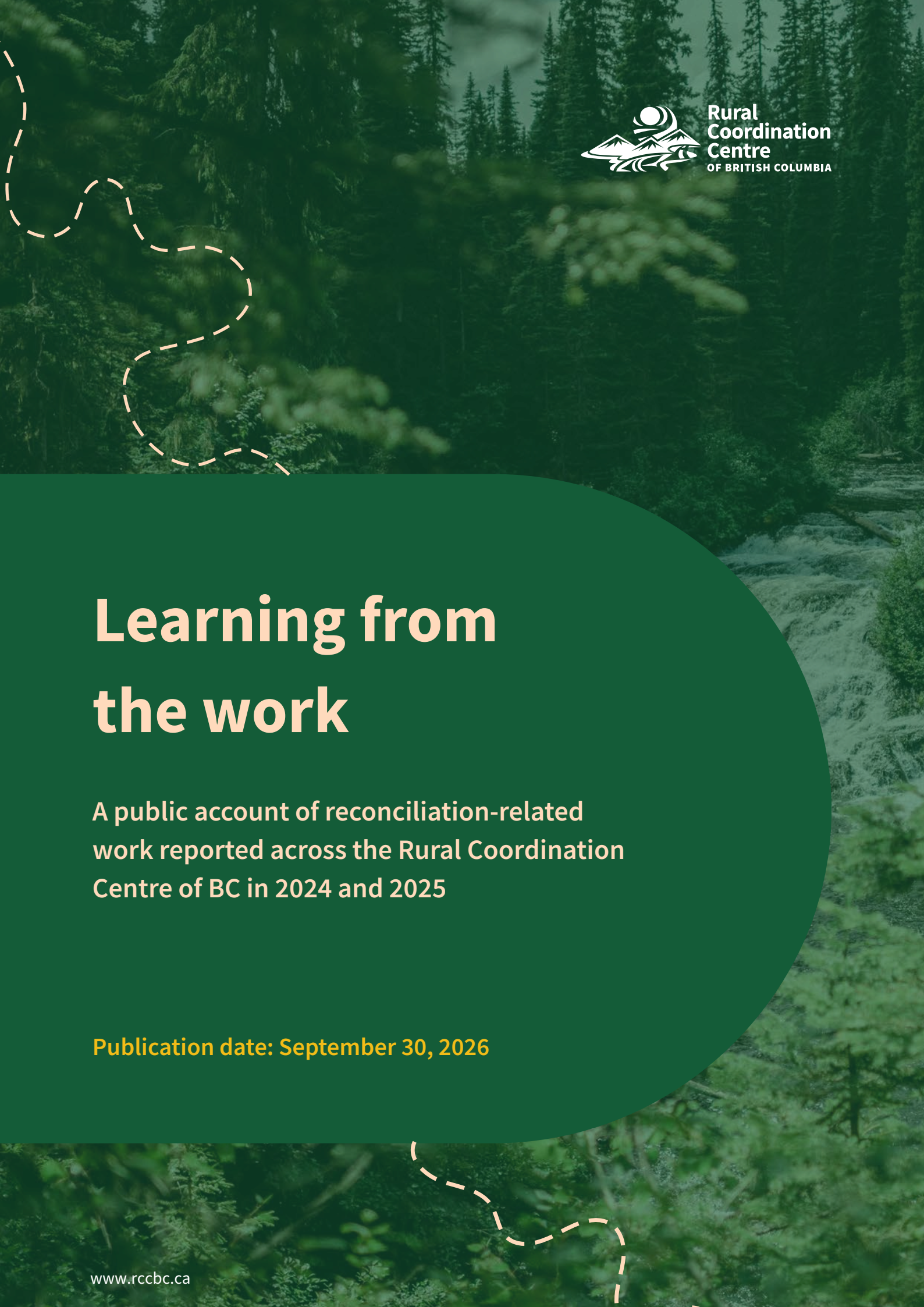


Rural Coordination Centre OF BRITISH COLUMBIA

Learning from the work

A public account of reconciliation-related work reported across the Rural Coordination Centre of BC in 2024 and 2025

Publication date: September 30, 2026

www.rccbc.ca

Contents

What this report brings together

Responsibility for reconciliation does not sit in one program or committee. Across RCCbc, it appears in Elders guiding a medical education gathering, a program changing how it opens conversations, a diabetes initiative establishing a First Nations Advisory Group and transport partners making persistent gaps visible. These activities are not equivalent or the whole of reconciliation. Together, they show responsibility distributed across the network while also revealing where the record is less clear about authority, action and follow-through.

This report is written from RCCbc's perspective. When we use "we", it means RCCbc as an organization. The work described here happens through relationships with Indigenous leaders, physicians, communities, health organizations, educators, researchers and other partners across the network. Each brings their own knowledge, responsibilities and authority. RCCbc remains responsible for our decisions, actions and how we respond in relation.

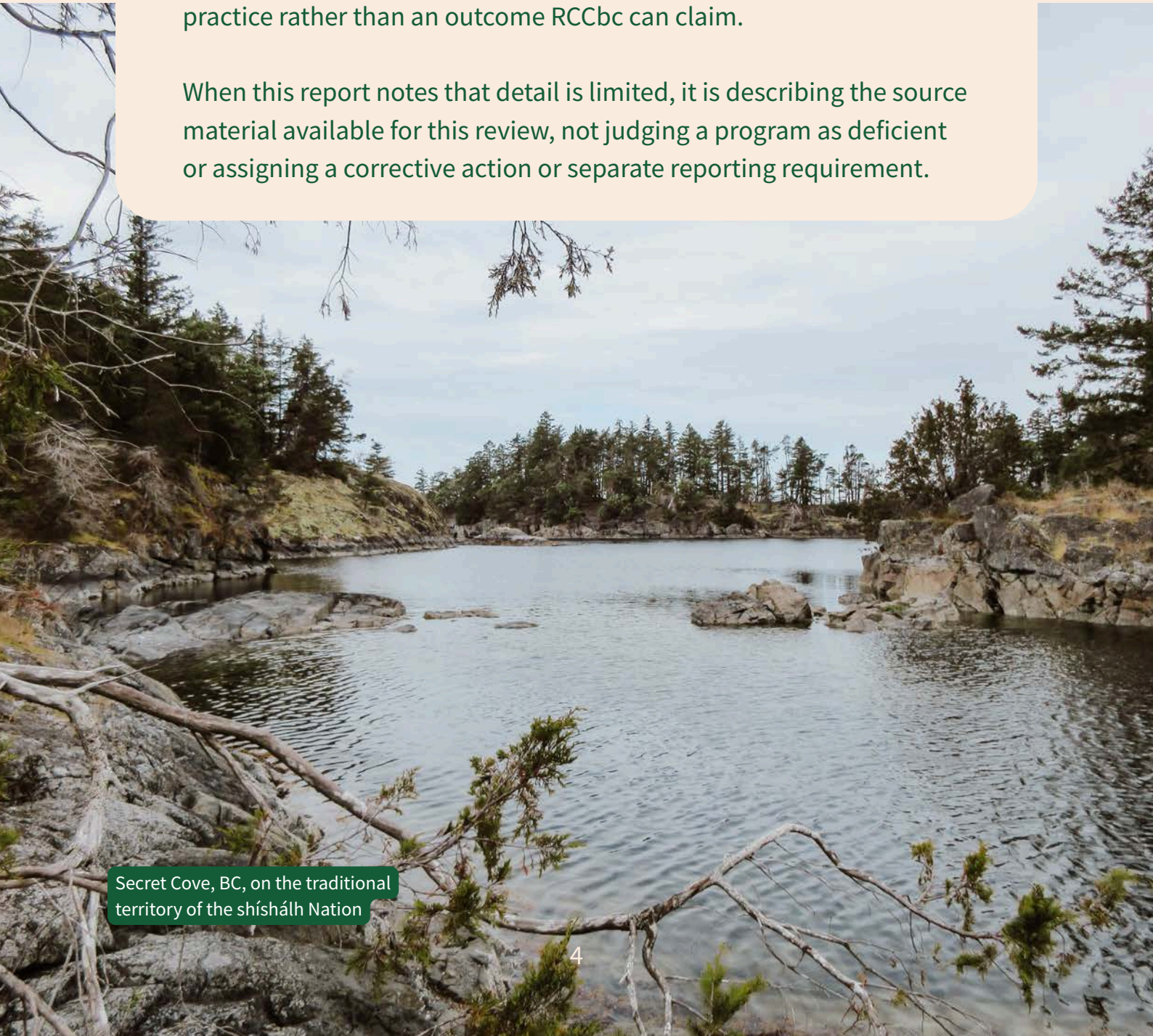
For several years, RCCbc has reported publicly on its reconciliation-related commitments and asked programs how their work contributes to the Truth and Reconciliation Commission of Canada's Calls to Action. This report maps submissions from RCCbc's 2024 and 2025 annual reporting to six connected priority areas. Those years bound the review, not the work itself.

The review comes as RCCbc prepares its next phase of work on Indigenous-specific anti-racism and cultural safety and humility. It shows where activity is taking place, how contributions connect and where earlier questions were too broad. The priority areas can help programs consider responsibility at the outset, while there is time to shape authority, relationships, resources, evaluation and communications.

As a public account and engagement tool, the report lets the network see what we have collectively reported for our own work, question or correct it and use practical prompts in planning. It does not transfer responsibility for RCCbc's commitments to Indigenous partners or the network as a whole.

This account is partial and open to correction. We have tried to stay close to what was documented, distinguish plans from completed work and avoid speaking on behalf of Indigenous Peoples or treating participation as endorsement. The activities described here do not prove reconciliation or cultural safety. Cultural safety is determined by people receiving care. Cultural humility remains an ongoing practice rather than an outcome RCCbc can claim.

When this report notes that detail is limited, it is describing the source material available for this review, not judging a program as deficient or assigning a corrective action or separate reporting requirement.



Secret Cove, BC, on the traditional territory of the shíshálh Nation

A longer history, and why this account comes now

RCCbc has worked as a rural health network since 2007. Over time, relationships with rural, remote and First Nations communities have developed through site visits, education, virtual care, research and advocacy, many predating public reporting around the Calls to Action. This report does not retrospectively label every relationship or activity as reconciliation or claim how Indigenous participants experienced it. The public record instead shows a growing effort to name and report RCCbc's responsibilities more clearly within its longer organizational history.

One driver of that more explicit work has been RCCbc for Inclusion, Social Justice and Equity (RISE), formed by RCCbc Core Members between 2018 and 2019. RISE developed and tested a conceptual evaluation matrix with the Rural Site Visits Project, then became a reference group helping programs connect their work to RCCbc's commitments and the Calls to Action.

Beyond specific initiatives and tools, RISE contributed to broader organizational learning by challenging assumptions, creating space for difficult conversations, strengthening relationships, and helping embed equity and reconciliation considerations into organizational decision-making. RISE's advisory committee has been stood down, while its internal leadership team continues and will take a new name. This transition represents an evolution of responsibility rather than a reduction of commitment. Reconciliation remains an organizational priority, with accountability increasingly embedded throughout RCCbc's structures, leadership and programs.

Developed with guidance from RISE, the 2021 progress report records earlier activity, a public apology from RCCbc's executive directors for any role RCCbc and its rural physician network may have played in perpetuating systemic racism, particularly anti-Indigenous racism, and a 2019 memorandum of understanding with First Nations Health Authority. It calls for reconciliation to be considered during project planning, not only after work begins. RCCbc continued this account in 2022–2023 and 2023.

These milestones locate the work, but they are not its full history. Much of that history lives in community visits, shared initiatives, conversations and decisions that RCCbc records cannot fully describe.

In 2026, we retrospectively mapped the 2024 and 2025 submissions to six connected priority areas. Applying them to work already reported, rather than recasting it, created a more consistent starting point for asking better questions earlier in a program's life.

The report therefore contains work at different scales: activities owned by RCCbc, work undertaken with partners and contributions supported through programs or the wider network. Mapping them together reveals connections without erasing differences in ownership, authority or accountability.

Six connected priority areas

The review brought together education, research, relationships, service access, organizational learning and early governance work. A single question about the Calls to Action did not distinguish among those activities. Drawing on the review and the sources below, RCCbc developed six overlapping priority areas, each highlighting a distinct responsibility: addressing racism; supporting cultural safety and humility; respecting Indigenous leadership, rights and authority; sustaining relationships and shared decisions; improving equitable access; and using evidence and stories accountably. Together, they offer a shared language for considering these responsibilities throughout a program's work.

These are connected areas of responsibility, not stages, rankings or a reconciliation score. They retain the connection to individual Calls to Action, particularly Calls 18 to 24, and are informed by RCCbc's commitments, RISE's learning, In Plain Sight and the British Columbia Cultural Safety and Humility Standard. The standard was developed by Health Standards Organization with First Nations Health Authority, input from Métis Nation British Columbia and public review. The priority areas do not replace Indigenous direction or these foundational sources.

For readers new to RCCbc, the areas provide a map of the elements coming together here. For people with long experience in Indigenous health, including Indigenous physicians, leaders and community partners, they are not presented as new knowledge. They are RCCbc's attempt to state its responsibilities clearly enough to be questioned and improved.

Indigenous-specific anti-racism
asks what policies, practices, assumptions and power structures allow racism to continue, and what is changing in response.

Cultural safety & humility
considers how people reflect, learn and change their practice. Cultural safety is determined by the person receiving care; cultural humility is ongoing.

Indigenous leadership, rights & self-determination
asks who requested the work, sets its direction, holds authority and resources, and how rights, knowledge and data sovereignty are respected.

Evidence, story & accountability
asks who shapes questions, holds authority over information, benefits and can correct the record, and how RCCbc reports change, uncertainty and unfinished work.

Relationships, trust & shared decisions
looks at how relationships are sustained, participation is supported and consent, partner direction and feedback shape decisions.

Access, equity & system change
considers barriers created by geography, transport, workforce, service design and racism, who defines the change needed and whether systems respond.

Programs contribute in different ways, and an activity may belong under several priority areas. The map shows where a connection was reported. It does not prove impact or cultural safety.

RCCbc's public commitment also names responsibility to the land and natural world. The 2024 and 2025 submissions did not describe this work consistently enough to establish a separate priority area. It remains part of the broader commitment. Further consideration would benefit from Indigenous leadership, attention to place and appropriate resourcing.

1 Indigenous-specific anti-racism

Indigenous-specific anti-racism looks beyond intent to the policies, practices, decisions and relationships that allow racism to continue, and to the responses taking shape. At the 2025 BC Rural Health Research Exchange, Dr. Terri Aldred and Erika Pritchard spoke about racism and discrimination described by Indigenous patients and community members seeking rural health care. Their presentation drew on a study led by Dr. Aldred and published in the Canadian Journal of Rural Medicine, based on Rural Site Visits interviews and focus groups across more than 100 communities. It brought a difficult gap into view: providers may believe care is equitable while Indigenous patients describe being dismissed, stereotyped or harmed.

Real-Time Virtual Support also reported work through its faculty development team to address Indigenous-specific racism and strengthen cultural humility in virtual care. The program developed learning with Indigenous partners for physicians providing virtual support.

Dr. Terri Aldred, Medical Director for Primary Care for the First Nations Health Authority

Within RCCbc, RISE reviewed the reconciliation commitment, helped develop an Action Plan and created reflection tools. It also supported RCCbc's expectation that Core Members receive San'yas Indigenous Cultural Safety Training and provided space for further learning.

The submissions said less about structural anti-racism than about cultural learning, relationships or access. This may reflect the questions we asked as much as the work itself. The record therefore offers limited evidence about what changed after the learning, whether in a policy, budget, hiring practice, program decision, clinical interaction or response to a concern.

2 Cultural safety & humility

First Nations Health Authority describes cultural safety and humility as related but distinct. Cultural safety addresses power imbalances and is determined by the person receiving care; cultural humility is the ongoing practice of self-reflection, learning and respectful relationships. RCCbc can track its efforts, changes and responses to concerns, but cannot certify or score safety on someone else's behalf or say that humility is complete.

Participants at the Indigenous Medical Education Gathering in March 2025 at the Musqueam Cultural Centre

The Indigenous Medical Education Gathering shows why the conditions around learning matter. In March 2025, 72 people gathered at the Musqueam Cultural Centre, including Indigenous physicians and learners, Elders, community members and others. Elders guided the gathering with support from a collaborative planning committee. Ceremony, sharing circles, storytelling, peer connection and time together shaped the experience alongside the formal program.

Through UBC Rural Continuing Professional Development, the Indigenous Patient-Led program continued Nawh Whu'nus'en: We See in Two Worlds. Its longitudinal, trauma-sensitive approach uses art, storytelling, medicine and relationship to support learning that reaches beyond the transfer of information. In 2025, Elders from Nak'azdli Whut'en guided the first land-based Level 3 workshop in Nak'azdli Whut'en.

Compassionate Leadership offers another example of learning grounded in relationship. Through RCCbc's partnership with the Atleo Centre for Compassionate Leadership, participants reflect on leadership practice, shared responsibility and conditions that can contribute to psychological, emotional and cultural safety.

In 2024, 212 participants took part across 18 cohorts. In 2025, 134 participants, including 84 family and specialist physicians, joined Team Atleo for 11 two-day experiential, land-based cohorts in Sḵwx̱wú7mesh Uxwumixw territory. By the end of 2025, 532 unique people, including 303 unique physicians, had participated since the program began in 2021. These figures describe participation and reach; they are not presented as a measure of cultural safety.

532

Compassionate Leadership participants 2021-2025

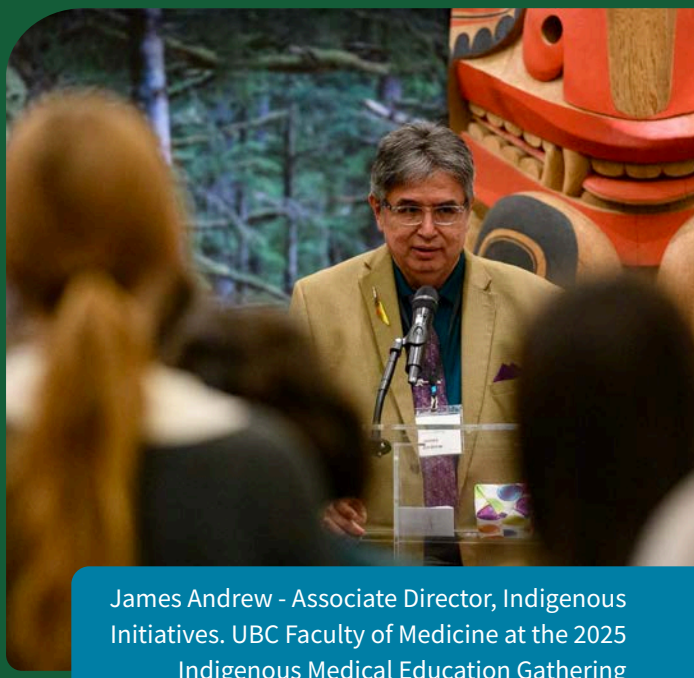
Participants at the Ya'ak-stalth Compassionate Leadership Gathering in October 2024 in Brackendale, BC

Point-of-Care Ultrasound reported adding trauma-informed practice to core content after feedback and learning shared by Indigenous peers and community members. Quality Team Coaching for Rural BC explored how privilege, paternalism, and personal responses can affect how a coach enters a team.

3 Indigenous leadership, rights & self-determination

Indigenous leadership includes authority, resources and the ability to shape or make decisions. Advice within a process controlled by others is not described here as shared governance.

The Indigenous Medical Education Gathering was Indigenous-led, with Indigenous physicians and leaders central to its direction, planning and delivery. Elders guided the gathering, and a collaborative planning committee shared the organizing work. It created space for Indigenous physicians, learners, Elders and community members to shape conversations about medical education.



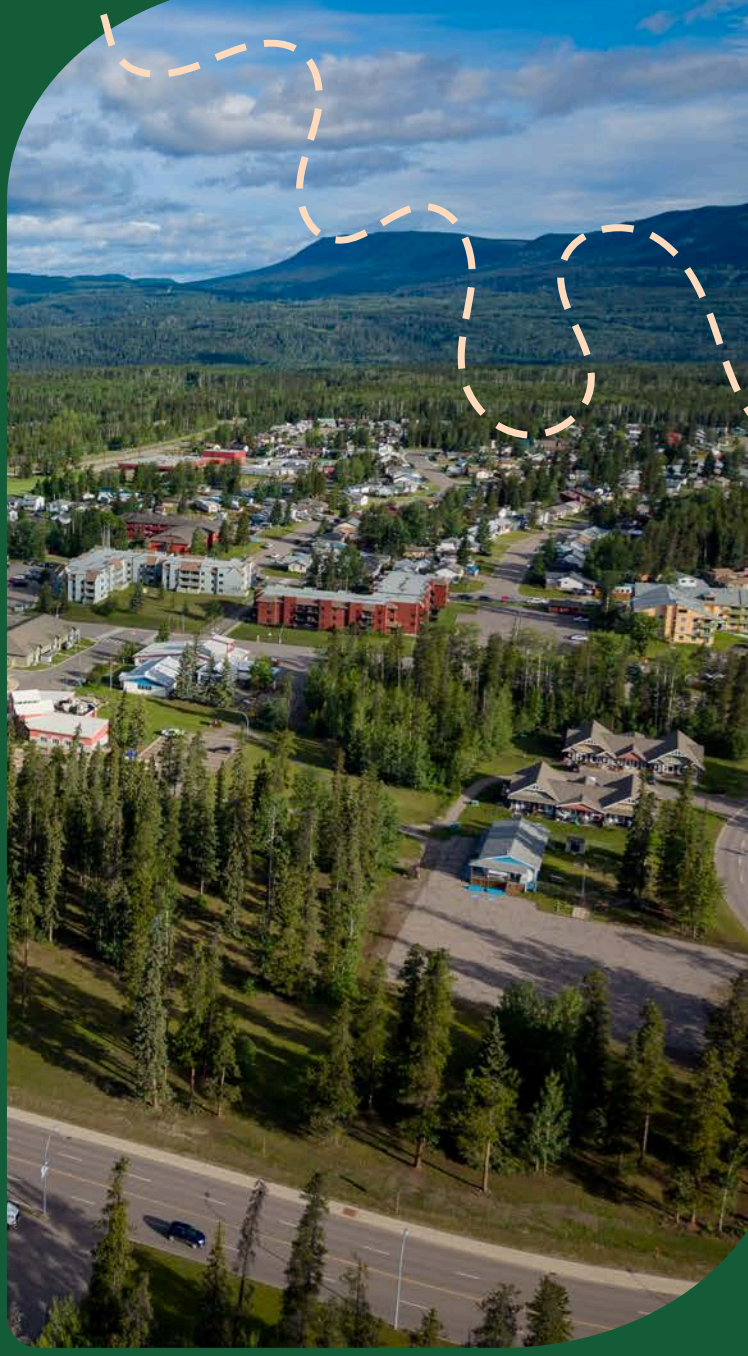
James Andrew - Associate Director, Indigenous Initiatives. UBC Faculty of Medicine at the 2025 Indigenous Medical Education Gathering

Ah-up-wa-eek (Chief Shawn Atleo) and Ya'ak-chamat-axa (Heather Atleo)

The partnership with the Atleo Centre offers a different example of Indigenous leadership shaping organizational learning. The work is guided by Ah-up-wa-eek (Chief Shawn Atleo) and Ya'ak-chamat-axa (Heather Atleo), flows from the governance principles of the House of Klaakishpitl and brings Indigenous knowledge together with trauma-informed practice, human development and relational systems learning. RCCbc participates as a partner and holds space; Team Atleo leads the work. The partnership is held through a memorandum of understanding and is grounded in relationship.

The Rural Type 2 Diabetes Remission Initiative established a First Nations Advisory Group in 2025 as planning advanced in Port Alberni and Tumbler Ridge. The group is intended to help guide direction, governance and understandings of health and wellness.

The Rural Personal Health Record example focuses on choices made during program design rather than an established leadership structure. Its 2025 submission set out intentions to build a sustained relationship with First Nations Health Authority, include an Indigenous patient partner and recognize self-determination and data sovereignty. The current record does not show whether or how those intentions were carried forward, or what they changed in relationships, governance or design. Indigenous involvement or input does not, on its own, establish Indigenous leadership. That distinction depends on who sets direction and holds decision-making authority.



Aerial view of Tumbler Ridge, BC

These examples bring forward questions that may be useful in planning: Who requested the work? Who holds decision-making authority? Whose knowledge is involved? How is participation supported and resourced? How is the work accountable and useful to the people and communities involved? They also draw attention to the risk of repeatedly relying on a small number of Indigenous physicians, leaders, or staff to carry out this work.

4 Relationships, trust & shared decisions

Relationships take time and presence. RCCbc does not determine whether trust exists.

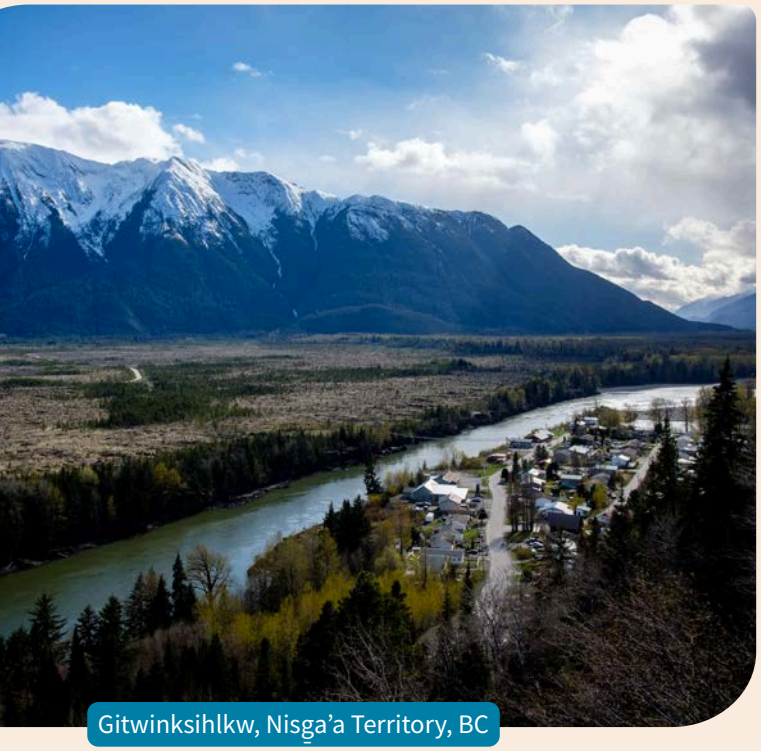
RISE provided continuity for some relationships with Indigenous Elders, Knowledge Keepers and communities. RCCbc understands that this continuity rests in the relationships themselves. Questions about whether and how those relationships continue belong in conversation with the people involved as the next phase is shaped.

The Compassionate Leadership cohorts offer another form of relational work. The learning begins with relationship and gives health care providers, leaders and partners time away from daily pressures to reflect on how they listen, communicate, build trust and move through complexity. In rural health, where people often work across distance, pressure and deep responsibility to community, these practices can support how people work together and approach difficult conversations and decisions.

In 2024, with guidance from Carrie Lamb, RCCbc developed a guideline for Indigenous facilitation and speaker fees, offerings and engagement. The public account notes that the guidance reflects one person's worldview and does not speak for all Indigenous Peoples. It is a starting point, not a formula. The guideline identifies compensation, offerings, protocols, consent and expectations as matters to explore within each relationship and consider in early budgeting.

Quality Team Coaching for Rural BC renamed its early "Discovery Sessions" as "Introduction Sessions" after recognizing that the original wording did not fit its collaborative intent. The change does not prove shared decision-making, but it shows the program adjusting how it enters a relationship.

Real-Time Virtual Support reported that virtual physicians worked with Indigenous community providers to adapt support to local geography, resources and care networks. The Rural Obstetrical and Maternity Sustainability Program set aside Indigenous Partnership funding for activities developed with local First Nations or Métis partners. The term partnership does not assume equal roles or authority in every case.



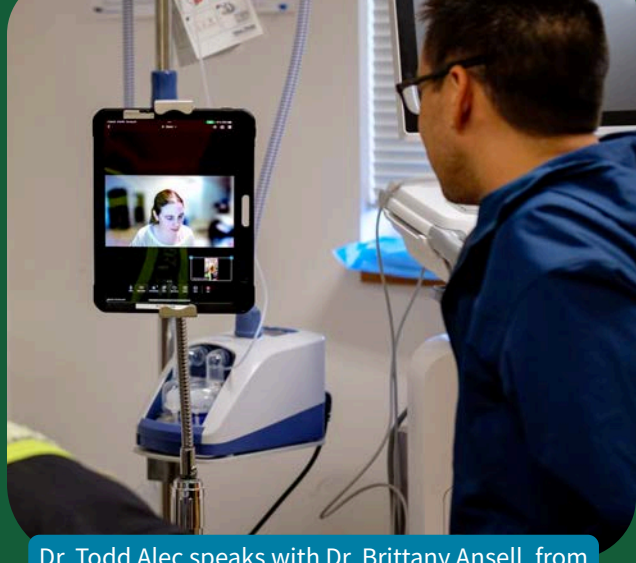
Gitwinksihlkw, Nisga'a Territory, BC

RTVS team members Dr. Arthur Cogswell, Dr. Matt Petrie and Rebecca Connop Price visiting Gitga'at territory.

Engagement and Outreach and Communications work across programs. Their approach starts with the community priorities and relationships that exist before a request for a story, photograph or endorsement. Within this approach, consent is treated as informed, ongoing and specific to the channel, with an opportunity to review how words and participation are presented. Context remains with a story, including what is uncertain or private.

Publication is one moment in a longer relationship. RCCbc communications can return learning, show follow-through and make connection and correction possible. This approach does not rely on Indigenous partners to validate RCCbc or share personal, cultural or traumatic material simply to strengthen an institutional story.

5 Access, equity & system change



Dr. Todd Alec speaks with Dr. Brittany Ansell, from the RUDi team, while at Takla Health Centre.

In First Nations, rural and remote communities, access is shaped by distance, transport, services and workforce capacity, and by whether care reflects community realities and can be received without racism.

Real-Time Virtual Support connected local providers with immediate physician support. Several patient pathways implemented through First Nations Health Authority offered access to primary care, mental health and substance use services. Pathway-use information and caller feedback can show reach and support improvement. They cannot, on their own, tell RCCbc whether a caller experienced culturally safe care.
In 2025, First Nations Health Authority, Northern Health and RCCbc planned FRANCINE for four remote northwest First Nations communities facing persistent primary care barriers. The 2025 submission describes planning for FRANCINE's launch. This report does not assess its subsequent implementation.

The Rural, Remote and First Nations Transport Partnership Table reconvened for three meetings in 2025. Partners advanced work on performance indicators and data tools. The Rural Obstetrical and Maternity Sustainability Program supported 32 rural maternity teams and continued its Indigenous Partnership funding. Point-of-Care Ultrasound and the Emergency Education Program supported local clinical capacity in places with limited diagnostic, specialist or emergency resources. These programs address important access conditions. The current record provides less detail about how Indigenous priorities, rights and decision-making shaped the work.

Access involves more than bringing a service closer. It includes who designs the service, where authority sits, whether local knowledge is respected and whether people can receive care without avoidable displacement or harm.

6 Evidence, story & accountability

Evidence and story can reveal experience and responsibility, or remove words and knowledge from context and serve an institution. It matters who shapes the question, controls the information and benefits.

RISE began with a conceptual evaluation matrix. Its Action Plan included evaluation, and the group helped bring health equity targets into program reporting. The priority areas build on that work by asking more clearly about authority, stage, evidence and follow-through.

RCCbc's public account of Compassionate Leadership describes witnessing, storytelling and shared accountability as part of how the work was understood and evaluated. It places participation information alongside experience and reflection without treating either as a measure of cultural safety.


Dr. Daisy Dulay

The Rural Physician Research Grant Program reported funding Dr. Daisy Dulay's project on gaps in cardiovascular risk management among Indigenous patients in rural northern British Columbia. A research topic concerning Indigenous patients does not, by itself, establish Indigenous leadership or community benefit. The submission records a grant award. It does not provide enough information to assess the project's governance, findings or community benefits.

Other programs raised similar questions. Transport advanced work on indicators and data tools; Real-Time Virtual Support collected pathway-use information and caller feedback; and the Rural Personal Health Record named data sovereignty as a design principle. The record does not establish who selected the measures, who can see and interpret the information, how community-level results are protected or what decisions the evidence can influence.

Alongside the 2024 and 2025 record, recent communications work illustrates a more relational approach to public storytelling. RCCbc's 2026 story One Heart at a Time documented a 2025 Indigenous-led mobile cardiovascular care initiative led by Dr. Miles Marchand. It brought community members' experiences together with clinical and service information, credited the people and partners who helped shape the story, acknowledged the Nations that welcomed the production team and provided a contact for follow-up. Community award features on Nisga'a Valley Health Authority and Tla'amin Nation similarly centred community leadership, local priorities and the people delivering care.

These experiences are informing more consistent ways of working with communities on media production. RCCbc is developing media packages and processes for sharing footage, photographs and other assets with participating communities and for discussing how those materials may be used. Work is also underway on appropriate expressions of thanks and practical guidance for community engagement in media production. The guidance is expected to address early relationship-building, local protocols, informed and ongoing consent, community review, attribution, storage, future use and the return or sharing of materials.

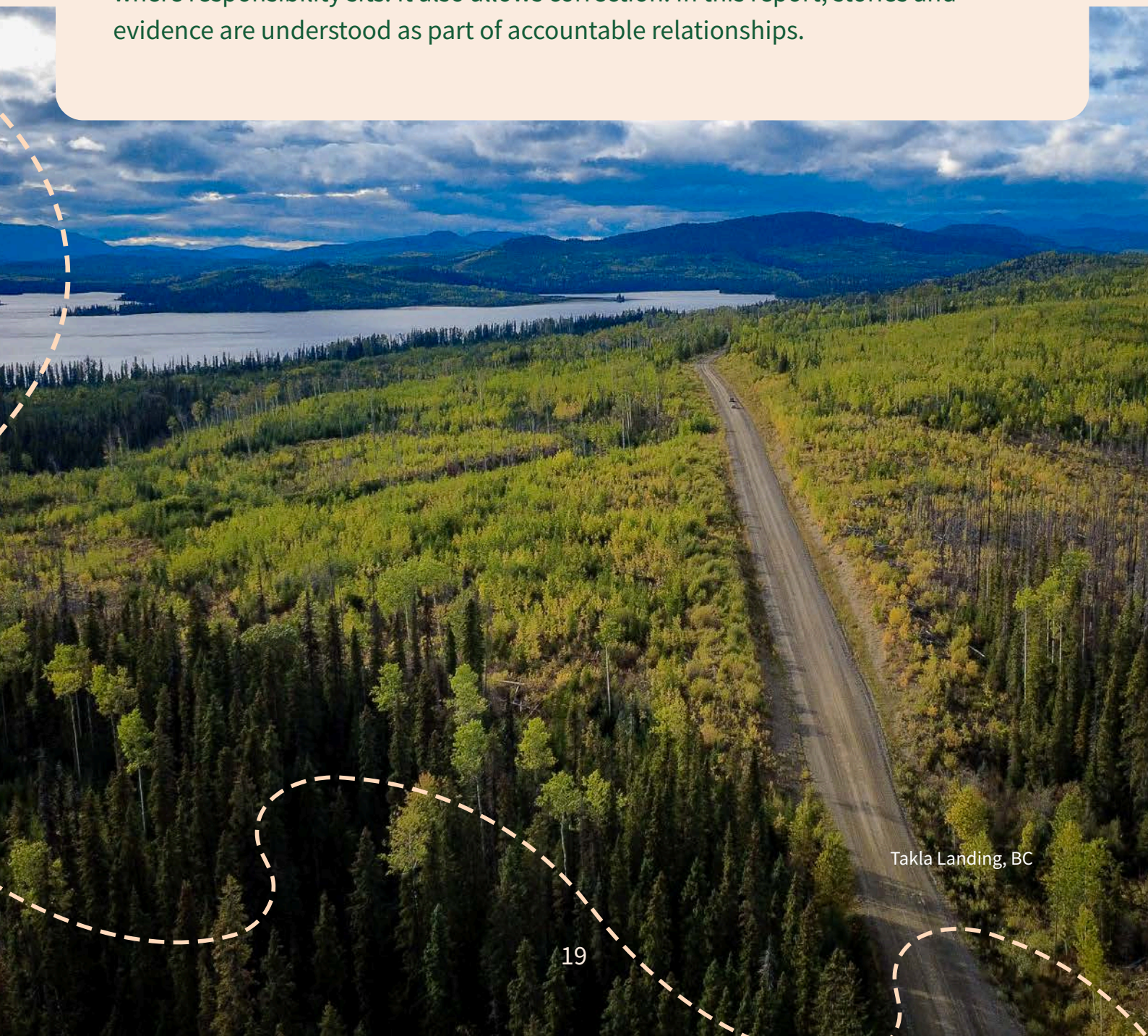
Aerial view of Yekoochie, BC.

Left: (left to right) Dr. Todd Alec, Michele Fleming, Sharon Vare, Dr. Miles Marchand, Jenny Kamer, and Stephanie Houlberg in Takla Landing during filming for 'One Heart at a Time'.

This guidance is intended to help RCCbc teams begin these conversations earlier and with greater care. It is not intended to create a single protocol for every Nation or community. Local direction, preferences and protocols remain central to each project.

Authority over First Nations data and information rests with the Nations involved, according to their laws, protocols and direction. The First Nations principles of OCAP® describe ownership, control, access and possession. OCAP® is a First Nations framework. Métis and Inuit partners have their own authorities, contexts and approaches to data and knowledge governance.

A fuller public account makes visible what changed, what remains uncertain and where responsibility sits. It also allows correction. In this report, stories and evidence are understood as part of accountable relationships.



Takla Landing, BC

What we learned from the two-year view

The work spans Indigenous health and leadership, internal learning, virtual care, maternity, transport, education, research, mentorship and engagement. That distribution reflects RCCbc as a network and confirms that one program or committee cannot carry reconciliation responsibilities for everyone else. RISE helped keep those responsibilities visible.

The record most often describes cultural safety and humility learning, relationship-building and work on access. It says less about structural anti-racism, Indigenous rights and decision-making authority, longer-term outcomes, or the governance of stories, evidence and data.

The pattern reflects what programs documented and the questions RCCbc asked. Work may have occurred without appearing in a submission; inclusion does not tell us whether an activity was effective or experienced positively.

The record speaks much more often about First Nations partners and communities than about Métis or Inuit Peoples. This report does not imply that RCCbc has equivalent relationships, engagement or outcomes with First Nations, Métis and Inuit Peoples. A distinction-based approach begins by being honest about what is known and where the record shows fewer relationships.

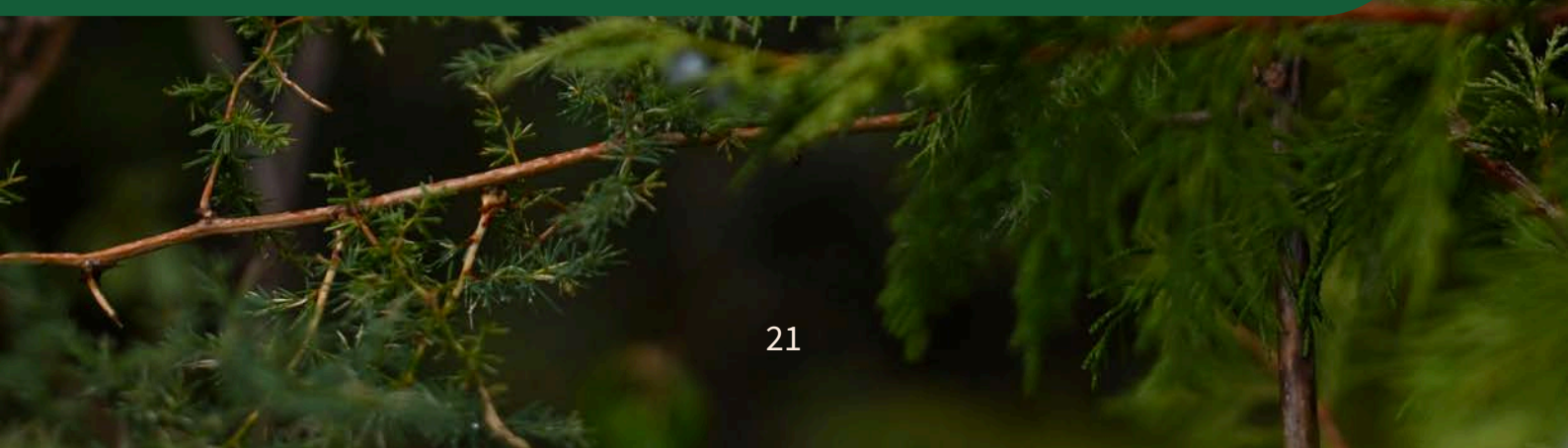
This report can serve as a baseline for RCCbc moving forward in how we record, understand and follow the work. It is not a measure of how much reconciliation has occurred.

A developing approach to asking and learning

For several years, RCCbc has asked programs about their contributions to the Calls to Action and the recommendations of In Plain Sight. The question helped make distributed work visible, but a year-end response can blur the difference between an idea, a learning activity, a partnership, a change in practice and an outcome.

This mapping looks back, applying the priority areas to work already reported in 2024 and 2025. It also offers a way to consider the areas earlier, while a program is being shaped and there is time to examine its plan, budget, governance, evaluation or communications approach. One option under consideration is to retain an annual public report while adding structured conversations with program leads about who shaped the work, its stage, what changed, where support may be useful and what could be revisited. This would support learning during the work rather than focusing only on annual report copy.

RCCbc has committed to developing shared tools that could connect commitments and partner direction with responsibility, status, evidence, learning and possible next steps. Health Standards Organization (HSO) standard 75000:2022 includes questions on accountability, partnerships, governance, resources, staff capacity, service design, quality, and evidence. RCCbc is considering a self-assessment of its organizational systems informed by the standard. It would examine structures and practices, not assign a level of cultural safety or humility.



RISE & the next stage

RISE became a reference group in 2020. It reviewed language, structures and policy frameworks, identified Calls to Action relevant to RCCbc, guided the 2021 progress report and encouraged programs to examine their work. A 2023 planning process led to an Action Plan. From 2024 through 2026, RISE concentrated on Indigenous-specific anti-racism and cultural safety and humility, created reflective tools, advised programs and health system partners and helped bring health equity targets into program reporting.

This experience also showed the limits of relying on a small group across a growing network. RISE could offer guidance and ask difficult questions, while responsibility for decisions and follow-through remained with program leads and organizational leadership.

RISE's advisory committee has been stood down, while its internal leadership team continues and will take a new name. This transition represents an evolution of responsibility rather than a reduction of commitment. Reconciliation remains an organizational priority, with accountability increasingly embedded throughout RCCbc's structures, leadership and programs.

The next phase builds on RISE's sustained contributions to reconciliation, Indigenous-specific anti-racism and cultural safety and humility.

What this review offers for the next phase

Our direction is toward rural health systems where Indigenous Peoples exercise leadership and self-determination, and where care is equitable, culturally safe and free from Indigenous-specific racism. RCCbc is one participant in that work. We are accountable for the decisions, programs and relationships within our own reach.

The review brings forward several considerations for future work:

- consideration of rights, relationships, authority, resources and follow-through when programs and projects begin
- clear distinctions among work that is Indigenous-led, undertaken in partnership, owned by RCCbc or supported through the wider network
- attention to the time, compensation and authority involved in Indigenous leadership, knowledge sharing, participation and review
- connections between education and changes in behaviour, team practice, policy, program design, budgets and decisions
- direction from First Nations, Métis and Inuit partners on the use of their names, stories, knowledge and information
- distinctions-based approaches that do not apply one relationship or protocol to all Indigenous Peoples
- ways for partners and readers to question or correct the public record
- public evidence that can show decisions, change, unfinished work and follow-through where it is appropriate and available

These considerations are prompts, not a checklist or a common sequence for every program. Their relevance depends on the work, the people involved, existing relationships, stage and scope.

Possible planning questions include: Who requested the work? Who can decide? What resources or supports may be relevant? How might feedback influence the plan? Who holds authority over the story, knowledge or data? What, if anything, is appropriate to return or report?

The 2024 and 2025 records give us a clearer place to continue from. Together, these records carry earlier relationships and commitments into a more focused approach to Indigenous-specific anti-racism, organizational responsibility and public accountability.

Rural Coordination Centre OF BRITISH COLUMBIA

Reconciliation report appendix

Companion to Learning from the Work, covering 2024 and 2025

The Rural Coordination Centre of BC (RCCbc) works across the territories of many First Nations throughout what is now British Columbia. We acknowledge their enduring relationships with these lands and waters and our responsibility to respect their rights and direction in the work we undertake together.

This appendix connects the 24 programs in the original mapping with the report's six priority areas. It forms part of RCCbc's ongoing commitment to reconciliation with First Nations, Métis and Inuit Peoples. The work and relationships extend beyond the reporting period.

RCCbc's Commitment to Reconciliation

Key	Priority area
1	**Indigenous-specific anti-racism**
2	**Cultural safety and humility**
3	**Indigenous leadership, rights and self-determination**
4	**Relationships, trust and shared decisions**
5	**Access, equity and system change**
6	**Evidence, story and accountability**

The numbers identify connections recorded in the review. They are not ratings or evidence of impact. Cultural safety is determined by people receiving care. An unlisted connection does not mean a program has no work in that area.

Foundations and source materials

How the priority areas and program mapping relate to the source record

RCCbc developed the six connected priority areas to organize this review and support clearer conversations about responsibility. They bring together learning from RISE, program reporting and RCCbc's commitments, informed by the sources below. They do not replace Indigenous direction or constitute an assessment against these sources.

Foundation	Relevance to this review
RCCbc's commitment and RISE's earlier work	Organizational responsibility, relationships and continuity with earlier learning.
Truth and Reconciliation Commission's Calls to Action	The starting point for program reporting, particularly the health-related Calls.
In Plain Sight	Attention to Indigenous-specific racism and accountability within health care.
UN Declaration on the Rights of Indigenous Peoples and B.C.'s Declaration Act	Context for Indigenous rights and self-determination.
B.C. Cultural Safety and Humility Standard	Attention to organizational governance, leadership and service practices.

Evidence behind the program tables

Record	Use in this appendix
2024 review	Annual submissions and follow-up conversations brought together by Gabby Atkinson, Jayleen Emery and RISE.
2024–2025 overview	The "By Program" worksheet supplies the 24-program coverage and priority connections used here.
Public annual reporting	Published accounts support selected examples and provide additional context.

Program mapping 1 of 6

Reported work and its connections to the six priority areas

Priority references reproduce the original program mapping. The narrative also draws on supplementary sources and may discuss connections not coded in that mapping. The connections are not exhaustive.

Program	What the record describes	Areas
Compassionate Leadership	Team Atleo leads Compassionate Leadership, with RCCbc providing support and space. The 2024 record describes Indigenous ways of knowing and relational leadership. Public reporting adds accounts of cohorts and learning in 2025. Participation figures describe reach, while reflections describe experience.	2, 3, 4
Emergency Education Program (EEP)	2025 reporting describes training, mentorship and rural placements for physicians serving rural and Indigenous communities. The submission connects emergency-care learning with cultural safety and local context. It does not establish patient-experienced safety.	2
General Rural Internal Medicine (GRIM)	2025 reporting describes collaboration with an Indigenous physician on research into patients' experiences of travelling for care. It also records attention to Indigenous internal medicine residents during a rural career event. These are research and learning contributions.	5
Isolated Medical Provider Aftercare Team (IMPACT)	The 2024 record describes peer support available to providers in First Nations communities, including Nisga'a communities. It reports support with patient management and transport decisions. The mapping contains no further 2025 account of this work.	2, 4

Priority key: page 25. Source context: page 26.

Program mapping 2 of 6

Reported work and its connections to the six priority areas

Program	What the record describes	Areas
Indigenous-led Health Initiatives	Across 2024 and 2025, the record describes RISE's reflection and evaluation work and support for Indigenous physicians and learners. The 2025 Indigenous Medical Education Gathering brought people together with Elders' guidance. RISE also reviewed RCCbc's reconciliation commitment.	2, 3, 6
Mindfulness in Medicine	2025 reporting connects mindfulness practice with noticing bias, prejudice and privilege. The program describes reflection as a way to support more considered choices in practice. This records an approach to learning rather than evidence of changed patient experience.	2
Network of Rural Divisions	2025 reporting describes physician co-leads sharing learning and gratitude for the lands they occupy. In-person gatherings make space to listen to a local Elder. These examples describe ongoing learning and how meetings begin.	2
Point-of-Care Ultrasound (PoCUS)	2025 reporting states that HOUSE and Rural POCUS Rounds introduced trauma-informed practice into core content following feedback and teachings from Indigenous peers and community members. This describes a reported curriculum change.	2, 4

Program mapping 3 of 6

Reported work and its connections to the six priority areas

Program	What the record describes	Areas
Quality Team Coaching for Rural BC (QTC4RBC)	The record describes cultural humility and psychological safety learning. In 2025, the program reported renaming “Discovery Sessions” as “Introduction Sessions” through learning with teams that include First Nations community members. The public annual report also records this change.	2, 4
RCCbc Research	The 2024 record describes Indigenous research contributions and collaborative work with First Nations Health Authority. In 2025, Dr. Terri Aldred and Erika Pritchard presented Indigenous rural British Columbians’ experiences of racism in health care at the BC Rural Health Research Exchange.	1, 4, 6
Rural Continuing Medical Education (RCME) and Rural Programs Liaisons	Both years describe SPIFI funding and resources that support rural physicians to engage with Indigenous communities. The reported purpose is to learn and strengthen relationships with health care providers, including attention to traditional healing practices.	5
Rural Global Health Partnership Initiative	2025 reporting describes a commitment to support Indigenous-led and Indigenous-centred work. It encourages applications from rural physicians partnering with First Nations communities. This describes funding intent and eligibility, without establishing the delivery or outcomes of a particular project.	5

Program mapping 4 of 6

Reported work and its connections to the six priority areas

Program	What the record describes	Areas
Rural Health Services Research Network of BC	The 2024 record describes Indigenous perspectives in education and project design, traditional wellness approaches in learning materials, and rural health data work. It includes attention to Indigenous worldviews in climate learning. The mapping records no additional relevant 2025 detail.	2, 4, 6
Rural Obstetrical and Maternity Sustainability Program (ROAM)	2025 reporting describes support for maternity teams to improve access and quality of care for Indigenous community members. Dedicated Indigenous Partnership funding supports activities co-designed with local Indigenous partners. Public reporting also records this funding approach.	2, 4
Real-Time Virtual Support (RTVS)	2025 reporting describes clinical support for providers, patient pathways through First Nations Health Authority, and use of pathway information and caller feedback. Partners also planned the launch of FRANCINE. The source describes planning, which does not establish whether delivery began later.	2, 4, 5, 6
Rural Personal Health Record	2025 reporting describes cultural safety learning and intentions to involve an Indigenous patient partner and develop a sustained connection with First Nations Health Authority. It names self-determination and data sovereignty as design aims. These intentions do not establish completed partnerships or governance arrangements.	2, 4, 5

Program mapping 5 of 6

Reported work and its connections to the six priority areas

Program	What the record describes	Areas
Rural Medicine Interest Longitudinal Mentorship	Across both years, the record describes mentorship and exposure to rural practice. The program connects learners with rural physicians and community realities, creating opportunities to consider cultural context and Indigenous care within rural medical learning.	2, 5
Rural Physician Research Grant Program	The 2024 record describes an intention to include Indigenous perspectives in funding review. In 2025, the program reported a grant for Dr. Daisy Dulay's study of cardiovascular risk management among Indigenous patients in rural northern BC. A grant award does not establish research findings.	5
Sustaining Pediatrics in Rural & Underserved Communities (SPRUCe)	2025 reporting records an expression of interest for a Compassionate Leadership cohort with CHARLiE virtual care providers. This is a proposed learning activity. The source does not establish that the cohort took place.	4
Thriving Project	2025 reporting describes experiential learning, reflection and dialogue intended to challenge assumptions in medical culture. The program connects relational approaches to well-being with cultural humility. These statements describe the program's approach and intentions.	2, 6

Program mapping 6 of 6

Reported work and its connections to the six priority areas

Program	What the record describes	Areas
Transport	Both years connect transport work with equitable access. The 2025 public report records the reconvened Rural, Remote and First Nations Transport Partnership Table and work to advance performance indicators and data tools. The record supports ongoing coordination and development.	5, 6
Towards Unity for Health (TUFH)	The 2024 record describes learning about colonization and relationships developed with Takla Lake First Nation. In 2025, learning continued with the Rural Doctors Network of Australia, including engagement with Indigenous physicians. The record describes exchange and partnership-building.	4
Type 2 Diabetes Project	2025 public reporting records a First Nations Advisory Group and implementation planning in Port Alberni and Tumbler Ridge. It describes work with community and First Nations partners to shape services. Delivery and early outcome collection appear as plans for 2026.	2, 4
UBC Rural Continuing Professional Development	Across both years, the record describes the Indigenous Patient-Led program and trauma-sensitive education. Public reporting adds the first land-based Level 3 workshop in 2025, guided by Elders from Nak'azdli Whut'en. The evidence describes learning and delivery.	2, 3

Contributors and further reading

Acknowledging the work behind this report

This report draws on information and reflections contributed by program staff and leads across RCCbc. Their annual submissions and follow-up conversations provide the foundation for this account.

Gabrielle Atkinson and Jayleen Emery, working with RCCbc for Inclusion, Social Justice and Equity (RISE), brought together the 2024 review through annual reporting and further conversations with programs. Andi Bloom, an SFU co-op student working with RCCbc Communications, helped organize the 2025 material and map contributions across both years.

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