “strategic planning,” “strategic management,” “evaluating public sector annual reports,” “performance information in the public sector,” “public sector accountability,” “organizational performance,” “First Nations governance,” “Indigenous health governance,” “reciprocal accountability,” “traditional Indigenous healing practices,” “racism in healthcare,” “culturally sensitive healthcare,” “Indigenous community-led healthcare initiatives”.

3.1 Defining Strategy and Strategic Planning

The literature for strategic planning within public administration is missing an agreed upon definition of what exactly strategic planning entails as its main components and defining characteristics. Bryson, Edwards, and Slyke offer a useful, narrow, and succinct definition by describing strategic planning as a “...deliberative, disciplined effort to produce fundamental decisions and actions that shape and guide what an organization (or other entity) is, what it does, and why” (2018, p.317). Rumelt (2011) defines strategy as a “...cohesive response to an important challenge” and consisting of a diagnosis, a guiding policy, and coherent action. Boyne and Walker (2010) broaden this problem-centric perspective and envision strategy as a “...means by which organizations can improve their performance and provide better services.”

There is a particular effort within the literature to define key concepts within the field of strategic planning. For instance, the term *strategy* itself varies between those studying and working within the field of strategic planning and management. Aldea, Iacob, Hillegersberg, Quartel, and Franken (2018) coalesce these varying elements and definitions and build what has become a commonly used understanding of strategy as a “...plan or action that an organization takes to realize their objectives” to include the explanation that a strategy also represents “...the understanding of an organization’s assets, position, and their relation to the environment. A strategy must identify, protect, acquire, and sustain critical capabilities, in order to provide mitigation against future uncertainties” (Aldea *et al.*, 2018, p. 86). This fulsome definition of strategy provides a more nuanced understanding of the term, one that incorporates key components that were previously overlooked or underemphasized.

The formal process of organization-level strategic planning in public institutions has a relatively recent history of beginning in the United States in the 1980s after having been in practice in the business and for-profit sector since the 1960s (Bryson, Edwards, and Slyke, 2018, p.318). Aside from sharing similar procedures, tools, and practices in strategic planning, a key distinction in the aim of the exercise between the public and private sectors is a focus on “...distinction in service” not in market share or profit (Deming, 2018, p.5).

3.2 Strategic Management

An extensive search of the literature also shows careful efforts taken by various authors to distinguish between the practices of strategic planning and strategic management. These two areas of practice are closely related but also contain distinct differences that separate them from one another. Rothaermel (2015, p.4) defines strategic management as “the integrative management field that combines *analysis*, *formulation*, and *implementation* in the quest for competitive advantage.” In the public sector, this competitive advantage equates to a firm organizational foundation that positions the agency for superior performance and enables the efficient and effective allocation of resources in alignment with organizational objectives. Walker (2013, p.675) similarly emphasizes performance when describing strategic management as “...organizational

practice that examines the relationships between strategic aims, processes, and content, typically using a contingency framework, which posits that successful organizations adapt to their environment in the pursuit of higher performance”. The view here, as echoed throughout the literature, sees strategic management as a broader set of oversight and monitoring processes designed to increase resilience and shore up the ability to adapt to changing environmental conditions while also enhancing organizational performance. This overarching management framework, of which strategic planning is a critical component, is essential in strategy-making and strategy-implementing processes, especially in the context of a new organization where the mission must be clarified, capabilities analyzed, and the vision, values, and long-term goals of the agency established (McNabb & Lee, 2021, pp 20-21).

These institution-building guideposts serve not only to set the overall direction of the organization but also act as a foundation upon which strategy can be shaped and implemented. As McNabb and Lee explain (2021, p.20), “...[s]trategies that are formed can have meaning and be achievable if they are designed on a foundation of the organization’s core mission and what it wants to achieve.” Thus, in the case of the First Nations Health Authority, strategies that are designed to meet the organization’s goals and objectives must be in alignment with the overall mission which states: “The FNHA supports BC First Nations individuals, families, and communities to achieve and enjoy the highest level health and wellness by: working with them on their health and wellness journeys; honouring traditions and cultures; and championing First Nations health and wellness within the FNHA organization and with all of our partners” (FNHA, 2022).

This mission statement embodies and communicates what strategic management and planning in the public sector are ultimately about, that is, organizational purpose, meaning, values, and virtue (Bryson, 2018, p.132). This succinct yet powerful statement tells the reader what matters most for the FNHA is achieving the highest level of health and wellness for BC First Nations individuals, families, and communities and that the values of collaboration, partnership, and traditional knowledge will inform and be at the centre of the organization’s aims and objectives. A clear and purposeful path forward can act as a catalyst where the mission “...will itself be a source of power for the organization that can have positive effects on performance” (Bryson, 2018, p.133).

3.3 Evidence-Based Strategic Planning

There is agreement in the literature pointing towards the need for more empirical work in the academic field of strategic management and planning research. At present, more data is required to fill in the gaps and provide a more fulsome understanding of how strategic planning works, what the best practices and outcomes are, and what contributes to its success. There are a few key pioneering studies that help to fill these gaps in the literature to a limited extent; however, the consensus is that far more research is needed to broaden and deepen an understanding of strategic planning that sheds light on how and under what conditions it can facilitate more effective government actions (George, 2020). This remains a rich and underexplored area for empirical

research as public-sector strategic planning approaches in both theory and practice vary between differing methods and an overall, cohesive framework is lacking. Moreover, complexity within the field persists as “...strategic planning is not a single thing, but instead consists of a set of concepts, procedures, tools, and practices that combine in different ways to create a variety of *approaches*” (Bryson, Edwards, and Slyke, 2018, p.320).

A notable study cited in the literature sought to bridge this gap between practice and theory within the field of strategic planning was conducted by Lee, McGuire, and Kim (2017) and focused on the problem of homelessness within US counties. More specifically, the study sought to understand what impacts could measurably be observed between strategic plans and the role of collaboration on the one hand, and on the other, the effects of these efforts on the problem of homelessness as tracked by the number of beds made available in US homeless shelters. The central research questions the study sought to answer were “...whether and how the *design* of a *collaboratively* derived strategic plan affects the efforts of government to resolve a public ill” (Lee, McGuire, and Kim, 2017, p.360). For the purposes of the study, collaboration is defined as “...a process whereby two or more entities (and the persons representing the entities) work together to solve a problem that just one entity cannot solve on its own” (Lee, McGuire, and Kim, 2017, p.360).

Using a mixed methods approach and 10-year-long panel design involving 145 county-level strategic plans from 124 county governments, the study (2017) produced three main findings. First, there was a strong causative relationship established between having a strategic plan and having more shelter beds for homeless people. Second, the quality of the strategic plan as indicated by its level of detail and number of components in the plan’s design strongly and positively correlated with a greater number of beds. Third, collaboration among stakeholders was shown to impact the quality of the strategic plan and increase the number of components in the design, which in turn, was significantly and positively associated with an increase in shelter beds. These cause-and-effect findings of the study empirically demonstrate that greater stakeholder engagement and diversity of participation in drafting strategic plans resulting in higher quality plan designs directly equates with an increase in shelter beds for homeless people. Strategic planning theory and literature often draw this link between greater collaboration and richer plan designs maximizing the opportunity for organizational objectives to be realized; however, prior to this landmark study, the empirical data supporting this theoretical and intuitive stance was lacking.

3.4 Strategic Plan Implementation

While there is agreement in the literature that strategic plans are positively associated with improved organizational outcomes and objectives, there is a gap in the research informing the *practice* and *implementation* of strategic planning. As the study discussed above demonstrates, there is a strong causal relationship between a public sector entity having a strategic plan and achieving better organizational outcomes; however, there is limited practical information relating to the ‘how’ question of planning – that is, *how to do* strategic plans successfully. The study does

show that the quality of the plan matters greatly as measured by its various components in realizing organizational aims, but this finding does not detail the processes by which quality is achieved other than demonstrating that increased stakeholder engagement significantly improves the design and quality of the plan (Lee, McGuire, and Kim, 2017). The study's empirical findings are foundational to the theoretical research that posits strategic planning is beneficial and contributes to organizational performance; however, there remains a gap within the literature that goes beyond a limited conceptualization of strategic planning as a prescriptive set of steps to broader insights that practitioners can rely on for the successful drafting and implementation of their strategic plans.

A recent study (George, 2020) set out to address this gap in the literature and provide a more wholistic understanding of the *practice* of strategic planning through evidence-based research. The study entailed using multi-informant and multisource survey data from 127 Flemish municipalities to demonstrate that successful strategic plan implementation is reliant on the interplay between people, process, and the strategic plan itself. These municipalities were chosen as study subjects due in part to the Flemish government's recent requirement that each municipality submit a multiyear plan aimed at increasing accountability and improving overall financial stability. As these local governments shared similar institutional and economic characteristics, they offered the study a relatively homogenous sample group from which to test the study's propositions regarding the variations between people, process, and plan influencing the successful implementation of the strategic plan.

These variables were chosen for their use and ubiquity within the literature (Johnsen, 2015; Bryson, Edwards, and Van Slyke, 2018; Armstrong, Cools, & Sadler-Smith, 2012; George & Desmidt, 2018) and as they are considered "...core concepts within strategic management theory – namely, (1) the cognitive style of the SP team (*people*), (2) procedural rationality and constructive conflict during SP (*process*), and (3) the strategic decision quality of the strategic plan (*plan*)" (George, 2020, p.794). The rationale with the use of these variables is that they are chronologically and causally linked in such a way that determines the implementation of the strategic plan. Thus, the study's main premise is that the people involved in strategic planning will necessarily influence the process, which in turn, will affect the quality of the strategic plan, and ultimately these three elements will influence the implementation of the strategic plan (George, 2020).

The cognitive style of the strategic planning team refers to the dominant or favoured approach of information processing which includes three main styles: a creating style, a knowing style, and a planning style (Armstrong, Cools, & Sadler-Smith, 2012, p. 252). 'Creators' as part of the SP team can be thought of as those people who like variety, new ideas, innovation and tend to look for creative solutions and avoid routine (George, 2020, p.797). Individuals who can be classified as 'knowers' have strong analytical skills and tend to assess and process information through a logical, rational, and impersonal lens; these team members "...make informed decisions on the

basis of a thorough analysis of facts and figures and rational arguments” (Armstrong, Cools, & Sadler-Smith, 2012, p. 252). The ‘planner’ type team member tends to be well prepared and prioritizes time management, decisive agendas, and detailed action plans (George, 2020, p.794). It is argued (George et al., 2018) that these varied cognitive styles that are each associated with differing preferential approaches to information processing will influence how teams actually engage in the practice of strategic planning, thereby linking *people* and *process* together in a causal relationship.

Within strategic management theory, the process of strategic planning is seen to have two main components or sub-processes. The first of these sub-processes is procedural rationality which refers to the extent that the SP team scans its environment to search for and analyze information and utilize analytical tools to identify, isolate, and focus on crucial information during strategic planning (George, 2020, p.794). The second component underlying the process of strategic planning is constructive conflict which points to the dynamic of the SP team and whether there is a free flow of ideas and viewpoints where team members can openly debate and disagree on information in a give-and-take manner (George, 2020, p.794). Both of these sub-processes of the strategic planning process “...ensure that strategic plans are grounded in the best available information, with a clear understanding of issues and viewpoints, as opposed to being grounded in the whim of the day or the perspective of overly dominant leaders, thus raising the quality of the plan as a set of strategic decisions” (George, 2020, p.794).

The final link in the chain of causation for strategic plan implementation is the plan itself which is often overlooked within the literature as an important antecedent of successful implementation. Depending on the defining characteristics of the people and process links, the plan can vary significantly in quality and therefore impact the likelihood of its successful execution and administration. Hence, a low-quality plan is less likely to succeed in the implementation phase as compared to a plan of substance with high strategic decision quality which “...makes it clear to the organization and its stakeholders what it wants to achieve, how, and why – thus encouraging the actual implementation of the strategic plan” (George, 2020, p.795).

Taken together then, the study of Flemish municipalities did indeed prove a causal pathway between people, process, and plan and successful strategic plan implementation. The findings from the survey data demonstrate that ‘creators’ as part of the SP team facilitate procedural rationality during the planning process but not necessarily constructive conflict, while involving ‘knowers’ and ‘planners’ was seen to have no significant impact. Further, the study found that procedural rationality and constructive conflict are positively and significantly associated with the strategic decision quality of the strategic plan; however, it is unclear from the findings how constructive conflict is a factor in plan quality as this sub-process is not statistically significant in the survey data and does not demonstrate a causal relationship. If constructive conflict does not positively correlate to the various cognitive styles of creating, knowing, and planning, there could be other

team characteristics to encourage this method of information sharing and processing such as expertise in SP, functional diversity, and demographic diversity. The study further found that the strategic decision quality of the strategic plan, developed from the sub-processes of procedural rationality and constructive conflict, is positively and significantly associated with successful strategic plan implementation.

3.5 Strategic Planning Smart Practices

An extensive search of the literature shows general agreement between researchers in the field that the practice of strategic planning does not conform to a set of prescriptive and routinized set of steps that can be checked off a list as carried out, but rather is a highly contingent and specified process designed to meet the unique needs of each individual public sector organization (George, 2017; Walker, 2013; Johnsen, 2015). For instance, an organization's strategic stance will be shaped by how it responds to various problems, issues, and potential solutions related to its policy sphere or service area given available organizational resources and capacity constraints (Johnsen, 2015). Although there is no one-size-fits-all approach to strategic planning given the unique qualities particular of differing public organizations in terms of strategy choices, environmental conditions, and internal processes and structures, the literature points to fundamental practices and conditions thought of as necessary for successful strategy formulation and strategic plan implementation (George, 2020). Sufficient organizational support and resources are required to facilitate formalized strategic planning practices such as stakeholder engagement, strategy formulation based on an assessment of organizational objectives, and environmental scanning that analyzes both internal and external conditions.

Given that the practice of strategic planning lacks conformity, the literature often refers to the typology developed in the pioneering work of Miles and Snow (1978) to help characterize and categorize various strategic planning approaches adopted by public sector organizations and distill which practices generated the best results. The strategic archetypes of *defender*, *prospecter*, *analyzer*, and *reactor* developed by Miles and Snow illustrate the varied ways in which organizations respond to their environments and adapt to change either in a way that maximizes or hinders performance. A *prospecter* organization can be described as proactive, future-oriented, and seeking new opportunities to apply innovations to existing services and opportunities whereas a *defender* type is more focused on core business, efficiency, maintaining a stable portfolio of services that are delivered reliably, and adopting tried and tested innovations (Walker, 2013, pp. 676-677). The *analyzer* type can best be described as a hybrid strategy borrowing from aspects of both the prospecter and defender categories. This type of organization seeks risk adjusted efficiency and is on the lookout for new ideas but waits to adopt only those practices that appear to be the most promising (Walker, 2013, p.677). The final *reactor* type of organization stands apart from the other types in that it lacks a consistent and coherent strategy and only takes action when compelled to do so by powerful actors in its environment such as higher levels of government or regulatory agencies (Walker, 2013, p.677).

These varying strategy types are adopted by organizations in accordance with their particular set of circumstances and as a response to environmental cues and conditions. Prospectors tend to favour incremental approaches to strategy formulation and implementation as well as decentralized structures that allow for quick and nimble reaction to their environment, whereas defenders operate in centralized structures and use a more methodical approach characterized by extensive formal planning, collecting and analyzing large amounts of data on service needs, evaluating options for meeting those needs, and utilizing sophisticated cost/benefit analyses (Bryson, Berry, and Yang, 2010, p.510; Walker, 2013, p.677). Analyzers chart a hybrid path of intermediate structures and processes that are contingent on whether a proactive or more conservative strategy is pursued, and reactor types fare the worst outcomes in terms of performance due to their lack of strategy and inconsistent structures and processes (Walker, 2013, p.677). Bryson, Berry, and Yang (2010, p.510) highlight that this framework of varying types draws a distinction between strategic stance and strategic actions where the former refers to the "...extent to which the agency is proactive or reactive...whereas strategic actions focus on substantive approaches to markets, services, revenues, external organizational relations, and internal organizational relations. A strategy thus is a combination of both stance and actions."

Diverging from Miles and Snow (1978) who proposed that organizations adopt a single strategic archetype, Boyne and Walker (2004) argue that strategies can be mixed and combined to improve agency adaptability and performance. The ability to adapt to a changing environment with its flux of challenges and opportunities is particularly important for public sector organizations given the unpredictability and changing nature of political leadership and priorities which could impact the strategies of public agencies (Walker, 2013, p.680). Moreover, pursuing a mix of strategies allows for increased flexibility which public managers can make use of when choosing between competing objectives and having to "...trade off different performance outcomes in the management of their organizations" (Walker, 2013, p.680).

In accordance with Miles and Snow's proposition regarding organizational performance, Boyne and Walker (2010) determined that the prospecting and defending strategy types outperform reacting. This should not be seen as too surprising given that reacting is a passive organizational posture that is marked by its absence of a coherent and consistent strategy. A cautionary note in the literature regarding the dangers of this passive stance indicates that public organizations taking "...instruction from major stakeholders' demands and organizations in the environment are likely to drift toward a reactor stance and will likely see a decline in their performance" (Walker, 2013, p.680). Conversely, prospecting strategies marked by experimentation, innovation, and the search for new markets and services along with strategy qualities related to defending such as a commitment to maintaining existing services and spheres of influence while improving efficiency are deliberative and proactive strategic stances that positively correlate with enhanced organizational performance.

While there is a tendency in the literature to view reacting as a strategic failure or 'lemon' (Miles and Snow, 1978; Andrews, Boyne, Law, and Walker, 2012), some authors are careful to offer a more nuanced perspective and argue that reactor strategies can be purposeful and are best suited for organizations responding to citizen needs and demands or regulator requirements (Meier et al., 2007, p.362). In many cases, the reactor types "...cede their environmental strategy to regulators (or organizations that create rules and procedures for the reacting organization) who then set the organization's priorities" (Meier et al., 2007, p.362).

The causal connection between strategy, environment, and performance has been demonstrated in several public sector studies. Andrews, Boyne, Law, and Walker (2012) used the context of Welsh local government to study the effects of external conditions on strategy implementation and organizational performance. A key finding of the study showed that strategic aims are best achieved in stable environments where the complexity of external conditions relating to economic, social, or political factors is minimal. It was further found that the effectiveness of varying strategy types and content was similarly vulnerable to dynamic external conditions and performance suffered for organizations whether they were engaged in prospecting, defending, or reacting. The research data of Owens and Kukla-Acevedo (2012) assessing network diversity and organizational performance gathered from over 500 school districts in Texas echo the findings of the Welsh study that successful strategic execution is more likely in a stable environment. These studies demonstrate an inverse relationship between strategy and environment where greater institutional resources are required as external stability decreases. In mitigating the negative impacts and uncertainty of dynamic external conditions, public managers must dedicate more of their time and resources as compared with what is needed when operating in a technical environment that is straightforward and simple.

Although strategies work best in stable environments, public sector organizations must be prepared with a set of best practices that will support strategic effectiveness in the face of complex and rapidly changing external conditions. Andrews, Boyne, Law, and Walker (2012) show that one such best practice is the adoption of an incremental style of strategy implementation. As this approach is less rigid than highly centralized and structured strategic processes, it offers the public agency the ability to be flexible and adapt strategies as they are implemented in response to changing environmental conditions (pp. 102-105, 159). Adopting a mix of strategies, rather than relying on a single approach, is another best practice that public organizations can use to proactively respond to environmental uncertainties and challenges. A prospecting strategy characterized by its proactive stance that actively seeks new opportunities to apply innovations to existing services is ideally suited to meet the demands of changing organizational contexts (Walker, 2013, pp. 676-677). However, a defending strategy that focuses on core services that are delivered reliably and at low cost while maintaining centralized structures to facilitate formal

planning, data collection, and organizational evaluation is best suited when the external environment has some degree of predictability and stability (Walker, 2013, pp. 676-677).

3.6 Organizational Performance and Reporting

There is a commonality in the literature on performance reporting for public sector organizations that indicates a consensus on the chronology or point of origin for when a focus on performance measurement and reporting became a priority and requirement for government agencies. McGeough, 2014; Gerrish, 2015; and Walker and Andrews, 2013 all point towards the New Public Management (NPM) movement beginning approximately in the mid-1980s as the catalyst for a greater focus and emphasis on achieving results through strategic planning and performance measurement. The thinking behind NPM was to make public sector organizations more ‘business-like’ in the sense that efficiency and effectiveness would become the hallmark indicators of organizational success. The influence of NPM reforms and private sector management practices in public organizations is evident by the degree to which performance measurement and reporting have grown to become central concepts within the field of public administration research and practice. Andersen, Boesen, and Pedersen (2016, p. 852) argue that the proliferation of performance literature in recent decades points to performance as “...an important – possibly *the* most important – concept in public administration”. Broadly defined, performance can be thought of as the “...actual achievement of a unit relative to its intended achievements, such as the attainment of goals and objectives” (Jung, 2011, p. 195). The way that actual achievements are assessed and evaluated against intended achievements is through the use of *performance criteria* such as efficiency or effectiveness. For instance, in the case of the FNHA, this performance assessment could be measured as the extent to which the organization achieved

In an effort to refine and further clarify the concept of performance as applied to public organizations, Andersen, Boesen, and Pedersen (2016) go beyond the face-value of various performance criteria to analyze the systematic differences of key individual indicators. Applying a critical lens to the conceptualization of performance criteria not only opens the evaluative space to be more inclusive of other relevant indicators that are typically left out of performance assessments such as equal access to services, but also delineates differing aspects of performance criteria. Andersen, Boesen, and Pedersen (2016) distinguish between a *performance criterion* “...as a theoretically defined standard based on achievements that can be evaluated” (p. 853) and a *conceptual space* which in contrast “...consists of one or more *distinctions* representing various qualities or characteristics of criteria corresponding to how these criteria are judged to be similar or different” (p. 853).

For instance, effectiveness is an example of a performance criterion; in the case of a hospital, effectiveness could refer to a measure of ER wait times. Broadening the conceptual space for this performance criterion would facilitate a more robust analysis by going a step further to determine “...which stakeholder decided that effectiveness should be a performance criterion for the

organization in question” (p. 853). This work to systematize performance indicators is useful in discerning what is included and what is left out of performance assessments and why. Moreover, for a robust performance assessment, it is necessary to determine the unit of analysis, whether the criteria being used are subjective, formal or informal, and which, if any, process or product focus is evaluated (Andersen, Boesen, and Pedersen, 2016).

Commensurate with the centrality of the concept of performance is its widely debated nature within the literature. As somewhat of a pushback on the business-like and market standards ushered into public sector organizations by the NPM movement, some scholars have argued that a myopic focus on efficiency and effectiveness is counterproductive to a broader understanding of the governance of public services inclusive of other performance measures related to democratic outcomes such as responsiveness and accountability (Walker & Andrews, 2013, pp. 103-104). These policy debates regarding the most salient performance indicators for public organizations “...have often been shaped by a contest between economic theories of government that focus on the pursuit of economies of size and scope and political theories that regard closeness and responsiveness to the citizenry as the *raison d’etre* of local units of government” (Walker & Andrews, 2013, p. 104).

This ongoing debate within the literature on the best suited variables with which to judge organizational performance fails to articulate the notion that this central concept within public management research and practice is flexible and able to adapt to varying organizational settings. Organizational performance is not a single, invariant thing but rather a multidimensional construct with varying performance indicators that can be tailored and individualized to the unique characteristics of any given organization to assess and evaluate performance. The debate or contest between the use of more traditional concepts in judging performance such as efficiency, effectiveness, and financial performance as opposed to more democratic-related concepts such as societal outcomes and responsiveness to the citizenry need not be an either/or divide, but rather the discussion on organizational performance could be expanded to take note of its rather broad applicability to varying organizational contexts. Whereas some government organizations that are less public-facing may benefit from a more classical approach of assessing efficiency gains and financial performance, other public sector settings with more citizen engagement may be best suited to other evaluative indicators such as responsiveness in addition to effectiveness, efficiency, and financial outcomes. A promising sign of a move in this direction towards a more holistic and inclusive understanding of the concept of organizational performance are more recent contributions to the literature (Walker and Andrews, 2013; Andersen, Boesen, and Pedersen, 2016; George, Walker, and Monster, 2019). This recent research includes varying indicators and uses of organizational performance and debunks the theory that this is a unidimensional construct which is inherently limited in its applicability.

Given that organizational performance in the public sector is a contested concept within the literature (Johnsen, 2005; Walker *et al.*, 2018) and the importance of varying performance indicators are also debated, two main models to help inform the conceptualization of organizational performance have been developed. The 3Es model links together key performance indicators that focus on the economy, efficiency, and effectiveness of public service delivery. The measurement of ‘economy’ refers to the “...cost of procuring specific service inputs (facilities, staff, equipment) for a given product/service. ‘Efficiency’ refers to the cost per unit of output, as well as a measurement of user satisfaction levels derived from the responsiveness of services to public preferences. ‘Effectiveness’ is the measure of goal alignment and actual achievement of service objectives (Walker and Andrews, 2013, p.103).

A noticeable ‘E’ indicator missing from this model is ‘equity’. The efficient allocation of resources is undoubtedly an important indicator of organizational performance; however, equity concerns and the fair distribution of services across different groups is arguably as equally important. The trend in recent years to include GBA+ analysis in evaluations of government programs and services is an encouraging sign that equity indicators are increasingly relied upon to assess performance. Similar to the 3Es model, the inputs-outputs-outcomes (IOO) model is designed to measure the relationship between required resources (inputs) and the quantity and/or quality of products or services delivered (outputs) (McGeough, 2014, p. 3; Walker and Andrews, 2013, p. 103-104). An important difference however is that the outcomes indicator of the IOO model goes beyond measuring efficiency and is used for assessing equity and impact concerns as it measures the effect that public policies and services have on recipients. While both of these models offer a baseline from which to evaluate public service performance, there is general agreement within the literature that these indicators are limited and could be broadened to include other dimensions of performance such as transparency, accountability, governance, and democratic outcomes (Walker, Boyne, and Brewer, 2010; Walker and Andrews, 2013; Andersen, Boesen, and Pedersen, 2016; George, Walker, and Monster, 2019).

Another area of debate within the literature, in addition to researchers identifying the most salient performance indicators while discrediting others, concerns the relationship between strategic planning (SP) and organizational performance (OP) and the extent to which the former positively or negatively impacts the latter. Notwithstanding the sheer popularity of strategic planning as a preferred management approach and its status as among the five most consistently popular managerial approaches worldwide (Rigby and Bilodeau, 2013; Wolf and Floyd, 2017), the effectiveness of strategy formulation and implementation processes has had its fair share of critique and even outright condemnation with one scholar going so far as to describe the approach as the “big lie of SP” (Martin, 2014). Proponents of SP argue that that this management tool is popular for a reason, that is, because it works to improve organizational performance. Moreover, this line of thinking extends, SP assists managers and teams in identifying internal and external conditions that can be used towards finding the ideal fit between the organization and its

environment. Further, SP facilitates processes of thorough analysis that inform and ground an approach to decision-making that is both systematic and strategic. And finally, SP offers a formalized process to chart and map out concrete goals, plans, and strategies that are designed to illustrate what an organization wants to achieve and how.

While supporters of SP argue that the benefits of this approach for organizational performance are undeniable, others have criticized strategic planning for being "...overly rational and for inhibiting strategic thinking" (George, Walker, and Monster, 2019, p.810). One of the earliest and most vocal detractors of SP was Mintzberg (1994) who argued that strategic planning and strategic thinking are not one and the same and the former may actually hinder or undermine the latter (p.12-13). Mintzberg discusses the so-called pitfalls to planning such as a lack of top management support for the process and organizational climates not congenial to planning but goes further to identify what he perceives to be the real problems that lay deeper than these pitfalls (p. 12-15). Undermining true strategic thinking is a set of fallacies, notably about "...the capabilities of predicting discontinuities, about being able to detach strategists from the subjects of their strategy making, and about being able to formalize the strategy making process in the first place" (Mintzberg, 1994, p. 12).

Referencing and building on Mintzberg's critiques, Martin (2014) highlights the point that 'strategy' and 'planning' are two separate and distinct processes that are often conflated in the literature. Whereas strategy is flexible, deliberate, and adaptable to rapidly changing conditions in the environment, planning masquerades as strategy but is instead a fixed plan that is designed to respond or confront a future that can only be guessed at and explicitly limits or cuts off entirely possibilities and options (Martin, 2014, pp. 1-4). This critique of strategic planning holds that true strategy is responsive to challenges in real time and is about "...placing bets and making hard choices. The objective is not to eliminate risk but to increase the odds of success" (Martin, 2014, p. 1). These views of strategic planning as an exercise in rigidity and unresponsiveness tend towards reductionism and miss a wholistic understanding of SP. The primary idea behind these critiques is that strategy and planning are mutually exclusive processes, that one necessarily precludes the other. However, the planning part of SP need not interfere with strategy-making as both processes can work together to facilitate the formulation of goals, strategies, and plans while also encouraging a strategic stance that is flexible and capable of responding to unforeseen challenges and rapidly changing environmental conditions.

In response to this ongoing debate over the effectiveness of strategic planning, George, Walker, and Monster (2019) undertook a meta-analysis of 87 correlations from 31 empirical studies to determine whether SP improves organizational performance. The study found that strategic planning does indeed demonstrate a positive, moderate, and significant impact on organizational performance in the public and private sectors, across international settings. These findings that suggest beneficial outcomes related to SP contradict many of the critiques of strategic planning

and further demonstrate that it should be part of the standard managerial approaches used in contemporary organizations. An important caveat to the study's overall findings that showed the impact of SP in enhancing organizational effectiveness (in terms of successfully achieving goals), is that strategic planning demonstrated no positive correlation in achieving efficiency gains (George, Walker, and Monster, 2019).

In stark contrast to Mintzberg's prediction (1994) of the fall of SP more than a quarter of a century ago, this study demonstrates empirical validity for significant performance benefits stemming from strategic planning. Mintzberg and fellow critics viewed strategic planning as an overly rational and prescriptive process that ultimately inhibited true strategic thinking. However, the findings from this meta-analysis and other studies (George, 2017) demonstrate that the popularity of SP is indeed merited and that positive outcomes can be attributed to the strategic planning process. As these studies show, while the benefits of SP for organizational performance are real, they are not predetermined as a result of an organization undertaking strategic planning as a requisite, mechanical process. Rather, positive organizational outcomes, such as enhanced effectiveness and engagement, are contingent on how the SP process is conducted (Bryson, 2015). Therefore, it is not a given that strategic planning will automatically result in improved organizational performance – simply having a plan is not enough.

One of the qualities that makes SP particularly effective in generating beneficial outcomes is the degree to which the process is comprehensive, meaning that sufficient resources are given to ensure careful deliberation and consideration of many available options. A comprehensive SP process is an informed one where clear strategies and goals are developed through a robust analysis of the internal and external environment and a range of options and possible courses of action are generated. These strategic options are then carefully considered and weighed against their potential merits and drawbacks before final decisions are made and the plan moved towards the implementation phase.

This type of fulsome SP process requires "...strategic reasoning ability – that is, having human resources with the ability to generate, evaluate, and select relevant strategies for the organization" (George, Walker, and Monster, 2019). Given this particular skillset, it is not surprising that recent research (George, 2017; George, Walker, and Monster, 2019) has drawn a link between the effectiveness of strategic plans and the people involved in the SP process. George *et al.* (2016) found through their study's survey data that a participatory SP process involving both internal, lower-level staff and external stakeholders such as citizens has been shown to result in positive outcomes. Typically, these groups have been left out of the planning process, oftentimes leading to a lack of well-informed, citizen-centric plans reflecting a narrow, top-down process (George *et al.*, 2016). Opening the planning process up and making it more participatory can produce better outcomes; however, there is a fine balance to be struck here as too much stakeholder involvement in the SP process can derail planning efforts with its added complexity.

3.7 Indigenous Health Governance in BC

The founding of the First Nations Health Authority represents a significant step towards the recognition of Indigenous sovereignty and the right to self-determination for First Nations people in BC. The term sovereignty refers to the idea of authority and “...implies the supreme power from which all specific political powers are derived” (Shrinkhal, 2021, p. 72). Therefore, self-determination can be thought of as a natural extension or expression of sovereignty leading to autonomous decision-making and the “power of choice in action” (RCAP Volume 2, 1996). Indigenous claims to sovereignty in Canada were gaining momentum and increasingly effective during the closing years of the 20th century. Set against the backdrop of successful land claim settlements, precedent-setting legal cases, and the publication of the Royal Commission on Aboriginal Peoples that advocated for sweeping change with its recommendations in several areas for increasing Indigenous autonomy, political leaders could no longer dismiss or downplay Indigenous calls for greater recognition, respect, and equality.

This momentum towards Indigenous sovereignty and self-determination was strengthened by the Supreme Court of Canada’s 1997 decision in the *Delgamuukw v. British Columbia* case where the Court found that Aboriginal title in the Province was never extinguished or transferred as a result of European conquest and colonization (Roth, 2002, p. 150). Although the ruling did not go as far as the First Nations plaintiffs would have wanted in establishing absolute Aboriginal ownership and jurisdiction to the exclusion of the Crown over contested provincial lands, the *Delgamuukw* decision was seen by many as a “...blow to the legacy of colonialism” (Borrows, 1999, p. 542). A succession of key cases over the years including *Calder*, *Guerin*, *Sparrow*, and *Haida Nation* signify the progress of Canadian jurisprudence towards reconciliation with Indigenous peoples (Borrows, 2015, p. 711). Another important step in recognizing Aboriginal title and rights came in the *Tsilhqot’in Nation v. British Columbia* decision when the Supreme Court of Canada affirmed the Constitution’s recognition of pre-existing legal systems in Canada prior to European contact (Borrows, 2015, p. 703). The Court’s recognition in 2014 of the existence of Aboriginal law previous to European claims of sovereignty in present-day Canada upholds Aboriginal title and a collection of rights in accordance with the doctrine of continuity (Borrows, 2015, p. 704). These key cases along with Section 35 of the *Constitution Act, 1982* that recognizes and affirms existing Aboriginal and treaty rights, uphold the inherent right to Aboriginal self-government. Accordingly, First Nations in BC have the legal, constitutional right to self-determination and decision-making authority over matters impacting First Nations communities including control over the sphere of healthcare.

The establishment of the First Nations Health Authority and its broader Indigenous-led governance structure marks a truly unique and historic approach to health service design and delivery for Indigenous people in Canada. For far too long, the mainstream healthcare system was the only option for First Nations people living in BC who wanted or needed access to health services. However, this system has often caused more harm than good for Indigenous patients seeking

medical care. There is a strong consensus within the literature that the mainstream Western healthcare system has done a great disservice to Indigenous people in Canada due to its insidious racism and tendency to deliver culturally insensitive and inappropriate care (Baba and Reading, 2012; O’Neil *et al.*, 2016; Harfield *et al.*, 2018; McCallum and Boyer, 2018; Lewis, Williams, and Jones, 2020; Turpel-Lafond, 2020). The literature is replete with examples of negative impacts, harms, and even death occurring as a result of Indigenous people coming into contact with the mainstream healthcare system (Boyer, 2017; Browne *et al.*, 2022). Notably, Mary Ellen Turpel-Lafond (2020), a Canadian lawyer, judge, and advocate, recently undertook an investigative approach to uncover the often unseen or hidden (at least to non-Indigenous observers) racism that pervades the BC healthcare system. The end result of this investigative work is a thorough and revealing report (2020) that sheds light on the systemic racism faced by Indigenous people in BC when accessing healthcare. The report offers an inside and in-depth look at a healthcare system that is vastly different than the one seen and experienced by non-Indigenous people in BC. The findings include a number of detailed personal accounts from Indigenous people describing the racist and discriminatory treatment that they were subjected to by healthcare workers. The following is one Indigenous woman’s devastating account from the report of how she was treated in a BC hospital after undergoing surgery:

Racist Treatment After Surgeries Leaves Woman Fearing Hospitals

Within the last two years, an Indigenous woman from a remote community in B.C. has twice travelled to a hospital in a larger centre to undergo surgery for brain aneurysms. On both occasions, she has experienced racist treatment from the recovery room nurses.

The woman describes waking up from the first surgery in 2018 feeling very unwell, needing to vomit but with dry heaves. She recalls one of the nurses yelling at her across the recovery room: *“You’re going through withdrawal; it’s from all the alcohol you people drink; you’ll have to wait for your booze.”* She says she was subsequently moved to a different room for three days where she got no nursing assistance.

The same thing happened in the recovery room in 2019, where she came-to feeling very sick and dry heaving. Once again, a nurse made reference to alcohol, suggesting she was going through withdrawal with the comment: *“You people drink too much.”*

The woman hadn’t been drinking before either surgery and wonders if she was having a reaction to the drugs used to sedate her. The woman inquired about getting help from an Aboriginal Health worker but was told none were available and no one advised her about the patient complaint process. Complaints to her surgeon went unanswered.

These experiences have left the woman so fearful that she plans to refuse any future surgeries. She feels the risk to her safety is higher attending this hospital than it would be living with an aneurysm. She says she was treated in a way no human being should be treated and is frightened that the lack of treatment could result in her dying.

This type of discriminatory and harmful experience endured by this Indigenous woman is indicative of a wider problem of systemic racism within the BC healthcare system that impacts many more Indigenous people within the Province (Turpel-Lafond, 2020). This Indigenous-

specific racism within BC's healthcare system is symptomatic of Canada's colonial history and centuries-old subjugation of Indigenous people (Boyer, 2017, pp. E1408-E1409; Turpel-Lafond, 2020, pp. 6-7). As this legacy of oppression is deeply rooted within the Canadian socio-cultural context, multi-tiered and system-level efforts to address and uproot anti-Indigenous racism within healthcare are needed. These efforts must be transformational at their core and support healthcare cultures, policies, and practices that prioritize health equity. The founding of the FNHA is a vital contribution to this transformational process that is occurring within the broader context of reconciliation. In accordance with the Truth and Reconciliation's Calls to Action, there has been a push across the areas of child welfare, education, justice, and health to redress harms and renew the relationship between Indigenous and non-Indigenous Canadians (O'Neil *et al.*, 2016, p. 232). A key component of this renewed relationship is greater Indigenous autonomy and jurisdictional authority. In the spirit of reconciliation, the relationship between Indigenous and non-Indigenous people must evolve and allow for more meaningful forms of political, economic, and socio-cultural empowerment for Indigenous Canadians. The FNHA is a realization of this vision of reconciliation. The creation of a First Nations health governance structure rooted within the ideals of partnership and Indigenous self-determination "...can be understood as an enactment of many of the aims, principles, and calls to action outlined by the TRC" (O'Neil *et al.*, 2016, p. 233).

Indigenous self-determination in the area of healthcare is crucial in counteracting the high incidence of Indigenous-specific racism and discrimination in the mainstream healthcare system. Although the first of its kind in Canada, the FNHA is part of a broader movement of Indigenous populations around the world establishing Indigenous-specific primary healthcare services, designed for, and managed by Indigenous people. The literature demonstrates several notable examples of Indigenous groups in various settler/colonial countries that have made significant strides in repatriating healthcare services back into the control of Indigenous communities. In Columbia, a non-profit health insurance company called *Anas Wayuu* was established in 2001 by two Indigenous associations representing 120 different Indigenous communities and includes a wide network of health centres, clinics, and hospitals offering essential health services that complement the mainstream system but also provide traditional Indigenous medicine and care (Lavoie *et al.*, 2016). *Anas Wayuu* provides its patients culturally safe and appropriate care, including the option to receive services in the local Indigenous language (Lavoie *et al.*, 2016). Similar to *Anas Wayuu*, this type of Indigenous-led healthcare is demonstrating its effectiveness in delivering responsive care and improving health outcomes in other settler/colonial countries such as Australia, New Zealand, and the US (Lavoie *et al.*, 2016).

This global movement of Indigenous populations mobilizing to regain autonomy over healthcare is driven by the prevalence of racism in the mainstream system and the persistence of health inequities between Indigenous and non-Indigenous people (Achan *et al.*, 2021). However, another driving force to repatriate healthcare back into Indigenous communities stems from the fundamental difference and disconnect between mainstream Western medical care and traditional

Indigenous healing practices. Although these two medical modalities can come together and complement one another, they remain worlds apart. Whereas Western medicine approaches healthcare from a disease perspective, primarily concerned with the diagnosis and treatment of illness, traditional Indigenous health philosophy advocates for a holistic approach where “...nothing beneficial to health is left out of health planning and implementation” (Achan *et al.*, 2021, pg. 1). This broad and inclusive type of Indigenous healthcare relies on a range of healing practices that are often overlooked by the mainstream health system such as ceremonies, plant, animal, or mineral-based medicines, energetic therapies, and physical or hands-on techniques (FNHA, 2022). These healing practices are designed to treat the whole person including their emotional and spiritual health rather than limited to the treatment of a specific malady. The founding of the FNHA represents an opportunity for the integration of traditional Indigenous healing knowledge with the biomedicine model of care, thus offering Indigenous patients comprehensive care that incorporates treatment as well as holistic health promotion programs (FNHA, 2023). This evolution of BC’s healthcare system means that Indigenous patients have greater access to comprehensive, culturally appropriate care that offers the real possibility of achieving health equity in the Province by narrowing and ultimately closing the persistent health gaps between Indigenous and non-Indigenous people living in BC (PHO & FNHA Annual Report, 2021).

Given the poorer health outcomes of Indigenous people and the failure of mainstream health services to adequately meet the needs of Indigenous communities in BC, a new health governance model rooted in Indigenous values was needed to address the ongoing health crisis. The FNHA health governance structure is first and foremost committed to and guided by the value of community (FNHA, 2022). Through a process of ongoing engagement, the health authority receives direction from community leadership and First Nations groups throughout the Province on a number of issues affecting the health and wellness of Indigenous people (FNHA, 2022). The literature demonstrates that this community engagement and community-led governance model is a primary factor in the success of Indigenous healthcare services over mainstream systems in improving the health of Indigenous communities (Harfield *et al.*, 2018, p. 2). This model is particularly effective in improving health outcomes because it is “...underpinned by the values and principles of the communities” that are served (Harfield *et al.*, 2018, p. 2). This community-informed health services model is in stark contrast to the longstanding status quo of dismissing Indigenous perspectives on health and wellness in the design and delivery of Indigenous health services which instead “...were guided by the *Indian Act* and controlled by distant federal government offices with little or no insight into the health needs of the communities they served (O’Neil *et al.*, 2016, p. 230).

A key characteristic of the First Nations health governance structure in BC is the notion of *reciprocal accountability* which points to the renewed and strengthened relationships between the Tripartite and regional partners in working together to deliver innovative health solutions and support First Nations decision-making (Evaluation Tripartite Framework, 2019). This system of

shared accountability between representatives of First Nations leadership, Health Canada, the BC Ministry of Health, and the regional health authorities facilitates improved coordination, relationships, and understandings between these various health organizations and outlines a mutual responsibility to monitor and evaluate progress (O’Neil *et al.*, 2016, 232). While there is much praise for this idea of reciprocal accountability and its potential to improve collaboration and heighten transparency between key partners, the literature also highlights certain limitations of this novel governance approach. What makes reciprocal accountability in the context of the FNHA particularly unique is the absence of a traditional chain of accountability where one entity is explicitly answerable to another. In place of a more conventional structure of responsibility, “...an alternative model has been used to define the relationships between these bodies” (Wilmot, 2018, p. 290). Instead of a top-down approach, the parties can hold one another accountable through processes of discussion, engagement, and ultimately negotiation (Wilmot, 2018, p. 290). On the surface level, this type of mutual accountability seems like a positive development; however, a closer look at the Tripartite agreements reveals a rather one-sided obligation where “...the accountability framework currently focuses solely on the FNHA’s responsibilities to its funder” (Dwyer *et al.*, 2014, p. 1099). In addition to the FNHA, there are other First Nations health organizations in Canada that are working to implement a process of mutual accountability where all parties involved are answerable to one another (Dwyer *et al.*, 2014, p. 1099).

Dwyer *et al.* (2014) note that shifting Indigenous health governance models away from top-down processes of accountability is a necessary skill and that “...developing such a skill is an integral part of the self-government project, and essential to the refinement of approaches to accountability and to contractual instruments” (p. 1099). Whereas some scholars may argue that the agreements between the Tripartite partners do not demonstrate clear lines of shared accountability, which to a limited extent is true, there is in practice evidence of reciprocal responsibility and transparency. In 2017, an evaluation was conducted of Health Canada’s role as a governance partner in supporting the transfer of responsibilities from the federal First Nations and Inuit Health Branch to the newly created First Nations Health Authority in October 2013. The evaluation found that Health Canada adhered to the concept of reciprocal accountability and supported the FNHA through processes of stakeholder engagement, the development of new partnerships, and open access to other federal departments and agencies (Evaluation Tripartite Framework, 2019, p. 13). Therefore, what may be lacking in a contractual sense in terms of accountability, there is evidence that the ideal of reciprocal accountability between the Tripartite partners is alive and well in practice.

In addition to community informed decision making and reciprocal accountability, other characteristics contributing to the success of Indigenous-led healthcare models over mainstream systems in improving Indigenous health outcomes include accessible health services, continuous quality improvement, a culturally appropriate and skilled workforce, flexible approaches to care, holistic healthcare, and self-determination and empowerment (Harfield *et al.*, 2018, pp. 4-11). A meta-analysis of Indigenous primary healthcare service delivery models from several

settler/colonial countries including Canada found these particular qualities to be present in many Indigenous-led healthcare systems and a key source of their success (Harfield *et al.*, 2018). The value and significance of this study is particularly pronounced as the analysis was led by an Indigenous researcher who helped inform the process with an understanding of Indigenous beliefs, values, and experiences.

A key finding of the study is that culture is the most prominent characteristic and acts as a foundational factor supporting the other eight characteristics (Harfield *et al.*, 2018). Further evidenced by this review was the interdependent nature of these various qualities and their global application throughout Indigenous primary healthcare service delivery models (Harfield *et al.*, 2018). An example of this interdependence is seen when Indigenous staff in healthcare settings are able to offer holistic and flexible care with their knowledge and awareness of community cultural values, customs, and beliefs. This culturally appropriate care further embeds and strengthens the role of culture within service delivery and reinforces the vital function of the other characteristics. The centrality of culture in connecting these key qualities of Indigenous-led healthcare is depicted in the figure below and demonstrates how culture is critical to “...ensuring community participation, enabling Indigenous ownership and governance by engaging communities, and engaging in quality improvement processes and defining outcomes and indicators” (Harfield *et al.*, 2018, p. 6).



Figure 2: Characteristics of Indigenous Primary Health Care Service Delivery Models

The governance model of the FNHA as demonstrated in part by its seven directives align with the characteristics of Indigenous-led healthcare models as discussed in the findings of the above noted study. A guiding principle of the FNHA to “lead with culture” shows a clear congruence with the centrality of culture found in other Indigenous service delivery models (FNHA, 2022). The health authority’s directives were formalized through in-depth processes of stakeholder and community engagement and include the following: community-driven, Nation-based; increase First Nations decision-making and control; improve services; foster meaningful collaboration and partnership; develop human and economic capacity; be without prejudice to First Nations interests; and function at a high operational standard (FNHA, 2022). In helping to fulfill these directives, the health authority is flanked by its governance partners, the First Nations Health Council (FNHC) and the First Nations Health Directors Association (FNHDA). The FNHC is the political arm of this governance structure and takes a leadership role in health advocacy, research, policy and planning, and the implementation of the First Nations Health Plans (Consensus Paper, 2011). The FNHC is a regionally representative body with three members appointed by each of the five regions in BC, and it is tasked with political and advocacy functions including, but not limited to, promoting the transfer of health services to local and regional levels where possible and developing strategic partnerships with other First Nations organizations and government ministries and departments (Consensus Paper, 2011). Complementing and supporting these efforts, the FNHDA acts as a technical advisory body to the FNHC and the FNHA on matters relating to policy, program planning and design, and the implementation of First Nations Health Plans (Guidebook: Building Blocks for Transformation, 2013, pp. 36-37). The membership of the FNHDA is comprised of health directors and managers working in First Nations communities and it is the responsibility of this body to support the education efforts, knowledge transfer, professional development, and best practices of senior-level staff; moreover, the FNHDA is tasked with taking the lead on implementing transparent and effective governance processes (Guidebook: Building Blocks for Transformation, 2013, pp. 36-37).

As discussed above, community engagement and involvement in decision-making is a key feature of Indigenous-led healthcare service delivery models and contributes in large part to their success. This is certainly the case with the FNHA which has formalized engagement processes central to, and built-in, its governance structure. The “Engagement and Approval Pathway” is a community participation and consensus building model by which the FNHA and FNHC gathers input and guidance from First Nations communities, chiefs, health leaders, front-line health workers, federal and provincial partners, and other key decision makers in BC First Nations health in order to inform and support the health and wellness work of the organization (FNHA, 2022). This five-step process is grounded in the concept of reciprocal accountability and the ideals of the seven directives and includes engagement, discussion and developing options, summarizing areas of agreement, building consensus, and ratification (FNHA, 2022).

This model, which is at the heart of FNHA operations, gives First Nations people a say in their own healthcare and allows community members to contribute to priority-setting and ongoing improvement initiatives within the organization. This grassroots approach to healthcare service delivery was a collective effort designed by BC First Nations and adopted as part of Resolution 2011-01 at *Gathering Wisdom for a Shared Journey IV* which is an innovative engagement forum that takes place annually and attracts healthcare professionals, government officials, and First Nations leadership (Consensus Paper, 2011; FNHA, 2022). This unique conference represents just one of many numerous engagement initiatives that inform FNHA operations and service delivery. Meetings and engagement sessions at the provincial, regional, sub-regional, and community levels provide direction and feedback for key governance functions and directly inform and influence decision-making. The FNHA governance structure is emblematic of a self-determining and community-driven organization where First Nations people in BC have the opportunity to play an active role in their personal and collective wellness.

3.8 Conclusion

This chapter has discussed the main themes of this research including strategic planning and management, organizational performance measurement, and First Nations governance characteristics both within the FNHA and other Indigenous healthcare service delivery models in countries with a similar settler/colonial history as Canada. The literature for strategic planning offered key insights into this often-misunderstood management tool and showed its evolution from the private sector to its use in public sector organizational planning as part of the New Public Management movement. Although there is a certain level of complexity associated with strategic planning due to its lack of an agreed upon definition within the literature and its varying set of concepts, procedures, tools, and practices that combine in different ways to create a variety of approaches, several key researchers working in the field have purposefully moved towards a more practical rather than theoretical understanding of strategic planning so as to simplify its application for practitioners. These researchers have identified a set of best practices while at the same time cautioning that there is no one-size-fits-all approach given the unique qualities particular to differing public organizations in terms of strategy choices, environmental conditions, and internal processes and structures. However, notwithstanding the highly contingent nature of strategic planning, the literature points to fundamental practices and conditions thought of as necessary for successful strategy formulation and strategic plan implementation. Sufficient organizational support and resources are required to facilitate formalized strategic planning practices such as stakeholder engagement, strategy formulation based on an assessment of organizational objectives, and environmental scanning that analyzes both internal and external conditions.

Next, this chapter discussed organizational performance and measurement which, similar to strategic planning, has its roots within the set of public sector reforms known as New Public Management. In an attempt to make government agencies and departments more ‘business-like’ and efficient, public-sector managers became increasingly focused on organizational performance

and measurement. This preoccupation with performance within public sector organizations is likely why the concept of performance has grown to become possibly the most important concept in public administration. In response to the popularity of performance measurement, the literature cautions that too much focus on efficiency and effectiveness can be counterproductive to a broader understanding of the governance of public services inclusive of other performance measures related to democratic outcomes such as responsiveness and accountability.

This cautionary note highlights an ongoing debate within the literature regarding the best suited variables with which to judge organizational performance. Some scholars with a less entrenched view of performance reporting point to the concept's flexible nature and its adaptability to varying organizational settings. They argue that organizational performance is not a single, invariant thing but rather a multidimensional construct with varying performance indicators that can be tailored and individualized to the unique characteristics of any given organization to assess and evaluate performance. This section also discussed the two main models of organizational performance as identified within the literature including the 3Es model which uses economy, efficiency, and effectiveness as its performance indicators and the inputs-outputs-outcomes (IOO) model which is designed to measure the relationship between required resources (inputs) and the quantity and/or quality of products or services delivered (outputs). An important difference between the two performance models is that the outcomes indicator of the IOO model goes beyond measuring efficiency and is used for assessing equity and impact concerns as it measures the effect that public policies and services have on recipients. This section concludes with a discussion of the relationship between strategic planning and organizational performance and the extent to which the former positively or negatively impacts the latter. This relationship has had its fair share of criticism from detractors and is at the center of a longstanding debate over the effectiveness of strategic planning and its overall impact on organizational performance.

Next, this chapter moved on to a discussion of the key traits of Indigenous-led healthcare service delivery models as identified within the literature and took a close look at the specific health governance structure of the FNHA. This section highlighted the harms faced by Indigenous people when accessing care through the mainstream health system. The prevalence of anti-Indigenous racism and discrimination within BC's healthcare system is well documented in the recent investigative report *In Plain Sight* by Mary Ellen Turpel-Lafond. The findings of this report with its abundant evidence of widespread racism echo what Indigenous people in BC have been saying for years – that the mainstream health system is dangerous for Indigenous patients due to its pervasive discriminatory treatment including stereotyping, disrespectful personal interactions, and poorer quality of care.

As shown in the literature, Indigenous-specific racism and poor health outcomes are common among mainstream healthcare systems in various settler colonial countries such as Canada, there has been a global movement by Indigenous groups to repatriate healthcare back into the control of

their communities. This devolution of healthcare down to the community level provides Indigenous patients greater access to comprehensive, culturally appropriate care that offers the real possibility of closing the persistent health gaps between Indigenous and non-Indigenous people around the world.

Given the poorer health outcomes of Indigenous people and the failure of mainstream health services to adequately meet the needs of Indigenous communities in BC, a new health governance model rooted in Indigenous values was developed to address the ongoing health crisis.

The following table identifies the main themes in the literature review and those areas researched in the primary research:

| Theme in Literature Review | Link to Primary Research |
|------------------------------------|---|
| Strategic planning smart practices | Content analysis of FNHA service plans p. 43 |
| Organizational performance | FNHA performance measures pg. 45 |
| Performance indicators | Development of FNHA performance indicators and reporting process pg. 48 |

Chapter 4: Methodology and Methods

This chapter outlines the methodology and methods used to address this study's central research question: *How have the FNHA annual reports, five-year plan, and service plans changed in content since their inception?*

This research did not require ethical review or approval from the University of Victoria Human Research Ethics Board as no human participants were involved in the research process. Data collection methods did not entail any ethical considerations as FNHA service plans and annual reports are publicly available on the main FNHA website. It is important to note, however, that as a non-Indigenous person conducting research on an Indigenous organization, a culturally respectful process was followed throughout this study. The research methodology and methods utilized prioritize Indigenous-produced resources and content that reflect Indigenous values, beliefs, and ways of knowing. BC First Nations perspectives on health and wellness are highlighted in this research and include views encompassing the importance of traditional healing practices, cultural safety and humility, and community wellness that includes but extends beyond the health of the individual.

4.1 Methodology

This research study utilized a qualitative research design with two primary components, a literature review and a document analysis. An exploratory research approach is used in this thesis to analyze FNHA service plans and annual reports and address research questions. An exploratory methodology was chosen as it is ideally suited for research where there is no prior relevant information available on the research topic. As there is no prior targeted research on FNHA plans and annual reports, an exploratory methodology lends itself to investigating this previously under explored area and increase knowledge on this topic.

Although this research does not include the direct participation of First Nations individuals, it has been a primary aim to incorporate Indigenous voices throughout this study through the inclusion of research by Indigenous scholars, health data produced by and in partnership with the First Nations Health Authority, and with interview excerpts from Indigenous participants from relevant studies. Indigenous knowledge is prioritized within this research, which can be a decolonizing process as once marginalized voices are brought to the forefront to shape and inform the research process (Chilisa & Tsheko, 2014). The integration of Indigenous sources of data and scholarship within this study support an ethical and culturally respectful process that amplifies Indigenous voices, values and worldviews. The inclusive approach of two-eyed seeing which is rooted in the idea that there are multiple ways of knowing and understanding was essential to this study's overall methodology. In analyzing FNHA plans and reports, the two-eyed seeing approach was useful in bringing together western concepts of strategic planning and performance reporting with Indigenous ways of knowing and being. This approach was used throughout the research process

but was particularly helpful when reviewing health data and Indigenous health outcomes as it allowed for a broader perspective that saw the resilience and many strengths of First Nations people and contextualized health disparities alongside the success story of the founding of the FNHA. Two-eyed seeing fostered a holistic understanding where FNHA strategic planning and annual reporting processes were seen together, rather than apart from, Indigenous values and traditions such as the importance of culture, reciprocal accountability, and community engagement. As this approach recognizes the value and validity of both western and Indigenous knowledge systems, it was useful in helping to integrate typically separate and distinct worldviews into a coherent, inclusive, and whole perspective.

Grounding this study within an Indigenous-centric perspective was essential in overcoming a deficit-based view typical of many research initiatives in favour of emphasizing a resilience perspective that draws on the strengths, achievements, and contributions of Indigenous people (Drawson, Toombs, & Mushquash, 2017, p. 13). This resilience perspective is rooted in the concept of an inherent right of self-determination that is inclusive of healthcare rights. The starting point and central premise of this research study is that Indigenous autonomy and authority over the sphere of healthcare is not only highly beneficial for First Nations health and wellness, but also critical to improving health outcomes and closing persistent gaps in health indicators. Healthcare that is provided by and for First Nations is an expression of the principle of self-determination and ensures a higher quality of care and more culturally appropriate services for First Nations than the mainstream system alone provides. While this study recognizes the problem of health disparities between Indigenous and non-Indigenous Canadians, it frames this issue within the wider context of Indigenous self-determination, strength, and resilience.

Utilizing an Indigenous research approach in this study by incorporating Indigenous knowledge was critical to understanding the health and wellness concerns of Indigenous communities in BC. An Indigenous research approach prioritizes Indigenous values, traditions, and knowledge (Drawson, Toombs, & Mushquash, 2017). By drawing on Indigenous scholarship and document sources produced by the FNHA, Indigenous values, beliefs, and ways of knowing are represented within this research. Moreover, this Indigenous methodology is necessary to “...prevent the prioritization of Western ways of knowing, which is common in most scientific pursuits” (Drawson, Toombs, & Mushquash, 2017, p. 13). Prioritizing marginalized voices over the dominant worldview is an important aspect of Indigenous research efforts, as is conducting research that is respectful, collaborative, and relational.

Aside from these general points of agreement within the literature to reflect and respect Indigenous voices, cultural beliefs, and ways of knowing, there is no specified process or set of steps that constitutes an Indigenous research method or methodology. There is an important commonality within Indigenous research methods to avoid a problem-centric or deficits-based perspective. A systematic review by Drawson, Toombs, and Mushquash (2017) of Indigenous research methods and methodologies in peer-reviewed literature identified the use of a wide array of approaches including storytelling, yarning, culture-specific methods, and community-based participatory

research. Throughout this diversity of approaches, the review further found the absence of an overarching, cohesive framework or agreed upon definition of what Indigenous research is and how such efforts differ from mainstream research practices. Generally, there was little effort within this reviewed literature to operationalize terminology and provide a definition of Indigenous research methodology, with the exception of Makomenaw (2012): “one where the researcher understands the role of Indigenous history, culture, language, and self-determination in the lives of Indigenous Peoples” (p.858). Given this definition of Indigenous methodology, the present study is informed by these criteria as the story of self-determination and empowerment are central themes in this body of work and are set against the backdrop of both culture and history.

In addition to an Indigenous research methodology, this study also employs a comparative lens for a longitudinal analysis of nearly a decade of strategic plans and annual reports. This methodology is particularly helpful in assessing how these documents have evolved or changed over time and identifying those components that were resistant to change. A comparative methodology is used in this study to compare and contrast data across different time periods and to track fluctuations in the variables of interest.

4.2 Methods

To answer the primary research question of this thesis and determine the extent to which there is congruency between the FNHA service plans and annual reports, data analysis and document review methods were used to collect data.

A document review was conducted on FNHA service plans and annual reports beginning with the first fiscal year of operations (2013/14) and ending with the plans and reports for the current year of reporting (2021/22). This first step was used to identify the main components of FNHA service plans, which include the following elements: vision statement, mission statement, values, goals, outcome statements, organization chart, objectives, strategies, key priorities, annual key priorities, performance measures, and directives.

The document review method was used as a next step to analyze FNHA annual reports and determine its main components which include: vision statement, mission statement, values, message from the board chair, message from the CEO, financial report, goals, outcome statements, organizational chart, objectives, strategies, key priorities, annual key priorities, performance measures, and directives. To note, not all components listed here appeared in every year’s service plan and annual report. As will be discussed in greater detail in the following chapter, these documents changed in format and content from year to year.

4.3 Data Analysis

The next step was to sort and analyze the data that had been gathered. Each year’s plan was compared to the corresponding annual report. Excel spreadsheets were used to categorize the various components of FNHA service plans and annual reports (see attached appendices). Content

analysis was the main research tool used to identify certain words, themes, concepts, and categories within FNHA service plans and annual reports. This method was also used to analyze and quantify patterns such as similarities or differences within the documents. For instance, Excel was used to track how many goals or performance indicators were outlined in a particular year's service plan and annual report and show how these units of measurement evolved over the course of FNHA operations. The quantification of this type of qualitative data is useful in identifying patterns and drawing meaning from the text.

As the number and level of detail associated with goals and performance indicators grows, it can point to the maturing of a newer organization and indicate the presence of more resources being dedicated to organizational planning and reporting. Content analysis was used in this research study as it can be particularly useful in tracking change and development within an organizational setting. Given that plans and reports are generated annually, the documents can be compared to identify certain trends and changes. Even subtle changes within these documents can signal substantive developments. For instance, the 2015/16 FNHA annual report included goals as previous years' reports; however, this particular year's goals were not focused on the transition of authority and responsibilities from the federal government to the FNHA. This subtle change in the nature and direction of organizational goals signaled a turning point for the FNHA and an institutional shift away from managing the interim period of operations towards broadening its reach and mandate beyond day-to-day operations to program development designed to meet client needs.

4.4 Strengths and Limitations

A content analysis approach with the use of documentary data such as an organization's service plans and annual reports has both strengths and limitations. In terms of what makes this method preferable over other types of qualitative research such as interviews and focus groups, a content/document analysis is arguably a more efficient and less time-consuming approach to gathering data. Typically, the research method of content analysis relies on the use of documentation that is already available as opposed to other qualitative research methods where data must be generated from the observations, interactions, beliefs, values, behaviours and perceptions of research participants. Additionally, this content analysis approach that analyzes FNHA service plans and annual reports is ideally suited to fit with an Indigenous research paradigm as this data collection method relies on organizational literature that is produced by First Nations and reflects culturally relevant and respectful information and data points.

By using FNHA materials to assess planning and reporting practices, First Nations perspectives on health and wellness are reflected throughout this research process. For instance, performance indicators used in FNHA annual reports to measure progress made towards various goals reflect First Nations values, voices, and worldviews. Rather than conventional concepts of performance that are overly concerned with measures of efficiency, the FNHA uses a suite of indicators that are meaningful to BC First Nations such as reporting on community engagement efforts, reciprocal

accountability, and regional integration. Another advantage of content analysis over other types of qualitative methods is that a research ethics review process is often not required as this type of research does not directly involve human participants. A further strength of the content analysis approach is the availability of required resources. Many documents are publicly available and obtainable without special permission, as is the case with FNHA service plans and annual reports. This availability of documents adds to the efficiency argument for the content analysis method of research as this approach involves more of a process of data selection than data generation which requires far fewer resources such as time and human participants.

Another key advantage of conducting a document analysis is its inherent unobtrusiveness as compared to field research methods where participant/researcher bias can impact the quality of data collected. The potential for bias and lack of rigor are common critiques levied against qualitative research methods. In countering such concerns, and guarding research efforts against tendencies towards bias, *reflexivity* in qualitative research is considered critically necessary and an integral component of the research process itself. Mackieson *et al.* define reflexivity as "...the researcher's awareness of the influence they are having on what they are studying and, simultaneously, of how the research process is affecting them" (2018, p. 3). Although a document analysis approach is not altogether immune from concerns related to reflexivity, this method is significantly less prone to issues of bias and influence that are inherent in other qualitative research methods. Unlike human participants taking part in a study, documents are unaffected by the research process and do not react or change as a result of being observed.

Notwithstanding the noted strengths of document analysis as a research method, this approach does have its drawbacks. The readily available nature of many documents was cited as an advantage of document analysis; however, a caveat to this availability is that the sheer volume of documentary data to analyze may undermine the research endeavour altogether. Establishing clear boundaries of analysis at the outset can help to streamline data collection and avoid the process of sorting through large amounts of data that can overwhelm the researcher and become a conceptually complex task (Mackieson *et al.*, 2018, pp. 5-6). Another limitation to consider with document analysis is that although there may be a significant amount of documentary data available with broad coverage, this data may not offer the relevance and level of detail required for the purposes of the research. Conversely, the research may be hindered not by too many sources of data, but by not enough. Bowen (2009) highlights the problem of *low retrievability* where required documentation is not available or retrievable as access to documents can sometimes be deliberately blocked (p. 32). Assessing these limitations against the strengths of a document analysis, the efficiency and unobtrusive nature of this approach in particular made it the ideal qualitative research method for this study, not to mention its suitability in answering the research questions.

Chapter 5: Findings

This chapter presents the findings of this study that have been observed through a systematic content analysis of the summary service plans and annual reports of the First Nations Health Authority (FNHA). The format of these plans, including their main components, will be discussed. Tables in appendices A through I outline a detailed comparison of FNHA plan goals and performance measures as captured in service plans and annual reports over nearly a decade of FNHA operations. Changes in various plan and report components are detailed in appendices J and K.

5.1 Summary Service Plans

Since the founding of the FNHA in 2013, there have been nine summary service plans to date produced by the organization. The first three years' plans are referred to as interim health plans as this was a period of significant transition during which staff, programs, services, and funding were being transferred from the First Nations and Inuit Health Branch of Health Canada to the newly established offices of the FNHA. Following this period of transition, the FNHA implemented its five-year health plan format comprised of the annual summary service plans from 2016/17 to 2020/21. Together these plans were designed to set a stable and predictable path forward for the new health authority. There is a high degree of continuity in the plans over this five-year period as the FNHA had chosen a set of four main organization-wide goals to focus on which include the following: Enhance First Nations health governance; Champion the BC First Nations Perspective on health and wellness; Advance excellence in programs and services; and Operate as an efficient, effective, and excellent First Nations health organization. These goals have in turn influenced the continuity of the outcome statements, objectives, and strategies as outlined in the plans. Due to the dual health crises of the Covid-19 pandemic and the opioid overdose crisis in BC, this first five-year health plan was extended to include the 2021/22 summary service plan with a renewed five-year plan to be introduced in the next fiscal year.

A common thread throughout the summary service plans over the past nine-year period is the strong emphasis on a BC First Nations perspective and community engagement to inform the FNHA planning process. Each plan outlines the health planning approach as beginning with citizen engagement at the community level which informs First Nations community health and wellness plans that in turn inform the FNHA interim health plans, the summary service plans, the FNHDA strategic plan, and the FNHC strategic plan. Taken together, this bottom-up approach to planning then influences the Tripartite planning process between First Nations leadership and the provincial and federal levels of government. Another significant commonality found in the summary service plans is a strong regional emphasis with the establishment of regional health and wellness plans, strengthened regional governance processes, and planned approaches to improve partnerships across the provincial healthcare ecosystem. This regional lens stems in part from the FNHA

mandate to move decision-making closer to home through successful collaboration with First Nations communities, regional health authorities, and other health system partners.

The inaugural summary service plan of 2013/14 entitled “A Year in Transition” emphasizes service continuity as its operational focus as funding, programs, and services are transferred from the FNIHB to the FNHA in a phased approach that began July 2, 2013 and concluded October 1, 2013. A key priority of this plan was to ensure a seamless transition and avoid service disruption through ongoing diligence, change management, and careful planning. During this ‘transfer’ period, there was close coordination and cooperation between the FNIHB and the FNHA to oversee the novation of all contribution agreements and ensure service continuity. While one of the main priorities of this plan is to ensure a smooth transition of Health Canada responsibilities to the FNHA, it also lays the foundation for the new health authority by outlining its vision, organizational structure, departmental priorities, engagement processes, interim health goals, and the seven directives. The following year’s interim plan builds on this foundation by introducing the shared values of the FNHA, FNHDA, and FNHC. These values of respect, discipline, relationships, culture, excellence, and fairness have remained consistent throughout the multi-year summary service plans.

The goals of these first two interim health plans reflect the priorities of the successful transfer of services and organizational development and include: Transition, Governance and Decision-Making, Health Services and Improvements, Partnerships, and Leadership, Organizational Development, and Planning. These initial plans also introduce the foundational concept of *reciprocal accountability* which outlines the system of shared responsibility between the FNHA and its governance partners. This idea of a collective sense of accountability is repeated throughout successive plans and conveys the traditional First Nations belief that each member of the community plays a part and contributes to the overall wellness of the whole community. The phrase “We are now all simultaneously owners and customers” underscores this notion of reciprocal accountability and is often repeated throughout FNHA plans.

The third interim health plan acts as a bridge between successive plans and the first two plans that were primarily focused on the historic transfer of services from Health Canada to the FNHA in that its goals shift away from managing the transition period towards a more future-oriented focus that prioritizes efficient and effective governance processes and high operational standards. These goals in the third plan act as a precursor to the set of four main organization-wide goals that appear in the following six plans and take more of a similar form than the goals in the previous two health plans. The format of the plans remains relatively consistent throughout the nine-year period with slight variation between earlier plans that included transition outcomes and later plans that added results-oriented data points highlighting progress made in health services utilization and improving First Nations health status across several key indicators including primary health care, mental health and wellness, and maternal and child health. There are some notable changes between the first- and second-year interim health plans that indicate a certain level of organizational maturing or development is taking place. These changes include the addition of a mission statement and

organizational values in the 2014/15 interim health plan. These foundational components remain consistent throughout successive plans and appear in each of the following seven plans along with other bedrock elements such as organizational vision and the seven directives which have been included, and remain unchanged, throughout all nine summary service plans.

5.2 Goals, Outcome Statements, Objectives, and Strategies

A mainstay of all the summary service plans throughout the nine years of FNHA operations is the inclusion of goals. As noted above, these goals remain unchanged in the plans from 2016/17 to 2020/21 that together make up the five-year health plan. Accompanying these goals in the five-year health plan are outcome statements which articulate the desired changed state resulting from actions taken in alignment with organizational goals over the five-year period. These outcome statements include: Sustainable and accountable governance structures leading change; Culturally safe and supported health and wellness journeys; Advancements in the quality and cultural safety of programs and services available to First Nations individuals, families, and communities in BC; and, FNHA is an established leading edge First Nations health organization.

Along with each goal and outcome statement are a set of three objectives, except with goal #2 (Champion the BC First Nations Perspective on health and wellness) which has two accompanying objectives. The aim of these objectives is to operationalize the goals and describe how each goal will be achieved. Furthermore, each objective is paired with a set of three strategy statements that are intended to describe the specific mechanisms and processes by which each objective will be achieved. The start of the five-year plan in 2016/17 also included annual key priorities that accompanied each of the objectives and were added to highlight specific core areas of focus for each fiscal year. There were no annual key priorities in the initial three interim plans; however, with the start of the five-year health plan, this indicator was added and appeared in four of the six successive plans. Unlike the goals, outcome statements, objectives, and strategies in the six summary strategic plans that make up the five-year health plan, the annual key priorities change in number, content, and frequency. Whereas these other components are fixed and unchanging over the six-year period from 2016/17 to 2021/22, the annual key priorities are more fluid.

The findings above regarding summary service plans and their constituent goals, outcome statements, objectives, and strategies are mainly from the six-year period comprising the five-year health plan. Whereas the interim service plans from 2013/14 to 2015/16 articulate various goals, their format and content differ significantly from the plans that follow. The inaugural plan stands out not only because it is the first FNHA service plan but also because its content differs so significantly from other plans in that it has no outcome statements, objectives, or strategies. Rather this plan uses different language and indicators to highlight its mandate such as organizational priority areas, milestones, and initiatives. The other two interim plans also do not have any outcome statements; however, they do contain strategies and the inclusion of objectives starts with the third interim service plan of 2015/16.

5.3 Performance Measures and New Developments

The inaugural summary service plan of 2013/14 contains goals, priorities, and initiatives but no performance measurement indicators. A section in this initial plan entitled ‘Evaluation and Reporting’ briefly outlines the plan to develop an evaluation framework that will be in alignment with other evaluation and reporting processes such as the tripartite evaluation of the implementation of the Framework Agreement and also include meaningful health and wellness indicators. Another key criterion in the development of this new evaluation and reporting process is that an assessment of organizational performance needs to be linked to a planning cycle that is anchored in the regular Gathering Wisdom conferences (Interim Health Plan, 2013/14, p. 15). The second interim health plan of 2014/15 does not include any performance measures; however, this plan does note the challenge of “A significant number of accountability planning and evaluation requirements and expectations” (Interim Health Plan, 2014/15, p. 16). The third interim health plan of 2015/16 notes that the FNHA is developing a performance measurement approach and outlines four initial high-level performance indicators including: First Nations are satisfied with Regional Caucuses; First Nations’ participation in wellness challenges, screenings, and programs increases; Services delivered to and by First Nations increase; and FNHA investments leverage or generate additional resources in support of First Nations health and wellness (Interim Health Plan, 2015/16, p. 33).

With the introduction of the 2016/17 summary service plan that launched the start of the five-year health plan, between one and three performance indicators follows each of the four fixed goals that the organization focused on in the years since (Annex D). The following plan in 2017/18 outlines between one and two performance indicators for each of the four fixed goals that remain unchanged, other than slight modifications, over the course of successive plans to the current year (Annex E). In addition to these fixed performance indicators between 2017/18 and 2021/22, the 2017/18 summary service plan introduced three organizational excellence health performance standards which include: Annual board of director review of corporate policies on target; the percentage of compliance with inclusion of Directives and Operating Principles in decision-making processes; and the percentage of staff performance partnership agreements completed, including staff wellness plans (Summary Service Plan, 2017/18, p. 31).

Although the plans from 2016/17 to 2021/22 have a fairly fixed format and use the same templated language each year, there were some notable new developments or added components. For instance, the 2017/18 plan includes a section referring to the 2015 Truth and Reconciliation Commission’s final report including its Calls to Action and notes the opportunity for the FNHA to contribute to the national process of healing through advancing and making progress on the health and wellness related priorities outlined by the Commission (Summary Service Plan, 2017/18, p. 9). The 2018/19 plan includes the addition of a new section called “Reflecting on our Progress” which outlines a number of statistics and indicators in key areas of FNHA operations including cultural safety and humility; data governance and knowledge development; program and service reviews; partnerships; primary health care; mental health and wellness; health benefits; and

maternal and child health. This year's plan also includes "Appendix A: The FNHA and The Truth and Reconciliation Commission of Canada" which goes beyond the seven health-specific Calls to Action to include justice reforms and initiatives to work with Indigenous offenders in the criminal justice system to advance a broader healing and wellness-based approach that is in alignment with and supports the TRC's national project of reconciliation (Summary Service Plan, 2018/19, p. 43). The following year's plan in 2019/20 includes the addition of seven organization-wide key priorities: 1. Evolving the FNHA operating model, including regionalization; 2. Renewed partnerships with First Nations; 3. Wellness; 4. Knowledge development and exchange; 5. Cultural safety and humility; 6. Service excellence - mental health and wellness, primary health care, and health benefits; and 7. Leadership and culture development (Summary Service Plan, 2019/20, pp. 35-43). In light of the Covid-19 pandemic and the worsening opioid overdose crisis, this list of key priorities was amended in the 2021/22 plan to replace the first priority regarding evolving the FNHA operating model to focus on public health emergencies (Summary Service Plan, 2021/22, p. 36).

5.4 Annual Reports

Whereas the FNHA summary service plans after 2015/16 are fairly fixed in format and content, the annual reports differ significantly in that they are much more dynamic and detailed. The annual reports do have a basic templated format in that each report opens with a message from the Board Chair, a message from the CEO, and is structured in accordance with the goals from the summary service plans; however, beyond this broad outline, the annual reports are replete with highly detailed information regarding various organizational initiatives, developments, and milestones that change from year to year. The first FNHA annual report in 2011/12 preceded the launch of the health authority in 2013 and reported on various First Nations health initiatives and progress achieved towards implementing the *British Columbia Tripartite Framework Agreement on First Nations Health Governance*. The letter from the chair and message from the CEO that open the report outline the historic process involving the transitioning of the *First Nations Health Society* into the *Interim First Nations Health Authority*. There are no specified performance measurement outcomes contained in this interim report; however, there is a table of milestone resolutions accompanied by a 'progress to date' list that indicates each action item as complete, near complete, or ongoing (Annual Report, 2011/12, p. 5). This interim annual report is paired with other reporting documents including interim FNHA audited financial statements and interim FNHA Board of Directors remuneration. The following annual report for fiscal year 2012/13 is also accompanied by these additional reporting documents as well as a schedule of FNHC retainer and meeting fees and a schedule of FNHDA meeting fees. All other annual reports up to the most recent year of reporting (2020/21) are paired with FNHA audited financial statements and FNHA, FNHC, and FNHDA remuneration costs.

Similar to the first few FNHA summary service plans, the earlier annual reports primarily consist of reporting on progress made towards fulfilling transition requirements and transfer responsibilities. There is alignment between these early plans and reports in that the transition

priorities established in the interim health plans are reflected and reported on in the annual reports. For instance, the five organizational priority areas of Transition; Governance and Decision-Making; Health Services and Improvements; Partnerships; and Leadership, Organizational Development and Planning as outlined in the interim health plan of 2013/14 are each reported on in this fiscal year's annual report. As the FNHA was in the process of developing a performance tracking approach during this initial period of organizational development, the reporting format for these five priority areas consists of relevant facts, figures, and statistics as well as updates on various programs and services that support the advancement of each priority area. For example, progress made towards fulfilling priority number three 'Health Services and Improvements' includes reporting on the expansion of certain health benefits such as dental, vision care, and mental health in terms of the total number of clients served (Annual Report, 2013/14, pp. 16-25).

5.5 Performance Measurement and Reporting

As the FNHA performance measurement and tracking approach was in development for the first three years of operations, the 2016/17 summary service plan introduced several initial key performance indicators to track the progress of each of the four main goals in the plan. This is the first year of FNHA operations that specified performance indicators are used to measure organizational progress. For goal number one to "Enhance First Nations Health Governance", the performance indicators as outlined in the summary service plan are "Regional Caucus Satisfaction" and "Planned Partnership Activities Completed" (Summary Service Plan, 2016/17, p. 21). The 2016/17 annual report shows alignment with these performance indicators from the summary service plan as it reports that there was a Regional Caucus attendee satisfaction rate of 83% (p. 12), and that 91.4% of planned partnership activities were completed in this fiscal year (p. 15). For goal number two to "Champion the BC First Nations Perspective on Health and Wellness" from the 2016/17 summary service plan, the performance indicator is "Participant Satisfaction with FNHA Sponsored Wellness Events and Initiatives" (Summary Service Plan, 2016/17, p. 25). Again, there is alignment with this performance measure in the 2016/17 annual report as it shows there is 100% respondent satisfaction with the Elders Engagement Fair; 100% overall satisfaction with Winter Wellness Grants; 94% respondent satisfaction with wellness screenings; 83% respondent satisfaction with the wellness room at Gathering Our Voices; and 74% overall respondent satisfaction with Gathering Our Voices workshops (p. 40).

For goal number three to "Advance Excellence in Programs and Services" from the 2016/17 summary service plan, the performance indicators are "Partnership Satisfaction Between FNHA and First Nations Health Organizations", "Client Satisfaction with Health Benefits through Surveys", and "Adoption Rate of the Declaration on Lateral Kindness by FNHC, FNHDA, and FNHA" (p. 29). The 2016/17 annual report shows partial alignment with these indicators as it reports data from the health benefits client satisfaction survey (p. 63); however, does not provide a performance assessment for the "Partnership Satisfaction Between FNHA and First Nations Health Organizations" indicator as the report outlines that new information and data gathering tools are in development and both planning and reporting processes remain under review (p. 75).

Moreover, the report states that resources will evolve for the 2017/18 fiscal year as reporting improvements are underway to support this goal and performance measure (p. 75). The fourth FNHA goal to “Operate as an Efficient, Effective, and Excellent First Nations Health Organization” from the 2016/17 summary service plan (p. 31), the performance indicators are “Embed Wellness Operating Principles in Operational Decision-Making Activities”, and “Conduct an Annual Employee Engagement Survey to Identify Key Areas Needing Growth or Improvement” (p. 33). Regarding this engagement survey performance indicator, the 2016/17 annual report states that the use of this evaluation tool is delayed “Due to the unique nature of our organization, it was decided to take the necessary time to develop a new organizational culture workforce survey of greater relevance to the FNHA” (p. 82). The annual report goes on to say that the new survey will be developed over the course of the 2017/18 fiscal year and performance measuring using this newly created assessment tool would begin in 2018/19 (p. 82). The use of the other performance indicator for this fourth goal regarding FNHA operating principles in decision-making was also delayed as the organization undertook an employee-driven update of the operating principles in 2016/17 (p. 84). The report states that the use of this performance evaluation tool to track progress in operational decision-making activities will be on hold until revisions are finalized (p. 84).

The start of the FNHA five-year health plan in 2016/17 introduced the above four organization-wide goals and their respective performance measurement indicators. The following year’s plan of 2017/18 broadened the evaluative framework with the addition of three organizational excellence health performance standards: 1. Annual board of director review of corporate policies on target; 2. percentage compliance with inclusion of Directives and Operating Principles in decision-making processes; and 3. percentage of staff performance partnership agreements completed, including staff wellness plans (p. 31). The 2017/18 annual report shows alignment with the 2017/18 summary service plan’s added assessment measures as it includes data for each of the three organizational excellence health performance standards (p. 93). The 2017/18 annual report also shows a higher degree of congruency between the goals, outcome statements, objectives, and annual key priorities outlined in the same year’s plan than previous service plans. For instance, each goal’s list of objectives in the summary service plan that articulate action items and the operationalizing of goals is included in the annual report with key updates to indicate progress achieved towards each individual objective.

There is less alignment with earlier FNHA service plans and reports in terms of projected performance indicators and reporting on actual performance results. As data gathering methods for assessing and measuring organizational performance were under development in early operational years and undergoing change and improvements, the results of some performance targets as outlined in earlier service plans were not captured in the corresponding annual reports. More recent performance measuring and tracking shows greater alignment of performance targets and results as the FNHA’s methodology for measuring organizational progress has matured and improved over the years. As the number and level of detail associated with goals and performance

indicators grows, it can point to the maturing of a newer organization and indicate the presence of more resources being dedicated to organizational planning and reporting. For instance, each goal's performance target as outlined in the 2021/2022 service plan is captured in the annual report with data to demonstrate the extent of progress achieved on each performance indicator. This is in contrast to earlier reports that did not include several data points for key targets as outlined in the corresponding year's plan.

5.6 Summary

This systematic content analysis of FNHA summary service plans and annual reports reveals several key findings. Primarily this literature shows the founding of a new organization and the growth and development of this health authority over its nearly decade of operations. The first three years of FNHA service plans are referred to as interim health plans as much of the strategy and focus of these plans are directed towards managing the interim period of transition marked by a transfer of staff, programs, services, and funding from the First Nations and Inuit Health Branch of Health Canada to the newly established offices of the FNHA. Following this period of transition, the FNHA implemented its five-year health plan format comprised of the annual summary service plans from 2016/17 to 2020/21. These plans are notable for their high degree of continuity as each year's plan in this period has the same set of four organization-wide goals which in turn influenced and established a set of mostly unchanging outcome statements, objectives, and strategies. Another key takeaway of FNHA service plans is the inclusion of BC First Nations perspectives in the planning process and strong emphasis on community engagement. This citizen-informed, grassroots, bottom-up approach is a central and defining feature of FNHA operations that influences its approach to planning, reporting, designing services and programs, and collaborating with its governance partners. Another key theme consistently echoed throughout each year's service plan is the strong emphasis on regional collaboration and the push to strengthen regional governance processes. This emphasis is strongly linked to community engagement efforts and the organizational objective to give First Nations a greater say in their healthcare through regionalization that moves decision-making closer to home.

Chapter 6: Discussion and Analysis

This chapter summarizes key findings and discusses the significance of these results within the context of the main research questions that provide the framework for this thesis. The research presented here began with the goal to explore the work of the First Nations Health Authority through an assessment of its strategic summary plans, five-year plan, and annual reports and assess the performance of the FNHA through published results in annual reports to determine if stated goals and objectives are being met and improving the health and wellness of Indigenous people in BC.

An in-depth content analysis of this organizational literature was the method chosen to answer the primary research question of this thesis which asks how FNHA service plans, the 5-year health plan, and annual reports have changed since their inception. This analysis revealed that FNHA plans and reports mirrored the current state of the organization with each year and changed in content in accordance with broader organizational shifts and changes. For instance, the preceding Findings chapter showed how the first few years following the founding of the FNHA in 2013, service plans were referred to as interim plans until the 2016/17 fiscal year as a way of indicating a time of transition for the new health authority as staff, programs, services, and funding were being transferred from the First Nations and Inuit Health Branch of Health Canada to the newly established offices of the FNHA. Following this period of transition, the FNHA implemented its five-year health plan format comprised of the annual summary service plans from 2016/17 to 2020/21. After an initial three-year period of transition and change, the five-year health plan signaled a period of relative stability for the new organization where it could focus more resources towards strategic planning initiatives and performance measurement rather than on managing the transition period. During this period of relative stability following the transfer period, FNHA plans and reports are still works in progress and undergoing revision and improvement. Performance measurement indicators in particular were in flux in earlier plans and reports as data collection methods and targets for assessing progress towards organizational goals and objectives were still in development.

6.1 Answering the Research Questions

- How have the FNHA annual reports, five-year plans, and service plans changed in content since their inception?

As the preceding Findings chapter detailed, FNHA service plans and annual reports have had significant changes in content over nearly a decade of operations. The attached appendices chart the various component changes and show the growth of a new organization attempting to find its operational footing and make the shift from a reactive to a proactive organization. The first few years of FNHA operations are referred to in service plans and annual reports as an interim or transition period. This was a time of significant change as service delivery responsibilities for First

Nations health and wellness were shifting from Health Canada to the newly created FNHA. FNHA operations during this transfer period can be characterized as more reactive in nature than proactive as the organization was responding to the directives as detailed in the *Tripartite Framework Agreement* and managing the transfer of responsibilities, resources, and infrastructure for Indigenous health in BC to the new First Nations health authority. As the FNHA transitions out of this interim period of reactive change management, plans and annual reports change in content to reflect this organizational shift away from short-term planning towards a more proactive, long-term strategy-driven stance.

The 2016/17 fiscal year's planning and reporting cycle marks the start of the first five-year plan with its focus on four main organizational goals that prioritize service excellence and good governance. This five-year plan that is comprised of annual service plans is particularly notable for the lack of content change from year to year. The goals, outcome statements, outcomes, and strategies in these service plans are fixed and unchanging. In contrast, the corresponding annual reports are dynamic and varied in content each year. Although the annual reports provide updates on goals included in the corresponding year's service plan, there is a disconnect between the two in terms of content presentation. Starting with the 2016/17 fiscal year, the service plans are nearly identical to one another and static in content. There are certain components of a plan that may not change from year to year in order to support the long-term vision of the organization and provide a degree of stability.

For instance, organization-wide goals may remain fixed for a longer period of time as these may not be achievable in the short-term and instead require a long-term commitment. Strategies, on the other hand, should be fluid rather than fixed and adaptable to changing conditions. For instance, when the BC healthcare system was hit with the dual crises of the Covid-19 pandemic and the opioid overdose crisis, the strategies in the FNHA service plans for 2020/21 and 2021/22 did not change from the strategies outlined in the 2016/17, 2017/18, 2018/19, and 2019/20 service plans despite these new challenges and a vastly different and complex operating environment compared to earlier years. Rather than changing their strategic stance to indicate a proactive response to these dual public health emergencies, the FNHA chose instead to extend the five-year plan by an additional year to 2021/22 and keep all objectives, outcomes, and strategies the same as previous plans.

Contrary to the FNHA service plans that remain static in the face of rapidly changing environmental conditions, the annual reports for 2020/21 and 2021/22 provide status updates on the FNHA response to Covid-19 and the opioid overdose crisis. These public health emergencies led the FNHA to activate its emergency response structure enabling the health authority to support community health emergency preparedness for acquiring and distributing resources and essential services to First Nations communities (FNHA Annual Report, 2020/21, p. 11). The FNHA played a key role in providing personal protective equipment, organizing testing sites, and advocating for priority vaccination for rural and remote First Nations communities and communities with high numbers of positive cases (FNHA Annual Report, 2020/21, p. 11). In response to the opioid

overdose and toxic drug crisis, the FNHA played an important role in collecting and publicly releasing surveillance data highlighting the disproportionate number of drug-related deaths among First Nations people and advocating for trauma-informed harm reduction approaches (FNHA Annual Report, 2020/21, p. 11). Given that these FNHA interventions for both Covid-19 and the overdose crisis were outlined in the last two annual reports but not included in the service plans shows there is a disconnect and lack of alignment between FNHA plans and reports.

- To what extent is there congruency between the FNHA service plans and annual reports such that plan goals inform and influence organizational outcomes?

The cause-effect relationship between plan goals and performance outcomes has been stronger in more recent years of reporting as compared to early years of FNHA operations. As the FNHA evaluation framework was in development during the interim period, there was no performance reporting mechanism in place in the annual reports to track the progress of transition-related goals as outlined in FNHA plans from 2013/14 to 2014/15. Initial alignment between plan goals and performance reporting begins with the 2015/16 service plan that introduced key deliverables not related to managing the transition period for which the same year's annual report provided performance updates. As data collection methods for assessing and measuring organizational performance were under development in early operational years and being modified, there was less congruency between plan goals and performance measurement during this period. Over time, there was a considerable improvement in alignment between plan goals and performance measures as outlined in annual reports. Notwithstanding this greater alignment between plan goals and performance reporting, there remain points of disconnect between FNHA service plans and annual reports. Whereas the annual reports are dynamic and change in content from year to year, FNHA service plans are static in content and do not reflect changing environmental conditions and shifts in strategy as addressed in the reports. For instance, in reading FNHA plans alone, one would never know the organization was recently facing a global pandemic and a toxic drug overdose crisis at the same time. FNHA plans need to better align with information addressed in its annual reports and reflect the current reality of the organization.

- What impact has the work of the FNHA had on the health outcomes of Indigenous people in BC?

Recently a new collaborative effort began between the offices of the Provincial Health Officer of BC and the FNHA's Chief Medical Officer to work together to report on the health and wellness of First Nations people in BC by using an updated suite of health status indicators. A public-facing report called the *First Nations Population Health and Wellness Agenda* will be jointly published every two-and-a-half years from 2019 until 2030 to provide a status report on progress made to close the gaps in health between First Nations and other British Columbians. This report will include the original health outcome indicators as outlined in the previously discussed *Transformative Change Accord: First Nations Health Plan (TCA:FNHP)*, one of the foundational documents leading to the founding of the FNHA. Additionally, a newly established set of 15 health

indicators rooted in a wellness-based approach will also be included in the report and reflect a First Nations perspective on health and wellness (PHO & FNHA Annual Report, p.10, 2021).

The most recent health outcome statistics show improvement and gains made in Indigenous health; however, there are still persistent gaps across several key indicators between First Nations people in BC and other residents. During the previous ten years of reporting, only one indicator out of five met the target as outlined in the TCA:FNHP (PHO & FNHA Annual Report, p.9, 2021). Although the rate of diabetes has continued to increase among Status First Nations, the rate of increase has decelerated resulting in an overall reduction in the gap (PHO & FNHA Annual Report, p.9, 2021). This indicator met and even exceeded the TCA:FNHP target; however, while indicators measuring life expectancy at birth and the age-standardized mortality rate among Status First Nations show improvement, the gaps between First Nations and other residents in BC have widened; as a result, these indicators did not meet the TCA:FNHP targets (PHO & FNHA Annual Report, p.9, 2021). The youth suicide mortality rate of Status First Nations has decreased since the baseline year of reporting in 2009 and the gap has been reduced; however, this indicator did not meet the TCA:FNHP target. Unlike the previous four indicators which show signs of improvement, the gap in the infant mortality rate among Status First Nations has widened; as a result, this indicator did not meet the TCA:FNHP target (PHO & FNHA Annual Report, p.93, 2021).

Although four out of five health outcome targets have not been met, these indicators are showing improvement and trending in the right direction. Through its suite of programs and services rooted in Indigenous perspectives of health and wellness, the impact of the FNHA has been meaningful for First Nations in BC. As the FNHA's Acting Chief Medical Officer notes, "The First Nations Population Health and Wellness Agenda is much more than just a health status report... It is an act of self-determination. First Nations are controlling our own data and telling our own story in a way that reflects our strengths and resilience" (FNHA Annual Report, 2021/22, p. 22).

6.2 FNHA Service Plans and Strategic Planning

The literature review in chapter three of this thesis discussed the main points of research within the field of public sector strategic planning. A notable study cited in the literature conducted by Lee, McGuire, and Kim (2017) found that the quality of a strategic plan, as measured by its various components, matters greatly in realizing organizational aims and showed that strategic planning overall is beneficial and contributes to organizational performance. This study showed that richer plan designs maximize the opportunity for organizational objectives to be realized. Considering these study findings when assessing FNHA service plans, this research found a rich level of detail to be lacking in FNHA plans. For instance, strategies listed in the five-year plan under the goal to "Enhance First Nations Health Governance" include "Enhance capacity on a regional basis to advance regional priorities and processes; Work with the FNHC and FNHDA to engage BC First Nations in a manner that is equitable, efficient, and cost-effective; and Support the implementation of regional partnership accords". These strategies point to a general desired end state and answer

the question of ‘what’ the organization intends to do but does not answer the question of ‘how’ these ends will be achieved.

The strategies outlined in FNHA service plans include the broad goals, vision, and values of the organization; however, these strategies lack sufficient detail and fail to incorporate the methods by which goals will be achieved. Rumelt (2011) notes that “A good strategy does more than urge us forward toward a goal or vision; it honestly acknowledges the challenges we face and provides an approach to overcoming them” (p. 2). According to this definition of what constitutes a good strategy, there are key elements missing in FNHA strategies such as a definition of the obstacle or difficulty the strategy is designed to meet; and the method or approach that will be used in overcoming the stated challenge. Strategies that are vague and lacking in important detail lower the overall quality of the plan and risk addressing critical issues in an effective manner. As discussed in the literature review, a low-quality plan is less likely to succeed in the implementation phase as compared to a plan of substance with high strategic decision quality which “...makes it clear to the organization and its stakeholders what it wants to achieve, how, and why – thus encouraging the actual implementation of the strategic plan” (George, 2020, p.795).

6.3 FNHA Annual Reports and Performance Measurement

The suite of FNHA performance targets outlined in service plans and annual reports both include and go beyond traditional concepts used in judging performance such as efficiency, effectiveness, and financial performance to include a broader set of performance measures that consider citizen engagement, client satisfaction, staff and organizational wellness, and cultural initiatives. For example, the targets set to measure progress made towards the goal to “Advance excellence in programs and services” include monitoring the percentage of funding arrangements for which *reciprocal accountability* targets are met, the level of FNHA program information access, client satisfaction rate, percentage of service standards on target, and percentage of clients who received at least one FNHA benefit per year (FNHA Service Plan, 2021/22, p. 29). Performance measurement for the goal to “Operate as an efficient, effective, and excellent First Nations health organization” include tracking the percentage of planned organization-wide cultural initiatives, the percentage of self-identified Indigenous staff, and the participation rate in an organizational culture workforce survey (FNHA Service Plan, 2021/22, p. 33).

This array of FNHA performance targets reflects the discussion in the literature review that highlighted the flexibility and variability of organizational performance indicators such that they can be tailored and individualized to the unique characteristics of any given organization to assess and evaluate performance. Drawing on the 3Es model to assess FNHA performance reporting, ‘economy’ and ‘efficiency’ are less often used to measure progress than the indicator of ‘effectiveness’. FNHA annual reports rely on the ‘effectiveness’ indicator to illustrate the measure of goal alignment and actual achievement of service objectives (Walker and Andrews, 2013, p.103). Reporting also includes other dimensions of performance such as equity, transparency,

accountability, governance, and democratic outcomes (Walker, Boyne, and Brewer, 2010; Walker and Andrews, 2013; Andersen, Boesen, and Pedersen, 2016; George, Walker, and Monster, 2019).

Although this analysis has highlighted a disconnect between FNHA service plans and annual reports in that the former are static and unchanging whereas the latter are dynamic and responsive to changing environmental conditions, there is a positive relationship between FNHA strategic planning (SP) and organizational performance (OP). As noted above, the SP study by Lee, McGuire, and Kim (2017) found that the quality of a strategic plan as measured by its various components and level of detail was shown to be beneficial in realizing organizational objectives. The study further concluded that simply having a strategic plan, regardless of plan quality, also improves organizational performance. Although, higher plan quality is positively correlated with improved organizational performance, the presence alone of a strategic plan is enough to ensure gains in performance (Lee, McGuire, and Kim, 2017). While the work of other scholars (Bryson, 2015; George, 2017) refutes this premise that a strategic plan alone regardless of quality is sufficient to ensure improved organizational performance, in the case of the FNHA, there is a positive relationship between plans and reports, notwithstanding the need for greater plan quality. Most FNHA plan components such as goals, objectives, outcomes, key priorities, and performance measures do correspond to annual report components; however, ensuring a more comprehensive SP process marked by sufficient resources, careful deliberation and consideration of many available options would increase plan quality and improve organizational performance. A fulsome and informed SP process where clear strategies and goals are developed through a robust analysis will create richer plan designs and maximize the opportunity for organizational objectives to be realized.

Chapter 7: Conclusion

This thesis began with a series of research questions relating to the evolution of FNHA service plans and annual reports over nearly a decade of operations. The primary research question was formulated to look at how FNHA service plans, the five-year plan, and annual reports have changed in content since their inception. Given that plans and reports are generated annually, the documents can be compared to identify certain trends and changes. Even subtle changes within these documents can signal substantive developments. For instance, the 2015/16 FNHA annual report included goals that were not focused on managing the transition of authority and responsibilities from the federal government to the FNHA. This subtle change in the nature and direction of organizational goals signaled a turning point for the FNHA and an institutional shift away from managing the interim period of operations towards broadening its reach and mandate beyond day-to-day operations to program development designed to meet client needs.

The purpose of this thesis was to evaluate these changes in FNHA plans and reports and determine. The findings from this research demonstrate that while FNHA plans and reports are helpful in some areas such as outlining goals and reporting on performance, there is room for improvement in terms of reformulating plan strategies so they are strategic in nature and not akin to goals. Additionally, greater alignment between FNHA plans and reports is needed to better reflect the challenges faced by the organization and the strategies designed and implemented to respond to these challenges.

7.1 Research Implications

This thesis builds on prior research to highlight the importance of strategic plans and performance reporting for public sector organizations. The research presented here contributes to the wider field of knowledge by providing insights into how strategic planning can help organizations achieve their long-term goals. This research can be particularly beneficial for the application of strategic planning in Indigenous-led public-sector organizations. Through a thorough analysis of existing literature, this thesis highlights the positive impact of strategic planning on various aspects of organizational performance, including problem resolution, stakeholder engagement, and client satisfaction. Furthermore, this research identifies smart practices for strategic planning and suggests practical recommendations for organizations looking to implement effective strategic planning processes. A case study approach was used in this thesis to provide an evaluative lens to FNHA service plans and annual reports and assess how these materials have changed over nearly a decade of operations and determine the extent to which they are serving their intended purpose.

An analysis of this organizational literature showed points of disconnect between FNHA service plans and annual reports. This moderate lack of congruency between plans and reports was an unexpected finding of this research and highlights the need to improve strategic planning processes to produce higher quality plans that better align with information included in annual reports. A

further implication of this research is to delineate a distinction between strategies and goals as the latter is often conflated with the former. This points to another unexpected finding of this research where FNHA strategies as outlined in annual service plans lack a sufficient amount of detail and instead offer an intention or goal that lacks the key components of a strategy. An effective strategy contain a clear diagnosis of the problem or obstacle to be overcome and offer a method designed to mitigate the identified challenge. FNHA strategies are more akin to goals, vision, or aims and may be re-formulated to better position the organization to meet challenges, achieve objectives, and respond effectively to changing environmental conditions. A recommended practice for strategy formulation is to change strategies with each year's plan to better align with fluctuating challenges, opportunities, and internal and external operating environments. The strategies outlined in FNHA service plans comprising the five-year plan are fixed, static, and unresponsive to changing environmental conditions.

7.2 Thesis Limitations and Future Research

In conducting research, this thesis used a document analysis as the primary data collection method. As outlined in chapter four, a document analysis has several benefits that made it a suitable approach for this study; however, there are also a number of limitations to this method of research resulting in underexplored areas for future research to build upon. Going forward, interviews with FNHA staff and senior leadership may be useful to build on this thesis and fill in the gaps of knowledge such as gaining a more fulsome understanding of the FNHA strategic planning process in practice. For instance, future research efforts could focus on understanding how *people*, *process*, and *plan* interact and come together during strategic planning. George, 2017; and George, Walker, and Monster, 2019 have drawn a link between the effectiveness of strategic plans and the people involved in the SP process in that a more democratic approach can lead to greater plan quality.

A document analysis of FNHA plans and reports was not able to determine to what extent the process of strategic planning was participatory. Interviews or surveys with FNHA staff could reveal the level of involvement in organizational planning processes by lower-level staff and external stakeholders. Typically, these groups are left out of the planning process; however, research shows that a more participatory approach can produce better outcomes. An interview research design could also be used to gain a better understanding around one of the unexpected findings of this thesis which is the disconnect between FNHA plans and reports to the extent that certain strategies that were outlined in the annual reports were not included in the corresponding service plans.

7.3 Strengths of FNHA Plans and Reports

While this thesis focused on areas of possible improvement in terms of FNHA planning and reporting processes, it is important to note that there are several key areas of strength in FNHA plans and reports that may guide and inform these processes for other Indigenous-led organizations. Firstly, the FNHA allocates the time and resources required to produce annual plans

and reports. Research shows that organizational objectives are significantly improved by having a strategic plan (Lee, McGuire, and Kim, 2017). Further, FNHA plans have a number of components outlining the organization's objectives, activities, areas of focus, and indicators of success, all of which create a rich plan design that research shows to be positively correlated with better organizational outcomes (Lee, McGuire, and Kim, 2017). FNHA plans and reports also excel at identifying organizational priorities, setting long-term goals, and monitoring progress with meaningful indicators and markers of success. These performance indicators are clearly defined, measurable, and align with targets outlined in yearly plans. FNHA reports are highly detailed and dynamic and provide organizational context such as information on the FNHA's operating environment, regional partnerships, community engagement initiatives, challenges faced, and opportunities for improvement. Should the FNHA choose to amend plans and reports in accordance with this study's findings and a western-based strategic planning and reporting framework, the main recommendations include to regularly conduct a situation analysis to remain aware of emerging issues and trends; regularly review and adjust strategic plans based on new information and changing operating conditions – this will help ensure the plan remains relevant and effective. It is further recommended to have an inclusive, participatory planning process that includes key stakeholders, senior leadership, and staff from all levels. This open type of planning process will lend itself to creating more fulsome, comprehensive plans that are strategic in nature, highly relevant, and actionable.

7.4 Final Reflections

A focused evaluation of organizational strategic plans and annual reports is important for several reasons. Firstly, plans and reports must be assessed to determine whether they are serving their intended purpose. This purpose entails providing clarity on organizational goals and objectives and outlining vision and mission statements. Moreover, plans and reports are intended to articulate strategy, set targets, and enable performance monitoring and evaluation. A micro-level analysis into this type of organizational literature is helpful in highlighting areas of misalignment and improving planning and reporting processes. In a public sector context, analysis of service plans and annual reports is particularly useful in assessing performance and accountability where the metric of profitability is not a consideration as it is with private-sector organizations. In particular, the exercise of evaluating FNHA service plans and annual reports matters and is important because it reveals whether organizational goals, objectives, strategies, targets, and performance measures are aligned with the overall mission of the organization to improve the health and wellness of First Nations people in BC. However, it is important to note that traditional western approaches to strategic planning and performance reporting may not always align with Indigenous worldviews and cultural values. It may therefore be challenging for Indigenous-led organizations to adopt and implement these processes in ways that are relevant and meaningful to the communities they serve. A key takeaway from this research is that it is essential to develop planning and reporting literature that takes into account the unique needs of Indigenous-led organizations and is tailored to their cultural context. This area for further research could include smart practices, case studies, and

examples of both western and Indigenous ways of knowing coming together to guide and inform planning and reporting processes in a manner similar to two-eyed seeing that combines different ways of seeing the world to gain a more comprehensive and holistic understanding.

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Appendix

APPENDIX A: FNHA SERVICE PLAN GOALS AND ANNUAL REPORT PERFORMANCE MEASURES 2013/14

| Service Plan 2013/14 Goals | Annual Report 2013/14 Performance Measures |
|--|--|
| <ol style="list-style-type: none"> 1. In accordance with the Tripartite Framework Agreement, complete the smooth transition of Health Canada responsibilities to the First Nations Health Authority. 2. Develop and align regional-based supports to ensure effective, efficient and equitable engagement processes that enhance First Nations governance and decision making in health. 3. With the province and other partners, implement effective mechanisms to integrate planning and delivery of high quality health services to BC First Nation individuals, families and communities. 4. Enhance partnerships and collaborative initiatives with BC First Nations and with the province of BC, Regional Health Authorities and federal government departments. 5. Establish the FNHA as a model First Nations health organization, and as a partner to BC First Nations' community health organizations to better meet regional priorities, promote community based and community led development, and to enable health services improvement. | <p>As noted in 2013/14 plan: An evaluation and reporting approach for tracking progress and achievements relative to annual or multi-year organizational priorities and goals will be developed (p. 15).</p> <p>Although there are no formalized performance targets and measurements developed at this stage of FNHA operations, there are detailed progress updates outlining achievements made towards plan goals in the corresponding 2013/14 annual report.</p> |

APPENDIX B: FNHA SERVICE PLAN GOALS AND ANNUAL REPORT PERFORMANCE MEASURES 2014/15

| Service Plan 2014/15 Goals | Annual Report 2014/15 Performance Measures |
|--|---|
| <ol style="list-style-type: none"> 1. Implement Framework Agreement and Sub-Agreement commitments / Smooth delivery of programs and services / Enable migration of service continuity agreements. 2. Create an effective working partnership with the FNHC and the FNHDA / Support regional capacity development and alignment / Support regional planning / Support community wellness planning / Engage BC First Nations. 3. Implement Joint Project Board initiatives and investments / Enhance existing programs and services / Improve the First Nations Health Benefits program / Ground services improvements and transformation in a First Nations wellness perspective 4. Establish partnerships with BC First Nations health providers / Implement tripartite and bilateral health plans and agreements / Coordinate effectively with the BC Ministry of Health / Support the Deputy Ministers' tables on social determinants / Strategic external partnership development / Implement regional Partnership Accords. 5. Establish organizational planning process / Organizational development, employee engagement and staffing strategies/ Establish wellness approach as the basis of our organizational culture / Implement leading edge FNHA infrastructure / Advance accreditation / Explore innovative approaches and business opportunities / Establish health information systems and wellness indicator frameworks. | <p>Broad goals in 2014/15 plan mainly related to managing transition period with no formalized targets in plan or performance tracking in corresponding annual report. Progress made towards certain goals is outlined in report.</p> |

APPENDIX C: FNHA SERVICE PLAN GOALS AND ANNUAL REPORT PERFORMANCE MEASURES 2015/16

| Service Plan 2015/16 Goals | Annual Report 2015/16 Performance Measures |
|--|--|
| <ol style="list-style-type: none"> 1. Enhance First Nations health governance 2. Promote and implement the BC First Nations perspective on wellness as a health and wellness champion 3. Improve health services and programs as a health and wellness partner 4. Strengthen the FNHA as a sustainable and effective First Nations health organization <p>As noted in 2015/16 plan: The FNHA is developing a performance measurement approach as part of our planning framework (p. 33).</p> <p>There are four initial Key Performance Indicators - one associated with each goal. Each has a number of sub-indicators that aggregate to the following high-level indicators:</p> <ol style="list-style-type: none"> 1. First Nations are satisfied with Regional Caucuses (Goal 1: Governance) 2. First Nations' participation in wellness challenges, screenings and programs increases (Goal 2: Health & Wellness Partner) 3. Services delivered to and by First Nations increase (Goal 3: Improve Health Services) 4. FNHA investments leverage or generate additional resources in support of First Nations health and wellness (Goal 4: Strengthen Sustainability) | <p>Plan goals align with corresponding annual report performance measurements:</p> <p>Goal 1 Performance Measure - First Nations Satisfaction with Regional Caucuses - Measuring First Nations satisfaction at the Regional Caucuses is part of FNHA's performance measurement approach. As a key performance measure, we are pleased to report that overall satisfaction was 94% based on satisfaction surveys performed during the caucuses. For the first time we also included survey questions focused specifically on engagement which, resulted in a 77% satisfaction rate in that area. Both of these measures will serve as the baseline for caucus satisfaction in future years.</p> <p>Goal 2 Performance Measure - First Nations' participation in health screening – Health screenings were tallied at a number of key cultural and FNHA events. Total health screening numbers are outlined in annual report.</p> <p>Goal 3 Performance Measure - Joint Project Board (JPB) Projects: Increase services delivered to and by First Nations- As of March 31, 2016, 30 unique projects have been approved across all regions and the PHSA. To date, funding for 54 health care professionals has been made available to address gaps in primary care.</p> <p>Goal 4 Performance Measure - FNHA investments leverage or generate additional resources in support for First Nations health and wellness –</p> <ul style="list-style-type: none"> • We leveraged our \$600,000 contribution with an additional \$1.3 million from Simon Fraser University and St. Paul's Hospital Foundation to fund the \$1.9 million FNHA Chair in Heart Health and Wellness at St. Paul's Hospital, the first of its kind in Western Canada. • Our \$187,500 investment was matched by the BC Aboriginal Association of Friendship Centres to deliver the Doulas for Aboriginal Families Grant Program. • The Ministry of Health, FNHA and the BC Aboriginal Association of Friendship Centres each contributed funding to deliver a range of programs and activities delivered by the Aboriginal Sports, Recreation and Physical Activity Partners Council in alignment with the FNHA's wellness approach and Being Active wellness stream. |

APPENDIX D: FNHA SERVICE PLAN GOALS AND ANNUAL REPORT PERFORMANCE MEASURES 2016/17

| Service Plan 2016/17 Goals | Annual Report 2016/17 Performance Measures |
|--|--|
| <p>1. Enhance First Nations health governance 2. Champion the BC First Nations Perspective on Health and Wellness 3. Advance Excellence in Programs and Services 4. Operate as an Efficient, Effective, and Excellent First Nations Health Organization</p> <p>Performance measures as outlined in plan:</p> <p>Goal 1 – Regional caucus satisfaction and planned partnership activities completed</p> <p>Goal 2 – Participant satisfaction with FNHA sponsored wellness events and initiatives</p> <p>Goal 3 - Partnership satisfaction between FNHA and First Nations health organizations / Client satisfaction with health benefits through surveys / Adoption rate of the declaration on lateral kindness by FNHC, FNHDA and FNHA</p> <p>Goal 4 - Embed wellness operating principles in operational decision making activities / Conduct an annual employee engagement survey to identify key areas needing growth or improvement</p> | <p>1. Performance Measure: Regional Caucus Satisfaction</p> <p>The FNHA, FNHC and FNHDA each host one day of Regional Caucus. Attendee satisfaction with the FNHA day of Caucus was 83% (satisfied or very satisfied). A revised performance measure has been developed for 2017/2018, moving away from Regional Caucus as the only engagement source.</p> <p>2. Performance Measure: Participant Satisfaction with FNHA-Sponsored Wellness Events and Initiatives Participant satisfaction with FNHA-sponsored wellness events, screenings and grants was on target for this year.</p> <ul style="list-style-type: none"> • 100% overall satisfaction with Winter Wellness Grants • 100% respondent satisfaction with Elders engagement fair • 94% respondent satisfaction with wellness screenings • 83% respondent satisfaction with wellness room at Gathering Our Voices • 74% overall respondent satisfaction with Gathering Our Voices workshops <p>3. Performance Measure: Partnership Satisfaction Between the FNHA and First Nations Health Organizations</p> <p>No data for this indicator as new performance metric is in development.</p> <p>A new performance measure has been developed for 2017/2018 to effectively track satisfaction with partnership processes by First Nations communities and health organizations and will be a priority for next year. The three new sub-measures are: • Percentage of funding agreement holders upholding mandatory program and financial requirements • Percentage of FNHA responses to funding agreement holders within targeted time frames • FNHA program information access</p> <p>Performance Measure: Health Benefits Client Satisfaction Survey</p> <p>Health Benefits launched the Client Satisfaction Survey online in November 2016 with a paper version made available in March 2017. The client satisfaction survey provides the FNHA with the opportunity to get feedback on how we are doing and which areas we can focus on to better meet the needs of our clients. As of 2016/2017, the organization will have a baseline indicator that we will</p> |

| | |
|--|---|
| | <p>measure ourselves against year after year. The survey is ongoing.</p> <p>Performance Measure: Adoption of the Declaration on Lateral Kindness</p> <p>100% complete. The joint Declaration on Lateral Kindness was signed and adopted by the FNHC, FNHDA and FNHA on February 27, 2017.</p> <p>4. Performance Measure: Employee Engagement Survey</p> <p>No data for this indicator as new performance metric is in development.</p> <p>Due to the unique nature of our organization and culture, it was decided to take the necessary time to develop a new organizational culture workforce survey of greater relevance to the FNHA. 2017/2018 will be used to build this new survey; we will begin tracking in 2018/2019</p> <p>Performance Measure: FNHA Operating Principles in Decision-Making</p> <p>No data for this indicator as new performance metric is in development.</p> <p>The FNHA Operating Principles are referenced in all of the organization’s decision sheets and business cases. Because we embarked on an employee-driven update of the Operating Principles and Leadership Statement this year, the use of our tracking measures for decision-making is on hold until revisions are finalized.</p> |
|--|---|

APPENDIX E: FNHA SERVICE PLAN GOALS AND ANNUAL REPORT PERFORMANCE MEASURES 2017/18

| Service Plan 2017/18 Goals | Annual Report 2017/18 Performance Measures |
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| <p>1. Enhance First Nations Health Governance</p> <p>2. Champion the BC First Nations Perspective on Health and Wellness</p> <p>3. Advance Excellence in Programs and Services</p> <p>4. Operate as an Efficient, Effective, and Excellent First Nations Health Organization</p> <p>Goal 1 – Indicator = First Nations health governance effectiveness by measuring: % engagement impact and % planned FNHC/FNHDA/FNHA partnership activities on target;</p> <p>Indicator = Governance Partnership Effectiveness by measuring: % planned tripartite and bilateral partnership activities completed and % planned tripartite and bilateral partnership initiatives on target</p> <p>Goal 2 – Indicator = Impact as a health and wellness partner by measuring: wellness movement impact, Cultural Safety and Cultural Humility initiatives impact and number of requests to use FNHA materials in other agency plans/materials</p> <p>Goal 3 – Indicator = FNHA and First Nations health organization partnerships by measuring: % funding agreement holders upholding mandatory program and financial requirements; % FNHA responses to funding agreement holders within targeted time frames and FNHA program information access</p> <p>Indicator = Service quality by measuring: Health Benefits client satisfaction, % Health Benefits service standards on target and Environmental Public Health Officer Community Work Plan objectives achieved according to service standards</p> <p>Goal 4 – Indicator = Organizational excellence by measuring: % planned organization-wide cultural initiatives on target, % self-identified Aboriginal staff and participation rate in organizational culture workforce survey.</p> <p>FNHA will also be tracking three organizational excellence health performance standards: ♦ Annual Board of Director review of corporate policies on target; ♦ % Compliance with inclusion of Directives and Operating Principles in decision-making processes; and ♦ % Staff performance partnership agreements completed, including staff wellness plans</p> | <p>1. Goal 1 Performance Measure: First Nations health governance effectiveness</p> <p>% ENGAGEMENT IMPACT</p> <p>The FNHC, FNHDA and FNHA implemented an engagement plan in 2017/2018 to improve engagement efforts and better align engagement with community health outcomes and advice. In 2018/2019, processes will continue to be refreshed to address survey results and ensure engagement with BC First Nations is conducted in a manner that is equitable, efficient and cost-effective.</p> <ul style="list-style-type: none"> » 74% of respondents agreed that day 1 of Regional Caucus was a productive and good use of time. » 59% of respondents agreed that there was sufficient time to contribute and engage during the day. » 45% of respondents agreed that they felt their voice was heard as a result of participating in the day. <p>2. Goal 2 Performance Measure: Impact as a health and wellness partner</p> <p>WELLNESS MOVEMENT IMPACT</p> <ul style="list-style-type: none"> • » An estimated 20,000 people took part in Day of Wellness events across BC. • » The FNHA funded 165 Day of Wellness Grants, totaling over \$238,000, and funded 168 Winter Wellness Grants, totaling \$320,000. • » 98% of participants at the Elders Gathering indicated that they agreed/ strongly agreed that they gained health and wellness knowledge from the Gathering and 87% agreed/strongly agreed that they view the FNHA as their health and wellness partner. <p>CULTURAL SAFETY AND CULTURAL HUMILITY INITIATIVES IMPACT</p> <ol style="list-style-type: none"> 1. » The FNHA created a new online platform for tracking It Starts with Me cultural safety and humility campaign pledges, and tracked more than 400 new commitments from across the province. 2. » Over 90% of participants in FNHA cultural safety and cultural humility webinars reported they would recommend the webinars to others and over 95% reported they would apply what they learned from the webinar at work. Over 90% stated the sessions helped them understand how cultural safety and humility contributes to quality. |

3. » 5,784 visits to the FNHA cultural safety and humility webinar page.

OF REQUESTS TO USE FNHA MATERIALS IN OTHER AGENCY PLANS/MATERIALS

» Received requests from 7 agencies to use FNHA materials in their plans/ materials. This included requests to use materials related to First Nations Perspective on Health and Wellness, early years development and health care transformation.

3. **Goal 3 Performance Measure:** FNHA and First Nations health organization partnerships

% FUNDING AGREEMENT HOLDERS UPHOLDING MANDATORY PROGRAM AND FINANCIAL REQUIREMENTS

Progress was made to establish more efficient processes to track funding arrangements requirements, including an interim systems solution to be launched in 2018/2019.

% FNHA RESPONSES TO FUNDING AGREEMENT HOLDERS WITHIN TARGETED TIME FRAMES

Work continues to further develop feedback processes to track the FNHA responses to funding agreement holders.

FNHA PROGRAM INFORMATION ACCESS

A system to track access to program information for the FNHA’s mandatory programs is in place. Top web pages accessed this year include traditional healing, mental wellness and substance use, maternal child and family health, Jordan’s Principle and “What We Do.”

Goal 3 Performance Measure: Service Quality

HEALTH BENEFITS CLIENT SATISFACTION

The FNHA collects feedback from clients through the Health Benefits Client Satisfaction Survey. The Client Satisfaction Survey is helping the FNHA understand the drivers of overall satisfaction (e.g., extent of coverage, timeliness, availability of information) and monitor changes in satisfaction resulting from changes in the program as it evolves over time. In 2017/2018, overall satisfaction rate was 28.6%, showing an improvement from the baseline of 25% set in 2016/2017.

% HEALTH BENEFITS SERVICE STANDARDS ON TARGET

Health Benefits continues to improve its service standards performance for claims related to dental, medical, vision and medical transportation services. It achieved an average of 91% of service standard targets for 2017/2018, representing a 5% increase from the 2016/2017 average of 86%

4. **Goal 4 Performance Measure:** Organizational Excellence

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| | <p>% PLANNED ORGANIZATION-WIDE CULTURAL INITIATIVES ON TARGET</p> <p>Organization-wide cultural initiatives took place throughout the year at the FNHA and included wellness events with cultural elements, practising lateral kindness, cultural knowledge and perspective activities and leadership activities. Monday morning cultural openings took place at most FNHA locations with the majority of the FNHA committee meetings opened with a prayer.</p> <p>% SELF-IDENTIFIED ABORIGINAL STAFF</p> <p>At the end of 2017/2018, 34% of FNHA staff self-identified as Aboriginal, close to meeting the target of 35%, but down from 2016/2017, which was 38%.</p> <p>PARTICIPATION RATE IN ORGANIZATIONAL CULTURAL WORKFORCE SURVEY</p> <p>In 2017/2018, the FNHA worked to develop an organizational culture workforce survey that is relevant to the unique nature of the organization. The FNHA Employee Engagement Survey will be launched in 2018/2019.</p> <p>Organizational Excellence: Health Performance Standards</p> <p>ANNUAL BOARD OF DIRECTOR REVIEW OF CORPORATE POLICIES ON TARGET</p> <p>In 2017/2018, all requirements of the annual corporate policy review calendar established by the FNHA Board of Directors were met, with a total of 41 policies going to the Board in 2017/2018.</p> <p>% COMPLIANCE WITH INCLUSION OF DIRECTIVES AND OPERATING PRINCIPLES IN DECISION-MAKING PROCESSES</p> <p>In 2017/2018, the FNHA worked to improve transparency and compliance with including 7 Directives and Operating Principles within decision-making throughout the FNHA. The vast majority (89%) of submitted decision sheets included reference to the 7 Directives and Operating Principles. In addition, most of the FNHA committees included reference to the 7 Directives and Operating Principles in records of decisions for meetings.</p> <p>% STAFF PERFORMANCE PARTNERSHIP AGREEMENTS COMPLETED, INCLUDING STAFF WELLNESS PLANS</p> <p>The FNHA provides extensive communication and training at the beginning of a fiscal year for the performance partnership review process. 62% of FNHA employees participated in the performance partnership process in 2017/2018. 60% of employees fully completed their performance partnerships by June 2017.</p> |
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APPENDIX F: FNHA SERVICE PLAN GOALS AND ANNUAL REPORT PERFORMANCE MEASURES 2018/19

| Service Plan 2018/19 Goals | Annual Report 2018/19 Performance Measures |
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| <ul style="list-style-type: none"> Enhance First Nations Health Governance Champion the BC First Nations Perspective on Health and Wellness Advance Excellence in Programs and Services Operate as an Efficient, Effective, and Excellent First Nations Health Organization <p>Goal 1 – Indicator = First Nations health governance effectiveness by measuring: % engagement impact and % FNHC/FNHDA/FNHA partnership activities on target</p> <p>Indicator = Governance Partnership Effectiveness by measuring: % planned tripartite and bilateral partnership activities completed and % planned tripartite and bilateral partnership initiatives on target</p> <p>Goal 2 – Indicator = Impact as a health and wellness partner by measuring: wellness movement impact, Cultural Safety and Cultural Humility initiatives impact and number of requests to use FNHA materials in other agency plans/materials</p> <p>Goal 3 – Indicator = FNHA and First Nations health organization partnerships by measuring: % funding agreement holders upholding mandatory program and financial requirements; % FNHA responses to funding agreement holders within targeted time frames and FNHA program information access</p> <p>Indicator = Service quality by measuring: Health Benefits client satisfaction, % Health Benefits service standards on target; % of clients who received at least one FNHA benefit per year; and Environmental Public Health Officer Community Work Plan objectives achieved according to service standards</p> <p>Goal 4 – Indicator = Organizational excellence by measuring: % planned organization-wide cultural initiatives on target, % self-identified Aboriginal staff and participation rate in organizational culture workforce survey.</p> <p>FNHA will also be tracking three organizational excellence health performance standards: ♦ Annual Board of Director review of corporate policies on target; ♦ % Compliance with inclusion of Directives and Operating Principles in decision-making processes; and ♦ % Staff performance partnership agreements completed, including staff wellness plans</p> | <ul style="list-style-type: none"> Goal 1 Performance Measure: First Nations health governance effectiveness <p>% ENGAGEMENT IMPACT</p> <p>Engagement Impact</p> <p><i>Spring and Fall 2018 Regional Caucuses:</i> 83 per cent of Caucus survey respondents reported overall satisfaction. 65 per cent of Caucus survey respondents felt they had the opportunity to contribute and engage. 51 per cent felt their voice was heard. <i>Gathering Wisdom for a Shared Journey IX:</i> 78 per cent of Gathering Wisdom survey respondents felt the day was a productive and good use of time. 37 per cent felt there was sufficient opportunity to contribute and engage in discussion. 27 per cent felt their voice was heard.</p> <ul style="list-style-type: none"> Goal 2 Performance Measure: Impact as a health and wellness partner <p>WELLNESS MOVEMENT IMPACT</p> <p>The FNHA distributed 130 Indigenous Peoples Day of Wellness Grants and 145 Winter Wellness Grants. The number of Wellness Grants funded was 14% fewer than last fiscal year with 8% less funding.</p> <p>449 Tobacco Time Out participants – down from 800 last fiscal year.</p> <p>Across all governance engagement events held this year, 72% of survey respondents view the FNHA as their health and wellness partner, a 7% decrease from the previous year.</p> <p>CULTURAL SAFETY AND CULTURAL HUMILITY INITIATIVES IMPACT</p> <p>Twenty-one Cultural Safety and Humility “It Starts with Me” campaign pledges were made in 2018/2019, down from 36 in 2017/2018 and 400 in 2016/2017 when the campaign was launched.</p> <p>The number of visits to the FNHA wellness and cultural safety and humility portal were 14,207 in 2018/2019, down slightly from the previous year’s portal visits of 15,204.</p> <p># OF REQUESTS TO USE FNHA MATERIALS IN OTHER AGENCY PLANS/MATERIALS</p> <p>Number of requests to use FNHA materials increased over the fiscal year and more than doubled from 79 requests in Q3 to 200 requests in</p> |

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| | <p>Q4. Over one-third of Q4 requests were specific to <i>Coyote's Food Medicines</i> materials.</p> <ul style="list-style-type: none"> • Goal 3 Performance Measure: FNHA and First Nations health organization partnerships <p>% FUNDING AGREEMENT HOLDERS UPHOLDING MANDATORY PROGRAM AND FINANCIAL REQUIREMENTS</p> <p>Funding arrangement holders provide annual narrative and financial reporting. In 2018/2019, 11% of arrangement holders submitted financial reports and 10% submitted narrative reports by the submission deadline of July 29, 2019. The FNHA continues to work together with the FNHA's funding recipients, supporting Health Directors and financial staff in reporting submissions and developing related training.</p> <p>% FNHA RESPONSES TO FUNDING AGREEMENT HOLDERS WITHIN TARGETED TIME FRAMES</p> <p>Tracking of reporting requirements as required by funding arrangements is ongoing, including responses within targeted time frames. In 2018/2019, tracking of reporting conducted included mandatory reports (Financial, Narrative, MT log, e-SDRT, Immunization and Drinking Water).</p> <p>FNHA PROGRAM INFORMATION ACCESS</p> <p>Top FNHA program webpages accessed: traditional healing, mental wellness and substance use (treatment centres), and maternal child and family health (Jordan's Principle). Increase in access to FNHA webpages on the campaign related to legalization of non-medical cannabis.</p> <ul style="list-style-type: none"> • Goal 3 Performance Measure: Service Quality <p>HEALTH BENEFITS CLIENT SATISFACTION</p> <p>In 2018/2019, the overall satisfaction rate for First Nations Health Benefits was 25.6 per cent compared with 28.6 per cent in 2017/2018. This decrease may reflect challenges associated with the implementation of PharmaCare Plan.</p> <p>% HEALTH BENEFITS SERVICE STANDARDS ON TARGET</p> <p>Health Benefits achieved an average of 80% of service standards targets for 2018/2019. This represents a decline from 2018/2019 average of 91%.</p> <p>% of clients who received at least one FNHA benefit per year</p> <p>77.6% of clients received at least one FNHA benefit in 2018/2019.</p> <p>Environmental Public Health Officer Community Work Plan objectives achieved according to service standards</p> <p>No data reported on this indicator in 2018/19 report.</p> |
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| | <ul style="list-style-type: none"> • Goal 4 Performance Measure: Organizational Excellence <p>% PLANNED ORGANIZATION-WIDE CULTURAL INITIATIVES ON TARGET</p> <p>Held a variety of cultural activities in 2018/2019, including wellness meetings, a wellness picnic, a guided tour of the Museum of Anthropology, sharing stories, cultural teachings, drum making, canoeing and morning prayers.</p> <p>Self-identified Indigenous staff</p> <p>In 2018/2019 35% of the overall FNHA workforce self-identified as Indigenous (compared to 34% in 2017/2018).</p> <p>Participation rate in organizational cultural workforce survey</p> <p>Received a response rate of 86% in the HOWL Survey (540/625 employees completed).</p> <p>Activities on target as per a project plan aligned to the annual implementation calendar.</p> <p>OPERATIONAL EXCELLENCE</p> <p>Annual Board of Director review of corporate policies on target</p> <p>Policy calendar requirements were met for this fiscal year and 16 policies were approved.</p> <p><i>Good Progress</i></p> <p>% compliance with inclusion of Directives and Operating Principles in decision- making processes</p> <p>Sixty decision documents were signed in 2018/2019. 85% (51 of 60 total submitted decision sheets) included rationalization of the decision in the context of the 7 Directives and Operating Principles. Work is in progress to ensure a single validated template is available to all staff.</p> <p><i>Mixed Progress</i></p> <p>% staff performance partnership agreements completed including staff wellness plan</p> <p>In 2018/2019, 61% of staff completed Performance Partnerships agreements. This is similar to last fiscal year in which 62% of staff completed the Performance Partnership process.</p> |
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APPENDIX G: FNHA SERVICE PLAN GOALS AND ANNUAL REPORT PERFORMANCE MEASURES 2019/20

| Service Plan 2019/20 Goals | Annual Report 2019/20 Performance Measures |
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| <ul style="list-style-type: none"> Enhance First Nations Health Governance Champion the BC First Nations Perspective on Health and Wellness Advance Excellence in Programs and Services Operate as an Efficient, Effective, and Excellent First Nations Health Organization <p>Goal 1 – Indicator = First Nations health governance effectiveness by measuring: % engagement impact and % FNHC/FNHDA/FNHA partnership activities on target</p> <p>Indicator = Governance Partnership Effectiveness by measuring: % planned tripartite and bilateral partnership activities completed and % planned tripartite and bilateral partnership initiatives on target</p> <p>Goal 2 – Indicator = Impact as a health and wellness partner by measuring: wellness movement impact, Cultural Safety and Cultural Humility initiatives impact and number of requests to use FNHA materials in other agency plans/materials</p> <p>Goal 3 – Indicator = FNHA and First Nations health organization partnerships by measuring: % funding agreement holders for which reciprocal accountability targets are met; and FNHA program information access</p> <p>Indicator = Service quality by measuring: Health Benefits overall client satisfaction rate; % Health Benefits service standards on target; % of clients who received at least one FNHA benefit per year; and Environmental Public Health Officer Community Work Plan objectives achieved according to service standards and changes to FNHA programs and services</p> <p>Goal 4 – Indicator = Organizational excellence by measuring: % planned organization-wide cultural initiatives on target, % self-identified Aboriginal staff and participation rate in organizational culture workforce survey.</p> <p>Goal 4 – Indicator = Information Management Information Technology by measuring: % approved organization-wide IMIT-related initiatives on target (scope, schedule, budget), % planned organization-wide enterprise architecture roadmap developed and % planned enterprise data governance and analytics strategy developed and implemented.</p> <p>FNHA will also be tracking three organizational excellence health performance standards: ♦ Annual Board of Director review of corporate policies on target; ♦ % Compliance with inclusion of Directives and Operating Principles in decision-making processes; and ♦ % Staff performance partnership agreements completed, including staff wellness plans</p> | <ul style="list-style-type: none"> Goal 1 Performance Measure: First Nations health governance effectiveness <p>% ENGAGEMENT IMPACT</p> <p>Spring 2019 Governance Caucus and Fall 2019 Shared Regional Health Assemblies:</p> <ul style="list-style-type: none"> 88 per cent of survey respondents reported overall satisfaction 81 per cent of respondents felt they had the opportunity to contribute and engage 70 per cent felt their voice was heard. <p>Gathering Wisdom for a Shared Journey X:</p> <ul style="list-style-type: none"> 88 per cent of survey respondents felt the session was a productive and good use of time 53 per cent of respondents were satisfied with the opportunity to contribute and engage 43 per cent felt their voice was heard. <p>% Tripartite and bilateral partnership activities completed</p> <p>All trilateral partnership meeting commitments were met. Bilateral partnership activities between the FNHA and several federal and provincial partners (including the BC Ministry of Health, Health Canada and Indigenous Services Canada-First Nations and Inuit Health Branch) were delayed due to leadership changes at the FNHA and among partner organizations. All planned bilateral activities with the BC Ministry of Mental Health and Addictions proceeded as planned.</p> <p>% Tripartite and bilateral partnership initiatives on target</p> <p>Met commitments in both FNHA-BC Ministry of Health Letter of Mutual Accountability and FNHA-Indigenous Services Canada- First Nations and Inuit Health Branch Shared Vision and Common Understanding.</p> <p>FNHA-Health Canada Joint Executive Agenda and draft Joint Work Plan in place; Joint Executive Agenda not refreshed since 2018/2019 and draft Joint Work Plan not finalized due to changes in leadership in both organizations.</p> <p>Did not meet commitment to refresh FNHA-Indigenous Services Canada-BC Region Protocol Agreement (Memorandum of Understanding) in 2019/2020.</p> <p>A Joint Action Plan on Cultural Safety and Humility (2019-2021) between Health Canada, the FNHA, Indigenous Services Canada and the Public Health Agency of Canada was developed.</p> |

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| | <p>The FNHA and the BC Ministry of Mental Health and Addictions continue to collaborate on the overdose response, the FNHA remains involved in key strategy implementation initiatives, and the FNHA continues to support effective implementation of the Tripartite Memorandum of Understanding on Mental Health and Wellness.</p> <ul style="list-style-type: none"> • Goal 2 Performance Measure: Impact as a health and wellness partner <p>WELLNESS MOVEMENT IMPACT</p> <p>The FNHA distributed 127 Indigenous Peoples Day of Wellness Grants, totalling \$324,200, and 88 Winter Wellness Grants, totalling \$193,482. The number of Wellness Grants funded was seven per cent fewer for Indigenous Peoples Day of Wellness Grants and 38 per cent fewer for Winter Wellness Grants compared to 2018/2019.</p> <p>Across all governance engagement events held this year, 84 per cent of survey respondents view the FNHA as their health and wellness partner, a 12 per cent increase from the previous year. Visits to the FNHA wellness web pages increased over the fiscal year.</p> <p>Cultural Safety and Cultural Humility Initiatives Impact</p> <p>New Declarations of Commitment to Cultural Safety and Humility were signed with the National Federation of Optometric Regulators Authorities of Canada, Emergency Management BC, BC Patient Safety Quality Council, BC College of Family Physicians and Doctors of BC.</p> <p>The number of visits to the FNHA wellness and cultural safety and humility portal was 12,687 in 2019/2020, compared to 14,207 in 2018/2019. The Cultural Safety and Humility “It Starts with Me” campaign was inactive in 2019/2020.</p> <p># Requests to use FNHA materials in other agency plans/materials</p> <p>The number of requests to use FNHA materials in other agency plans/materials was only partially measured this fiscal year. During first half of the year, 305 requests to use FNHA materials were received.</p> <ul style="list-style-type: none"> • Goal 3 Performance Measure: FNHA and First Nations health organization partnerships <p>% funding arrangement holders for which Reciprocal Accountability targets are met</p> <p>A total of 56 funding arrangement-related community visits and 3,928 community contacts (phones, emails and letters) were completed in 2019/2020.</p> <p>Reporting for 2018/2019 was collected during the 2019/2020 fiscal year:</p> <ul style="list-style-type: none"> • Sixty-six per cent of funding arrangement holders submitted financial reports for 2018/2019 and 76 per cent received an FNHA acknowledgement letter. |
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| | <ul style="list-style-type: none"> • Fifty-five per cent of funding arrangement holders' submitted narrative reports for 2018/19 and 80 per cent received an FNHA acknowledgment letter. • Eighty-one per cent of Joint Project Board projects submitted 2018/2019 financial reports and 85 per cent of projects submitted 2018/2019 narrative reports. <p>The submission deadline for 2019/2020 reporting was extended due to COVID-19 pandemic pressures.</p> <p>FNHA program information access</p> <p>The top FNHA program web pages accessed were Traditional Healing, Treatment Centres, Jordan's Principle, Mental Wellness and Substance Use, Health Benefits, and Cannabis. The number of visits to the FNHA website for program and service information increased over the fiscal year.</p> <ul style="list-style-type: none"> • Goal 3 Performance Measure: Service Quality <p>HEALTH BENEFITS CLIENT SATISFACTION</p> <p>In 2019/2020, the overall client satisfaction rate was 32.8 per cent compared to the 2018/2019 satisfaction rate of 25.6 per cent. The number of survey responses received was 570, 22 per cent less than 2018/2019.</p> <p>% Health Benefits service standards on target</p> <p>On September 16, 2019, Health Benefits transitioned dental, vision, medical supplies and equipment, and a portion of pharmacy benefits to Pacific Blue Cross. In addition to coverage improvements, the transition resulted in improved turnaround times for claim processing. However, due to differences in how Pacific Blue Cross tracks services, they are not directly comparable with how Health Benefits tracked its performance. In the coming year, the FNHA will work to align performance measurement methods to provide comparable results.</p> <p>For areas with available data, service standards comparing 2019/2020 to the prior year:</p> <ul style="list-style-type: none"> • Medical transportation achieved its services standards 67 per cent of the time, compared with 82 per cent in 2018/2019. • Pharmacy achieved its services standards 80 per cent of the time, compared with 99 per cent in 2018/2019. <p>These decreases were attributed to staffing capacity challenges and significant increases in demand for medical transportation. Health Benefits is presently working to increase these service standards to target levels.</p> <p>% of clients who received at least one FNHA Health Benefit per year</p> <p>80.1 per cent of eligible clients made at least one pharmacy, dental, medical services and equipment or vision FNHA benefit claim, up from 77.6 per cent in 2018/2019.</p> |
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| | <p>Environmental Public Health Officer Community Work Plans objectives achieved according to service standards</p> <p>Eighty-three per cent of Community Work Plans were completed for 2019/2020, up from 71 per cent in 2018/2019</p> <p>Changes to FNHA programs and services</p> <p>Completed a new Health Benefits Framework and submitted corresponding amendments to the Health Benefits section of the Programs and Services Guide.</p> <ul style="list-style-type: none"> • Goal 4 Performance Measure: Organizational Excellence <p>% planned organization-wide cultural initiatives on target</p> <p>One hundred per cent of staff recruitment processes include cultural safety and humility questions. One hundred per cent of job postings indicate that preference is given to First Nations, Métis and Inuit applicants. Ninety-five per cent of planned Monday morning cultural openings at FNHA locations proceeded.</p> <p>% self-identified Indigenous staff</p> <p>In 2019/2020, 34 per cent of the overall FNHA workforce self-identified as Indigenous.</p> <p>Participation rate in organizational culture workforce survey</p> <p>Eighty-seven per cent of staff participated in the HOWL Survey; a one per cent increase from 2018/2019. The HOWL Survey action planning activities included 30 team action planning sessions and 28 individual sessions.</p> <p>Goal 4 Performance Measure: Information Management Information Technology</p> <p>% of approved organization-wide IMIT-related initiatives on target (scope, schedule, budget)</p> <p>One hundred per cent of multi-year organization-wide IMIT projects remained on target throughout the fiscal year. Projects included data centre transition, multifactor authentication, SharePoint updates and Windows Server updates.</p> <p>% of planned organization-wide enterprise architecture roadmap developed</p> <p>Completed Enterprise Architecture Framework, Practice Guide and Impact Assessments. Completed the FNHA Approved Software Application List and Software Acquisition Procedure.</p> <p>% of planned enterprise data governance and analytics strategy developed and implemented</p> <p>Completed Enterprise Information Management Strategy. Completed draft FNHA Data Strategy Framework.</p> <p>Organizational Excellence Measures:</p> |
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| | <p>Annual Board of Director review of corporate policies on target</p> <p>Policy calendar requirements were met for this fiscal year.</p> <p>% compliance with inclusion of Directives and Operating Principles in decision-making processes</p> <p>Sixty-six decision documents were signed in 2019/2020. Eighty-eight per cent (66 of 75 total submitted decision sheets) included rationalization of the decision in the context of the 7 Directives and Operating Principles.</p> <p>% staff performance partnership agreements completed including staff wellness plan</p> <p>In 2019/2020, 62 per cent of staff completed Performance Partnerships agreements, compared to 61 per cent in 2018/2019.</p> |
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APPENDIX H: FNHA SERVICE PLAN GOALS AND ANNUAL REPORT PERFORMANCE MEASURES 2020/21

| Service Plan 2020/21 Goals | Annual Report 2020/21 Performance Measures |
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| <ul style="list-style-type: none"> Enhance First Nations Health Governance Champion the BC First Nations Perspective on Health and Wellness Advance Excellence in Programs and Services Operate as an Efficient, Effective, and Excellent First Nations Health Organization <p>Goal 1 – Indicator = First Nations health governance effectiveness by measuring: % engagement impact and % FNHC/FNHDA/FNHA partnership activities on target</p> <p>Indicator = Governance Partnership Effectiveness by measuring: % planned tripartite and bilateral partnership activities completed and % planned tripartite and bilateral partnership initiatives on target</p> <p>Goal 2 – Indicator = Impact as a health and wellness partner by measuring: wellness movement impact, Cultural Safety and Cultural Humility initiatives impact and number of requests to use FNHA materials in other agency plans/materials</p> <p>Goal 3 – Indicator = FNHA and First Nations health organization partnerships by measuring: % funding agreement holders for which reciprocal accountability targets are met; and FNHA program information access</p> <p>Indicator = Service quality by measuring: Health Benefits overall client satisfaction rate; % Health Benefits service standards on target; % of clients who received at least one FNHA benefit per year; and Environmental Public Health Officer Community Work Plan objectives achieved according to service standards and changes to FNHA programs and services</p> <p>Goal 4 – Indicator = Organizational excellence by measuring: % planned organization-wide cultural initiatives on target, % self-identified Aboriginal staff and participation rate in organizational culture workforce survey.</p> <p>Goal 4 – Indicator = Information Management Information Technology by measuring: % approved organization-wide IMIT-related initiatives on target (scope, schedule, budget), % planned organization-wide enterprise architecture roadmap developed and % planned enterprise data governance and analytics strategy developed and implemented.</p> <p>FNHA will also be tracking three organizational excellence health performance standards: ♦ Annual Board of Director review of corporate policies on target; ♦ % Compliance with inclusion of Directives and Operating Principles in decision-making processes; and ♦ % Staff performance partnership agreements completed, including staff wellness plans</p> | <ul style="list-style-type: none"> Goal 1 Performance Measure: First Nations health governance effectiveness <p>% ENGAGEMENT IMPACT</p> <p>Spring engagement sessions were cancelled due to COVID-19. Survey results from the Vancouver Coastal and Interior regions' virtual fall Regional Caucus sessions in November 2020</p> <ul style="list-style-type: none"> 91% of Caucus survey respondents reported overall satisfaction 63% reported they had the opportunity to contribute 63% felt their voice was heard <p>PER CENT FNHC/FNHDA/FNHA PARTNERSHIP ACTIVITIES ON TARGET</p> <p>The FNHC, FNHDA and FNHA held two virtual multi-day Joint Planning sessions in October 2020 and February 2021.</p> <p>COVID-19 delayed some partnership work, while significant additional work occurred in other emergent areas such as multiple and detailed FNHA/FNHC/FNHDA joint meetings and discussions on anti-racism and cultural safety and humility</p> <ul style="list-style-type: none"> Goal 1 Performance Measure: Governance Partnership Effectiveness <p>PER CENT TRIPARTITE AND BILATERAL PARTNERSHIP ACTIVITIES COMPLETED</p> <p>Several trilateral and bilateral partnership activities were not held during 2020/2021 due to COVID-19 impacts. However, regular and frequent calls (sometimes daily) occurred between the FNHA Chief Executive Officer, FNHA Chief Medical Officer, other FNHA staff and other partners regarding COVID-19, including for example, the Ministry of Health, Indigenous Services Canada and others.</p> <p>PER CENT TRIPARTITE AND BILATERAL PARTNERSHIP INITIATIVES ON TARGET</p> <p>Significant COVID-19 response work took place and regular meetings were held throughout 2020/2021 with partners. Agreements signed include: FNHA-Ministry of Health Letter of Mutual Accountability; FNHA-Indigenous Service Canada Shared Vision Common Understanding Agreement; and FNHA-Ministry of Mental Health and Addictions Letter of Understanding.</p> <p>Progress was achieved against commitments in both the FNHA-BC Ministry of Health Letter of Mutual Accountability and FNHA-Indigenous Services Canada Shared Vision and Common Understanding.</p> <ul style="list-style-type: none"> Goal 2 Performance Measure: Impact as a health and wellness partner |

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| | <p>WELLNESS MOVEMENT IMPACT</p> <p>Wellness Grants supported innovative online activities this fiscal year.</p> <ul style="list-style-type: none"> • 115 Indigenous Peoples Day of Wellness Grants approved (127 in previous year) • 130 Winter Wellness Grants approved (compared to 90 previous year) <p>Top-performing social media posts were on topics including COVID-19, vaccines, general wellness, harm reduction and program information.</p> <p>CULTURAL SAFETY AND CULTURAL HUMILITY INITIATIVES IMPACT</p> <p>The FNHA, FNHC and FNHDA jointly developed the Anti-Racism, Cultural Safety and Humility Framework and Action Plan and regions led work with partners locally. Significant FNHA data contributions were reflected in the In Plain Sight report. Steady public access to the FNHA website cultural safety portal was maintained throughout the fiscal year.</p> <p>NUMBER OF REQUESTS TO USE FNHA MATERIALS IN OTHER AGENCY PLANS/MATERIALS</p> <p>Requests to use the First Nations Perspective on Health and Wellness were received regularly but were declined due to the uncertainty of ownership of graphic. A protocol for sharing materials is in development.</p> <ul style="list-style-type: none"> • Goal 3 Performance Measure: FNHA and First Nations health organization partnerships <p>PER CENT FUNDING ARRANGEMENTS FOR WHICH RECIPROCAL ACCOUNTABILITY TARGETS ARE MET</p> <p>In light of COVID-19, the FNHA offered reporting deadline extensions to agreement recipients. However, COVID-19 negatively impacted year-over-year progress on the percentage of agreement holders providing annual narrative and financial reporting. Reporting for 2020/2021</p> <ul style="list-style-type: none"> • 15% of agreement holders submitted financial reports (66.8% in 2019/2020) • 22% submitted narrative reports (67.6% in 2019/2020) <p>FNHA PROGRAM INFORMATION ACCESS</p> <p>The top FNHA program web-based content accessed was eHealth and virtual health, COVID-19, overdose and harm reduction, traditional healing and treatment centres.</p> <p>Goal 3 Performance Measure: Service Quality</p> <p>HEALTH BENEFITS OVERALL CLIENT SATISFACTION RATE</p> <p>In 2020/2021, the overall satisfaction rate for First Nations Health Benefits was 45.5 percent compared with 32.8 percent in 2019/2020.</p> |
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| | <p>HEALTH BENEFITS SERVICE STANDARDS ON TARGET</p> <ul style="list-style-type: none"> • Medical Transportation – 78.8% of service standards on target (increase of 13.6% from 2019/2020) • Pharmacy – 90.4% of service standards on target (increase of 10.6% from 2019/2020) • Mental Health – 88.3% of service standards on target (new service standard) <p>PER CENT OF CLIENTS WHO RECEIVED AT LEAST ONE FNHA BENEFIT PER YEAR</p> <p>Total number of eligible FNHA Health Benefits clients in 2020/2021 was 151,199, an increase of 1.4% from 2019/2020. Of these, 76.7% of clients made at least one health benefit claim in the 2020/2021 fiscal year, which represents a decrease of 4.4% from 2019/2020. The decrease was attributed to service restrictions as a result of COVID-19.</p> <p>ENVIRONMENTAL PUBLIC HEALTH OFFICER COMMUNITY WORK PLANS OBJECTIVES ACHIEVED ACCORDING TO SERVICE STANDARDS</p> <p>Despite COVID restrictions, the FNHA Environmental Public Health Services and Indigenous Services Canada, Pacific Region continued a co-operative approach to solving many long-term drinking water concerns and issues. In collaboration with our Nation’s leadership and the funding commitment from the federal government, this improved drinking water supplies and eliminated unsafe conditions, enabling the lifting of four long-term drinking water advisories.</p> <p>CHANGES TO FNHA PROGRAMS AND SERVICES</p> <p>The FNHA pivoted to various services to virtual or other platforms due to COVID-19, including Nursing, Health Benefits, Mental Health, Cultural Supports, First Nations Virtual Doctor of the Day, First Nations Virtual Substance Use and Psychiatry Service, and Online Treatment and Healing Programs. Additional federal funding for 2020/2021 was available for supports such as mental health and wage top-ups for front line workers in response to COVID-19. The FNHA continued to support First Nations communities to update their health and wellness plan using a transformed approach.</p> <p>Goal 4 Performance Measure: Organizational Excellence</p> <p>PER CENT PLANNED ORGANIZATION-WIDE CULTURAL INITIATIVES ON TARGET</p> <p>All staff recruitment processes in 2020/2021 included cultural safety and humility questions, and all postings indicated preference for First Nations, Métis, and Inuit applicants.</p> <p>COVID-19 impacted abilities and capacity to gather to participate in organization-wide cultural activities. However, staff were invited to multiple all-staff virtual gatherings and Human Resources, in partnership with the FNHA Mental Health team and Tsow-Tun-Le-Lum Elders, launched a weekly Mindful Mondays webinar.</p> <p>SELF-IDENTIFIED INDIGENOUS STAFF</p> |
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In 2020/2021, 32% of the overall FNHA workforce were self-identified Indigenous (compared to 34 per cent in 2019/2020) and 27% of incoming new hires self-identified as Indigenous.

PARTICIPATION RATE IN ORGANIZATIONAL CULTURAL WORKFORCE

The HOWL Pulse Survey (administered in the summer of 2020 in place of the full HOWL survey during the level three emergency response) achieved 72% staff participation rate. A second HOWL Pulse survey was launched in March 2021.

Goal 4 Performance Measure: Information Management Information Technology

INFORMATION MANAGEMENT INFORMATION TECHNOLOGY

PER CENT APPROVED ORGANIZATION-WIDE INFORMATION MANAGEMENT/INFORMATION TECHNOLOGY -RELATED INITIATIVES ON TARGET (SCOPE, SCHEDULE, BUDGET)

Planned Information Management/Information Technology initiatives such as Data Centre Transition, Identity Access Management, and SharePoint were undertaken in 2020/2021 as planned. Other projects were initiated as planned.

PER CENT PLANNED ORGANIZATION-WIDE ENTERPRISE ARCHITECTURE ROADMAP DEVELOPED

An FNHA Approved Software Application List was approved and updated with stakeholders along with the completion of a Software Acquisition Procedure. An FNHA Cloud Strategy was completed, and the organization continues to move forward on work on business architecture, application and data architecture deliverables.

The FNHA addressed COVID-19 initiatives through privacy security risk assessment and architecture impact assessment reviews. Innovative solutions were adopted, including the FNHA Mobile App and FNHA Remote Workforce Enablement, in alignment with the FNHA Digital Enablement Strategy.

PER CENT PLANNED ENTERPRISE DATA GOVERNANCE AND ANALYTICS STRATEGY DEVELOPED AND IMPLEMENTED

Due to COVID-19 response needs, there was a lack of capacity to significantly advance work, however work is ongoing this fiscal.

OPERATIONAL EXCELLENCE MEASURES:

ANNUAL BOARD OF DIRECTOR REVIEW OF CORPORATE POLICIES ON TARGET

Meeting target for this fiscal year.

PER CENT COMPLIANCE WITH INCLUSION OF DIRECTIVES AND OPERATING PRINCIPLES IN DECISION-MAKING PROCESSES

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| | <p>Decision sheets signed this year considered the decision in the context of the FNHA's 7 Directives and Operating Principles.</p> <p>PER CENT STAFF PERFORMANCE PARTNERSHIP AGREEMENTS COMPLETED INCLUDING STAFF WELLNESS PLAN</p> <p>In 2020/2021, 48 per cent of staff performance partnerships were noted as completed as of March 31, compared to 62 per cent in 2019/2020. However, deadlines for completion were extended until the end of July 2021, so many are still coming in.</p> |
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APPENDIX I: FNHA SERVICE PLAN GOALS AND ANNUAL REPORT PERFORMANCE MEASURES 2021/22

| Service Plan 2021/22 Goals | Annual Report 2021/22 Performance Measures |
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| <ul style="list-style-type: none"> Enhance First Nations Health Governance Champion the BC First Nations Perspective on Health and Wellness Advance Excellence in Programs and Services Operate as an Efficient, Effective, and Excellent First Nations Health Organization <p>Goal 1 – Indicator = First Nations health governance effectiveness by measuring: % engagement impact and % FNHC/FNHDA/FNHA partnership activities on target</p> <p>Indicator = Governance Partnership Effectiveness by measuring: % planned tripartite and bilateral partnership activities completed and % planned tripartite and bilateral partnership initiatives on target</p> <p>Goal 2 – Indicator = Impact as a health and wellness partner by measuring: wellness movement impact, Cultural Safety and Cultural Humility initiatives impact and number of requests to use FNHA materials in other agency plans/materials</p> <p>Goal 3 – Indicator = FNHA and First Nations health organization partnerships by measuring: % funding agreement holders for which reciprocal accountability targets are met; and FNHA program information access</p> <p>Indicator = Service quality by measuring: Health Benefits overall client satisfaction rate; % Health Benefits service standards on target; % of clients who received at least one FNHA benefit per year; and Environmental Public Health Officer Community Work Plan objectives achieved according to service standards and changes to FNHA programs and services</p> <p>Goal 4 – Indicator = Organizational excellence by measuring: % planned organization-wide cultural initiatives on target, % self-identified Aboriginal staff and participation rate in organizational culture workforce survey.</p> <p>Goal 4 – Indicator = Information Management Information Technology by measuring: % approved organization-wide IMIT-related initiatives on target (scope, schedule, budget), % planned organization-wide enterprise architecture roadmap developed and % planned enterprise data governance and analytics strategy developed and implemented.</p> <p>FNHA will also be tracking three organizational excellence health performance standards: ♦ Annual Board of Director review of corporate policies on target; ♦ % Compliance with inclusion of Directives and Operating Principles in decision-making processes; and ♦ % Staff performance partnership agreements completed, including staff wellness plans</p> | <ul style="list-style-type: none"> Goal 1 Performance Measure: First Nations health governance effectiveness <p>% ENGAGEMENT IMPACT</p> <p>9 caucus sessions held – 85% caucus survey respondents satisfied</p> <p>FNHA/FNHDA/FNHA Partnership Activities 90% completed</p> <ul style="list-style-type: none"> 2 joint planning meetings Monthly <i>In Plain Sight</i> Provincial Task Team meetings Monthly town halls on public health emergency response <p>Goal 1 Performance Measure: Governance Partnership Effectiveness</p> <p>PER CENT TRIPARTITE AND BILATERAL PARTNERSHIP ACTIVITIES COMPLETED</p> <p>80% completed – 2 TCFNH meetings / FNHA-MMHA meetings / FNHA-ISC meeting</p> <p>PER CENT TRIPARTITE AND BILATERAL PARTNERSHIP INITIATIVES ON TARGET</p> <p>75% on target – FNHA-MMHA Letter of Understanding on track / FNHA-ISC BC Region Protocol Agreement on track</p> <ul style="list-style-type: none"> Goal 2 Performance Measure: Impact as a health and wellness partner <p>WELLNESS MOVEMENT IMPACT</p> <p>111 Indigenous Peoples Day of Wellness grants funded. 103 Winter Wellness grants funded.</p> <p>CULTURAL SAFETY AND CULTURAL HUMILITY INITIATIVES IMPACT</p> <p>Anti-racism, CSH Framework and Action Plan complete. Guidebook on Indigenous-specific anti-racism being developed with education and training on delivering a coordinated approach to implementing CSH.</p> <p>NUMBER OF REQUESTS TO USE FNHA MATERIALS IN OTHER AGENCY PLANS/MATERIALS</p> <ul style="list-style-type: none"> 46 agency/partner requests received 22 agency/partner request received for First Nations Perspective on Health and Wellness 100s of individual inquiries received |

Goal 3 Performance Measure: FNHA and First Nations health organization partnerships

PER CENT FUNDING ARRANGEMENTS FOR WHICH RECIPROCAL ACCOUNTABILITY TARGETS ARE MET

- 49%, financial reports received from community partners - up 15% from previous year
- 53% narrative reports received from community partners, up 22% from previous year

ACCESS TO FNHA PROGRAM INFORMATION

420,000 visits to program sites – top searches and posts = Covid-19; treatment centres; VDOD; mental wellness and substance use; traditional healing

Goal 3 Performance Measure: Service Quality

HEALTH BENEFITS OVERALL CLIENT SATISFACTION RATE

48.4% up from 44.7% Number of surveys: 550 to 681

ACHIEVEMENT OF HEALTH BENEFITS SERVICE STANDARDS: ON TARGET

- Medical Transportation: 81.5% from 79.5%
- Pharmacy: 86.3% from 75%
- Mental Health: 100% from 97.4%

ENVIRONMENTAL PUBLIC HEALTH OFFICER COMMUNITY WORK PLAN OBJECTIVES ACHIEVED

95 Community-Based Water Monitors installed. 30 communities received funding to combat the effects of climate change on traditional foods, medicines and marine food harvesting

CLIENTS RECEIVING MORE THAN ONE BENEFIT A YEAR

- 81.1% up from 77.4%
- Number of eligible clients: 149,852 to 152,067

CHANGES TO FNHA PROGRAMS AND SERVICES: In the past year, the FNvSUPS program continued to expand, building off existing connections with referring agents and creating new relationships with local community resources and external partners to best support client care.

Goal 4 Performance Measure: Organizational Excellence

PLANNED ORGANIZATION-WIDE CULTURAL INITIATIVES

- 80% on target

SELF-IDENTIFIED INDIGENOUS STAFF

- 32% of overall FNHA workforce

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| | <ul style="list-style-type: none"> • 26% of external new hires <p>PARTICIPATION RATE IN ORGANIZATIONAL CULTURE WORKFORCE SURVEY</p> <ul style="list-style-type: none"> • 81% completion of HOWL employee engagement survey • 621 FNHA employees <p>Goal 4 Performance Measure: Information Management Information Technology</p> <p>INFORMATION MANAGEMENT INFORMATION TECHNOLOGY</p> <p>PER CENT APPROVED ORGANIZATION-WIDE INFORMATION MANAGEMENT/INFORMATION TECHNOLOGY -RELATED INITIATIVES ON TARGET (SCOPE, SCHEDULE, BUDGET)</p> <ul style="list-style-type: none"> • 100% on target <p>DEVELOPMENT OF PLANNED ORGANIZATION-WIDE ENTERPRISE ARCHITECTURE ROADMAP</p> <ul style="list-style-type: none"> • On Target <p>PLANNED ENTERPRISE DATA GOVERNANCE AND ANALYTICS STRATEGY</p> <ul style="list-style-type: none"> • Postponed to 2022/23 <p>OPERATIONAL EXCELLENCE MEASURES:</p> <p>ANNUAL BOARD OF DIRECTOR REVIEW OF CORPORATE POLICIES ON TARGET</p> <ul style="list-style-type: none"> • 100% submission of corporate policies scheduled for review <p>% COMPLIANCE WITH INCLUSION OF DIRECTIONS AND OPERATING PRINCIPLES IN DECISION-MAKING PROCESSES</p> <ul style="list-style-type: none"> • 100% decision sheets considered 7 Directives and Operating Principles <p>% STAFF PERFORMANCE PARTNERSHIP AGREEMENTS COMPLETED, INCLUDING STAFF WELLNESS PLAN</p> <ul style="list-style-type: none"> • 59% of performance partnership agreements completed • 100% that included a staff wellness plan |
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APPENDIX K: CONTENT ANALYSIS OF FNHA ANNUAL REPORTS FROM 2013/14 TO 2021/22

| FNHA Annual Reports | | | | | | | | | | | | | | | | |
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| | Vision | Mission | Values | Message from the Board Chair | Message from the CEO | Financial Report | Goals | Outcomes Statements | Objectives | Strategies | Key Priorities | Annual Key Priorities | Performance Measures | New Developments | Notes | |
| | Healthy, Self-Determining, and Vibrant BC First Nations Children, Families, and Communities | The First Nations Health Authority supports BC First Nations individuals, families and communities to achieve and enjoy the highest level of health and wellness by working with them on their health and wellness journeys; honouring traditions and cultures; and championing First Nations health and wellness within the First Nations Health Authority organization and with all of our partners (SSP 2018-19) | Respect, Discipline, Relationships, Culture, Excellence, and Fairness | | | | | | | | | | | | | |
| 2013-14 | Yes | No | No | Yes | Yes | Yes | Transition Goals (Five priority areas) | No | No | No | No | No | | | | |
| 2014-15 | No | Yes | No | Yes | Yes | Yes | Transition Goals (same) | No | No | No | No | No | | | | |
| 2015-16 | No | No | No | Yes | Yes | Yes | Different goals - not focused on transition | No | Yes - different from 5-year plan objectives - included in appendix | No | No | No | | | | |
| 2016-17 | No change | No change | No change | No change | No change | No change | Start of 5 year health plan with a focus on 4 main goals in SSPs - 1. Enhance First Nations Health Governance; 2. Champion the BC First Nations Perspective on Health and Wellness; 3. Advance Excellence in Programs and Services; and 4. Operate as an Efficient, Effective and Excellent First Nations Health Organization | Yes - start with 5 year health plan and accompany each goal 1. Sustainable and accountable governance structures leading change 2. Culturally safe and supported health and wellness journeys 3. Advancements in the quality and cultural safety of programs and services available to First Nations individuals, families, and communities in BC 4. FNHA is an established leading edge First Nations health organization | Yes | Yes | Yes | Yes | Yes - changed in number and content | Yes | KEY DELIVERABLES - SSP states that FNHA developing a performance measurement approach - 4 initial key performance indicators - Annual Report provides performance updates on these indicators - ALIGNMENT between SSP and AR | |
| 2017-18 | No change | No change | No change | No change | No change | No change | No change | No change | No change | No change | Yes | Yes - changed in number and content | No change | Addition of 3 organizational excellence health performance standards: 1. Annual board of director review of corporate policies on target; 2. % compliance with Directives and Operating Principles in decision-making processes; and 3. % staff performance partnership agreements completed, including staff wellness plans | | |
| 2018-19 | No change | No change | No change | No change | No change | No change | No change | No change | No change | No change | Yes | No annual key priorities | Slight modification to one PI for goal #3/ Change to one PI for goal #4 | Addition of new section in this SSP called "Reflecting on our Progress" Addition of Appendix A "FNHA and the TRC" | | |
| 2019-20 | No change | No change | No change | No change | No change | No change | No change | No change | No change | No change | Yes | Yes | No change | Addition of 7 organization-wide key priorities: 1. Evolving the FNHA operating model, including regionalization; 2. Renewed partnerships with First Nations; 3. Wellness; 4. Knowledge development and exchange; 5. Cultural safety and humility; 6. Service excellence - mental health and wellness, primary health care, and health benefits; and 7. Leadership and culture development | | |
| 2020-21 | No change | No change | No change | No change | No change | No change | No change | No change | No change | No change | Yes | Yes | No change | Reflecting on our Progress" section from 2018/19 SSP (included in 2019/20) | | |
| 2021-22 | No change | No change | No change | No change | No change | No change | No change | No change | No change | No change | Yes | No annual key priorities | No change | Six organization-wide key priorities: 1. Public health emergencies; 2. Anti-racism and cultural safety and humility; 3. Renewed partnerships with First Nations; 4. Wellness; 5. Knowledge development and exchange; 6. Service excellence | FNHA 5 year health plan extended for another year into the 2022/22 SSP due to the Covid-19 pandemic. | |