Evaluation of the Weeneebayko Area Health Integration Framework Agreement (WAHIFA)

Final Evaluation Report

Report Prepared For:

Health Canada

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LIST OF ACRONYMS

AANDC	Aboriginal Affairs and Northern Development Canada
CCAC	Community Care Access Centre
CFI	Child and Family Intervention Services
CNO	Chief Nursing Officer
EMR	Electronic Medical Records
EPR	Emergency Preparedness and Response
EWG	Evaluation Working Group
FNHA	First Nations Health Authority
FNHC	First Nations Health Council
FNHDA	First Nations Health Directors Association
FNIHB	First Nations and Inuit Health Branch
JBAS	James Bay Ambulance Services
JBCMHP	James Bay Community Mental Health Program
JBGH	James Bay General Hospital
KGH	Kingston General Hospital
MCFN	Moose Cree First Nation
MOHLTC	Ontario Ministry of Health and Long Term Care
MTPF	Medical Transportation Policy Framework
NAN	Nishnawbe Aski Nation
NE LHIN	North East Local Health Integration Network
NESGS	North East Specialized Geriatric Services
NIHB	Non-Insured Health Benefits
NNADAP	National Native Alcohol and Drug Abuse Program
OTN	Ontario Telemedicine Network
PHU	Porcupine Health Unit
PSW	Personal Support Worker
RN	Registered Nurse
RPN	Registered Practical Nurse
SLFNHA	Sioux Lookout First Nations Health Authority
SLMHC	Sioux Lookout Meno Ya Win Health Centre
TCFNH	Tripartite Committee on First Nations Health
THP	Traditional Healing Program
UNS	Under or Never Screened
WAHA	Weeneebayko Area Health Authority
WAHIFA	Weeneebayko Area Health Integration Framework Agreement
WGH	Weeneebayko General Hospital

EXECUTIVE SUMMARY

PURPOSE OF THE EVALUATION

The Weeneebayko Area Health Integration Framework Agreement (WAHIFA) was signed by Health Canada, the Ontario Ministry of Health and Long Term Care (MOHLTC), five First Nations communities and the Municipality of Moosonee (which is predominantly First Nations) in 2007 to better integrate federal and provincial health care services in the region. The activities of the WAHIFA are implemented by the Weeneebayko Area Health Authority (WAHA), which was created in October 2010. WAHA provides a range of health care and related services and programming for about 12,000 residents in six James Bay Coastal communities (Peawanuck, Kashechewan, Attawapiskat, Fort Albany, Moosonee and Moose Factory).

This evaluation fulfils a requirement stipulated in the WAHIFA, which requires the parties to evaluate the implementation of the agreement and the effectiveness of the integration every five years. The objective of the evaluation is to determine if the integration is achieving its objectives and goals, identify challenges and recommend areas for improvement. The evaluation covers the activities of WAHIFA for the transition period from October 1, 2010 to March 31, 2015.

EVALUATION METHODOLGY

The evaluation was conducted in three phases. The purpose of Phase I was to develop a detailed work plan which was then implemented in the subsequent phases. Phase II consisted of the following field research:

- An extensive review of the documents and files associated with WAHIFA and activities and programming delivered by WAHA;
- Interviews with 45 key informants including 28 representatives of WAHA, 6 staff members of Health Canada, 4 representatives of NE LHIN and MOHLTC, 3 community leaders such as chiefs and mayors and 4 external stakeholders;
- Site visits and community consultations involving focus groups in five of the WAHIFA communities, visits to health care facilities and service delivery locations and in-person interviews with service delivery staff and community representatives; and
- A literature review of similar initiatives implemented in Canada and interviews with representatives of such initiatives.

In Phase III, we conducted detailed data analysis to answer the evaluation questions and prepared a report of the evaluation findings, conclusions and recommendations.

A limitation of the evaluation is that two lines of evidence are key informant interviews and consultations with First Nation communities. To reduce the effect of respondent biases, the strict confidentiality of responses and design and methodology of the evaluation were clearly communicated to respondents and the answers were cross-checked with findings from other lines of evidence for consistency and validation. It also should be acknowledged that the perspectives and opinions of two First Nations in Moose Factory served by WAHA (Moose Cree and MoCreebec) are not reflected in this report, as the community leadership refused to participate in the evaluation.

The evaluation was implemented in close cooperation and coordination with the Operational Assessment of the Weeneebayko Area Health Authority (WAHA) conducted by the Hay Group. The results of the Operational Assessments were used to confirm and validate some of the findings of the evaluation.

KEY FINDINGS AND CONCLUSIONS

The key findings and conclusions resulting from the evaluation of the WAHIFA are as follows:

1. **The objectives of the Weeneebayko Area Health Integration Framework Agreement (WAHIFA) and the extent to which these objectives have been achieved are perceived differently among the signatories of the agreement.**

   While most key informants (i.e. representatives of WAHA, Health Canada the province of Ontario and the NE LHIN) view the key objective of the Agreement as the amalgamation of the two hospitals — the James Bay General Hospital (JBGH) and the Weeneebayko General Hospital (WGH) — to achieve efficiencies and better coordination, most representatives of the First Nations communities consulted indicated that they signed the Agreement because they were promised improved health care services, a new hospital, and more programming, such as public health and long term care services under First Nations control. While most key informants consider the WAHIFA as somewhat successful in achieving its objectives, First Nations communities indicated that their expectations have not been fulfilled to an adequate level.

2. **Most of the requirements and provisions stipulated in WAHIFA have been implemented. However, significant issues and gaps remain with regard to Public Health, Long Term Care, a hospital funding formula that recognizes the remote location of WAHA, and further integration of the continuum of health care programming in the region.**

   Most stipulated provisions and requirements of WAHIFA have already been implemented; however, significant gaps and issues remain with regard to developing a new hospital funding formula that recognizes the remote northern location of WAHA; delivering long-term care and public health programming; and integrating the continuum of health care programming in the region. In addition, the signing of a Special Act to provide First Nations communities greater control over WAHA was stipulated in the WAHIFA but has not been undertaken by the province and there exist varying perspectives among stakeholders regarding the need for a Special Act.

3. **Some progress has been made in achieving the intended results of the WAHIFA.**

   The results of the evaluation demonstrate that the integration has made some progress in terms of producing the intended results of WAHIFA. In particular, over the past several years, two hospitals (JBGH and WGH) have been amalgamated under one organization, a new health authority governed by First Nations has been created, the internal policies and procedures of both hospitals continue to be integrated, and new consolidated collective agreements have been negotiated and signed. WAHA has also implemented a number of initiatives to improve the quality and accessibility of health care and related programming in the region. Examples of such initiatives include implementation of cancer screening projects, a traditional healing program, telemedicine, geriatric clinics, dialysis clinics, a diabetes program, several public health initiatives, hiring of Cree translators, and joining of the provincial Meditech system to increase the quality of patient data. WAHA has also created a quality improvement department to constantly assess and improve the quality of its services and programming (e.g., through incident reporting and client satisfaction surveys).

   Factors that have contributed to the success of the integration include the endorsement of the Agreement by the communities in the region; the dedication and hard work of many WAHA staff members; the hiring of a more qualified senior team in recent years; the recruitment of staff from the local communities;

increased communication by signatories in recent years; and the joining of WAHA into provincial health care systems, which helped WAHA benefit from provincial benchmarks.

4. **Operating deficits, lack of pre-merger planning and insufficient efforts to build relationships with First Nations communities have limited the achievement of some WAHIFA objectives.**

Due to operating deficits, WAHA has been constrained in its ability to provide a complete continuum of health care programming, such as public health and long term care services under First Nations control. While significant planning has been done, the development of and funding for a new hospital has proceeded slowly. Some pressing gaps in health care programming include lack of access to long-term care services in some communities. As an illustration, elderly patients in Peawanuck, Kashechewan and Attawapiskat are being transported outside of the communities for long-term care, which is traumatizing for both families and the patients.

Some other factors that have constrained the success of WAHIFA include limited pre-merger planning and preparation after signing the WAHIFA agreement (2007) and prior to the amalgamation of the two hospitals (2010); the late formation of a formal body or process to provide oversight and monitor the integration; limited resources allocated to cover the cost of integration and increasing cost of operations (e.g., labour cost and inflation); limited engagement in terms of building relationships with First Nations leaders to create a sense of ownership and support for WAHA by First Nations communities; high staff turnover and difficulties associated with hiring and retaining staff members; aging infrastructure; and region and community specific factors such as remote and isolated locations and limited capacity within the communities.

Despite governance mechanisms and community engagement, WAHA has struggled to establish positive and trusted relationships with the First Nations communities, engage community leaders in programming, and communicate its success and challenges to community members at an adequate level. The evaluation found that there is insufficient awareness of WAHA activities and some dissatisfaction with the implementation of the Agreement by First Nations communities. It is critical that extensive communications and community engagement efforts are undertaken to build relationships between WAHA and First Nations communities in order to increase the degree of support and sense of ownership of WAHA among the First Nations communities. It is also necessary to build these relationships in order to fully achieve WAHIFA objectives and to enable further integration of health care programming in the region.

RECOMMENDATIONS

The key recommendations arising from the evaluation of the WAHIFA are as follows:

1. **Strengthen and formalize the tripartite oversight body to monitor implementation of the requirements and provisions of the WAHIFA, and to support and guide WAHA activities and programming.**

The strengthening of the coordinating and oversight body through a formalized Terms of Reference that stipulates that the tripartite body meet regularly to discuss the implementation of the Agreement and monitor, guide and support activities and programming implemented by WAHA will help to facilitate the successful implementation of the WAHIFA.

2. **Strengthen WAHA's governance structure by involving community leaders and those who have adequate technical expertise in providing health care in the region.**

There is a need for signatories to work with First Nations communities and WAHA to identify opportunities to strengthen WAHA's governance structure. Some options to be considered include the creation of a political support committee involving First Nations leadership in the region; creation of a technical advisory committee that brings together First Nations specialists (Band Health Directors and Community Service Directors with the WAHA Directors) and health care experts from within and outside the region; and strengthening the capacity of First Nations board members to ensure that WAHA activities reflect the priorities of First Nations communities.

3. **Develop and implement a comprehensive communications and community engagement strategy to increase the sense of ownership and support for WAHA within the communities and become more responsive to community needs.**

Developing a communications and engagement strategy to increase awareness of WAHA's activities, programming and accomplishments will help to improve the profile and reputation of the organization; and increase community awareness and support for the accomplishments and activities of WAHA. Listening to community needs and requests and reflecting those needs in WAHA programming and services will help to increase the degree of support and sense of ownership of WAHA by First Nations communities.

4. **Devote efforts to gain a common understanding of the need for a Special Act.**

Starting an immediate dialogue with the communities is necessary to in order to gain a common understanding of the need for the Special Act. Increased understanding of the need for a Special Act will increase community confidence in and support for WAHIFA, and encourage their participation in WAHA activities.

5. **Facilitate the development of a new hospital in the region.**

Expediting the current process of planning and construction of a new hospital in the region and communicating the progress to communities will help to increase satisfaction of the communities with the WAHIFA.

6. **Develop a funding formula that takes into consideration the remote and isolated location of the hospital.**

Working with Health Canada, the province and the NE LHIN to develop a funding model that accurately takes into consideration the location and isolation of the communities and particular difficulties in doing business in the region will help WAHA accurately forecast and budget their resources for effective delivery of its programming and services. The funding formula should also recognize the role and enable WAHA to have sufficient resources to deliver long-term care and public health programming as well as integrate the continuum of health care programming in the region.

7. **Develop strategies to increase staff retention and reduce turnover.**

Working with signatories to develop long-term strategies and effective staff retention approaches will help reduce staff turnover. This should include the hiring of people from the area, when possible. In addition, increasing the level of communication, openness and transparency within WAHA will increase job satisfaction and help to create a more supportive and motivating work environment.

8. **Enhance current efforts of WAHA to deliver culturally safe and appropriate programming.**

Ensuring that First Nations culture and traditions are integrated at all levels of WAHA operations will increase the cultural safety of the services as well as enhance the sense of ownership among First Nations communities. Enhancing the orientation and training program for existing and new staff members will ensure they have an adequate understanding of the First Nations culture and traditions, and deliver culturally appropriate services. Ensuring that WAHA senior management undertake regular consultations with First Nations communities will help gain the trust of community members that culturally safe and appropriate programming is being provided.

9. Further integrate the continuum of health care programming in the region.

The oversight committee should monitor the management of the NIHB programs to ensure greater effectiveness, coordination and integration of NIHB activities associated with administering the programs (e.g., booking appointments, travel arrangements, approvals, etc.) in order to increase the quality of the services that communities receive. Providing culturally sensitive customer service and ensuring all inquiries and requests by clients and communities have properly been handled and complaints and incident reports have effectively been addressed will increase community confidence in WAHA operations and services. Efforts should be devoted to integrating existing health care prevention, promotion and education programming. The cost of the region's health care will continue to rise unless significant efforts are invested to implement integrated and effective health care prevention, promotion and education activities. Increased integration and coordination of the programming by various service providers will also ensure continuity of care for community members. Working with FNIHB, First Nations communities and NE LHIN to better increase community capacity and eventually integrate all public health programming in the region will help to avoid duplication and overlap.

I. INTRODUCTION

This section describes the purpose and background of the evaluation of the Weeneebayko Area Health Integration Framework Agreement (WAHIFA).

A. PURPOSE OF THE EVALUATION

The Weeneebayko Area Health Integration Framework Agreement (WAHIFA) was signed between Health Canada, the Ontario Ministry of Health and Long Term Care (MOHLTC), five First Nations communities and the Municipality of Moosonee in 2007 to better integrate federal and provincial health care services in the region. The activities of the WAHIFA are implemented by the Weeneebayko Area Health Authority (WAHA), which was created in October 2010.

This evaluation fulfils a requirement stipulated in WAHIFA, which requires the parties to evaluate the implementation of the agreement and the effectiveness of the integration every five years. The objective of the evaluation is to determine if the integration is achieving its objectives and goals, identify challenges and recommend areas for improvement. The evaluation covers the activities of WAHIFA for the transition period from October 1, 2010 to March 31, 2015. The findings of the evaluation will provide Health Canada, First Nations and Inuit Health Branch (FNIHB) Ontario Region, the Ministry of Health and Long Term Care (MOHLTC), North East Local Health Integration Network (NE LHIN), and WAHA reliable information to support decision-making based on achievements made to date.

B. STRUCTURE OF THE REPORT

The next chapter outlines the evaluation questions and methodology. Chapter III provides a description of the WAHIFA agreement and WAHA. Chapter IV describes the key findings of the evaluation. Chapter V summarizes the main conclusions and Chapter VI presents recommendations for WAHIFA signatories.

II. EVALUATION METHODOLOGY

This section describes the design and the methodology of the evaluation of WAHIFA.

A. EVALUATION SCOPE

The period covered for this evaluation is from October 1, 2010 to March 31, 2015. The focus of the evaluation is on health care, health centres and hospitals. Ambulance services are excluded. The evaluation was guided by the Evaluation Working Group (EWG) which is comprised of representatives from Health Canada, WAHA, the MOHLTC and the NE LHIN. The EWG is responsible for overseeing the processes leading to the final WAHIFA Implementation Evaluation Report as requested by the senior level WAHA Tripartite Working Group.

B. EVALUATION ISSUES AND QUESTIONS

Based on the review of the WAHIFA files and documents, a set of evaluation questions related to the implementation, effectiveness and design and delivery of the WAHIFA have been developed to help guide this evaluation. These evaluation questions are as follows:

Table 1: List of Related Evaluation Issues and Questions

ISSUES	EVALUATION QUESTIONS
Achievement of Implementation Objectives	**1. To what extent have the requirements and provisions of WAHIFA with regards to the initial integration activities been implemented?** **2. To what extent have the requirements and provisions of WAHIFA with regards to the five-year transition period been implemented?** **3. To what extent have the funding and contribution commitments identified in WAHIFA been implemented?** **4. To what extent have the requirements and provisions of WAHIFA with regards to providing non-insured health benefits (NIHB) been implemented?** **5. To what extent have the requirements of WAHIFA with regards to long-term care been implemented?** 6. **To what extent have the requirements of WAHIFA with regards to the provision of public health services been implemented?**
Demonstration of Effectiveness	**7. To what extent has the integration been effective in achieving its goals and producing expected results, in terms of:** • Enhancing local control of the planning, management and delivery of the Health Care and Related Programs and Services; • Improving coordination of federal and provincial programs and services; • Recognizing the composition, need and population health gaps of the residents of the Weeneebayko Area; • Improving the quality, accessibility, delivery, effectiveness, efficiency and cultural appropriateness of the Health Care and Related Programs and Services for the residents of the Weeneebayko Area; • Improving the utilization of health professionals, facilities and equipment from the federal and provincial systems, reducing duplication and achieving gains in the efficiency of Health Care and Related Programs and Services;

ISSUES	EVALUATION QUESTIONS
	• Promoting ongoing sustainability of the Health Care and Related Programs and Services; and • Providing new opportunities for excellence and innovation. **8. Are there any unintended outcomes, positive or negative, that can be attributed to the activities implemented through WAHIFA?** **9. What are the key factors contributing to the success of the implementation of the WAHIFA? What were the key obstacles and challenges experienced during the integration process?**
Design and Delivery	**10. Are there alternative delivery mechanisms that may produce intended outcomes and results more effectively or efficiently?** **11. What are the opportunities to improve the WAHIFA integration process, delivery mechanism and/or governance structure?** **12. What are the opportunities to further integrate the publicly funded health services in the seven James Bay coastal communities served by WAHA?**

C. DATA COLLECTION

This project was undertaken in two phases. The first phase consisted of initial interviews as well as a file and document review leading to the development of a detailed Evaluation Work Plan and comprehensive Performance Measurement Strategy which outlined the strategies and methodologies which were implemented in the second phase of the project. The field research undertaken in the second phase of the project included:

- **A detailed review of documents and files related to WAHIFA.** A review was conducted which included documents and files demonstrating activities undertaken and outputs and outcomes produced by WAHA such as budgets, strategic and operational plans, audited financial statements, quality improvement plans and results of client satisfaction surveys. In addition, WAHIFA related documents and files produced by North East Local Health Integrated Network (NE LHIN) and Health Canada such as briefing notes, contribution agreements, descriptions of supported projects and initiatives and ministerial audits were reviewed.

- **Interviews with 45 key informants.** We conducted telephone or in-person interviews with 28 representatives of WAHA, including senior and middle management and members of the board; 6 staff members of Health Canada who were involved in the design and delivery of the WAHIFA agreement activities of WAHA; 4 representatives of NE LHIN and MOHLTC; 3 community leaders such as chiefs and mayors; and 4 external stakeholders who are not directly involved in the design and delivery of WAHIFA agreement but have adequate outsider knowledge of the programming implemented by WAHA.

Table 2: List of Key Informants Interviewed

KEY INFORMANTS	# OF INTERVIEWS
WAHA staff, senior and middle management	22
WAHA board members	6
FNIHB staff	6
Representatives NE LHIN or MOHLTC	4
External stakeholders	4
Chiefs or mayors in the communities	3
Total	**45**

- **Site visits and focus group discussions and interviews with community representatives**. As part of the field research, site visits were organized to the region which included focus group discussions with community members, tour of community health facilities and in-person interviews with chiefs, staff members at health facilities, and other community stakeholders. As demonstrated in the following table, of the seven communities covered under the scope of this evaluation, consultations were conducted with representatives of five communities. Two communities declined to participate in the evaluation.

Table 3: Community Consultations

KEY INFORMANTS	CONSULTATIONS
Fort Albany	• Focus group discussion involving community representatives including the chief, members of the council and other community representatives; • In-person interviews with the chief and several community representatives; • Tour of the community and the hospital, observations and in-person interviews with 2 staff members at the clinic.
Kashechewan	• Focus group discussion involving community representatives including the chief and members of the council; • In-person interview with the chief and several community representatives; • Tour of the community and the nursing station administered by Health Canada, observations and in-person interviews with 2 staff members at the station.
Town of Moosonee	• Focus group discussion involving community representatives including the chief and members of the council and other members of the community; • Tour of the community and the health clinic, observations and in-person interviews with 3 staff members at the clinic.
Attawapiskat	• Focus group discussion involving community representatives including members of the council and other community representatives; • Tour of the community and the hospital and health clinic in the community.
Weenusk (Peawanuk)	• Focus group discussion involving community representatives including members of the council and other members of the community; • Tour of the community and the nursing station run by Health Canada, observations and in-person interviews with 3 staff members at the station.
Moose Cree	• The community declined to participate in the evaluation. • A tour of the community and the community health facilities was conducted as part of the trip.
MoCreebec	• The community declined to participate in the evaluation. • A tour of the community and the community health facilities was conducted as part of the trip.

- **Literature review and a review of similar programs.** This evaluation methodology was not included in the initial design of the evaluation; however, it became necessary in order to identify alternative options for the design and delivery of WAHA operations. As part of this methodology, we conducted a review of First Nations health authorities created in Canada as well as 6 in-person and phone interviews with representatives of such organizations.

The evaluation was implemented in close cooperation and coordination with the Operational Assessment of the Weeneebayko Area Health Authority (WAHA) conducted by the Hay Group. The results of the Operational Assessments were used to confirm and validate some of the findings of the evaluation.

D. DATA ANALYSIS AND REPORTING

The data from each of the evaluation methodologies were summarized to address each of the relevant evaluation issues/questions. The data analysis strategy included the triangulation of multiple lines of evidence. This involved the extraction of the results from each line of inquiry that related to each evaluation issue and cross validation of the findings. As part of this step, we took into account the strengths and limitations of each line of inquiry.

E. DATA RELIABILITY AND LIMITATIONS

The main strategy to achieve high reliability of the findings has been the inclusion of ***multiple lines of evidence*** in the methodology. Interviews were conducted with a large sample of respondents who represent a broad range of WAHIFA participants and stakeholders. In addition, an extensive literature and document review was conducted. Each key finding reported and/or conclusion presented in this report has been triangulated and confirmed from two or more lines of evidence to ensure reliability. Second, larger sample sizes were targeted for all interviews to increase the reliability and validity of findings. The key informant interview sample included almost all representatives of Health Canada and NE LHIN who were involved in the design and delivery of the WAHIFA and our interviews with WAHA staff included most of the senior and middle management of the organization.

Despite these steps, it is important to acknowledge certain limitations. The main limitation is the potential for respondent biases. For example, many of the respondents are employed and/or are direct beneficiaries of WAHIFA, which can lead to possible biases in their responses. Several measures were implemented in order to reduce the effect of respondent biases: (i) communicated the purpose of this evaluation, its design and methodology, and strict confidentiality of responses clearly to respondents; (ii) the interviews were conducted by skilled interviewers; and (iii) we cross-checked answers from each sample of respondents with the other groups for consistency and validation. It also should be acknowledged that the perspectives and opinions of two First Nations communities in Moose Factory served by WAHA (Moose Cree and MoCreebec) are not reflected in this report, as the community leadership refused to participate in the evaluation.

We used a culturally sensitive evaluation approach to increase participation by First Nations communities and obtain their perspective. Our approach included using team members who have extensive experience working with Aboriginal people in Canada, engaging community leadership (e.g., sending formal invitation letters, obtaining formal approvals, communicating directly and providing proper explanation of assignment), providing Cree translation during each visit, refining the evaluation and data collection methodologies jointly with the communities during each site visit, addressing the privacy and confidentiality concerns of participants, and providing incentives (e.g., food and refreshments) to encourage participation.

III. DESCRIPTION OF THE WAHIFA AND WAHA

This chapter provides a detailed description of the Weeneebayko Area Health Integration Framework Agreement (WAHIFA) and the activities and programming implemented by the Weeneebayko Area Health Authority (WAHA).

A. BACKGROUND

On August 31, 2007, Health Canada, the Ministry of Health and Long Term Care (MOHLTC), the Municipality of Moosonee and five First Nations communities located in James Bay Coastal communities (Attawapiskat, Fort Albany, Kashechewan, MoCreebec, and Weenusk) and the Municipality of Moosonee, signed the Weeneebayko Area Health Integration Framework Agreement (WAHIFA), which created the Weeneebayko Area Health Authority (WAHA) on October 1, 2010, to operate integrated services through the amalgamation of federal and provincial hospitals in the area.

The WAHIFA goals for integration were to:

- Enhance local control of the planning, management and delivery of the Health Care and Related Programs and Services in a manner that:
  - ✓ Allows better coordination of federal and provincial programs and services;
  - ✓ Recognizes the composition, needs and population health gaps of the residents of the Weeneebayko Area; and
  - ✓ Improves the quality, accessibility, delivery, effectiveness, efficiency and cultural appropriateness of Health Care and Related Programs and Services for the residents of the Weeneebayko Area.
- Improve the utilization of health professionals, facilities and equipment from the federal and provincial systems, reduce duplication, and achieve gains in the efficiency of Health Care and Related Programs and Services.
- Promote the on-going sustainability of the Health Care and Related Programs and Services.
- Provide new opportunities for excellence and innovation.

WAHA's vision is to distinguish itself as a provider of quality health services with a holistic approach that reflects the distinct needs of all peoples in the Weeneebayko region. The mission of the organization is to become a regional, community-focused organization committed to providing optimum health care as close to home as possible.

WAHA's values include:

- Commitment to promoting healthier lifestyles while continuing to improve the holistic, lifelong wellbeing of all peoples in the Weeneebayko area;
- Supporting families and communities through health education, advocacy and Cree language services; and
- Commitment to providing high-quality health services, including a traditional healing program and cultural healing methods.

B. DESIGN AND SERVICE DELIVERY

1. Service Delivery Structure

WAHA provides health care services within the six predominantly First Nations communities. The figure on page 11 depicts the WAHA service delivery structure. The types of services provided by WAHA are summarized below:

Out-Patient Services

WAHA provides a range of out-patient services, including:

- *Aging at Home-Regional Discharge Planning Program*, which works in collaboration with the health care team, patients and families to help patients return home or get to other care facilities more suited to their needs. Other regional services and resources include an Equipment Loan Program (e.g., grab bars for the bathroom), Patient Navigator services (e.g., translation support, referral to community services, advocacy for clients who are elders), and a Foot Care Nurse who outreaches to the coastal communities and conducts foot care clinics.

- *Family Medicine.* Individuals with non-emergency medical conditions or who are seeking information are able to book an appointment and receive medical assistance at a clinic in all seven WAHA communities including the Weeneebayko General Hospital (WGH) Family Medicine Clinic; Moosonee Health Clinic; Fort Albany Site Open Clinic; Attawapiskat Site Walk-In Clinic, Kashechewan Nursing Station; and Peawanuck Nursing Station.

- *Telemedicine.* A two-way video conferencing tool that allows patients to speak to a physician without the need to travel. This service provides supplementary care to patients when an in-person visit is not possible or required. Telemedicine is offered in all seven WAHA communities through the Ontario Telemedicine Network (OTN). The use of OTN for video assessments of patients has increased dramatically over the past years. This allows WAHA's professionals, including physicians, therapists, dieticians, etc. in one community, to manage patients in the other communities.

- *Dental Care Services* include a full range of dental treatments such as hygiene (cleaning), fillings, root canals, prostho (dentures, hockey mouthguards, night guards), perio surgery (gum surgery), extraction (tooth removal), as well as preventative tips for keeping teeth and gums healthy. WAHA's Dental Services are affiliated with the University of Toronto, University of Western Ontario and Mount Sinai Hospital.

- *Diabetes Program.* A community-based Diabetes Health Education Program that assists people of all ages with the treatment and management of diabetes. Services provided include diabetes information and education; diet education; managing diabetes - on-going support and assistance; understanding diabetes treatment options; specialty services such as chiropody, ophthalmology & pediatric diabetes treatment.

- *Rehabilitation Services.* Physiotherapy and occupational therapy services offered to in-patients and out-patients through the Rehabilitation Services Department at Weeneebayko General Hospital. Home visits are also conducted in all communities serviced by WAHA (every 4 months in Moose Factory, Moosonee, Fort Albany, Attawapiskat, and Kashechewan, and once a year in Peawanuck.)

- *Diagnostic Imaging.* WAHA's main Diagnostic Imaging Department is located in WGH in Moose Factory and services the whole WAHA region. Services provided include General Radiography (X-Rays); Fluoroscopy (Live Videoing); Ultrasonography (Ultrasounds); Digital Mammography (Mammograms); Diagnostic Mammograms – OBSP (50 years of age and able to self-refer); ECG & Halter Monitoring (Heart Tests); and PACS System (Computerized X-Rays). Basic x-ray capacity is provided in most Coastal Communities.

- *Specialty Clinics.* WAHA holds multiple specialty clinics throughout the year. These specialty clinics at WGH are staffed by consultants, many of whom have an affiliation with Queen's University School of Medicine. WAHA Specialty Clinics provide access to specialist services to all communities in the region. The services provided in specialty clinics include:

    - Internal Medicine
    - Obstetrics and Gynaecology
    - Cardiology
    - Neurology
    - Colposcopy
    - ENT (Ear, nose, throat)
    - EchoCardiology
    - Nephrology
    - Spirometry
    - Diabetic Retinal Screening
    - Psychiatry
    - Pediatric Cardiology
    - Rheumatology
    - Orthopaedics
    - Pediatric Endocrinology
    - Urogynecology
    - Urology
    - Audiology
    - Pediatrics
    - Developmental Pediatrics
    - Ophthalmology

    The specialty clinics can also be accessed through the Telemedicine services.

- *Community Mental Health.* The James Bay Community Mental Health Program (JBCMHP) provides comprehensive mental health services in all WAHA communities. Services provided include access to community counselors, a psychiatric clinic nurse and a range of other mental health professionals (Regional Clinical Worker, Regional Crisis Intervention/Early Episode Clinician, Regional Court Worker/Case Manager, Concurrent Disorder Worker). The JBCMHP works in collaboration with Sagashtawao Healing Lodge in Moosonee, a drug and alcohol treatment centre serving the entire WAHA region, and the Traditional Healing Program. Psychiatrist services are offered through monthly community clinics (twice a year in Peawanuck) and Telemedicine services.

- *Dialysis services* are provided by WAHA's Dialysis Department located in the WGH, Moose Factory.

Inpatient Services

WAHA inpatient services are provided through three inpatient departments, including the Weeneebayko General Hospital (WGH), Fort Albany and Attawapiskat hospitals. The services include:

- Acute Care (obstetrics, medical/surgery services, pediatrics, palliative care, Special Care Unit);
- Patient Transfer to WGH in Moose Factory, Kingston General Hospital, and Timmins District Hospital;
- Diagnostic Imaging; and
- Coordination of Care with social services, rehabilitation services, diabetes program, home care, and community mental health services.

In addition, WAHA has an Inpatient Pharmacy, which is located within WGH in Moose Factory and provides prescriptions for all patients that become inpatients at WGH, Fort Albany or Attawapiskat Hospitals.

Patients at hospitals are also eligible to receive social services. WGH's Social Services Department provides support for inpatients and their families during their stay at WGH. Some of the services provided include: visits with the patients, patient activities, liaison services between patient and staff, translation services, discharge planning, requesting letter from physicians, assistance with completion of application forms, arranging pastors/ministers visits, and arranging legal services.

Traditional Healing Program

The Traditional Healing Program (THP) exists to support WAHA community members and their families, with emphasis on serving those who are surviving residential school members, or family members of survivors. The THP offers a variety of services with traditional and cultural healing options, focusing on the mind, body, and spirit of the person. Key programs and services include counseling for individuals, youth, couples, families and community groups; counseling services for addictions, grief, sense of cultural loss, personal crisis situations and suicidal ideations; healing for residential school survivors and family members; ceremonies such as rites of passage, sweat lodges, shake tents and seasonal ceremonies; and traditional Cree knowledge recovery through traditional medicines.

Non-Insured Health Benefits

The Non-Insured Health Benefits (NIHB) program provides transportation benefits for eligible clients when they are not otherwise available on reserve or in the community of residence. In the WAHA region, transportation assistance is provided when a physician medically refers an individual elsewhere for treatment. Transportation arrangements are coordinated between Weeneebayko Patient Services in Kingston, Health Canada, and WAHA NIHB in Moosonee. Client eligibility (Indian Status) is determined by Aboriginal Affairs and Northern Developments Canada.

In 2013, at WAHA's request, the administrative model for the delivery of NIHB Medical Transportation in the WAHA area was transferred back to Health Canada to assume a greater role in the delivery of their program. Health Canada developed a direct billing relationship with most commercial vendors involved in the provision of medical transportation services while WAHA retained responsibility for air charter services and local medical travel and two boarding homes (Moosonee and Timmins).

Ambulance Services

Weeneebayko Paramedic Services provides pre-hospital care in five of the six WAHA communities, as well as provide support services for Peawanuck's First Responder Team. The administration office of Weeneebayko Paramedic Services is located in Moosonee and it is fully accredited with Ontario's Ministry of Health Emergency Services.

Laboratory

WAHA's Laboratory Services operates one main laboratory Weeneebayko General Hospital (WGH), and 3 satellite laboratories at Fort Albany Hospital, Attawapiskat Hospital, and the Moosonee Health Centre. The satellite laboratories collect samples and do necessary preparation work prior to transporting to WGH where samples are processed or redirected to appropriate specialty labs. The main laboratory at WGH provides standard and specialized testing services, as well as referrals to Timmins District Hospital, Kingston General Hospital or Timmins Public Health for specialized chemistry, hematology, biopsies, gen microbiology, and virology tests.

Corporate and Support Services

The Support Services Department provides non-medical services that include: maintenance/operations of facilities, housekeeping, laundry, dietary (patient meals), reprocessing and medical devices (cleaning and sterilizing medical equipment), IT support (data and communication needs), material management (ensuring adequate supplies at each facility), housing (for out of town staff/locums), capital planning, and projects and equipment (funding and planning to purchase /construct facilities and equipment).

Emergency Room

Emergency room services are available in all WAHA communities. The emergency rooms provide year-round, 24 hour emergency care and are staffed by qualified medical personnel. They provide comprehensive services treating people who require urgent care. Emergency room medical staff also uses WAHA's telemedicine services to consult with an emergency doctor to assess whether a patient needs to be transported to WGH, Timmins District Hospital (TDH), or Kingston General Hospital (KGH).

Operating Room

Surgical consultations and procedures are provided to all of WAHA's coastal communities including Moosonee/Moose Factory from WGH. The services include one major and one minor operating room within WGH, a weekly surgical clinic in Moosonee and periodic surgical visits to the remote communities for consultations and follow-up.

Cancer Care Project

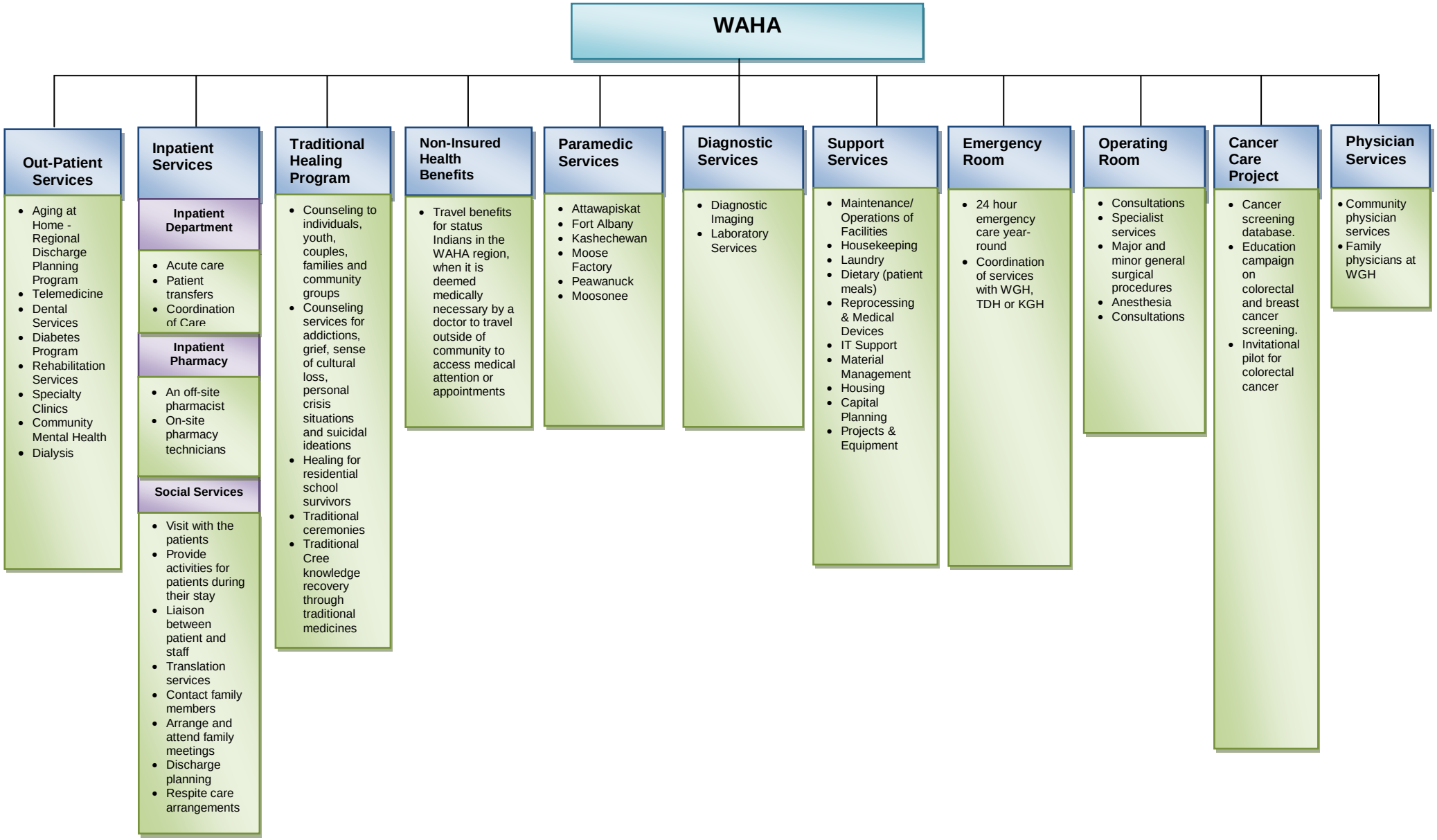
Aboriginal populations are over-represented in cancer under or never screened (UNS) populations. The focus of the WAHA Under/Never Screened Cancer Pilot Project is to increase colorectal and breast cancer screening within select Aboriginal populations in Northeast Ontario. To administer the pilot project, WAHA is working in partnership with the North East Cancer Centre in Sudbury and a number of community partners including WAHA, the Wikwemikong Health Centre, Mnaamodzawin Health Services, M'Chigeeng Health Services, Noojmowin Teg Health Centre, Mamamweswen/North Shore Tribal Council Health Services, and N'Mninoeyaa Aboriginal Health Access Centre. The objectives of the project are:

- To engage in chart audits to establish a screening eligible database for the region;
- To reach out to communities to build relationships/partnerships to assist in educating the population about breast and colorectal screening;
- To educate healthcare practitioners about provincial cancer screening guidelines; and
- To develop a culturally safe and relevant cancer awareness campaign in order to increase awareness about breast and colorectal cancer.

Physician Services

WAHA also provides the services of physicians for all seven communities covered by WAHA programming. Family physicians provide hospitalist, obstetric, emergency medicine, and primary care. When fully staffed, WAHA has 12 FTE Family Physicians, and always has one surgeon and one anaesthetist on duty 24/7.

Figure 1: Design of the WAHA Service Delivery



C. TARGET GROUPS

WAHA services a total 12,000 First Nations people living in six communities across the James Bay coastal area. The communities are located in remote and isolated regions, and most have no road access. The size and existing health care capacity varies greatly across communities.

D. GOVERNANCE STRUCTURE

WAHA is governed by 12 voting Board Members comprised of two First Nations representatives from each of the six signatory communities. There are also 4 ex-officio non-voting Board Members. Community representatives are appointed by their respective Chiefs, Mayor and Councils. As per By-Laws and Legislation, the 4 Ex-Officio Board Members include the Chief of Staff, President of the Medical Staff, WAHA CEO, and VP Patient Care/CNE. In late 2014, the 2 representatives from Kashechewan were removed from the WAHA board following a decision by the Kashechewan Chief and Council. The following table provides the names and positions of board members for the 2015/16 fiscal year.

Table 4: WAHA Board Members, 2015/16

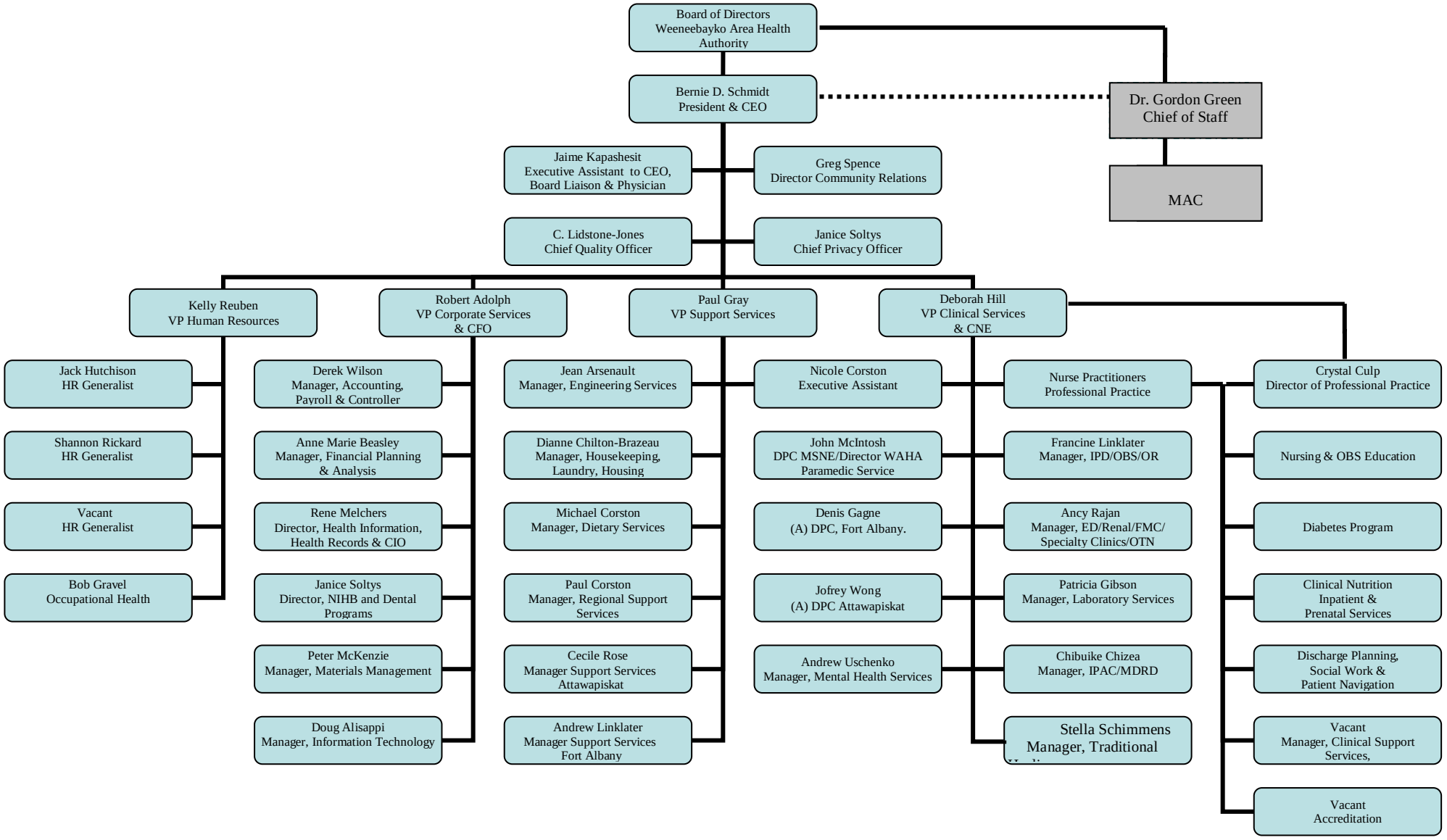
COMMUNITY/ORGANIZATION	REPRESENTATIVES
Fort Albany	• Leo Loone, - Chairman • Gisele Kataquapit
Attawapiskat	• Mike Okimaw • Christine Koostachin
Weenusk	• Luke Gull • Mike Wabano, - Vice-Chair
MoCreebec, Moose Factory	• George Small Jr. - Treasurer • Dorothy Wynne
Town of Moosonee	• Rick Wabano • Shannon MacGillivray, ~~Vice Chair~~
Kashechewan	• Sophia Lazarus • Josephine Williams
Moose Cree, Moose Factory	• Two non-voting observers
WAHA Ex-Officio, non-voting members	• Dr. Gordon Green, WAHA Chief of Staff • Dr. Arnold Hill, WAHA, President of Med. Staff • Bernie Schmidt, WAHA President and CEO (Secretary) • Deb Hill, WAHA VP Patient Care/CNO

In 2012 FNIHB ON established and leads a three party forum including HC FNIHB ON, WAHA and provincial government representatives (Ministry of Health & NELHIN) to discuss and review the WAHIFA implementation.

WAHA's organizational chart is presented on the following page. As demonstrated, organizational activities of WAHA are overseen by Bernie D. Schmidt, President and CEO who reports to the board of directors. The CEO is supported by Executive Assistant Jaime Kapashesit, Director Community Relations Greg Spence, Chief Privacy Officer Janice Soltys, and Chief Quality Officer C. Lidstone-Jones. WAHA also has four vice presidents:

- VP Human Resources
- VP Corporate Services & CFO
- VP Support Services
- VP Patient Care & CNE

Figure 2: WAHA Organizational Chart, January 2016



E. BUDGET AND RESOURCES

Under WAHIFA, Canada committed to lease the existing federal hospital facility to WAHA for $1 per month for a maximum term of 25 years. The province assumed responsibility for hospital services funding and Health Canada reallocated its existing funding of $12 million per year into five spending elements (Primary Care Nursing for Attawapiskat and Fort Albany, Ancillary Physicians Services, Hospital Operations during integration (first 5 years and now ended), Enhanced Community Health Programs, Design and Construction of Improved Health Care Infrastructure). WAHA was to set aside fixed funding for capital infrastructure project costs ($2 million per year) to cover provincially approved future Health Care Infrastructure costs.[1] Between 2007 and 2010, Health Canada provided WAHA with an additional $3.155 million through the Aboriginal Health Transition Fund to support the implementation of the WAHIFA.

The following table provides a detailed description of WAHA revenues and expenditures over the transition period.

Table 5: WAHA Revenues and Expenditures, 2010/11 to 2015/16

Category	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 (Forecast)
Revenue						
NELHIN	$16,265,284.00	$21,679,286.00	$21,787,109.00	$23,221,360.00	$23,041,931.00	$23,265,334.00
Ministry of Health and LTC	$6,999,802.00	$5,158,521.00	$5,326,216.00	$5,208,637.00	$5,927,747.00	$5,409,467.00
Health Canada	$15,365,855.00	$12,000,000.00	$12,000,000.00	$12,000,000.00	$12,000,000.00	$12,000,000.00
Patient Services	$800,792.00	$1,543,517.00	$1,278,267.00	$1,198,805.00	$1,193,610.00	$620,000.00
Rental	$989,827.00	$883,731.00	$968,972.00	$809,912.00	$828,935.00	$760,000.00
Insurance Recoveries	$0.00	$0.00	$965,751.00	$1,863,969.00	$2,258,634.00	$3,328,220.00
Other Recoveries / Activities	$1,698,407.00	$1,620,198.00	$1,308,944.00	$856,882.00	$703,634.00	$2,591,779.00
Specially-funded Provincial Programs	$7,499,904.00	$7,695,660.00	$8,108,582.00	$8,432,204.00	$9,609,916.00	$10,573,043.00
Specially-funded Federal Programs	$13,920,474.00	$15,931,922.00	$14,141,180.00	$13,294,430.00	$13,600,408.00	$13,396,000.00
Deferred Capital contributions Equipment	$1,187,061.00	$779,976.00	$596,571.00	$721,089.00	$907,217.00	$400,000.00
Total Revenue	**$64,727,406.00**	**$67,292,811.00**	**$66,481,592.00**	**$67,607,288.00**	**$70,072,032.00**	**$72,343,843.00**
Expenses						
Salaries and Wages	$20,340,395.00	$18,408,830.00	$19,573,215.00	$21,894,164.00	$21,825,443.00	$21,320,000.00
Isolated post allowance	$2,425,218.00	$3,120,854.00	$3,255,657.00	$2,837,222.00	$2,796,398.00	$3,100,000.00
Employee Benefits	$4,260,518.00	$3,000,663.00	$3,101,414.00	$3,473,469.00	$3,455,975.00	$3,700,000.00
Medical Staff Remuneration	$7,734,686.00	$6,402,589.00	$6,112,395.00	$5,638,949.00	$6,098,053.00	$6,164,500.00
Professional Fees	$1,011,980.00	$1,275,400.00	$1,233,516.00	$1,026,054.00	$959,967.00	$900,000.00
Travel and training	$1,478,949.00	$1,901,690.00	$1,723,670.00	$1,447,167.00	$1,131,106.00	$750,000.00
Supplies & Other costs	$12,670,090.00	$8,219,292.00	$8,331,126.00	$8,595,593.00	$8,455,694.00	$8,371,672.00
Carrying Charges	$196,318.00	$640,352.00	$474,102.00	$459,648.00	$589,211.00	$200,000.00
Insurance Claims	$0.00	$0.00	$965,751.00	$1,202,517.00	$720,750.00	$380,265.00
Attawapiskat oil spill	$0.00	$0.00	$0.00	$0.00	$710,546.00	$3,012,631.00
Fuel	$0.00	$614,075.00	$1,178,686.00	$1,715,672.00	$1,504,244.00	$1,300,000.00
Specially-funded Provincial Programs	$4,327,059.00	$7,794,914.00	$8,108,582.00	$8,681,375.00	$9,608,751.00	$10,573,043.00
Specially-funded Federal Programs	$12,279,931.00	$16,504,601.00	$17,278,429.00	$13,500,720.00	$13,899,362.00	$13,396,000.00
Depreciation Equipment	$644,450.00	$1,033,212.00	$932,973.00	$1,102,895.00	$1,280,192.00	$1,148,000.00
Total Expenses	**$67,369,594.00**	**$68,916,472.00**	**$72,269,516.00**	**$71,575,445.00**	**$73,035,692.00**	**$74,316,111.00**

1 According to the WAHIFA agreement and the Health Canada Contribution Agreement, on March 31, 2016, WAHA was required to set aside $10,550,000 to meet future capital infrastructure requirements. This obligation is reflected in the Table 5, as part of the WAHA's $22.3 million current liabilities

Category	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 (Forecast)
Operating Deficiency of Revenue over Expenses	-$2,642,188.00	-$1,623,661.00	-$5,787,924.00	-$3,968,157.00	-$2,963,660.00	-$1,972,268.00
Deferred Capital contributions Buildings	-$297,385.00	-$1,310,237.00	-$2,010,159.00	-$2,007,502.00	-$1,492,139.00	-$1,665,000.00
Depreciation Buildings	$81,834.00	$1,080,897.00	$1,474,857.00	$1,876,225.00	$1,581,822.00	$1,400,000.00
Deficiency of Revenue over Expenses before the undernoted	-$2,857,739.00	-$1,853,001.00	-$6,323,226.00	-$4,099,434.00	-$2,873,977.00	-$2,237,268.00
Hospital Operations - surpluses repayable	-$138,721.00	-$42,000.00	$0.00	-$133,695.00	$0.00	$0.00
NELHIN working funds deficit funding	$7,308,202.00	-$498,402.00	$0.00	$0.00	$0.00	$0.00
Health Canada hospital deficit funding	$3,000,000.00	$954,725.00	$0.00	$0.00	$0.00	$0.00
Adjustment to assets and liab. assumed on integration	-$5,037,743.00	$0.00	$0.00	$0.00	$0.00	$0.00
Carrying charges on working funds deficit on integration	-$243,203.00	$0.00	$0.00	$0.00	$0.00	$0.00
Surplus (Deficiency) of Revenue over Expenses	$2,030,796.00	-$1,438,678.00	-$6,323,226.00	-$4,233,129.00	-$2,873,977.00	-$2,237,268.00
Operating Deficiency percentage of revenue	-4.1%	-2.4%	-8.7%	-5.9%	-4.2%	-2.7%
Net Specially-funded Provincial Programs	N/A	-$99,254.00	$0.00	-$249,171.00	$1,165.00	$0.00
Net Specially-funded Federal Programs	N/A	-$572,679.00	-$3,137,249.00	-$206,290.00	-$298,954.00	$0.00
Working Capital						
Current Assets	$17,244,847.00	$20,021,718.00	$9,623,477.00	$6,418,559.00	$7,830,699.00	$7,750,000.00
Current Liabilities	$21,225,671.00	$25,971,031.00	$20,407,457.00	$22,795,390.00	$27,767,722.00	$30,004,990.00
Working Capital Surplus (Deficit)	-$3,980,824.00	-$5,949,313.00	-$10,783,980.00	-$16,376,831.00	-$19,937,023.00	-$22,254,990.00
Current Ratio	0.81	0.77	0.47	0.28	0.28	0.26

Source: Hay Group. 2016. Weeneebayko Area Health Authority (WAHA) Operational Assessment Project Report

The following table provides a breakdown of the Health Canada's clinical and client care funding provided to WAHA. Over the period covered under the evaluation, of the $54.0 million provided for clinical and client care, $20.7 million was allocated to hospital operations, $13.5 million was allocated to nursing services, $6.8 million was allocated to ancillary physician services, $6.6 million was allocated to future capital improvements, and $6.5 million was invested in enhanced community programs.

Table 6: Health Canada's Clinical and Client Care Funding, 2014/11 to 2014/15

AREAS OF PROGRAMMING	2010-2011[2]	2011-2012	2012-2013	2013-2014	2014-2015	TOTAL
Nursing services	$1,500,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000	$13,500,000
Ancillary physician services	$750,000	$1,500,000	$1,500,000	$1,500,000	$1,500,000	$6,750,000
Hospital operations	$2,700,000	$4,000,000	$4,000,000	$4,000,000	$6,000,000	$20,700,000
Enhanced community programs	$500,000	$1,500,000	$1,500,000	$1,500,000	$1,500,000	$6,500,000
Future capital	$550,000	$2,000,000	$2,000,000	$2,000,000	0	$6,550,000
Totals	**$6,000,000**	**$12,000,000**	**$12,000,000**	**$12,000,000**	**$12,000,000**	**$54,000,000**

Source: Hay Group. 2016. Weeneebayko Area Health Authority (WAHA) Operational Assessment Project Report

2 As WAHA was established on October 01, 2010, the first fiscal year reflects only six months of operations from 01 October, 2010 to 01 April, 2011.

WAHA receives funding from a number of specifically-funded federal programs such as NIHB medical transportation, dental care, and pharmacy, IRS RHSP, Health System Transformation Fund and Health System Capacity.

Table 7: Breakdown of Specifically-Funded Federal Programs administered by WAHA 2014/15

Programs	2014/15
Canada Prenatal Nutrition Program (CPNP)	$ 95,408
Community Facilities O&M	$823,449
Health System Transformation Fund	$298,550
Health System Capacity – Capital OM	$970,777
Indian Residential Schools Resolution Health Support Program (IRS RHSP)	$1,084,983
NIHB - Medical Transportation	$7,194,291
NIHB – Dental	$1,582,709
NIHB – Audiology/MSE	$41,109
Total	**$12,091,276**

WAHA is experiencing budget deficits and financial difficulties. As noted earlier, over the period covered under this evaluation, the organization experienced an operational deficit of approximately $2.9 million and a net working capital deficit over $13 million in 2014/15. This working capital deficit takes into account the fact that WAHA has used for operational purposes the $6.550 million (cumulative funding from October 1, 2010 to September 30, 2014) allocated by Health Canada for infrastructure improvement to support hospital operations. WAHA is currently implementing a Hospital Improvement Plan in order to attain a balanced budget and reduce the deficit.

In addition to programming and services delivered by WAHA, both Health Canada and NE LHIN are also funding a number projects and initiatives in the region through signing of contribution agreements with communities directly. For example, as demonstrated in the following table, for 2016/17 fiscal year, Health Canada has budgeted a total $7.3 million for six communities in the region, of which $6.7 million will be spent on delivering public health programming.

Table 8: Health Canada Funding for Public Health Programing in the Region, 2016/17

Program	Attawapiskat	Fort Albany	Kashechewan	Mocreebec	Moose Cree	Weenusk	Total
Aboriginal Diabetes	-	-	$129,257	-	$75,478	-	**$204,735**
Aboriginal Head Start on Reserve (AHSOR)	-	$96,989	-	-	$58,185	$7,673	**$162,847**
Aboriginal Diabetes Initiative	$145,476	$85,641	-	-	-	$30,846	**$261,963**
Aboriginal Diabetes Initiative Food Security	$2,750	$2,750	-	-	-	$2,750	**$8,250**
Brighter Futures (BF)	$161,100	$185,210	$151,584	$61,465	$150,778	$79,723	**$789,860**
Building Healthy Communities (BHC)	-	$176,577	$135,857	$58,754	$122,754	$68,331	**$562,273**
Canada PreNatal Nutrition	-	-	-	-	$24,354	-	**$24,354**
Communicable Disease Control - Public Health Nursing services & Community Health Representatives (CHRs)	$14,881	$28,112	-	-	-	$6,294	**$49,287**
Fetal Alcohol Spectrum Disorder (FASD)	-	$51,050	-	-	$30,137	$4,014	**$85,201**
Food Security	-		-	-	$2,750	-	**$2,750**
Health Planning and Management	-	$194,546	$147,802	-	$1,008,945	-	**$1,351,293**
Healthy Child Development - Public Health Nursing services & Community Health Representatives (CHRs)	$44,643	$84,335	-	-	-	$18,884	**$147,862**

Program	Attawapiskat	Fort Albany	Kashechewan	Mocreebec	Moose Cree	Weenusk	Total
Healthy Living - Public Health Nursing services & Community Health Representatives (CHRs)	$44,643	$84,335	-	-	-	$18,884	**$147,862**
Home and Community Care Service Delivery	$401,144	$489,040	$381,795	-	$547,481	$70,204	**$1,889,664**
Maternal Child Health (MCH)	-	$84,403	-	-	$56,207	$20,211	**$160,821**
Mental Wellness - Public Health Nursing services & Community Health Representatives (CHRs)	$44,643	$84,335	-	-	-	$18,884	**$147,862**
National Aboriginal Youth Suicide Prevention Strategy (NAYSPS)	$28,711	$29,522	$31,787	-	$20,994	$12,653	**$123,667**
National Native Alcohol & Drug Abuse Program (NNADAP)	$48,206	$46,032	$46,030	-	$46,838	$46,031	**$233,137**
Moose Cree Healing Centre (NNADAP)	-	-	-	-	$204,851	-	**$204,851**
Youth Solvent Abuse Program (YSAP)	$120,175	-	-	-		$1,374	**$121,549**
Total For Public Health Programming	**$1,056,372**	**$1,722,877**	**$1,024,112**	**$120,219**	**$2,349,752**	**$406,756**	**$6,680,088**
Other Funding							
Community Facilities O&M	$106,852	$90,740	-	-	-	$191,971	**$389,563**
Evaluation Plan	-	-	-	-	$796	-	**$796**
Five Year Evaluation Report	-	-	-	-	$9,095	-	**$9,095**
Operations and Maintenance	-	-	$135,949	-	$38,317	-	**$174,266**
Total (other funding)	**$106,852**	**$90,740**	**$135,949**	**$0**	**$48,208**	**$191,971**	**$573,720**
Total	**$1,163,224**	**$1,813,617**	**$1,160,061**	**$120,219**	**$2,397,960**	**$598,727**	**$7,253,808**

Source: Email by Lori Lori Doran, A/Regional Executive, February 1, 2016

F. LOGIC MODEL

A logic model for WAHA is provided on page 19. A logic model describes the key elements of an initiative in a logical sequence, to assist in understanding the strategy underlying the initiative, and the pathway the initiative has been designed to follow in order to achieve the intended results. The logic model identifies the key activities that constitute the initiative, as well as the sequence of direct and intermediate outcomes that are expected to result from these activities.

1. Needs and Resources

From the logic model, needs are first considered from the perspective of the objectives the program is trying to accomplish. The long-term identified need includes:

- Disparities in the health status of First Nations peoples and communities along the James Bay coast due to European-introduced infectious disease and the destabilization of traditional Cree medicine and cultural practices;
- Limitations in united, streamlined and comprehensive health services infrastructure;
- Lack of management coordination between health care service providers;
- Gaps and overlaps in health services and operations; and
- Limited access to culturally-safe health care services.

In order to address these needs, WAHA needs to have access to consistent resources, which include:

- Timely and sufficient funding;
- Appropriate resources for implementation;
- Stable community stakeholders who are committed to work to address the health issues in the region; and
- Adequacy of the resources for cultural relevance and appropriateness.

2. Activities

In order to achieve its objectives and generate expected outcomes, WAHA is engaged in four types of activities, including:

- *Discussions and negotiations among stakeholders and communicating the negotiated agreement* including transition of the governance to a newly established First Nation-led organization, managing health services, creating governance and board structures representing the regions' stakeholders, developing mission and vision statements and recruiting a CEO for WAHA.

- *Management and oversight.* Responsible for evaluating the Initiative, ensuring continuity through the transition period, and planning a long-term capital budget for new health care facilities.

- *Coordination and integration* for all health care and related programs and services, policies and procedures, job classifications, reporting requirements/processes, health records program, and nursing staff and other hospital staff.

- *Operations and service delivery* (i.e., programs and services and the facilities). Receives directions from the Board of Directors and incorporates Aboriginal beliefs, values, and practices.

3. Outputs

Key outputs related to WAHIFA implementation included the creation of WAHA to govern the management of the health services in the region, development of the draft Special Act Legislation, information and plans for coordination/integration, review of the health services gaps and overlaps, development of the strategies to address these gaps and areas of overlap in the services and operations, development of the long-term capital plan for new health care facilities, and integration/coordination of the management of two hospitals.

4. Outcomes

The three immediate outcomes related to this initiative are:

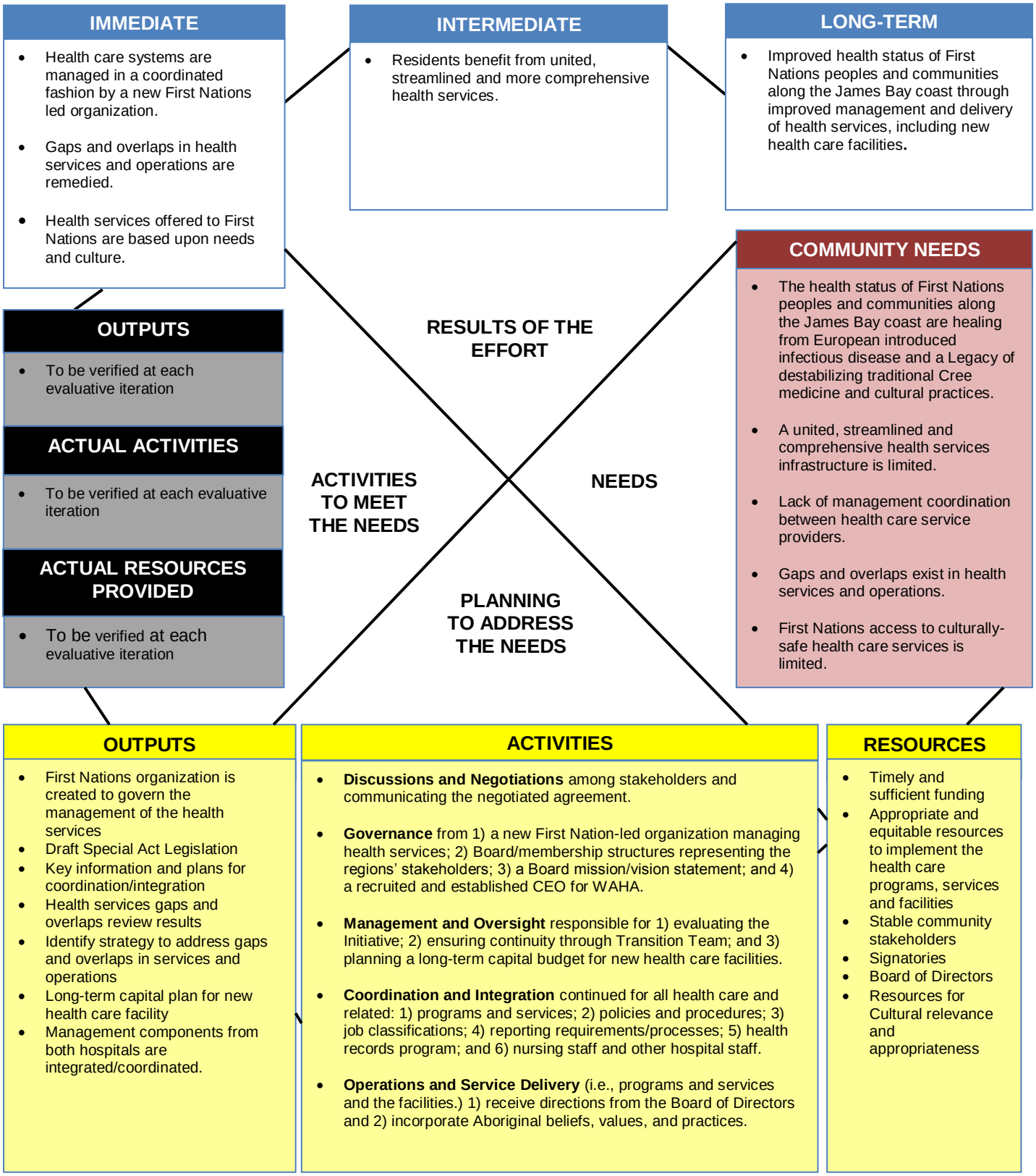
- *Health care systems are managed in a coordinated fashion by a new First Nations led organization.* Creation of WAHA (which is governed by community representatives) and integration of the activities of two hospitals will result in more coordinated health care services for First Nations communities in the region.

- *Gaps and overlaps in health services and operations are remedied.* Integration of the two hospitals' activities will aid in the identification and remedy of overlap in services and service gaps.

- *Health services offered to First Nations are based upon needs and culture.* One of the key activities undertaken by WAHA is to ensure all services delivered for First Nations communities in the region are culturally safe and appropriate.

In the intermediate term, the program is intended to benefit residents through the provision of united, streamlined and more comprehensive health services. The integration of the activities is expected to contribute to increased quality and accessibility of the services. The ultimate outcome of the activities undertaken by WAHA is to ensure improved health status of First Nations peoples and communities along the James Bay coast through improved management and delivery of health services, including new health care facilities.

Figure 3: WAHIFA Logic Model


IMMEDIATE
Health care systems are managed in a coordinated fashion by a new First Nations led organization.
Gaps and overlaps in health services and operations are remedied.
Health services offered to First Nations are based upon needs and culture.
INTERMEDIATE
Residents benefit from united, streamlined and more comprehensive health services.
LONG-TERM
Improved health status of First Nations peoples and communities along the James Bay coast through improved management and delivery of health services, including new health care facilities.
COMMUNITY NEEDS
The health status of First Nations peoples and communities along the James Bay coast are healing from European introduced infectious disease and a Legacy of destabilizing traditional Cree medicine and cultural practices.
A united, streamlined and comprehensive health services infrastructure is limited.
Lack of management coordination between health care service providers.
Gaps and overlaps exist in health services and operations.
First Nations access to culturally-safe health care services is limited.
OUTPUTS
To be verified at each evaluative iteration
ACTUAL ACTIVITIES
To be verified at each evaluative iteration
ACTUAL RESOURCES PROVIDED
To be verified at each evaluative iteration
RESULTS OF THE EFFORT
ACTIVITIES TO MEET THE NEEDS
NEEDS
PLANNING TO ADDRESS THE NEEDS
OUTPUTS
First Nations organization is created to govern the management of the health services
Draft Special Act Legislation
Key information and plans for coordination/integration
Health services gaps and overlaps review results
Identify strategy to address gaps and overlaps in services and operations
Long-term capital plan for new health care facility
Management components from both hospitals are integrated/coordinated.
ACTIVITIES
Discussions and Negotiations among stakeholders and communicating the negotiated agreement.
Governance from 1) a new First Nation-led organization managing health services; 2) Board/membership structures representing the regions' stakeholders; 3) a Board mission/vision statement; and 4) a recruited and established CEO for WAHA.
Management and Oversight responsible for 1) evaluating the Initiative; 2) ensuring continuity through Transition Team; and 3) planning a long-term capital budget for new health care facilities.
Coordination and Integration continued for all health care and related: 1) programs and services; 2) policies and procedures; 3) job classifications; 4) reporting requirements/processes; 5) health records program; and 6) nursing staff and other hospital staff.
Operations and Service Delivery (i.e., programs and services and the facilities.) 1) receive directions from the Board of Directors and 2) incorporate Aboriginal beliefs, values, and practices.
RESOURCES
Timely and sufficient funding
Appropriate and equitable resources to implement the health care programs, services and facilities
Stable community stakeholders
Signatories
Board of Directors
Resources for Cultural relevance and appropriateness

IV. EVALUATION FINDINGS

This chapter summarizes the key findings of the evaluation gathered from all lines of evidence.

A. ACHIEVEMENT OF OBJECTIVES

This section describes the evaluation findings regarding the extent to which the objectives of the WAHIFA have been achieved.

1. **There seems to be different perceptions regarding the vision of WAHIFA. While key informants consider the main objective to be the amalgamation of the two hospitals for enhanced integration and coordination of health services for the Coastal Region and improving the health status of the population, representatives of the First Nations communities view the Agreement as a promise to build a new hospital in the region and increase access to and availability of the health care services, public health and long term care programming.**

   As demonstrated in the following table, the main objectives of WAHIFA most frequently stated by key informants (i.e. WAHA staff members and representatives of FNIHB and NE LHIN) are to achieve amalgamation of two hospitals (the provincially run James Bay General Hospital (JBGH) and the federally run Weeneebayko General Hospital (WGH)), improve coordination and integration of the services between federal and provincial governments and First Nations communities in the region, and improve the quality and accessibility of the services for the communities.

Table 9: Key Objectives of WAHIFA

OBJECTIVES OF WAHIFA	NUMBER OF KEY INFORMANTS
Amalgamation of two hospitals to achieve more integrated health services and better coordination between federal and provincial governments and the communities	16
Improving quality and accessibility of the health care services, increasing efficiencies and maximizing available resources	9
Ensuring First Nations have control over health programming in the region and making the services more relevant to them	5
Creation of a new health authority overseeing the provisions of the health services for seven communities	2

The representatives of the First Nations communities visited have a somewhat different understanding of the objectives of WAHIFA. Most community focus group participants, particularly the chiefs, stated that they signed the WAHIFA because they were promised a new hospital, better and improved health care services, and new programming such as public health and long term care services. Most importantly, the community stakeholders stated that they were promised that the agreement would provide full protection of their treaty rights (which is stated in WAHIFA) and that a Special Act would be enacted to ensure the new hospital and the services remained under First Nations control. The community interpretation of the treaty rights include:

- Continued commitment by the federal government to provide health care services to First Nations communities in the region. These rights are enshrined in the Treaties and Legislation.

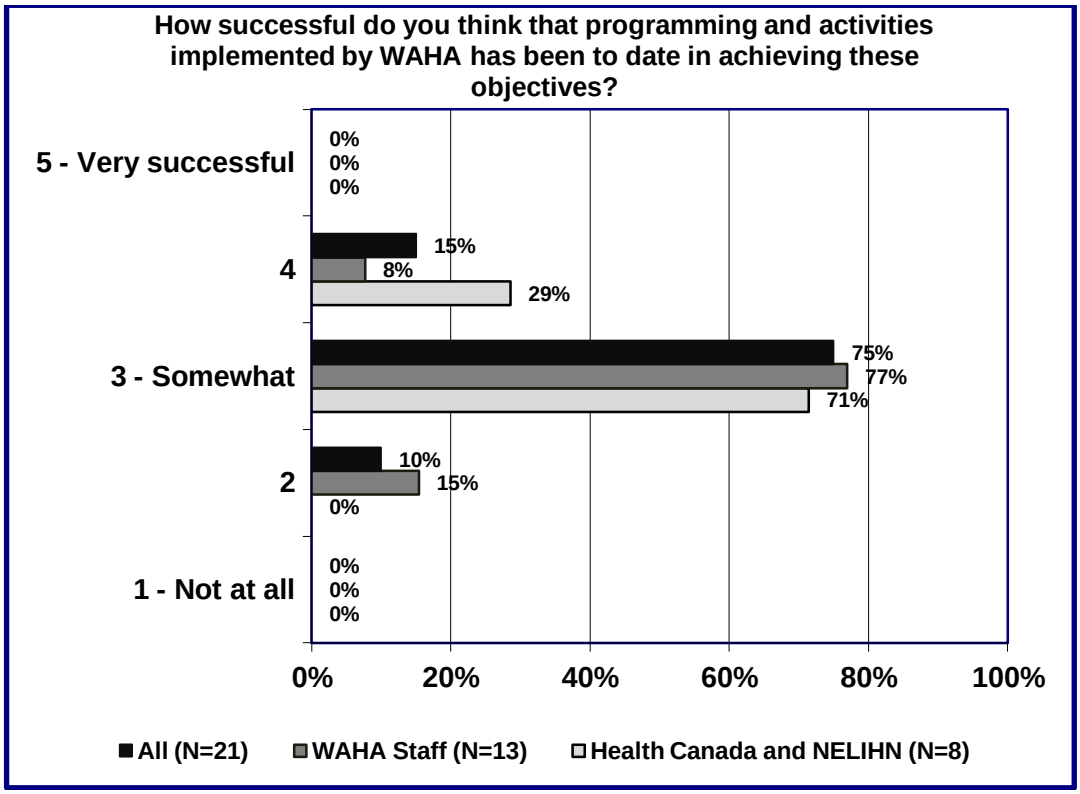
- Full control of the hospital operations by the First Nations and limited interference by the provincial government in the governance of the hospital operations. In particular, community informants stated that the communities were promised that under the WAHIFA, the provincial government would not have the authority to dissolve the current corporation and take over the hospital under any circumstances.
- Provision of culturally appropriate health care services such as traditional healing, traditional food and services in Cree language.

At the time of the agreement signing, the communities expected WAHA to become an organization that would proactively assess their health care needs, develop appropriate programming and intervention to address health care gaps, and advocate on their behalf with provincial and federal governments for betterment of the health care and related programming in the region.

2. There is disagreement between the communities and key informants with regard to the success of the WAHA in achieving the objectives of the WAHIFA. While WAHA staff members and representatives of Health Canada and NE LHIN consider the WAHIFA as somewhat successful, community stakeholders consulted consider the Agreement not successful.

- *WAHA staff members and representatives of Health Canada and NE LHIN consider WAHA as somewhat successful in achieving the objectives of the WAHIFA*. As part of the interviews, key informants were asked to rate the success of WAHA in achieving the objectives of the WAHIFA on a scale of 1 to 5. The average rating provided by all key informants was 3.1, with 75% of key informants providing a rating of 3, 15% providing a rating of 4, and 10% providing a rating of 2. The ratings provided by WAHA staff members and representatives of Health Canada and NE LHIN were very similar.

Figure 4: Achievement of WAHIFA Objectives



According to key informants, significant progress has been made in one of the five major perceived objectives of the WAHA. Two hospitals (JBGH and WGH) have been amalgamated under one organization, a new health authority governed by First Nations has been created, the internal policies and procedures of both hospitals continue to be integrated, and new collective agreements have been negotiated and signed.

According to key informants, WAHA has also undertaken a number of new initiatives and projects to improve the quality and accessibility of the services in the region, including:

- Meditech, which is an integrated hospital information system that allows WAHA to share information (e.g., patient records) with 23 similar hospitals located in the region for smooth patient transfer and service delivery, streamline its financial and annual reporting to the province and also contract some of its back office functions to some of the other hospitals in the region (10)
- Telemedicine - a two-way video conferencing tool that allows patients to speak to health care service providers without the need to travel. WAHA's telemedicine program includes ER telemedicine, telehealth pathology (exploration), tele-ophthalmology, and geriatric follow-up (7)
- Geriatric clinics in the communities (Fort Albany, Moosonee, Moose Factory and Peawanuck), which helped to assess the needs of the elderly, trained home support workers and developed home support services (7)
- Cancer Care Project to increase screening for colorectal and breast cancer, which has over 130 people registered to participate in the program (5)
- Traditional healing program which offers a variety of services with traditional and cultural healing options. The program was started in 2010 and involves 22 Healers that work in the region on a monthly basis and has over 11,000 client contacts coming through the program on a yearly basis (5)

However, according to key informants, many of the new initiatives and programming have recently been implemented and their impact in improving the quality of the services is uneven across communities. As an illustration, communities located in Moose Factory Island have benefited the most, while the communities in remote areas such as Peawanuck and Kashechewan have seen the least improvements. Even though WAHA provides support in Peawanuck and Kashechewan, they are served by federally operated Nursing Stations and WAHA has limited input. In addition, WAHA has not been able to achieve operating efficiencies and address the accumulating deficit from hospital operations. Significant gaps remain in the coordination of activities between various service providers in the region. Both the provincial and federal governments implement health programming in the region, often with little involvement and coordination with WAHA. Due to operating deficits, WAHA has been constrained in its ability to proactively assess the health needs of the communities and coordinate the activities of other service providers in the region to address those needs. A number of emergencies in the communities (e.g., oil spill in Attawapiskat hospital, fire in Moosonee, repetitive flooding, etc.) have also affected WAHA's ability to provide quality care and services detracting significant financial resources and staff time.

Finally, key informants reported that, although WAHA is governed by a board representing all signatory communities, they perceive the board has very little control over health programming. The participation of the First Nations board members in decision making and the capacity of these board members are limited because they are appointed by and report to the chiefs and community politics affect their decisions.

- *Community representatives view WAHA as not very successful in achieving its objectives*[3]. According to the focus group participants and chiefs interviewed, expectations of the WAHIFA have not been fulfilled to an adequate level. In particular, the quality and consistency of the health care services received by some community members, particularly those in remote areas, have not improved over the past five years. The new hospital that was promised at the time of the signing of the WAHIFA, and which was instrumental for communities signing the agreement, is yet to be built.

  According to community stakeholders, there is a lack of coordination of health services in the region and a general feeling of disconnection with WAHA. The community visits indicated that a significant proportion of residents do not feel represented by WAHA at an adequate level. The majority of community representatives consulted stated that feel that they have little control over WAHA and the decisions that affect its operations. Most First Nations board members interviewed stated that they do not play a major role in the decision making process, even though they make the decisions. According to First Nations community representatives, the government of Ontario has not met one of the provisions of WAHIFA which is to pass a Special Act to limit provincial involvement and ensure more First Nations control over the WAHA. WAHA is currently managed under provincial legislation (Public Hospitals Act) and NE LIHN has the right to dissolve the corporation and take over hospital operations. Without a Special Act, the First Nations communities are concerned that such a takeover may happen and they will lose control over the hospitals and the health services in the region.

B. IMPLEMENTATION OF THE WAHIFA

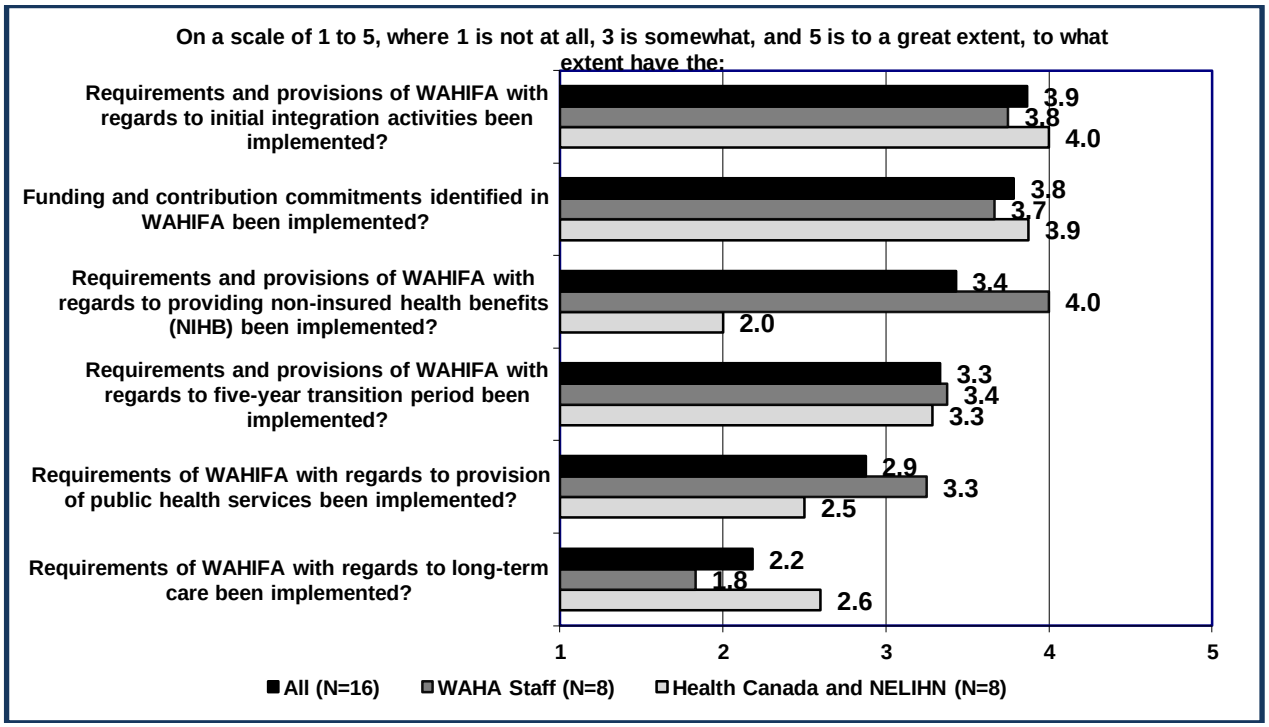
3. The community perspectives were collected through focus group discussion and in-person interviews during the site visits using non-structured focus group and interview guides. To ensure simplicity of the data collection process, no rating questions were asked during the consultations with community representatives. The conversations and discussions were tape recorded, and later transcribed into Word documents. The summary of the results from all focus group discussion and in-person interviews related to success of the Agreement and the integration process is provided in this section.

The WAHIFA agreement stipulated a number of requirements related to the initial integration and five-year transition period, provision of long-term care, public health, and Non-Insured Health Benefits (NIHB) programming and funding commitments by the federal and provincial governments. A detailed description of the requirements and provisions stipulated in the WAHIFA and a mapping of the progress made towards implementation of each requirement are provided in Appendix II. This section provides a summary of the findings.

1. Most requirements and provisions stipulated in the WAHIFA have been implemented. However, significant issues and gaps remain with regard to signing of a Special Act, managing of the NIHB program, and delivering quality public health and long-term care programming.

Key informants were asked to rate the extent to which the different provisions and requirements of the WAHIFA agreement have been implemented. According to the key informants, initial integration activities have been implemented (an average rating of 3.9), and funding commitments made by the federal and provincial governments have been successfully implemented (an average rating of 3.8). Some progress has been made in terms of implementing commitments and provisions related to NIHB (an average rating of 3.4), and some progress has been achieved with regard to requirements related to the five-year transition period (an average of 3.0). According to key informants, little progress has been made in terms of the WAHIFA provisions related to public health and long-term care services.

Figure 5: Implementation of WAHIFA Requirements and Provisions



The following paragraphs summarize the key progress made and remaining major gaps in each area of the agreement:

- *Initial integration activities and five year transition period.* The results of the interviews with key informants and community stakeholders combined with findings of the document and file review demonstrated that most requirements and provisions of the WAHIFA related to initial integration activities and the five-year transition period have been implemented. In particular, WAHA was established in October 2010 representing all signatory communities in the region; the Weenebayko General Hospital (WGH) and James Bay General Hospital (JBGH) were amalgamated under a single governance framework in order to be managed under common policies, procedures and consolidated budget; and new collective agreements were signed with existing staff members. The major gaps in fulfilling provisions of WAHIFA related to the initial integration and five-year transition period, are summarized as follows:

  - The integration was implemented without the signing of a Special Act. The purpose of the Special Act was to provide for the essentials of WAHA operations - traditional foods and ceremonies as well as to ensure legislative protection so that WAHA did not and would not negatively impact treaty rights and obligations in the future. To date, although WAHA has been able to provide traditional healing programs, the current legislation does not allow it to provide traditional food. According to representatives of the provincial government, Ontario decided not to pursue the Special Act because WAHA was already established through an asset transfer agreement under the Corporations Act and other traditional programs and food could be provided through other legislative avenues. However, as noted earlier, the Special Act was one of the most important conditions put forward by First Nations communities in the WAHIFA. According to community stakeholders, they expected that the Special Act would limit provincial jurisdiction over WAHA and enhance First Nations control. Community stakeholders noted that after signing of the WAHIFA, the province did not provide communities with a satisfactory justification for why it considered the Special Act unnecessary. The leadership in the communities interpreted this as an attempt to avoid provincial obligations under the WAHIFA and an effort to gain strong legislative and administrative power over the WAHA and its operations. Without the Special Act, the communities feel that the WAHIFA agreement does not provide adequate protection of their treaty rights (even though the protection is clearly stated in WAHIFA and enshrined in the Treaties and Legislation) and the province has more power over WAHA than the communities.

  - The remote northern location of the WAHA was not recognized in the hospital funding formula. Although WAHA received some additional funding due to its remote location (e.g., $224,000 in 2013-2014 as part of the 1% increase for small hospitals in Ontario), no specific funding formula was developed that recognized the specific needs of the communities and the conditions under which WAHA operates.

  - Not all nursing and community based health programs have been transferred to WAHA. Section 10 of the agreement requires WAHA to obtain band resolutions and transfer and administer federal nursing programs in the region. However, at the time of the evaluation, the nursing stations at Kashechewan and Peawanuck were still run by Health Canada through signing of contribution agreements with the communities. The band councils have yet to sign the resolutions to transfer the stations to WAHA.

- *Funding and contribution commitments.* The document review and key informant interviews demonstrate that both Health Canada and the province have fulfilled all contribution commitments under Section 6 of the agreement. In particular, Health Canada signed a contribution agreement with WAHA for $12 million per year. The ministry provided $6 million in additional base funding to fulfill the Ontario funding commitment to WAHA. For the period from October 1, 2010 to March 31,

2011, the pro-rated base funding amount of $3 million was provided.[4] The major gaps related to funding and contribution commitments are summarized as follows:

- NE LHIN delayed paying its portion of the deficit, which increased the financial burden on WAHA. According to WAHIFA agreements, both the province and Health Canada were going to pay off the deficits of their respective hospitals. However, the document review and key informant interviews demonstrate that as it took some time for WAHA to comply with planning and operating requirements of Ontario, NE LHIN did not make the payment until June 2012 (21 months later). In addition, NE LHIN used its own method of calculating deficit which resulted in a discounted amount of $6.8 million (instead of $7.3 million which WAHA was expecting). The delay caused significant financial difficulties for WAHA.[5]

- According to the WAHIFA agreement and the Health Canada Contribution Agreement, on March 31, 2016, WAHA was required to set aside $10,550,000 to meet future capital infrastructure requirements. While this obligation is reflected on the Authority's balance sheet the funds were not available at the time of the evaluation.

- Section 4.2 of the WAHIFA agreement indicates that the parties would work cooperatively to obtain funding for the initial integration and transition activities. Over the period covered under the evaluation, WAHA has received some funding from both the province and the federal government to cover the cost of integration. However, this funding has not been sufficient to cover the total costs of integration and transition.

- WAHIFA did not incorporate a funding growth component to account for inflation and increasing salaries and wages.

- *Non-insured Health Benefits Program.* WAHIFA required WAHA to take responsibility for the delivery of some NIHB services. WAHA started administering NIHB activities soon after it was created and it established a NIHB Working Group in 2011 to oversee management of the program. However, according to representatives of WAHA, administrating the program resulted in significant financial losses for the organization. WAHA had to provide significant up-front funding for this program. In addition, about 8% of NIHB travel requests were declined or discounted by Health Canada (as explained below, mostly due to WAHA's poor control over the rules and requirements of the Non-Insured Health Benefits Medical Transportation Policy Framework) which increased WAHA's financial deficits. Consequently, in 2013, at WAHA's request, the administrative model for the delivery of NIHB Medical Transportation in the WAHA area was transferred back to Health Canada, with Health Canada assuming a greater role. Health Canada developed a direct billing relationship with most commercial vendors involved in the provision of medical transportation services while WAHA retained responsibility for air charter services, local medical travel and two boarding homes in Moosonee and Timmins.[6] The transfer NIHB program was implemented in a short period of time and according to representatives of Health Canada, they had to create complex systems and processes for processing the claims, booking of the appointments, and organizing payments and transportation, which was associated with many challenges. The process has evolved and improved since transfer and according to WAHA, there has been a 30% increase in the number of travel warrants over the 5-year period covered under this evaluation. However, compared to WAHA, Health Canada implemented more strict control over the rules and requirements of the Non-Insured Health Benefits Medical Transportation Policy Framework

4 Health Canada, Strategic Planning and Audit Division. Review of Commitments and Timeline from WAHIFA, August 14, 2014.
5 WAHA 2012. Report to Health Canada, November 1, 2011.
6 WAHA 2012. Report to Health Canada, November 1, 2011.

(MTPF), which, according to community members, has increased the number of requests for non-medical escorts being declined. Increased rejections for escorts has created problems for some community members, especially elderly patients who do not speak English and who miss medical appointments because they are afraid to travel without a family member. During the focus groups, community members mentioned cases where elderly patients did not have an escort and were lost and left unattended at a hostel or hospital. Although the NIHB program has procedures to allow community members to appeal the decisions, it is not clear the extent to which communities are aware of these procedures and have the necessary capacity and support to use them. The NIHB program also has the exception process, which allows for discretionary decision making outside the policy to accommodate special requests. However, it is unclear the extent to which the exception systems are being administered to accommodate those who need the services the most, or the extent to which the communities are aware of the system and have the necessary support to use it. Other issues noted by the communities related to medical travel included lack of return travel benefits for some escorts, which creates financial burden on families; and lack of proper equipment at airports and airplanes to accommodate the sick and the elderly (e.g., wheelchairs and washrooms in planes).

The NIHB program has negatively affected the profile of WAHA in the region, Despite communication about the transfer and the changes in the administration of the NIHB program, community members perceive WAHA as the main service provider in the region and increased rejections for escorts have negatively affected the reputation of WAHA. The community consultations indicated that the NIHB program is currently one of the biggest areas of dissatisfaction for all communities in the region, particularly the booking of medical appointments and arranging of medical transportation. Both key informant interviews and community consultations concluded that having a number of service providers involved in delivery of NIHB program is creating many administrative difficulties and there is a need for streamlined service provision. In particular, as a health authority representing the interests of the communities in the region, WAHA needs to continue to advocate for its community members and should become a single point of contact for all health care services, including the NIHB program. According to some key informants, significant financial losses incurred by WAHA related to administration of the NIHB program in the past may have been avoidable with improvements in the management of the program and proper training for staff. Many areas for potential cost savings were not realized due to bureaucratic and administrative barriers. With reductions in turnover for staff and management, this situation is improving. Some of the areas where potential cost savings could be achieved include:

- *Booking the medical appointments in advance and working with community representatives closely to decrease the number of appointments that are missed*. Although the evaluation lacked performance data to confirm, during the consultations, community representatives indicated that many appointments are booked at the last minute. Community members often receive notification 12 to 24 hours prior to an appointment, not allowing time to make adequate child care and escort arrangements. Last-minute referrals and patients' ability to confirm their willingness to travel in a timely fashion are contributing to increased numbers of medical appointments being missed. Missed appointments result in unnecessary expenditures associated with transportation (e.g., sometimes planes have to return back empty).

- *Better coordinating travel arrangements with other service providers*. Currently, the appointments are booked by staff at the Kingston General Hospital are approved by Health Canada in Ottawa, and medical transportation is arranged by WAHA. WAHA is much closer to the communities and has much better understanding of the community needs and realities. It

is in a much better position to coordinate the travel booking, approvals and arrangements with all other service providers.

- *Better coordination of the transportation arrangements to save cost and improve client satisfaction.* There are many opportunities to improve coordination of the transportation arrangements, increase efficiencies and save cost for the program. For example, according to community representatives, sometimes clients are transferred to Moose Factory island for initial diagnosis and then again south (e.g., Kingston or Timmins). Such transportation is further affected by bad weather conditions, flights schedules and the availability of the proper means of transportation. Better coordination would make sure that patients receive proper care and diagnosis in their communities and are transferred directly south if needed without being transported to the hospital on the island.

- *Leveraging a portion of the travel costs from community members*. Currently, clients who happen to be in the vicinity of the hospital (e.g., Timmins or Kingston) at the time of their medical appointments are required to return to their communities and then be transported again to their medical appointment. This procedure is explained by NIHB guidelines, which does not allow clients to be transported from outside of their communities. However, the program could save cost and improve client satisfaction if some clients were allowed to pay their own ticket to travel to medical appointments and then transported back to their communities.

- *Improved management of certain aspects of the program delivery to achieve cost savings on case-by-case basis.* Examples of such opportunities include bringing specialists (e.g., ophthalmologists, optometrists, etc.), when appropriate, to the communities instead of transporting community members; and increasing use of Ontario Telemedicine Network (OTN) to diagnose and treat patients remotely.

Although a direct comparison is impossible due to many regional and organizational differences, there are indications that cost savings in NIHB program administration might be achieved if an approach similar to that used in British Columbia was employed. Further exploring the experience of the BC First Nations Health Authority in administering the NIHB program and incorporating some of the best practices and lessons learned in the operation of the NIHB programming in that region might be helpful.

- *Public health.* The document review and key informant interviews demonstrate that over the period covered under the evaluation, WAHA has implemented a number of initiatives and activities to support the development of public health programming in the region. In 2011, WAHA established a tri-party working group to examine regional public health service delivery, identify gaps in programming gaps, and develop a service model – a conceptual framework for strengthening public health in the Weeneebayko Area. The working group developed a work plan to guide public health programming in the region and introduced several public health projects such as an oral health dental hygiene pilot project (e.g., screening and prevention program in children 0 to 7 years) and a dog control pilot project (e.g., dog registry was created and all dogs serviced were microchipped) for the WAHA region. These WAHA-implemented public health projects have resulted in positive impacts in the communities. In particular, the dog control pilot project is viewed by some key informants and community stakeholders as contributing to a reduced number of stray dogs in the communities and more effective population and rabies control.

  In addition to WAHA, both Health Canada and NE LHIN have implemented a range of public health programming in the region through signing of contribution agreements directly with the

communities. For example, for 2016/17 fiscal year, Health Canada has budgeted a total $7.3 million for six communities in the region, of which $6.7 million will be spent on delivering public health programming. The largest share of public health funding by Health Canada is spent on supporting Home and Community Care Service Delivery program ($1.9 million), Health Planning and Management ($1.4 million), Brighter Futures program ($789,860), Building Healthy Communities ($562,273), Aboriginal Diabetes Initiative ($261,963), and the residential component of the National Native Alcohol & Drug Abuse Program ($233,137).

Despite substantial efforts, significant issues remain with regard to availability of integrated and coordinated public health programming in the region. A review of the program documents demonstrates that some of the public health activities identified in the conceptual framework developed by WAHA are not being implemented consistently. According to community stakeholders and key informants, the region is also experiencing significant gaps in many other areas of public health programming due to a lack of co-ordinated, integrated and legislative framework, along with permanent funding supports, for an effective public health model (e.g., community-specific research and surveillance, mental health, chronic diseases, sexual health, food safety, rabies control, etc.). Some of the other major gaps in the public health programming in the region are reported to include:

- A lack of coordination among the multiple public health programs and services providers for the Weeneebayko area communities.[7] There are many organizations involved in delivering public health programming (the federal government, provincial government, First Nations, NE LHIN, Porcupine Health Unit Public Health Unit, WAHA, local Bands/Councils and the municipality of Moosonee) with little coordination among them. This contributes to programming gaps, duplication and inefficiencies between programs.

- The lack of formally delegated authority to set priorities for public health services and programs. No single entity has the authority or responsibility to enforce standards in the Weeneebayko region and ensure compliance. WAHA lacks the required human and financial resources, capacity, and leadership and legislative authority to bring the various stakeholders together, provide strategic direction, and coordinate public health activities.

- A lack of capacity among communities to participate in decision-making, planning and skills building with respect to public health.

- *Long-term care*. Some progress has been made in the provision of long-term care services for the elderly. Section 9 of the agreement outlined Ontario's commitment to work with the communities, through WAHA, to determine the long-term care needs of area residents and develop policies and programs to strengthen long-term care in the region. According to findings of the evaluation, care for the elderly (including long-term care beds) is part of the new hospital development. In addition, since 2013, NE LHIN, together with WAHA and the Red Cross, have been delivering geriatric services that include needs assessment and the development of community elderly care plans, training of personal support workers and elderly support services. Nevertheless, the evaluation found the lack of proper long-term care facilities and services to be one of the most critical issues in the region. Of the six communities served by WAHA, 4 have access to some type of long-term care beds (or chronic care in Attawapiskat and Fort Albany). The situation in the other communities is very problematic and will continue to be as long as Health Canada continues to operate these sites. Elderly residents needing care have to be transported outside of their communities to live in

7 Stakeholders include the federal government, provincial government, First Nations, NE LHIN, Porcupine Health Unit Public Health Unit, WAHA, local Bands/Councils and the municipality of Moosonee.

long-term care facilities. According to community stakeholders, this is very traumatizing for many elderly, especially residential schools survivors, who often do not see their families anymore. In many cases, the elderly refuse treatment and decide to die with their families rather than live in a long-term care facility. The elderly prefer to be treated and cared for within their own communities and be with their own family members.

- *Strategic Infrastructure Development Plan and Ontario Capital Planning Process.* WAHIFA required WAHA to develop Strategic Infrastructure Development Plan and participate in Ontario Capital Planning Process to support health care infrastructure development projects in the region. The document review and key informant interviews demonstrate that WAHA has already prepared and submitted the Strategic Infrastructure Development Plan and a Stage 1 Proposal to province. The proposal notes the essential redevelopment of the WGH facilities is the highest capital priority for WAHA to ensure continued availability of services to residents. The submission recommends that the WGH facility be rebuilt on a new site on the mainland in Moosonee and that a Health Centre similar to that currently located in Moosonee be established in Moose Factory. The full Stage 1 proposal (Part A and Part B Service Support) was submitted in October 2013. Stage One approval has not yet been granted by the Ontario Ministry of Health and Long Term Care. Recently, Health Canada, the NE LHIN, the Ontario Ministry of Health and Long Term Care and WAHA agreed to establish a working group to develop timelines with key milestones for each stage that needs to be developed as well as a business case to outline the need for the new hospital.[8]

8 Hey Group. 2016. Weeneebayko Area Health Authority (WAHA) Operational Assessment Project Report.

C. IMPACTS OF WAHIFA

The WAHIFA identified a number of intended impacts as a result of the implementation of the requirements and activities of the Agreement. This section describes the success of the WAHIFA in achieving its intended impacts and the factors that have contributed to and constrained success.

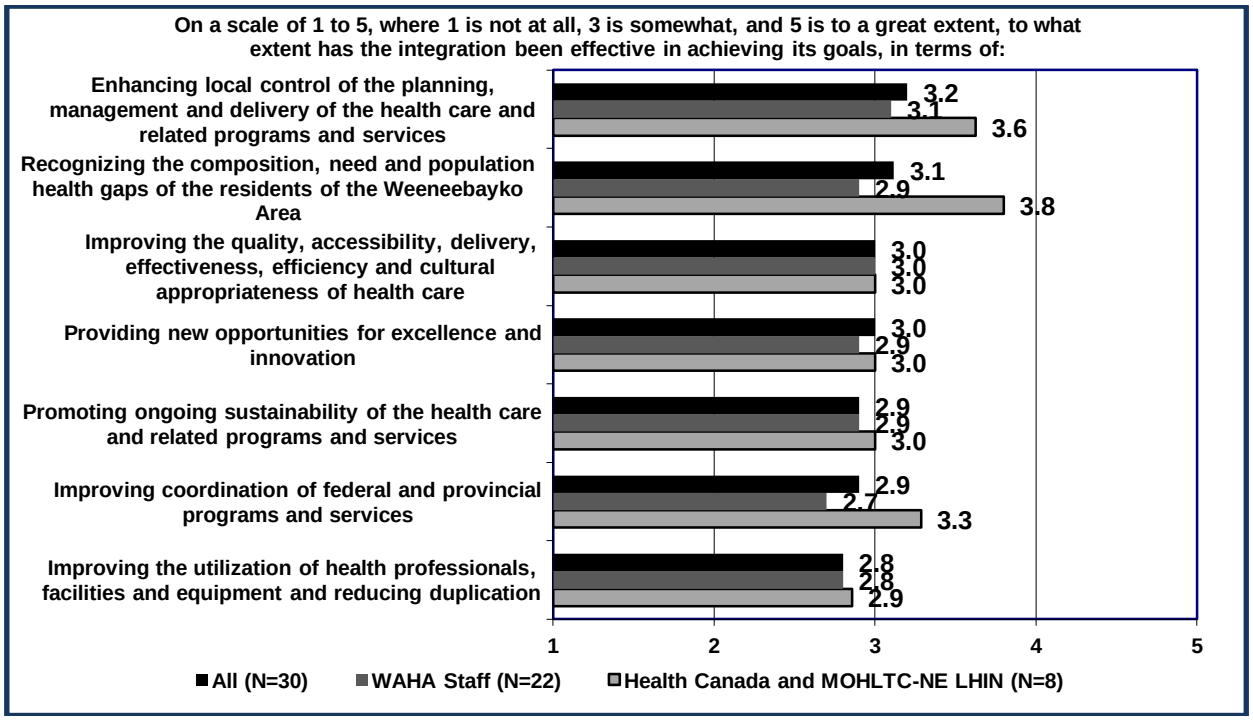
1. Key informants consider the WAHIFA as somewhat successful in achieving its intended impacts in the region.

The key informants interviewed were asked to rate the extent to which the integration has achieved its intended impacts. As demonstrated in the following figure, key informants report the integration has been somewhat successful in all areas, including:

- Enhancing local control of the planning, management and delivery of the health care and related programs and services;
- Improving coordination of federal and provincial programs and services;
- Improving the quality, accessibility, delivery, effectiveness, efficiency and cultural appropriateness of health care programs and services;
- Recognizing the composition, need and population health gaps of the residents;
- Promoting ongoing sustainability of health care and related programs and services;
- Improving the utilization of health professionals, facilities and equipment from the federal and provincial systems, reducing duplication and achieving gains in the efficiency; and
- Providing new opportunities for excellence and innovation.

The ratings provided by WAHA staff and the representatives of NE LHIN and the Ministry were similar.

Figure 6: Achievement of Intended Impacts of WAHIFA



The following paragraphs summarize the justification and examples provided by key informants to support their rating:

- *Enhancing local control of the planning, management and delivery of the health care and related programs and services.* Key informants who provided higher ratings emphasized the establishment of WAHA, which is governed by representatives of the communities appointed by chiefs. WAHA holds regular board meetings where community concerns are discussed and has organized several community consultations to obtain input for management and decision-making. Key informants who provided lower ratings suggested community representation on the WAHA board is more symbolic, and the communities do not have actual control over and participation in the decision making process. They indicated that WAHA has yet to become an organization that represents First Nations' interests in adequate level.

- *Improving coordination of federal and provincial programs and services.* Key informants who provided higher ratings noted that the activities of the provincially run James Bay General Hospital (JBGH) and the federally run Weeneebayko General Hospital (WGH) are now managed by WAHA under one administration. WAHA receives funding from both federal and provincial governments and works in close collaboration with Health Canada and NE LHIN. All hospital operations, administration, policies, procedures and manuals continue to be integrated. WAHA also provides physician services to nursing stations in Peawanuck and Kashechewan run by Health Canada. Key informants that provided lower ratings explained that both the federal and provincial governments continue to fund many programs and services in the region with little coordination with WAHA. There is no common table or discussion board where the WAHIFA signatories come together to coordinate their activities and align programming. Interaction between the federal and provincial government over the programming is rare, ad hoc and depends on initiatives of individual staff members.

- *Improving the quality, accessibility, delivery, effectiveness, efficiency and cultural appropriateness of health care and related programs and services.* Key informants highlighted a number of actions undertaken by WAHA and new programming initiated to improve the quality, accessibility, effectiveness, efficiency and cultural appropriateness of services in the region. Examples included geriatrics clinics, dialysis clinics, a diabetes program, traditional healing program, training of personal support workers in the communities, public health initiatives (e.g., stray dogs), cancer screening, Cree translators, and cultural sensitivity training delivered to staff members. WAHA has also created a quality improvement department to constantly assess and improve the quality of its services and programming (e.g., through incident reporting and client and staff satisfaction surveys). Key informants report, however, that many of the new projects and initiatives are short-term, have only recently been launched and have yet to make a significant impact at the community level. In addition, enforcement of the rules for the NIHB program and have resulted in some restrictions for medical escorts which community members view as a further decreased in access to quality services for community members.

- *Recognizing the composition, need and population health gaps of the residents of the Weeneebayko Area.* WAHA has undertaken several initiatives to improve the quality of the performance data collected. In particular, several consultations and surveys with communities were conducted in recent years to learn about their needs and health priorities. WAHA has also recently joined Meditech to collect better patient information and benchmark service delivery indicators with peer hospitals. However, according to key informants, there are no mechanisms in place to regularly collect and report population health and surveillance data from the communities. The lack of data is one of the most critical issues affecting the delivery of the health programs in the region.

- *Improving the utilization of health professionals, facilities and equipment and reducing duplication.* According to key informants, more centralized decision making over staff members, facilities and equipment has helped to better coordinate and improve utilization. The major problems affecting utilization include deteriorating inventory (e.g., the hospital in Moose Factory was built in 1949 and constantly needs major capital improvements), high staff turnover, difficulties with staff recruitment, and inadequate resources for replacing old equipment.

- *Promoting ongoing sustainability of the health care and related programs and services.* Key informants report that the sustainability of the regions' health care programs has been enhanced by merging the two hospitals' administration and management; however, the ongoing deficit is a major impediment.

- *Providing new opportunities for excellence and innovation.* Since the integration, WAHA has implemented several innovative approaches including use of the OTN (Ontario Telemedicine Network), which allows assessment and diagnosis of patients in remote communities from a distance; joining Meditech, which improved collection and reporting of patient data; and the implementation of several innovative ideas such as geriatric clinics, and creation of quality improvement and discharge planning departments within the organization. Key informants explain that, although these approaches have made a positive contribution, WAHA has been overwhelmed with the integration activities and numerous emergencies in the communities (e.g., oil spill in Attawapiskat hospital and fire in Moosonee), leaving little time for innovation. The ongoing deficit and lack of adequate funding have further deteriorated WAHA's ability to implement innovation.

2. Most programs and initiatives implemented by WAHA in recent years are new, and the utilization and the impacts of such programs are still being assessed across communities. An ongoing operating deficit and a number of emergencies have further impacted WAHA's ability to provide improvements in quality care for the region. The region's most pressing health care gaps include consistent access to services by physicians and other specialized health care services and better coordination of the existing services among the service providers.

Results of the site visits demonstrated that communities are somewhat aware of, and acknowledge, projects implemented by WAHA to improve the quality of services in the region. However, as most of these programs and initiatives are new, the utilization and the impacts of such programs are uneven across communities. For example, as demonstrated in the following table, in 2012/13, during the community consultations conducted by WAHA, a majority of the participants indicated that they did not have adequate knowledge to rate and/or never used the services of WAHA's dialysis program, aging at home program, social work program, breast screening program, occupational therapy program, traditional healing program, community mental health program, telemedicine, and physiotherapy services delivered by WAHA. Almost half of the respondents also were not familiar with or never used the services of the diabetes health program, in-patient department services and specialty clinics.

Communities consider the services and programming delivered by WAHA as insufficient to meet their needs. For example, in 2012/13, during the community consultations conducted by WAHA (n=309), 43% of the community representatives rated the overall quality of the WAHA programming as 'average', and 25% rated the quality of the services as 'poor'. Only one-third of the representatives rated the quality as 'good'. As demonstrated in the following table, community members were more satisfied with the quality of the WAHA's ambulance, physiotherapy, breast screening, surgery, telemedicine and traditional healing programs compared to all other programming and services, especially with NIHB program, community mental health program, aging at home program and dental services.

Table 10: Community Satisfaction with Services Provided by WAHA

Based on your experience, please rate the services, departments or programs that you have used at WAHA?

Service, Program, Department	Good		Average		Poor		Total users		Not used/no response (n=314)	
	#	%	#	%	#	%	#	%	#	%
Overall services of WAHA	**100**	**32%**	**133**	**43%**	**76**	**25%**	**309**	**100%**	**25**	**8%**
James Bay Ambulance Service	101	47%	75	35%	40	19%	**216**	**100%**	118	**38%**
Physiotherapy	74	45%	49	30%	42	25%	**165**	**100%**	169	**54%**
Breast screening program	46	41%	36	32%	31	27%	**113**	**100%**	221	**70%**
Operating room/ surgery	84	41%	84	41%	35	17%	**203**	**100%**	131	**42%**
Telemedicine	57	39%	59	40%	32	22%	**148**	**100%**	186	**59%**
Traditional healing program	48	39%	48	39%	27	22%	**123**	**100%**	211	**67%**
Diagnostic imaging (x-ray/ ultrasound)	90	38%	94	39%	56	23%	**240**	**100%**	94	**30%**
Diabetes health program	63	37%	70	41%	38	22%	**171**	**100%**	163	**52%**
Occupational therapy	46	37%	49	40%	28	23%	**123**	**100%**	211	**67%**
Dialysis / renal unit	22	35%	22	35%	18	29%	**62**	**100%**	272	**87%**
Family medicine clinic	86	33%	115	44%	61	23%	**262**	**100%**	72	**23%**
Emergency department	83	31%	118	45%	64	24%	**265**	**100%**	69	**22%**
Laboratory services	82	31%	109	41%	72	27%	**263**	**100%**	71	**23%**
Specialty clinics	55	30%	83	45%	45	25%	**183**	**100%**	151	**48%**
In-patient department	52	29%	78	43%	50	28%	**180**	**100%**	154	**49%**
Dental services	64	24%	109	41%	95	35%	**268**	**100%**	66	**21%**
Aging at Home	17	23%	25	33%	33	44%	**75**	**100%**	259	**82%**
Community mental health program	33	23%	49	34%	61	43%	**143**	**100%**	191	**61%**
Social work	24	22%	49	44%	38	34%	**111**	**100%**	223	**71%**
Non-insured health benefits	38	19%	73	36%	90	45%	**201**	**100%**	133	**42%**

Source: WAHA 2012/13 Community Consultation Summary Tables

An ongoing operational deficit and a number of emergencies in the region have further deteriorated WAHA's ability to improve quality of the health care programming and the services in the region. According to key informants and community stakeholders, in order to reduce operating deficits and balance the budget, under the pressure from funders, WAHA has been improving productivity and efficiency in a number of different areas of operations, which has taken focus away from improving the amount of the services delivered and increasing quality because additional resources are not available. A number of emergencies that happened in recent years (e.g., oil spill at Attawapiskat Hospital and fire in Moosonee health clinic) have further shifted focus and resources from improving the health care in the region. There is a perception that these challenges and difficulties have not been adequately communicated and discussed with community stakeholders and staff members, which has negatively affected staff morale and the reputation and profile of WAHA. There is a degree of dissatisfaction among community members with regard to the services provided by WAHA and a sense of diminishing availably and quality of the health care in the region. According to community representatives, as discussed earlier, the access to quality health care has declined, due to an increased number of

requests for escorts being denied since WAHA returned the NIHB program back to Health Canada in 2013.

The evaluation identified a number of gaps in the accessibility of health care services in the region, summarized as follows:

- *Lack of proper access to doctors for diagnosis and treatment*. With the exception of the communities located in vicinity of Moose Factory Island, which have direct access to the WGH, the consensus of the representatives in the other communities is that they face serious challenges with physician access. Depending on the location of the communities, the community representatives stated that the visits by physicians happen periodically (e.g., twice or once a month), which is not adequate to provide proper care. As demonstrated in the following table, over the past two years, slight improvements in the overall number of physician days available in Moosonee and Fort Albany have been achieved while the availability of the doctors in remote communities such as Kashechewan and Attawapiskat have actually declined.

Table 11: Change in Average Monthly Physician Days from 2013 to 2015

Community	Change in Average Monthly Physician Days
Moosonee	+4.6 days
Peawanuk	+0.3 days
Kashechewan	-1.8 days
Attawapiskat	-0.4 days
Ft. Albany	+2.2 days

Source: Email communication from Robert Adolph on Jan 29, 2016

The wait lists to see physicians in some communities are very long. For example, despite improvements in the availability of physician days in Moosonee, the health center in town has over 300 community members on waiting lists and it may take up to 4 months for an individual to see a doctor. In Attawapiskat, some residents reported waiting over one year to be able to see a doctor and staff members at the health center confirmed the existence of long waiting lists. Although the integration of Meditech is expected to facilitate doctors' access to electronic medical records, according to community representatives, often visiting doctors do not have adequate knowledge of the patient's background and time spent in the communities is inadequate to provide proper care. All health facilities (i.e., the nursing stations in Kashechewan and Peawanuck, the hospital in Fort Albany, and the health centers in Attawapiskat and Moosonee) are staffed by nurses. Although the use of OTN has significantly improved nurses' ability to consult with doctors and other health care professionals from a distance and provide diagnosis and treatment, there is an indication that the use of the system is uneven across the communities. The other issues at nursing stations and health centers include high turnover of staff and nurses and the hiring of those outside of the region who do not speak Cree and have limited understanding of the community realities, culture and traditions.

- *Lack of proper access to many types of health care professionals, such as ophthalmologists and mental health professionals.* Noted by community members and confirmed by many key informants in the region, waiting lists to see certain specialists may take long time and vary from several months to a year depending on location of the community and type of the services. Domestic violence, suicide, addiction and other mental health issues are affecting the communities at very high levels and the available mental health programming is not adequate to address the existing

needs. Communities lack access to professional counselling and mental health therapists to deal with suicide, grief, loss and other mental health issues.

- *Lack of coordination among service providers*. There is a limited communication, consultation and coordination of activities and programming between the community leadership, WAHA, Health Canada and NE LHIN. According to community stakeholders and some key informants, responsibility for different services is often disputed among the service providers and community members constantly fall through the cracks. Although impossible to verify independently, community members reported experiencing language barriers, mistreatment and lack of care when they stay in hostels, and visit hospitals and health care professionals in Kingston and Timmins. Communities expect WAHA to continue to advocate on their behalf to increase cultural safety and appropriateness of services offered by partner organizations.

3. WAHIFA has resulted in unintended outcomes, both positive and negative.

According to some key informants, a positive unintended impact of the WAHIFA is the greater recognition among local First Nations of their contribution and a desire to take more active role in the management of the region's health care services. Despite the many difficulties associated with the quality of the health care services, the integration has resulted in an increased focus on First Nations' control over their health programming. An increasing number of community members want to be involved in the decision making process.

A negative unintended outcome of the Program is discontent among some of the region's chiefs with the current situation of health care in the region. Prior to the integration, the chiefs were on the board of the federally run Weeneebayko General Hospital (WGH) and made most of the governance decisions. In the current system, chiefs are not involved directly in management of WAHA. Instead, they are represented by their appointees. The perception that some of the board members may have limited capacity to adequately govern the organization and participate in board decision making process has resulted in some community stakeholders indicating that they are losing control of WAHA and their treaty rights.

4. A range of key factors have contributed to the success of the integration.

The evaluation explored key factors that may have contributed to the success of the integration. The factors identified by key informants include:

- *Participation of six communities in the region.* With the exception of one First Nation in Moose Factory (Moose Cree First Nation), six communities in the region signed the agreement, which resulted in the creation of WAHA and amalgamation of two hospitals in the region. Having communities agree on WAHIFA was a major milestone for the success of the integration.

- *The motivation and the hard work of many staff members at WAHA* who work overtime under difficult conditions to deliver the services and programming. Over the past two years, the capacity of the WAHA to deliver its services has significantly increased. According to key informants, WAHA has recruited a new senior leadership team which includes members with the necessary qualifications and aspirations to implement the integration and improve the operations of the organization.

- *Recruiting and training of staff members from local communities* who have a strong understanding of the local culture and traditions, and a greater dedication to the community. It is anticipated that by employing local staff, staff turnover will be reduced.

- *Increased communication between WAHA, NE LHIN and Health Canada in recent years*. Key informants noted that over the last several years, senior leadership teams at WAHA, NE LHIN and Health Canada have increased their degree of communication and collaboration. They hold regular phone calls, face-to-face meetings and Tripartite meetings to discuss issues and explore solutions for problems.

- *Integration into the provincial health care system and Meditech*, which has helped to align WAHA operations with provincial standards and best practices, and increase the quality of patient care and service delivery.

5. A number of factors served as obstacles limiting the success of the integration.

Constraining factors related to the signatories, include:

- *Inadequate planning and preparation after the signing of the WAHIFA in 2007.* According to many key informants, after the agreement was signed, insufficient consideration was given to the efforts and cost that would be required for the integration and transition (e.g., harmonization of the policies and procedures) and potential issues and problems (e.g., legislative issues). The communities were not consulted at an adequate level and their understanding of the agreement was vague. Once the asset transfer agreement was completed to create WAHA in 2010, WAHA had to deal with numerous changes in a short period of time without proper support from the signatories.

- *Lack of oversight*. The agreement lacked a body to provide oversight during the implementation. According to key informants, after the integration, WAHA was provided with little and mostly uncoordinated support from the signatories to ensure effective implementation. As a new organization, WAHA lacked capacity, resources, and support to successfully implement the integration. HC FNIHB ON initiated an ad hoc Tripartite oversight group in 2012.

- *Lack of budget and adequate resources dedicated for the integration and to cover increasing cost of operations*. The document review and key informant interviews demonstrate that the integration resulted in significant costs for WAHA. WAHIFA indicated that the signatories would work together to obtain additional funding to cover the cost of integration. However, the agreement did not provide concrete funding commitments. Consequently, WAHA accumulated significant costs associated with the integration without receiving any additional funding support. In addition, WAHIFA did not include consideration to account for raising cost of operations (e.g., increase in labour cost), which further deteriorated the financial position of the organization.

The constraining factors related to WAHA, include:

- *Insufficient efforts to work with First Nations community leaders and involve them in the decision making process.* Additional efforts are required by senior management at WAHA to engage community leaders and build relationships based on mutual trust. According to community stakeholders, the relationships between WAHA senior management and community leaders (e.g., Mushkegowuk Council and chiefs) are strained due to a perception of differing views on health care in the region. According to community representatives, in order to engage communities, WAHA senior management need to demonstrate their understanding of the effects of colonization, and

participate in open and continuous face-to-face dialogue and communication. They also indicated that WAHA needs to further enhance its orientation and training program for existing and new staff members to enhance their understanding of First Nations culture and traditions. Community representatives and key informants stated that the buildings and infrastructure operated by WAHA lack cultural design elements and art to create a welcoming and safe environment for First Nations people.

- *High staff turnover, vacancies and issues related to management*. The document review and key informant interviews demonstrate that WAHA has experienced significant difficulties hiring qualified senior staff members. The organization has had three CEOs and the position of the CFO was vacant for several years. The senior leadership at WAHA has recently been enhanced by hiring a number of qualified staff members and the management environment has been improving. For example, in 2011/12 staff satisfaction surveys, staff members (n=123 or 30% of all 433 staff members) gave WAHA an overall average ranking of 5.3 on a 10 point scale (1 being the lowest rating and 10 being the highest rating) and gave average ranking of 6.0 on a 10 point scale 2013/14 survey. The same year, 81% of staff who participated in the survey indicated they are satisfied with their jobs. Nevertheless, WAHA continues to struggle with the recruitment and retention of qualified staff. For example, according to program documents, in the 2012/13 fiscal year, the staff turnover rate at Attawapiskat Hospital was 100%, the turnover rate at Fort Albany Hospital was 75%, and at WGH it was 65%.[9] High turnover is affecting staffing at all levels, from nurses to senior staff. High turnover of service delivery staff requires WAHA to utilize agency/locum staff who often do not have adequate understanding of the local communities and skills to work with First Nations people. The majority of WAHA staff interviewed indicated that there exists potential for further improvement in their work environment that would improve job satisfaction and reduce staff turnover. The most frequent suggestions to improve job satisfaction and reduce turnover provided by these key informants are as follows:

  - Increase the extent to which staff are involved in the decision making process;
  - Ensure that decisions are adequately discussed and communicated to staff members, because lack of communication demotivates staff and creates resistance for change; and
  - Ensure that staff receive increased encouragement, support and guidance to work hard, serve the communities, and excel in their positions and duties.

- *Lack of consistent communication strategy with communities*. WAHA does not have a comprehensive strategy for consistent and open communication with the communities to inform them about the activities undertaken and to listen to community concerns and suggestions. The evaluation identified that the communities are not sufficiently informed about the activities undertaken by WAHA or WAHA's accomplishments. In recent years, WAHA has significantly increased its efforts to communicate with communities. In particular, it has created community specific newsletters, started publishing annual reports, created a new website for the organization, and organized regular radio programs. In 2013, WAHA also organized community discussions to listen to their needs and complaints. However, the consensus of community representatives consulted is that communication efforts by WAHA have been insufficient to engage communities and gain their interest at an adequate level.

- *Insufficient level of client service by WAHA has negatively affected its reputation among the communities.* Some examples of the lack of service mentioned by community representatives are that phone calls are often not answered or returned. Some clients feel that they need to call many times and leave many messages before being able to receive a response to their inquiries. There

9 WAHA Quality Improvement Plan, 2013/14

are many cases when patients file incident reports and complaints but never hear back from WAHA with regard to the outcome of those reports.

- *Housing is an issue***.** According to representatives of WAHA, access to safe and affordable housing in an on-going struggle for the region and impacts WAHA's ability to attract and retain qualified individuals. This is a regional challenge that impacts each of the communities WAHA serves.

- *WAHA is struggling to provide services in Cree.* According to community stakeholders, WAHA does not have an adequate number of staff who can provide services in Cree. Many community members, especially the elderly, are having difficulties accessing services due to language barriers. More Cree speaking workers and translators are needed, especially during the evenings and weekends.

- *Aging infrastructure.* Key informants and community stakeholders noted that WAHA facilities are old, deteriorated and some of them are in need of urgent repair or upgrades. The main hospital in the region, Weeneebayko General Hospital, was built in 1949 and requires significant maintenance. Most other buildings operated by WAHA also need significant improvements. Lack of proper infrastructure makes it difficult to implement new initiatives.

Factors related to First Nation communities include:

- *Lack of capacity and political divide in the communities*. According to key informants, the communities in the region and their leadership are largely divided and lack unity on different political issues including health care. Often, the positions taken by the chiefs reflect their interests or their particular communities instead of the region overall. Some key informants stated that some chiefs in the communities have a limited understanding of the region's health care and their role with respect to WAHA operations. The divide is especially evident with regard to location of the new hospital.

- *Difficulties associated with doing business in remote and isolated regions.* According to key informants, due to geographic isolation and the lack of a roadway system in the region, it is very costly to transport people, products, equipment, and patients to the region, especially before the winter freeze and during the spring break up. Staff training and relocation costs are significant. The communities constantly experience emergencies. A number of events and emergencies have happened that diverted resources and affected the operations of WAHA including a fire at the Moosonee health clinic, a fuel spill at Attawapiskat hospital, flooding and suicide clusters.

- *Lack of locally trained health care professionals*. Key informants noted that there is a general lack of locally trained professionals in the area of health care. The chiefs encounter difficulty appointing board members who have the necessary qualifications to govern a hospital. While the region lacks programs for training, recruiting and retaining local professionals, hiring outside professionals incurs higher costs and contributes to high turnover. Increased use of OTN and web-based learning is having a positive, cost-effective impact.

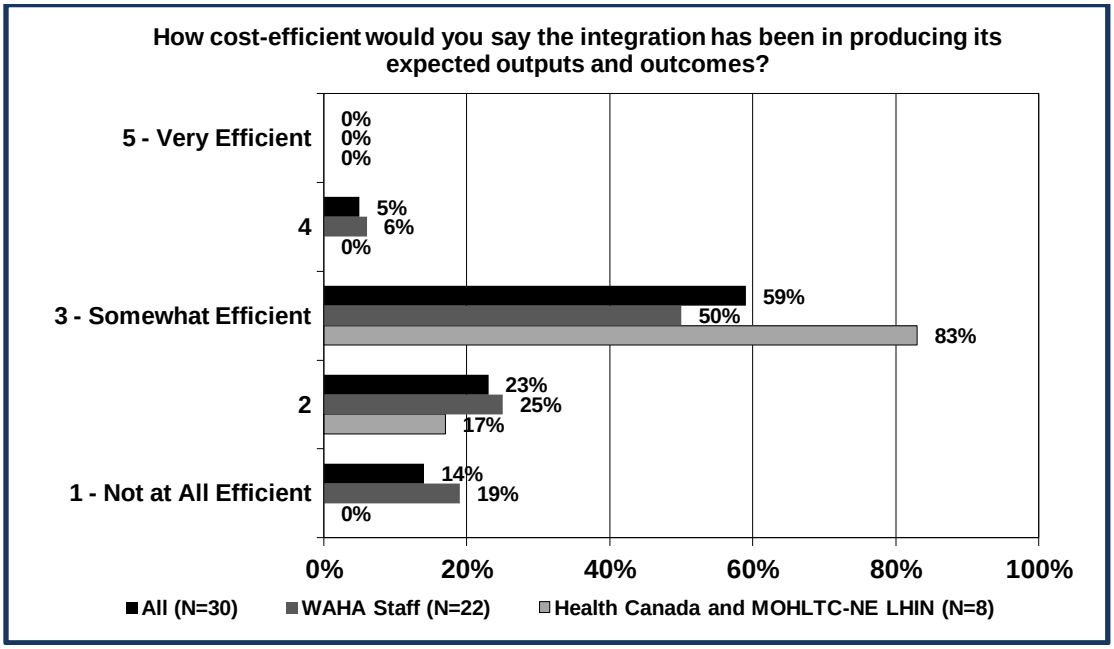
D. DESIGN AND DELIVERY

This section provides the evaluation findings regarding the design and delivery of the activities implemented as a result of the WAHIFA.

1. Key informants consider the integration not very efficient in producing its expected outputs and outcomes.

Key informants were asked to rate the extent to which the integration has been cost-effective in producing its expected outputs and outcomes on a scale of 1 to 5 where 1 is not at all efficient, 3 is somewhat efficient and 5 is very efficient. The average rating provided by all key informants was 2.5, with 59% providing a rating of 3, 23% providing a rating of 2 and 14% providing a rating of 1. The ratings provided by WAHA staff members and representatives of Health Canada and NE LHIN were somewhat similar.

Figure 7: Efficiency of WAHIFA in Producing Expected Outputs and Outcomes



Key informants explain that the integration resulted in a high deficit, which negatively affected the ability to increase quality in programs and services provided by WAHA. As noted earlier, over the period covered under this evaluation, the organization experienced significant deficit, including an operational deficit of approximately $2.9 million and a net working capital deficit over $13 million in 2014/15. This net working capital deficit takes into account the fact that WAHA has used for operational purposes the $6.550 million (cumulative funding from October 1, 2010 to September 30, 2014) allocated by Health Canada for infrastructure improvement to support hospital operations. WAHA is currently implementing a Hospital Improvement Plan in order to attain a balanced budget and reduce the deficit Key informants agreed that implementation of the Hospital Improvement plan has helped WAHA to cut costs and become more efficient over time. The evaluation identified a number of factors that have constrained the cost-effectiveness of the integration and contributed to the deficit, including:

- *Lack of proper planning.* The document review and key informant interviews demonstrate that prior to the integration, both James Bay General Hospital (JBGH) and Weeneebayko General Hospital (WGH) were in a significant deficit situation. At the time of the signing of the WAHIFA, the province and Health Canada decided to pay off accumulated deficit. However, it appears that no proper assessment was conducted to identify and tackle the real causes of the accumulating deficit.

- *The integration resulted in some cost savings associated with the administration and management of the hospitals but also required much greater expenditures associated with the transition*. A review of the WAHA documents and files demonstrates that prior to the integration of WGH and JBGH, the

combined administrative overhead for both organizations was $3.2 million (2009/10). The same expenditures for WAHA in 2012/13 were $1.35 million indicating a saving of over $1.85 million.[10] Post-integration of the two hospitals, WAHA incurred estimated one-time costs of $14.5 million related to a number of extraordinary costs and integration expenses, which was much greater than the cost savings achieved from the integration.[11]

- *WAHIFA did not include an increase in funding for WAHA to account for inflation and the increasing cost of collective agreements*. Instead, the agreement required the organization to set aside $2 million annually for future infrastructure improvements, which further reduced operational funding.

- *Many aspects of the integration were mismanaged, resulting in higher costs.* According to key informants, at the time of the integration, the then senior management at WAHA lacked the capacity to effectively manage the integration. Instead, the organization hired a significant number of consultants to conduct the integration (e.g., handling merger of collective agreements, harmonization of different pay rates, benefits systems and pay dates), which resulted in higher costs. The senior management at the time of the integration did not take into consideration the new mandate of the organization, and continued the business as it was before. They did not give adequate consideration to cost-efficiency, expecting the funders to bail out the deficit as it had happened prior to the integration. These are not the characteristics of the current senior management team.

- *Lack of oversight over staffing*. According to key informants, merging two completely different organizational cultures resulted in many uncertainties within the organization and limited oversight and supervision for staff members over their vacations, stress or medical leaves, and other employee benefits. Increased number of staff took advantage of the loopholes which created a financial burden on WAHA. For example, as the new organization did not have proper systems in place, an increased number of staff members took paid traditional and stress leaves for extended time periods (e.g., 3 to 6 months). At any point in time over the past five years, approximately 5% of all staff members were on medical leave, the cost of which WAHA was obligated to cover, including salaries, travel to outside of the region, and staff replacement. The cost of replacing staff absentees and turnover has been a huge constraint on the WAHA budget. The organization has taken some steps to have tighter control over employee absentees and negotiated stricter terms for medical leaves in the most recent collective agreements. However, the high turnover and use of the short-term agency staff replacements is still a significant issue.

- *Increasing health care needs in the communities.* The lack of performance and surveillance data from the region does not support a clear assessment of the health care needs of the communities. However, there is a strong perception among all stakeholders (WAHA staff and community representatives) that the need for health care and the severity of the health issues faced by the communities have significantly increased over the last decade. Increased population of the region, intergenerational trauma and effects of the residential schools on families, unhealthy life styles (e.g., drinking, smoking, etc.), poverty and high cost of fresh produce, and untreated complications of various disease and health conditions (e.g., diabetes) has increased the demand for health care programming.

2. Key informants highlighted a number of areas where the cost-effectiveness of WAHA operations could be improved.

10 WAHA 2012. Hospital Improvement Plan 2012/14.
11 NE LHIN, Briefing Note: Weeneebayko Area Health Authority (WAHA) - Hospital - Operating Pressures 2015/16, October 27, 2015

These areas include:

- Collaboration with other hospitals in the region to achieve economies of scale in procurement and contracting other hospitals to do back-office services (HR, finance, purchasing, etc.) through use of Meditech.

- Work with Health Canada, NE LHIN and NIHB program to explore opportunities to reduce the cost of travel and transportation to the region. In particular:

  - Explore options for bringing more specialists to the region instead of sending community members south for medical appointments.
  - Achieve a partial reduction in training costs by utilizing online training options instead of transporting staff members to the south to participate in in-person training sessions, and developing mentorship programs to train staff members within the organization.

- Explore options to reduce turnover of existing staff members, increase retention and reduce use of agency nurses. Focus on training and recruiting staff members from local communities in the long term.

- Increase financial and fiscal accountability and reporting within the organization.

- Develop a proper funding formula to run hospital operations and public health programming in the region that takes into account the needs of the communities and high cost of doing business.

- Ensure the new hospital is built at Moosonee to cut the cost of transportation to the Island (Moose Factory).

- Increase board education and capacity to better involve board members in the activities of the WAHA and continue to organize board meetings in the region.

- Consolidate all funding agreements. The number of funding agreements between WAHA and different funders requires significant administrative efforts and management.

- In cooperation with all funding sources, better coordinate existing health care programming to avoid duplication and overlap in services.

3. There are alternative approaches, governance structures or strategies that may achieve the intended results more effectively or efficiently.

When asked if there are alternative approaches, governance structures or strategies that may achieve the intended results more effectively or efficiently, approximately 56% of key informants interviewed said yes, approximately 32% were unsure and 12% suggested the current structure and approach was most efficient.

The most frequent suggestions by key infomants of more effective or efficient approaches are as follows:

- Preparing a Special Act.

- Ensuring more involvement in WAHA and its operations by First Nations communities. This would provide more sense of ownership to communities and increase their support for WAHA.

- Establishing an advisory committee to provide guidance and support to WAHA and ensure all provisions and requirements of WAHIFA have been implemented. The body should include all signatories and should meet regularly to help ensure that all signatories are fulfilling their roles and responsibilities at an adequate level and supporting the organization to succeed.

- Revising the current structure of the board to allow some board members to be selected through a competitive and open process. This approach would support the recruitment of board members that possess the necessary skills and qualifications to run hospital operations and reduce the effects of community politics in the hospital operations.

- Expand working groups in different areas of WAHA operations (e.g., Mental Wellness, Public Health, etc.) and involving key community stakeholders in these working groups to guide WAHA programming.

- Bringing all public health programming under one umbrella and improving coordination and communication of the programming in the region.

4. A review of similar initiatives indicates that there are a number of alternative design and delivery approaches used in other regions, some of which could possibly be applied to WAHA.

A detailed review of similar First Nations health authorities created in other regions of Canada demonstrated that it is very difficult to develop a set of alternative design and delivery strategies based on similar approaches taken in other regions. The size, geographic location, the level of isolation, and remoteness and diverse needs of the communities in each region makes it impossible to create a single design for a health authority that can address the needs across all areas. Nevertheless, the review identified a number of common themes, lessons learned and promising practices from other health authorities, some of which could possibly be applied in the James Bay coast. These common themes, lessons learned and best practices are summarized as follows. It should be noted that each lesson and practice mentioned deserves a more detailed review to identify the potential for application in the region.

- *Creation of an advisory body of signatories to monitor the implementation of the agreement and the activities of the health authority*. Both the British Columbia First Nations Health Authority (FNHA) and Sioux Lookout Meno Ya Win Health Centre have created a body representing signatories, which coordinates and aligns programming and planning efforts between the province, First Nations, and the federal government. The creation of this group has been critical to the success of both organizations.

- *Creation of a First Nations political support group.* The governance structure of the BC FNHA includes The First Nations Health Council (FNHC) represented by all First Nations communities in BC, which provides political leadership for the implementation of the tripartite agreement and support the activities of the health authority. The political support provided by the FNHC has played a critical role in the success of the activities of the BC FNHA and ensured its programming is aligned with the health priorities of First Nations in BC. Similar arrangements could help WAHA to gain necessary political support from the chiefs and community leaders.

- *Creation of a technical support group*. The governance structure of the BC FNHA includes the First Nations Health Directors Association (FNHDA), which plays a technical advisory role in the activities of the health authority. The FNHDA is composed of health directors and managers working in First Nations communities in the region. It provides advice to the health authority in the areas of education, knowledge transfer, professional development and best practices. Similar arrangements could strengthen the capacity of the WAHA and bring technical expertise from the communities into the decision making process.

5. Key informants and community members provided a variety of suggestions and recommendations with respect to how the integration and the activities and programming implemented by WAHA could be improved.

Numerous recommendations were provided by key informants regarding how the initiative could be improved. The recommendations, as well as the number of responses reported, are provided in the following table.

Table 12: Key Informants Suggestions to Enhance WAHA Activities and Programming

Area	Recommendation
Design and Delivery	▪ There are many providers involved in delivery of health care programming in the communities (especially public health). Increase coordination of all health programming in the region, and reduce duplication and overlap of the activities. Consider consolidating all programming under one organization. (16) ▪ Improve customer service and responsiveness of WAHA to complaints and inquiries coming from communities. (13) ▪ Change the structure of the board by allowing some board members to be selected based on their qualifications (11) ▪ Change regional approach of service delivery and make it community and patient driven. Currently, the delivery is program or system driven and various service delivery organizations are involved in delivering the programming. Ensure the patients and communities are the center of all services and make sure it is easy for community members to navigate through the systems. (9)
Implementation	▪ Take over the administration of the NIHB program from Health Canada, improve the management of the program and explore opportunities to increase the quality of the services that the communities receive. WAHA cannot build a positive reputation in the communities if it continues to ignore the many problems associated with the NIHB. (13) ▪ Increase focus on preventative and promotional programming to avoid future medical complications and raising cost of health care. (11) ▪ Focus on increasing quality and availability of the services and efficient delivery, instead of focusing on reducing the programming. Focus on cuts have resulted in a reduction of the quality of the services. (10) ▪ Increase long-term and chronic care beds and facilities in the communities to avoid sending the elderly outside of their communities. (8) ▪ Develop a proper performance measurement system to monitor the activities of the WAHA. (8) ▪ Increase public health programming and resources for WAHA and dedicate a specific public health professional to this area. (6)
Communication and building positive relations with the communities	▪ Develop proper communication strategies and open lines of communication with the communities. Involve chiefs and community leaders in WAHA operations and build mutual trust and positive relationships with them. (14) ▪ Increase transparency and openness within the organization. Ensure all decisions are adequately communicated and discussed with staff to gain their support. (11) ▪ Create a First Nations-friendly environment at all WAHA facilities and establishments. Ensure First Nations arts and culture are incorporated into the services and facilities to

Area	Recommendation
	support healing. (8) ▪ Ensure all staff members, especially senior management and service delivery personnel, have adequate understanding of the effects of colonization, residential schools and trauma and can provide culturally safe services. (7)
Management and Human Resources	▪ Address the staff turnover by hiring locals, and provide better incentives and positive treatment to existing staff members. (19) ▪ Change the management approach and treatment of the WAHA employees and make it open, fair, and based on existing best practices in the industry. (8) ▪ Ensure staff members have adequate support and guidance from the senior management. (8) ▪ Create open and transparent communications within the organization and avoid retaliating against those who disagree with the current management style. (8) ▪ Create a supportive team environment and work collaboratively with staff and management to find possible ways of addressing gaps and improving staff performance. (7) ▪ Create an innovative and supportive environment to utilize the inspiration, ideas and creativity of existing staff members. (6) ▪ Ensure hard work of staff is appreciated and rewarded by providing adequate acknowledgement for their work by senior management. (5)
Funding	▪ Develop a funding standard/mechanism specific to the region which reflects the remote and isolated location of the communities and specific health care needs in the region. (18) ▪ Increase the amount of funding for the programming implemented by WAHA. The current level of programming funding is not sufficient. (17)

During the community consultations, community representatives were asked to provide recommendations on how the design and delivery of the health care services and programming in the region could be improved. The recommendations and suggestions provided by community stakeholders are summarized as follows:[12]

- *Increase access to and quality of health care and related services in the communities*. Stakeholders in all communities visited indicated a need for improving the amount and quality of the services provided by physicians, dentists, long-term care, medical travel and transportation, paramedics, ophthalmologists, and mental health services. Increasing the extent these services are offered in the communities would increase access for community members and reduce transportation costs. There is a need for physicians to be stationed in the communities. (5)

- *Communities need a long-term care facility*. Community stakeholders indicated that it is very important for community members to be able to care for their elderly in the community. The elderly, many of whom are residential school survivors, are traumatized again in last stages of their lives by being sent for long-term care outside their communities. (4)

- *Better coordination of health care services in the communities*. Community stakeholders noted that there is a need for a body or an organization that would represent all complaints and requests coming from the communities and improve the coordination of services. According to communities, WAHA needs to become such an organization and lead the integration and coordination in the region. In addition, WAHA needs to be the voice of the communities and advocate on their behalf. The service providers should work together, communicate regularly and collaborate on issues and programs. Improved coordination will help to increase the efficiency and effectiveness of the

12 The numbers in the brackets indicate the number of communities that have raised the issue or provided the recommendations.

services. In particular, medical transportation and escort services provided by Health Canada need to be better coordinated by WAHA. (3)

- *There is a need to train and recruit local nurses and health staff.* According to community stakeholders, turnover of nurses and front line service delivery staff is a very significant issue. The nurses and staff members from the communities are more likely to understand the communities' needs, speak Cree, stay longer in their positions and provide overall better services. (3)

- *There is a need to improve the capacity of the communities to address their health care needs.* Community stakeholders noted a need for community members to come together and work to address all their issues, including health care, mental health and suicide. Promoting First Nations culture and traditions to improve community connections and bonds, improve self-esteem, and develop a strong cultural identify should be a part of the capacity building efforts. (3)

- *There is a need to enhance existing prevention, education and promotion programming*. According to community stakeholders, many of the complications in health care needs could be prevented with better education and promotion programming and services delivered in the community. (2)

- *Better surveillance and data collection efforts* will help to identify community needs and develop programming to address them. (2)

- *Build the new hospital that was promised during signing of the WAHIFA*. Community stakeholders noted that having a new hospital would improve access to health services for all residents in the region. (2)

- *There is a need for increased communication and community engagement from WAHA.* According to community representatives, more regular discussions and engagement with the communities are needed. WAHA board members and senior management need to be open and engage directly with the communities on a regular basis. Communication from WAHA needs to be regular and very transparent. (1)

- *Increase staff members' cultural competency and the cultural safety of the services*. According to community stakeholders, the staff members at WAHA should have knowledge of First Nations traditions and culture. Nurses and medical staff at health centers should show increased compassion and care for their patients. (1)

- *Increase WAHA's funding.* According to community stakeholders, WAHA needs more support and funding to increase the quality and availability of the services in the region. Recent pressure from funders to address operational deficit have affected the quality and availability of the services. (1)

V. CONCLUSIONS AND RECOMMENDATIONS

This chapter provides conclusions and recommendations resulting from the evaluation of the WAHIFA.

A. CONCLUSIONS

The key findings and conclusions resulting from the evaluation of the WAHIFA are as follows:

1. **The objectives of the Weeneebayko Area Health Integration Framework Agreement (WAHIFA) and the extent to which these objectives have been achieved are perceived differently among the signatories of the agreement.**

   While most key informants (i.e. representatives of WAHA, Health Canada the province of Ontario and the NE LHIN) view the key objective of the Agreement as the amalgamation of the two hospitals — the James Bay General Hospital (JBGH) and the Weeneebayko General Hospital (WGH) — to achieve efficiencies and better coordination, most representatives of the First Nations communities consulted indicated that they signed the Agreement because they were promised improved health care services, a new hospital, and more programming, such as public health and long term care services under First Nations control. While most key informants consider the WAHIFA as somewhat successful in achieving its objectives, First Nations communities indicated that their expectations have not been fulfilled to an adequate level.

2. **Most of the requirements and provisions stipulated in WAHIFA have been implemented. However, significant issues and gaps remain with regard to Public Health, Long Term Care, a hospital funding formula that recognizes the remote location of WAHA, and further integration of the continuum of health care programming in the region.**

   Most stipulated provisions and requirements of WAHIFA have already been implemented; however, significant gaps and issues remain with regard to developing a new hospital funding formula that recognizes the remote northern location of WAHA; delivering long-term care and public health programming; and integrating the continuum of health care programming in the region. In addition, the signing of a Special Act to provide First Nations communities greater control over WAHA was stipulated in the WAHIFA but has not been undertaken by the province and there exist varying perspectives among stakeholders regarding the need for a Special Act.

3. **Some progress has been made in achieving the intended results of the WAHIFA.**

   The results of the evaluation demonstrate that the integration has made some progress in terms of producing the intended results of WAHIFA. In particular, over the past several years, two hospitals (JBGH and WGH) have been amalgamated under one organization, a new health authority governed by First Nations has been created, the internal policies and procedures of both hospitals continue to be integrated, and new consolidated collective agreements have been negotiated and signed. WAHA has also implemented a number of initiatives to improve the quality and accessibility of health care and related programming in the region. Examples of such initiatives include implementation of cancer screening projects, a traditional healing program, telemedicine, geriatric clinics, dialysis clinics, a diabetes program, several public health initiatives, hiring of Cree translators, and joining ~~of~~ the provincial Meditech system to increase the quality of patient data. WAHA has also created a quality improvement department to constantly assess and improve the quality of its services and programming (e.g., through incident reporting and client satisfaction surveys).

Factors that have contributed to the success of the integration include the endorsement of the Agreement by the communities in the region; the dedication and hard work of many WAHA staff members; the hiring of a more qualified senior team in recent years; the recruitment of staff from the local communities; increased communication by signatories in recent years; and the joining of WAHA into provincial health care systems, which helped WAHA benefit from provincial benchmarks.

4. **Operating deficits, lack of pre-merger planning and insufficient efforts to build relationships with First Nations communities have limited the achievement of some WAHIFA objectives.**

Due to operating deficits, WAHA has been constrained in its ability to provide a complete continuum of health care programming, such as public health and long term care services under First Nations control. While significant planning has been done, the development of and funding for a new hospital has proceeded slowly. Some pressing gaps in health care programming include lack of access to long-term care services in some communities. As an illustration, elderly patients in Peawanuck, Kashechewan and Attawapiskat are being transported outside of the communities for long-term care, which is traumatizing for both families and the patients.

Some other factors that have constrained the success of WAHIFA include limited pre-merger planning and preparation after signing the WAHIFA agreement (2007) and prior to the amalgamation of the two hospitals (2010); the late formation of a formal body or process to provide oversight and monitor the integration; limited resources allocated to cover the cost of integration and increasing cost of operations (e.g., labour cost and inflation); limited engagement in terms of building relationships with First Nations leaders to create a sense of ownership and support for WAHA by First Nations communities; high staff turnover and difficulties associated with hiring and retaining staff members; aging infrastructure; and region and community specific factors such as remote and isolated locations and limited capacity within the communities.

Despite governance mechanisms and community engagement, WAHA has struggled to establish positive and trusted relationships with the First Nations communities, engage community leaders in programming, and communicate its success and challenges to community members at an adequate level. The evaluation found that there is insufficient awareness of WAHA activities and some dissatisfaction with the implementation of the Agreement by First Nations communities. It is critical that extensive communications and community engagement efforts are undertaken to build relationships between WAHA and First Nations communities in order to increase the degree of support and sense of ownership of WAHA among the First Nations communities. It is also necessary to build these relationships in order to fully achieve WAHIFA objectives and to enable further integration of health care programming in the region.

B. RECOMMENDATIONS

The recommendations arising from the evaluation of the WAHIFA are as follows:

1. **Strengthen and formalize the tripartite oversight body to monitor implementation of the requirements and provisions of the WAHIFA, and to support and guide WAHA activities and programming.**

The strengthening of the coordinating and oversight body through a formalized Terms of Reference that stipulates that the tripartite body meet regularly to discuss the implementation of the Agreement and monitor, guide and support activities and programming implemented by WAHA will help to facilitate the successful implementation of the WAHIFA.

2. **Strengthen WAHA's governance structure by involving community leaders and those who have adequate technical expertise in providing health care in the region.**

   There is a need for signatories to work with First Nations communities and WAHA to identify opportunities to strengthen WAHA's governance structure. Some options to be considered include the creation of a political support committee involving First Nations leadership in the region; creation of a technical advisory committee that brings together First Nations specialists (Band Health Directors and Community Service Directors with the WAHA Directors) and health care experts from within and outside the region; and strengthening the capacity of First Nations board members to ensure that WAHA activities reflect the priorities of First Nations communities.

3. **Develop and implement a comprehensive communications and community engagement strategy to increase the sense of ownership and support for WAHA within the communities and become more responsive to community needs.**

   Developing a communications and engagement strategy to increase awareness of WAHA's activities, programming and accomplishments will help to improve the profile and reputation of the organization; and increase community awareness and support for the accomplishments and activities of WAHA. Listening to community needs and requests and reflecting those needs in WAHA programming and services will help to increase the degree of support and sense of ownership of WAHA by First Nations communities.

4. **Devote efforts to ensure a common understanding of the need for a Special Act.**

   Starting an immediate dialogue with the communities is necessary to in order to gain a common understanding of the need for the Special Act. Increased understanding of the need for a Special Act will increase community confidence in and support for WAHIFA, and encourage their participation in WAHA activities.

5. **Facilitate the development of a new hospital in the region.**

   Expediting the current process of planning and construction of a new hospital in the region and communicating the progress to communities will help to increase satisfaction of the communities with the WAHIFA.

6. **Develop a funding formula that takes into consideration the remote and isolated location of the hospital.**

   Working with Health Canada, the province and the NE LHIN to develop a funding model that accurately takes into consideration the location and isolation of the communities and particular difficulties in doing business in the region will help WAHA accurately forecast and budget their resources for effective delivery of its programming and services. The funding formula should also recognize the role and enable WAHA to have sufficient resources to deliver long-term care and public health programming as well as integrate the continuum of health care programming in the region.

7. **Develop strategies to increase staff retention and reduce turnover.**

   Working with signatories to develop long-term strategies and effective staff retention approaches will help reduce staff turnover. This should include the hiring of people from the area, when possible. In addition,

increasing the level of communication, openness and transparency within WAHA will increase job satisfaction and help to create a more supportive and motivating work environment.

8. Enhance current efforts of WAHA to deliver culturally safe and appropriate programming.

Ensuring that First Nations culture and traditions are integrated at all levels of WAHA operations will increase the cultural safety of the services as well as enhance the sense of ownership among First Nations communities. Enhancing the orientation and training program for existing and new staff members will ensure they have an adequate understanding of the First Nations culture and traditions, and deliver culturally appropriate services. Ensuring that WAHA senior management undertake regular consultations with First Nations communities will help gain the trust of community members that culturally safe and appropriate programming is being provided.

9. Further integrate the continuum of health care programming in the region.

The oversight committee should monitor the management of the NIHB programs to ensure greater effectiveness, coordination and integration of NIHB activities associated with administering the programs (e.g., booking appointments, travel arrangements, approvals, etc.) in order to increase the quality of the services that communities receive. Providing culturally sensitive customer service and ensuring all inquiries and requests by clients and communities have properly been handled and complaints and incident reports have effectively been addressed will increase community confidence in WAHA operations and services. Efforts should be devoted to integrating existing health care prevention, promotion and education programming. The cost of the region's health care will continue to rise unless significant efforts are invested to implement integrated and effective health care prevention, promotion and education activities. Increased integration and coordination of the programming by various service providers will also ensure continuity of care for community members. Working with FNIHB, First Nations communities and NE LHIN to better increase community capacity and eventually integrate all public health programming in the region will help to avoid duplication and overlap.