



Evaluation of Health Canada's First Nations Health Facilities Program 2010-2011 to 2014-2015

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List of Acronyms

AFN	Assembly of First Nations
AHSOR	Aboriginal Head Start on Reserve
BC	British Columbia
CA	Contribution Agreement
CARC	Capital Allocation and Review Committees
CFMP	Capital Facilities and Maintenance Program
CIAD	Capacity, Infrastructure and Accountability Division
CIRF	Community Infrastructure Renewal Fund
CPRC	Capital Program Review Committee
CSB	Corporate Services Branch
F/P/T	Federal/Provincial/Territorial
FCIR	Facility Condition Inspection Report
FNHA	First Nations Health Authority
FNIHB	First Nations and Inuit Health Branch
HFP	Health Facilities Program
HQ	Headquarters
IFA	Integrated Facility Audits
HIS	Indian Health Service
INAC	Indigenous and Northern Affairs Canada
ITK	Inuit Tapiriit Kanatami
LHIN	Local Health Integrated Networks
LTCP	Long Term Capital Plan
MOHLTC	Ministry of Ontario Health and Long-Term Care
n-LTCP	National Long Term Capital Plan
NNADAP	Native Alcohol and Drug Abuse Program
O&M	Operations and Maintenance
OAG	Office of the Auditor General
P/Ts	Provinces and Territories
PAA	Program Alignment Architecture
RHS	Regional Health Survey
r-LTCP	Regional Long Term Capital Plan
TRA	Threat and Risk Assessment
TRC	Truth and Reconciliation Commission (of Canada)

Executive Summary

The purpose of the evaluation was to assess the relevance and performance of Health Canada's Health Facilities Program (HFP) for the period of 2010/11 to 2014/15.

The evaluation was required in accordance with section 42.1 of the *Financial Administration Act*, which requires that every department shall conduct, every five years, a review of the relevance and effectiveness of each ongoing program of grants and contributions.

The HFP is an established program administered through the First Nations and Inuit Health Branch (FNIHB) at Health Canada. The HFP administers contribution agreements and direct departmental spending that provide First Nations communities and/or health care providers with the facilities required to safely and efficiently deliver health programs and services. This program directly impacts the working conditions of Health Canada staff engaged in the delivery of health programs and services to First Nations communities. Health Canada/FNIHB has no ownership or other legal interest in any capital assets (health facilities) funded through the HFP.

The HFP provides funds to undertake both major and minor capital construction projects. Major capital projects are defined as those that either expand the footprint of an existing building, or create a new or replacement building. Minor capital construction projects are those that do not meet the definition of a major project, and may include projects to update systems in disrepair or at the end of their lifecycles such as replacing roofs, window or door systems. In addition, Health Canada provides funds for the operations and maintenance (O&M) of health facilities. Program expenditures for the five years covered by the evaluation were approximately \$451M (2010/11 to 2014/15).

The HFP supports a portfolio of 739 buildings, which include 426 health-related buildings (such as health centers, health offices, health stations, nursing stations), 213 residences, 96 operational buildings (such as garages, storage building, warehouses, offices) and four hospital complexes.

Findings and Conclusions on Relevance

There is a strong need for the Federal Government to continue activities that support the maintenance, construction, acquisition/leasing, expansion and/or renovation of health facilities in First Nations communities. This need results from the continued significant disparity between the health status of First Nations people living on-reserve, and the non-Indigenous population of Canada. A key component needed to assist in eliminating this disparity is the provision of safe health facilities that can contribute to First Nations communities' capacity to efficiently deliver health programs and services, a need that has been highlighted in the recent *Calls to Action* from the TRC.

The overall design of the HFP is responsive to client needs; however, the extent to which this program could respond was hampered considerably during the period covered by the evaluation by the limited funds available to address both O&M and capital demands within First Nations communities related to health facilities. The actual gap between demand for capital funding and program funding during the period covered by the evaluation was substantial. To help address this gap, Budget 2016 included additional commitments for improving health facilities in First Nations communities. In addition to the funding gap, there are a number of pressures that challenged the HFP to be responsive to adequately filling gaps during the period covered by the evaluation such as increased number and scope of programs offered by FNIHB within existing facilities, evolving demands and standards for health programming and facilities, population growth and demographic shifts, and increased costs associated with new technologies, construction, and utilities.

The objectives and activities of HFP align with the priorities of both the federal government and Health Canada. During the period covered by the evaluation, the program remained aligned with the priorities as outlined in Speech(es) from the Throne, and in particular the 2015 commitment to close gaps in health outcomes between Indigenous and non-Indigenous communities.

The previous evaluation noted that the HFP was aligned with federal roles and responsibilities. These roles and responsibilities have not changed substantially during the current evaluation period. The HFP is aligned with federal roles and responsibilities as established in various policies and authorities. There is no evidence of overlap with other programming at either the federal or provincial/territorial levels.

Findings and Conclusions on Performance

There has been progress in updating various guidelines and policies during the period covered by the evaluation, although there have been some delays in the dissemination and implementation. Internal policies and manuals are generally perceived by program representatives as timely and useful, with some specific suggestions for improvement.

The HFP has facilitated First Nations recipients' access to and awareness of tools and training largely by tailoring program resources to individual community needs. Tailoring resources to the particular needs of each First Nations community is perceived as essential by those working directly with the communities. Health Canada representatives did note, however, that the smaller, remote communities tend to face the greatest challenges with respect to increasing their capacity with less progress having been made in these communities.

There remain ongoing challenges with respect to the overall condition and functionality of health facilities in First Nations communities, particularly within the context of increasing costs of maintenance and construction, capacity issues in communities, and changes in types and amounts of health services and programming delivered in communities.

- There is considerable variability in how each type of audit and inspection is conducted across the regions. This makes it difficult to compare or roll-up findings and recommendations for a specific type of audit or inspection. With the exception of the Integrated Facility Audits, which have some standardized criteria, other audit and inspection reports reviewed across the regions did not have common criteria, structure or areas of focus.
- A quarter of health facilities did not have an audit or inspection conducted over the five-year period covered by the evaluation. Half of the facilities (51%) were inspected more than once. For most of the period covered by the evaluation, the policy was to inspect facilities every five years. In 2014-15, the HFP developed a policy of a 3-year cycle for facility inspections.
- Of the 83 audits and inspections examined between 2010/11 and 2014/15, 27 (33%) had a priority one issue and 71 (86%) had a priority two issue. Further, of the approximately 1,900 findings found in these audits and inspections, approximately 30% were critical issues (6% priority one and 24% priority two). Priority one issues represent a significant threat requiring immediate action. Priority two issues represent a substantial concern requiring action without delay. Examples of Priority one and two recommendations included missing carbon monoxide detectors, no plans for emergency environmental events, needed repairs to roofing materials, sanitary issues, replacement of soffit vent panels, cracking foundations, shifting structures, fire doors, adequate space in hallways, space definition (confined space) and septic systems.
- There are significant concerns related to O&M activities for many of the facilities as identified through audits and inspections and the evaluation document review, case studies and interviews. This is likely due to the capacity challenges within some communities, combined with limited funding and aging facilities in relatively harsh conditions.

The planning and prioritization under the long-term capital planning process has effectively prioritized key capital investments during the period, albeit a limited number and scope given the funding limitations. Increased national involvement in this process, combined with extensive involvement by the regions, are highlighted as contributors to success.

There are considerable challenges with respect to information systems for the HFP, making it difficult for the program to have access to accurate and up-to-date information to inform funding allocation plans and report on program results. These are longstanding issues that were also raised by the previous evaluation of the HFP. Given these challenges, regions have developed various tools and systems to meet their immediate information needs for managing and delivering the program at the regional level. FNIHB and Corporate Service Branch are currently developing options to address the IT issues.

It is challenging to quantitatively assess the overall economy and efficiency of the HFP given issues related to administrative and financial data integrity and availability. There are more qualitative indications that the HFP has demonstrated economy and efficiency through the achievement of the 80% target derived from the Modernization Capital Framework for minor capital investments, the integration of regional involvement in planning contributing to accurate prioritization of investments, and ongoing collaboration and coordination between the HFP and other federal departments and some provinces to gain efficiencies, accommodate other health services and leverage various initiatives. The one area highlighted as a challenge to effective resource utilization was the investments made late in the fiscal year in the HFP that are difficult to plan for and do not necessarily get assigned to the highest priority projects identified during the planning process.

The HFP design and implementation processes are somewhat similar to other capital funding programs from different jurisdictions. There are a few processes identified in other programs that could be further reviewed by the HFP to determine if they would be relevant and useful to enhancing the Program's economy and efficiency, and potentially effectiveness. These were found primarily in the areas of O&M investments, information management systems, and capacity building.

RECOMMENDATION 1

Health Canada should work with First Nations communities to ensure that FNIHB's policy on the frequency of audits and inspections is implemented as intended (currently, every three years) and that deficiencies related to the health and safety requirements or building codes are systematically tracked and prioritized in the annual capital plans, both regionally and nationally.

The evaluation identified that there are a significant proportion of facilities that are not inspected on a regular basis. During the period covered by the evaluation, the program tracked priority issues identified in Integrated Facility Audits, but did not track priority issues for other types of audits and inspections (i.e., Threat and Risk Assessments (TRAs) or Facility Condition Inspection Reports (FCIRs)). The evaluation's review of Regional Long Term Capital Plans and National Long Term Capital Plans during the period covered by the evaluation could not make a direct link between planned

investments and addressing the high priority issues identified in audits and inspections. As of 2015/16, the program has developed a systematic process for tracking audit and inspection recommendations.

RECOMMENDATION 2

Health Canada should replace its existing management information system for the HFP with one that can provide program-level analyses of activities, outputs and outcomes that can also be accurately linked to expenditure data.

There are significant issues related to the administrative and financial data available for the HFP. There are gaps in administrative information required to manage the portfolio of facilities. Key considerations in improving these systems would be to develop standard key measures for real property management (e.g., effective age, facilities condition index) to assist in the management of the program and decision-making, particularly with the assessment of need, identification of risk, and expenditure forecasting.

RECOMMENDATION 3

Health Canada should increase the level of consistency across regions with respect to a core set of standards related to facility audits and inspections, while continuing to allow for regional flexibility.

This would include standards with respect to inspection criteria, reporting, and data capture for follow-up of recommendations. Consistency in core standards across the regions would allow the program to analyse data at the national level, thus providing HFP with a greater understanding of the program as a whole rather than as individual regions.

Management Response and Action Plan

Evaluation of Health Canada's Health Facilities Program 2010-2011 to 2014-2015

Recommendations	Response	Action Plan	Deliverables	Expected Completion Date	Accountability	Resources
Recommendation as stated in the evaluation report	Identify whether program management agrees, agrees with conditions, or disagrees with the recommendation, and why	Identify what action(s) program management will take to address the recommendation	Identify key deliverables	Identify timeline for implementation of each deliverable	Identify Senior Management and Executive (DG and ADM level) accountable for the implementation of each deliverable	Describe the human and/or financial resources required to complete recommendation, including the source of resources (additional vs. existing budget)
Recommendation 1 Health Canada should work with First Nations communities to ensure that FNIHB's policy on the frequency of audits/inspections is implemented as intended (currently, every three years) and that deficiencies related to the health and safety requirements or building codes are	Management agrees with the recommendation.	Health Canada will track and report on frequency of audits/inspections as per the FNIHB Framework for Planning and Managing Capital Contributions. In 2015/16, Health Canada developed a systematic process for tracking audit and inspection recommendations in order to improve data capture and tracking. Tracking results will be presented for 2015-16 and 2016-17. Capital recommendations will be included in the Long Term	1.1 Tracking Results for 2015-16 and 2016-17 1.2 Capital recommendations reflected in 2018/19 LTCP.	1.1 August 2017 1.2 March 31, 2018	FNIHB, CIAD, Director and FNIHB, Regional Executives	Existing budget

<p>systematically tracked, and prioritized in a timely manner in the annual capital plans, both regionally and nationally.</p>		<p>Capital Plan (LTCP) effective 2017-18, based upon the available capital budget.</p>				
<p>Recommendation 2 Health Canada should replace its existing functional management information system for the HFP with one that is able to provide program-level analyses of activities, outputs and outcomes that can also be accurately linked to expenditure data.</p>	<p>Management agrees with the recommendation.</p>	<p>FNIHB recognizes the need to have a fully functional real property management information system and work has been underway to advance a solution, while also recognizing the need to work within the Health Canada – Shared Services Canada priority list (as of March 2016, the project was ranked 42 out of 59 on the priority list). FNIHB will continue to work through the departmental Investment Planning process for an appropriate replacement system for the existing Real Property Management Information System (RPMIS). Efforts will focus on developing options and a Business Case that will reflect a project scope which has evolved to include different types of assets from different program areas [e.g. Aboriginal Head Start On</p>	<p>As committed in the MRAP to the Audit of Health Facilities Program (2017): 2.1 Develop a business case to replace the legacy RPMIS. 2.2 Real property information management system mitigation strategy in place.</p>	<p>As committed in the MRAP to the Audit of Health Facilities Program (2017): 2.1 March 31, 2019 2.2. July 31, 2017</p>	<p>FNIHB, CIAD, Director and FNIHB, Regional Executives</p>	<p>Existing budget</p>

		<p>Reserve, National Native Alcohol & Drug Abuse Program]. This will require a consistent reporting approach across different programs and regions. The Government of Canada IT funding requirements have changed since the project was originally started, which will have implications on the steps and timing required to complete the project depending on the option chosen.</p> <p>In the interim, FNIHB will continue to implement mitigation measures to ensure business processes can be followed and information of value is collected. A formal strategy will be developed to consider 1) using appropriate components of the existing system to the extent possible, including the following applications: main building information database, Facility Cost Estimating System (FCES), and asset management; and, 2) implement regionally consistent processes and templates, related to: Project Brief, Long Term Capital Plan and audit and inspection</p>				
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		<p>follow-up. Work around solutions mainly include the use of excel spreadsheets (e.g. LTCP) and Word templates (e.g. Project Brief).</p> <p>Please note: While no new development can occur on RPMIS (development platform is no longer supported), the System will be supported and remain active until a replacement solution is implemented. There is no concern for System malfunction or data loss.</p>				
<p>Recommendation 3</p> <p>Health Canada should increase the level of consistency across regions with respect to a core set of standards related to facility audits/inspections, while continuing to allow for regional flexibility.</p>	<p>Management agrees with the recommendation.</p>	<p>In 2015/16, Health Canada developed a systematic process for tracking audit and inspection recommendations in order to improve data capture and follow-up.</p> <p>Health Canada is committed to increasing the consistency of facility inspections across the regions and will develop a core standard to improve the ability to compare and roll-up findings and recommendations.</p>	<p>3.1 An Inspection Protocol and Report Template for FNIHB lead inspections.</p>	<p>3.1 October 31, 2017</p>	<p>FNIHB, CIAD, Director</p>	<p>Existing budget</p>

1.0 Evaluation Purpose

The purpose of the evaluation was to assess the relevance and performance of Health Canada's Health Facilities Program (HFP) for the period of 2010/11 to 2014/15.

The evaluation was required in accordance with section 42.1 of the *Financial Administration Act*, which requires that every department shall conduct, every five years, a review of the relevance and effectiveness of each ongoing program of grants and contributions. The Treasury Board of Canada's *Policy on Results (2016)* defines such a review as a form of evaluation. The evaluation has been conducted to provide Health Canada's senior management, central agencies, Ministers, Parliamentarians and Canadians with a credible and neutral assessment of the ongoing relevance and performance (defined in terms of effectiveness, efficiency and economy) of the HFP. More specifically, the evaluation will provide the Deputy Minister of Health Canada, as well as senior management, with reliable information to support decision-making regarding the achievements made by the HFP to provide long-term capital support for First Nations health facilities and associated lands that enable First Nations communities to deliver a variety of health programs and services.

2.0 Program Description

2.1 Program Context

The HFP is an established program administered through the First Nations and Inuit Health Branch (FNIHB) at Health Canada. The HFP administers contribution agreements and direct departmental spending that provide First Nations communities and/or health care providers with the facilities required to safely and efficiently deliver health programs and services. This program directly impacts the working conditions of Health Canada staff engaged in the delivery of health programs and services to First Nations and Inuit.

A 2012 evaluation of the HFP included the activities carried out during fiscal years 2005/2006 to 2009/2010. The evaluation found the Program to be relevant and to have made progress towards the achievement of its immediate and intermediate outcomes. The evaluation provided three recommendations related to data availability for decision-making, project prioritization, and operations and maintenance (O&M) processes. With the exception of the recommendation related to restructuring or replacing the HFP's information management system (Real Property Management Information System), all of the management actions associated with these recommendations have been completed.

2.2 Program Profile

The HFP is designed to enhance the delivery of health programs and services through infrastructure by providing funding to eligible recipients for the construction, acquisition, leasing, expansion and/or renovation of health facilities, as well as security services. These activities provide First Nations, and FNIHB staff with the space required to safely and efficiently deliver health care services in First Nations communities. In addition, preventative and corrective measures are carried out to enable First Nations to improve the working conditions for Health Facilities staff and to maintain or restore compliance with building codes, environmental legislation, and occupational health and safety standards.

The Department uses a variety of Contribution Agreements for the administration and management of First Nations community health programs and services. These agreements vary in terms of level of control, flexibility, authority, reporting requirements and accountability and are categorized by funding model. First Nations communities can decide among the different funding models based on their eligibility, interests, needs and capacity. The funding models are outlined as follows:

- **Set Funding Model** – FNIHB designs the programs. Recipients are generally able to redirect resources within the same sub-sub activity (with the written approval of the Minister). Interim and year-end reports are required. Duration of the agreements is up to three (3) years.
- **Flexible Funding Model** – Recipients must establish a Multi-Year Work Plan, including a health management structure. Recipients generally have the flexibility to reallocate funds within the same Program Authority and are allowed to carry forward program funding (with written approval from the Minister) for reinvestment in the following fiscal year within the same Program Authority. Annual reports, including year-end audit reports, are mandatory. Duration of the agreements is two (2) to five (5) years.
- **Block Funding Model** – Recipients determine their health priorities, prepare a Health Plan (HP) accordingly, and establish their health management structure. Recipients are able to generally reallocate funds across all authorities and are allowed to retain surpluses for reinvestment in priorities (listed in the approved HP). Annual reports and year-end audit reports are mandatory as well as an evaluation report every five (5) years. Duration of agreements is five (5) to ten (10) years.

Health Canada/FNIHB has no ownership or other legal interest in any capital assets (health facilities) funded through the HFP. When Health Canada staff are requested to work in First Nation Health Facilities for the purpose of delivering health programs at the request of the First Nation recipient, the recipient is required as a condition of funding to allow Health Canada to use these facilities free of charge or to enter into agreements to

allow such free use by way of permit or designation under sections 28(2) and 38(2) of the *Indian Act*.

The HFP provides funds to undertake both major and minor capital construction projects. Major capital projects are defined as those that either expand the footprint of an existing building, or create a new or replacement building. Minor capital construction projects are those that do not meet the definition of a major project, and may include projects to update systems in disrepair or at the end of their lifecycles such as replacing roofs, window or door systems. Upper and lower materiality are not considered in the designation of major vs. minor capital projects.

In addition, Health Canada provides funds for the operations and maintenance (O&M) of health facilities. There is also limited, ad-hoc funding for facility operating/maintenance/capital requirements provided via the National Native Alcohol and Drug Abuse Program (NNADAP) and the Aboriginal Head Start on Reserve (AHSOR) program.

Eligible expenditures under the HFP agreements could include: (i) construction, replacement, acquisition, leasing, renovation, repairs or expansion of Health Facilities and associated residences and/or operational buildings; (ii) equipment for the support of health service delivery within the recipient community; (iii) the remediation of environmental and/or Occupational Health & Safety issues associated with the facility. More specifically, this could include salaries, professional and legal fees and disbursements, feasibility studies, surveys, environmental assessments and remediation, architecture and engineering fees, security services, construction materials, supplies, construction equipment rentals, health and other support equipment, transport costs, and security-related equipment necessary to complete the capital activity and/or to maintain the health infrastructure condition in order to support the delivery of health programming efficiently.

There are three types of audits and inspections conducted by the program:

- **Integrated Facility Audits (IFAs)** are coordinated by the national office and the process is focused on auditing the condition and performance of a facility's infrastructure and buildings, and auditing the performance of the facility's operations and maintenance practices. A listing of representative audit criteria is identified in the Integrated Facility Audit Report Template which includes a checklist; however, other regulatory requirements, standards, codes of practice, policies and directives may be used in developing recommendations, whether or not they are identified as audit criteria.
- **Facility Condition Inspection Reports (FCIRs)** focus on evaluating the condition of a facility's infrastructure. They are undertaken through regional offices, either by internal resources or through contracted providers, and do not follow a standard reporting template, nor are the qualifications of the individuals undertaking the inspections consistent across all regions as regional organization

structures and staffing practices vary. As of 2014-15, Facility Condition inspections are conducted on all HFP funded facilities in a three-year cycle.

- **Threat and Risk Assessments (TRAs)**¹. A TRA is a thorough and systematic identification of areas of potential threats in a given set of circumstances, followed by an in-depth analysis of threat possibilities for each identifying the type, degree and likelihood of occurrence. The use of TRAs is determined by the region, but are mostly being conducted in Manitoba and Saskatchewan. The criteria used to determine whether a TRA should be undertaken include Band Council, Branch and/or departmental direction, managerial concerns, complaints from employees or the general public, security-related occurrences, and plans related to the design and/or renovation of health facilities. These assessments are intended to provide some assurance regarding the appropriateness of safeguards present in workplaces not controlled by Health Canada but in which federal employees work (i.e., relevant to personnel working conditions).

Facilities

According to 2015 data provided by the Program (see Table 1), the HFP supports a portfolio of 739 buildings, which include 426 health-related buildings (such as health centers, health offices, health stations, nursing stations, dental annexes, and NNADAP centres), 213 residences, 96 operational buildings (such as garages, storage building, warehouses, offices) and four hospital complexes.^{2,3} It should be noted that the portfolio size for HFP varies according how buildings are counted (e.g., annexes, residences), timeframe, and inclusions/exclusions (e.g., hospitals, on-reserve buildings only, operational buildings such as garages).

Nursing stations are usually located in remote/isolated areas, with no year-round access to other health facilities. Health Stations are found in remote/isolated areas that can be accessed by road or air, with poor road conditions. Health Centres are usually located in non-isolated or semi-isolated areas, where nearest hospital is located less than 350 KM from the service centre. Health Offices are usually located in non-isolated or semi-isolated areas when other health services are available in nearby communities.

The distribution of buildings by type and region is presented in Table 1. Not all types of building designations are found in all regions; for instance, there are no Nursing Stations in Alberta and Atlantic, there are no Health Stations in Quebec, there are no Health Offices in Manitoba, Quebec, and Saskatchewan, and there are no residences in the Atlantic region.

Health services buildings, residences and NNADAP facilities are found in 467 different communities, including 145 communities in Ontario, 94 communities in Saskatchewan, 82 communities in Manitoba, 64 communities in Alberta, 44 communities in Quebec and 38 communities in the Atlantic region.⁴

The distribution of the facility space by region for the 639 health service buildings, residences and NNADAP facilities has Manitoba, Ontario and Saskatchewan each accounting for approximately 20% of the space followed by 17% of the space in Alberta, 14% in Quebec and 7% in the Atlantic region.

Table 1: Health Facilities Program funded building portfolio by building designation and location

Building Designation	Alberta	Atlantic	Manitoba	Ontario	Quebec	Saskatchewan	TOTAL
Nursing Station	-	-	22	19	11	12	64
Health Centre	43	26	10	38	16	68	201
Health Station	2	1	26	44	-	1	74
Health Office	3	9	-	24	-	-	36
Residences^a	25	-	56	46	30	56	213
Dental Annexes^b	-	4	-	-	-	-	4
NNADAP Facilities	16	7	3	7	5	9	47
Subtotal	89	47	117	178	62	146	639
							0
Hospital Complexes	-	-	2	2	-	-	4
Operational Build.	22	-	38	15	7	14	96
TOTAL	111	47	157	195	69	160	739

Source: RPMIS – extraction January 12, 2015.

^a When residence space is attached to health services building, it is captured under the footprint of the building. Therefore, in this count, only stand-alone residences are included.

^b The four dental annexes indicated are attached to community schools in the Atlantic region. Such annexes offer supplemental space to the main health facility in the community and administration of this space is considered to be undertaken by the main facility, and as a result, they are not always considered as stand-alone separate buildings

Governance Structure and Delivery

HFP is managed at the national level through FNIHB's Capacity, Infrastructure and Accountability Division (CIAD). CIAD defines the main objectives of HFP and strategic directions, plays a strong role in allocating funds and monitoring expenditures, and establishes national standards, policies and guidelines for regional and community partners. The CIAD also acts as the secretariat of the Capital Program Review Committee (CPRC). The development of the national level Long-Term Capital Plan (n-LTCP) is under the direction of CIAD. During the period of the evaluation, this process has evolved somewhat from essentially a simple compilation of the regional LTCPs, to more engagement and involvement by national representatives to play a challenge role

in assessing priorities on a national level. CIAD is supported in the regional offices by Corporate Services Branch's (CSB) Regional Real Property Division. CSB is responsible for the IT systems owned by the Real Property and Security Directorate, and FNIHB is responsible for IT systems under its purview.

The CPRC supports the implementation and fulfils an overall monitoring function of the HFP and is composed of representatives from each region, as well as from the Office of Nursing Services, the Community Programs Directorate, the Primary Health Care and Public Health Directorate, FNIHB Financial Services Directorate and Corporate Services Branch.

Capital Allocation and Review Committees (CARCs) are regional committees composed generally of an HFP representative (Chairperson), a Program Medical Officer, Regional Nursing Officer, Resource Management representative and Zone Directors (if applicable). CARC is an advisory body that makes recommendations to the regional executive officer regarding such things as annual capital priorities and the Regional Long Term Capital Plan (r-LTCP). The prioritization process and development of the r-LTCP is conducted through the CARC at the regional level based on criteria forwarded to the regions in the call letters issued by the National office.

FNIHB Regional Directors are involved in the management and delivery of the HFP and contribute significantly to the program being delivered in an effective, efficient manner that supports FNIHB Programming. HFP regional and zone staff, supported by CSB's Regional Real Property Division staff, are responsible for implementing capital contribution agreements, undertaking recipient risk assessments, providing technical advice to recipients, monitoring capital projects and managing capital contributions.

During the period covered by the evaluation, the *Capital Modernization Program Framework Policy* (2011) was introduced to "promote more efficient, systematic and sustainable management of Health Canada funded health facility capital assets in First Nations and Inuit communities based on targets and industrial standards." The Framework Policy was approved in 2011/12 with a two-year implementation target. One of the key principles of the Policy is that 80% of capital investments are to be allocated to minor capital projects.

2.3 Program Logic Model and Narrative

The long-term expected outcome for the Program is safe health facilities that allow First Nations communities to efficiently deliver health programs and services.

There are numerous, outputs, immediate and intermediate outcomes needed to achieve this final outcome. The activities and outputs in the HFP logic model are divided across three areas:

- Policy Development;
- Capacity Building; and

- Data Collection, Monitoring and Analysis for risk based, strategic infrastructure investment planning.

These activities and outputs are expected to contribute to the following outcomes:

Immediate Outcomes

- Guidelines, policies and manuals are updated and implemented in a timely manner;
- First Nations recipients have access to and are aware of the resources available through the Program to increase their capacity;
- Recipients' facility O&M management plans are implemented and facilities conform to applicable regulations, codes and standards; and
- Capital Program funding allocation plans are developed based on the most up-to-date information.

Intermediate Outcomes

- First Nations recipients' technical and administrative capacity to coordinate and sustain facility management activities is enhanced; and
- Funding allocation for the implementation of recapitalization and remedial activities as well as new construction projects is prioritized based on evidence of need leading to risk minimization.

The connection between these outputs and the expected outcomes is depicted in the logic model (see Appendix 1). The evaluation assessed the degree to which the defined outputs were being produced and outcomes were being achieved over the evaluation time frame.

2.4 Program Alignment Architecture and Resources

The HFP is a sub-sub program (3.3.1.3) under Health Canada's Program Alignment Architecture (PAA) Program 3.3: *Health Infrastructure Support for First Nations and Inuit*. The HFP Program supports Health Canada's Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status.

The Program's financial expenditures for the years 2010/2011 through 2014/2015 are presented below (**Table 2**). Overall, the Program expended approximately \$451 million over five years.

Table 2: Program Expenditures by Type – All Sources of Funding (\$M)

Fund Description	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015
<i>FNIHB</i>					
Salaries & Wages	0.8	0.7	0.9	0.8	2.5
Uncontrollable	0.0	0.1	0.0	0.0	0.1
Other Operating	1.4	2.0	7.0	6.0	6.0
Contributions	42.4	42.3	72.6	80.7	71.0
Capital	0.7	0.5	0.2	1.1	0.0
Subtotal	45.2	45.6	80.7	88.6	79.5
<i>Other non-FNIHB sources^a</i>					
Salaries & Wages	1.4	0.9	0.8	0.9	0.0
Uncontrollable	0.0	0.1	0.0	0.0	0.0
Other Operating	1.9	1.0	0.0	0.0	0.0
Contributions	85.7	18.1	0.0	0.0	0.0
Capital	0.6	0.0	0.0	0.0	0.0
Subtotal	89.7	20.0	0.9	0.9	0.0
<i>All sources</i>					
Salaries & Wages	2.1	1.7	1.7	1.6	2.5
Uncontrollable	0.1	0.2	0.0	0.0	0.1
Other Operating	3.3	3.0	7.0	6.0	6.0
Contributions	128.1	60.4	72.6	80.7	71.0
Capital	1.3	0.5	0.2	1.1	0.0
Grand Total	134.8	65.6	81.6	89.5	79.5

Source: CFOB.

^a Funding allocated through Regions and Programs Bureau (RAPB)

Notes: Excludes funding for hospital services. Excludes funding associated with Pacific region. Includes capital expenditures associated with NNADAP program if these are coded as capital. Any NNADAP capital funding that is flowed via O&M or grants and contributions would be excluded from table above.

3.0 Evaluation Description

3.1 Evaluation Scope, Approach and Design

The scope of the evaluation covered the period from April 1, 2010 to March 31, 2015. During the planning process, the evaluation's scope was calibrated in recognition of the following:

- In terms of relevance, the Program has not experienced any major changes in direction since its last evaluation; therefore, the current evaluation provided only an update on the relevance of the Program so as to reduce the level of effort and depth in this area.

- In terms of performance, and in accordance with the BC Tripartite Framework Agreement on First Nations Health Governance and sub-agreements, the evaluation did not include an assessment of any services transferred to the BC First Nations Health Authority on July 2013.

The evaluation issues were aligned with the Treasury Board of Canada's *Policy on Results* (2016)⁵. An outcome-based evaluation approach was implemented for the evaluation to assess the progress made towards the achievement of the expected outcomes and whether there were any unintended consequences. However, due to the procedural nature of the program, many of the outcomes are actually more output in orientation.

The Treasury Board's *Policy on Results* (2016) also guided the identification of the evaluation design and data collection methods so that the evaluation would meet the objectives and requirements of the policy. A non-experimental design was used based on the evaluation matrix document, which detailed the evaluation strategy for this program and provided consistency in the collection of data to support the evaluation. The evaluation followed the *Agreement for FNIHB Departmental Evaluations* developed between the Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), FNIHB, and the Office of Evaluation, Health Canada, and Public Health Agency of Canada, regarding the evaluation of FNIHB programming. As this program focuses on First Nation communities, this includes the AFN having been consulted during the development of the evaluation methodology and provided the opportunity to review and comment on the instruments used in First Nations communities, the preliminary findings, and the evaluation report.

Data for the evaluation was collected using various methods, which included a document review, an administrative data review, key informant interviews, case studies with two First Nations communities that included site visits, mini-case studies that consisted of a more detailed analysis of administrative data, and a systems/process analysis of three other health facilities programs. Data were analysed by triangulating information gathered from the different methods listed above. The use of multiple lines of evidence and triangulation were intended to increase the reliability and credibility of the evaluation findings and conclusions.

For the purposes of the evaluation, the terms "partners" and "stakeholders" are used as follows: Partners are organizations that assist in the implementation of the Program or that have parallel programs that assist with health facilities for the client population or related issues (e.g., Corporate Services Branch, provincial/territorial governments, AFN). Stakeholders are the beneficiaries of the HFP (e.g., recipients of contribution agreements, First Nation communities, individuals).

3.2 Limitations and Mitigation Strategies

Most evaluations face constraints that may have implications for the validity and reliability of evaluation findings and conclusions. The following table outlines the limitations encountered during the implementation of the selected methods for this evaluation. Also noted are the mitigation strategies put in place to ensure that the evaluation findings can be used with confidence to guide program planning and decision making.

Table 3: Limitations, Impacts and Mitigation Strategies

Limitation	Impact	Mitigation Strategy
The evaluation team was unable to conduct a survey of First Nations community representatives as planned due to challenges in obtaining contact information for community representatives.	The perspectives of First Nations clients and community representatives may not be generalizable in the evaluation findings.	The evaluation methods were modified to include a small number of mini-case studies that involved more detailed analyses of administrative data, plans, audits and interviews with community representatives where feasible within the timeframe for the data collection.
Limited program activity, output and performance data is collected or systematically compiled. The data collected and compiled vary considerably across regions.	Analyses at a program level for some indicators are not possible.	Where possible, the evaluation team has attempted to compile data and extract variables from different systems in order to link and analyse.
Financial data for the program obtained from different sources does not necessarily reconcile for some years and areas of expenditures.	Accurate assessment of resource utilization is challenging.	Where CFOB data is available to address specific indicators, the evaluation team has relied on this as the primary source. Subsequent sources are utilized but the challenges are documented along with specific gaps/areas of interpretation.

4.0 Relevance: Issue #1 – Continued Need for Program

There is a need for the Federal Government to continue activities that support the maintenance, construction, acquisition/leasing, expansion and/or renovation of health facilities in First Nations communities. However, there has been a demonstrated gap between need and the resources available for health facilities in First Nations communities.

First Nations health facilities provide the foundation for the delivery of health programs and services in First Nations communities across Canada. The effective delivery of health care in First Nations communities is critical as demonstrated by the disparity between the health status of First Nations people living on-reserve, and the non-Indigenous population of Canada. While the overall design of the HFP is responsive to the needs for First Nations to have safe health facilities to efficiently deliver health programs and services, the actual gap between assessed needs and program funding during the period covered by the evaluation was substantial. To help address this gap, Budget 2016 included additional commitments for improving health facilities in First Nations communities.

The HFP is operating within the context of considerable and continuing health disparities between First Nations people living on-reserve and the non-Indigenous population of Canada. The health-related needs of First Nations people living on-reserve are relatively well-studied and documented, finding significantly poorer overall health for these groups ranging from specific acute disease prevalence rates through to broader measures of social determinants of health at the community level. First Nations people in many communities continue to experience inequitable access to health services for various reasons including geographic challenges (remote, isolated communities with limited services), changes in health systems (e.g., centralization of services), challenges navigating complex health systems, economic barriers and cultural barriers.⁶⁷ These challenges and disparities indicate a strong need for health facilities that can support the delivery of health programs and services in First Nations communities. This need was echoed in the various *Calls to Action* from the Truth and Reconciliation Commission (TRC) (TRC, 2015) by indicating a need for increased funding of Aboriginal health centres.

According to document review, interviews and case studies, the overall design of the HFP is responsive to the needs of First Nations communities, related to equitable access to health services and defining and receiving health services in a culturally safe manner. To respond to the need for equitable access to health services, the HFP is designed to provide First Nations communities with resources (e.g., funds, tools, expert support) that will assist them in constructing and maintaining safe health facilities that are located directly within their communities (access to health services). The HFP is designed to have Health Canada representatives work with First Nations communities

to support communities to conduct functional needs assessments, construct appropriate buildings, and then staff and maintain their own health facilities (define and receive health services in a culturally safe manner).

While the overall design of the HFP was assessed as responsive to the needs of First Nations, the actual gap between assessed needs and program funding during the period covered by the evaluation was substantial. In 2011, program documentation estimated the annual gap in funding to be approximately \$55M. This included an estimated \$30M per year gap in renovation/recapitalization investments, based on a targeted recapitalization rate of approximately 2.5% of inventory replacement value per year (i.e., 2.5% of \$1.2B = \$30M) that is consistent with industry targets, and an estimated annual gap of \$20-\$25M in O&M based on a regional survey, historical data, and surplus investments from FNIHB in this area.⁸ The O&M funding gap is challenging to accurately assess given the limited information on O&M requirements, and the legacy-based approach to funding in this area (e.g., proportions historically allocated by region and in many cases at the community level) rather than based on solid needs assessments. As noted in Table 4, the O&M expenditures have remained relatively constant for the most recent three-year period at approximately \$39M annually.

Table 4: Program Expenditures by Activity – All Sources of Funding (\$M)

	2011-2012	2012-2013	2013-2014	2014-2015
FNIHB				
Capital Investments	14.3	42.0	49.4	38.4
Community Facilities O&M	31.3	38.7	39.2	38.9
Health Facilities - Policy Development & Program Oversight	-	-	-	2.2
Subtotal FNIHB	45.6	80.7	88.6	79.5
Other non-FNIHB funding sources^a	20.0	0.9	0.9	0.0
Total	65.6	81.6	89.5	79.5

Source: CFOB.

^a Funding allocated through Regions and Programs Bureau (RAPB)

Notes: Excludes funding for hospital services. Excludes funding associated with Pacific region. Includes capital expenditures associated with NNADAP program if these are coded as capital. Any NNADAP capital funding that is flowed via O&M or grants and contributions would be excluded from table above

The cumulative impact of the estimated annual gap in funding for renovation/recapitalization of the HFP portfolio was outlined in the long-term capital plan (LTCP) for 2014/15. Based on the LTCP regional and national planning process, the cumulative estimated gap for renovation and recapitalization was \$196M as of 2014 (see Table 5). This figure did not include gaps in O&M as noted above; however, the understanding in managing real property portfolios is that underspending in O&M generally contributes to higher renovation and recapitalization costs through the premature degradation of building systems. The majority of the unfunded projects that were identified were major capital (77%) which is challenging to address within the

Capital Modernization Framework Policy (2011) that intends to allocate only 20% of annual funding to major capital projects.⁹

Table 5: Unfunded capital projects, as of 2014/15 (\$M)

Grand Total as of 2014	
Major	150.7
Minor	44.9
Total	195.6

Source: n-LTCP 2014-15

There are a number of pressures related to the HFP context that are contributing to the funding gap described above. Some of these pressures include the increased number and scope of programs offered by FNIHB within existing facilities, evolving demands and standards for health programming and facilities, population growth and demographic shifts, challenges building in remote areas, and increased costs associated with new technologies, construction, utilities and age of facilities.

According to the case studies and mini-case studies, community representatives perceive that the number of FNIHB initiatives and programs along with their scope has increased substantially over the past decade. It is challenging to determine and trace the actual growth during this period given the changes in reporting structure (e.g., PAA structure change in 2011/12 for DPR reporting), and the establishment of new agreements (BC Tripartite Agreement) which have an impact on how expenditures are coded. Some examples found from recent evaluations are a 25% increase in funding for core FNIHB Mental Wellness Programs from 2010/11 to 2013/14,¹⁰ many of which are delivered through on-reserve health facilities. There was also a 11% increase in funding for FNIHB Home and Community Care Programming from 2009-10 through to 2011-12, with many of these activities being delivered from health facilities within communities. While community representatives considered this growth beneficial, the FNIHB programming does not always come with additional capital funding. This results in considerable strain and challenges for the communities when working out of health facilities that were designed and constructed on average well before this increase, with approximately 84% of the facilities being at least 10 years old. As of 2015, 29% of the building portfolio was between 20 and 29 years of age, 47% is between 10 and 19 years of age, and 16% is less than 10 years old. According to information provided by the program, the average lifecycle of these facilities is in the 25-year range¹¹ compared to the average 35- to 40-year range.¹² This would mean that over half of the facilities are likely coming to the end of their life cycle within the next 10 years. This would require an extensive amount of capital investments in a very short period.

The continued need for the HFP is reflected in the changing population and needs of First Nations communities. According to the National Household Survey (NHS) in 2011, the number of First Nations people increased by 22.9% between 2006 and 2011, compared with 5.2% for the non-Indigenous population. From interviews and case studies it was noted that there is an increased demand for more group rooms, additional

examination rooms, improved IT infrastructure, lab/specimen preparation facilities, traditional healing facilities, and exercise facilities. Health programming needs and associated infrastructure requirements are articulated during health planning and the development of functional plans. For example, one site consulted indicated that prior to the construction of their new health centre, the exercise equipment obtained through a diabetes initiative had to be housed in the primary care waiting room. The growth in programming combined with the growth and changing demographics in communities leads to various challenges including a shortage of overall space available, as well as the optimal functioning of the space to meet changing needs.

Health facility standards have evolved which also impact the pressures on new construction and what is considered adequate with respect to current facilities. As noted in the 2012 FNIHB Strategic Plan there is the intention to work towards harmonization with provincial systems which would include having similar standards to those used by provincial partners. For example, the *Canadian Standards Association Z-8000* that was originally published in 2011 and reaffirmed in 2016 provides the nationally recognized baseline for the design and construction of health care facilities. Program representatives indicated that while the standards are relevant and useful in most cases, they are contributing to greater construction costs, specifically for new builds.

Other pressures noted from the document review and interviews included inflation in construction costs (estimated at approximately 34% increase in costs per m² between 2010-2018), which could impact capital expenditures, and costs in utilities for health facilities (average annual energy rate increase of approximately 6%) which could result in a substantial increase in O&M budgets for remote communities that rely on oil for heating and electricity generation.

To help address this gap, Budget 2016 included commitments for improving health facilities in First Nations communities. As noted in Chapter 3 "A Better Future for Indigenous Peoples" of the 2016 Budget Document *Growing the Middle Class*, health infrastructure on reserve is aging and in some cases is insufficient to meet growing community needs. The budget proposed to invest \$270 million over five years to support the construction, renovation and repair of nursing stations, residences for health care workers, and health offices that provide health information on reserve. This included an allocation of \$82 million in each of 2016-17 and 2017-18 under "Indigenous Peoples – Social Infrastructure" funding.

5.0 Relevance: Issue #2 – Alignment with Government Priorities

The objectives and activities of HFP align with government priorities and departmental strategic outcomes.

Throughout the evaluation period, a number of government commitments have been made related to the health of First Nations communities. In the 2013 Speech from the Throne, *Seizing Canada's Moment: Prosperity and Opportunity in an Uncertain World*, it was noted that "our Government will continue to work in partnership with Aboriginal peoples to create healthy, prosperous, self-sufficient communities" (p. 22). The 2015 Speech from the Throne, *Making Real Change Happen*, noted that "the Government will work co-operatively to implement recommendations of the Truth and Reconciliation Commission of Canada." Under the TRC, there are several relevant *Calls to Action* related to Indigenous health, five of which are directly addressed to the federal government. These relate to the HFP in that many of the services and programs being called for will require the use of health facilities on-reserve.

Key investments in First Nations and Inuit health designed to improve the quality of health services in First Nations communities and continued funding for the HFP were also outlined in the 2011 and 2013 budget speeches, during the period covered by the evaluation. More recently in the 2016 Budget Speech, increased funding levels were allocated to First Nations health facilities on-reserve.

Finally, the HFP aligns with Health Canada's Strategic Outcome #3: *First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status*. The HFP helps to ensure that health facilities in First Nations communities are able to support effective health services and programs.

6.0 Relevance: Issue #3 – Alignment with Federal Roles and Responsibilities

The HFP is aligned with federal roles and responsibilities as established in various policies and authorities.

The previous evaluation noted that the HFP was aligned with federal roles and responsibilities. These roles and responsibilities have not changed substantially during the current evaluation period. Improving the health of Indigenous people is a shared responsibility between federal, provincial/territorial and Indigenous partners and reflects the legacy of historical program and funding decisions by successive governments intended to improve the health of First Nations and Inuit.

The *1979 Indian Health Policy* remains the key policy foundation and is based on the legal authority of the Department of Health Act to preserve and protect the health and wellbeing of Canadians, as well as the Canadian Constitution (section 91.24), treaties and other historical practices. The *1979 Indian Health Policy* aims to improve the health status in First Nations and Inuit communities yet also recognizes the interrelated nature of the Canadian health system. Specifically, pillar four of the Policy states that one of the most significant federal roles in the Canadian health system is public health activities on reserves.

Consistent with the findings from the previous evaluation, this evaluation did not identify overlap between the HFP and other programs or sources of funds for health facilities on-reserve. There are some areas of complementarity where First Nations communities have benefitted from provincial initiatives (e.g., IT infrastructure investments; funding of in-community physicians), or other federal government programs (e.g., e-health, NNADAP); however, these are generally facilitating greater levels of efficiency and economy overall for investments in the communities.

7.0 Performance: Issue #4 – Achievement of Expected Outcomes (Effectiveness)

7.1 Immediate Outcomes

Immediate Outcome #1: Guidelines, policies and manuals are updated and implemented in a timely manner.

The HFP has successfully updated guidelines and policies for recipients during the period covered by the evaluation. There have been some issues related to their dissemination among recipients; however, internal policies and manuals are generally perceived by program representatives as timely and useful, with some specific suggestions for improvement.

The evaluation reviewed in detail three documents (policy, manual and guide) that were identified by program representatives as the key resources that had been developed or updated during the period covered by the evaluation.

- *Capital Modernization Program Framework Policy (2011)*. The Policy's objective is "to promote more efficient, systematic and sustainable management of Health Canada funded health facility capital assets in First Nations and Inuit communities based on targets and industrial standards." The Framework Policy was newly developed and approved in 2011/12 with a two-year implementation target. Implementation of the Policy has been timely with the key principle of 80% of investments being allocated to minor capital projects having been achieved by 2014/15 according to the administrative data review. In addition, findings from interviews and the document review indicated that regional planning and priority

setting for capital investments have been guided by considerations of primary health needs, effective age of health facilities and vulnerability of communities.

- *HFP Property Planning and Management Manual* (2005; 2011). This Manual was originally drafted in 2005 and updated in 2011. The Manual is designed to define, explain, expand and interpret key program, strategic planning and management processes that support recipients in the field of capital investment and management of their local health facilities. The primary audience is Health Canada employees. Very little feedback was received from regional program representatives during interviews on the usefulness of the Manual, and to what extent the updates were timely. Representatives from the national office indicated that aspects of the manual were no longer relevant and would require additional updates, particularly with respect to contracting and integrating aspects of the Modernization Framework.
- *Operations and Maintenance Guide* (2011/12). This guide was developed to introduce the concepts of operations and maintenance within the context of health facilities management, and to outline specific considerations for recipients to consider when developing their facility O&M management plans. To date there has been variable dissemination to recipients across and within regions. According to interviews, there were some concerns with respect to distribution of the Guide within the context of an ongoing O&M funding gap, variable capacity across communities, challenges with its utility for some communities, and inconsistencies across and within regions for O&M inclusions, costs and considerations.

In addition to the guides and manuals that are developed by the national office, interviews with regional representatives indicated that they are involved in developing and disseminating manuals and tools for recipients. Examples included videos, checklists, orientation binders tailored to specific facilities, spreadsheets for budget and expenditure monitoring, O&M planning templates, and various capital project tools. The intended audiences for these vary including health directors, maintenance staff, and band councillors.

Immediate Outcome #2: First Nations recipients have access to and are aware of the resources available through the Program to increase their capacity

The HFP has facilitated First Nations recipients' access to and awareness of tools and training by tailoring program resources to individual community needs. Health Canada representatives did note, however, that the smaller, remote communities tend to face the greatest challenges with respect to increasing their capacity.

Interviews with program representatives indicated that there is no formal capacity building component of the HFP. Rather, capacity building occurs at the regional and local levels primarily through regional staff interactions and liaisons directly with

recipients. The evaluation found numerous examples of manuals and tools that regions had developed and/or tailored for various recipients according to their needs and capacity. In addition, there were numerous examples provided through case studies, mini-case studies and interviews of how regional staff work to build capacity with communities through one-on-one coaching, demonstration of maintenance techniques, various forms of mentoring through the development of capital projects, and hands-on practice with implementing various planning and monitoring tools. In addition, facility audits and inspections were also highlighted by regional representatives as good opportunities to visit and walk through the facilities with recipient staff to identify and discuss O&M issues and how to address them quickly and efficiently. Tailoring resources to the particular needs of each First Nations community is perceived as essential by those working directly with the communities.

One indication of enhanced capacity is the type of agreements that recipients have for their O&M funding arrangements. As illustrated in Table 6, in 2014/2015, there were 280 First Nation bands that had a signed O&M agreement in place. This is a non-unique count given some bands may have two agreements, of different types, in place in the same year. The number of bands with O&M agreements has presented some fluctuation over the evaluation period, from a low of 271 signed agreements in 2010/2011 to a high of 296 signed agreements in 2012/13.¹³ It is noticeable that flexible agreements are the most often used. Approximately two-thirds of agreements each year are using either a Flexible or Block Funding model indicating some level of community capacity.

Table 6: Number of communities with O&M contribution agreements, by type of agreement, as per April 1st of each fiscal year

	2010/11	2011/12	2012/13	2013/14	2014/15	Total
Block	2 (1%)	12 (4%)	29 (10%)	41 (14%)	53 (19%)	137 (10%)
Flexible	163 (60%)	186 (63%)	171 (58%)	161 (56%)	162 (58%)	843 (59%)
Set	87 (32%)	82 (28%)	75 (25%)	70 (24%)	62 (22%)	376 (26%)
Special	19 (6%)	14 (5%)	21 (7%)	17 (6%)	3 (1%)	74 (5%)
Total	271	294	296	289	280	1,430

Source: M CCS

Note: Includes First Nations bands in the MCSS data file that do not have a health facility in the RPMIS.

As previously noted in the evaluation limitations, the planned survey of community representatives was not undertaken due to the challenges involved in developing an adequate survey frame. As a result, there was limited information collected directly from communities as to their level of awareness and assessment of the adequacy of the tools and training available. Information derived from the two case studies and mini-case studies highlight the tailored, one-on-one coaching and support as the key approach to capacity development. This is effective in addressing the considerable variation in capacity among recipients with respect to facilities planning, construction and maintenance. More formal tools, guides and manuals were rarely mentioned during interviews, suggesting limited dissemination and awareness. Although the program currently does not include capacity building as a stated objective, these types of formal tools may be beneficial to the smaller more remote communities that face significant capacity issues.

Immediate Outcome #3: Recipients' facility O&M management plans are implemented and facilities conform to applicable regulations, codes and standards

There remain ongoing challenges with respect to the overall condition and functionality of health facilities in First Nations communities, particularly within the context of increasing costs of maintenance and construction, capacity issues in communities, and changes in types and amounts of health services and programming delivered in communities. The policy of auditing the facilities every five years was not met for all facilities. During the period covered by the evaluation, the program tracked priority issues identified in IFAs, but did not track priority issues for other types of audits and inspections (i.e., TRAs or FCIRs) As of 2015/16, the program has implemented a systematic process for tracking audit and inspection recommendations and follow up.

Recipient O&M management plans

According to interviews, health facility O&M plans vary considerably according to the type of agreement, community capacity and type of facilities. The requirement to create an O&M management plan is tied to the terms and conditions associated with the funding provided to the recipient, determined by the type of contribution agreement (CA) that the community has signed. As previously mentioned, there are three types of funding arrangements based on recipient capacity. Recipients of O&M funding through a Set CA are expected to include an O&M schedule for their facilities in the Program Plan. Recipients of O&M funding through a Flexible CA are expected to identify O&M plans and activities in their Multi-Year Workplan, while those with a Block CA describe their approach in their Community Health Plan. The level of detail for O&M plans vary. The actual development of the CA plans (i.e., Program Plan, Multi-Year Workplan and community Health Plan) is a recipient responsibility and FNIHB's Health Planning and Quality Management Program provides guidance.

The HFP does not systematically compile all O&M plans at a national level. As a result, the evaluators used proxy indications of the extent to which O&M plans had been implemented in the sample of facilities that had been audited through IFAs. Although IFAs do not make specific reference to O&M management plans, it is possible to determine whether a priority issue identified in the audit or inspection is related to O&M. It is expected that if O&M management plans were being followed in a timely fashion, these issues would not have been present.

The following root causes¹⁴ are considered the main reason for non-compliance with O&M plans:

- **Maintenance, Inspection & Testing:** The component or element is not achieving an acceptable level of performance. With minor maintenance, performance can be confirmed, or restored to an acceptable level. Cases where further inspection or testing is recommended are excluded.
- **Management** – performance of the component or element is limited by the operational practices and/or standard operating procedures in place at the facility.
- **Rust-Out:** Due to its condition, the reliability of the component or element cannot be assured. Cases where the problem is due to age are excluded.

Other root causes noted in the IFA template include:

- **Design** – the observed condition is likely a result of the design of the element, or the design of the element is likely to have contributed to the observed condition.
- **Installation/Workmanship** – the component or element is operating at a sub-optimal level and cannot be relied upon to perform according to its design capacity due to improper installation or workmanship.
- **Vandalism** (visible and obvious only, not based on hearsay or comments from onsite staff) – the component or element has been subject to obvious vandalism.
- **Space Planning & Use** – performance of the component or element is constrained by space planning and/or use.

Among those buildings where a critical property issue was identified, O&M related issues (i.e. maintenance, management or rust-out) were identified in 725 cases (76%) (see Table 7).

Table 7: Critical property issues by first determinant

	2010-11	2011-12	2012-13	2013-14	2014-15	Total
O&M Related	-	-	-	-	-	725
Maintenance	10	42	95	78	96	374
Management	17	46	57	100	78	298
Rust-out	1	13	17	13	9	53
Design	24	23	28	25	24	124
Installation	8	15	20	26	6	75
Other	1	-	65	6	3	75
Vandalism	-	4	-	8	2	14
Total	61	143	282	256	218	960

Of the 83 IFAs that were undertaken during the evaluation period, 41% (34) of the IFAs identified at least one priority one issue related to O&M and 95% (79) identified at least one priority two issue related to O&M.¹⁵ This indicates that there are significant issues related to O&M that are translating into code violations as identified through the IFAs.

Facilities conform to applicable regulations, codes and standards

There is considerable variability in how audits and inspections are conducted. With the exception of the IFAs, which have some standardized criteria, other audit and inspection reports reviewed across the regions did not have common criteria, structure or areas of focus. This makes comparison and roll-up of findings and recommendations challenging if not impossible.

When combining all types of audits and inspections (IFAs, FCIRs, TRAs) during the evaluation period, there have been 646 audits and inspections of health services buildings and treatment centres. The diversity in frequency of audits across regions is considerable. Overall, 75% of health service and treatment center facilities (318/422) have been audited or inspected at least once during the evaluation period. Therefore, the policy of auditing the facilities every five years was not met for all facilities. As of 2014/15, HFP policy is for facilities to be inspected on a 3-year cycle.

Out of the 318 facilities audited/inspected, the frequency of the audits is quite diverse. Approximately one half of facilities (49%) were audited once during the evaluation period; 24% were audited twice and 13% were audited 3 times. Approximately 14% were audited four times or more. There were a number of reasons provided by interviewees for the frequency of audits and inspections:

- requests, incidents and follow-ups;
- planning considerations for capital investments and placement on regional LTCP; and,

- extremely limited capacity resulted in some regions focusing on emergencies and high risk facilities/communities (e.g., Ontario, SK). Other regions have a systematic approach to conducting audits and inspection (e.g., Atlantic, Quebec).

The 83 IFAs that were undertaken during the evaluation period were coded to extract the information as to whether regulations, codes and standards were met or not. Overall, 77 out of 83 (93%) audits and inspections identified at least one finding during this period. Of the 1,900 findings found in these audits and inspections, approximately 30% were critical issues (6% priority one and 24% priority two).¹⁶¹⁷ Examples of priority one and two recommendations included missing carbon monoxide detectors, no plans for emergency environmental events, needed repairs to roofing materials, sanitary issues, replacement of soffit vent panels, cracking foundations, shifting structures, fire doors, adequate space in hallways, space definition (confined space) and septic systems.

During the period covered by the evaluation, the program tracked priority issues identified in IFAs, but did not track priority issues for other types of audits and inspections (i.e., TRAs or FCIRs). The program compiled and reported information in two DPRs indicating in 2013-14 that 70 % of "high priority" recommendations stemming from IFAs had been addressed on schedule, while in 2014-15, this dropped to 51%. As of 2015/16, the program has developed a systematic process for tracking audit and inspection recommendations.

The evaluation found a strong link between receipt of minor/major capital funds within a five-year period of an IFA, suggesting that issues raised by an audit or inspection were then later addressed through capital funds. The 24 IFAs that were undertaken in 2010/11 and 2011/12 were selected as a sample to track the extent to which their recommendations from audits were implemented within the evaluation period. The evaluation team focused on an in-depth analysis of IFAs as a more standardized approach to facility audits that could be compiled and compared across years and regions.¹⁸ Most of the communities identified in the sample (20/24) obtained funding via the LTCP process in the three to four years following the IFA, indicating that there is a strong likelihood that recommendations related to capital investments are being addressed, at least in part. Among the four communities that did not obtain capital funding through the LTCP process, three of these had issues that would not have been addressed through capital investments.

Immediate Outcome #4: Capital Program funding allocation plans are developed based on the most up-to-date information.

There are considerable challenges with respect to information systems for the HFP, making it difficult for the program to have access to accurate and up-to-date information to inform funding allocation plans and report on program results.

The Real Property Management Information System (RPMIS) was developed by FNIHB around 2002 to capture specific information relating to FNIHB-funded health

infrastructure being used to support First Nations in delivering federally-supported health programs and services. The information that can be potentially captured in such a system is “an essential component of the programs’ evidence-based approach to strategic and operational planning, reporting and corporate risk management”.¹⁹ The functionality of RPMIS was modelled after conventional building asset management systems of the day, configured to meet specific business requirements arising from the legacy operations of HC’s capital contribution program.

Several basic modules were implemented during the initial development phase. In 2008, the department concluded The Way Forward initiative requiring consolidation and transition of all branch owned Information Technology (IT) personnel and services under the Information Management Services Directorate (IMSD). Consequently, all branch owned IT contracts were cancelled, stopping the transfer of RPMIS support responsibility from the HFP in-house consultant to IMSD from being accomplished. Following the closure of The Way Forward initiative, in 2009, work on RPMIS was not completed as Lotus Notes technology was considered prime for sunsetting as per Government of Canada direction. As a result, the HFP and regional system users’ abilities to fulfil critical reporting, strategic planning and risk management requirements that rely on up-to-date information in the RPMIS remains significantly impaired.²⁰

The HFP is currently developing various options in attempts to address their IT issues. FNIHB has initiated a new investment plan project (currently on department investment plan) that aims to provide a holistic solution per HFP’s critical business requirements (RPMIS High Level Business Requirements Analysis, FNIHB, 2014). HFP is currently collaborating with IMSD to investigate options in attempts to address their IT issues. However, progress has been challenged by the complexity and low priority ranking of the project. As of March 2016, the project was ranked 42 out of 59 on the Health Canada – Shared Services Canada priority list.

Given the challenges with RPMIS, regions have developed various ad hoc data systems ranging from multiple spreadsheets to various types of databases to meet their immediate information needs for managing and delivering the program at the regional level. Nonetheless, interviews with HFP representatives indicated that the limited functionality of the management information system²¹ has presented a considerable challenge for the management of the program on various levels. This included having accurate data to understand the overall condition of the portfolio to support planning, forecasting and investment, to report on program performance, and to follow-up on the implementation of recommendations.

7.2 Intermediate Outcomes

Intermediate Outcome #1: First Nations recipients’ technical and administrative capacity to coordinate and sustain facility management activities is enhanced.

Although there has been some progress towards this outcome, primarily among those communities that are already operating at a relatively higher level of

functionality, there is generally considerable variation in capacity among recipients.

The interviews with regional representatives indicated that there has been some progress in enhancing recipients' technical and administrative capacity to coordinate and sustain facility management activities during the past five years, but that this is considerably more noticeable among those communities that are already operating at a relatively higher level of functionality. There remain particular challenges in observing this outcome among the more vulnerable communities that for various reasons have lower levels of capacity and greater challenges. One case study demonstrated that capacity to coordinate and sustain facility management was greatly increased over a relatively short period (approximately 5 years) with the construction of a new facility under the direction of a highly capable health centre team. Another case study highlighted the gains made by teams and recipients that are already likely rating highly on several community capacity dimensions.

One aspect highlighted throughout the case studies, mini-case studies and interviews was the considerable variation in capacity among recipients with respect to facilities planning, construction and maintenance. Challenges with capacity were noted among the smaller, more remote communities with significant issues related to training and skill levels, and staff retention. Some regional representatives indicated a need for more generalized training for facilities maintenance staff.

Intermediate Outcome #2: Funding allocation for the implementation of recapitalization and remedial activities as well as new construction projects is prioritized based on evidence of need leading to risk minimization.

Regional involvement in the planning and prioritization of funding allocation is a key contributor to ensuring that allocation is based on need and risk minimization considerations. Evidence of need being considered in funding allocation is found in the positive correlation between age of facility and funding amounts.

According to interviews and document review, capital projects are prioritized at the regional level based on assessments of need and vulnerability. The prioritization process and development of the regional LTCP is conducted through the CARC at the regional level based on criteria forwarded to the regions in the call letters issued by the National office. According to interviews with regional representatives, the development of the LTCP at the regional level is appropriate given that those liaising most closely with the communities and directly engaged in the delivery of the HFP are involved in the assessment of priorities. Regions have direct knowledge of communities' needs through ongoing liaison and consultations. According to interviews with national representatives, the development of the national level LTCP has evolved somewhat during the period covered by the evaluation from essentially a simple compilation of the regional LTCPs, to more engagement and involvement by national representatives to play a challenge role in assessing priorities on a national level.

Given that the “effective age²²” for the health facilities could not be calculated, the evaluation used year of construction as a proxy and compared those to funding decisions. Among those communities that receive capital funding, there is a weak positive correlation between the amount of funding provided and the age of the oldest facility. This suggests that funding is being prioritized to some extent according to need as assessed through facilities’ chronic age.

7.3 Longer-Term Outcome

Longer-Term Outcome: Safe health facilities that allow First Nations communities to efficiently deliver health programs and services

Although it is not possible for the evaluation to objectively assess the safety of the health facilities due to a number of gaps in program data collection, the evaluation did find that there remain ongoing challenges with respect to the overall condition and functionality of health facilities in First Nations communities. However, none of the 83 IFAs recommended that a facility be closed, suggesting a certain level of safety and security.

The evaluation is not able to objectively assess the safety of the health facilities due to a number of gaps in program data including: in audits and inspections with approximately one-quarter of facilities not audited or inspected during the evaluation period; audit and inspection recommendations not being consistently compiled across regions; and code/regulation violations identified by audits and inspections not being systematically tracked to determine if and when they have been addressed.

However, as previously mentioned in Section 7.1, the evaluation found that there remain ongoing challenges with respect to the overall condition and functionality of health facilities in First Nations communities. The 83 audits and inspections examined between 2010/11 and 2014/15 identified 1,900 findings of which approximately 30% were critical issues (6% priority one and 24% priority two). Nonetheless, the evaluation did find that none of the 83 IFAs recommended that a facility be closed, suggesting a certain level of safety and security.

Anecdotal evidence from the interviews suggests both improvements to the safety of the health facilities, but also challenges. For example, one interviewee stated that a new health facility built in 2016 improved the privacy of patients by splitting the band office from the health facility. Another interviewee noted that their new facility allowed them to consolidate some of the equipment and supplies (e.g., exercise equipment, homecare equipment and supplies, public health equipment, lab equipment) contributing to better, more efficient service. However, another interviewee described a situation in which their facility hadn’t been renovated in 20 years, which resulted in major flooding due to the roof collapsing, costing approximately \$50,000 in damages. The roof was repaired, but at a higher cost due to the flood. Further, according to the interviewee, the facility’s floor needs to be replaced, the basement is not wheel chair accessible and the kitchen is in poor condition.

The Audit of Physical Security at Health Canada and the Public Health Agency of Canada conducted in September 2016 found physical security vulnerabilities at nursing stations in remote and isolated communities. The management response and action plan associated with the recommendation stemming from this finding has been agreed upon and is now being implemented by the program. Further, as noted throughout the report, there are examples of where the health facilities have facilitated the efficient delivery of health programs and services (new construction providing greater space for services and programming), but also situations with the facilities have made it more difficult to deliver effective health programs and services (limited space requires storing equipment in waiting rooms).

Please see Section 8.0 for an assessment of whether or not the health facilities allow First Nations communities to efficiently deliver health programs and services.

8.0 Performance: Issue #5 – Demonstration of Economy and Efficiency

The evaluation collected information in four main areas in order to assess efficiency and economy²³: (1) program expenditures, (2) efficiencies, (3) comparisons with other programs' systems and processes and (4) performance measurement. These were based on the findings from the document review, administrative data review, systems and process analysis, and key informant interviews.

Several types of financial data were used to inform the analysis of efficiency and economy including: program budget and expenditures, costs associated with building construction and renovation (both planned and actuals), as well as operations and maintenance expenditures (O&M). The source of program budget and expenditures was CFOB, whereas the information on construction and renovations plans were provided by both program headquarters and the regions.

Economy - Program Expenditures and Planning

Significant proportions of the program budget being added late in the year from supplementary funds was noted in interviews as having the potential to lead to the expenditure of resources on capital projects that were “shovel-ready” late in the year, but that may have been lower priority than some projects that required more time for planning and development. Nonetheless, overall the optimal use of resources and planning has been facilitated through regions extensive involvement in the LTCP process.

Although a detailed comparison between budgeted and actual expenditures was not possible with the data provided for the evaluation, from a review of the Departmental Performance Reports (DPRs), over one-half of expenditures are above the amounts

originally planned, with extra funding coming from other unspecified sources. This presented some challenges to the planning and overall economy of the program by having to expend resources at times on capital projects that were “shovel-ready” late in the year, but that may have been lower priority than some projects that required more time for planning and development. Overall, however, planning was found to be enhanced through the extensive involvement of regions in the prioritization process.

The current evaluation was unable to make a direct comparison between annual budgets and expenditures using data sourced from CFOB given the differences in how budgets and expenditures are captured and allocated for the HFP within the financial data systems. According to financial data provided by CFOB for the HFP, the Program expended approximately \$451M from 2010/11 to 2014/15 (see Table 8). According to DPRs reviewed that reported planned and actual spending at the sub-sub Program level (2013/14; 2014/15), significant proportions of the program budget are added late in the year from supplementary funds. Although amounts provided in DPRs cannot be compared directly to the expenditures in Table 8 given the different filters used (e.g., excluding Pacific Region), the data indicates that planned spending can actually be doubled through additional funds received. For example, in 2013/14, the planned spending was \$41.8M but the actual spending ended up being \$103.6M. Similarly, in 2014/15 the planned spending was \$32.3M while the actual spending was more than double at \$79.7M. According to the DPRs, the variance between planned and actual spending is mainly due to additional funding from other sources, such as carry forward in order to make essential and priority capital investments in First Nations and Inuit infrastructure.

Table 8: Health Facilities Program expenditures by region, 2010-11 to 2014-15, \$M, excluding Pacific Region

	ATL	QC	ON	MB	SK	AB	NR	HQ	Total
2010-11	7.43	8.11	26.96	51.86	15.80	24.67	0.00	0.00	134.83
2011-12	5.37	5.73	18.26	11.78	9.81	14.69	0.00	0.00	65.64
2012-13	4.62	7.00	24.70	15.85	11.74	17.17	0.00	0.51	81.59
2013-14	3.98	6.56	26.56	18.91	12.22	20.66	0.00	0.60	89.49
2014-15	3.59	4.34	24.98	26.15	7.90	10.90	0.19	1.47	79.52
Total	24.99	31.74	121.46	124.55	57.47	88.09	0.19	2.58	451.09
Regional Distribution									
2010-11	5.5%	6.0%	20.0%	38.5%	11.7%	18.3%	0.0%	0.0%	100.0%
2011-12	8.2%	8.7%	27.8%	17.9%	14.9%	22.4%	0.0%	0.0%	100.0%
2012-13	5.7%	8.6%	30.3%	19.4%	14.4%	21.0%	0.0%	0.6%	100.0%
2013-14	4.5%	7.3%	29.7%	21.1%	13.6%	23.1%	0.0%	0.7%	100.0%
2014-15	4.5%	5.5%	31.4%	32.9%	9.9%	13.7%	0.2%	1.8%	100.0%

Source: CFOB. Notes: Excludes funding for hospital services. Includes capital expenditures associated with NNADAP program if these are coded as capital. Any NNADAP capital funding that is flown via O&M or G&Cs would be excluded from table above.

Given the high level of demand for capital funding in most regions along with limited resources during the evaluation period, it was perceived as essential to accurately prioritize investments. The one area where a few questions were raised by respondents was with respect to how additional funds that came available later in the fiscal year were allocated. There was some concern that given the challenges that were faced by some communities with respect to capacity to manage capital projects, that despite them having the highest need, they did not necessarily receive the extra funding that was released later in the year. This may have resulted at times with communities that had a strong need with higher priority were passed over at that stage in the year for communities that had projects ready to go, but of lower priority.

According to interviews, the optimal use of resources and planning was directly related to the regions extensive involvement in the LTCP process. Given the high level of demand for capital funding in most regions along with limited resources for investment during the evaluation period, it was generally perceived that the prioritization process was accurate and valid given that those most involved and knowledgeable about the communities were also involved in the development of the regional LTCP. This involvement was characterized as essential to accurately prioritize investments.

Finally, the Capital Program Modernization Framework (CPMF) was introduced in April 2011 with the primary objective to promote more efficient, systematic and sustainable management of Health Canada funded health facility capital assets. Under this framework, priority for new construction, replacement and recapitalization was given to primary health needs, health facilities with the oldest effective age, and the most vulnerable communities. One of the key components of the Framework was to allocate 80% of the capital funds to minor capital and the remaining 20% to major capital projects. Prior to the 2014-15, the planned proportion of funding allocated to minor capital projects ranged from 27% to 66% depending on the year studied. By 2014-15, the HFP met the target outlined in the Framework when the n-LTCP had planned 80% of funding allocated to minor capital projects.²⁴

Efficiencies

The evaluation found various examples where there are program efficiencies. These included ongoing coordination between the program and other federal departments and some provinces/territories to gain efficiencies through collaboration.

From the document review, case studies, systems/process analysis, and interviews, there were a number of examples of how the Program is producing outputs and achieving outcomes in an economical manner. Some of these included:

- Some coordination between the HFP and Indigenous and Northern Affairs Canada (INAC) to gain efficiencies with respect to facility inspections with a pilot project currently underway to undertake joint inspections in some regions. Harmonization of programs with INAC and the provinces were noted as objectives in Health Canada's First Nations and Inuit Health Strategic Plan published in 2012. As well, the INAC-Health Canada Joint Strategic Issues and Opportunities Work Plan 2015-2016 noted three areas for potential joint work related to capital infrastructure: (1) joint inspections; (2) combined circuit rider training program for building maintenance (community and health facilities), and (3) collaborative planning for major projects including aspects such as co-locating dental infrastructure in INAC funding schools in the Atlantic region, and efforts to incorporate AHSOR space in new school constructions in the Saskatchewan region. Collaboration between INAC and HC may occasionally occur at the community level, but there were very few examples of this noted by interviewees. On occasion, there may be some coordination at the community level if there are

capital investments happening by both INAC and HC in a similar timeframe, but this is more information sharing than coordination. It was noted that little new capital investment has been made over the past five years by INAC, thereby limiting the opportunities to collaborate.

- There is variation among the regions with respect to the extent they coordinate and collaborate with provincial governments on health facilities for First Nations communities. The evaluation found various examples of how HFP funded facilities are being designed and supported to accommodate visiting provincially funded physicians and nurse practitioners on-reserve to provide primary care services to the recipient population; although this appears to be coordinated often at a local level (by community) rather than through provincial/federal coordinated initiatives. In the Ontario region the Government of Ontario has a large community health sector, involving just over 900 health service provider organizations. Among these organizations are 10 Aboriginal Health Access Centres providing services both on, close to and off reserve, in urban, rural, and northern locations. The 14 LHINs have the mandate to align and integrate the provision of health services in their catchment areas, across a considerable range of health service providers. Duplication and overlap are thereby minimized. For example, in the 2014-15 Annual Report of the North West LHIN: "The North West LHIN's goal is to work collaboratively with the Aboriginal community and federal and provincial agencies to improve access to culturally-sensitive and culturally-appropriate health care programs and services." North West LHIN officials meet with Health Canada officials with respect to the 72 First Nations communities within the LHIN. In contrast, in Manitoba for those Indigenous communities under the 1964 Memorandum of Agreement, there seems to be limited coordination between Manitoba's Health Capital Planning and the HFP, based on interviewee input. The province provides health and infrastructure services to these communities directly. For example, the province has recently built two dialysis centres and has also upgraded older nursing stations to Indigenous Health Centres.
- A trial initiative is currently underway promoted by HFP in a few regions to cluster various resources related to facility operations and management to then support a group of smaller communities who on their own would be unlikely to have access to the variety and skills of these resources.

Best and Innovative Practices

The evaluation reviewed other capital planning and management programs related to either Indigenous communities and/or health facilities. The aim of this analysis was to identify best practices and innovative approaches to programming in this area, and to then compare and contrast with the HFP to highlight where there were similarities, as well as areas that differed but could be considered by HFP when making program improvements.

The systems/process analysis focused on a small selection of capital infrastructure programs²⁵. The four programs examined included:

- *Indigenous and Northern Affairs Canada (INAC) Capital Facilities and Maintenance Program (CFMP)*. The other main Canadian federal fund for capital infrastructure on First Nations' reserves.
- *Ontario Ministry of Health and Long-Term Care (MOHLTC) Community Infrastructure Renewal Fund (CIRF)*. Funding of 10 Aboriginal Health Access Centres and the role of 14 'Local Health Integration Networks' (LHINs).
- *Manitoba Health – Capital Planning*. A Memorandum of Agreement between the Federal Department of National Health & Welfare and the Manitoba Department of Health that was signed in 1964 to provide health service delivery to Northern First Nations.
- *United States Department of Health & Human Services, Indian Health Service (IHS), Office of Environmental Health & Engineering*. The IHS provides health service delivery for approximately 2.2 million American Indians and Alaska Natives and includes over 650 health facilities.

Methods included a website/document review and interviews with program representatives.

Review of Planning/Priority Setting Processes

Overall, the evaluation found that planning and priority setting among the other programs consisted of nested planning processes that linked to broader planning with considerable input and participation from regions. This is similar to the HFP planning and priority setting process for capital investments. Given the shifts in the role of the national office to playing more of a challenge role combined with explicit call letters as of 2013/14, the LTCP process is quite similar to the other programs. The main characteristics of the other programs' planning priority setting included:

- Nested planning processes and/or policy guidance or priority lists help ensure that capital funding is aligned with broader health and capital plans. Generally, regional plans are guided by and must align with a national master plan that identifies priorities for funding. This is characteristic of HFP as well as through the use of call letters outlining priorities from a national perspective.

- Regional entities/endorsing organizations can be used to assess health infrastructure needs within their catchment areas and endorse/submit capital applications considering the need of and alignment with overall regional health systems. This is characteristic of the HFP use of CARC.
- Headquarters organizations are used to rank applications for capital funding based on need and risk, even if the regional bodies have already provided prioritized projects. This ensures risk assessment and consistent ranking across regions and alignment with national priorities and considerations. This is more characteristic of HFP since 2013/14.
- Priority ranking of infrastructure applications are guided by a national priority ranking framework or standardized criteria/rating scale to promote consistency and transparency. This is an area upon which the HFP is currently working; however, the criteria and rating scales are not yet standardized at the regional and national levels.
- Criteria for prioritizing capital funding included:
 1. Condition of assets and associated risks, emphasizing health and safety – informed from facility audits and inspections
 2. Population needs for health services and programming
 3. Distance to other health services
 4. Patient experience/ delivery of care
 5. Cost saving efficiencies
 6. Alternative funding models
 7. Future growth in demand for health services
 8. Regional/endorsing organization's priorities/input
 9. Post occupancy evaluations are used to inform future facilities/capital planning and design, and improve overall health delivery at facilities.

Review of Governance/ Management Processes

The evaluation found that across the other programs reviewed it was common practice to operate with Investment Management Boards or Advisory Committees that were used to oversee, guide and set standards for capital funding decisions. Management control frameworks were used to provide guidelines for governance, financial management, funding, reporting, risk assessment, and monitoring. This is similar to the implementation of the HFP's CARCs and CPRC and the tools and frameworks used to manage the HFP.

Review of O&M Funding Processes

The review of other programs found that regional entities set specific targets for capital expenditures and O&M to foster adequate maintenance of facilities based on periodic inspections of asset conditions and the population served. Having infrastructure funded through one capital fund with streams that support not only new projects but also asset sustainment and co-location was found to help to ensure the maintenance of existing facilities. A single application process was found to lessen the burden on applicants and allowed for integrated decision-making by the funder on what type of funding is

required. Another finding from the review was that making funding conditional on having accredited facility inspections assisted in focusing resources on the highest O&M needs. With respect to the HFP, the evaluation found that decisions related to allocation of O&M funding vary according to regions, but are largely based on historical allocations. In addition, some regions use a square metre formula, and less frequently allocate based on formally assessed needs. It should be noted that this is not necessarily a result of program design, as funding is provided to the regions for O&M and then they decide how it is to be allocated by community. Some choose to do it historically, others with a formula and a few based on need.

Review of Information Systems

The review found that information systems are used to record infrastructure/facilities information and the results of inspections in a standardized, consistent format for decision-making and reporting. Software-based planning systems are used to determine facility and staff requirements based on community requirements and infrastructure data. Data from these systems can be used to assess risks and set priorities. However, both INAC's Capital Facilities and Maintenance Program and Ontario Ministry of Health and Long Term Care's Community Infrastructure Renewal Fund reported challenges in keeping systems up-to-date. In comparison, the HFP has encountered challenges with the current information systems to monitor and manage the program.

Capacity Building

A few of the programs noted that technical advisory groups, training and mentorship programs were found to help communities and health service providers to conduct inspections, complete plans, submit project applications and business cases, and maximize the use of existing infrastructure.

Performance Measurement

Overall, the evaluation found considerable challenges with respect to performance measurement for the Program.

The RPMIS has limited functionality as a management information system, although planning and the development of options is again underway in an attempt to find a solution that will provide the Program with adequate administrative data that can be used for various management functions. During the period covered by the evaluation, the program collected limited performance information. The program reported on some HFP-specific performance indicators via Health Canada's DPRs in 2013-14 and 2014-15: 1) the percentage of "high priority" recommendations stemming from IFAs that are addressed on schedule; and 2) the number of recipients that have signed contribution agreements that start in 2011-12 or later that have developed plans for managing the operations and maintenance of the Health Infrastructure. For both indicators for these two years, the HFP reported exceeding their targets. In addition, during the evaluation period, HFP reported for five years (2010-11 to 2014-15) via the Departmental

Dashboard on "national percentage of audited health facilities [IFAs] with critical property issues and number of outstanding critical recommendations". In order to report on these indicators, HFP worked with the regions to obtain data based on the IFAs conducted in the regions. However, interviews with regional representatives indicated that during the period covered by the evaluation, they were not directly involved in performance reporting at the national level, but would provide ad hoc reports on an as-requested basis to the national office.

The HFP revised the logic model and PMS in both 2014/15 and 2015/16 to better reflect the Program's activities and associated outputs and outcomes, which also led to revised performance indicators. This review was done in consultation with CFOB and TBS, and the regions were engaged in this process. The Program also developed a systematic process for tracking audit and inspection recommendations in response to an OAG recommendation.

9.0 Conclusions

9.1 Relevance Conclusions

Continued Need

There is a strong need for the Federal Government to continue activities that support the maintenance, construction, acquisition/leasing, expansion and/or renovation of health facilities in First Nations communities. This need results from the continued significant disparity between the health status of First Nations people living on-reserve, and the non-Indigenous population of Canada. A key component needed to assist in eliminating this disparity is the provision of safe health facilities that can contribute to First Nations communities' capacity to efficiently deliver health programs and services, a need that has been highlighted in the recent *Calls to Action* from the TRC.

The overall design of the HFP is responsive to client needs; however, the extent to which this program could respond was hampered considerably during the period covered by the evaluation by the limited funds available to address both O&M and capital demands within First Nations communities related to health facilities. The actual gap between demand for capital funding and program funding during the period covered by the evaluation was substantial. To help address this gap, Budget 2016 included additional commitments for improving health facilities in First Nations communities. In addition to the funding gap, there are number of pressures that challenged the HFP to be responsive to adequately filling gaps during the period covered by the evaluation such as increased number and scope of programs offered by FNIHB within existing facilities, evolving demands and standards for health programming and facilities, population growth and demographic shifts, and increased costs associated with new technologies, construction, and utilities.

Alignment with Government Priorities

The objectives and activities of HFP align with the priorities of both the federal government and Health Canada. During the period covered by the evaluation, the program remained aligned with the priorities as outlined in Speech(es) from the Throne, and in particular the 2015 commitment to close gaps in health outcomes between Indigenous and non-Indigenous communities.

Alignment with Federal Roles and Responsibilities

The previous evaluation noted that the HFP was aligned with federal roles and responsibilities. These roles and responsibilities have not changed substantially during the current evaluation period. The HFP is aligned with federal roles and responsibilities as established in various policies and authorities. There is no evidence of overlap with other programming at either the federal or provincial/territorial levels.

9.2 Performance Conclusions

There has been progress in updating various guidelines and policies during the period covered by the evaluation, although there have been some delays in the dissemination and implementation. Internal policies and manuals are generally perceived by program representatives as timely and useful, with some specific suggestions for improvement.

The HFP has facilitated First Nations recipients' access to and awareness of tools and training largely by tailoring program resources to individual community needs. Tailoring resources to the particular needs of each First Nations community is perceived as essential by those working directly with the communities. Health Canada representatives did note, however, that the smaller, remote communities tend to face the greatest challenges with respect to increasing their capacity with less progress having been made in these communities.

There remain ongoing challenges with respect to the overall condition and functionality of health facilities in First Nations communities, particularly within the context of increasing costs of maintenance and construction, capacity issues in communities, and changes in types and amounts of health services and programming delivered in communities.

- There is considerable variability in how each type of audit and inspection is conducted across the regions. This makes it difficult to compare or roll-up findings and recommendations for a specific type of audit or inspection. With the exception of the Integrated Facility Audits, which have some standardized criteria, other audit and inspection reports reviewed across the regions did not have common criteria, structure or areas of focus.

- A quarter of health facilities did not have an audit or inspection conducted over the five-year period covered by the evaluation. Half of the facilities (51%) were inspected more than once. For most of the period covered by the evaluation, the policy was to inspect facilities every five years. In 2014-15, the HFP developed a policy of a 3-year cycle for facility audits and inspections.
- Of the 83 audits and inspections examined between 2010/11 and 2014/15, 27 (33%) had a priority one issue and 71 (86%) had a priority two issue. Further, of the approximately 1,900 findings found in these audits and inspections, approximately 30% were critical issues (6% priority one and 24% priority two).
- There are significant concerns related to O&M activities for many of the facilities as identified through audits and inspections and the evaluation document review, case studies and interviews. This is likely due to the capacity challenges within some communities, combined with limited funding and aging facilities in relatively harsh conditions.

The planning and prioritization under the long-term capital planning process has effectively prioritized key capital investments during the period, albeit a limited number and scope given the funding limitations. Increased national involvement in this process, combined with extensive involvement by the regions, are highlighted as contributors to success.

There are considerable challenges with respect to information systems for the HFP, making it difficult for the program to have access to accurate and up-to-date information to inform funding allocation plans and report on program results. These are longstanding issues that were also raised by the previous evaluation of the HFP. Given these challenges, regions have developed various tools and systems to meet their immediate information needs for managing and delivering the program at the regional level. FNIHB and CSB are currently developing options to address the IT issues.

Demonstration of Economy and Efficiency

It is challenging to quantitatively assess the overall economy and efficiency of the HFP given issues related to administrative and financial data integrity and availability. There are more qualitative indications that the HFP has demonstrated economy and efficiency through the achievement of the 80% target derived from the Modernization Capital Framework for minor capital investments, the integration of regional involvement in planning contributing to accurate prioritization of investments, and ongoing collaboration and coordination between the HFP and other federal departments and some provinces to gain efficiencies, accommodate other health services and leverage various initiatives. The one area highlighted as a challenge to effective resource utilization was the investments made late in the fiscal year in the HFP that are difficult to plan for and do not necessarily get assigned to the highest priority projects identified during the planning process.

The HFP design and implementation processes are somewhat similar to other capital funding programs from different jurisdictions. There are a few processes identified in other programs that could be further reviewed by the HFP to determine if they would be relevant and useful to enhancing the Program's economy and efficiency, and potentially effectiveness. These were found primarily in the areas of O&M investments, information management systems, and capacity building.

10.0 Recommendations

RECOMMENDATION 1

Health Canada should work with First Nations communities to ensure that FNIHB's policy on the frequency of audits and inspections is implemented as intended (currently, every three years) and that deficiencies related to the health and safety requirements or building codes are systematically tracked and prioritized in the annual capital plans, both regionally and nationally.

The evaluation identified that there are a significant proportion of facilities that are not inspected on a regular basis. During the period covered by the evaluation, the program tracked priority issues identified in IFAs, but did not track priority issues for other types of audits and inspections (i.e., TRAs or FCIRs). The evaluation's review of r-LTCP and n-LTCP during the period covered by the evaluation could not make a direct link between planned investments and addressing the high priority issues identified in audits and inspections. As of 2015/16, the program developed a systematic process for tracking audit and inspection recommendations.

RECOMMENDATION 2

Health Canada should replace its existing management information system for the HFP with one that can provide program-level analyses of activities, outputs and outcomes that can also be accurately linked to expenditure data.

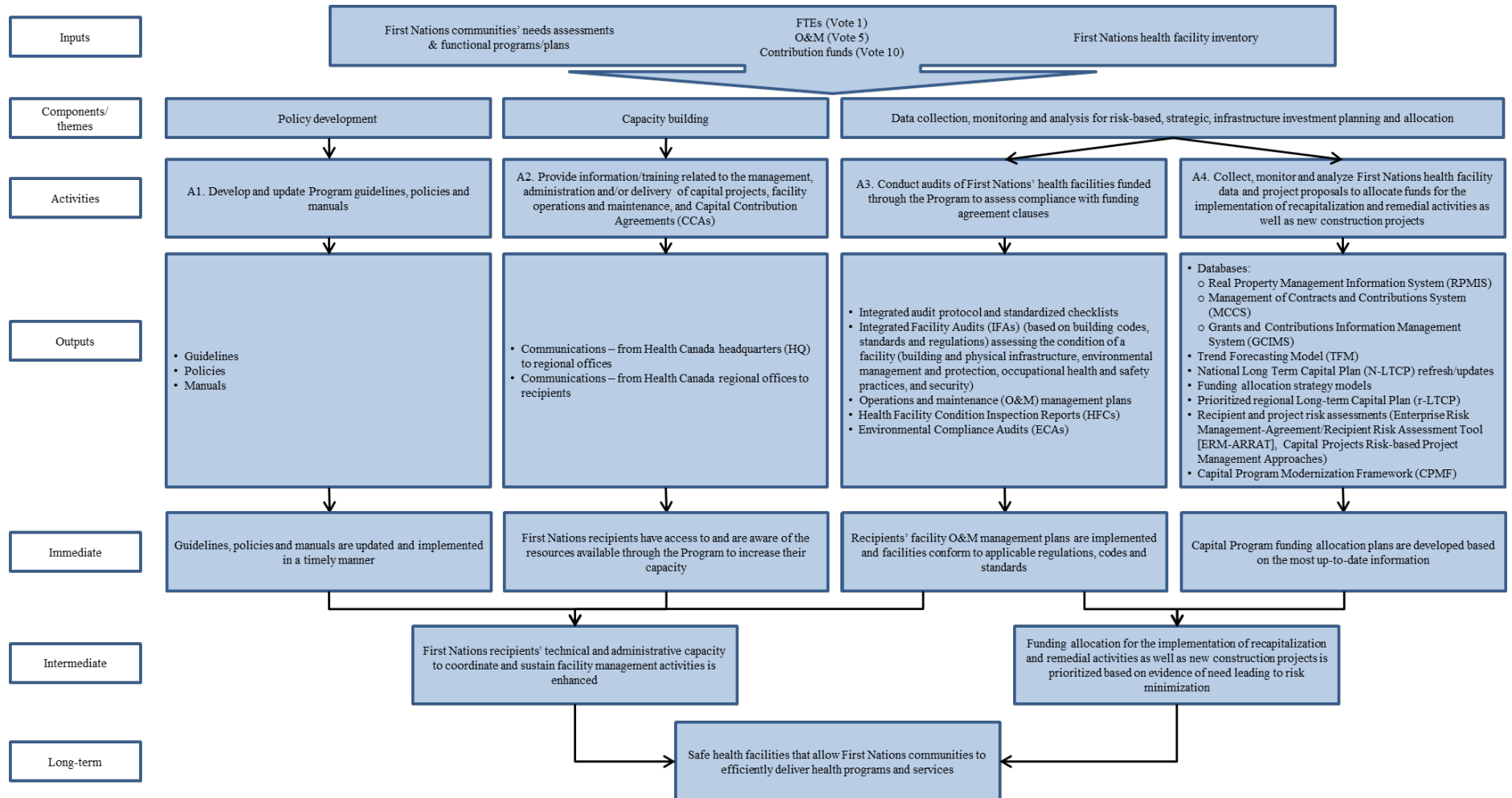
There are significant issues related to the administrative and financial data available for the HFP. There are gaps in administrative information required to manage the portfolio of facilities. Key considerations in improving these systems would be to develop standard key measures for real property management (e.g., effective age, facilities condition index) to assist in the management of the program and decision-making, particularly with the assessment of need, identification of risk, and expenditure forecasting.

RECOMMENDATION 3

Health Canada should increase the level of consistency across regions with respect to a core set of standards related to facility audits and inspections, while continuing to allow for regional flexibility.

This would include standards with respect to inspection criteria, reporting, and data capture for follow-up of recommendations. Consistency in core standards across the regions would allow the program to analyse data at the national level, thus providing HFP with a greater understanding of the program as a whole rather than as individual regions.

Appendix 1 – Logic Model



Appendix 2 – Comparative Capital Infrastructure Programs

The systems/process analysis focused on a small selection of capital infrastructure programs. Methods included a website/document review and interviews with program representatives. The four programs examined included:

- *Indigenous and Northern Affairs Canada (INAC) Capital Facilities and Maintenance Program (CFMP)*. While this fund is focused on community infrastructure, not health infrastructure, it is the main other Canadian federal fund for capital infrastructure on First Nations' reserves and there are opportunities currently being pursued to coordinate and collaborate with HFCP.
- *Ontario Ministry of Health and Long-Term Care (MOHLTC) Community Infrastructure Renewal Fund (CIRF)*. Outside of British Columbia, Ontario has the largest number of First Nations communities of any province. The approach in Ontario includes funding of 10 Aboriginal Health Access Centres and the important role of 14 'Local Health Integration Networks' (LHINs) to assure alignment and integration and avoid duplication among health service providers in their respective catchment areas. .
- *Manitoba Health – Capital Planning*. Manitoba has many First Nations communities and a Memorandum of Agreement between the Federal Department of National Health & Welfare and the Manitoba Department of Health that was signed in 1964 to provide health service delivery to Northern First Nations. Health investments in these communities are made by both federal and/or provincial capital funds.
- *United States Department of Health & Human Services, Indian Health Service (IHS), Office of Environmental Health & Engineering*. The IHS provides health service delivery for approximately 2.2 million American Indians and Alaska Natives and includes over 650 health facilities. The IHS has a similar administrative structure to Health Canada and similar program drivers.

Appendix 3: Summary of Findings

Rating of Findings: Ratings have been provided to indicate the degree to which each evaluation issue and question have been addressed.

Relevance Rating Symbols and Significance: A summary of Relevance ratings is presented in Table 1 below. A description of the Relevance Ratings Symbols and Significance can be found in the Legend.

Table 1: Relevance Rating Symbols and Significance

Questions	Indicators	Overall Rating	Summary
Continued Need for the Program			
Does the Program continue to address a demonstrable need? Is the Program responsive to the needs of its client population?	<ul style="list-style-type: none"> Extent to which Program-funded health facilities meet the identified service delivery needs of First Nations communities served by the Program 	High	<p>There is a strong need for the Federal Government to continue activities that support the maintenance, construction, acquisition/leasing, expansion and/or renovation of health facilities in First Nations communities. This need results from the continued significant disparity between the health status of First Nations people living on-reserve, and the non-Indigenous population of Canada. A key component needed to assist in eliminating this disparity is the provision of safe health facilities that can contribute to First Nations communities' capacity to efficiently deliver health programs and services, a need that has been highlighted in the recent Calls to Action from the TRC.</p> <p>The overall design of the HFP is responsive to client needs; however, the extent to which this program could respond was hampered considerably during the period covered by the evaluation by the limited funds available to address both O&M and capital demands within First Nations communities related to health facilities. The actual gap between demand for capital funding and program funding during the period covered by the evaluation was substantial.</p>
Alignment with Government Priorities			
Is the Program aligned with federal government priorities?	<ul style="list-style-type: none"> Extent to which the Program is aligned with current federal government priorities 	High	<p>The objectives and activities of HFP align with the priorities of both the federal government and Health Canada. During the period covered by the evaluation, the program remained aligned with the priorities as outlined in Speech(es) from the Throne, and in particular the 2015 commitment to close gaps in health outcomes between Indigenous and non-Indigenous communities.</p>
Is the Program aligned with departmental strategic outcomes?	<ul style="list-style-type: none"> Extent to which the Program is aligned with current departmental strategic outcomes 	High	

Questions	Indicators	Overall Rating	Summary
Alignment with Federal Roles and Responsibilities			
Is the Program aligned with federal roles and responsibilities?	<ul style="list-style-type: none"> Extent to which the Program is aligned with federal roles and responsibilities 	High	The previous evaluation noted that the HFP was aligned with federal roles and responsibilities. These roles and responsibilities have not changed substantially during the current evaluation period. The HFP is aligned with federal roles and responsibilities as established in various policies and authorities. There is no evidence of overlap with other programming at either the federal or provincial/territorial levels.

Legend - Relevance Rating Symbols and Significance:

- High There is a demonstrable need for program activities; there is a demonstrated link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are clear.
- Partial There is a partial need for program activities; there is some direct or indirect link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are partially clear.
- Low There is no demonstrable need for program activities; there is no clear link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program have not clearly been articulated.

Performance Rating Symbols and Significance:

A summary of Performance Ratings is presented in Table 2 below. A description of the Performance Ratings Symbols and Significance can be found in the Legend.

Table 2: Performance Rating Symbols and Significance

Questions	Indicators	Overall Rating	Summary
Achievement of Expected Outcomes (Effectiveness)			
Guidelines, policies and manuals are updated and implemented in a timely manner.	<ul style="list-style-type: none"> Number and type of Program tools/training revised/updated and reasons for the revision/update. Time elapsed during the revision/update of Program tools/training and between the revision/update and its sharing with regions. 	Progress Made; Further Work Warranted	There has been progress in updating various guidelines and policies during the period covered by the evaluation, although there have been some delays in the dissemination and implementation. Internal policies and manuals are generally perceived by program representatives as timely and useful, with some specific suggestions for improvement.
First Nations recipients have access to and are aware of the resources available through the Program to increase their capacity.	<ul style="list-style-type: none"> Evidence that Program resources have been disseminated/training provided to Health Canada regional staff and recipients by type of resource/training and type of channel used for dissemination/training. Level of awareness of and access to Program tools/training among Health Canada regional staff and recipients by type of tool/training. 	N/A	The HFP has facilitated First Nations recipients' access to and awareness of tools and training largely by tailoring program resources to individual community needs. Tailoring resources to the particular needs of each First Nations community is perceived as essential by those working directly with the communities. Health Canada representatives did note, however, that the smaller, remote communities tend to face the greatest challenges with respect to increasing their capacity with less progress having been made in these communities.

Questions	Indicators	Overall Rating	Summary
<p>Recipients' facility O&M management plans are implemented and facilities conform to applicable regulations, codes and standards</p>	<ul style="list-style-type: none"> Evidence that health facilities have been audited/inspected according to FNIHB policy/guidelines Extent to which recommendations stemming from audits/inspections have been addressed according to schedule Number and percentage of health facilities audited/inspected by type of health facility that conform to applicable regulations, codes and standards Number and percentage of health facilities audited/inspected by type of health facility in compliance with recipients' O&M management plans and security services schedule 	<p>Progress Made; Further Work Warranted</p>	<p>There remain ongoing challenges with respect to the overall condition and functionality of health facilities in First Nations communities, particularly within the context of increasing costs of maintenance and construction, capacity issues in communities, and changes in types and amounts of health services and programming delivered in communities.</p> <ul style="list-style-type: none"> There is considerable variability in how each type of audit and inspection is conducted across the regions. This makes it difficult to compare or roll-up findings and recommendations for a specific type of audit or inspection. With the exception of the Integrated Facility Audits, which have some standardized criteria, other audit and inspection reports reviewed across the regions did not have common criteria, structure or areas of focus. A quarter of health facilities did not have an audit or inspection conducted over the five-year period covered by the evaluation. Half of the facilities (51%) were inspected more than once. For most of the period covered by the evaluation, the policy was to inspect facilities every five years. In 2014-15, the HFP developed a policy of a 3-year cycle for facility audits and inspections. Of the 83 audits and inspections examined between 2010/11 and 2014/15, 27 (33%) had a priority one issue and 71 (86%) had a priority two issue. Further, of the approximately 1,900 findings found in these audits and inspections, approximately 30% were critical issues (6% priority one and 24% priority two). There are significant concerns related to O&M activities for many of the facilities as identified through audits and inspections and the evaluation document review, case studies and interviews. This is likely due to the capacity challenges within some communities, combined with limited funding and aging facilities in relatively harsh conditions.
<p>Capital Program funding allocation plans are developed based on the most up-to-date information</p>	<ul style="list-style-type: none"> Evidence that information management systems are functional and up-to-date Evidence that Program decision-making tools are developed/updated according to plans and in line with Program requirements 	<p>Little Progress; Priority for Attention</p>	<p>There are considerable challenges with respect to information systems for the HFP, making it difficult for the program to have access to accurate and up-to-date information to inform funding allocation plans and report on program results. These are longstanding issues that were also raised by the previous evaluation of the HFP. Given these challenges, regions have developed various tools and systems to meet their immediate information needs for managing and delivering the program at the regional level. FNIHB and CSB are currently developing options to address the IT issues.</p>
<p>First Nations recipients'</p>	<ul style="list-style-type: none"> Number and percentage of First 	<p>N/A</p>	<p>Although there has been some progress towards this outcome, primarily among</p>

Questions	Indicators	Overall Rating	Summary
<p>technical and administrative capacity to coordinate and sustain facility management activities is enhanced</p>	<p>Nations recipients that have signed CAs and have developed plans for managing the operations of their health infrastructure by type of agreement by type of plan</p> <ul style="list-style-type: none"> Evidence that First Nations recipients use/implement the tools developed by the Program 		<p>those communities that are already operating at a relatively higher level of functionality, there is generally considerable variation in capacity among recipients.</p>
<p>Funding allocation for the implementation of recapitalization and remedial activities as well as new construction projects is prioritized based on evidence of need leading to risk minimization</p>	<ul style="list-style-type: none"> Level of alignment between funding allocation decisions and the goals of giving priority to the most vulnerable First Nations communities, primary health needs and health facilities with the oldest effective age 	<p>Progress Made; Further Work Warranted</p>	<p>The planning and prioritization under the long-term capital planning process has effectively prioritized key capital investments during the period, albeit a limited number and scope given the funding limitations. Increased national involvement in this process, combined with extensive involvement by the regions, are highlighted as contributors to success.</p>
<p>Safe health facilities that allow First Nations communities to efficiently deliver health programs and services</p>	<ul style="list-style-type: none"> Level of impact of facility infrastructure renovation/modernization on health service delivery 	<p>Progress Made; Further Work Warranted</p>	<p>The evaluation is not able to objectively assess the safety of the health facilities due to a number of gaps in program data including: in audits and inspections with approximately one-quarter of facilities not audited or inspected during the evaluation period; audit and inspection recommendations not being consistently compiled across regions; and code/regulation violations identified by audits and inspections not being systematically tracked to determine if and when they have been addressed.</p> <p>However, the evaluation found that there remain ongoing challenges with respect to the overall condition and functionality of health facilities in First Nations communities. Nonetheless, the evaluation did find that none of the 83 IFAs recommended that a facility be closed, suggesting a certain level of safety and security.</p>
<p>Demonstration of Economy and Efficiency</p>			
<p>Is the Program using its existing resources optimally (e.g., funding priorities/greatest risk/need, trends in Facility Condition Index - FCI, effectiveness of planning process, complementarity with other federal programs)? Has the Program produced its outputs and achieved its</p>	<ul style="list-style-type: none"> Evidence that new construction investment decisions are based on an annual prioritization of the N-LTCP with a focus on 20% of funding towards major construction (new, replacement, expansion) and 80% towards minor construction Evidence that the approach to capital planning and capital asset management is harmonized with other federal 	<p>Achieved</p>	<p>It is challenging to quantitatively assess the overall economy and efficiency of the HFP given issues related to administrative and financial data integrity and availability. There are more qualitative indications that the HFP has demonstrated economy and efficiency through the achievement of the 80% target derived from the Modernization Capital Framework for minor capital investments, the integration of regional involvement in planning contributing to accurate prioritization of investments, and ongoing collaboration and coordination between the HFP and other federal departments and some provinces to gain efficiencies, accommodate other health services and leverage various initiatives. The one area highlighted as a challenge to effective resource</p>

Questions	Indicators	Overall Rating	Summary
<p>outcomes in the most economical manner (e.g., minimization of inputs vs. expenditures for economical lifecycle management)? How and in what ways can economy and/or sustainability be improved?</p>	<ul style="list-style-type: none"> departments and provinces/territories Evidence that new technologies, best practices and innovative approaches are considered and integrated into facility management and into capital planning, design and construction processes Number and percentage of health facility projects completed within expected time frames and budget by type of facility 		<p>utilization was the investments made late in the fiscal year in the HFP that are difficult to plan for and do not necessarily get assigned to the highest priority projects identified during the planning process.</p>
<p>Is performance data collected and used for decision-making?</p>	<ul style="list-style-type: none"> Evidence of the development of performance measures (e.g., Performance Measurement Strategies – PMSs), their implementation and data tracking 	<p>Little Progress; Priority for Attention</p>	<p>During the period covered by the evaluation, the program collected limited performance information.</p> <p>The HFP revised the logic model and PMS in both 2014/15 and 2015/16 to better reflect the Program's activities and associated outputs and outcomes, which also led to revised performance indicators. This review was done in consultation with CFOB and TBS, and the regions were engaged in this process. The Program also developed a systematic process for tracking audit and inspection recommendations in response to an OAG recommendation.</p>

Legend - Performance Rating Symbols and Significance:

Achieved	The intended outcomes or goals have been achieved or met.
Progress Made; Further Work Warranted	Considerable progress has been made to meet the intended outcomes or goals, but attention is still needed.
Little Progress; Priority for Attention	Little progress has been made to meet the intended outcomes or goals and attention is needed on a priority basis.

Table 3: Summary of Relevance Ratings

Evaluation Issue	High	Partial	Low
Issue: Continued need for the program			
Does the Program continue to address a demonstrable need? Is the Program responsive to the needs of its client population?	High	N/A	N/A
Issue: Aligned to federal government priorities			
Is the Program aligned with federal government priorities?	High	N/A	N/A
Is the Program aligned with departmental strategic outcomes?	High	N/A	N/A
Issue: Program consistent with federal roles and responsibilities			
Is the Program aligned with federal roles and responsibilities?	High	N/A	N/A

Legend - Relevance Rating Symbols:

- High There is a demonstrable need for program activities; there is a demonstrated link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are clear.
- Partial There is a partial need for program activities; there is some direct or indirect link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program are partially clear.
- Low There is no demonstrable need for program activities; there is no clear link between program objectives and (i) federal government priorities and (ii) departmental strategic outcomes; role and responsibilities for the federal government in delivering the program have not clearly been articulated.

Table 4: Summary of Performance Ratings

Evaluation Issue	Achieved	Progress Made; Further Work Warranted	Little Progress; Priority for Attention
Issue: Achievement of intended outcomes (effectiveness)			
Guidelines, policies and manuals are updated and implemented in a timely manner.	N/A	Progress Made; Further Work Warranted	N/A
First Nations recipients have access to and are aware of the resources available through the Program to increase their capacity.	N/A	N/A	N/A
Recipients' facility O&M management plans are implemented and facilities conform to applicable regulations, codes and standards.	N/A	Progress Made; Further Work Warranted	N/A
Capital Program funding allocation plans are developed based on the most up-to-date information.	N/A	N/A	Little Progress; Priority for Action
First Nations recipients' technical and administrative capacity to coordinate and sustain facility management activities is enhanced.	N/A	N/A	N/A
Funding allocation for the implementation of recapitalization and remedial activities as well as new construction projects is prioritized based on evidence of need leading to risk minimization.	Achieved	N/A	N/A
Safe health facilities that allow First Nations communities to efficiently deliver health programs and services.	N/A	Progress Made; Further Work Warranted	N/A
Issue: Demonstrated economy and efficiency			
Is the Program using its existing resources optimally (e.g., funding priorities/greatest risk/need, trends in Facility Condition Index - FCI, effectiveness of planning process, complementarity with other federal programs)? Has the Program produced its outputs and achieved its outcomes in the most economical manner (e.g., minimization of inputs vs. expenditures for economical lifecycle management)? How and in what ways can economy and/or sustainability be improved?	Achieved	N/A	N/A
Is performance data collected and used for decision-making?	N/A	N/A	Little Progress; Priority for Action

Legend - Performance Rating Symbols and Significance:

Achieved	The intended outcomes or goals have been achieved or met.
Progress Made; Further Work Warranted	Considerable progress has been made to meet the intended outcomes or goals, but attention is still needed.
Little Progress; Priority for Attention	Little progress has been made to meet the intended outcomes or goals and attention is needed on a priority basis.

Endnotes

¹ The term “Threat and Risk Assessment” has very specific meaning in the GOC context – the activities undertaken by FNIHB generally do not meet this definition, as they focus on identifying more operational / tactical physical security issues (e.g. assessment of the physical security attributes of a building – lighting, door locks, circulation patterns, file protection, etc), rather than focusing on documenting attributes of the local threat and risk environment. For this reason, Security Officers prefer using the terms “Security Audit” or “Security Assessment”

² There are discrepancies observed in the size of the facilities portfolio depending on the data source used. Figures used in this report are based on an RPMIS data extraction as of January 12, 2015 that was provided by program representatives, in which a total of 739 buildings was calculated.

³ Hospital complexes include 101 operational buildings, as mentioned in previous note. Program recommendation is to exclude these buildings from the count (and refer to the complexes only) to reduce the risk of over representing the number of facilities. In addition, two of the hospitals are located off reserve (Moose Factory and Norway House) and one is located on reserve (Percy Moore). The former Sioux Lookout complex is located off reserve and no longer provides hospital services. Throughout the analyses in this evaluation, hospitals and operational buildings are generally excluded.

⁴ This is a count of unique community names as entered in the RPMIS. Other analyses in this report use the number of First Nation bands as the unit of analysis to allow for linkages across facility, financial, demographic and audit data.

⁵ Although the planning process for the evaluation was based on the 2009 Evaluation policy, the evaluation also ensured compliance with the new Treasury Board *Policy on Results (2016)*.

⁶ National Collaborating Centre for Aboriginal Health (2013). An Overview of Aboriginal Health in Canada.

⁷ First Nations Information Governance Centre (2012). First Nations Regional Health Survey (RHS) 2008-10: National Report on Adults, Youth and Children Living in First Nations Communities.

⁸ Health Canada (2011) *Capital Program Modernization Framework - Business Planning and Management* Directorate Presentation Deck

⁹ As per the background contained in the Policy (2011), the shift of the capital asset expenditure focus from new construction and facility expansions to repairs, renovation and operations and maintenance was based on an analysis undertaken in 2010. The document indicates that the rationale for this is that investing more in preventive maintenance will minimize the deterioration of existing health care facilities and protect current investments and assets, making more limited funds available for new construction and expansion of facilities.

¹⁰ The funding decreased by approximately 10% in 2014/15, but this was offset to some extent by additional funding for other new initiatives (e.g., Mental Wellness - Public Health Nursing services & Community Health Representatives)

¹¹ 25-years was the average age of HFP buildings replaced under the CEAP investments in 2009-2011. It is not an HFP policy to replace all buildings at 25 years chronological age, nor is it to fund the construction of buildings with design and/or useful life of 25 years.

¹² CSA S478-95 Guideline on Durability in Buildings prescribes a design service life of 50 to 99 years (long life) for most residential, commercial and office buildings and health and educational buildings.

¹³ It should be noted that these numbers refer to the number of agreements, not the number of buildings/facilities. There may be multiple buildings covered under one agreement.

¹⁴ Root causes are defined in a standardized way and are used in all the IFAs to classify the issues identified.

¹⁵ Priority one issues represent a significant threat requiring immediate action. Priority two issues represent a substantial concern requiring action without delay.

¹⁶ Priority one issues represent a significant threat requiring immediate action. Priority two issues represent a substantial concern requiring action without delay.

¹⁷ Building codes apply to the construction of buildings; including extensions, substantial alterations, buildings undergoing a change for occupancy, and upgrading of buildings to remove an unacceptable hazard. Building codes are subject to change, and there is no obligation for buildings constructed according to codes of the day to be retrofitted to meet current codes until new work is done on the facility. This is consistent with industry practice.

¹⁸ It should be noted that the analyses based on the IFAs are not likely representative of inspections and audits across the program, as the selection of facilities to undergo an IFA may introduce certain biases (e.g., facilities with more extensive issues; facilities established as a priority for capital investments, etc.).

¹⁹ RPMIS High Level Business Requirements Analysis, FNIHB, 2014, 4

²⁰ RPMIS High Level Business Requirements Analysis, FNIHB, 2014

²¹ HFP representatives noted that several of the application of the RPMIS are functional; however, in some instances regions have developed unique workflows and processes that are different from those that were standardized in the various RPMIS applications. In other instances, the RPMIS workflow has been identified as cumbersome to use.

²² Effective age is a derived proxy measure of building serviceability. An effective age is calculated as the chronological age of the infrastructure modified to reflect the rejuvenating effects of capital investment over its life.

²³ The Treasury Board of Canada's Policy on Results (2016) and guidance document, *Assessing Program Resource Utilization When Evaluating Federal Programs* (2013), defines the demonstration of economy and efficiency as an assessment of resource utilization in relation to the production of outputs and progress toward expected outcomes. This assessment assumes that departments have standardized performance measurement systems and that financial systems' program cost data and information can be linked to specific inputs, activities, outputs and expected results.

²⁴ Even though these improvements are noted, the analysis of 2014-15 is based on a portion of the LTCP funding (not yet updated), and information on the final full allocation distribution was not identified in the documentation provided.

²⁵ See Annex 5 for a description of these programs.