Health Canada Santé Canada

Health Integration Initiative (HII)

First Nations and Inuit Health Branch

Evaluation Report

Approved by

Departmental Executive Committee on
Finance, Evaluation and Accountability (DEC-FEA)
Health Canada

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Canada

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Health Integration Initiative Chart of areas of concern and lessons carried forward

Identified Areas of concern/for improvement	Lessons Learned and applied to the Aboriginal Health Transition Fund based on evaluation findings	Further Considerations
A. PARTNERSHIP AND DECISION-MAKING		
1. Partnership concerns include three components: • Capacity of First Nations and Inuit to participate in partnerships Strong partnerships were the foundation of successful integration projects • Inconsistent representation Inconsistent representation and turn-over among some partners at project steering committee levels delayed the implementation of some activities. • Authority of partner representatives There was inconsistent decision-making authority of the membership of some project steering committees.	In the AHTF design, developmental funding is being provided, recognizing that some communities and tribal councils might need to develop tools or skills to begin to engage with Regional Health Authorities or P/Tts for the first time. Inconsistent representation is not possible to prevent. However, some of the HII projects placed a high value on developing briefing materials for partners and striving to share meeting results and decisions taken, to keep the momentum going. Others stressed the importance of engaging in joint goal-setting and vision development, and obtaining political level support. In the AHTF design, plans and projects are required to demonstrate high levels of support from partners. Plans are also encouraged to strive for formal agreements (Memoranda of Understanding, partnership charters) as a final deliverable, to spell out roles and responsibilities.	Further tools and resources for projects and Regions outlining how to create partnership and how to encourage high-level participation by decision-makers should be considered
B. PROJECT MANAGEMENT		
2. Lack of Regional FNIHB capacity to support integration initiatives and projects	In the AHTF design, one FTE at an ES-06 level has been funded for the eight FNIHB Regions each year of the AHTF.	
3. Some projects did not plan for sustainability and did not understand the nature of "transitional" initiatives, though this was required during the HII.	AHTF projects will require a sustainability plan and definitions of sustainability will be discussed.	Consider a review of the outcomes of the HII projects and their success at sustainability in future years and develop materials for projects on sustaining results as well as funding, based on the findings and needs identified by AHTF projects.

Identified Areas of concern/for improvement	Lessons Learned and applied to the Aboriginal Health Transition Fund based on evaluation findings	Further Considerations
4. The importance of communication activities by the projects and need for communication plans	The AHTF has developed a national communications plan, and is asking projects and plans to identify communications activities, as an important project function. Also, Regions and P/Ts are required to annually update and report to First Nation and Inuit (and off-reserve Aboriginal people) on the progress of their plans, so feedback and engagement processes are required.	
5. Informants in two different projects mentioned that monthly reporting templates were not considered helpful, primarily due to the lack of feedback on reports submitted, as well as the complexity of the template they were to follow.	In the design of the AHTF, frequency of reporting has been lessened. Projects in the pan-Canadian and integration envelopes will report twice yearly, and those in the adaptation envelope will report quarterly. Better clarity on Regional and National roles in the Secretariat has been achieved: The AHTF is designed so that the FNIHB Regions will manage FN/I contribution agreements, which are expected to involve the usual Regional feedback processes. (Due to the nature of the PHCTF funding, HII contribution agreements were managed at the Secretariat level and the role of Regions in approving deliverables and reports before submission to HQ was sometimes unclear.) The AHTF evaluation framework is in development. Plans are to link the performance measurement strategy and activity reporting with the evaluation activities, to minimize duplication of data collection.	
C. OTHER CONCERNS		
6. Geographical remoteness made project implementation more difficult in the north than in southern Canada in some projects.	While remoteness cannot be changed, the planning process and capacity funding provided by the AHTF may help to mitigate some of the difficulties (expenses of travelling great distances to meet, developing capacity so as not to rely on southern contractors, factoring in the risk of disruption of planning due to severe weather, etc.).	

Identified Areas of concern/for improvement	Lessons Learned and applied to the Aboriginal Health Transition Fund based on evaluation findings	Further Considerations
7- Approval processes and funding flow		
• Project funding lapsed since projects were unable to carry over funds from one year to the next.	In the design of the AHTF, and in response to other initiatives within the Branch, the new contribution agreement allows for multi-year agreements and for carry-over of funds to be considered, with 30 days notice to the Minister after the first year of funding.	Pilot projects and short-term initiatives are likely to continue to be used by government in order to gather evidence in developing programs and policies; however, if the AHTF is renewed after 2010, the Branch could consider better explaining the reason for short time frames and what will be tested during this period.
• The timeframe of the HII was too short for some project activities to be completed, after delays in developing the contribution agreements, and on the project side, when changes in staffing, delays in development of partnerships, inclement weather and other factors forced changes in workplans.	The AHTF is also time limited. It will terminate in March 2010. It is acknowledged that the Fund will operate in a complicated context, with many variables which could affect the progress of the activities. However, Regions, P/Ts and Aboriginal groups have been encouraged to consider a variety of projects, some with shorter timeframes which will run only 12-18 months. If implementation delays occur, the activity should still be able to be completed before March 2010.	
• Some project proponents did not understand that the three-year time frame of the fund included time needed to launch and develop the Initiative before projects could be selected and funded. Rather, some projects insisted that they should have been able to access three years of funding from the start date of the approval of their project. ("A three-year initiative should mean three years of funding.")	The Secretariat has also recommended that Regions and provinces and territories consider submitting interim plans, with a few projects that are ready to start early. Other activities could be identified for development later in the life cycle of the AHTF.	As only a few projects and plans have been approved to January 2007, there is still time to brief Regions and P/Ts about communicating messages about the length of time required for approval processes, contribution agreement negotiation and other processes before money flows to a project.
8. As an informant said on page 12: "*(...) with health and social services largely integrated and all services available to all resident, integration efforts needed a different focus in the territories*".	This issue is larger than the AHTF. However, the AHTF may look at new delivery mechanisms. AHTF includes the pan-Canadian envelope which permits research and activities by First Nations, Inuit and Metis in several parts of the country, which could allow for territorial-specific initiatives.	Research on territorial delivery mechanisms and challenges is also possible.

Health Canada

First Nations and Inuit Health Branch

Report on the Evaluation

of the Health Integration Initiative

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Executive Summary

This report sets out the findings and conclusions from a summative evaluation of First Nations and Inuit Health Branch's (FNIHB) Health Integration Initiative (HII). This evaluation, which was conducted over the fall of 2005 and winter of 2006, meets the program requirement of the HII for a comprehensive evaluation of the entire Initiative during its final year of funding.

Background

The Health Integration Initiative (HII) was established in 2003 as a first step in addressing the gap in health status between First Nations and Inuit peoples and other Canadians through better integration of federally funded health systems within First Nations and Inuit (FN/I) communities and those funded through Provincial and Territorial governments. The HII received a total of $10.8 million over the three-year period of August 2003 to March 2006 from the Aboriginal Envelope of the Primary Health Care Transition Fund to undertake the following activities:

- Integration projects: to provide experience-based information concerning the practicalities of integrating federally funded First Nations and Inuit health systems with provincial/territorial health systems;
- Research projects and activities: to assess and advance knowledge and understanding of health system integration nationally and internationally; and
- A policy framework: to provide guidance for future work in integration.

This evaluation report is intended to provide Health Canada and FNIHB senior management with information concerning successful change initiatives related to First Nations and Inuit health. It also provides Treasury Board secretariat with information concerning the investment in HII.

Methodology

The evaluation issues included the following:

- Did the Project achieve or contribute to greater integration of health services?
- What are the effects (positive or negative) of greater integration?
- What circumstances and actions contributed to achieving greater integration ("Enablers")?
- What circumstances and actions made integration more difficult, or contributed to undesired effects ("Barriers", "Pitfalls")?
- How did the roles within the health system(s) change with greater integration?
- What was the magnitude and cost of the changes?
- Are the changes likely to be sustainable?
- What do the project findings suggest about "next steps" in achieving better integration?

The methodology for this study included multiple lines of inquiry, including the review of documents, interviews with multiple stakeholder groups, case studies, and horizontal analysis across all lines of inquiry. Interviews were conducted with senior federal officials who knew the HII and with Project Partners who were actively involved in HII project activities. In all, 39 individuals were interviewed. Also, the information collected was compiled into a case study format that addressed in a structured way each Integration Project's contribution to the evaluation issues.

Some of the evaluation findings are based on the subjective opinions of knowledgeable persons involved in HII, which could be considered as a limitation to the methodology. However, the convergence of views expressed by informants suggests that these potential limitations to the methodology do not adversely affect the supportability of the evaluation's overall conclusions. Overall, the validity of the conclusions reached in this report is based on the various perspectives collected through the multiple lines of evidence used in the evaluation.

Findings and Conclusions

Findings and conclusions from the evaluation are organized into six subsections presented below.

Relevance

The evaluation identified a broad consensus indicating that integration of health services was a relevant policy priority primarily because the health of First Nations and Inuit people was perceived to be adversely affected by the lack of federal/provincial/territorial integrated health services delivery. Furthermore, HII was seen to be an effective program approach to supporting that policy priority.

The findings indicate that interviewees had different interpretations of how to define "integration", particularly in the territories. Even so, overall, the findings support the conclusion that, irrespective of the variances in the precise definition of integration, collaboration and co-operation among different levels of government was and continues to be relevant as a means of improving the health services provided to First Nations and Inuit populations. Furthermore, the HII was considered to be a relevant and valid vehicle for pursuing the policy objective of integration and it maximized its relevance to FN/I communities by selecting specific community health care areas that would benefit from further integration. HII did so by relying on a selection process and criteria that ensured that the projects were relevant to the objectives of the HII by being tripartite in nature and transitional.

HII Program Process

Governance: The evaluation determined that, in general, the governance structure within HII projects was effective inasmuch as it contributed to good progress and overall project success. Interviewees attributed their positive views on governance to the flexibility they were allowed to adjust structures as their project's needs evolved. Progress in a few projects was perceived to have been adversely affected by limited or inconsistent participation by some Project Partners. In other cases, these representatives were considered to lack the necessary decision-making authority to negotiate or make agreements, which delayed implementation of project objectives.

Communications: The findings suggest that HII provided a model for successful communication at two levels: within projects, and between projects and the FN/I communities they were working with. Specifically, the communication strategies and mechanisms used to manage and support HII projects contributed to the individual project's success, and the communications efforts at the project level with their respective communities were effective and contributed to project's success. This indicates that the emphasis placed on communications by HII program

management at the outset of the program and by particular projects contributed to both the overall success of HII and the progress of integration.

Overall, interviewees found the communications approaches, materials and instruments provided by the HII Secretariat to be useful, suggesting that HII's investment in their development was worthwhile. At the same time, several projects demonstrated remarkable communication strategies and activities that were innovative and cultural-based which were considered essential in building understanding and support for the HII.

Process Challenges: The Evaluation determined that the success of HII projects was adversely affected by the broad geographic area covered by some projects and the long time that it took to get some projects underway. The delays in launching some projects also caused financial pressures due to fiscal year-end cut-offs. Overall, this main process challenge identified in the Evaluation – delays in proposal approval – caused difficulties, but likely also contributed to ensuring HII's success and sustainable results. While it would be reasonable to encourage a more timely process in approving proposals for future HII-type initiatives, this should not be done at the expense of thoughtful and sound conditions that will improve the likelihood of funded projects' success.

Achieving Outcomes

HII projects have produced a number of documents and other outputs that contributed to immediate outcomes. Use of these outputs promotes integration at the community level. Even though interviewees with most projects indicated that there was always "more to be done", they indicated that their project had led to the creation of useful and often *essential* products that would lead to further integration. As a result, HII contributed to the creation of a foundation for community-level health integration.

Partnerships

The Evaluation determined that new and existing partnerships were an integral and essential part of HII. These partnerships were a primary vehicle for fostering community involvement and encouraging collaboration toward community-level outcomes, which contributed to the respective projects' success. New partnerships were formed and existing partnership relationships were strengthened. HII's partnerships led to effective working relationships in

other areas, and HII's partnerships are generally expected to continue once the HII projects are completed.

The fostering of sustainable partnerships was seen to be one of the HII's most important contributions.

Sustainability and the Potential for Replication

The evaluation determined that many elements of the HII projects would continue even after the project is no longer funded by HII. These sustained outcomes were related to infrastructure elements, the continuing use of new health care delivery models, better trained and informed personnel, and relationships. A major contributor to this sustainability was the design of HII, which ensured at the proposal stage that projects included an emphasis on sustainability factors such as staff training, community-specific site assessment, and included as many concerned community stakeholders as possible. This emphasis by HII led to outcomes that will continue beyond HII funding.

It is not unexpected that some activities that were funded by HII will cease unless other funding sources are identified. However, interviewees indicated that discontinuing those activities until alternative sources of funding are found would slow the integration initiatives in those project communities. Concerns about the nature of short-term, time-limited funding were frequently raised.

The evaluation also determined that there might be considerable potential for applying practices resulting from the HII projects to other communities as a way of promoting integration. The findings indicate that the "softer" approaches used in HII projects and many of the tangible products developed would likely be useful to any other community undertaking integration projects. The softer approaches included the methods for establishing and managing successful partnerships, and the tangible products include training materials and practical models for health care delivery.

Cost-Effectiveness

Even though there is no objective method of measuring HII's return on the funds invested, the Evaluation determined that, overall HII has been considered a cost-effective means of achieving its intended objectives. While indicating it was still too soon to tell and that their views were not

based on objective analysis, senior federal officers generally believed that HII was cost-effective at the project level, and Project Partners believed that their projects provided useful results for the amounts spent. The HII may have been a cost-effective experience for finding ways to advance integration in First Nations and Inuit communities.

SOME LESSONS LEARNED

Main innovative practices identified and lessons learned during the evaluation include the following:

- Collaboration and cooperation among different levels of government continues to be relevant as a means of improving the health services provided to First Nations and Inuit populations.
- HII was successful at achieving its objectives because the project selection process and criteria were closely tied to the program's objectives.
- Allowing flexibility in project governance contributed to overall project and program success.
- Emphasizing communication from the outset of the initiative contributed to project success.
- In its program design, FNIHB needs to take into consideration the large geographic distribution of communities.
- Partnerships are an important vehicle for fostering community involvement and change; they also contribute to sustained change.
- Emphasizing sustainability at the outset of a program helps to insure the sustainability of outcomes of individual projects.

OVERALL CONCLUSIONS

The Evaluation determined that HII addressed an important policy area, and it did so by targeting integration-related issues that were relevant to the communities directly involved in the projects.

Overall, HII was considered to be successful at meeting its objectives. Individual projects were successful inasmuch as they achieved intended outcomes and many of them established structures and arrangements that will continue to promote integration even after HII has ended. The evaluation also revealed that using partnerships, inclusive communications, and training were key to achieving the desired results. Furthermore, the lessons learned related to those partnerships and communication activities, and the materials and tools developed for training were considered to be applicable in other communities to other specific integration issues.

HII has provided FNIHB with a success story that it can use to further promote integration as a policy objective, and to demonstrate how successful change can be fostered in First Nations and Inuit communities.

Health Canada
First Nations and Inuit Health Branch
Evaluation of the Health Integration Initiative

This report sets out the findings and conclusions from a summative evaluation of First Nations and Inuit Health Branch's (FNIHB) Health Integration Initiative (HII). The evaluation was conducted over the fall of 2005 and winter of 2006.

A program requirement of the HII was that it undertake a comprehensive evaluation of the entire initiative during its final year of funding. Even though the HII was in its sunset phase at the time of the evaluation, it was useful for Health Canada to examine HII for useful knowledge to guide future FNIHB programming.

This evaluation is intended to provide Health Canada and FNIHB senior management with information concerning successful change initiatives related to First Nations and Inuit health. It also provides Treasury Board Secretariat with information concerning the investment in HII.

1.0 Introduction

This section of the report provides an overview of the Health Integration Initiative, its funding, and its activities.

1.1 Overview of the Health Integration Initiative

Federal, provincial, and territorial (F/P/T) governments and First Nations and Inuit (FN/I) organizations are all involved in FN/I health. However, as recent reports (i.e., RCAP, Kirby, Romanow) have pointed out, there is a lack of coordination and cooperation between F/P/T governments and FN/I organizations in health and a need for better F/P/T/Aboriginal collaboration.

In the Health Accord 2003, First Ministers committed to address the gap in health status between aboriginal and non-aboriginal peoples through better integration of services. They agreed to an F/P/T strategy to involve Aboriginal people to a greater extent in processes addressing health.

The Health Integration Initiative (HII) was established in 2003 as a first step in addressing the gap in health status between First Nations and Inuit peoples and other Canadians through better integration of federally funded health systems within First Nations and Inuit (FN/I) communities and those funded through Provincial and Territorial governments.

The HII was created to provide information on the meaning of service integration, and the steps in developing service integration models for First Nations and Inuit communities.

The primary objectives of the HII were:

- To explore, develop and analyze models for better integration in the delivery of health services to First Nations and Inuit Communities; and
- To investigate how to promote co-ordination, collaboration and integration among programs and services delivered by Federal, Provincial/Territorial, and First Nations/Inuit health systems.

The intended Strategic Outcome for HII was the establishment of efficient, effective and sustainable health services and programs for First Nations and Inuit through improved integration of federal and provincial/territorial health systems.

The long-term expected impacts of HII activities are:

- Reduced duplication of services and improved coordination of services;
- Closure of existing gaps in services and benefits between the federal and provincial health care systems, and between First Nations, Inuit and the rest of the population;
- Improvements in economies of scale by providing joint federal and provincial/territorial health services;
- Improved access to, timeliness and quality of health services; and
- Greater participation by First Nations and Inuit in health services.

The HII received a total of $10.8 million over the three-year period of August 2003 to March 2006 from the Aboriginal Envelope of the Primary Health Care Transition Fund to undertake the following activities:

- Integration projects: to provide experience-based information concerning the practicalities of integrating federally funded First Nations and Inuit health systems with provincial/territorial health systems;
- Research projects and activities: to assess and advance knowledge and understanding of health system integration nationally and internationally; and
- A policy framework: to provide guidance for future work in integration.

1.2 Overview of the HII Integration Projects

Project selection

The eight FNIHB Regions were responsible for identifying and implementing projects with budgets of approximately $800,000, which was considered to be the amount required for the partnership engagement and model development envisioned by the HII.

Project criteria included the following:

- project partners had to include FN/I organizations, a province or territory (or a regional or district health authority) and a FNIHB Regional office, with letters of support from all partners;
- projects had to be completed by end of March 2006, without need for incremental or ongoing funding; and
- projects were expected to generate useful information about integration.

Each project was assessed on its capacity to address the following issues:

- reducing duplication of effort within the health care system;
- reducing gaps in services between the PT health system and the federally-funded services for First Nations and Inuit communities;
- achieving potential economies of scale by combining and co-ordinating services by PTs and federally funded health services; and
- improving timeliness, access and quality of treatment and rehabilitation services.

This approach of inviting the Regions to develop proposals in partnership was chosen rather than a general Request For Proposals because there was only a small amount of money available, and this was a time-limited initiative. The Secretariat was aware that RFPs are often

criticized for raising expectations and consuming scarce community resources for proposal development, with proposals submitted which do not meet the criteria of the funder.

Also, it was not clear what the level of interest on the part of First Nations and Inuit communities in participating would be, so the expertise of senior managers at Regional level was needed to identify areas of the country where First Nations communities and provinces, or Inuit communities and provinces or territories, were prepared to participate in this process with FNIHB. In some regions, it was not possible to get letters of support from provinces/territories or the respective First Nations or Inuit organizations to undertake the proposed activities, and therefore the proposal was not approved.

Regions developed proposals, which were reviewed by the HII Steering Committee, comprising the eight Regional Directors, the director of Policy Development Division, the director general of Primary Health Care and Public Health Directorate, and chaired by the director general of the Strategic Policy, Planning and Analysis Directorate. Proposals were developed in an iterative process with the HII Secretariat, and reviewed and approved by the Associate Deputy Minister of FNIHB.

Each proposal went through several drafts before it was considered by the ADM. The first projects were approved in October 2004 and the rest were approved within the next six months.

The following eight integration projects were funded under HII. Additional information on these Integration Projects is provided in Appendix A.

- A Model for the Delivery of Primary and Public Health Care Services, Sioux Lookout District First Nations, Ontario
- Atlantic Nursing Collaborative Policy Project, Nova Scotia and New Brunswick
- Elsipogtog Health and Wellness Primary Health Care Project, Elsipogtog First Nation, New Brunswick
- Many Jurisdictions, One System Project, North Peace Tribal Council, Alberta
- Norway House Health Services Project, Norway House First Nation and Town, Manitoba
- Weeneebayko Area Health Services Integration Initiative, James Bay, Ontario
- Vancouver Island Chronic Illness Care Project, Vancouver Island, British Columbia
- Integrating Health Promotion and Illness Prevention Programs in Nunavut, Nunavut.

As part of HII, FNIHB also commissioned the development of research papers that relied on document reviews, internet searches and key informant interviews. The following research papers were developed:

- *Multi-Jurisdictional Initiatives in Aboriginal Health Services - Provincial Scan*;
- *Integrative Action--Building Bridges Across the Continuum of First Nations and Inuit Health Services: A Literature Review*; and
- *Environmental Scan of Health Services for Urban Aboriginal Persons*.

Those research papers were provided to FNIHB's Regions and to HII Integration Projects as a resource.

In addition, three workshops for project partners, staff and other invited guests were held to assist with project implementation and to share the results of projects. Reports from each of the workshops, held in February 2005, September 2005, and March 2006, were made available to participants.

1.3 Program Management

The management and oversight of HII activities were the joint responsibility of FNIHB's Regional Offices and the HII Secretariat in FNIHB. Health Canada's Health Integration Initiative Steering Committee (HIISC) provided overall direction to all HII activities, which were then implemented by the HII Secretariat. The role of the HII Secretariat was to:

- manage and distribute HII funding;
- implement a communications strategy;
- prepare the HII Annual Report;
- coordinate and support HII project implementation;
- develop the policy framework and research and analysis activities;
- liaise with national organizations; and
- coordinate and analyze evaluation strategy results.

The HII Secretariat was located within the Strategic Policy, Planning and Analysis Directorate of the First Nations and Inuit Health Branch (FNIHB), Health Canada.

2.0 Methodology

This section of the report sets out the methodology used for the evaluation. The methodological approach used reflected the standards of Program Evaluation and the expectations set out in Canada's Treasury Board Policy on Evaluation.

2.1 Evaluation Objectives and Issues

The Evaluation Framework developed for HII in 2005 guided the evaluation study. The formal objectives of the Evaluation were:

- to provide Health Canada and FNIHB senior management with information concerning successful change initiatives related to First Nations and Inuit health; and
- to provide Treasury Board Secretariat with information concerning the investment in HII.

The first objective also reflected the evaluation's intention to identify for Health Canada and FNIHB useful lessons learned.

The rationale for the Evaluation issues examined derived from policy questions identified in the early phases of HII's implementation. Those issues were articulated by FNIHB's Policy Development Division to provide guidance at the outset of the initiative. The issues are:

- Did the Project achieve or contribute to greater integration of health services?
- What are the effects (positive or negative) of greater integration?
- What circumstances and actions contributed to achieving greater integration ("Enablers")?
- What circumstances and actions made integration more difficult, or contributed to undesired effects ("Barriers", "Pitfalls")?
- How did the roles within the health system(s) change with greater integration?
- What was the magnitude and cost of the changes?
- Are the changes likely to be sustainable?
- What do the project findings suggest about "next steps" in achieving better integration?

2.2 Evaluation Design and Methodologies

The HII Evaluation Framework provided the main design elements of the evaluation methodologies. The methodologies and research instruments were developed in collaboration with the HII Secretariat to ensure they reflected the program and project characteristics.

As required in evaluation standards, the methodology for this study included multiple lines of inquiry. These included the review of documents, interviews with multiple stakeholder groups, case studies, and horizontal analysis across all lines of inquiry. Details of these methods are provided below.

Review of Documentation

HII projects and other activities generated several types of documents that contributed to the evaluation research. These included:

- monthly reports produced by project proponents to record interactions and progress, and to keep FNIHB informed;
- reports produced for funded research, analysis and policy activities;
- evaluation reports on Integration Projects;
- files, local documents, plans; and
- general correspondence.

These documents were reviewed for information relevant to the implementation of the HII. Where possible, additional context on the information contained in documentation was obtained during interviews.

Interviews

Interviews were conducted with senior federal officials who knew the HII and with Project Partners who were actively involved in HII project activities. All interviews followed a structured process. Questions were open-ended and the interviews were interactive, focusing on the interviewees' particular knowledge and perspective of HII.

Interviewees were identified through an iterative process. HII program personnel identified a first set of interviewees, and during interviews with those individuals, they were asked who else could be contacted to provide additional relevant information. This approach ensured that the interviews included, to the extent practicable, all people who were knowledgeable about HII.

In all, 39 individuals were interviewed. The interview guidelines are included as Appendix B.

Interviews with Federal Officers

Of the 39 interviews conducted for the evaluation, 18 were with senior federal officers. These were from First Nations and Inuit Health Branch and one from Human Resources and Social Development Canada. Individuals from FNIHB were from Headquarters and Regional Offices involved in HII projects. For each Province/Region where there was an Integration Project, either the Regional Director or a designate was interviewed.

Interviews with Project Partners

Project Partners consisted of provincial and territorial government representatives and other individuals involved in or influenced by integration initiatives. Of the 39 interviews conducted for the evaluation, 21 were conducted with Project Partners. For all HII Integration Projects, at minimum the Project Manager and a representative for the provincial government were interviewed.

The breakdown of the number of Project Partner interviews by project is set out in the following table:

HII Integration Project	Number of Project Partners Interviewed
Vancouver Island (BC)	4
North Peace Tribal Council (AB)	3
Norway House (MB)	2
Sioux Lookout (ON)	2
Weeneebayko Health Ahtushkaywin (ON)	3
Atlantic Nursing Project (NS and NB)	2
Elsipogtog First Nation (NB)	2
Nunavut (NT)	3
Total	21

Case Studies of HII Projects

A standard case study format was developed in collaboration with HII to provide a structure for addressing the evaluation questions within the specific parameters of each HII project. HII personnel were involved to provide valuable context and knowledge of recipients, which helped ensure that the case studies reflected HII's nomenclature, process, and interactions.

The information on each HII project that was collected through the review of documentation and interviews was compiled into the case study format to present in a structured way the findings and conclusions of each Integration Project's against the evaluation issues. The case studies, included as Appendix C, provided a useful foundation for horizontal analysis and synthesis.

Analysis

The case studies and other analytical compilations were examined and synthesized to determine each HII project's contribution to the evaluation issues. Using the structure of the interview guidelines and the case studies as an analytical framework, findings on similar matters were correlated horizontally to the evaluation questions to identify divergence and convergence of opinions and experiences. Convergence of findings against an evaluation question indicated support for a given conclusion. Where there was divergence in underlying findings, the divergences were examined to determine the underlying rationale for the differences. The divergent views are reported in a balanced and fair way in this report. This horizontal analysis across the evaluation questions enabled a compilation of qualitative and quantitative information, as set out in this report.

Level of Confidence

Overall, the research methods used in the evaluation provides a good level of confidence that the conclusions reached are valid. The Evaluation strived to conduct interviews with a minimum of three informants for each project. However, due to the timeframe of the interviews, this was not possible for all of the cases. Furthermore, some of the interviewed FNIHB Regional staff members were only able to address the policy aspects of HII, rather than specifics about the project(s) in their region.

Some of the evaluation findings are based on the opinions of knowledgeable persons involved in HII, and it is recognized that their opinion was subjective based on their experience with HII and other undertakings. This could be considered as a limitation to the methodology inasmuch as it that may influence the interpretation of the findings. However, as indicated later in this report, the common views expressed by informants suggest a convergence around what the major issues were and their experiences. Therefore, these potential limitations to the methodology do not adversely affect the evaluation's overall conclusions.

3.0 Findings and Conclusions

This section on findings and conclusions from the evaluation is organized into six subsections, as follows:

- the relevance of HII and of HII projects;
- HII's processes;
- immediate Outcomes;
- partnerships;
- sustainability and the potential for replication; and
- the cost-effectiveness of HII.

3.1 Relevance

The discussion on HII's relevance is organized under two sub-topics:

- the relevance of Integration as a policy priority, and
- the targeting of HII projects to relevant Community Health needs areas.

3.1.1 Integration Remains a Relevant Policy Priority

The evaluation identified a broad consensus indicating that integration was a relevant policy priority, because the health of First Nations and Inuit people was perceived to be negatively impacted by the lack of federal/provincial/territorial integrated health services delivery. Furthermore, HII was seen to be an effective program approach to supporting that policy priority.

Summary of Findings

The findings on relevance are based on interviews with Project Partners and Senior Health Canada Officials.

In the context of HII, integration was defined as "a general concept of collaboration and harmonization that looks at ways and means of improving coordination and collaboration between health systems funded by provincial/territorial (P/T) governments, and the First Nation and Inuit (FN/I) health system (funded by the federal government)". In HII, the term "integration" was generally used to describe interrelations between health systems funded by P/T governments and FN/I health systems.

Using HII's definition of integration (i.e. collaboration amongst the different levels of health care systems), 16 of the 19 interviewed Project Partners considered integration to be of "prime importance."

For example, one Project Partner supported this view by saying:

> "[There is] so much opportunity to provide better services if [the parties] work together."

Another interviewee said:

> "None of [the parties] can do it alone."

A third Project Partner said that:

> "Integration should be a priority given that the health status of FN/I people is poorer than anywhere else in the country."

One interviewed Project Partner indicated that integration is more fundamental in nature:

> "It is about putting the issue of health status at the core of efforts. Acceptance of the magnitude of the problem is needed."

Further, with the exception of interviewees from the Nunavut Project, all interviewed Project Partners expressed the view that the existing multi-jurisdictional approach to the delivery of health services was adversely impacting the health status of FN/I people. They identified a range of shortcomings in the current system, including gaps and duplications; the lack of a "global budget with ongoing funding" for health services delivery; fragmented "handoffs"; and an unwillingness on the part of the respective levels of government to take responsibility for the health of First Nations and Inuit people. While there was acknowledgment that factors other

than the lack of integration adversely impact on the delivery of health care services, the lack of integration was seen as a major contributor.

The interviewed Project Partners from the Nunavut Project, while not disagreeing with the significance of integration, indicated that health services delivery context in the territories differs from that in the provinces. They indicated that, with health and social services largely integrated and all services available to all residents, integration efforts needed a different focus in the territories.

There was broad consensus on the part of senior federal officials that integration was a relevant policy direction contributing to FN/I health. One senior official indicated that:

> "Poor/no integration is still one of the major barriers to overcome."

Others indicated that integration was :

> A "critical objective", a "key government policy direction" and that it was "the top priority as it is the only financially viable way to close the gap in existing services. Integration represents a systematic approach to addressing this gap."

Further, a senior official from FNIHB said:

> "Integration is 'THE' top priority for the Branch. It is the main vehicle that will contribute to sustainability and quality of services."

Another interviewee characterized integration as a vehicle through which to

> "facilitate the creation of a health system for people living on reserves that is coherent".

One senior federal official interviewed indicated that the current definition of integration adopted by the federal government did not resonate fully with the First Nations. While agreeing that the overall concept of integration was important, this interviewee stated that:

> "All the stakeholders are going to have to work at talking together to clearly define their views and perspectives."

Conclusions on the Relevance of Integration

The findings indicate that interviewees had different interpretations of how to define "integration." Even so, overall, the findings support the conclusion that integration, irrespective of the variances in its precise definition, was and continues to be relevant as a means of improving the health services provided to First Nations and Inuit populations. Furthermore, HII

was considered to be a relevant and valid vehicle for pursuing the policy objective of integration. Additional discussion of HII's performance as a vehicle supporting this policy direction is provided in later sections of this Evaluation report.

3.1.2 Projects Were Selected to Maximize Their Relevance

The evaluation determined that HII maximized its relevance to FN/I communities by selecting specific community health care areas that would benefit from further integration. This also supports the conclusion that HII was a relevant program.

Summary of Findings

The findings related to the relevance of HII projects is based on interviews with Project Partners and Senior Officials, and a review of HII project documentation.

Projects were selected based on specific criteria that ensured their alignment with HII's objectives. Specifically, as part of the Project Proposals submission requirements, applicants were required to provide information addressing why the proposal was identified as a priority to the target community or region. As a result, the proposal process ensured that all eight of the HII projects could demonstrate that they would be responding to relevant community-based health needs through greater integration.

A review of project documentation indicated that the objectives of projects were presented in a way that emphasized their linkage to integration. For example, the objectives of the Many Jurisdictions, One System Project with the North Peace Tribal Council in Alberta were to improve tripartite diabetes prevention, treatment and health promotion programs through improved integration. Similarly, the objectives of the Vancouver Island Project in British Columbia were to develop an integrated FNIHB, provincial and First Nation approach to chronic illness case management and to further advance the work of the BC Ministry of Health in chronic disease management initiatives for diabetes and congestive heart failure.

All interviewees with Project Partners and senior federal officials who were familiar with HII projects confirmed that the projects they were familiar with would, over time, achieve and demonstrate the benefits of integration within the project's selected area of health services. This, in turn, would help to demonstrate the benefits of greater integration that could be possible in other health services areas.

Conclusions on the Relevance of HII Projects

The findings support the conclusion that the process and criteria used to select HII projects ensured that HII's projects were relevant. Additional information related to the achievement of project objectives is provided later in sections 3.3 and 3.4.

3.2 HII Program Processes

This Evaluation of HII included three principal evaluation questions about HII's processes:

- governance over individual HII projects;
- communication strategies and mechanisms within projects; and
- other implementation challenges.

Each of these questions is discussed in a subsection below.

3.2.1 Governance

The evaluation determined that, in general, the governance structure within HII projects was effective inasmuch as it contributed to good progress and overall project success. Progress in a few projects was perceived to have been adversely affected by limited or inconsistent participation by some Project Partners. In other cases, these representatives were considered to lack the necessary decision-making authority to negotiate or make agreements, which delayed implementation of project objectives.

Summary of Findings

The findings on governance are based on interviews with Project Partners. Project documentation provided additional information on how the governance of individual projects functioned.

As part of HII's design, each project was required to assemble an advisory committee made up of representatives from three levels of government: one from a First Nations or Inuit community or tribal council or organization; one from a provincial or territorial government, or regional health authority; and one from the FNIHB Regional Office. Some advisory committees included additional Project Partners depending on the activities to be undertaken within the project. The

governance structure within individual projects varied and was established based on the project participants' views of what would work best for their HII project.

Interviews with Project Partners determined that they were all satisfied with the governance structure in place for their respective projects and they provided examples of specific elements of their project's governance structure/process that worked well. For example, one interviewee indicated that the governance approach adopted by their project was flexible in nature, in that the roles, responsibilities and participation adjusted over time as the project evolved. As an illustration of flexibility, one Project Partner indicated that the composition of their Steering Committee could be adjusted to include an additional person with specific knowledge that was required at a specific point in the project.

Project Partners indicated that the flexibility afforded to the projects' governance contributed to their ability to adjust and succeed. They indicated that they appreciated the ability to establish a governance structure that worked for them, and the ability to adjust those structures as the needs evolved. They felt that the ability to adjust quickly gave them the chance to achieve more within HII's relatively limited timeframe.

To the extent that project documentation discussed governance issues, it suggested that roles and responsibilities and project decision-making were working well in individual HII projects.

Even though individual projects had the ability to adjust their governance structures, some interviewees indicated that, at times, they found that this flexibility was not able to address all governance issues that emerged. In particular, based on interviewees, in half of the projects, the level of Project Partner participation was problematic. Evaluators were told that, in some projects, a Project Partner was not devoting the time necessary to ensure the project's success, due to what was seen as a lack of commitment. In other projects, Project Partners were not able to devote the time they would have liked to, mainly due to competing priorities or a lack of resources. As one of the interviewees for Sioux Lookout indicated:

> "One of the biggest challenges was to engage people, probably due to unreasonable workloads on their plates."

In those situations where Project Partners were not able to participate fully, other project participants had no choice but to wait for the Project Partner to become more engaged.

In other situations, interviewees indicated that their Project Partner did not have a high enough level of authority to facilitate decision making, which in turn delayed project progress. Those interviewees indicated that, because their projects needed to wait on their Project Partner or on higher decision-makers, they were not able to progress as much as they would have liked within HII's limited timeframe.

Whether or not these views on the unavailability of Project Partners or their lack of authority to make decisions are supportable, it could be expected that the complex issues involved in integration might take more time than originally anticipated and desired changes may require very high levels of authority. As a result, these views may be valid, but not illustrative of a problem with HII's governance principles.

Finally, a small number of interviewees indicated that they would have benefited from having defined more clearly at the outset everyone's roles and responsibilities.

Conclusions on Governance

Even though a small number of interviewees indicated that their Project Partner could have been more involved or more effective if they would have had more authority to make decisions, the evaluation concluded that the governance over individual projects contributed to the achievement of project objectives. Interviewees attributed their positive views on governance to the flexibility they were provided to adjust structures as their project's needs evolved.

3.2.2 Communication

The evaluation determined that the communication strategies and mechanisms used to manage and support HII projects contributed to the individual project's success. Furthermore, the communications efforts at the project level with their respective communities were effective and contributed to project's success.

Summary of Findings

This section on communications addressed two perspectives:

- communications among Project Partners to support project implementation, and
- communications between projects and their communities to build awareness of and support for the project.

These findings were based on interviews with Project Partners. Project documentation provided complementary information on communication practices within individual projects.

Communications Within Projects

As part of their routine operational processes, all projects relied on the more typical communication vehicles, such as meetings, teleconferences, and e-mails. In addition, some projects included other innovative approaches, including telehealth technology to provide project updates and poster boards describing details of projects.

The HII Secretariat invested considerable effort in developing communications tools and vehicles that could be adapted and used by Integration Projects. The evaluation determined that some of these were considered more useful than others.

Interviewed Project Partners were asked to rate the usefulness of the communications tools and vehicles provided by the HII Secretariat that they had used. Interviewees indicated that the most used tools and vehicles were the meetings with FNIHB Regions and other Project Partners. Of the 21 interviewed Project Partners, 16 had used these meetings. Of the 16 that had used the meetings, 13 rated them as

> "very helpful" or "extremely helpful".

Interviews determined that the other communications tools and vehicles would only apply to certain projects. Therefore, they were not broadly used. The following table illustrates which tools the 21 interviewed Project Partners used.

Communications Tool or Vehicle	Number of Project Partners who had Used the Tool or Vehicle (out of 21)
Proposal template and guidelines	9 (43%)
Information tools/deck and script for Regional Directors	1 (5%)
Feedback on proposals and assistance in refining proposals	9 (43%)
Meetings with FNIHB Regions and regional partners	16 (76%)
Baseline questionnaire (evaluation tools)	10 (48%)
Monthly reporting template	10 (48%)
HII Secretariat Director's or staff attendance at meetings	12 (57%)
Regional assistance during negotiations related to the approval of projects	6 (29%)

Overall, interviewees indicated that communications activities, materials and instruments were, on average, considered "helpful". Of the 21 Project Partners, 14 (67%) commented on the effectiveness of these items. The average score provided was a "3.4" where "3" was "helpful" and "4" was "very helpful."

These findings suggest that the HII Secretariat's investment in these tools was worthwhile. This conclusion can be supported even more by the fact that the tools or their underlying concepts could be used in future FNIHB initiatives.

Communications Between the Projects and Communities

Communications strategies and tools played an important role in furthering the success of projects.

Different HII projects used different communication strategies, modes, and tools. These included community visits, radio broadcasts to the community (or communities), radio talk shows disseminating information about projects, newsletters, and translation of project information into the different languages of the communities.

Dedicated communications personnel were also used. For example, the Weenebayko Area Project hired an individual on a full-time basis to help build and maintain consensus with the relevant community partners. Also, the "Many Jurisdictions One System" project staffed a position of "Communication Dissemination Coordinator" who spent a lot of time dialoguing with

the communities. This interaction positioned her well as a liaison between the remote communities and the Project Partners who were located a long distance away.

Project Partners saw consultation with FN/I community members as an integral component of project implementation and success. According to some interviewees, this was a particularly significant success factor since, historically, effective broad-based communication with FN/I people was most often lacking in this type of government-led initiative.

According to all interviewees who were involved "on the ground" with HII, projects engaged the communities to a great extent both in terms of consultation and communication. One interviewee indicated that

> "Presence [in the community] was key to the success of our HII project. Communication is better, and the ebb and flow is best when [HII Staff] are in the community."

One interview commented on the success of HII communications at the community level by saying:

> "I've never seen anything as successful. It was essential to have a direct link to the community in order to succeed."

Interviewed Project Partners also commented on the considerable challenges involved in communications for HII projects, including great geographical distances and the many different languages spoken within FN/I communities. However, even given these types of challenges, HII projects were seen to be effective at communicating with their target communities.

The findings strongly suggest that projects' communication efforts with their communities were an important success factor, and that these efforts were considered to be effective.

Conclusions on Communication

The findings suggest that HII provided a model for successful communication at two levels: within projects, and between projects and the FN/I communities they were working with. This indicates that the early investment in communications tools by HII program management at the outset of the program contributed to both the overall success of HII and the progress of integration.

Many interviewed Project Partners used the HII-provided communications approaches, materials and instruments, by some more than others. Overall, they found them to be useful, suggesting that HII's investment in their development was worthwhile.

3.2.3 Implementation Challenges

The Evaluation determined that the success of some HII projects was adversely affected by the broad geographic area covered by some projects and the long time that it took to get some projects underway. The delays in launching some projects also caused financial pressures due to fiscal year-end cut-offs.

Summary of Findings

The remoteness of many of the First Nations/Inuit communities involved in certain projects created significant challenges in terms of moving those projects forward. Specifically, there were logistical difficulties associated with working with some of the communities that were only accessible by air, and widely dispersed communities, such as Sioux Lookout where twenty-eight First Nations communities comprise the Sioux Lookout Zone. Another example was the Nunavut project where the geographical distance and unpredictable climate made it difficult to organize face-to-face meetings, which would have been a preferred method to communicate.

In practice, these challenges adversely affected the ability to bring Project Partners together, to visit and communicate with the communities, and to schedule HII community events. However, program personnel indicated that this type of logistical challenge caused by geographic distances exists in many FNIHB programs.

With respect to delays in launching projects, Project Partners from three of the projects indicated that they were delayed in getting started and that this had an adverse impact on implementation and progress. According to those interviewees, the main reason for start-up delays was due to delays in the approval of Project Proposals and development of contribution agreements by FNIHB. They indicated that this created a “challenging timeline” within which to accomplish project objectives, and that it caused pressures on funding since funds needed to be spent before fiscal year-end. For example, in the Sioux Lookout project, interviewees reported a seven-month period between proposal submission and signing the HII contribution agreement, which adversely affected the timeline of the entire project. On the other hand, program personnel indicated that “getting the project design right at the outset” might have slowed the process, but was an essential ingredient to the success of individual projects and of HII overall.

Conclusions on Implementation Challenges

Whereas the above challenges related to geography and project approval are valid, they are not atypical inasmuch as they are also associated with most complex FNIHB programs or initiatives. All programs or initiatives that work at the community level with First Nations and Inuit encounter difficulties in accessing remote locations and covering dispersed communities. Also, as indicated earlier, some of the expectations placed by HII on projects at the design stage contributed to their success. As a result, what was considered by proponents as a delay in project approval may have been part of a process of clarifying and improving the project proposal's focus and design to increase the chance for success.

Overall, the main process challenge identified in the Evaluation – delays in proposal approval and receipt of funding– caused difficulties, but likely also contributed to ensuring HII's success and sustainable results. While it would be reasonable to encourage a more timely process in approving proposals for future HII-type initiatives, this should not be done at the expense of thoughtful and sound conditions that will improve the likelihood of funded projects' success. There would be little advantage to FNIHB or to First Nations communities in approving quickly a number of proposals for projects that generate poor or negative results.

3.3 HII Projects are Achieving Planned Immediate Outcomes

HII projects have produced a number of documents and other outputs that represent immediate outcomes. The use of these outputs is promoting integration at the community level.

Summary of Findings

Immediate outcomes were identified through interviews with Project Partners and a review of the project documentation.

Interviewed Project Partners readily identified products that were developed through the HII project that were being used to promote integration at the community level. The creation of these products is an important outcome from HII projects, since they contribute to a foundation for further and more sustained integration efforts. Interviewees indicated that the following were noteworthy achievements of their projects:

- The Weeneebayko project developed a Draft Tripartite Agreement, a Draft Special Act towards the amalgamation of two area hospitals, and a Master Service Plan;

- The Atlantic Nursing Collaborative Policy project established 45 policies guiding nursing practice and provided a template for further policies;
- The Elsipogtog project developed a Collaborative Practice Manual and training materials on a population health approach;
- The Nunavut project resulted in a Five-year Action Plan including a mental health and addictions treatment approach, and a Gap/Duplication Analysis of programs related to maternal, child, and dental health;
- The Sioux Lookout project developed a plan for comprehensive health service delivery that is organized in a way to meet community needs and that would be supported by communities and built by the communities;
- The MJOS project created and distributed diabetic passports (portable comprehensive health records that First Nations patients are responsible for) and care maps (guides for nurses not specialized in diabetes that provide them with assessment tools and instructions for different scenarios);
- The Norway House project put in place a master plan for overall health services, including a primary health care model;
- In the Vancouver Island Project, a formal assessment process was created to select sites for projects, process maps were created to clarify clinicians' and organizations' responsibilities at each stage of the patient journey, and site leader job descriptions were created.

Conclusions on Immediate Outcomes

Even though interviewees with most projects indicated that there was always "more to be done", they indicated that their project had led to the creation of useful and often *essential* products that would lead to further integration. As a result, HII contributed to the creation of a foundation for community-level health integration.

3.4 Partnerships Contributed to HII Projects' Success

The Evaluation determined that the partnerships created during HII projects contributed to the respective projects' success. New partnerships were formed and existing partnership relationships were strengthened. The fostering of sustainable partnerships was seen to be one of the HII's most important contributions.

Summary of Findings

The evaluation findings related to partnerships were based primarily on interviews with Project Partners.

HII projects resulted in the creation of new partnerships and the strengthening of existing ones. For example, interviewees from the Nunavut project indicated that, as a result of their project, doors were opened for partnerships with community-based groups. Interviewees from the Vancouver Island project indicated that their project had facilitated new collaboration with the Regional Health Authority. An interviewee from the Weeneebayko Project reported a new partnership with the North East Local Health Integrated Network. Furthermore, interviewees from all projects indicated that continued collaboration with existing partners led to introductions to new contacts within the organizations involved, thereby strengthening existing organizational relationships.

Partnerships Were Considered To Be An Essential Ingredient of HII Projects

The evaluation findings indicated that partnerships were highly valued throughout the implementation of the HII projects. Partnerships were considered by interviewees to be the "crux of the project" and a key to their success. Project Partners from each of the eight HII projects reported extensive and significant interaction with other key partners involved in their project, even though the extent of partner interaction varied from one project to another.

Those interviewees also believed that continued partnership was essential for fostering ongoing collaboration toward desired outcomes at the community level. As one interviewee indicated:

> "Partnership and joint planning have to be done if we want to build healthy people and communities" and "Anything is possible if we work collaboratively".

Another interviewee said:

> "Through joint planning, things get done and people have a better understanding of each other and each others' roles."

Collaboration through partnership was seen as "an opportunity for creativity and to think outside of the box" and contributed to an awareness of "possible partnerships that could be explored outside of the normal working area".

Interviewees saw partnerships as a vehicle for open and honest communication and for inclusion of the communities. Partnerships also helped projects to reflect local culture including their political climate and calendar, and encouraged communities to "take ownership" of HII projects and their outcomes.

Interviewees also indicated that partnerships were most effective when they included three components. First, the individuals within the partnerships need to have the necessary knowledge of the issues and the authority to make decisions on behalf of the organization they represent. Second, the objectives of the partnership need to be clearly defined, promulgated and understood. Finally, the role and responsibilities of each individual within in the partnership need to be clearly defined and understood.

Partnerships Went Beyond the Specific HII Projects

Interviews with Project Partners also revealed that new partnerships extended to other areas beyond the HII projects and provided a foundation for working together after the HII project was finished.

The HII partnerships facilitated collaboration on other issues/initiatives that went beyond the scope of the project. For example, the partnerships established in the "Many Jurisdictions One System" (MJOS) project led to collaboration on a community mental health initiative. Interviewees indicated that the partnerships in the Norway House project led to discussions of collaboration on a number of initiatives including the Midwifery Program, the Aboriginal Health Human Resource Initiative, the Blueprint process, the Manitoba First Nations Health Technician Network and the Inter-governmental Committee on First Nations Health. These are all important unintended positive outcomes from HII.

Finally, the partnerships formed for the HII projects were expected to survive the end of the projects. Specifically, interviewees from seven of the eight HII projects indicated the intention to maintain the partnerships developed or enhanced as a result of HII even after the conclusion of their respective Projects. Those interviewees believed that continuing their partnerships was integral to the maintaining and building on the progress made to date.

Conclusions on Partnerships

The Evaluation determined that new and existing partnerships were an integral and essential part of HII. These partnerships were a primary vehicle for fostering community involvement and encouraging collaboration toward community level outcomes. HII's partnerships led to effective working relationships in other non-HII areas, and HII's partnerships are generally expected to continue once the HII projects are completed.

These conclusions suggest that partnerships were one of HII's most important success factors.

3.5 Sustainability of HII Projects and the Potential for their Replication in Other Communities

This section of the report sets out first the elements of HII projects that are expected to continue even after the formal HII project ends, and the factors that contributed to that sustainability. The section then discusses the findings on whether the HII projects could be replicated in other First Nations and Inuit communities, or could be applied across all those communities.

3.5.1 Many Elements of HII Projects Will Continue

The evaluation determined that many elements of the HII projects would continue even after the project is no longer funded by HII. A major contributor to this sustainability was the design of HII, which ensured at the proposal stage that projects included an emphasis on sustainability factors such as staff training, community-specific site assessment, and included as many concerned community stakeholders as possible.

Summary of Findings

The findings concerning the sustainability of HII projects are based on interviews with Project Partners. Some descriptive elements were also supported in project documentation.

The interviews revealed that the elements that will continue could be organized into four categories: infrastructure; health care models; resources; and relationships.

Infrastructure Elements That Are Expected To Continue

For some HII projects, organizational infrastructure created during the timeframe of the HII funding will continue to exist even after HII funding ends. For example:

- At the time of this evaluation, Weeneebayko was in the process of establishing the Weeneebayko Area Health Authority (WAHA) within the Ontario Legislature. An interviewee from the Weeneebayko Project reported that once approved

  "The WAHA [will be] a powerful vehicle to sustain [integration efforts]".

  An important function of the WAHA will be responsibility for the amalgamation of the federal and provincial hospitals in the Weeneebayko area, namely James Bay and Weeneebayko General Hospital.
- In the Elsipogtog Project, one of the project outcomes was discussion about recognition and designation of the community's health services as a Community Health Centre by the province, although perhaps with a modified focus.

Health Care Models That Are Expected To Continue

Interviewees from three of the HII projects indicated that the models of health care delivery adopted by their projects would continue to inform the delivery of health services in their communities following the conclusion of HII. These included:

- the Vancouver Island project, which adapted a chronic illness model,
- the Elsipogtog project, which adopted the population health model, and
- the Norway House project, which adopted the primary care model.

Benefits from Resource Investments Will Continue

HII projects identified many examples of resources, both in terms of human resources and various resource "tools", created through HII Projects that would continue to be funded and used after HII ended. Examples of human resources investments included:

- The Weeneebayko project established a staff complement for the eventual amalgamation of the hospitals.

- Training and education as part of all HII projects resulted in a staff complement with increased knowledge, experience and an increased skills set. According to interviewees, the investment in staff training equipped service providers with enhanced skills for delivering community-based health services.

Examples of resource tools produced through HII projects that will continue to benefit FN/I communities include:

- From the MJOS project, the *Care Maps,* the *Foot Care and Wound Care Guidelines*, *Diabetic Passport*, *Discharge Planning Document* and a *Cookbook* developed in relation to diabetic nutrition will all continue to be used.
- From the Elsipogtog project, the *Collaborative Practice Manual* will continue to guide health services delivery in the Community Health Centre.
- From the Atlantic Nursing project, the *Care Maps* and the *Nursing Policy Guidelines* will continue to guide the nursing community on the provision of nursing services in FN/I communities. The Nursing Policy Guidelines contain generic policy templates that will facilitate their future adaptation according to community-based needs.

Relationships That Are Expected To Continue

Interviewees from several HII projects indicated that the relationships developed as part of their HII projects would continue and be reinforced. These included both formal and informal working relationships.

In particular, interviewees reported that “collaborative approaches” to health services delivery would continue through the partnerships developed in the Projects. For example:

- Interviewees from the MJOS project indicated that the Liaison Committee between Northern Lights and North Peace would continue.
- Interviewees from the Elsipogtog project reported that the working relationship with the Beauséjour Regional Health Authority would continue.
- Interviewees from the Weeneebayko project indicated that the Steering Committee and all the existing hospital staff would be continued within the new amalgamated hospital organization.

HII's Design Contributed to Sustainability

The findings indicated that specific design features of HII helped to ensure that project elements would be sustained once HII ended. These design features enabled HII program management to encourage applicants to embed certain "sustainability" elements into their projects, thereby increasing the likelihood that the project (or some of its components) would continue even after HII ended. This is an important factor contributing to HII's success.

Because HII staff members were able to encourage sustainability elements, several different activities were included in projects that may not have been otherwise. For example, the Vancouver Island project included staff training on the chronic care illness model and made use of a web portal for self-directed learning. The MJOS project made use of a train-the-trainer methodology to foster the transfer of staff's knowledge and competencies after formal completion of the project.

Another sustainability element included in the Vancouver Island project was the development of site assessments and work plans that could be used as a baseline for future integration projects.

A third sustainability element reflected in projects was the focus on involving in the project as many concerned community stakeholders as possible. This helped to ensure the success of individual projects, and also built momentum for continued action after HII ended.

It could be argued that the encouragement to design sustainability elements into each project is likely one of HII's greatest success factors. In fact, interviewees from two projects provided additional ideas for promoting sustainability, including:

- establishing at the end of the HII project a clear point of contact to facilitate on-going communication between the community and FNIHB's region; and
- establishing during the HII project some type of partnership that would ensure continued staff training after HII ended.

Overall, the evaluation findings indicated that HII's design and program management contributed significantly to launching projects that could be sustained after the project ended, and that many aspects of projects will in fact continue. The findings indicated a strong commitment on the part of Project Partners to continue to build on the benefits derived from their HII projects. The creation of sustained change toward greater integration is an important achievement for HII, since, by doing so, the initiative has created a foundation for community-level health integration.

Continuing Some Activities Will Require New Funding Arrangements

To fully reflect the views of interviewees, it is important for the evaluation to recognize that many elements of the HII projects will not continue once HII ends, given that the HII was a transitional initiative. Even though interviewees identified activities and outcomes that would continue once HII ended, it is important to recognize that, without HII funding, many activities would be discontinued unless other funding sources were identified.

According to interviewees, the main outcomes affected by the end of HII funding are:

- the slowdown in integration-focused learning and knowledge transfer within communities, due to the absence of the training activities now funded by HII, and
- the elimination of certain integration-focused community services, due to the elimination of service-oriented staff positions that were funded transitionally through the HII project.

Interviewees emphasized the benefits of these activities and the importance of the related integration outcomes. At the same time, they recognized that HII funding was time-limited and that their community would need to find innovative solutions to continue with those activities.

Conclusions on Sustainability

The findings indicated that HII's design contributed to producing sustained project outcomes. These sustained outcomes were related to infrastructure elements, the continuing use of new health care delivery models, better trained and informed personnel, and relationships. In particular, HII's emphasis on including sustainability elements such as staff training, site assessments, and involving a broad range of stakeholders led to outcomes that will continue beyond HII funding.

It is not unexpected that some activities that were funded by HII will cease unless other funding sources are identified. Interviewees indicated that discontinuing those activities until alternative sources of funding are found would slow the integration initiatives in those project communities.

3.5.2 The Potential of Applying HII's Models of Integration to Other Communities

The evaluation determined that there might be considerable potential for applying practices resulting from the HII projects to other communities as a way of promoting integration.

Summary of Findings

The finding related to the proposal of HII models to other communities is based on interviews with Project Partners.

Interviewees from all of the HII projects suggested practices from their projects that, in their opinion, would be useful to other communities pursuing integration initiatives. The most often cited practices were the collaborative partnership approaches, the training methods and tools, and the models of health care delivery that were developed and applied in the HII projects.

With respect to applying the *collaborative partnership approaches*, Project Partners indicated that the design principles of the collaborative approaches and the processes required to engage partners and build collaborative relationships should be applicable in other First Nations and Inuit communities. They believed that including recognized experts and community leaders in the partnership arrangements would help to ensure the success of any integration initiative. Furthermore, the inclusive processes used in HII project partnerships should be effective in other communities.

With respect to training, several interviewed Project Partners indicated that the tools, resources, and approaches developed in their project would likely be useful to other communities addressing similar integration issues. Illustrations included knowledge transfer workshops and training materials on a population health approach. Interviewees indicated that those materials could be adapted to local situations with very little effort.

Finally, interviewees from projects that involved the design and delivery of alternative models of health care delivery indicated that the knowledge and techniques they had developed for delivery in their communities could be useful to other communities. They indicated that communities shared many of the same delivery challenges, and that the models they developed could provide, to some extent, some ready-made solutions. As indicated earlier, the Vancouver Island project adapted the chronic illness model, the Elsipogtog project adopted the population health model, and the Norway House project adopted the primary care model.

Conclusions on applying HII's models to other communities

Overall, the findings indicate that the "softer" approaches used in HII projects and many of the tangible products developed would likely be useful to any other community undertaking integration projects. The softer approaches included the methods for establishing and managing successful partnerships, and the tangible products include training materials and practical models for health care delivery.

3.6 HII Was Considered Cost-Effective

Even though there is no objective method of measuring HII's return on the funds invested, the Evaluation determined that, overall HII has been considered a cost-effective means of achieving its intended objectives.

Summary of Findings

The findings related to cost-effectiveness were based on interviews with senior federal officers and Project Partners.

HII was in many ways an experiment for finding ways to advance integration in First Nations and Inuit communities. Its objectives were to "explore, develop and analyze models" and to investigate how to promote co-ordination, collaboration and integration." Therefore, HII was intended to provide knowledge and experiences to inform future developments toward integration.

All interviewees agreed that there is no objective method of assessing HII's cost-effectiveness, and that their opinion was entirely subjective based on their experience with other programming.

Interviews with federal officers suggest that HII provided good value for the amount invested in the initiative. All of these interviewees indicated that it was too soon to judge fully whether (and to what extent) the ultimate objective of integration would be influenced by the HII projects. However, they also indicated to varying degrees that the projects were successful in informing future policies and processes. At one end of the spectrum, one of the more supportive interviewees said:

> "HII was a huge bargain in terms of leverage. I believe it will transform the whole system".

Another who was also supportive, but perhaps less so, indicated:

> "It is difficult to measure the cost-effectiveness in the short-term as there are a lot of start-up costs and not a long project time. Given this context, we need to be careful about how much to expect. But I expect a good return from HII efforts."

Interviews with Project Partners provided similar findings. Project Partners indicated that, without HII funding, the achievements in the communities would not have happened. As a result, they believed that their HII project was valuable and cost-effective.

No interviewees that indicated that HII had been a waste of effort or resources.

Conclusions on HII's Cost-Effectiveness

Overall, the Evaluation concludes that HII added value and, based on interviews, may have provided this value in a cost-effective way.

While indicating it was still too soon to tell and that their views were not based on objective analysis, senior federal officers generally believed that HII was a cost-effective experiment. At the project level, Project Partners believed that their projects provided useful results for the amounts spent. Overall, the Evaluation findings suggest that the HII may have been a cost effective experience for finding ways to advance integration in First Nations and Inuit communities. At least there is no evidence suggesting that HII was a misuse of resources.

4.0 Overall Conclusions

SOME LESSONS LEARNED

Main innovative practices identified and lessons learned during the evaluation include the following:

- Collaboration and cooperation among different levels of government continues to be relevant as a means of improving the health services provided to First Nations and Inuit populations.
- HII was successful at achieving its objectives because the project selection process and criteria were closely tied to the program's objectives.

- Allowing flexibility in project governance contributed to overall project and program success.
- Emphasizing the use of communications tools from the outset of the initiative contributed to project success.
- In its program design, FNIHB needs to take into consideration the large geographic distribution of communities.
- Partnerships are an important vehicle for fostering community involvement and change; they also contribute to sustained change.
- Emphasizing sustainability at the outset of a program helps to insure the sustainability of outcomes of individual projects.

The Evaluation determined that HII addressed an important policy area, and it did so by targeting integration-related issues that were relevant to the communities directly involved in the projects. HII was considered to be a relevant and valid vehicle for pursuing the policy objective of integration, and the process and criteria used to select HII projects ensured that HII's projects were relevant.

The flexibility to adjust governance structures as projects' needs evolved contributed to the achievement of project objectives. Also, HII provided a model for successful communication at two levels: within projects, and between projects and the FN/I communities they were working with.

Overall, HII was considered to be successful at meeting its objectives. Individual projects were successful inasmuch as they achieved intended outcomes and many of them established structures and arrangements that will continue to promote integration even after HII has ended. There was general agreement on the part of senior federal officials and Project Partners that HII was effective at demonstrating that integration could be achieved at the community level using tailored approaches.

The evaluation also revealed that using partnerships, inclusive communications, and training were key to achieving the desired results. Furthermore, the lessons learned related to those partnerships and communication activities, and the materials and tools developed for training, were considered to be applicable in other communities to other specific integration issues. These are important HII characteristics that FNIHB should integrate into the design of its future initiatives.

Finally, even though there is no objective measure, the results achieved through HII were considered to be good value for the approximately $10 million invested over three years.

HII has provided FNIHB with a success story that it can use to further promote integration as a policy objective, and to demonstrate how successful change can be fostered in First Nations and Inuit communities.

Appendices

Appendix A: HII Integration Project Descriptions

Appendix B: Evaluation Interview Guidelines Providing Detailed Evaluation Questions

Appendix C: Case Study Outline

Appendix A: HII Integration Project Descriptions

A Model for the Delivery of Primary and Public Health Care Services, Sioux Lookout District First Nations, Ontario

The Sioux Lookout First Nations and their partners received $800,000 through the Health Integration Initiative (HII). The project addressed issues of inaccessibility to primary health care services to communities comprising the Sioux Lookout Zone located in North-western Ontario. The project's objective was to create a holistic primary health care model using a community-based development approach.

Atlantic Nursing Collaborative Policy Project, Nova Scotia and New Brunswick

The Atlantic Nursing Collaborative Policy Project received $411,000 through HII for the First Nations health directors, the Province of Nova Scotia (and in Phase 2, the Province of New Brunswick) and FNIHB Atlantic Region to work with professional nursing colleges to explore the joint development of standards, policies, and guidelines related to nursing practice in Atlantic Canada's First Nations. The primary focus of the project was on client safety, as well as the recruitment and retention of nurses within the communities.

Elsipogtog Health and Wellness Primary Health Care Project, Elsipogtog First Nation, New Brunswick

The Elsipogtog Health and Wellness Primary Health Care project was a four-party initiative between the Elsipogtog First Nation, the Beauséjour Regional Health Authority, the New Brunswick Department of Health and Wellness and Université de Sherbrooke Family Medicine that received $776,707 through HII. The project's goal was to re-establish primary medical care in Elsipogtog, while expanding current primary health care services delivered there with a particular focus on Mental Health Services.

Many Jurisdictions, One System Project, North Peace Tribal Council, Alberta

The "Many Jurisdictions, One System" (MJOS) project undertaken by the North Peace Tribal Council of Alberta received $800,000 in HII funding. The project's aim was to develop and manage an integrated and coordinated system of diabetic care for the twelve First Nations of the North Peace Tribal Council.

Norway House Health Services Project, Norway House First Nation and Town, Manitoba

The Norway House Health Services project received $773,300 through HII. Norway House Health Services Inc. was jointly created and collaboratively run by the Norway House Cree Nation and the non-status community. The objective of the project was, in the short-run, to bring together various partners to research the existing health care delivery system; to identify gaps or duplication in service levels; and to develop a framework agreement for integrating the existing health care delivery systems. In the long run, the project goal was to implement a community-administered integrated health care system melding all, or nearly all, of the existing health services and programs.

Weeneebayko Area Health Integration Initiative, Weeneebayko, Ontario

The Weeneebayko Area Health Integration Initiative received $789,000 through HII. A tri-party agreement between the Province of Ontario, FNIHB and the Weeneebayko community was created in order to achieve the main goals of the initiative: the creation of a First Nation Weeneebayko Area Health Authority (WAHA) charged with the responsibility to plan and deliver integrated health services as well as take responsibility for the amalgamation of the federal and provincial hospitals in the Weeneebayko area, namely James Bay and Weeneebayko General Hospital.

Vancouver Island Chronic Illness Care Project, Vancouver Island, British Columbia

Vancouver Island First Nations in partnership with Vancouver Island Health Authority and FNIHB Pacific Region undertook the Vancouver Island Chronic Illness Care Project that received $1,200,000 through HII. The goal of the project was to build capacity for the integrated management of chronic illness in the collaborating First Nation communities which is to be

accomplished, in part, by the adaptation of the Chronic Illness Care Model to a number of First Nations sites on Vancouver Island as well as the forging of partnerships for the shared service delivery to the First Nations of Vancouver Island.

Integrating Health Promotion and Illness Prevention Programs in Nunavut, Nunavut Territory

The Integrating Health Promotion and Illness Prevention Programs project, which received $457,079 through HII, was a partnership between Nunavut Tunngavik Inc., the Government of Nunavut, and Health Canada's Northern Secretariat. The objective of the project was to increase the integration in the illness prevention and health promotion systems through the creation of a five year action plan for increased integration of federal and territorial programs and services in the areas of dental health, addictions treatment and maternal and child health.

Appendix B: Evaluation Interview Guidelines Providing Detailed Evaluation Questions

Interview Guideline

Senior Departmental Officials

OBJECTIVE

This guideline presents a series of questions for interviews with HC FNIHB senior managers. The results from these interviews will contribute to the evaluation findings and also inform the development of the interviews guideline for HII's external stakeholders.

OVERVIEW

The Health Integration Initiative (HII) was established in 2003 to address the gap in health status between First Nations and Inuit and Non-Aboriginal peoples through better integration of federally funded health systems within First Nations and Inuit communities and those funded through Provincial and Territorial governments. The primary objectives of the HII are to explore, develop, and analyze models for better integration in the delivery of health services to First Nations and Inuit communities. Additionally the HII is to investigate how to promote improved co-ordination, collaboration and integration among programs and services delivered by Federal, Provincial/Territorial, and First Nations/Inuit health systems. The HII received a total of $10.8 M over three years (August 2003 to March 2006) from the Aboriginal Envelope of the Primary Health Care Transition Fund.

BACKGROUND TO THE EVALUATION

A program requirement of the HII is that it must undertake a comprehensive evaluation of the entire initiative during its final year of funding. Although the HII is in the sunset phase, the evaluation provides Health Canada with the opportunity to examine the lessons learned, success factors, and administration issues associated with the initiative. The evaluation questions reflect the fundamental categories of the Treasury Board Evaluation Policy:

- Does HII continue to be consistent with departmental and government-wide priorities and does it realistically address an actual need? (relevance);

- Is HII effective in meeting its objectives, within budget and without unwanted outcomes? (success); and
- Are the most appropriate and efficient means being used to achieve objectives, relative to alternative design and delivery approaches? (cost-effectiveness).

INTERVIEW PROTOCOL

The interviews with senior officials are scheduled for one hour and will follow the general interview guide approach to qualitative interviewing. Interviews with senior officials will focus on their respective area of knowledge and concern. As a result, this guideline provides a set of discussion topics that will be adjusted for each interview. Given the senior level of interviewees, the style of the interviews will be interactive, conversational and situational, rather than question-and-answer. Notes taken during these interviews will contribute to further development of the evaluation methodology and to the evaluation analysis. Notes will be retained as part of the evaluation supporting evidence. Key informants will be asked whether they would like to review the notes from the interview to review their accuracy, and the notes will be provided if requested and revised as required.

Interviewees will be asked at the end of the interview whether they agree to be interviewed again at a later date as the evaluation research proceeds and conclusions are being developed.

Interview Questions

INTRODUCTION

1. What has been your involvement with HII? (nature of involvement and length of time)
2. Which elements of HII have you been involved in?
    a. Implementation of projects?
    b. Research?
    c. Policy direction?

RELEVANCE

3. How important is “integration” in terms of Federal directions in FN/I health? Why so, and what is expected to be achieved in the medium term?
4. What Policy Direction was it trying to achieve?

5. Given the policy direction, was a "project oriented" program an effective approach to achieve the intended outcomes? How aware are you of the other HII activities, such as communications tools, workshops, and commissioned research?
6. How has HII impacted the F/P/T/A agenda?

SUCCESS

7. What would be the best objective indicators of HII's success?
8. What integration successes are already visible—within the Branch, influencing policy, at the political level, or other levels? Are you aware of results at the community level?
9. In what ways did HII meet your expectations overall, or fall short of your expectations?

COST-EFFECTIVENESS

10. Was HII a cost-effective and appropriate mechanism for achieving sustained effort toward desired policy outcomes?
11. What were the strengths and weaknesses in HII's design and governance?
12. Are there program characteristics/parameters that worked particularly well, or that didn't?
13. How effective was HII's approach to allocating funds?

CLOSING

14. Are there any issues or questions that you believe need to be addressed as a higher priority by the evaluation?
15. Who else should be interviewed?
16. Do you have additional comments or questions about the evaluation's substance or process?

Interview Guideline
Project Partners

OBJECTIVE

This guideline presents a series of questions for interviews with Project Partners. The results from these interviews will inform the development and completion of the HII Project case study specific to each project and ultimately result in a final evaluation of the HII initiative including structural elements, Secretariat functions, the governance model as well as the research, policy and integration projects components/processes/outcomes.

OVERVIEW

The Health Integration Initiative (HII) was established in 2003 to address the gap in health status between First Nations and Inuit and Non-Aboriginal peoples through better integration of federally funded health systems within First Nations and Inuit communities and those funded through Provincial and Territorial governments. The primary objectives of the HII are to explore, develop, and analyze models for better integration in the delivery of health services to First Nations and Inuit communities. Additionally the HII is to investigate how to promote improved co-ordination, collaboration and integration among programs and services delivered by Federal, Provincial/Territorial, and First Nations/Inuit health systems. The HII received a total of $10.8 M over three years (August 2003 to March 2006) from the Aboriginal Envelope of the Primary Health Care Transition Fund.

BACKGROUND TO THE EVALUATION

A program requirement of the HII is that it must undertake a comprehensive evaluation of the entire initiative during its final year of funding. Although the HII is in the sunset phase, the evaluation provides Health Canada with the opportunity to examine the lessons learned, success factors, and administration issues associated with the initiative. The evaluation questions reflect the fundamental categories of the Treasury Board Evaluation Policy:

- Was the HII consistent with departmental and government-wide priorities and did it realistically address an actual need? (relevance);
- Was HII effective in meeting its objectives, within budget and without unwanted outcomes? (success); and

- Were the most appropriate and efficient means used to achieve objectives, relative to alternative design and delivery approaches? (cost-effectiveness).

INTERVIEW PROTOCOL

The interviews with Project Partners are scheduled for approximately one hour and will follow the general interview guide approach to qualitative interviewing. Interviews will focus on their respective area of knowledge and concern pertaining to the project associated with their province or territory. As a result, this guideline provides a set of discussion topics that will be adjusted for each interview. The format of the interview is question-and-answer: however, where appropriate, the style of the interviews will be interactive, conversational and situational. Results of the interviews will contribute to further development of the evaluation methodology, to the evaluation analysis and to the development and completion of the HII Project case studies. Interview notes will be retained as part of the evaluation supporting evidence.

Interviewees will be asked at the end of the interview whether they agree to be interviewed again at a later date as the evaluation research proceeds and conclusions are being developed.

Introduction and Permissions

2 minutes

Thank you for agreeing to speak with us regarding your involvement/knowledge of ***name of project***. This interview will take up to 60 minutes of your time.

Your input is important in informing the evaluation analysis of HII as well as the project case studies. Please be assured that your responses will be kept strictly confidential according to the federal government's policies and laws governing information. Responses will only be analyzed and presented at the group level; individual identifiers will not be presented. Please feel free to tell the interviewer if you do not feel confident enough to answer specific questions.

Interview Questions

OVERVIEW /INVOLVEMENT WITH HII PROJECT

1. What is the nature of your involvement with ***name of project*** – i.e., organization, position, length of time working with the project etc.?
2. How did you become involved with this HII project?
3. What is your understanding of HII and its objectives?

10 minutes.

RELEVANCE

4. How important is it for provincial and territorial health care systems and federally-funded ones at the First Nations and Inuit community level to work together and co-operate? Do you feel this is a priority?
5. Do you think the health of First Nations or Inuit people is affected by the many jurisdictions involved in the delivery of health services?

5 minutes.

PROCESS

The following sections are intended to gauge the satisfaction of the project partners with respect to the project and its outcomes and to identify progress made towards the integration of health services. For the purposes of HII, progress includes but is not limited to partnerships made, processes put in place, identification of a best practice, changes in the way health services are delivered at the community level either as a direct or indirect result of the project.

6. How was the project developed?
7. Were you satisfied with the governance structure in place for this project? If not, how might it have been improved?
8. How were communications among the project partners undertaken? Were there any methods, processes or practices that you particularly liked?
9. If there were any major obstacles or barriers that you/the project encountered, how were these overcome?
10. Were you or your organization involved in the project evaluation? How? Were there things you particularly liked?

11. What was your experience with the HII Secretariat and/or FNIHB Region? On a scale of 1 – 5 (see below for scale descriptor), please rate the following in terms of their helpfulness in the development/implementation of your project:

- Proposal template and guidelines?
- Information tools/deck and script for Regional Directors?
- Funding of FTE in Regions?
- O and M funding provided to the regional office by HQ?
- Feedback on proposals and assistance in refining proposals?
- Meetings with FNIHB Regions and regional partners?
- Baseline questionnaire (evaluation tools)?
- Monthly template (reporting)?
- HII Secretariat Director's or staff's attendance at meetings?
- Regional assistance during negotiations related to the approval of projects?
- Effectiveness of communications activities, materials and instruments (national, regional)?
- Other?

Are there any other types of support that would have been beneficial?

15 minutes.

OUTCOMES

12. What were the intended outcomes of the project from the perspective of your organization/community?
13. Which of these outcomes have been achieved to date? Are there unfinished activities or deferred activities that you would like to see accomplished?
14. What outcomes do you expect over the next 2 to 3 years?
15. Were there results/impacts (intended/non-intended) that were not specifically related to project goals or objectives?
16. In the context of the areas listed below, describe what you consider to be the successes of the project (either intended or unintended). Please note that you need only respond to the areas that you feel are most relevant to your experience.
    - Governance/legislation
    - Administration/management
    - Information handling
    - Health services delivery
    - Funding models
    - Service assessment and evaluation
    - Human resources

- Changing roles, responsibilities
- Partnerships developed
- Formal structures established
- Other

10 minutes.

PARTNERSHIP AND JOINT PLANNING

17. To what extent did you/your organization interact with other key partners of the project?
18. Will these partnerships be maintained in some form after the HII project concludes? Explain.
19. Have these partnerships facilitated collaboration on other issues/initiatives that go beyond the scope of the project?
20. What other partnerships were established as a result of this project?
21. Based on your experience with this project, what are some of the lessons learned with respect to partnership and joint planning?

10 minutes.

SUSTAINABILITY/GENERALIZABILITY

22. What are the aspects/elements of your project (i.e., processes, services, tools, alliances, etc.) that will continue after funding for your project stops in March 2006?
23. What mechanisms were put in place throughout the life of the project to foster sustainability? Were there any challenges you faced in this regard?
24. Are there practices resulting from this project (either in terms of the project initiative itself or the processes involved in developing and implementing the project) that would lend themselves to other integration initiatives both in and outside of the region? Please provide examples.

10 minutes.

CLOSING

25. Are there any questions or comments you would like to add including messages to FNIHB about the HII and/or your project?

Thank you again for your participation.

5 minutes

Total: 67 minutes

Appendix C: Case Studies

- A Model for the Delivery of Primary and Public Health Care Services, Sioux Lookout District First Nations, Ontario
- Atlantic Nursing Collaborative Policy Project, Nova Scotia and New Brunswick
- Elsipogtog Health and Wellness Primary Health Care Project, Elsipogtog First Nation, New Brunswick
- Many Jurisdictions, One System Project, North Peace Tribal Council, Alberta
- Norway House Health Services Project, Norway House First Nation and Town, Manitoba
- Weeneebayko Area Health Services Integration Initiative, James Bay, Ontario
- Vancouver Island Chronic Illness Care Project, Vancouver Island, British Columbia
- Integrating Health Promotion and Illness Prevention Programs in Nunavut, Nunavut Territory.

Health Canada – FNIHB

Evaluation of the Health Integration Initiative

A Model for the Delivery of Primary and Public Health Care Services, Sioux Lookout District First Nations, Sioux Lookout (ON)

BACKGROUND/DESCRIPTION

Relevance

Effective September 1, 2002 the provincial and federal hospitals in Sioux Lookout were amalgamated and health services were integrated to create the Meno-Ya-Win Health Centre, a provincial hospital.

This project aimed to promote adoption of a broader approach to primary health care that would extend beyond the deployment of physicians to communities. There was a perceived need for increased First Nations governance and management of health care as well as the integration and improved coordination of health services delivered at the community level and at the district level.

Nature of project relative to health needs of community

Twenty-eight First Nations communities comprise the Sioux Lookout Zone (SLZ) located in North-western Ontario. The town of Sioux Lookout acts as a health services hub for the majority of these First Nations communities. However, four communities located on the east side of the SLZ access some services from Thunder Bay and two communities located on the extreme west side near the Manitoba border access some services from the town of Red Lake. The majority of these communities are accessible only by air. Given the remote location of Sioux Lookout and Red Lake, and the communities they provide services to, access to a wide range of locally available health services is difficult to achieve. Some communities must fly their members upwards of 1,000 kilometres to gain access to health services provided by medical specialists.

Project Overview

The Sioux Lookout project addressed issues of accessibility to primary health care services to communities comprising the Sioux Lookout Zone located in North-western Ontario. This collaborative project created an implementation plan for a holistic model of primary health care using a community-based development approach.

The goals of this project were as follows:

- To design a comprehensive integrated primary health care model and implementation plan for the communities of the Sioux Lookout Zone;
- To design a district physicians plan within an integrated primary health care framework that includes a service delivery implementation plan;
- To design a nursing services plan within an integrated primary health care framework that includes a service delivery implementation plan.
- To design a mechanism for the governance and management of the primary health care systems that is First Nation centered.

Project Partners

Project Partners and participants included FNIHB (federal/regional), three existing physician groups, Sioux Lookout District First Nations, the Nishnawbe-Aski Nation (NAN), the Province of Ontario, Health Directors, Tribal Councils, NAN health personnel, community health personnel, and community members.

Timeline

The duration of the project was from November 2004 to March 31, 2006.

Funding

This project received $800 000.00 of funding through FNHIB (HII). A related initiative, the Sioux Lookout Anishinabe District Health Planning exercise, was funded by the provincial government through their allocation of funding from the Primary Health Care Transition Fund.

INFORMATION SOURCES

The information sources for this Case Study included project documentation and interviews with key informants. Documents included the project proposal, monthly reports, Sioux Lookout First Nations Health Authority (SLFNHA) Draft Evaluation Framework, Draft Interim Evaluation, and Draft Communication Strategy. Interviews were conducted with Gavin Brown, Associate Regional Director, FNIHB Ontario Region; Marlene Nosé, Senior Policy Analyst, FNIHB Ontario Region; Janet Gordon, Project Manager; and Anne Matte, Acting Regional Director, Ministry of Health and Long-Term Care Community Health and Acute Services Division, North Region Branch, province of Ontario.

PROCESS

Governance Structure

A series of working groups were created to oversee the collaboration and design of more integrated provincial funded services. There were working groups for Primary Health Care, Medical Coordination, Management and Governance, and Communications.

The project management working group included representatives from the federal and provincial governments and NAN. Also, the Sioux Lookout Chiefs appointed a seven person Chiefs Committee on Health to represent the Chiefs in the design phase. The Project Management team reported to this committee.

Communication Processes

A Communications Working Group was created to handle the communications aspect of the project. This working group identified the importance of building a collaborative relationship between all key stakeholders and taking the time necessary to build participation and agreements. The main goal of the working group was to design and implement a communications strategy to ensure stakeholder participation in the design and implementation phases of the project. This strategy was drafted and presented a work plan of activities to be undertaken under the following five main communications objectives:

1. To develop a strategy for the continuing engagement of all key stakeholders (three existing physician groups, NAN chiefs, federal government, provincial government, health directors, tribal councils, NAN health personnel, community health personnel, community members, etc.);
2. To develop written and oral communication products updating key stakeholders on the process toward implementation;
3. To attend key meetings of stakeholders to update them on information and solicit participation in the design process;
4. To ensure that the working groups are sharing the information they are developing with the other planning teams and stakeholders; and
5. To continue working with the Meno-Ya-Win Health Centre to ensure that both parties know what the other is doing.

TOOLS AND SUPPORT

- The Project Partner indicated that the feedback on the proposal was "very helpful" and the direct support provided by, and communications with FNIHB were "extremely helpful." No comments were provided on other tools or support.
- The interim evaluation report discussed the progress of the process, which was affected by the "seven month delay" from submission of the original proposal to signing the HII contribution agreement. The evaluation identified factors that the project needed to implement (e.g. resources, relationships), risks that need to be managed (e.g., difficulties caused by delays, adjustments required to work plans), and provides a chronology of the activities undertaken (e.g. process requirements).

CHALLENGES

Challenges identified included:

- Multiple participants – the Health Integration Initiative required collaboration among a number of participants and across jurisdictions, which added complexity to the project.
- Limited time to develop the model and implementation plan – the required outputs and outcomes required adherence to tight timelines.
- Provincial health reform – Initiatives underway in the province could impact the design of the model and viability of the implementation plan.
- Jurisdictional issues for integrated health services delivery – existing policies and programs of federal, provincial and municipal governments could impact integrated model design and implementation plan.
- The project had a difficult time getting community-level information – health status and financial information as part of planning – from FNIHB region (although it should be noted that obtaining data from the community and zone level is always time-consuming and such difficulties are not unique to this project---see the Elsipogtog project for similar challenges.)
- Information was late in coming, which delayed subsequent actions.

OUTCOMES

Results/impacts (intended and unintended) to date include the following:

- The project developed a plan for comprehensive health service delivery that is organized in a way to meet community needs and that would be supported by communities and implemented by the communities.
- The relationships were built “from the community up” and not prescribed by individuals or organizations outside of the community. Interviews indicated that other initiatives had created relationships without sufficient input from the communities affected.
- The project brought health care providers from involved communities together to talk about common issues and needs of the community, and provided an opportunity to network and plan together.

- The project has empowered health directors to look at their roles, and their capabilities.
- Key accomplishments in integration:
    - Governance/legislation: Chiefs have approved the district health plan.
    - Administration/management: there are plans to continue to further define roles and responsibilities of providers, administration, and management to make the system more efficient as well as to have system controlled by First Nations and managed by First Nations.
    - The project identified gaps in human resources, changing roles and responsibilities, and partnerships that need to be developed.
    - The project determined that capital infrastructure in communities is needed to support system.

There is a second phase to come that requires more detailed planning before implementation.

It is expected that, over the next 2 to 3 years, communities will become more involved in the health care delivery in their community.

SUSTAINABILITY/GENERALIZABILITY

- "The primary health care model we developed could be used by other communities, if adjusted for their population size and health needs."
- "The processes we followed for setting up partnerships and working together could be used in other communities".

PARTNERSHIP AND JOINT PLANNING

- All Partners were always invited to project management meetings – but they didn't always attend. Some partners wondered if these absences indicated that the organizations didn't make attendance a priority.
- One of the strengths was that the Project Partner at FNIHB Region Office attended all meetings.

LESSONS LEARNED

- One of biggest challenges was to engage people. This may have occurred due to their heavy workloads. Their home organizations should make arrangments to ensure they are available for the duration of the project. There is a need to ensure that the right people are at table and that they have support from their organizations.
- The project succeeded in that it made people think about, and be aware of, possible partnerships that could be explored outside the 'normal' working area – it encouraged thinking outside the box.
- "Need to consider political climate, since it can slow the process down. For example, the provincial election and two federal elections impacted how quickly we could make decisions, as did what was happening at the FN level".
- The federal government's timelines and the First Nations calendar do not necessarily align. For example, there are certain times of the year when First Nations people in northern areas are hunting and not available for meetings or consultations. The project had to take these into consideration in setting its timelines for deliverables, holding meetings, etc.

Health Canada – FNIHB
Evaluation of the Health Integration Initiative

Atlantic Nursing Collaborative Policy Project (NS and NB)

BACKGROUND/DESCRIPTION

Relevance

The vast majority of nurses in Atlantic Canada serving First Nations bands are band-employed and their employers are responsible for their supervision, professional development and adherence to provincially determined standards and competencies. Many of those First Nations bands have no clear mechanisms in place to provide direct professional leadership and support to their nurses nor do they have linkages to provincial programs to ensure an equivalent standard of competencies with their provincial colleagues.

Issues such as supervision and compliance with provincial law had been identified as concerns through existing tripartite relationships, which allowed community health staff to frame common issues. Health directors and nurses had identified the lack of clarity in Federal/Provincial/First Nation roles and responsibilities in setting standards and maintaining nursing staff competencies as a barrier to improving health outcomes and standards of practice. When the HII project started, there was willingness by First Nations health directors and leadership, the Province of Nova Scotia and the College of Registered Nurses of Nova Scotia to explore with FNIHB Atlantic Region the joint development of standards, policies, and guidelines related to nursing practice. The plan was to expand into New Brunswick and possibly into the other Atlantic provinces during the course of the project.

The project was in keeping with efforts by professional nursing associations to draw attention to the need for nursing policy guidelines and policies. In 2000, the Registered Nurses Association of Nova Scotia identified in a position statement "that quality care is achieved when nursing leadership facilitates the integration of evidence-based knowledge into practice; (and) enables registered nurses to practise as independent, accountable professionals…" This position statement also noted "nursing leaders in positions of authority recognize that professional accountability for outcomes and evidence-based decision-making drive professional practice. They establish a culture, capacity, and structures within organizations to enable both multi-level

participation in decisions affecting client care, and the integration of evidence of best practices into the delivery of nursing services."

Nature of project relative to health needs of community

Collaborating on nursing policy was expected to have a positive impact of the quality of First Nations and Inuit community health services, primarily in client safety, as well as to have a positive impact on recruitment and retention of nurses within communities.

Project Overview

This HII project offered the potential for improved understanding and collaboration between provincial health departments, regulatory bodies and First Nations health organizations, as well as identification of mechanisms to support First Nations health organizations to develop their cadre of professional staff.

This project involved collaborative work among all parties on standards, policies and guidelines related to nursing practice. This collaborative framework for nursing was developed by Band-employed health directors and nurses working together with provincial, professional and federal representatives. Those representatives included specialists in public health from health districts, and provincial bodies. They established an integrated, comprehensive package of standards, policies and guidelines to meet the needs of the individual communities and provide nurses with the necessary linkages to become more familiar with how they relate to provincial legislation and how they can optimize their function within their scope of practice.

Objectives

The principal objectives of the HII project were to:

- Develop a joint Federal/Provincial/First Nation framework for nursing in Nova Scotia (stage one) and New Brunswick (stage 2), with application to Newfoundland and Labrador and Prince Edward Island (following the pilot project);
- Encourage a closer working relationship between provincial regulatory bodies, provincial health authorities and the First Nation and Inuit communities;
- Initiate a dialogue regarding a collaborative method of providing continuing education and program competencies for First Nation employed nurses;

- Clarify roles for Federal, Provincial and First Nation parties in the context of devolved and transferred nursing services as well as the role of the regulatory body;
- Increased capacity of the First Nations organizations in the area of policy/guideline development and human resource management, so as to become more aware and effective managers of nursing staff at the First Nation level; and
- Improve links with professional public health departments and regulatory bodies based on mutually supported standards of practice and quality assurance that can support collaboration on, for example, immunization.

Project Partners

The partners for the project were FNIHB Atlantic Region, Atlantic Policy Congress, professional Nursing bodies, and First Nations Bands. Phase One also included the Nova Scotia Department of Health, while in Phase Two, the New Brunswick Department of Health and Wellness was represented.

Timeline

The duration of the funding was from December 2004 to March 31, 2006.

Funding/Resource Utilization

The amount of funding received from the HII for this project was $411,000.

INFORMATION SOURCES

The information sources for this case study included project documentation and interviews with key informants. Project documentation included the Project Proposal, Program Activity Reports, Agreement Summary Form from Health Canada, project logic model, project communication workplan, project communication strategy, and Consolidated Contribution Agreement.

Interviews were conducted with Deborah Vandewater, Project Coordinator, Atlantic Nursing Policy Collaborative Project; and Mahnaz FarhandMehr, Coordinator, Communicable Disease Prevention and Control, Nova Scotia Ministry of Health.

PROCESS

Governance Structure

An accountability and oversight framework was put together to indicate the responsibilities of the different parties involved:

- *Implementation*: The Atlantic Policy Congress (APC) oversaw the implementation of the integration project with collaboration and communication with the Mi'kmaq – Nova Scotia – Canada tripartite forum Health Committee.
- *Funding Decisions*: The nursing coordinator/contractor was funded via contribution agreement (to APC) and accountability for this position was in accordance with the terms and conditions of this agreement. The workplan was provided to the Atlantic Chiefs for ratification.
- *Evaluation*: The evaluation plan was operationalized based on the work plan developed with the collaborative working sub-group. Midterm evaluation plans were revisited as timelines changed on the project – a process evaluation was prepared following completion of phase 1 and prior to implementing phase 2 in 2005-06.
- *Reports*: Reports were generated by the nursing coordinator and provided first to APC and then to the collaborative working sub-group. Once the first draft was reviewed, amended and/or accepted it was provided to the co-management group as necessary.

A Nursing Policy Advisory Group was also created to vet, suggest and approve policies and guidelines and/or other tools and information proposed by the Project Coordinator.

Communication Processes

A communication strategy was developed for this project. The purpose of this strategy was to ensure that the progress of the collaboration on nursing policies project was effectively communicated to the province of Nova Scotia (stage one) and the province of New Brunswick (stage two) and the respective First Nations. The objectives of the strategy were:

- To ensure that First Nation Communities (Chiefs, Councils, Health Directors and Community Based Nurses) and respective provinces were actively involved in the development of the nursing policies;
- To ensure community involvement and understanding;
- To ensure consistent flow of information and updates on the progress of the project; and

- To build on the partnership model approach for the project for all key parties. Material reflected the vision and goals of the Atlantic First Nations, Health Canada, the provinces and the respective professional associations.

TOOLS AND SUPPORT

- Communication tools used included monthly phone calls with FNHB, reporting to Atlantic Policy Congress every two weeks, and the monthly HII reporting template to the Secretariat.
- Interviewees felt that most of the tools provided by the HII Secretariat and FNIHB were helpful. However, one informant felt that there were no tools made available to support communications. She also indicated that the HII monthly reporting template was cumbersome and confusing, and indicated that more feedback from the HII Secretariat on the monthly reports would have been appreciated.

CHALLENGES

- The short timeline of HII presented a challenge. This project ended up only having 15 months instead of the planned 24. Originally, the proposal was to include projects in all four Atlantic Provinces. However, because of the time limitation, they had to focus on two provinces (Nova Scotia and New Brunswick).
- Interviewees indicated that the First Nations Chiefs as well as the band employers and employees received little education or orientation regarding the policies developed through this project. This may impede the successful implementation of the policies.
- There were logistical challenges with regards to scheduling time with registered nurses and health directors. Given their busy schedules, it was a difficult process to find time to discuss policy suggestions with them.
- The advisory groups (one for each province) caused certain challenges for the Project Coordinator. Their memberships did not include many community nurses and/or health directors, even though their participation would have been of great value to the project. In addition, the Project Coordinator indicated that getting feedback from the advisory groups was “like pulling teeth”.

- Some of the partners in the project did not have much knowledge of the First Nations communities and their needs, which was a hindrance to the project, since the project timeline was very short and there was little time for learning curves.

OUTCOMES

- Forty-five policies and guidelines, grouped in six different policy categories, have been identified, reviewed and signed off by the Atlantic Policy Congress. Templates for the creation of further policies have also been designed.
- The expected outcomes in the next two to three years include the implementation of the policies and their evaluation in terms of quality assurance, effectiveness, safety and impact on the communities.
- There were no policies previously in place so creation of each of the policies developed was considered a success. For example, human resources policies were developed to deal with professional conduct issues faced by registered nurses working in the communities. These HR policies, as well as all policies developed, help to define the roles and responsibilities of health care professionals working with Atlantic Canada's First Nation communities, and decrease their professional vulnerability.

SUSTAINABILITY/GENERALIZABILITY

- In two provinces, Nova Scotia and New Brunswick, policy manuals were developed. In addition, a template has been created for the production of future policies. These can be shared with other jurisdictions.
- The processes used in this initiative would have great applicability to other such projects in other First Nations. In fact, a Manitoba community has requested information on the process used in the Atlantic Nursing Project.

PARTNERSHIP AND JOINT PLANNING

- The advisory committee was the focal point of the project's partnerships. The Project Coordinator ensured the liaison and constant communication between all members of the advisory group.
- Communications between partners were undertaken by means of minutes of meetings, emails, formal reports from the Project Coordinator and progress reports on the policy development.
- One interviewee expressed concern that the partnerships would not continue because the Project Coordinator held them together and, in her absence following the completion of HII project, the partnerships would not be maintained.

LESSONS LEARNED

- It is essential to have a good liaison between the communities and the FNIHB Region. Because this project had a Project Coordinator working within the community, this liaison was handled mostly through the Coordinator. There is concern that after the HII project ends, the links among all parties will not be maintained.
- Previous experience with, or knowledge of, First Nations is important to have when working with the communities. Partners and staff in similar initiatives should be familiar with First Nations because the short timeframes do not allow for much of a learning curve.

Health Canada – FNIHB
Evaluation of the Health Integration Initiative

Elsipogtog First Nation Integrated Primary Health Care Project (NB)

BACKGROUND/DESCRIPTION

Relevance

As the largest First Nation in New Brunswick, with membership of 2700 people, Elsipogtog (formerly known as Big Cove) represents a significant number of the Atlantic region's First Nation population. Inadequate access to culturally appropriate community-based services has been observed by the community and the limited access to physician services in New Brunswick as a whole is of particular concern.

While there were a variety of health services available to the people of the community, federally funded programs lacked co-ordination and integration with primary medical services available from the Regional Health Authority. Support was required to transition to a system where health service providers (whether community- or provincially- employed) collaborate in the care of this high-needs population, with a particular emphasis on mental health, health promotion and disease prevention. The HII project was built on the experience of the Eskasoni primary care project, with its four-party collaboration among a large First Nation community, the province, FNIHB Atlantic Region and a university medical facility, which received funding under the Health Transition Fund from 1997-2000.

Nature of project relative to health needs of community

Mental health in this community was a priority for both the Atlantic Region of FNIHB and community leadership. Elsipogtog First Nation has suffered an alarmingly high number of suicides (attempted and completed) over the past decade. Despite this, community members were reluctant to access provincial services available in neighbouring communities, feeling they were not culturally-appropriate. While enhanced resources had been provided to the community through FNIHB and made available through provincial mental health services in response to crises, the mental health situation was still a major concern, as services remained uncoordinated and lacked a strong system base to address prevention of mental unwellness as

well as diagnosis and treatment. Without funding for comprehensive mental health programming, Elsipogtog had improvised with various funding sources and program elements in order to deliver mental health services to its community. The partners in this proposal believed that integrating primary health care services within the community and with those available from the regional health authority would enhance opportunities to prevent, diagnose, and intervene in cases of severe mental health issues as well as to enhance overall health promotion and disease prevention activities.

Project Overview

The hope was that this project would succeed in locating medical care within the community health centre of Elsipogtog; harmonizing the health services in the existing community health programs; and better co-ordinating with similar services offered by Beauséjour Regional Health Authority (BRHA). In addition to mental health services, health promotion, disease prevention, and chronic disease management services were also to be integrated.

Objectives

The project goals were the following:

- To eliminate service gaps and overlaps in health care, harmonizing all services;
- To co-operate with the RHA to recruit physicians, a nurse practitioner and other heath care personnel to be located in the community, to increase local access to a comprehensive range of primary health care services;
- To integrate all current and future health services delivered in Elsipogtog in a collaborative, multidisciplinary, and holistic practice model based on a Population Health approach;
- To reduce demand on emergency services and allowing for the redistribution or reinvestment of resources by providing adequate physician services in the community; and
- To link, coordinate and liaise all Elsipogtog health services with their corresponding services within the Regional Health Authority and the Department of Health and Wellness of New Brunswick.

Project Partners

The main partners of the project were Elsipogtog First Nation (EFN), Beauséjour Regional Health Authority (BRHA), Province of New Brunswick Department of Health and Wellness (NBDHW), FNIHB Atlantic Region and Université de Sherbrooke Family Medicine Program.

Timeline

The duration of the funding was from January 2004 to March 31, 2006.

Funding

The amount of funding received for this project from the HII was $776,000.

INFORMATION SOURCES

The information sources for this case study included project documentation and interviews with key informants. Project documentation included the Project Proposal, the project's performance measurement strategy, table of services to be integrated, the project workplan, the answers to the twelve questions from the "Draft Baseline Questionnaire", the project RMAF, Project Activity Reports, meeting minutes, the project logic model, the Health Facility Plan, and the Midterm Evaluation of the Elsipogtog Health Care Integration Pilot Project.

Interviews were conducted with Eva Sock, Project Manager, Integrated Primary Health Care Elsipogtog Health and Wellness Centre; Dr. Louis-M. Simard, Vice-President Medical Services, Beauséjour Regional Health Authority; Tryna Booth, Senior Advisor, Policy and Strategic Planning, and Wade Were, Policy Advisor, Atlantic Region First Nations and Inuit Health Branch, Health Canada.

PROCESS

Governance Structure

The project partners formed an Advisory Team to work collaboratively, and to provide guidance and advice to the Project Manager overseeing the design, implementation and evaluation of this project.

The Elsipogtog Integrated Primary Health Care Project Advisory Team did the following:

- worked to improve communication and coordination between different levels of government and service providers;
- procured expertise in the area under study;
- assisted in identifying and addressing service gaps and overlaps of services;

- assisted in identifying researchers and stakeholders;
- assisted in identifying additional financial and in-kind support for continuing activities of the Integrated Primary Health Care Project; and
- provided input to project activities and reviewed reports and final evaluation.

The members were accountable for their respective programs as well as to the Advisory Team and reported regularly to their programs and to the Advisory Team. The Elsipogtog Primary Health Care Project Advisory Team operated in accordance with the directions from the Elsipogtog First Nation. The Advisory Team had no delegated authority except to make recommendations or to provide advice to the Elsipogtog First Nation in areas of improved coordination and integration of heath services, and in appropriate models for clinical governance, administration, change management and team building.

Early in the life of the project, an external evaluator was contracted to do a midterm and final evaluation of the project. He was considered a member of the advisory team.

Communication Processes

No formal communication strategy was developed. However, communication among partners was done through email, phone calls, monthly meetings and sharing of agendas and minutes. Advertisements in newspapers were used to make community members aware of the health services available. Interviewees identified the lack of a formal communication framework as a significant gap in the project.

TOOLS AND SUPPORT

- An external evaluator was contracted to conduct an evaluation of the project. The interviewees were very satisfied with the work done by the evaluator. They felt that the evaluator was very involved, taking the time to consult the community, and that he helped to prioritize the project's efforts and resources, in part with the logic model that he created for the project.

- In general, interviewees found the tools provided by HII and FNIHB (such as proposal template and baseline questionnaire) to be helpful and were very satisfied with the support provided by FNIHB both through their attendance at meetings and their feedback. The monthly template for reporting was deemed to be helpful but was not used significantly by the project coordinator.

CHALLENGES

- With regard to human resources, interviewees reported some resistance on the part of staff who were working in the community before the HII funding because the scope of their work had been modified.
- Though the interviewees were generally satisfied with the governance structure, they felt that responsibilities and accountabilities could have been more precisely defined.
- The overlap of responsibility for health care between the provincial and federal governments was considered a major challenge. With regard to primary health care, it was difficult to know where the responsibilities rested.
- Interviewees noted a lack of participation from the provincial government (Province of New Brunswick Department of Health and Wellness) and would have liked to have seen a greater involvement from this partner.
- Interviewees indicated it was always a challenge to know what First Nations health care funding was available, and then securing that funding. It was difficult to maintain programs when funding was inconsistent.

OUTCOMES

- Outcomes from this project were:
    - training of staff in population health and primary health care models, and skills building where there was a change of scope of work;
    - increased staff competencies;
    - recruitment of physicians for the health centre;
    - creation of a mental health discussion and position paper;

- collaboration between professionals and the BRHA; and
- increased responsibilities for nurses and greater access to physicians working as part of a care team.

- Outcomes expected over the next two to three years include:
  - sustained relationships;
  - improved health status in the community because of the availability of health services delivered within a primary health care model;
  - elimination of discrimination barriers to outside services; and
  - reduction of the use of emergency services, because emergency care is no longer the easiest and quickest way to see a physician.

- To integrate culture into the project, there was the creation of an Orientation package (LNO Way Orientation Manual), which presented values and principles in the Mi`kmaq way.

SUSTAINABILITY/GENERALIZABILITY

- Health services put in place will continue after the completion of the project. Also, the Collaborative Practice Manual will continue to be used.
- Mechanisms put in place during the project in order to help foster the sustainability of outcomes include:
  - the training that was given,
  - the commitment by management in the First Nations Health Centre, and
  - the collaboration with the Regional Health Authority.

- The integrated service delivery structures that this project has created were considered not only a model for other First Nations and Inuit communities, but also for other Canadian communities.

PARTNERSHIP AND JOINT PLANNING

- According to interviewees, the links between the partners were strong, though participation and support from the Province of New Brunswick Department of Health and Wellness was more limited than that of the other partners.
- Most of the partnerships are expected to be maintained after the completion of the HII initiative. Relationships between the community, the BRHA and FNIHB are strong and the parties continue to strive for improved collaboration with the province.
- The need for humility and respect when working with a variety of partners was identified as important for the partnerships to work. Each partner has its own way of contributing to the success of the project. Interviewees stressed the value of working collaboratively and the necessity of having the right partners at the table.

LESSONS LEARNED

- Communication was identified as essential for the success of an undertaking such as this project. Also, the elaboration of a communication strategy at the beginning of the project can be very helpful.
- A cultural component had not initially been included in the project, though it became evident to the Project Partners that it was important to create one. Work was done in collaboration with the community elders. The elders were educated with regard to the services available, and a healer was involved in developing the primary health care model. Project Partners were able to take advantage of monthly ceremonies held by the elders. This is something that should be considered when developing other initiatives involving First Nations.

Health Canada – FNIHB
Evaluation of the Health Integration Initiative

Many Jurisdictions, One System (AB)

BACKGROUND/DESCRIPTION

Relevance

First Nations communities in northern Canada face unique challenges in accessing health services due to remoteness from large service centres and transportation issues. In the case of First Nations in northern Alberta, the Government of Canada facilitates access to provincial hospital and physician services, paying premiums on First Nations' behalf. Two Regional Health Authorities provide health services under provincial jurisdiction, Northern Lights Health Region 9 and Capital Health Authority.

In addition, First Nations and Inuit Branch (FNIHB), Alberta Region provides funding and health services including health promotion and specialty programs on reserve. The twelve communities which comprise the North Peace Tribal Council (NPTC) access primary health care services which range from limited, part-time public health services, to full primary care nursing stations (in four communities).

Because of the small population within the Northern Lights Health Region area, specialty services such as dialysis are not locally available to NPTC communities. The Capital Health Authority is an Edmonton-based referral centre that provides specialty diagnostics and treatment and secondary- and tertiary-care for all northern Alberta residents. In some cases, First Nation members requiring ongoing services must physically move to Edmonton to access these services.

Nature of project relative to health needs of community

Diabetes is on the rise in the NPTC area, and the complication rates (blindness, renal failure, loss of sensation in limbs) tend to be higher, with earlier onset among First Nations than the general population. Accordingly, the NPTC health director was motivated to suggest a project to build on the linkages already established among the federal and provincial government

agencies and the First Nations, in the areas of co-ordination of diabetes care and improving the capacity for self-care among First Nations patients.

Project Overview

The "Many Jurisdictions, One System" (MJOS) model describes how an integrated and coordinated system of diabetic care for First Nations people can be developed and managed. This project was based on the belief that a holistic, multidisciplinary, multi-jurisdictional approach to health care and the integration of traditional knowledge with Western medicine would result in more appropriate utilization of resources, greater satisfaction for both patients and providers, and improved health status for the people of these First Nations communities.

Objectives

The objectives of the MJOS project were:

- to foster a collaborative and coordinated approach to health services planning;
- to improve the quality of diabetic care service delivery;
- to measure the efficiency and effectiveness of an integrated and coordinated health care delivery system;
- to improve the overall health and well-being of NPTC residents;
- to plan and implement case management;
- to formalize the partnership among the various levels of government;
- to develop a diabetic passport, owned by each patient, carried by each patient to provider appointments; and
- to foster a holistic, patient-centered approach to diabetic care.

Project Partners

The partners involved in this project were North Peace Tribal Council (NPTC) and its First Nations, FNIHB Alberta Region, the Capital Health Regional Authority and Northern Lights Regional Health Authority.

The project built on previous collaboration among NPTC, the Capital and Northern Lights Regional Health Authorities and FNIHB to improve access and to improve health services for the communities and individuals within the jurisdiction of the NPTC.

Timeline

The duration of the project was July 2004 to March 31, 2006.

Funding

HII funding for this project was $800,000. In addition, the Partnership received developmental funding and support from several sources, as follows:

- NPTC Chiefs furnished "seed" money to incubate and nurture the initiative.
- FNIHB, Alberta Region provided seed money.
- Capital Health provided in-kind support through the participation of various specialty staff.
- The Alberta Health and Wellness Aboriginal Strategy Fund for Partnership Projects (a competitive juried process) provided project funding for Partnership projects.
- The University of Alberta-based, Alberta Aboriginal Capacity and Developmental Research Environments (ACADRE) provided a planning grant for a partnership project (also as a competitive juried process).

INFORMATION SOURCES

The information sources for this case study included project documentation and interviews with key informants. Project documentation included the Project Proposal, Project Activity Reports, MJOS Draft Communications plan, MJOS Detailed Work Plan, budget reports and MJOS Project Charter.

Interviews were conducted with Kathleen Cardinal, Program Manager, Aboriginal Diabetes Initiative, First Nations and Inuit Health Branch, Alberta Region; Rayann Ulvick, Coordinator, MJOS project; and Maria Devlin, Patient Care Director, Capital Health Authority Royal Alexandra Hospital.

PROCESS

Governance Structure

The MJOS Partnership established a Project Steering Committee comprised of partner representatives and established the Terms of Reference for the Steering Committee. The Project Steering Committee hired a Project Director and established Project Offices (using in-

kind contributions) within existing space in NPTC administrative space in Bushe and Edmonton. Coordination activities were facilitated with the installation of video conferencing equipment at the Edmonton sub-office. The Project Director worked with the Steering Committee to develop a detailed Project work plan, milestones, and accountability mechanisms.

The Steering Committee met every two months for the first year of the project and quarterly thereafter. The meetings alternated between face-to-face and video conferencing. The meetings each included a cultural exchange and discussions of implementation successes and challenges.

The Steering Committee hired an evaluation team to develop the detailed logic model and evaluation plan collaboratively with the Partners, and to implement the evaluation plan. The plan included a formative evaluation and summative evaluation component. In addition, the Steering Committee developed and implemented a communication and dissemination strategy.

Communication Processes

MJOS project had a full-time communications coordinator. The Communications Plan she implemented included such elements as:

MJOS Communications Approval Process: Communications were approved through the MJOS Steering Committee. Any information to be circulated was to be emailed to the Steering Committee first.

MJOS Key Communication Messages were identified as:

- The emphasis was on integration and this included the use of both traditional wisdom and western knowledge.
- MJOS Partner Organizations recognized the value of working collaboratively and actively seek opportunities to achieve efficiencies and improve client/patient care by doing so.
- The MJOS Partnership seeks to understand the unique needs of NPTC First Nations people and to ensure that there is appropriate strategic alignment of services and resources by building on the areas of leadership, best practices, staff development, process improvements, customer and community focus, and integrated program delivery.
- Current MJOS integration and collaboration initiatives have resulted in increased access to, and improved quality of care for the people of the North Peace Tribal

Council First Nations communities, as well as more effective use of financial and human resources.

- Integration and collaboration are core strategies employed by MJOS to make the most effective use of resources and provide the greatest possible access to health services for the First Nations People of the NPTC First Nations Communities.

Other elements included in the Communications plan included creation of a project symbol and various tools, description of a project vision and Mission, identification of primary and secondary audiences, and strategic approaches.

TOOLS AND SUPPORT

- An external evaluation team was contracted early in the project to do the project evaluation. The interviewees were pleased with the evaluation process and one interviewee was particularly impressed with the evaluator involvement and the fact that they made the long trip to the communities for interviews.
- Interviewees were generally satisfied with the tools and support provided by HII Secretariat and FNIHB, though one interviewee indicated that he/she felt that there was limited support from HII Secretariat or FNIHB throughout the three years of the project. This person expressed dissatisfaction with the amount of communication between them and the other partners.

CHALLENGES

- A communication committee was established with membership from each partner organization. However, according to interviewees the committee was disbanded in June 2005 because there was a lack of commitment by some of the parties involved. The Steering Committee was likewise affected. Reasons proposed by one interviewee for the lack of participation include: the wrong person assigned to the committee and/or person assigned to the committee not senior enough within his or her organization to make the decisions required. This presented a problem for the Steering Committee

since it became difficult for things to get done without the same level of commitment from all involved parties.

- A constant challenge for initiatives in northern communities is the high staff turnover rate. It is difficult to recruit and maintain qualified staff to live on the reserves. There needs to be a continuous liaison function to help retain staff.
- The distance between Edmonton and High Level is approximately 11 hours by car, which creates an important geographical distance between the project partners. This challenge was in part overcome by having one of the project coordinators located within one of the North Peace Tribal Council's communities. This allowed having better communication with the community and because a strong liaison with Edmonton was maintained, this obstacle was minimized.
- One of the positive outcomes of this initiative was the hiring of a dietician who worked within the communities and helped the First Nations develop better eating habits to help keep diabetes in check. Unfortunately, this resource will likely be lost once the HII funding ceases. While it was clear from the beginning that funding for staff positions under the HII would not be ongoing, the informants were disappointed that, they were not able to secure funding to continue this position from other sources at the time of the interviews, This is a major challenge of project-based funding, since the communities are provided with important resources for a short time– such as the dietician who had gained the hard-earned trust of the communities – that are no longer available once project funding ends.
- The timeline of the initiative was a challenge for this project. North Peace Tribal Council had originally put a proposal together for a different funding source and had to rework an existing proposal to apply for the Health Integration Initiative. Once the proposal was reworked and finally approved, instead of having the anticipated three years for implementing the project, only 19 months were available.

OUTCOMES

- Planned outcomes which were achieved included the following: providing better integration of diabetes services amongst partners; development of foot care workshops and standardized foot care guidelines; development of a variety of circulated project

materials; better awareness within the communities of diabetes and available resources; re-established liaison between NPTC nurses and Northern Lights RHA nurses; creation and distribution of diabetic passports (portable comprehensive health records that First Nations patients keep and bring to each appointment) and care maps (guides for nurses not specialized in diabetes that provide them with assessment tools and instructions for different scenarios); provision of physician Health Links and educational services; recruitment of a registered dietician; and the incorporation of traditional First Nations world views and western world views.

- Outcomes not yet achieved at the time of the interviews included finalization of the evaluation report; completion and distribution of a cookbook that the dietician started compiling; and continued improvement of the coordination of the SLICK (mobile diabetes screening) program.
- Outcomes that interviewees expect to be achieved in the next two to three years include continued progress towards better health care for diabetes in North Peace communities; heightened awareness and knowledge of diabetes prevention and early detection of the disease and its related complications; and continued use of the diabetes passports.
- The interviewees praised the registered dietician that was hired to work within the communities. The assistance provided by the dietician was well received by the First Nations and was considered very helpful in educating them in the goal to prevent and control diabetes. Interviewees would like to see the services of a dietician continue in the future, though at the current time, the funding has not been identified.

SUSTAINABILITY/GENERALIZABILITY

- Aspects of the initiative that will continue once the funding has ceased include the diabetic passports; the care maps; the foot care and wound care guidelines; and the liaison committee between Northern Lights Regional Health Authority and North Peace Tribal Council.

- Formally, no methods were put into place specifically to foster sustainability. However, interviewees felt that the emphasis that was put on training has enabled the MJOS project to produce several sustainable tools such as the diabetic passports and the care maps.
- The partnerships formed during this project will be sustained after its completion, with the adoption of the Partnership Charter, as will the relationships built with the communities.

PARTNERSHIP AND JOINT PLANNING

- The partners in this project were North Peace Tribal Council (NPTC) and its First Nations; FNIHB Alberta Region; the Capital Health Regional Authority; and Northern Lights Regional Health Authority. Each partner appointed a senior staff member to sit of the NPTC MJOS steering committee. The relationships between the partners were reported by interviewees to be strong and communication among them regular and consistent.
- According to interviewees, there is a strong intention to maintain the relationships built through the HII project. The MJOS partnership was formalized by a charter, and can now serve as an umbrella under which other, small projects occur.

LESSONS LEARNED

- Key successes of the project, as identified by the interviewees include:
    - having project and communication coordinators helped the project administration and management;
    - the partnership charter clearly laid out the parties involved, the responsibilities of each, and the project expectations; and
    - the strong links existing between partners and importance of establishing formal structures such as the steering committee.

- There were a couple of lessons learned with regard to managing a partnership between various different parties. Delays were expected because there were so many parties at the table and each was depended on to accomplish tasks. Persistence was required from the project coordinators to keep all partners active and motivated. Missing in this initiative were measures to ensure that, if one person fails to attend a meeting or drops out of the initiative, the work would be delegated to another party. Such measures would be important in future undertakings.
- Another lesson learned during this project was that things do not always happen as quickly in First Nations communities as they may elsewhere.
- The importance of building strong relationships both with project partners and with the communities involved was cited as a lesson learned.

Health Canada – FNIHB
Evaluation of the Health Integration Initiative

Norway House Health Services Integration Project (MB)

BACKGROUND/DESCRIPTION

Relevance

Norway House, Manitoba is located at the top of Lake Winnipeg and is home to almost 6,000 people, primarily of Cree and Métis descent. It was established in 1814 by the Hudson's Bay Company. The First Nation is signatory to Treaty 5. The reserve and the town of Norway House are geographically situated in the Burntwood Regional Health Authority (BRHA) and several members of the community (both First Nation and Métis) are on the Board of the BRHA. Co-ordination of services available in the town and on the reserve, for all residents, was the focus of the HII project.

Norway House First Nation is one of the largest and most progressive First Nations in Manitoba. They administer their own Child and Family Services, Social Services, Education and Community Services.

The Norway House Hospital was built in 1950, by the Department of National Health and Welfare (currently Health Canada). At the time, it was a 38-bed facility that served the surrounding inland communities. It was downsized to a 16-bed facility and currently employs 41 people. The Norway House Clinic is attached by a walkway to the Hospital and is managed by the University of Manitoba (Northern Medical Unit) and is supported by an Agreement between FNIHB and the University. The Community Health Nurses offices are located at the clinic. Health services in the community are well utilized: the physicians see 12,000 patients per year and the after hours hospital emergency room sees more than 10,000 patients per year.

The Norway House Cree Nation (NHCN) has been interested for several years in the "transfer" of the Norway House Hospital to increase local authority, accountability and to decrease fragmented and costly services that are a direct result of jurisdictional issues in their community. Among these jurisdictional complications are the 1964 Agreement between Canada and Manitoba in which the federal government committed to provide treatment and public health nursing to Norway House. Provincial services are provided to non-status residents and community health services are funded federally. The Norway House Cree Nation is signatory to

two agreements with FNIHB, including a Health Transfer Agreement (recently renewed) and a Consolidated General Agreement for non-transferable programs including all of the medical transportation in and out of Norway House.

The federally-funded Norway House Hospital is central to the community's health system. From the FNIHB Region side, concerns about liability for the aging hospital structure are significant; the hospital must be considered in discussions on integration, but it is interconnected with other services. There appears to be openness on the part of the provincial government and the community to explore how the facility fits into the mix of services and whether a primary care clinic might meet community needs while making better use of resources.

A Role Study was conducted from 1997 to 2000 in which partners from the federal government, provincial government, municipal government and First Nation were involved. The study identified several options for improved co-ordination of services among the jurisdictions, including broader provincial involvement. Options available for the use of the hospital were examined, including the possibility that it could become part of the provincial system, but were never acted upon by the parties.

Project Overview

The Health Integration Initiative (HII) offered Norway House First Nation and the town the opportunity to complete planning towards an integrated health care delivery structure that meets the diverse health and wellness needs of the residents of the community, both status and non-status members. The non-status community, in conjunction with the Norway House Cree Nation, shared a leadership role in this initiative. This was evidenced by their collaborative effort in jointly creating the Norway House Health Services Inc. (NHHS) board. Once created through HII, the Board was the vehicle by which other aspects of the HII project were implemented. The NHHS Inc. has both First Nations and Métis members.

Objectives

The objectives of the Health Integration Initiative were twofold. In the short-run, it was expected to bring together the various partners to research the existing health care delivery system, to identify gaps or duplication in service levels and to develop a plan for integrating (to the degree possible) the existing health care delivery systems. In the long run, it was expected that a framework agreement would be negotiated for a community-administered integrated health care system melding all, or nearly all, of the existing health services and programs.

Project Partners

Partners included Manitoba Health, the Norway House Cree Nation (NHCN), FNIHB Manitoba Region, Burntwood Regional Health Authority (BRHA), Norway House Community Council (NHCC), Indian and Northern Affairs Canada (INAC) and the Northern Medical Unit (NMU) of the University of Manitoba. Norway House Health Services Inc was created as an umbrella of the partners to administer the project.

Timeline

The duration of the funding was from July 2004 to March 31, 2006.

Funding

The amount of funding received from the HII for this project was $773,300.

INFORMATION SOURCES

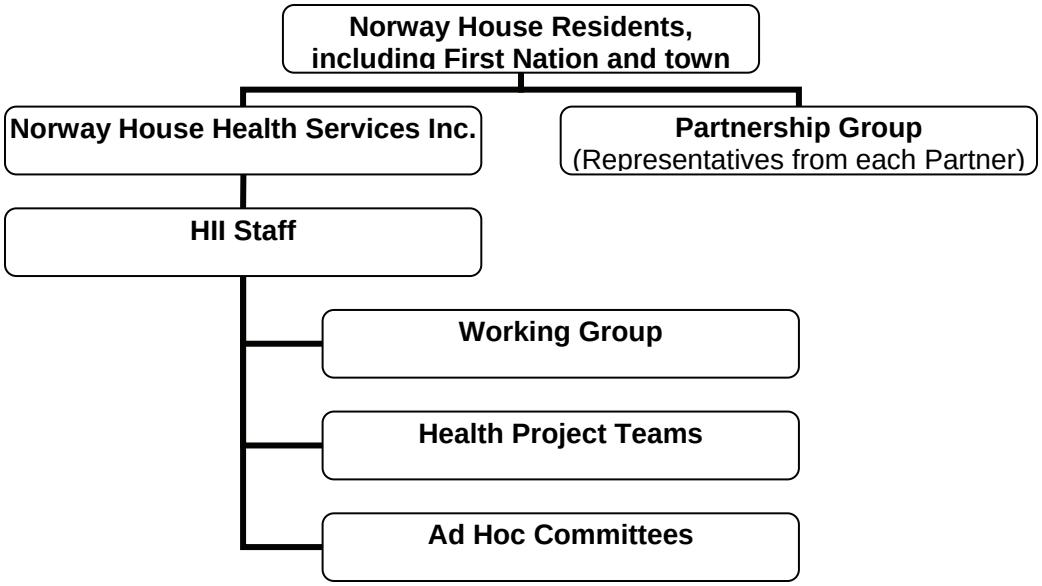
The information sources for this case study included project documentation and interviews with key informants. Project documentation included the Project Proposal, the Agreement Summary Form from Health Canada, Norway House HII monthly activity reports, workshop and forum summaries, summary presentation deck by NHHS, Norway House Hospital History presentation deck, HII expense reports, Draft Communication Plan, Norway House Health Integration Initiative Literature Synthesis presentation deck, correspondence between partners, site visit reports and the evaluation framework.

Interviews were conducted with Lisa Clarke, Coordinator, Health Integration Initiative Norway House, Norway House Health Services; Krista Van Aert and Dr. Dave Williams from FNIHB Manitoba Region, and Loretta Bayer, Director, Aboriginal Health Branch, Government of Manitoba.

PROCESS

Governance Structure

The following diagram displays the governance structure of the project.



Principals of the Partnership Group were:

- Jim Wolfe, FNIHB Manitoba Regional Director
- Marcia Thompson, Manitoba Health Assistant Deputy Minister
- Then-Councillor Eliza Clarke, NHHS Inc. President
- Then-Chief Ron Evans, NHCN
- Then-Mayor Lynne Mowatt, NHCC
- Karen McClelland, BRHA
- Mary Blais, INAC

The Working Group included representatives from the federal level (Jim Mair, Krista Van Aert and Dr. Dave Williams from FNIHB Region, as well as Irvin Smith from INAC), the provincial level (Loretta Bayer from Manitoba Health and Lloyd Martin from BRHA) and the NHHS Inc.

The following health project teams were established: Communication Plan and Community Consultation; Literature Review; Gap and Service Analysis; and Evaluation Plan.

The roles and responsibilities of the various groups were:

- NHHS Inc: Governing authority – decision makers
- HII staff: Coordination
- Health Project Teams: Advisory role
- Working Group: MOU development and advisory role

Communication Processes

A communication plan was drafted in December 2004 to present the communication processes to be undertaken. There was emphasis on the necessity of strong communication with the residents, employees and governments in order for the Health Integration Initiative to be successful.

The following principles were outlined to guide communications:

- timeliness and accuracy;
- cultural sensitivity;
- respect for keeping residents and staff informed;
- building and maintaining consensus for their work;
- respect of the confidentiality in sensitive areas ;
- key messages that focus on the prime motivation of improving health for residents.

Working Group and Partnership Group communications with stakeholders were the primary responsibility of the Chair, with support, as needed, from HII staff.

The major messages that were important to communicate to residents of Norway House as well as all stakeholders were:

- The project was about improving the health of the Norway House residents;
- Health will be improved by developing a more integrated health care delivery system with a focus on providing greater access to high quality health care services;
- The objective of the project was to have more and better services available in Norway House;
- Nothing in this work for this project took away, nor will it in any way derogate, from Aboriginal and Treaty Rights or the obligation of Canada to provide health care to First Nations people;
- This project was an opportunity to make a very significant difference and they need to work together with the best interest of health care in mind.

Communications that were undertaken with the community included community and elders forums as well as the distribution of a newsletter to every household.

TOOLS AND SUPPORT

- Communication activities were numerous and effective. Between partners, communication was ensured through email, agendas and meeting minutes. There were teleconferences to involve partners in different geographical areas.
- Interviewees were involved in the evaluation of the project. One interviewee felt that the independence and objectivity of the evaluation could have been questioned because the evaluator was a project employee who would be more likely to lean towards federal objectives, which could affect the provincial parties.
- Interviewees were disappointed that HII Secretariat Director or staff were unable to attend all of the community-level meetings. Though they were present at national meetings, they were able to attend only one steering committee meeting with all of the other Norway House partners, due to scheduling challenges and poor weather.

CHALLENGES

- Community and provincial legislation at first impeded the ability to move forward with certain aspects of the project. This challenge was surmounted as the project partners were able to have amendments made to the regulations that were hindering progress.
- With regard to written communications, it was difficult to write in a manner that was suitable to multiple levels of understanding. A Cree language interpreter was used to facilitate communications with the community members.
- Given the nature of the objectives set out by the HII projects, two or three years did not seem to be enough time to achieve these objectives. It is difficult to measure health outcomes in such a short period of time.

- An ongoing challenge is that the service delivery is provided in a silo approach. A key objective of this project was that this silo service delivery would be, in the long term, replaced with a common, coordinated approach that took into account all health services.
- The provincial and federal fiscal policies are very different. Matching the systems is an ongoing challenge.

OUTCOMES

- A master plan for overall health services is in place, including a primary health care model, and a proposal has been developed to move from the master plan to a functional plan, pulling together all the service changes to be implemented. A conceptual plan, dealing with the physical environment in which the aforementioned services will be dispensed, should be finished in the near future (Fall 2006). An expected outcome for the next two to three years is a new facility in which all health services will be available, replacing the current uncoordinated arrangement.
- Valuable partnerships have been formed and governance structures have been established.
- Funding has been centralized so that money is coming through one channel instead of multiple sources.
- Interviewees felt this was a very successful project.

SUSTAINABILITY/GENERALIZABILITY

- The project's processes will continue through funding from other sources and the functional planning process will proceed.
- The communication structures established between HII partners and Norway House Health Services Inc. have helped to foster sustainability. They will, along with processes and approaches developed throughout the project, be carried forward into any further work and could lend themselves to other integration initiatives.

PARTNERSHIP AND JOINT PLANNING

- There was extensive communication and collaboration between the various project partners. The partnerships, including the steering committee and working groups that arose from them, will be maintained after HII funding ceases.
- Maintaining a direct link with the community has been crucial to the success of this project. This is something that needs to be upheld in the future.

LESSONS LEARNED

- A lesson learned is that all involved stakeholders need to be at the table – all discussions have to be inclusive. Honesty and transparency amongst partners is essential.

Health Canada – FNIHB

Evaluation of the Health Integration Initiative

Weeneebayko Area Health Integration Initiative, Ontario

BACKGROUND/DESCRIPTION

Relevance

The Weeneebayko Area of northeastern Ontario is a region of 10,000 residents living in Weenusk First Nation, Attawapiskat First Nation, Kashechewan First Nation, Fort Albany First Nation, Moose Cree First Nation, Mocreebec Council of Crees and the Town of Moosonee. An estimated 90% of the Weeneebayko Area residents are Cree. The remaining Weeneebayko Area population consists of reserve and off-reserve residents, status and non-status First Nation people and a non-Aboriginal population.

The federal government provides health services funding to First Nation communities in Weeneebayko Area to support the Non-Insured Health Benefits Program and for the operation of primary care and community health services at community nursing stations and health centres. Federal funding is also provided via contribution agreement to the Weeneebayko Health Ahtuskaywin (WHA) that currently manages the Weeneebayko General Hospital (WGH). In addition to the WGH, the James Bay General Hospital (JBGH) is a provincial hospital headquartered in Moosonee that also provides services in the communities of Fort Albany and Attawapiskat First Nations.

The amalgamation of the federal and provincial hospitals is a priority activity.

There was consensus among Project Partners on the importance of collaboration among the different levels of government and the adverse impact on health status of the many jurisdictions currently involved in the delivery of health services on First Nations and Inuit people. Interviewees felt that that the current approach to the delivery of health services is “fractured” and that this fragmentation is “toxic”. They indicated that collaboration was of “prime importance” and that it should be “the priority for anyone involved in health care”. They expressed the need for recognition of the magnitude of the problem and the need for equal

access to services for First Nations and Inuit people. One interviewee suggested that, if the relevant parties do not succeed in coming together, that "there will be no health system to speak of."

Project Overview

The overall objective of the Weeneebayko Area Health Integration Initiative (WAHII) was to create a First Nation Health Authority (Weeneebayko Area Health Authority) charged with the responsibility to plan and deliver integrated health services. An important function of the WAHA would be responsibility for the amalgamation of the federal and provincial hospitals in the Weeneebayko area, namely James Bay and Weeneebayko General Hospital.

In order to achieve the objective, a tripartite agreement between the Province of Ontario, the FNIHB Region, and the community needed to be established. This agreement would detail the plan for the amalgamation of the hospitals, operating funding and delivery arrangements for all health services across the region, and related capital funding. With the finalization of such an agreement, a Special Act is required to be promulgated in the Ontario Legislature to facilitate the WAHA taking over the assets of both hospitals and other services including two Nursing Stations.

Other project objectives included the development of a Master Services Plan. The purpose of this Plan was to: make recommendations for identified program requirements and/or necessary modifications to customize federal and provincial programs to fit with the proposed health integration model; and, to prepare an implementation plan to move to new program arrangements over time, including dealing with labour adjustment issues, focusing first on senior management.

Project Partners

Partners included the FNIHB Ontario Region, the Province of Ontario, and First Nations representatives of the Weeneebayko Area.

Funding

The amount of funding received for this Project from the HII was $787,000.

INFORMATION SOURCES

The information sources for this case study included project documentation and interviews with key informants. Project documentation included the Project Proposal, Project Activity Reports, Principal Planner's Reports, Monthly Reports, Project Evaluations, Steering Committee documentation, the WAHII Master Service Plan, the Draft Act to Establish the Weeneebayko Area Regional Health Authority (WAHA), and the Project Timeline and Work Plan.

Interviews were conducted with Gavin Brown, Associate Regional Director, FNIHB Ontario Region; Anne Matte, Acting Regional Director, Ministry of Health and Long-Term Care; Jim Harrold, Project Manager; and Kelly Reuben, Director, Human Resources, Weeneebayko Health Authority.

PROCESS

Governance Structure

A Steering Committee was established to oversee the planning of the integration initiative. This Committee was comprised of various community representatives and a representative of the James Bay General Hospital. It had a Principal Planner and a Chair who represented the Steering Committee on the Tripartite Committee. The Steering Committee was to focus on planning the integration of health services, including planning for the migration of WGH from federal to provincial control, and identifying appropriate health services funding mechanisms.

The Steering Committee was comprised of one representative chosen by each of the following communities and organizations:

- Mushkegowuk Tribal Council
- Weenusk First Nation
- Attawapiskat First Nation
- Kashechewan First Nation
- Fort Albany First Nation
- Moose Cree First Nation
- Mocreebec Council of the Crees

- Town of Moosonee
- James Bay General Hospital

The Steering Committee was tasked with carrying out the work required to create the Weeneebayko Area Health Authority (WAHA). Once the WAHA is created, the Steering Committee will dissolve and the WAHA will take on their responsibilities and continue their work.

A Tripartite Committee was created to facilitate collaboration between the Steering Committee, Health Canada and Ontario's Ministry of Health and Long-Term Care (MOHLTC). The Tripartite Committee was tasked with coordinating the activities of the three parties and guiding the Steering Committee in its endeavours to achieve its objectives.

The Tripartite Committee was comprised of:

- Health Canada's Associate Regional Director, First Nations and Inuit Health Branch, Ontario Region
- The Ontario Ministry of Health and Long Term Care's Regional Director and Program Manager, Northern Ontario, and
- The Chair of the Steering Committee, representing the Weeneebayko Area

Communication Processes

There was an emphasis on communication/consultation to ensure inclusion of the community level perspective. Presence in the community was considered an important contributor to the success of this Project. Communication was considered more effective with community presence in the project.

There were weekly calls with all Project Partners as well as monthly meetings with the Steering Committee and regular meetings between the Steering Committee and the Tripartite Committee.

At the request of the eight HII project managers, a monthly teleconference with the HII Secretariat was initiated in March 2005. Also, there was extensive communication with both the Province and FNIHB Region.

Multiple modes of communication to the public were used in the project, including radio broadcasts to the general public, community visits geared towards the Chief and Council, and newsletters. Given that many community residents do not speak English, translation of communication materials into the local Cree language, both verbally and in writing, was required, which added to costs and delays.

TOOLS AND SUPPORT

The communications activities, materials and instruments from FNIHB Region were considered effective and helpful. The Project Partners also reported that the meetings with FNIHB Region and with regional partners, as well as regional assistance during negotiations related to the approval of projects were very helpful. Conversely, the monthly reporting template was not considered helpful, primarily due to the lack of feedback received on reports submitted.

The Baseline Evaluation Questionnaire was found to be helpful; however, in their opinion, there were problems with the evaluation model. The Project Evaluation was identified as one of the challenges faced by the Project. Although there was agreement on the value of evaluation, the HII evaluation model was considered to be of limited value. Some Project Partners observed that it was important to adopt a real-time evaluation framework where evaluation was done on an ongoing basis to inform changes to the project's work plan throughout its implementation. Such a model was used by the Sioux Lookout project but was not implemented in the case of WAHII.

CHALLENGES

WAHII faced challenges relating to the remoteness of the communities in the Weeneebayko area. These communities are spread across 500 km^2 and are only accessible by air. This translated into challenges including travel expenses, weather constraints, attendance at meetings, and consultation with the community. In an effort to address some of the issues posed by the geographical constraints, Steering Committee members (consisting of various community representatives) acted as community contacts.

An ongoing challenge identified by interviewees is resistance on the part of the provincial hospital to integrate with the federal hospital.

OUTCOMES

It had initially been anticipated that the amalgamation of the federal and provincial hospitals in the Weeneebayko area would be completed within the HII project timeframe. However, there were prerequisites to this process including negotiation of a tripartite agreement and approval of a Special Act in the Ontario Legislature. Negotiations for the tripartite agreement were delayed, as both the province and FNIHB Ontario Region were required to go to their respective Treasury Boards to obtain mandates giving them authority to negotiate.

These mandates have since been put into effect and the Partners were in the process of finalizing a draft agreement. It was anticipated that the agreement would be finalized by the summer of 2006. A draft of the Special Act will be submitted to the Ontario Legislature once the tripartite agreement has been finalized. Approval of the Special Act will give authority to the creation of the Weeneebayko Area Health Authority, which will in turn begin the procedure of amalgamating the two area hospitals.

The WAHA concept has been developed. The Master Service Plan with Facilities Review has been completed.

Within the next two to three years, it is anticipated that the Weeneebayko area will have a fully integrated health care system under the provincial government – a more efficient, less fragmented health care system with more programming to provide care.

Key Accomplishments

- Governance/legislation
    - Special Act to be introduced into Ontario Legislature will give new authority to WAHA and to the amalgamation of the two Weeneebayko area hospitals.
- Health service delivery
    - Once the Project objectives are complete, the Weeneebayko area will have an integrated health services delivery model.
- Service assessment and evaluation
    - Completion of the Master Service Plan that is integral to the success of the entire initiative.

- Formal structures established
    - Amalgamation of the two hospitals into one hospital under the provincial government is anticipated as a result of the project.

SUSTAINABILITY/GENERALIZABILITY

- The creation of the health authority is considered an essential vehicle to sustain the progress made to date. It will continue with long-term implementation of the plans developed after the HII project.
- Aspects that could be relevant elsewhere:
    - the collaborative approach undertaken by all partners;
    - a high level of community representation;
    - return to basic principles – i.e. improving health care, health status;
    - the WAHII was built from the ground up and has included all concerned parties.
- One informant recommended that FNIHB should develop an approach for communicating the information on lessons learned from HII. It would be important to use these lessons learned so that other initiatives benefit from the HII experience.
- It was also recommended that a policy to support system transformation should be developed.

PARTNERSHIP AND JOINT PLANNING

- Interviewees indicated that the success of their partnership and planning activities depended on the following:
    - open and honest communication;
    - transparency in decision-making;
    - clear objectives and anticipated results; and,
    - clarity of roles.

LESSONS LEARNED

- Advice from the project for other First Nations and Inuit communities
  - Need a system that allows for growth, change and development in order to deal with the key health issues of people on reserve;
  - The need to adopt a primary health care focus. There are three major components to this, particularly for Aboriginal health given the characteristics of the population:
    - Multi-disciplinary teams providing health care and a movement away from physician-centred model;
    - Fundamental focus on illness prevention and health promotion; and
    - Strong linkages with existing disease management programs so people who are already sick can be appropriately treated.

Health Canada – FNIHB
Evaluation of the Health Integration Initiative

Vancouver Island Chronic Illness Care Project (BC)

BACKGROUND/DESCRIPTION

Relevance

Numerous studies attest to the need for attention to the health needs of First Nations people. In particular, chronic illnesses such as arthritis, asthma, depression and diabetes affect First Nations and other Aboriginal people at a greater rate than the non-Aboriginal population.

In addition, Status Indians have a much higher rate of preventable admissions to hospital than the general population. A significant factor in the health of First Nations people is that their care is provided under a complicated variety of jurisdictions, resulting in a lack of continuity of care. This HII project was especially concerned with addressing these issues in a way that improved the capacity of the First Nation health care agencies and those working with them.

Nature of project relative to health needs of community

Studies in British Columbia have shown that people with chronic illness accounted for a disproportionate utilization of hospital and medical services. One of the keys to improved service is considered to be better coordination among health care providers in different health care sectors – that is, in primary care settings, hospitals, and home care. Horizontal integration of independent agencies, practitioners and jurisdictions is particularly challenging in a First Nations context. That was why the Vancouver Island Chronic Illness Care Project focussed on six sites in order to test the model of chronic illness management, which had been developed in the United States. The test sites were selected through discussion with Project Partners and included both rural and urban settings.

Project Overview

The purpose of this project was to enhance coordination of service delivery among Vancouver Island First Nations and their mandated health agencies, First Nations and Inuit Health Branch (FNIHB), Pacific Region, Vancouver Island Health Authority (VIHA) and private practitioners serving First Nations communities. The HII funding supported the planning and implementation

of transitional activities to create a legacy of improved capacity and greater service coordination. The project focused on developing partnerships, improving integration of delivery systems, increasing use of decision support systems and information technology, and enhancing resources for patient self-management.

Objectives

The overall goal of the project was to build capacity for integrated management of chronic illness in the collaborating First Nation communities, through better coordination and increased continuity of care between sectors and across jurisdictions. This was to be achieved in terms of the following objectives:

- to adopt the Chronic Illness Care Model to a number of First Nation sites on Vancouver Island;
- to develop and implement a plan to improve secondary and tertiary prevention of chronic illness;
- to forge partnerships for shared service delivery to First Nations of Vancouver Island;
- to identify and develop clinical and community leadership appropriate to each partner;
- to develop and train six multidisciplinary teams to apply the Chronic Illness Care Model in their daily practice;
- to develop tools and resources for training in patient self-management;
- to enhance continuing professional education for clinicians working in remote areas; and
- to enhance coordination of service delivery among First Nations and their mandated health agencies, FNIHB, and the Vancouver Island Heath Authority (VIHA).

Project Partners

The partners involved in this project were Vancouver Island First Nations – which included the mandated health agencies and tribal councils representing 43 First Nations – as well as the Vancouver Island Health Authority and the FNIHB Pacific Region.

Timeline

The duration of the funding was from November 2004 to March 31, 2006.

Funding

The amount of funding received for this project under the HII was $1,200,000.

INFORMATION SOURCES

The information sources for this case study included project documentation and interviews with key informants. Project documentation included the project proposal, correspondence with Health Canada, activity reports, management committee terms of reference, documentation from the Site Leaders Seminar, site visit reports, communications plan, project consolidated contribution agreement, agreement summary form and project workplan.

Interviews were conducted with Cindy Hlus, Project Coordinator for the Vancouver Island Chronic Illness Project, based out of the Inter Tribal Health Authority; Tom Bradfield, Director of Aboriginal Health, Vancouver Island Health Authority; Victoria Power-Pollitt, Director of Primary Health Care and Chronic Disease Management Office, Vancouver Island Health Authority; and Ryan Johnstone, Regional Policy and Program Officer, Pacific Region, First Nations and Inuit Health Branch, Health Canada.

PROCESS

Governance Structure

An accountability and oversight framework was developed within the project proposal. This framework outlined the roles and responsibilities of Project Partners, the relationships of First Nations, provincial and federal governments, as well as the management structures put in place.

The project structure included the following teams whose memberships and responsibilities were outlined within the accountability framework:

- *Principals Committee* with responsibility for project design, implementation plans and budget.
- *Project Management Committee* with overall accountability to the Vancouver Island First Nations for the management of the project.
- *Lead Organization* responsible for day-to-day operations of the project (which was the Inter Tribal Health Authority).

- *Project Co-ordinator* responsible for the project's effectiveness including developing a detailed plan, developing infrastructure support, and overall management of tasks.
- *Implementation Coordinating Committee* responsible for ensuring implementation and coordination made up of community health directors (or their designates) plus project staff.

Communication Processes

- A communications plan was developed to guide the communications of the project partners. This plan identified various audiences (e.g. board members or community members) and, for each, outlined the key messages and the resources available to support those communications. A multi-layer process for communication between Project Partners was devised. Means of communication included regular meetings with agendas, briefing notes and minutes; site visits; bi-weekly site leader teleconferences; face to face meetings (seminars) with site leaders every two to three months; and visits to the communities by the project coordinator.

TOOLS AND SUPPORT

- In general, interviewees felt that the tools and support provided by the HII Secretariat and FNHIB Region was helpful, and considered many tools, such as feedback on proposals and HII Secretariat staff attendance at meetings, to be extremely helpful.
- Additional tools that would have been helpful to the success of the project include information on previous FNIHB projects that may have had some relevance to this project. Also, more opportunities to exchange information with other HII projects would have been useful.
- One of the interviewees had participated in the project evaluation. This interviewee indicated that the project logic model was "very linear", which is different from the nature of First Nations research. The project evaluation was an evaluation of the process rather than of the outcomes, because it was too soon to be able to evaluate outcomes.

CHALLENGES

- Staff turnover was a challenge throughout this project. Some of the employee turnover at the sites was due to the HII project's timelines and accountabilities, which employees were unable to cope with given the lack of resources. As staff left, new staff had to be trained and oriented. To deal with this challenge, it became important to build organizational memory, to standardize operations and to draw up a workplan to keep the project on schedule.
- The short timeframe of the HII was challenging for this project. The funding was for a limited time only and, therefore, there was a rush to accomplish as much as possible. It was much too short a timeframe for the objectives laid out by HII. In addition to the short timeline was the steep learning curve associated with dealing with First Nations health care that accompanied a project of this nature. Both of those challenging factors affected the ability to successfully reach objectives.
- The shift from a reactive to a proactive care delivery structure was challenging. Emphasis should have been placed more on change management skills, rather than additional clinical skills. The change management character of the project required a steady commitment (two to three days a week) by the project site leaders.

OUTCOMES

- The intended outcomes of the project were: to develop a collaborative approach to improve care delivery and health outcomes to First Nations providers, Vancouver Island Health Authority and private practitioners; to train staff to use the expanded chronic illness model in First Nations health context; to build on team development; to have increased understanding by partners of First Nations health care needs; to introduce information technology to enhance program management, communication and education opportunities for staff and clients; and to increase client self-management of chronic illness.

- The majority of these outcomes have been achieved and most are still ongoing. The increase in client self-management of chronic illness is difficult to establish and did not occur within the timeframe of the project. Staff training was successful, and will require ongoing support and renewal. With respect to technology, new technologies have been well integrated, especially videoconferencing. In addition, the selection of new software to assist with information management has been done and staff training to use this system was planned.
- Outcomes expected over the next two to three years include the following: collaborations should continue to develop with new projects, since existing relationships have been a positive experience; the chronic illness care model will continue to be used and First Nations adaptations will be further explored; use of team-based delivery of health services and technology, especially on remote sites, is expected to increase; the importance of client self-management should become evident in the future as team attitudes and skills expand.
- The interviewees were able to provide many examples of successes of the project. Site managers became familiar with the benefits of the project management process, such as the project charter, terms of reference, detailed timelines, briefing notes, and agendas. There was an increased focus on chronic illness and gaps in its care. Site assessment tools and processes (check list for self-assessment or external assessment and reporting framework to the site manager) were developed. A formal assessment process was also created to select sites for projects focusing on site strengths, needs and readiness for implementing a chronic illness care model. Process maps were used to clarify clinicians' and organizations' responsibilities at each stage of the patient journey, which led to many observations of gaps and/or overlaps in patient handoffs and consequently, to planning and policy changes to help rectify these issues. On the human resources front, site leader job descriptions were created.
- It was stated that this project touched upon dozens, if not hundreds, of care providers. Their improved skills will persist long after the completion of the project, and lessons learned from the test projects were to be disseminated through the final report, evaluation report and the Project Partner efforts to publish results in peer-reviewed journals.

SUSTAINABILITY/GENERALIZABILITY

- The training to service providers as well as understanding of the expanded chronic illness model will continue to enhance health service delivery at the test sites after the completion of the project. The relationships and partnerships created will likely be maintained and the technology acquired through the project will stay in place and continue to be used for communication and networking.
- The site assessments undertaken led to the development of work plans that could be used as baselines for in-house improvement projects that could be undertaken in the future.

PARTNERSHIP AND JOINT PLANNING

- Partnerships developed during this project were quite strong. Interviewees felt positive that the relationships would be maintained after the completion of the HII project. The VIHA is very interested in closing service gaps and reducing health disparities in First Nation communities and they realize that this can only be achieved through collaboration with other organizations.
- Lessons learned with regard to partnerships and joint planning identified by interviewees include the following: identifying a purpose for change is important to get buy-in from potential partners; it is crucial to have a strong central team leading the project; listening and understanding between partners is key – you can't just make assumptions, you have to try and understand the different perspectives; and maximizing information technology, since it is a tool that can simplify project activities and encourage success.

LESSONS LEARNED

- The project could have benefited from more involvement from the principal partners and the management committee. However, the time pressures on both the members' schedules and those of the project were considerable.
- There were better results when project coordinators and/or site leaders were more knowledgeable about the community and could make a sufficient time commitment required for this type of project. One interviewee stated that community knowledge was just as important to look for in potential candidates for these positions as was clinical knowledge and skills.
- According to interviewees, HII placed an emphasis on the financial aspects of the projects, with less emphasis on the projects themselves. This approach may not have done justice to the projects that have much more potential but are not fully developed.
- In the future, it may be valuable to consider giving projects more flexible timelines given that each community has very unique needs and that mobilizing resources is a significant challenge for First Nations communities. The timeframes were considered an impediment to the success of projects.
- Having a project website would have been helpful for communication among project sites.

Health Canada – FNIHB

Evaluation of the Health Integration Initiative

Integrating Health Promotion and Illness Prevention Programs Project, Nunavut

BACKGROUND/DESCRIPTION

Relevance

When Nunavut was created in 1999, the territory adopted an integrated model for providing health services to all of its residents, regardless of ethnicity. In the 2002 Romanow Commission report, *The Future of Health Care in Canada*, this model of health integration was held up as an example to the rest of Canada. Today, Nunavut's Department of Health and Social Services continues to apply this unique model to its primary health care planning, its public health planning and its on-going health reform initiatives.

While Nunavut delivers health services to the entire population, the federal government provides funding through Health Canada for Inuit-specific health promotion and disease prevention programming, as well as health promotion funding for the general population through the Public Health Agency of Canada. Health Canada wanted to explore ways to improve the effectiveness of federal investments in the territory by increasing program efficiencies, building on existing opportunities and strengthening collaboration between all the parties involved in Nunavut's health system. This project was a timely opportunity to review the situation in Nunavut and identify new ways of working in the territory.

Nature of project relative to health needs of community

The delivery of health services and programs is made difficult by the history and geography of Nunavut. The cost of living is extremely high as is the cost of providing health services. The isolation of communities means that access to many services is limited and many communities experience a shortage of health care professionals. Retention of health professionals in communities is a major problem in Nunavut. Because of all these factors, integrated health care is essential to providing effective health care to the communities.

Project Overview

The planned outcome of the "Integrating Health Promotion and Illness Prevention Programs in Nunavut" project was a five year plan for Nunavut focussing on increased integration of federal and territorial health promotion and illness prevention programs in the areas of dental health, addictions treatment and child health. This integration project was expected to foster a shift from curing illnesses and repairing injuries to health promotion and illness prevention models of care in the territory, which supports Health Canada's programs and the Government of Nunavut's strategic plan to bring care "Closer to Home". It was also expected to identify new ways of working in the territory to maximize the impact and effectiveness of Health Canada's and the Government of Nunavut's investments in health promotion and illness prevention programming.

Objectives

The short-term objectives of the project were:

- to build on existing partnerships between the federal and territorial governments and the Inuit organization, Nunavut Tunngavik Incorporated (NTI), in the delivery of community health promotion and illness prevention programs in Nunavut;
- to review the existing health programs in the areas of dental health, addictions treatment and maternal and child health, with particular emphasis on health promotion and illness prevention and identify areas where there are duplication/gaps in services;
- to develop an action plan that would identify the threats inherent in the system and the opportunities available. This action plan is to design a way forward that minimizes the threats and maximizes the integration opportunities and will provide direction to Health Canada and the Government of Nunavut's activities in the territory; and
- to design culturally-based addictions treatment centre models as one part of a program to meet the needs of Nunavut residents who cannot presently be served in the territory for treatment of addictions.

Its long-term objectives were:

- to support the Government of Nunavut's efforts to realize the "Closer to Home" vision by improving integration of federal and territorial investments within illness prevention programs with the ultimate goal of contributing to the improved health status of the population in Nunavut; and

- to support increased community capacity. Included in this was the objective of decreasing the overall dependency on the health system by fostering greater confidence in self-care and developing a system where people are more informed to make decisions about their own self-care.

Project Partners

The project was a tripartite partnership between Health Canada's Northern Secretariat, the Government of Nunavut and Nunavut Tunngavik Incorporated.

Timeline

The duration of the project was from February 2005 to March 31st, 2006.

Funding

The funding received for this project under the HII was $457,000.00.

INFORMATION SOURCES

The information sources for this Case Study included project documentation and interviews with key informants. Project documentation included the Project Proposal, Project monthly activity reporting forms, Agreement Summary Form from Health Canada, the Consolidated Contribution Agreement, Research Proposal, Job Descriptions of HII Project Coordinator and Administrative Assistant and Project Workplan.

Interviews were conducted with Wayne Gouvereau, Executive Director, Department of Health and Social Services, Government of Nunavut; Pierre Lecomte, Project co-ordinator, Department of Social and Cultural Development, Nunavut Tunngavik Inc.; and Tasha Stefanis, Policy Analyst, First Nations and Inuit Health Branch, Northern Secretariat.

PROCESS

Governance Structure

The federal, territorial and NTI health integration partners formed an Advisory Committee overseeing the review, evaluation and planning functions for the HII initiative. The advisory committee approved the review of the health care system and the strategic planning process including options development. The committee approved reports, the final strategic plan and project evaluation.

Communication Processes

Communications among project partners were undertaken mainly through meetings or teleconferences. Teleconferences were held on a monthly basis. Given the geographical distance, face-to-face meetings were financially and logistically difficult.

TOOLS AND SUPPORT

- An evaluation by an external evaluator was undertaken while the project was underway. Interviewees were pleased by the evaluation process and believed it was a useful tool for the objective identification of issues.
- Opinions were mixed as to the effectiveness and helpfulness of the tools made available to the project by the HII Secretariat, such as the proposal template and guidelines, the monthly reporting template, and the baseline questionnaire. One interviewee indicated that the tools used were only “somewhat helpful”, whereas, the other two interviewees who commented on the tools indicated they were either “helpful” or “very helpful.”
- All parties interviewed felt that the partial funding of an FTE in the FNIHB Regions was extremely helpful.

CHALLENGES

- Recruitment was a significant challenge for this project. The time required to recruit someone in Iqualuit was not factored into the original timeline. It took about five months to recruit the human resources necessary, which put the project behind.
- The Health Integration Initiative was developed without adequate inclusion of Inuit and recognition of what integration means in a territorial context. The terms of the Nunavut project had to be negotiated and the project shaped to reflect the Inuit situation and to take into account the uniqueness of Nunavut's health delivery structure.
- Location and climate of Nunavut was an ever-present challenge: face-to-face meetings were difficult as some partners were located in Ottawa while the others were in Iqualuit, Nunavut. A community forum, which took months to organize, had to be cancelled at the last minute due to bad weather.

OUTCOMES

- A five-year action plan was created, including a mental health and addictions treatment approach that is culturally relevant. This plan has the potential to have a large impact on the delivery of health services in the areas of addictions and mental health, maternal care and dental care. Now that the Plan is completed, the next step involves implementation.
- There was increased collaboration amongst the three partner groups. Their working relationship remains strong even after completion of the HII project.
- The project allowed for the creation of better models for enhancing health services delivery; increasing cost-effectiveness of delivery; and maximization of programs.

SUSTAINABILITY/GENERALIZABILITY

- The five-year action plan has been created, as intended. However, now implementation needs to happen. Interviewees feel uncertain around future funding to support sustained action.

- Although no mechanisms were put in place during the project specifically to implement the Plan, the responsibility for implementation rests primarily with the Government of Nunavut and is expected to proceed based on the enhanced working relationship of the HII partners.
- A series of six community consultations was undertaken and, through this, much knowledge was gained with regards to the health services needs of Inuit communities in Nunavut and considerations for developing Inuit-specific programs and services. This information should be applicable to other related projects or undertakings.

PARTNERSHIP AND JOINT PLANNING

- Communication between partners was constant throughout the project.
- The intent was for the partnerships to be maintained after conclusion of the HII project. There is an attempt to set up an advisory committee for the implementation of the plan, which would bring in a few more partners.

LESSONS LEARNED

- The geographical distance involved was an important factor in this project that had to be dealt with on a regular basis. Given the geographical distance and difficult climate, it was difficult to organize face-to-face meetings, which interviewees deemed important for the success of the project. Even phone conversations had delays caused by the large distance between Iqualuit and Ottawa.
- One interviewee indicated that it might have been better to limit the scope of the undertaking by not including maternal and child health promotion at this phase of the initiative. Rather, they suggested it would have been practical to focus more time and effort on treatment for mental health and addictions, which are significant problems in the communities and underlie many other community issues.