PRIMARY HEALTH CARE

A Framework That Fits

Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative

Implementation Plan

Professionals: Working Together to Strengthen Primary Health Care

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative is all about making a good thing better. Canadians know that health care providers on the front line are there to respond with care and skill to their health care needs. Primary health care providers are not only committed to caring for their patients directly, they also facilitate access for patients to other specialized services. But, more and more Canadians are expecting better co-ordination between those providers and they want to optimize their access to the skills and competencies of a range of health care professionals. As much as they want to be treated for illness, they want health promotion advice and information about preventing disease and illness, too.

The EICP Initiative, funded through Health Canada's Primary Health Care Transition Fund, is designed to confirm the research which states that interdisciplinary collaboration in primary health care has significant benefits for both patients and health care professionals. Over the next year-and-a-half, the Initiative will put a spotlight on the best practices and examples that show that collaboration is "value-added" for our health care system. The Initiative's legacy will be a body of research, a consultation process that will engage health care providers and get them thinking more about working together, and a framework for collaboration that encourages change and more co-operation.

For more information: *Tel:* **(613) 526-3090 ext. 460** • *E-mail:* **info@eicp-acis.ca** • *Web site:* **www.eicp-acis.ca**

The EICP Initiative will deliver:

- A set of principles and a framework that will enhance the prospects and options for more collaborative care in settings across the country;
- Research about best practices and the state of collaborative care in Canada;
- Tools to help primary health care providers work together more effectively; and
- Recommendations that will help the public, provincial/territorial governments, regional health authorities, regulators, private insurers and educators embrace and implement the principles and framework.With the leadership of some of the key players in primary health care in Canada, the EICP Initiative will capture the very best of what is being achieved in interdisciplinary collaboration in this country and will help us learn from it. It is the goal of the EICP Initiative to light the way ahead.

EICP Partners include:

- Canadian Association of Occupational Therapists
- Canadian Association of Social Workers
- Canadian Association of Speech-Language Pathologists and Audiologists
- Canadian Medical Association
- Canadian Nurses Association
- Canadian Pharmacists Association
- Canadian Physiotherapy Association
- Canadian Psychological Association
- College of Family Physicians of Canada
- Dietitians of Canada
- Canadian Coalition on Enhancing Preventative Practices of Health Professionals

For more information:

Tel: (613) 526-3090 ext. 460
E-mail: info@eicp-acis.ca
Web site: www.eicp-acis.ca

Table of Contents

Acronyms

AGIP	Advisory Group Interprofessional Practitioners
CAOT	Canadian Association of Occupational Therapists
CASLPA	Canadian Association of Speech-Language Pathologists and Audiologists
CASW	Canadian Association of Social Workers
CCARH	Canadian Centre for Analysis of Regionalization and Health
CEPHP	Canadian Coalition on Enhancing Preventative Practices of Health Professionals
CFPC	College of Family Physicians of Canada
CHCC	Community Health Care Centres
CHSRF	Canadian Health Services Research Foundation
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institute of Health Research
CMA	Canadian Medical Association
CNA	Canadian Nurses Association
CPA (Physiotherapy)	Canadian Physiotherapy Association
CPA (Psychology)	Canadian Psychological Association
CPhA	Canadian Pharmacists Association
DC	Dietitians of Canada
EICP	Enhancing Interdisciplinary Collaboration in Primary Health Care
IECPCP	Interdisciplinary Education for Collaborative, Patient-Centred Practice
IHHRD	Integrated Health Human Resources Development
IPCA	Interdisciplinary Primary Care Agency
P&F	Principles & Framework
PHC	Primary Health Care
SC	Steering Committee

Executive Summary

Primary health care involves responding to illness within the broader determinants of health. It also includes co-ordinating, integrating and expanding systems and services to provide more population health, sickness prevention and health promotion by all disciplines. It encourages the best use of all health providers to maximize the potential of all health resources.[1]

Primary Health Care (PHC) is the backbone of the Canadian health system. The PHC system has been experiencing changes that have had a significant impact on patients/clients, providers and governments. For most Canadians, primary health care providers are the first point of contact with the health system. Primary health care providers are not only committed to caring for their patients directly, but also facilitating access for patients to other specialized services. They play a co-ordinating function in response to each patient's needs.

How can the health system produce the best outcomes for patients/clients? And how do we create the conditions for health care providers to work together in the most effective and efficient way? These are two of the most important questions facing primary health care today—they are also the questions that members of the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative hope to address.

By steeping ourselves in the daily challenges of practitioners and policy-makers, as well as the knowledge of the barriers and enabling factors, it is our intention to create a realistic blueprint for change. Recognizing that solutions must reflect the community, the EICP Secretariat has devised a plan that is based on solid information, informed by targeted research and supported by a variety of communications vehicles to get messages out to stakeholders. The process will continue to evolve throughout the course of the initiative, guided by the Steering Committee and the continuous feedback of stakeholders, and measured against appropriate performance measures, as set out in our evaluation plan.

In this report, you will also find a Research Model, a Change Management Model and an Evaluation Model, which demonstrate how knowledge, change and actions are connected with outcomes. While there will be unknowns—risks and intangibles—inherent in such a process, we believe that the Principles and Framework will help to make interdisciplinary collaboration a reality in the primary health care field.

[1] Definition adapted from: A. Mable and J. Marriott, *Sharing the learning—The health transition fund synthesis series: Primary health care* (Ottawa: Health Canada, 2002).

Introduction

Between January 2004 and March 2006, the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative will receive a $6.5 million contribution agreement from Health Canada's Primary Health Care Transition Fund through the Canadian Psychological Association.

This initiative is led by health professionals through a partnership of 10 national associations and a coalition that includes:

- Canadian Association of Occupational Therapists
- Canadian Association of Social Workers
- Canadian Association of Speech-Language Pathologists and Audiologists
- Canadian Medical Association
- Canadian Nurses Association
- Canadian Pharmacists Association
- Canadian Physiotherapy Association
- Canadian Psychological Association
- College of Family Physicians of Canada
- Dietitians of Canada
- Canadian Coalition on Enhancing Preventative Practices of Health Professionals

The Initiative will be led by a Secretariat housed within The Conference Board of Canada, which will manage the process of enhancing interdisciplinary collaboration in primary health care. Recognizing that systemic change can only happen through individual commitment to shared ideals, the EICP Steering Committee and Secretariat are embarking on a two-year program to develop guiding Principles and Framework, which will have the commitment of practitioners and policy-makers. Stakeholders will provide constant feedback, as the Principles and Framework continue to develop. It is anticipated that, as an increasing number of practitioners become engaged in the dialogue, momentum will build toward implementing the framework in 2006.

This report summarizes the work plan to accomplish this goal. This workplan includes the following three components

- Research (Literature reviews, commissioned reports, consultations, interviews, reports)
- Change management (workshops, meetings)
- Communications (website, media releases)
- Evaluation (questionnaires, analysis, interviews, data collection)

Steering Committee Members

Ondina Love
Executive Director
Canadian Association of Speech–Language Pathologists and Audiologists
401-200 Elgin St.
Ottawa, ON K2P 1L5
Tel: 613-567-9968
Fax: 613-567-2859
E-mail: ondina@caslpa.ca

Sharon Fotheringham
Manager of Professional Standards
Canadian Association of Speech–Language Pathologists and Audiologists
401-200 Elgin St.
Ottawa, ON K2P 1L5
Tel: 613-567-9968
Fax: 613-567-2859
E-mail: Sharon@caslpa.ca

Owen Adams
Assistant Secretary General
Canadian Medical Association
1867 Alta Vista Dr.
Ottawa, ON K1G 3Y6
Tel: 613-731-9331, Ext. 2259
Fax: 613-237-3520
E-mail: owen.adams@cma.ca

Janet Davies
Director, Policy, Regulation and Research
Canadian Nurses Association
50 The Driveway
Ottawa, ON K2P 1E2
Tel: 613-237-2133
Fax: 613-237-3520
E-mail: jdavies@cna-aiic.ca

Marlene Wyatt
Director of Professional Standards
Dietitians of Canada
Box 772, Station B
Ottawa, ON K1P 5P8
Tel: 613-563-1055
Fax: 613-563-1360
E-mail: mwyatt@dietitians.ca

Dr. Barry Power
Director, Practice Development
Canadian Pharmacists Association
1785 Alta Vista Drive
Ottawa, ON K1G 3Y6
Tel: 613-523-7877, Ext. 220
Fax: 613-523-0445
E-mail: BPower@pharmacists.ca

Dr. John Service
Executive Director
Canadian Psychological Association
151 Slater Street, Suite 205
Ottawa, ON K1P 5H3
Tel: 613-237-2144
Fax: 613-237-1674
E-mail: jservice@cpa.ca

Dr. Dawn Burnett
Director, Practice and Policy
Canadian Physiotherapy Association
205-1400 Blair Place
Gloucester, ON K1J 9B8
Tel: 613-564-5454
Fax: 613-564-1577
E-mail: dburnett@physiotherapy.ca

Pamela C. Fralick
Chief Executive Officer
Canadian Physiotherapy Association
410-2345 Yonge St.
Toronto, ON M4P 2E5
Tel: 416-932-1888
Fax: 416-932-9708
E-mail: pfralick@physiotherapy.ca

Donna S. Klaiman
Director of Standards and Professional Affairs
Canadian Association of Occupational Therapists
3400-1125 Colonel By Drive
Ottawa, ON K1S 5R1
Tel: 613-523-2268, Ext. 229
Fax: 613-523-2552
E-mail: dklaiman@caot.ca

Marsha Sharp
Chief Executive Officer
Dietitians of Canada
604-480 University Ave.
Toronto, ON M5G 1V2
Tel: 905-689-3864 (main office: 416-596-0857)
Fax: 416-596-0603 (main office)
E-mail: msharp@dietitians.ca

Eugenia Repetur Moreno
Executive Director
Canadian Association of Social Workers
402-383 Parkdale Ave.
Ottawa, ON K1Y 4R4
Tel: 613-729-6668
Fax: 613-729-9608
E-mail: morenoeu@casw-acts.ca

Dr. John Maxted
Director of Health Policy and Communications
The College of Family Physicians of Canada
2630 Skymark Avenue
Mississauga, ON L4W 5A4
Tel: 905-629-0900, Ext. 302
Fax: 905-629-0893
E-mail: jmaxted@cfpc.ca

Dr. Paula Stewart
Canadian Coalition on Enhancing Preventative Practices of Health Professionals
167 Bathurst 5th Conc. RR7
Perth, ON K7H 3C9
Tel: (613) 267-2673
E-mail: paula@paulajstewart.ca

Roles and Responsibilities of the Steering Committee

The contribution agreement between the Canadian Psychological Association and Health Canada establishes a management structure for the EICP project that provides for a:

- Steering Committee composed of 10 national organizations plus the coalition, with the role of providing overall direction to the project and direction to the project's Executive Director.

Based on these parameters, we have developed the following governance model for the project:

The Steering Committee (SC) is responsible for overall strategic and policy direction of the project. The Executive Director of the secretariat has day-to-day responsibility for project management and for achieving immediate outcome project results. Strategic and policy level decisions are to be discussed and approved by the Steering Committee; other decisions are within the scope of responsibility of the Executive Director. The Executive Director is directly supported by a change management consultant, an evaluation consultant, a research director and a project assistant. The Executive Director also has access to other human resources within the Conference Board, which is hosting the secretariat.

Committee members have agreed to:

1. Work diligently and effectively to realize the EICP Initiative goals;
2. Work effectively with the Conference Board to meet the requirements of Health Canada;
3. Provide effective policy and financial oversight to the EICP Initiative;
4. Engage in timely decision-making by the EICP Initiative's Steering Committee or subcommittees;
5. Communicate in an effective and timely fashion with partner organizations and their constituencies;
6. Facilitate timely decision-making by the partner organizations and their constituencies;
7. Engage target constituencies, as required, to meet the goals of the EICP Initiative; and
8. Operate within the terms of reference of the Steering Committee.

Initiative Commitments

The Secretariat and the Steering committee have agreed that the EICP initiative wil be governed by the following operating guidelines.

INCLUSIVE: The EIPC Steering Committee and project team will work to ensure balance and breadth of perspective at all EIPC hosted events, consultations or roundtables.

INDEPENDENT: All Steering Committee members have a shared interest in advancing interdisciplinary collaboration in primary care in Canada. The Steering Committee has the latitude it requires to undertake any research or work it considers necessary and to determine the nature and scope of its recommendations.

TRANSPARENT: The EICP Steering and project team will operate in an open and transparent manner and will post on the EICP Web site: formal submissions it receives; any research, focus groups, surveys or public opinion research it commissions or undertakes; interim reports or recommendations it makes to the project authority; and, its final report.

ACCESSIBLE: Every reasonable effort will be made to raise awareness of the EIPC initiative among interested primary health care stakeholders and to enable them to share their views and perspectives with the project team. The project team will use multiple communications channels to share information about the EICP initiative and to receive third party input and advice.

RESPECTFUL: The EIPC Steering Committee and project team will respond to all reasonable information requests or queries in a timely, responsible and complete fashion, with due regard to the privacy rights of individuals. The EICP Steering Committee will review, on its merits, any proposal or recommendations it receives to enhance inter-disciplinary collaboration in primary health care in Canada.

EVIDENCE-BASED: The EICP Steering Committee's recommendations and conclusions will be based on a thorough and objective assessment of the best available evidence.

RESPONSIBLE: The EICP project team will undertake its research, engagement and deliberative processes in a responsible, comprehensive and timely fashion that ensures breadth of perspective and respect for the professional judgement and capacities of providers, patients, regulators and governments.

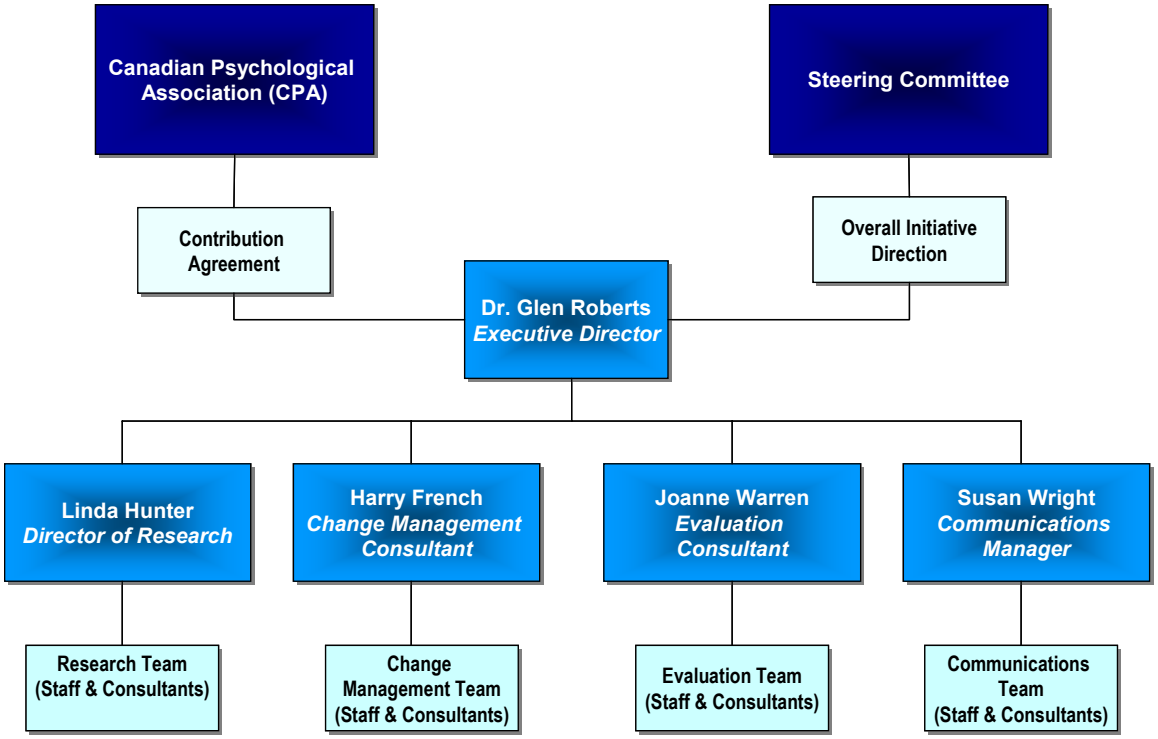
FLEXIBLE: The EICP Steering Committee will adjust its processes, activities and general timeframes to take account of the evolving public and policy environment and to accommodate the broadest possible participation by interested stakeholders in its activities and deliberations.

Project Management

Management Approach and Structure

On behalf of the Canadian Psychological Association (CPA) and its national consortium of associations, The Conference Board of Canada will oversee the management and deliverables of the EICP Initiative, which is to be completed by March 31, 2006.

An organizational framework, team and budget have been developed to carry out the three-year initiative. As illustrated in the attached organization chart, the Executive Director will oversee four senior staff (director of research, change management consultant, communications manager and evaluation consultant), who will take the lead in implementing the four project components to achieve the objectives as identified by the Steering Committee. Four phases have been identified in the initiative's life cycle: Initiation and Planning, Research, Development and Implementation, and Closure.



Objectives

The goals of the EICP Initiative are:

- To develop a set of Guiding Principles and a Framework to enhance interdisciplinary collaboration in Primary Health Care (PHC);
- To have the Principles and Framework broadly supported by PHC practitioners, as evidenced through ratification by the national organizations; and
- To support the national organizations and other stakeholders in the implementation of the Principles and Framework.

Budget

The following chart indicates the aggregate expenditures for each of the Initiative's sub-components:

Sub-totals	
Research	1,057,747
Change	1,293,074
Evaluation	286,985
Project Management	2,000,400
Communication	465,644
Steering Committee	1,396,150
Total	**6,500,000**

Project Implementation Plan

Conceptual Framework

The EICP Initiative involves Primary Health Care providers and other stakeholders in the process, which will:

- Develop a set of principles and framework that describe how PHC providers can work together effectively in every setting and what conditions will need to be in place to make this happen;
- Develop tools for PHC providers to use to work more effectively together; and
- Work with the public, provincial/territorial governments, regional health authorities, regulators, private insurers and education to implement the principles and framework.

There are six stages in this process:

1. *Analyze* the factors which affect the interdisciplinary work of PHC health professionals and the public's access to these professionals and services;
2. *Consult stakeholders* to gather their input into the principles and framework, and to build broad support;
3. *"Test drive" the framework* through a second series of consultations with professional associations, providers, governments and the public;
4. *Ensure* that the principles and framework are broadly supported by PHC practitioners through ratification by their national associations;
5. *Develop tools and strategies* to support the implementation of the principles and framework; and
6. *Build a base* for the ongoing support of the implementation process.

Operational Plan

The Conference Board's Initiative team will employ a number of vehicles to create the transition to collaborative primary health care:

- Literature review
- Up to 24 key interviews
- 16 group consultations
- Three surveys during the course of the initiative
- A parallel survey on the Initiative's Web site
- Five commissioned reports on: Interdisciplinary Collaboration, Policy Context, Individual Providers and Health Service Organizations, Public Health and Social Context and Cost Effectiveness Analysis.

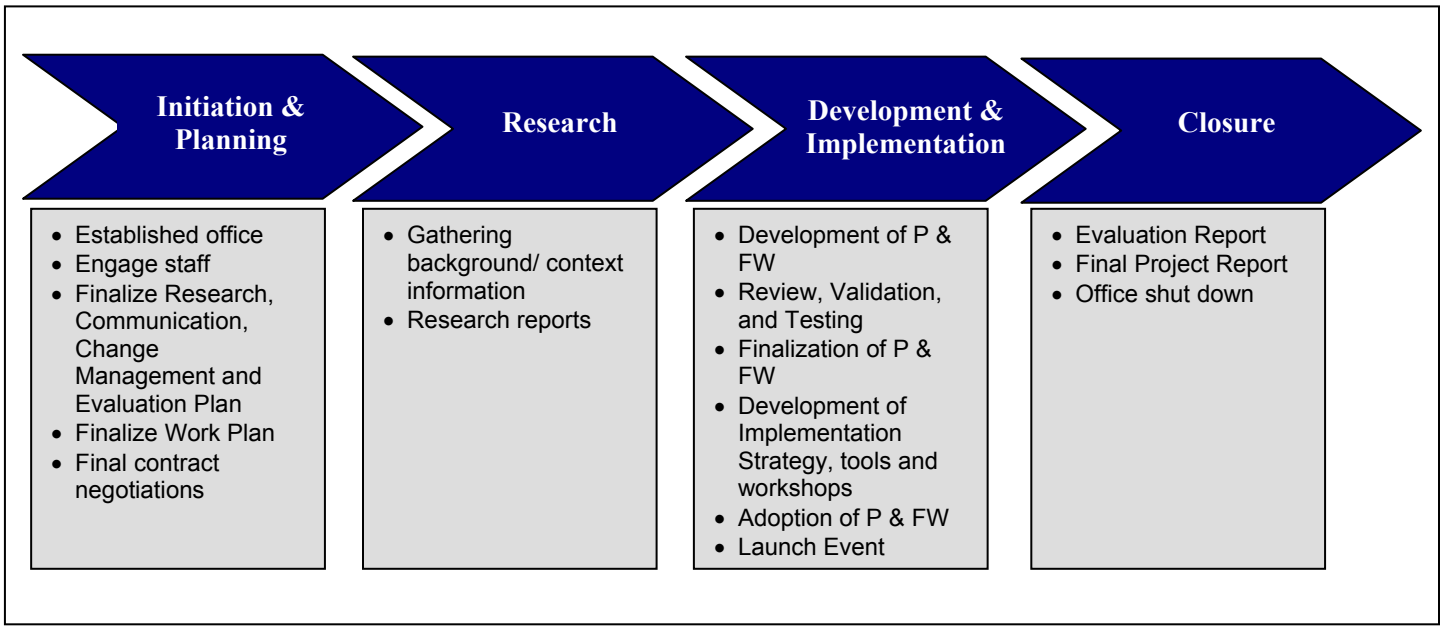
- These reports will feed into a Summative Analysis, which includes: level of readiness for IPHC services, analysis of gaps, inventory of best practices and recommendations for actions that will enhance interdisciplinary collaboration.

Life Cycle of the Initiative

The Secretariat is using principles of project management, based on The Project Management Body of Knowledge[2]. This is an official designation from the Project Management Institute, which is based in Pennsylvania.

The Initiative's life cycle includes:

1. Initiation and Planning
2. Research
3. Development and Implementation
4. Closure



[2] A Guide to the Project Management Body of Knowledge: 2000 Edition, Project Management Institute; Newtown Square, Pennsylvania, USA.

Initiation and Planning

Final contract negotiations between the Canadian Psychological Association and The Conference Board of Canada were completed in July 2004. An office was established for the initiative within The Conference Board of Canada, staff was engaged and the work plan was refined.

The first planning meeting with the Steering Committee and core staff took place June 27, 2004. At this meeting, project goals and outcomes were confirmed, Initiative Commitments were established, and the Steering Committee's Terms of Reference and Memorandum of Understanding (MOU) were refined. Funders' expectations were clarified and the roles of the Steering Committee, Executive Director, Health Canada and other stakeholders were established.

The work plan and budget have been refined to increase the depth of stakeholder engagement and strengthen the communications role to support the Initiative. Implementation issues were discussed with key stakeholders at a meeting on June 29, 2004.

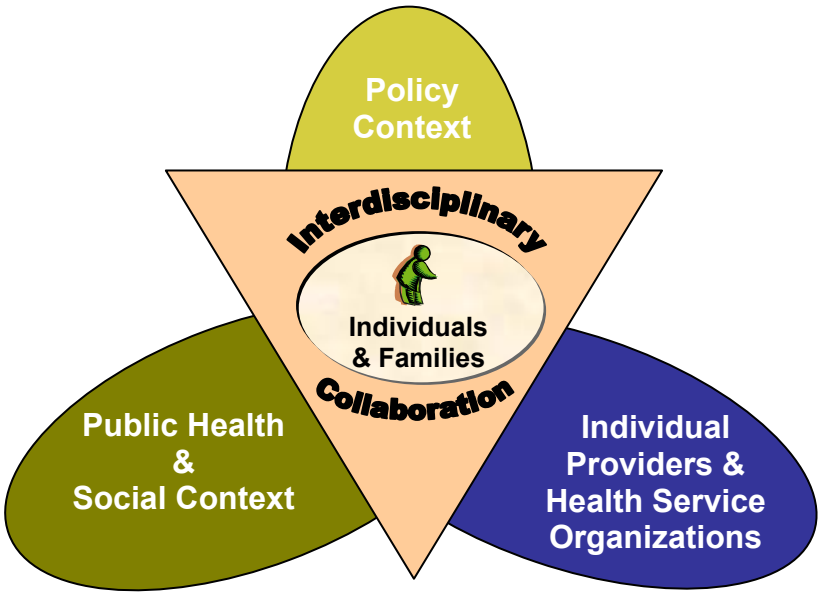
Communications, Change Management, Research Management and Evaluation plans were developed by the end of August, following these discussions with the Steering Committee.

Research

Our research is used throughout the change process to enable informed dialogue by key stakeholders. It provides a general overview of interdisciplinary collaboration in primary health care in Canada.

As this model demonstrates interdisciplinary collaboration in primary health care aims to better meet the health needs of individuals and families. Elements within policy context, individual providers and health organizations, and public health and social context affect interdisciplinary collaboration.

Research Framework



Interdisciplinary collaboration in primary health care aims to better meet the health needs of individuals and families. Elements within policy context, individual providers and health organizations, and public health and social context affect (positively or negatively) interdisciplinary collaboration.

Surveys will establish a baseline of information, by assessing the readiness of primary health care givers to be part of a collaborative approach. This baseline will also inform the evaluation component of the project. Three research papers will examine policy context, individual providers and health service organizations, and public health and social context—all areas that affect interdisciplinary collaboration. These research papers will build the business case for interdisciplinary collaboration in Primary Health Care in Canada, and provide recommendations as to how it can be enhanced.

The Policy Context paper examines predominant primary health care structures in Canada, using three models from different regions to provide context. It looks at current providers' payment mechanisms, examines the liability framework and regulatory frameworks, and reviews federal, provincial and territorial policies for primary health care. Finally, it will propose directions for reform and present the vision of governments and health professional associations. A Cost Effectiveness Analysis will also be included to further the business case.

The Individual Providers and Health Organizations paper summarizes individual attitudes and perceptions of interdisciplinary collaboration. It researches the quality of life and job

satisfaction of health practitioners and their access to interdisciplinary continuing education. It lays out the operational issues and challenges in primary health care settings and gives an overview of strategies that have been successful in overcoming barriers. Population health, public access to primary health care services and public perceptions of interdisciplinary primary health care are the focus of the paper on Public Health and Social Context. The paper will examine the role of PHC in addressing population health issues and concerns, from health behaviour and screening to diagnosis, management, rehabilitation, support and palliative care. Unmet needs of the population, such as chronic disease management, will also be described. The paper will include Canadians' self-health perceptions and reveal the health status of multicultural communities, children and people with mental and communications disorders.

A Summative Analysis of policy, public health, social contexts, individual health providers and organizational issues will indicate the level of readiness for interdisciplinary collaboration, as well as analyze the gaps and steps required to reach a state of readiness. The inventory of best practices will feed into communications tools that will help to ensure buy-in from providers. Finally, this report will make recommendations to enhance interdisciplinary collaboration.

An exhaustive Literature Review, which includes grey literature, summarizes the most relevant policy and discussion papers, research reports, program guidelines, published literature, academic and government reports, doctoral dissertations and internet resources, and provides a solid foundation for an informed dialogue.

Up to 24 key informant interviews will help to shape models of interdisciplinary primary health care collaboration in Canada and provide policy context for reform. Two surveys of providers will be taken: one for those involved in interdisciplinary primary health care practices and one for those not involved in them. The surveys will reveal differences in individual attitudes, operational issues, quality of life and job satisfaction. A third survey will examine the views of patients receiving care from interdisciplinary health groups. Questions will focus on patient satisfaction, quality of care and quality of life issues.

Throughout September, the Initiative's team will hold group consultations with health providers in 13 locations across Canada, with 14–16 participants in each session. Locations include: Winnipeg; Regina; North Battleford (Saskatchewan); Vancouver; Prince George; Yellowknife; Calgary; Cochrane (Ontario); St. John's; Montreal; Halifax; St. John; and Toronto. Patient group consultations will be held in three locations across Canada. For those who cannot attend, a parallel survey through the Web site will give individuals a chance to participate.

Regional workshops will be used to validate the research. They will be held in Halifax, Montreal, Calgary, Yellowknife and Toronto, and will include representatives of national organizations, health providers' groups and public sector representatives.

Development and Implementation

Four task groups of 25 participants will study barriers and enabling factors for the transition to collaborative primary health care and will make their recommendations in January. The groups will examine liability and risk management, funding, health records and regulatory factors, based on relevant literature, informant interviews and research papers.

A workshop with Steering Committee members and key stakeholders in February 2005 will develop a collaborative framework that describes how different parts of the primary health care system should relate to one another, as well as the system's overall relationship with other related systems. Regional consultations and research reports will form the basis of discussion. The workshop discussions and the findings to this point will lead to a second, more detailed version of the Principles and Framework. This version will be reviewed by the membership of participating organizations in February and March 2005 and fed back into the process. Views will be collected through workshops at the national, provincial and territorial levels, the project Web site and member associations.

A second series of group consultations in Toronto, Montreal, Halifax, Calgary and Yellowknife will take place in March 2005, in which primary health care practitioners and policy-makers will determine whether or not the Principles and Framework have successfully captured the essential elements. In April 2005, PHC practitioners will be asked to determine the usefulness of the Principles and Framework to individual practitioners and organizations.

A finalized version of the Principles and Framework will be written and available by May 2005 and member associations will be asked to formally commit to its implementation by October 2005. A public launch of the Principles and Framework, and its implication for the public, will take place in November 2005.

An Implementation Strategy will be developed and discussed through workshops between November 2005 and January 2006. A toolkit will be developed to support the implementation process and a series of interdisciplinary workshops will be held in early 2006 to support the use of these tools. Key stakeholders will be engaged in implementing the Principles and Framework through a series of meetings. An evaluation report and a final project report will be written in March 2006, as the Initiative winds down its activities.

Change Management

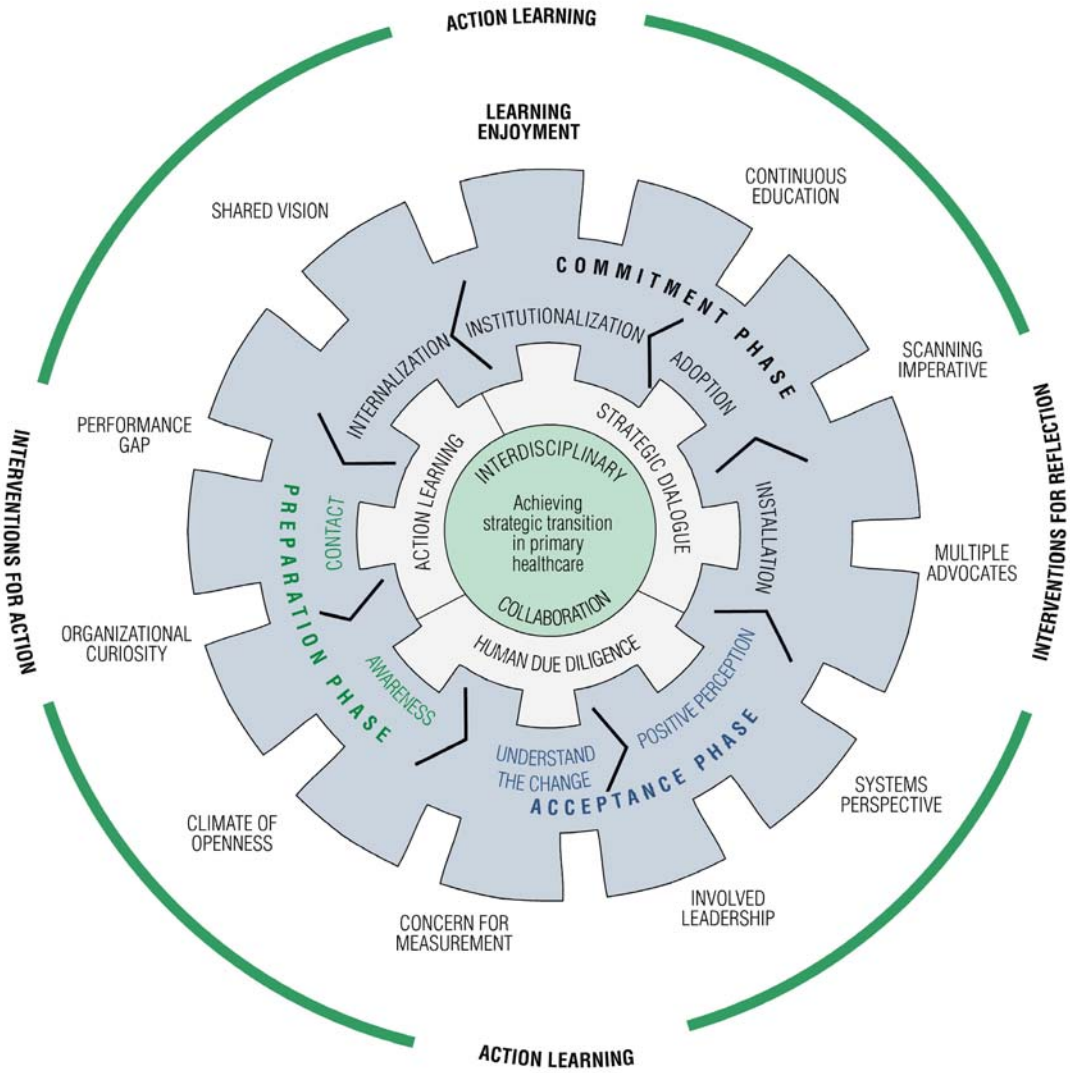
Change Management Process Model

The overall objective of the EICP Initiative is to develop Principles and a Framework to advance interdisciplinary collaborative care in primary health care settings. The Principles and Framework will be relevant to the various practice settings across Canada and will help to better define the relationships between clients/patients and various practitioners, as well as how health care integrates with other elements of the health system.

Change is very personal and building consensus takes time. It is only possible when a critical mass of support for a transition can be built among key stakeholders. The policy environment will have an impact on the change process. Over the period of this initiative (January 2004—March 2006), it is anticipated that the primary health care community will develop an awareness of the need for change, the options available, and move into a positive perception of change, as a precursor to commitment to the change process which they, as a community, have identified.

The Initiative's team will be taking steps to develop a baseline, against which change can be measured. For example, a survey of stakeholders will be taken to benchmark their initial readiness for change. A literature review of the research on changes to health systems was undertaken and presented to a meeting of the Steering Committee on July 29–30, 2004. The primary objective of this session was to explore the concept of interdisciplinary collaboration and to construct a *First Approximation of the Principles and Framework* for the EICP Initiative to guide staff in the development and implementation of its work plan. The Principles and Framework will continue to be tested throughout the course of the Initiative, using feedback to refine and enhance the content through three iterations.

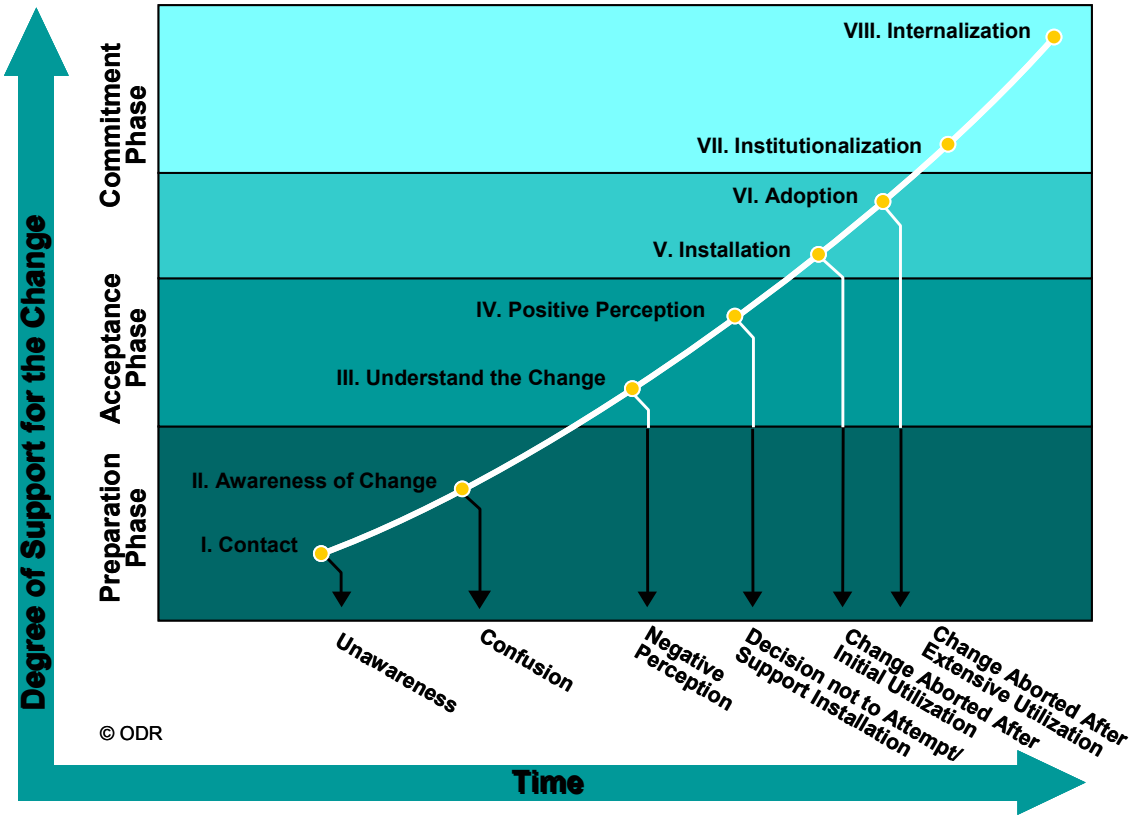
The following Change Process Model begins with the recognition of critical change indicators from the environment in which primary health care operates. The transition is developmental, with the primary health care practitioner progressing up a commitment curve. Acknowledging the factors of learning and change facilitates this journey. By using processes such as strategic dialogue and learning through action, that emphasize the human side of transition, primary health care givers are expected to reach the "positive perception" part of the acceptance phase (as illustrated in the Change Commitment Curve chart) by the end of the Initiative's two-year program.



The transition process begins with the recognition of critical change indicators by the primary health care environment. These indicators, or signals, begin to influence the primary health care practitioner to move from the current state of care and quality services to a more strategic focus on interdisciplinary collaboration. Building a leadership culture among practitioners is the basis for greater interdisciplinary collaboration and begins with creating a more conscious, shared vision of the change process, which includes recognition of individual roles and responsibilities and respect for professional, autonomous clinical decision-making. Change is a social process which follows the same pattern as learning. Using experiential and strategic dialogue techniques, existing beliefs and assumptions will be revealed and re-examined. Based on the work of A. Dibela and J. Gould, in connection with the U.S. Healthcare Forum, and their own experience, steering committee members have built their own change process model. In the next phases, strategies, tools and techniques for intervention processes will be developed by change

management experts. The ultimate goal is to establish a positive learning environment in the primary health care field—one that will enhance the strategic transition to interdisciplinary collaboration practices.

Change Commitment Curve



Communications

Communications activities are vital to raising overall awareness of the initiative, making participants aware of the process and facilitating stakeholder engagement. They can also help to ensure that all stakeholders have realistic expectations of outcomes. They will form an important part of the toolkit that facilitates the implementation of the Principles and Framework by the primary health care community.

A number of key audiences have been identified, including:

- Steering Committee member associations
- Key national health professional associations, licensing and accreditation bodies
- Governments, hospitals and regulators
- Public, population and community health providers and advocates
- Insurance companies, private vendors and suppliers
- Patient, consumer and disease support groups
- Media
- Public

The professional communications staff of the Initiative will produce vehicles that ensure key messages reach their audiences, helping to build support for change at all levels. Their approach will be to use existing events, activities and consultations as outlets for communications vehicles. The Initiative's Web site will be used as a primary outreach vehicle, in addition to key stakeholder Web sites, newsletters and annual general meetings. Media relations will target specialized media, with limited focus on mainstream media. A video has been developed to describe the EICP Initiative and create an awareness of the importance of primary care reform.

Communications Activities and Vehicles

A number of communications products will support the Initiative's activities, including:

- An interactive project Web site
- Four targeted mailouts
- Four e-newsletters
- Two DVD/Videos (one which defines the project and another to be included the final toolkit)
- Targeted interventions (AGMs and events)
- Collateral material for "branding"
- A legacy EICP toolkit and DVD

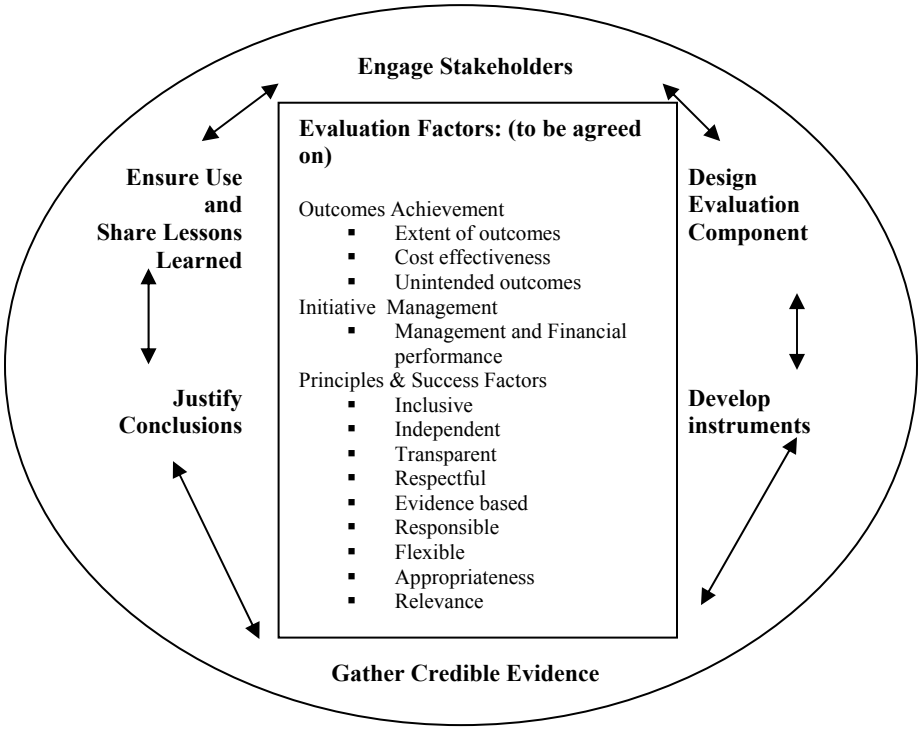
Evaluation

The EICP Secretariat proposes to work closely with the Steering Committee and Initiative stakeholders to customize the approach to program evaluation. The steps in the evaluation model are:

- Engage stakeholders in validating information and findings
- Design an overall evaluation framework, including performance measures
- Establish instruments and protocols to collect data
- Gather credible evidence, including baseline information
- Develop and justify conclusions through assessing and monitoring outcomes
- Monitor risks, assumptions and the use of risk mitigating strategies
- Share knowledge and lessons gained, and provide recommendations

Progress toward outcomes will use performance measures agreed to by the Steering Committee. Expected outcomes and performance measures form the basis for the performance management framework. Cost effectiveness will be measured by examining the proportion of project activities that contribute to outcomes, the relative cost of selected activities, the Steering Committee's perspective on cost effectiveness and the relative cost and use of project management resources. Management performance will be evaluated by examining the appropriate use of resources and informed and timely action. Financial performance will be evaluated against budget. We anticipate that the Health Council will provide indicators of primary health care reform to guide our evaluation.

Evaluation Model



While the above evaluation model's outer circle appears sequential, it really emphasizes the ongoing interaction, with spiraling progress and knowledge building throughout the evaluation process. The most important dimensions are the constant interaction with stakeholders and the importance of credibility and objectivity in gathering information. Evaluation becomes a tool to share lessons learned and improve performance—a hallmark of effective change.

The project logic model for the Initiative looks at immediate, intermediate and final outcomes. Since the immediate phase is two years, this covers the span of the project and is the only level that will be examined in the evaluation, although these outcomes are designed with an eye to long-term goals.

The Initiative will be evaluated against the Operational Guidelines: inclusive, independent, transparent, accessible, respectful, evidence-based, responsible and flexible behaviour. Two overarching themes—relevance and appropriateness—will be included in this assessment.

Immediate Outcomes

During the first year of the initiate, the EICP Secretariat expects to achieve the following outcomes with the key stakeholder groups:

Practitioners:

- Increased interest and knowledge of primary health care practitioners about the nature and requirements of successful collaborative care initiatives, based on best practices
- Increased agreement among practitioners regarding the nature and requirements of successful collaborative care initiatives, based on the Principles and Framework
- Increased commitment by practitioners to implementing the Principles and Framework of Collaborative Care across the country

Policy-Makers:

- Increased interest and knowledge of policy-makers about the nature and requirements of successful collaborative care initiatives, based on best practices
- Increased agreement among policy-makers about the nature and requirements of successful collaborative care initiatives, based on the Principles and Framework
- Increased commitment by policy-makers to implementing policies that facilitate collaborative primary care, based on the Principles and Framework, which address barrier issues

Associations:
Increased commitment by the boards of professional associations to implement the Principles and Framework of Collaborative Care

Performance Measures

The following represent some examples of proposed performance measures:

- Mailing, publishing and Web site statistics, including feedback from associations
- The number and profiles of participants and their level of engagement in research task groups, consultations and workshops
- The number and profile of signatories to the Principles and Framework
- Analysis of communications and media coverage
- Survey and interview results

Activities

Here are some of the proposed activities that will form the basis for evaluation:

- Data-gathering, both quantitative and qualitative
- Establishing an initial baseline
- Analysis and consultation with team members
- Developing conclusions and identifying sustaining or corrective action, in consultation with team members and the Steering Committee
- Sharing information and lessons learned

Risks and Risk Management

Every project has risks, but the key to project implementation success is the skillful management of risk. The key risks and corresponding risk management strategies are shown here:

- There is a risk that we will be unable to secure consensus among Steering Committee members on various issues, including overall direction for the Initiative, research, change management, communication and evaluation components. Clearly defining the governance structure of the Initiative and using team-building and team dynamics strategies will help to ensure that stakeholders have ownership of the process, leading to consensus.
- Similarly, there is a risk of being unable to secure consensus among Steering Committee members on the Principles and Framework. We will employ a number of strategies to ensure that consensus can be reached, including: facilitating communication; building trust and respect within the team; understanding the priorities and demands of each organization, surveying to determine barriers and enabling factors; being realistic about the timelines between policy development and changing regulations and legislation; and, enhancing grassroots feedback.
- Once the Steering Committee has agreed on the final Principles and Framework, there is a risk that it will not be possible to ensure the commitment of essential policy-makers to them. Here, we will rely on mechanisms such as focus groups,

consultations, validation, pilot initiatives and communications plans to encourage ownership of the Initiative among key policy-makers.

- Similarly, to generate increased interest among influential practitioners (champions), who will be at the forefront of implementing collaborative primary care, we will use these mechanisms to include them in the process and gain commitment to the Principles and Framework. We will use tools such as consultations, communication based on barriers and enabling factors, incentives, pilot initiatives, success stories and a tool kit to accomplish this.
- The same practices and tools will be used to generate increased interest among practitioners to implement collaborative primary care, based on the Principles and Framework.

Conclusion

Ultimately, Canadians and primary health care practitioners want the same thing—to produce the best possible health outcomes for patients. Only if all health providers consciously work together to broaden their definition of health to include population health, sickness prevention and health promotion practices, will that become possible. While this report sets out a work plan and framework for achieving that goal, it is predicated on finding leaders from the PHC community who will champion the cause and who show a willingness to embrace change from within. As the Initiative progresses, the Implementation Plan will be modified to reflect incoming research, feedback and the budget, acting as a 'living document.'

Appendix A: EICP Secretariat Contacts

Dr. Glen Roberts
Executive Director, EICP Initiative
Tel: 613-526-3090, Ext. 460
E-mail: roberts@conferenceboard.ca

Linda Hunter
Director of Research
Tel: 613-526-3090, Ext. 279
E-mail: hunter@conferenceboard.ca

Joanne Warren
Evaluation Consultant
Tel: 613-526-3090, Ext. 273
E-mail: warren@conferenceboard.ca

Susan Wright
Communications Manager
Tel: 613-526-3090, Ext. 318
E-mail: wright@conferenceboard.ca

Sarah Coombs
Evaluation Consultant
Tel: 613-526-3090, Ext. 296
E-mail: coombs@conferenceboard.ca

Harry French
Change Management Consultant
Tel: 613-526-3090, Ext. 414
E-mail: french@conferenceboard.ca

Carole Stonebridge
Senior Research Associate
Tel: 613-526-3090, Ext. 416
E-mail: stonebridge@conferenceboard.ca

Verena Shapiro
Research/Project Assistant
Tel: 613-526-3090, Ext. 270
E-mail: shapiro@conferenceboard.ca

Ruth Coward
Research/Project Assistant
Tel: 613-526-3090, Ext. 379
E-mail: coward@conferenceboard.ca

Appendix B: Project DVD/Video (attached)

Appendix C: Launch Press Release

More Collaboration the Key to Primary Health Care Reform

OTTAWA, September 9, 2004 – Canada's leaders in primary health care are joining forces to examine how they can work together more collaboratively to deliver quality health services and improve health outcomes for their patients and clients.

An injection of $6.5 million in funding from the Health Canada Primary Health Care Transition Fund has created an opportunity for health care professionals on the front line to take a fresh look at how to encourage interdisciplinary collaboration. This would lead to better co-ordination of their work to improve access to health promotion, disease prevention and health care services in their communities.

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative, has already established an ambitious schedule of research and consultations so it can complete its work by the spring of 2006.

Specifically, the EICP Initiative will deliver:

- A set of principles and a framework that will enhance the prospects and options for more collaborative care in settings across the country;
- Research about best practices and the state of collaborative care in Canada;
- Tools to help primary health care providers work together more effectively; and
- Recommendations that will help the public, provincial/territorial governments, regional health authorities, regulators, private insurers and educators embrace and implement the principles and framework.

"Our ultimate goal is the development of a set of principles and a framework for collaboration that primary health care providers can really run with, " says Dr. John Service, Executive Director of the Canadian Psychological Association and chair of the EICP Steering Committee. "This Initiative will be successful if we can prove the "value added" of collaborative care for patients/clients and their health care providers, and start a movement within the health care sector to champion this new approach."

Primary health care often refers to the first level of care and the initial point of contact that a patient/client has with the health system. Collaboration in primary health care can mean anything from the co-location of providers, such as physicians, nurses, dietitians, occupational therapists, pharmacists, psychologists, physiotherapists, social workers, speech-language pathologists and audiologists, to more holistic teams of professionals with complementary skills and training. Collaboration among the professions can also lead to a stronger emphasis on preventative approaches and health promotion.

"Collaboration among the various providers of health services at the primary care level is absolutely the key to getting more out of our health care system and improving health outcomes for patients and clients, " says Dr. Service. "This Initiative will allow us to highlight best practices and share the wisdom of those professionals who recognize the power of collaboration to ensure that patients/clients have access to the right professional and the right services, at the right time."

“Reforms at the primary health care level will have a ripple effect through the entire health care system, “ says Dr. Glen Roberts, Executive Director for the EICP Initiative. “If we get it right at the front line, we have a better chance of sustaining our system in the longer term, by achieving savings while enhancing our capacity to deliver quality services.”

The Initiative will commence a series of consultations with stakeholder groups and governments this fall, and will begin to gather Canadian data about collaborative practices. The EICP Initiative will devote considerable attention to the impediments and “enablers” to collaboration (e.g. funding structures, resistance to change by the professions, regulations, professional liability and the application of technologies in health care).

Funding for this announcement originates from the $800 million Primary Health Care Transition Fund (PHCTF), which was established in September 2000 by the Government of Canada to support the efforts of provinces and territories, and other stakeholders, to develop and implement transitional primary health care reform initiatives, as part of the overall renewal of Canada's health care system.

The EICP Initiative will be guided by representatives of many of the key primary health care providers in Canada and will be managed by The Conference Board of Canada. Partners include: Canadian Association of Occupational Therapists; Canadian Association of Social Workers; Canadian Association of Speech-Language Pathologists and Audiologists; Canadian Medical Association; Canadian Nurses Association; Canadian Pharmacists Association; Canadian Physiotherapy Association; Canadian Psychological Association; College of Family Physicians of Canada; and Dietitians of Canada.

The EICP Initiative also launched a web site today at www.eicp-acis.ca.
that will track the Initiative’s progress, provide background information about collaboration in primary health care and offer interactive features, such as on-line surveys.

For more information:

EICP Initiative Media spokespersons:

Dr. Glen Roberts, EICP Executive Director
& Dr. John Service, EICP Chair

Tel: 613-526-3090 ext. 460
Fax: 613-526-4857
E-mail: info@eicp-acis.ca
Web site: www.eicp-acis.ca.

Appendix D: Output/Activity Matrix

1.0 ESTABLISHING THE PROJECT OFFICE			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
1.1 Established office, engage staff, refine the work plan	1.1.1 Final contract negotiations with the Conference Board of Canada	SC	To be completed by the end of July 04
	1.1.2 Planning Meeting with SC and core staff to do the following: a) confirm project goals and outcomes b) develop guiding principles for project work - SC TERMS of REFERENCE - SC MOA c) stakeholder analysis (role, expectations, contributions) d) confirm expectations of funder e) clarify roles and responsibilities of SC, ED, HC, others BEGUN AND ONGOING	 SC and staff SC SC SC SC and staff	 July 04 July 04 July 04 July 04, ongoing July 04: MOA, Terms of Reference
2.0 PLANNING THE PROJECT			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
2.1 Redevelop the work plan	2.1.1 Redevelop the work plan and budget	SC, Chair and ED	July 04
	2.1.2 Project Implementation Meeting (1.5 days) to bring together broader group of key stakeholders to discuss implementation issues.	ED and staff	June 29, 30/04
	2.1.3 Development of Communication, Research Change Management and Evaluation Plan	ED and staff	July 27/04

3.0 GATHERING BACKGROUND/ CONTEXT INFORMATION			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
Describing the current context			
3.1 Document to guide project and approach to work.	3.1.1 Development of research work plan	Director of Research	July 27/04
3.2 Establish research team	3.2.1 Recruit sub-contractors, clarify roles and expectations	Director of Research	July 04
3.3 Development of research tools	3.3.1 development of literature review matrix, interview guides, surveys, group consultations guides	Director of Research	August 06/04
3.4 Report describing interdisciplinary collaboration	3.4.1 This report will include definition and objectives of interdisciplinary primary health care (IPHC), models of IPHC, Examples of IPHC in Canada, Effectiveness and cost-effectiveness of IPHC, and a review of interdisciplinary collaboration and patient outcomes. Methodology: a) lit review b) key informant interviews c) survey of providers involved in IPHC (see 3.6.1) d) economic analysis	Research Team	September 03/04
3.5 Report describing the policy context and external environment for primary health care	3.5.1 This report will include a description of up to three predominant models for the delivery of primary health care in Canada, a description of current providers' payment mechanisms, a brief overview of liability frameworks, a review of regulatory frameworks, and a description of primary care reform in Canada, which will include a review of F/P/T/ policies and directions for reform. The vision for PHC services expressed by the health professional associations will also be presented. Methodology: a) lit review b) key informant interviews	Research Team	September 03/04

3.0 GATHERING BACKGROUND/ CONTEXT INFORMATION			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
Describing the current context			
3.6 Report describing the issues related to individual providers and health organizations that affect IPHC	3.6.1 This report will include a summary of individual attitudes and perceptions of interdisciplinary collaboration, issues related to quality of life and job satisfaction of health practitioners, interdisciplinary continuing education, operational issues and challenges in primary health care settings (e.g., EHRs, information systems, shortages of health professionals). Successful strategies in overcoming barriers will also be presented. Methodology: a) lit review b) small-group consultations with health providers and administrative staff c) 2 national surveys to determine the views of health providers involved in IPHC and those not involved in IPHC.	Research Team	September 04 Vancouver 09/08 Prince George, BC 09/10 Calgary 09/15 Toronto 09/24 Montréal 09/21 Cochrane, ON 09/17 North Battleford 09/03 Winnipeg 08/30 Regina 09/01 Yellowknife 09/13 St. John, NB 09/23 Halifax 09/22 St. John's, Nfl. 09/20
3.7 Report describing public health and social context related to IPHC	3.7.1 This report will present the role of PHC in addressing population health issues and concerns, the benefits of interdisciplinary collaboration for the management of public health concerns, a brief description of the health status of certain communities, including multicultural, aboriginal, children, and people with mental and communication disorders. Also, a description of how the Canadian public currently access PHC services and public perception of IPHC will be provided. Methodology: a) lit review (Canadian and international) b) small-group consultations with patients served by IPHC practices c) survey to determine the views of the patients and families regarding PHC and interdisciplinary practices	Research Team	September 04 Toronto 09/23 North Battleford 09/02 Yellowknife 09/14
3.8 Report presenting the synthesis and integration of research findings	3.8.1 This report will include the level of readiness of Canadian PHC to widely adopt and participate in interdisciplinary practices. Also, an analysis of the gaps encountered and inventory of good practices, as well as recommendations to enhance interdisciplinary collaboration will be presented.	Research Team	September 28/04

3.0 GATHERING BACKGROUND/ CONTEXT INFORMATION			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
3.9 Verification of Research findings with broader audience.	3.9.1 One-day Regional Workshops (5 @ 26 people) to bring disciplines together to: a) discuss and comment the synthesis and integration of research findings reports; b) provide information on how issues are expressed in different regions; c) provide an opportunity for cross-discipline discussion; and d) discuss implications for the focus of the Project. <u>Participants:</u> 1 Representative from each group consultation (3.6.1) 16 Representatives from associations 8 Representatives from policy makers, RHA reps, government, regulators etc.	Director of Research and ED	October 04 Toronto 12/03 Montréal 11/26 Halifax 12/09 Calgary 12/01 Yellowknife 11/29
3.10 Synthesis of Context and Current Situation information and analysis of implications for project	3.10.1 Writing of Context and Current Situation Report a) First Draft b) Final Report	ED and staff	 October 18/04 November 11/04
	3.10.2 Review by SC	SC	November 18/04

4.0 DEVELOPING THE PRINCIPLES AND FRAMEWORK			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
Barriers and Enabling Factors			
4.1 Recommendations for each issue area regarding what needs to be done to support implementation of the P and F.	4.1.1 Barrier/Enabling Factors Task Groups (4 @ 25 people) established to study and develop recommendations in the following areas: - liability/risk management - funding - health records - regulatory factors - health human resources* <u>Methodology:</u> a) Identification of Task Group themes and members b) Task Groups established c) Lit reviews and consult key informants for each issue d) Development of issue papers e) Groups formulate recommendations * proposed	ED and staff	All in Ottawa January 10/05 January 13/05 January 17/05 January 20/05 January 24/05
4.2 Identification of focus areas for project. Framework to describe how different parts of the PHC "system" should relate, as well as its relationship with other systems (Vertical and Horizontal integration)	4.2.1 Workshop with SC and key stakeholders (2 days, 35 people max.) <u>Methodology:</u> a) Present findings from Context and Current Situation Report and Regional Consultations b) Discuss implications for the Project (e.g. where should we focus our activities?) c) Development of a Collaborative Framework d) Use Framework as basis for discussion of broad Principles.	ED and staff	February 07, 08/05 Ottawa

4.0 DEVELOPING THE PRINCIPLES AND FRAMEWORK			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
Review of P and FW by Organizations			
4.3 Review of P and FW by Organizations	4.3.1 Preparation of workshop format and tool for gathering feedback (for use by Nat. Orgs.)	ED and staff	February/March 05
	4.3.2 National Orgs. get feedback from their memberships and other stakeholders (e.g. regulators) Methodology: a) awareness raising through journal and newsletter articles b) workshops at national/provincial/ territorial meetings c) collect feedback through associations, and via Project website	SC	February/March 05
	4.3.3 Analysis of feedback	ED and staff	February 05
	4.3.4 Amendments to P and FW based on feedback	ED and staff	February 05
	4.3.5 Development of overall change strategy for adoption	SC, staff	March 05
Validation of Principles and Framework			
4.4 Input from PHC practitioners and policy makers to determine if P and FW accurately capture the essential elements	4.4.1 Develop protocol for validation process	ED and staff	TBD
	4.4.2 Reconvene the groups of PHC Practitioners in 3.9.1 to discuss P and FW and provide feedback (5 @ 26 people max.) Participants: Representatives from previous workshops (3.9.1) 16 Representatives from associations 8 Representatives from policy makers, RHA reps, government, regulators etc.	ED and staff	Mar 16/05 Toronto Mar 18/05 Montréal Mar 30/05 Halifax Mar 23/05 Calgary Mar 21/05 Yellowknife
	4.4.3 Identify potential Test Sites	ED and staff	April 05
Testing of Principles and Framework			
4.5 Input from PHC practitioners to determine usefulness of P and FW to organizations and individual practitioners	4.5.1 Identification of potential sites	ED and staff	April 05
	4.5.2 Developing testing protocol	TBD	TBD
	4.5.3 Testing with PHC practitioners	TBD	TBD
Finalize Principles and Framework			
4.6 Final version of P and FW	4.6.1 Write next version of P and FW based on feedback	ED and staff	May 05

5.0 ADOPTION OF PRINCIPLES AND FRAMEWORK			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
5.1 Associations formally committed to P and FW	5.1.1 Identification of process required for adoption in each Association	ED and staff Participants include PHC Practitioners, Gov't reps, RHA reps, regulators	March 05
	5.1.2 Development of "toolkit" to support adoption	SC, staff	March 05
	5.1.3 Development of tailored strategy to support adoption in each Assoc.	SC	May 05
	5.1.4 Formal ratification by individual Associations	SC	October 05
	5.1.5 Joint ratification by all Associations	SC	October 05
	5.2.1 Launch Event (with Media)	SC	November 05
5.2 Public event to raise awareness of P and FW, and what it means for public			

6.0 IMPLEMENTATION OF PRINCIPLES AND FRAMEWORK			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
Development of Implementation Strategy			
6.1 Develop Implementation Strategy	6.1.1 Preparation of discussion paper	ED and staff	November 05-April 06
	6.1.2 Workshop (1 day, 30-60 people) with SC and invited participants to identify implementation issues and how to move forward.	ED and staff	TBD Ottawa
Development of tools and workshops to support implementation of P and FW at different levels			
6.2 Diagnostic "readiness to change" tools for individuals, organizations and health regions	6.2.1 Development of tools	ED and staff SC and key stakeholders (including gov'ts) participate	November 05 – January 06
6.3 Interdisciplinary workshops to support use of "readiness to change" tools	6.3.1 Development of workshops to support tools (5x 1-day workshops, with a "leadership group" of invited participants, in the same regions/locations as 4.4.2) to determine how best to support the change process.	ED and staff	Jan 11/06 Toronto Jan 18/06 Montréal Jan 25/06 Halifax Feb 01/06 Calgary Feb 08/06 Yellowknife
	6.3.2 Dissemination strategy, in collaboration with Nat. Orgs. (e.g. integration into continuing education strategy) and other stakeholders	Chair, ED	TBD
6.4 Meetings with key stakeholders	6.4.1 Analysis of stakeholders' role and positions with respect to implementation of P and FW	ED and staff	TBD
	6.4.2 Development of strategy to help stakeholders to understand and support implementation of P and FW	ED and staff	TBD
	6.4.3 Communications and meetings with key stakeholders	ED and staff	TBD

7.0 EVALUATION			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
7.1 Evaluation Report	7.1.1 Determine which outcomes have been achieved	SC, ED and staff	January 06
	7.1.2 Process evaluation	Outside "audit"	February 06
	7.1.3 1 day debrief with SC, Staff and key informants	ED and staff	March 15/06
8.0 FINAL REPORT			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
8.1 Final Project Report	8.1.1 Report written	ED and staff	March 7/06
	8.1.2 Review and approval by SC	SC	March 15/06
	8.1.3 Submission to Funder	ED/CPA	March 15/06
9.0 OFFICE SHUT DOWN			
Outputs	**Inputs**		
	Actions required	**Responsible**	**When**
9.1 Disposition of Project files, resources and assets	9.1.1 Store with Signatory Organization (CPA)	ED and staff	March/06

www.eicp-acis.ca

For more information: *Tel:* **(613) 526-3090 ext. 460** • *E-mail:* **info@eicp-acis.ca**