Rural, Remote, First Nations and Indigenous COVID-19 Response Framework

May 26, 2020

This is a living document and current as of May 26, 2020.

The document and the framework will continue to be developed over the coming months. It will be implemented by health authorities in communities in consultation with local leaders and recognizing the unique nature of individual communities.

Minister's Message

It's my honour to present to British Columbians a new collaborative framework that will help ensure people living in rural, remote and Indigenous communities in B.C. have access to critical health care they can count on to meet their unique needs during the COVID-19 pandemic and into the future.

We recognize that people living in rural, remote and Indigenous communities have unique challenges in accessing the health care they need. That's why this new collaborative framework will bring immediate relief to these communities, including a commitment to moving patients to the critical care they need at a moment's notice.

This will help our work to stop the spread of COVID-19, while supporting better health outcomes into the future. The framework was developed through a partnership between the First Nations Health Authority, Northern Health and Provincial Health Services Authority. The work is guided by the principles of cultural safety and humility, and adds to work underway by the Rural Coordination Centre of BC. Thank you for your work on this, and to meeting the needs of our stakeholders and residents. Their needs are at the heart of the framework.

We understand communities have vast and varying needs, which is why the framework provides flexibility so local leaders in rural, remote and Indigenous communities can adapt it to meet their unique needs. It will be implemented through full engagement with each of the community's local leaders.

We're taking care to do it right – to learn and apply these lessons, adapting as we go. We're giving it the same 100% effort we've made in addressing COVID-19 along the way. Everyone involved across the health-care system and the province are working together on this.

My sincere thanks to the First Nations Health Authority, the Office of the Provincial Health Officer – in particular, Dr. Danièle Behn Smith, Aboriginal Health Physician Advisor – Northern Health, the Provincial Health Services Authority and the Ministry of Health for their dedicated work towards this framework.

Even though we are spread throughout the province, we are all in this together.

Sincerely,

Adrian Dix
Minister of Health

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Overview

- As B.C.'s health system responds to the COVID-19 pandemic, the unique and varied needs of communities across British Columbia present a range of challenges.

- For COVID-19, data to date suggest that **80% of infections are mild or asymptomatic, 15% are severe, requiring oxygen, and 5% are critical, requiring ventilation**. The challenges in the latter cases are that the decline and need for access to critical and ventilated care can be rapid and escalate in a matter of hours. This poses specific challenges for citizens living in rural and remote regions of our province. Understanding the **challenges inherent to a pandemic response in-and-for First Nations and Indigenous[1] communities, and communities that are rural and remote is critical.**

- It is important to acknowledge that the challenges of these communities' response to the pandemic are longstanding and have an ongoing impact on the quality of care and access to services experienced in these rural, remote and isolated communities. This has been the focus of work for the last several years by the Rural Coordination Centre of B.C., which has led a process that seeks to identify and co-create solutions to the challenges of rural health by bringing together policy makers, educators, health-care administrators, researchers and health professionals/service providers.

  The areas of focus for this partnered work includes:

  - Co-creating culturally safe and appropriate primary health care;
  - Designing, planning for and implementing team-based care;
  - Increasing citizen and community involvement in health-care transformation processes; and
  - Improving access and transitions for patients in rural and remote communities, with a focus on virtual enhanced care and patient transport.

- B.C. has made excellent strides in supporting a health system that responds to cultural values. The mandate of the FNHA was established by B.C. First Nations through the adoption of the *Consensus Paper 2011* and *Consensus Paper 2012* and is further defined in the *Tripartite Framework Agreement on First Nations Health Governance* (2011), which laid the foundation for the development of the first-ever First Nations Health Authority (FNHA) established in 2013.

- The FNHA provide provincewide infrastructure for First Nations communities in B.C., which includes a regional service delivery system for community-driven, nation-based decision making.

- FNHA leadership is essential to a culturally-safe response, and important in the development of community relevant service pathways for First Nations people and communities in partnership with the regional health authorities.

[1] To be concise and inclusive throughout this framework, the term "First Nations and Indigenous" is used to represent all First Nations (status and non-status, living at home and away from home), Métis (citizens and self-identified), and Inuit people living in British Columbia.

- Despite this progress, realities of accessing culturally-safe care are further exacerbated by social inequities and inter-generational trauma that are experienced in many First Nations and Indigenous communities. Therefore, **attention to cultural safety and humility** is essential as the partners work together to develop the service pathways.

- The framework includes:
  - Overarching guiding principles;
  - Definition/description of rural, remote and First Nations and Indigenous geography;
  - Planning for a patient choice enabled rural and remote system;
    - Setting clinical pathways for patients to get to the right level of care;
    - Supporting informed community and individual choices;
    - Implementing community cohort centres[2] close to hospital services; and,
    - Ensuring a robust transportation infrastructure.

- To support the framework, BC Emergency Health Services (BCEHS) has prepared significant additional resources for its fleet. This amounts to an additional 55 ground ambulances across the province, including six in Northern Health. In addition, BCEHS prepared five additional air resources, with an additional two possible if needed.

- The framework is a guide for the Ministry of Health, regional health authorities, First Nations Health Authority, BCEHS, communities, program administrators, service providers and policy makers to address the care management needs related to COVID-19 of British Columbians residing in rural and remote British Columbia.

- There will be ongoing engagement between First Nations and Indigenous communities, and rural and remote health service providers. This will develop processes and service pathways that help individuals, communities, and rural and remote health practitioners to build the pathways within the specific context of their community and regional network of services.

- Through the engagement process, the provincial partners will gain an understanding of the community and regional context in order to design a response that considers the specific community assets and risks that impact health and wellness, particularly in relation to the COVID-19 pandemic.

- This framework will provide a permanent and needed operational platform framework to better meet the urgent and emergent health needs of First Nations and Indigenous communities, and rural or remote communities.

[2] A community cohort centre is a temporary location set up to accommodate patients with COVID-19, supporting self-isolation close to acute and critical care health-care supports in the event they need them.

Rural and Remote Focus

There is not a single definition of rural and remote. For example, rural and remote in Fraser Health means something much different than rural or remote in Northern Health. For the purposes of this document, **rural** is defined as outlined in the table below and is reflective of the rural and remote realities relevant to this document. The term **remote** is more fluid and considers distance and accessibility in its definition.

Category	Population (Community and Catchment Area)	Level of Care
Rural	3,500-20,000	Some specialized acute services (such as perinatal and day surgery). Long-term care and assisted living generally available in all communities.
		Limited general inpatient care to meet basic acute care needs of local population. Public health, and mental health and substance use services available in community. Long-term care and assisted living services available in some communities.
Small Rural	1,000-3,500	Primary and community care that meets most health needs of the population, with potential for urgent and basic emergency care in some locations. Emergency transportation mechanisms are crucial. Visiting child, youth and family, and mental health and addictions outreach services.
Remote	0-1,000	First aid and nurse-led/remote certified practice care to meet immediate needs of remote population. May include facilities for itinerant primary and community care that meets basic health needs as well as established urgent/emergent community care services. Community too small and dispersed to sustain local health services. Health service needs addressed in neighboring communities.

PRINCIPLES

The overarching principles underpinning this framework are consistent with the pandemic response public health measures and take into account the unique realities and context of rural and remote communities. These principles influence both the public health and care management response to COVID-19 and include:

- **Evidence-informed decision making** – guides decision making based on the best available evidence.
- **Informed choice** – a dialogue that supports informed decision making and choice by individuals or communities.
- **Flexibility** – ensures timeliness and relevance to the community context.
- **Collaboration** – promotes all levels of government and First Nations and Indigenous communities working together to support the health and well-being of communities and their membership.
- **Geography** – influences decisions critical to clinical and transportation pathways.

- **Community networks** – recognizes the interconnectedness of rural and remote communities amongst themselves and with other communities.
- **Local contexts** – influence the relevance and effectiveness of specific public health measures.
- **First Nations and Indigenous rights and entitlement** – are heard, recognized and supported.
- **Culturally safe and respectful implementation of policies, programs and services.**
- **Collaborative dialogue** – occurs between partners, which could be in the context of pre-existing agreements, in order to maintain clarity of action and sustained relationships.

ASSUMPTIONS

The assumptions underlying planning for rural and remote communities include recognizing that:

- There is geographic variability in the intensity and timing of the pandemic.
- There is great diversity in community infrastructure and capacity to address the impacts of the pandemic on communities and its members.
- The impact of the pandemic will differ across a community, with some individuals affected more than others.
- The well-being of communities, including individual mental wellness, will be affected socially, spiritually, and economically.
- There is a wide range of opportunities to care for people in the community and, if people are confident in their ability to self-isolate and receive care in their community, this will affect their decision to stay or leave the community.
- Ensuring appropriate supports and care for people in the community will enable the community members to make informed choices regarding their care, and when they may choose to leave the community.
- First Nations and Indigenous communities have distinct historical and contemporary realities that differ from those of non-First Nations and Indigenous British Columbians and require a distinctions-based approach.

Rural and Remote Context

A strong sense of place characterizes rural and remote British Columbia and impacts the way health-care providers carry out their work. The nature of rural service delivery requires partnerships across multiple sectors, and creativity to meet the needs of both communities and the individuals who live in these communities.

Geography

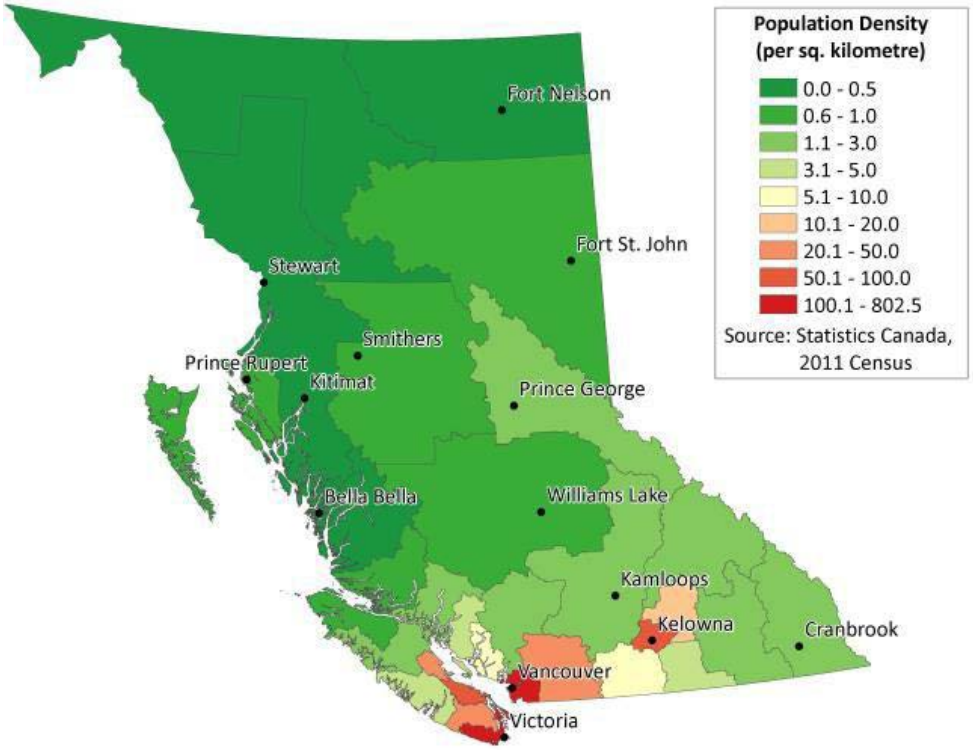
The geography of rural and remote communities in British Columbia is characterized by variation and difference. Almost 95% of British Columbia's land base is rural and remote. The land is home to diverse cultures and rich with natural resources.

The health and well-being of First Nations and Indigenous communities is closely linked to their connections with the land, and from the strength of culture, language and traditions that grow from that connectivity. Rural and remote British Columbia supports the economy through agriculture, mining, forestry, energy development and tourism.

Population

The populations of rural British Columbia are often small, dispersed and fluctuating. Many areas of the province have less than five people per square kilometre (B.C. Ministry of Health, 2015) as depicted in the map below.

Figure 1: British Columbia population per square kilometre

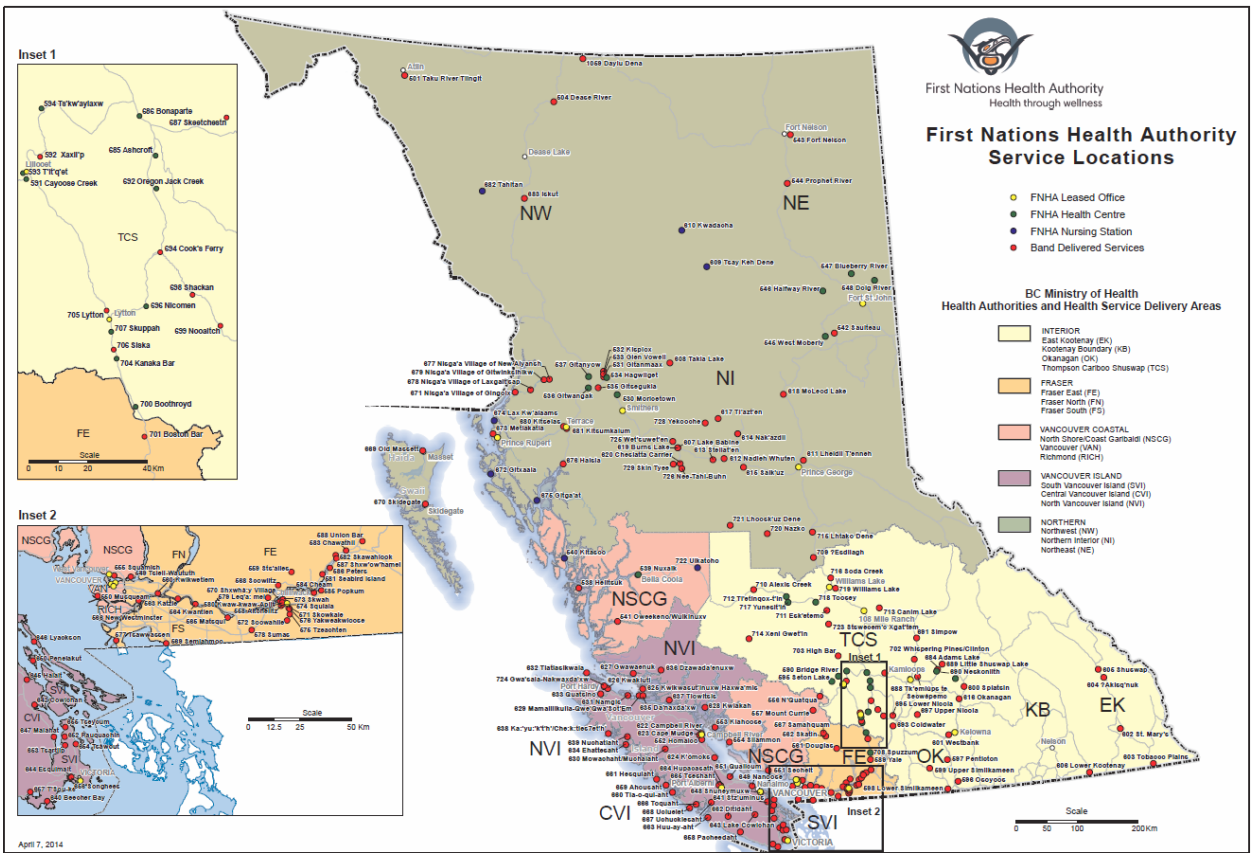


First Nations and Indigenous Communities

First Nations and Indigenous peoples comprise approximately 200,000 people in British Columbia. There are 203 distinct First Nations in B.C., each with their own unique traditions and history. More than 30 different First Nation languages and close to 60 dialects are spoken in the province.[3]

[3] Retrieved April 15, 2020 from: www.welcomebc.ca/Choose-B-C/Explore-British-Columbia/B-C-First-Nations-Indigenous-People.

Map of British Columbia First Nations Communities



The First Nations Health Authority (FNHA) is the first provincewide health authority focused on supporting the health and wellness of First Nations in Canada. On Oct. 13, 2011, First Nations in B.C. (under the First Nations Health Society), the Province of British Columbia and the Government of Canada signed the British Columbia Tripartite Framework Agreement on First Nation Health Governance.

FNHA works to transform the way health care is delivered to First Nations through direct services, provincial partnership and collaboration, and health systems innovation, including embedding cultural safety and humility and intergenerational trauma-informed care throughout the health system. FNHA collaborates with the federal and provincial governments, regional health authorities and other system partners to co-ordinate and integrate health programs and services to achieve better health outcomes for First Nations in British Columbia.

The First Nations Health Authority is also responsible for planning, management, service delivery and funding of health programs and services in partnership with First Nations communities.

These services are largely focused on health promotion and disease prevention, and include:

- Primary health care;
- Children, youth and maternal health;
- Mental health and wellness;
- Communicable disease control;
- Environmental health and research;
- First Nations health benefits (non-insured health benefits);
- eHealth and telehealth;
- Health and wellness planning; and,
- Health infrastructure and human resources.

FNHA is developed by and for BC First Nations, and is a partner of the First Nations Health Governance structure, which, is guided by its seven directives and shared values and is committed to creating the space for First Nations communities to self-determine their path towards wellness and nation rebuilding.

Community **isolation** is also taken into account when considering remoteness of First Nations and Indigenous communities. The following table identifies and defines these categorizations:

Zone 1: Non-isolated	Located within 50 km of the nearest service centre, with year-round road access.
Zone 2: Semi-isolated	Located between 50 and 350 km from the nearest service centre, with year-round road access.
Zone 3: Isolated	Located over 350 km from the nearest service centre, with year-round road access.
Zone 4: Remote isolated	Community has no year-round road access to a service centre and, as a result, experiences a higher cost of transportation.

A Framework for Providing Care in Rural and Remote Areas

Patient choice is central to this framework. People living in rural and remote British Columbia expect to be active partners in the development of their care pathway. In the context of COVID-19, supports are being put into place to help people do their part to *flatten the curve* by having options on how to self-isolate in ways that work for them. Rural and remote British Columbians will be able to make informed decisions to self-isolate at home, in the community with additional supports or near a hospital. Challenges to accessing important services such as testing may require creative solutions to help effectively identify cases, manage outbreaks and support care planning.

In support of this framework, an operational guidance document will include:

- *Understanding the community* tools;
- Clinical pathways;
- Transport pathways;
- Community cohorting pathway;
- Examples of roles and responsibilities between FNHA and regional health authorities; and,
- Guidance documents supporting community and individual decision making.

Guided Conversation to Support Individual Choice

An individual with symptoms of COVID-19 has decisions to make regarding their care pathway that need to be guided by their conversation with a clinical care team. This is a conversation that is grounded in cultural safety and humility, allowing them to make an informed choice based on their understanding of their care needs within the context of their community. Supports to guide these conversations will be part of the framework's operational guide.

Open and honest communication of these choices allow an individual and their family to understand the risks and ensures the community can support the choices made.

Planning that establishes the infrastructure and processes associated with the choices available to individuals and their families enables:

- Choices that are informed by the potential risks to health and well-being, and the range of supports and community assets available that may mitigate these risks.
- Transportation services suited to the choices made by the patient with the clinical care team
- Community supports to be mobilized such as access to healthy food, social supports, mental wellness and traditional cultural practices.

Supporting Informed Community Choices

By developing processes that support informed community and individual choices, a care team will be able to partner with the individual and their family within the context of the community and transportation network.

Understanding the context of the community and the clinical pathways available to the individual diagnosed with COVID-19 in a rural, remote, and First Nations and Indigenous community allows partners to establish the infrastructure and processes that enable an informed choice to be made. These choices may include self-isolating at home, self-isolating elsewhere in the community, or self-isolating in a community closer to an acute care hospital or critical care unit with the relevant and appropriate social, physical and clinical supports in place.

Clinical Service Delivery

Clinical pathways are specific to the context of a region and community and need to consider the assets available to support service delivery and care. The operation guidance document will describe these pathways. Clinical pathways acknowledge factors unique to First Nations and Indigenous communities. By describing these pathways, clinical care teams will have the guidance they need to effectively support individuals with symptoms consistent with COVID-19.

Led by the medical health officer, the public health communicable disease team are responsible for overseeing the screening, testing, identification, notification/reporting, contact tracing, follow-up and monitoring processes of positive COVID-19 cases. This team works closely with the clinical care team providing clinical care and supports for people identified with COVID-19 and their contacts. The public health communicable disease team works in partnership with FNHA communicable disease team, Office of the Chief Medical Officer, and the regional health authority to lead and oversee the public health functions in First Nations communities.

Members of the clinical care team involved in supporting a rural/remote First Nations and Indigenous community during the COVID-19 response are advised to work through clinical pathways specific to their situation. The clinical care team will vary dependent on the community context. In some situations, the clinical care team may be present in the community through the services of a nursing station, a community health centre, a diagnostic and treatment centre or a primary care clinic. In more remote and isolated communities, members of the clinical care team may be itinerant, or services may be provided through virtual means such as the Virtual Doctor of the Day program.

The clinical care team or circle of care, whether virtual or physically present in the community, may consist of a primary care physician, nurse practitioner, community health nurse/primary care nurse, a community health representative, additional Indigenous-specific supports, community paramedic or other first responders present in some First Nations and Indigenous communities. In relation to the COVID-19 response, these local clinical care teams are supported by a public health team, including the medical health officer and nurses with expertise in communicable disease control, the BC Emergency Health Services patient transfer team and the acute care specialized services team.

A further consideration in supporting people living in rural and remote communities and, in particular, First Nations and Indigenous communities, is the role of the broader community support team (circle of community support) that can be mobilized to support an individual and community. The focus of these services includes: supporting mental health and wellness; mobilizing social and cultural traditions supports; and enabling safe housing, transportation and food security. These supports may be available within the community or from the broader system of services provided by FNHA. The communication pathways between the public health communicable disease team, the clinical care team and the community support team are important to describe and work out in advance.

Establishing the Processes and Infrastructure to Support Individual and Community Choice

Planning of the processes and infrastructure necessary to support individual and community choices is guided by the following principles:

- Supporting self-isolation: Identifying and creating appropriate spaces and opportunities to self-isolate. Options may include self-isolation at home, self-isolation elsewhere in the community such as in dedicated modular homes or self-isolating at a community cohort centre[4] closer to acute care or critical care unit.
- Destigmatizing the practice of self-isolating through education.
- Approaches to self-isolate and receive care are appropriate, sustainable and culturally safe.
- Transparency of available options given the unique character of the community and supports.
- Enhancing primary care services if needed. This may include bringing a health-care team in to the community (versus requiring people to leave to seek care) and new programs such as the First Nations Virtual Doctor of the Day. This program has created a virtual platform to support increased access to primary care services in rural and remote communities.
- Increased access to diagnostics and testing. The FNHA is expanding the capacity to do local testing for COVID-19 and other diseases by purchasing additional testing equipment to allow testing to be done locally.
- Access to appropriate transportation and clinically appropriate response times to transfer people if they are sick, and the potential for these to change as demand increases.
- Understanding and respecting people's wishes. Supporting advance directives and in-community palliative care where this is desired.
- Ensuring transition to the nearest community is culturally safe, and that opportunities to self-isolate are safe and supported with appropriate education and health monitoring.
- Awareness that being located outside of one's community and away from one's established supports can pose as a hazard and risk to a person.

[4] A community cohort centre is a temporary location set up to accommodate patients with COVID-19, supporting self-isolation close to acute and critical care health-care supports in the event they need them.

The partners may choose to establish community cohort centres to enable individuals to choose to temporarily relocate to a location in closer proximity to an acute care hospital or critical care unit. The decision to establish these centres should be made based on the community and regional context, discussions with partners and the type of facility (e.g., hotel, existing health-care facility) available.

Establishing a community cohort centre takes planning. Considerations include:

- Acceptable to the person and culturally safe;
- Strength-based, trauma-informed and seek to reduce harm;
- Offered as close to home as possible;
- Achieved through partnership to provide safe accommodation, housekeeping and food services;
- Supporting appropriate self-isolation practices;
- Preserving important relationships, connection and a sense of community;
- Holistic and wellness-oriented;
- Responsive to health and wellness care needs;
- Facilitating voluntary participation; and
- Regularly reviewed for evidence-based effectiveness.

Building out a Robust Transportation System

The Provincial Patient Transfer Emergency Operations Centre is comprised of transport leads from each health authority, BCEHS, Rural Coordination Centre of BC, Rural and Remote Division of Family Practice, and the Ministry of Health, as well as a member of the Health Emergency Coordination Centre. This group has been established to provide the following functions in support of the British Columbia's emergency response to COVID-19:

1. Operational and inter- and intra- health authority patient transfers.
2. Development of clinical guidelines and standards for patient transport in relation to COVID-19.
3. Support the development of provincial policy.

In B.C., patient transfers occur for several reasons. Hospital inpatients are routinely transferred from smaller community centres to tertiary centres for access to specialized services. These patients are usually less acute, and transfers can be scheduled in advance. When patients require rapid access to a higher level of acute or critical care services, patients are transferred on an urgent basis – as dictated by their medical need – to sites where the appropriate medically necessary services are available. All these transfer services are co-ordinated, managed and delivered through BC Emergency Health Services (BCEHS).

In preparation for COVID-19, BCEHS has prepared significant additional resources for its fleet. This amounts to an additional 55 ground ambulances across the province, including six in Northern Health. They have also prepared five additional air resources, with an additional two possible if needed. BCEHS functions as a provincial service, which allows for quick repositioning of transport resources as required to meet local needs should some areas experience higher levels of outbreak than others.

Changes that patients in rural and remote areas will be able to expect include early referral and transport options that will support them being nearer to acute and critical care services, if they so choose. Patients will have flexible options that take their local context into consideration during planning of their care. In order to support self-isolation in a location that works best for the patient, flexible options will include patient transfers prior to being medically necessary or admitted to hospital. BCEHS will continue to co-ordinate, manage and deliver all patient transfers – including early referrals. Additionally, BCEHS will work with other transport partners (e.g., BC Transit) to deliver elements of this framework. Patients can continue to expect being the centre of all decision making regarding their care journey.

Transportation services to the community cohort centre or other similar options need to be pre-determined should the individual choose to self-isolate away from the community. The partners will establish a transportation plan to support an individual's right to informed choice as to whether they wish to receive care in their community or to leave and seek care elsewhere. The transportation plan may include a personal vehicle, alternative transit options, water transport or community-based transportation options for low acuity or asymptomatic, vulnerable individuals.

Linked to this will be a surge capacity plan for ground and air transportation resources co-ordinated and provided by BCEHS. The plan will trigger increased levels of resources in the system to meet service level demands. Transportation planning will include early referral and transfer to community cohort centres, and rapid acute/critical care transfers to COVID-19 designated hospitals. Transportation protocols will be developed by each health authority in collaboration with BCEHS and with input from rural/remote, and First Nations and Indigenous communities. The health authorities, FNHA and BCEHS need to finalize regional specific transfer algorithms, transport referral pathways and risk stratification algorithms.

BCEHS and partners are currently planning for expanded capacity to meet local needs should a surge in demand arise as a result of COVID-19. This surge planning involves modelling out needed capacity for transport based on different possibilities of epidemic progression and planning for the increase in transport capacity if needed. This increase in capacity will be phased in and may involve bringing in external partners such as the Canadian Armed Forces.

Key actions that will be undertaken include:

- Determining surrounding BCEHS stations that will support the COVID-19 sites and the community cohort centres.
- Establishing staffing strategies to ensure resources are appropriately staffed in each area.
- Building out and then staging additional ground fleet and air resources in areas that may need additional support and can support surrounding areas.
- Completing a surge capacity plan that acknowledges different epidemiologic models for COVID-19.

Conclusion

This framework will provide a permanent and needed operational framework to better meet the urgent and emergent health needs of First Nations, Indigenous, rural, remote and isolated communities.

This work will be:

- Evidence-informed;
- Promote informed patient choice;
- Support flexible and local decision making;
- Recognize the rights of First Nations and Indigenous partners; and,
- Be implemented in a way that is culturally safe and respectful.

The Province, health authorities, BC Emergency Health Services and the First Nations Health Authority are committed to ensuring individuals in these communities are empowered and have options to make decisions on how they receive the care they need.