

***MULTIPLE INTERVENTION PROGRAMS
INVITATIONAL SYMPOSIA SERIES***

3rd ANNUAL SYMPOSIUM

***ACHIEVING VERTICAL AND HORIZONTAL
INTEGRATION***

***IN MULTIPLE INTERVENTION PROGRAMS:
ISSUES IN STRUCTURES, PROCESSES, AND EQUITY***

PROCEEDINGS

Kathryn M. Clinton, University of Ottawa
Jo-Anne MacDonald, University of Ottawa
Nancy Edwards, University of Ottawa
Lynne MacLean, University of Ottawa

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MULTIPLE INTERVENTION PROGRAMS

ACHIEVING VERTICAL AND HORIZONTAL INTEGRATION: ISSUES IN STRUCTURES, PROCESSES, AND EQUITY

The complexities of the social, political, economic and environmental factors that influence health and inequalities in health, and the fact that most of these determinants lie outside of the exclusive jurisdiction of the health sector; requires the health sector to act in collaboration with other sectors of government and society in order to more effectively address those factors that influence health and well-being. (Public Health Agency of Canada and the World Health Organization, 2008, p. iii)

Intersectoral action makes possible the joining of forces, knowledge and means to understand and solve complex issues whose solutions lie outside the capacity and responsibility of a single sector. It can be both a strategy and a process, and can be used to promote and achieve shared goals in many areas including policy, research, planning, practice and funding. ... Intersectoral action has two dimensions: a horizontal dimension that links different sectors at a given level (e.g. partners in the health, education and justice sectors at the community level); and a vertical dimension that links different levels within each sector (e.g. local, provincial and federal government partners within the health sector). Both dimensions are important for success. (Public Health Agency of Canada, 1999, p. 5)

A lack of integration weakens the likelihood that clients will access the right combination of programs and services at the right time. Opportunities to achieve synergies are lost; the compliance burden is greater than it needs to be, and in some cases, when they use a program provided by one department or level of government, citizens and businesses are denied access or inadvertently penalized for using a program provided by another. (Treasury Board of Canada Secretariat, 2004, p. 1)

These quotes provide the reader with an overview of some of the key issues that intervention integration draws attention to and attempts to address. Keep these in mind as you gather insights from these Proceedings of the 2009 Multiple Intervention Programs Symposium, "Achieving Vertical and Horizontal Integration."

INTRODUCTION

The Multiple Intervention Programs Invitational Symposia Series was developed to address topical and challenging issues of relevance to invited researchers, decision makers, and program planners working in the field of public health and specifically focused on Multiple Intervention Programming (MIPs).¹

The objectives of the Symposia Series were to:

- Develop strategies to integrate multiple intervention program research findings into programs and policies;
- Identify new multiple intervention program research approaches sensitive to government needs and realities; and
- Document insights gained for participants and the larger public health community.

The third in a series of three invitational symposia was held in April, 2009 under the direction of Dr. Nancy Edwards of the University of Ottawa. Previous symposia looked at issues of context and equity within MIPs (Inaugural Symposium 2007: “Changing Contexts”) and (Symposium 2008: “Addressing Public Health Inequities”).

Symposium Background, Purpose, and Organization

The theme for the 2009 symposium was “Achieving Vertical and Horizontal Integration.” The symposium tackled the question of how issues of MIP structure, process, and equity related to vertical and horizontal integration can improve MIP outcomes. In addition to researchers, decision makers, and program planners, key leaders of community health services where integration is essential to effectiveness and efficiency were invited to participate.

The overarching goal of the symposium was to examine the theoretical, empirical, experiential, and ethical base for the vertical and horizontal integration of multiple intervention programs.

The objectives of this symposium were to explore:

1. The challenges inherent in developing accountability, governance, and other structural components essential for integration;
2. The critical processes required for successful integration; and
3. The ethical foundations for an equity-oriented approach to integration.

Symposium presentations, panel discussions, and work groups provided venues to explore how to develop MIP program policy, design, and research, and how to work together over and across sectoral and jurisdictional levels to improve public health.

¹ Multi-level and multi-strategy community health programs.

In preparation for the symposium, participants were asked to consider issues relevant to multiple intervention programs and integration. Background readings were provided to initiate this process.

Symposium Opening

The symposium began with welcomes, introductions, and opening remarks by Nancy Edwards. She set out the objectives of the Symposium to provide the context for the broad-ranging and substantive presentations and deliberations to follow. Edwards then thanked the Symposium sponsors and introduced and thanked the members of the Planning Team and the MICOP (Multiple Intervention Community of Practice) Group who assisted with Symposium planning and organization.

THE SYMPOSIUM UNDERWAY

Working on Key Aspects of Vertical and Horizontal Integration in MIPs

The symposium was organized around its three objectives. Presentations followed by discussant sessions aimed to provide: 1) an overview of integration for MIPs; 2) an appreciation of cutting-edge research and cross-cutting themes in vertical and horizontal integration and 3) various perspectives on each of the objectives: exploring structural, process, and equity issues related to integration and MIPs.

Exploring Vertical and Horizontal Integration for Multiple Intervention Programs: An Overview

Moving Beyond the Rhetoric: Incorporating Horizontal and Vertical Integration into Multiple Intervention Programs

Speaker: Nancy Edwards

Incorporating vertical and horizontal integration into multiple intervention programs (MIPs) holds great promise for tackling pressing health issues. MIPs are comprehensive programs distinguishable by their deliberately coordinated multi-strategy and multi-level interventions. Edwards suggested that immunization, tobacco control, and injury prevention programs are testament to the success of using a set of strategies to target multiple system levels. However, while the use of multiple strategies is routine in complex programs, targeting local to global systems remains less common. Thus, understanding how to achieve and study vertical and horizontal integration was a fitting theme for this year's symposium.

Edwards set the stage for symposium discussions by sharing her insights about vertical and horizontal integration and the challenges these approaches face. Verticality reflects a service delivery mode of thinking that considers how all levels of the system must work together to achieve objectives, often to address a specific disease. Vertical programs are effective when rapid responses and time-limited approaches are required for integration of

programs into mainstream health services. The eradication of smallpox illustrates the success of a vertical approach. Horizontality refers how to work across sectors, or across departments and organizations.

Despite its merits, arguments against a vertical approach to delivery include: a limited chance for sustainability; neglect of some of the underlying determinants; negative spinoff effects for health systems and non-targeted populations; potential duplication of services; and lack of pooling of funding or resources. Horizontal approaches are similarly criticized, as discussions remain at the policy level (intersectoral action) or at the service delivery sector without attention to differing levels of jurisdiction. Edwards suggested that governance structures and funding arrangements are two key program elements that we must bear in mind as we think about the relative strengths and weaknesses of vertical and horizontal integration. This is because they tend to lock us into particular ways of working that are not necessarily intersectoral. So a question is presented: How do we work within these existing structures that cannot be easily dismantled?

The MIP framework offers a way to move forward in understanding how we might work towards vertical and horizontal integration. The success of using an intersectoral approach begins with naming the 'problematique' and ensuring both a vertical and horizontal view of the problem. Defining the 'problematique' includes considering: 1) how a health sector driven entrance to issues frames our understanding of problems; 2) how existing formalized documentation and surveillance systems may narrow definitions of problems; 3) how data on social structures and resource distribution are required to understand inequities; and 4) how health and equity impact assessments can be used to facilitate integration. At the second stage of the MIP framework, the selection of intervention options also has implications for how we can work intersectorally. Edwards suggested that selecting interventions requires consideration of organizational mandates, accountability frameworks, existing partnerships and capacities that may narrow the range of intervention options, potential policy levers, time-scales for change at different system levels, and sustainability, spread of innovations, and scaling-up strategies.

Ending the introductory session to the symposium, Edwards acknowledged the shifting state of science around population and public health and movement from understanding complex interventions to understanding complex interventions within complex adaptive systems. Moving beyond the rhetoric to incorporating horizontal and vertical integration in MIPs requires that we:

- Purposefully extend assessment of problems beyond the health sector and across jurisdictional levels;
- Capture the experience of those working on the front-lines and those who are experiencing inequalities;

- Systematically examine the shorter and longer term trade-offs between horizontally-directed and vertically-oriented approaches;
- Consider what policy levers might be used at all system levels and within a range of sectors to impact the health of populations and to reduce inequities; and
- Build a new research agenda and funding mechanisms that fit with new directions in horizontal and vertical integration of programs.

Discussants: Barbara Riley and Bernard Lamontagne

Following Edwards' presentation, Barbara Riley and Bernard Lamontagne offered insights about incorporating horizontal and vertical integration gained from their experiences. Riley recalled her interest in horizontal and vertical integration, which began over twenty years ago as she led the evaluation of the Heart Health Action Program in Ontario. This initiative engaged communities across the province in the development of comprehensive programs that linked a number of different sectors and crossed local, provincial, and national jurisdictions. According to Riley, by many accounts the programs had all the ingredients of success for horizontal and vertical integration. Yet, in many ways they also had the ingredients for failure. Expectations for demonstrable changes in behaviours and decreased cardiovascular disease fell short.

Since then Riley has been committed to establishing an evaluation and research approach to create realistic expectations for these programs and how they can work more effectively. As she thinks about the challenges for developing programs that involve many sectors and systems, Riley has learned that we need to develop a systems lens to guide the examination of situations and the complex forces operating at different levels and across different sectors. Riley echoed that public health does not necessarily need to lead and suggested a 'Jujitsu' approach whereby public health considers how to best position itself in order to strategically influence and infiltrate thinking and action across levels and systems. In closing, Riley described how a new science for public health research should not only be asking new questions and exploring new methodologies, but shifting its mindset to one that is less about proving and more about improving.

Bernard Lamontagne provided insights about horizontal and vertical integration gained through his experiences with the introduction of Local Health Integration Networks (LHINs) in Ontario. The development of a strategic plan for LHINs required and exemplified many layers of horizontal and vertical integration. Arriving at a strategic plan to improve the health of citizens, client experience with health services, and health system sustainability involved: 1) working with a number of partners across various system levels to re-conceptualize the population (inclusive of age, health conditions, and geographic location); 2) integrating ministerial and regional mission and vision statements; and 3) engaging health service providers and community of care advisories.

According to Lamontagne, a number of dis-incentives to integration persist. Physicians, primary health care, and public health are essential partners for successful integration. Yet, they are not part of LHIN funding and resistance exists to move dollars to other parts of the health system. However, improving population health, enhancing the quality and effectiveness of services, and meeting the growing demands for services are key drivers to find ways to make integration work. Lamontagne ended with a humorous but important message: 'Ready; Aim; Fire': We need to fire in the approximate range (be willing to experiment); then aim (give efforts a chance to fail and then improve upon), and then we will be ready to shoot for real (with forethought).

Cutting Edge Research and Cross-Cutting Themes in Vertical/Horizontal Integration

Speakers: Erica DiRuggiero, Elizabeth Gyorfi-Dyke, Christine Kurtz-Landy

The second session of the symposium highlighted cutting edge research in vertical and horizontal integration by graduate students. Doctoral student Erica Di Ruggiero opened the session describing her research interest related to processes leading to vertical and horizontal integration in the context of policy implementation. Early research suggests that intersectoral action is strongest and outcomes best achieved when collaborations are both vertical and horizontal, occur at several levels simultaneously, and are integrated or supported through policy legislation. Di Ruggiero proposed a need to question how vertical and horizontal integration are conceptualized in different policy contexts and how to best understand the processes for integration.

Switching from her PhD student lens to her research funding hat, Di Ruggiero offered suggestions to encourage knowledge development in this area. Enabling conditions include support for natural policy experiments, unconventional programs of research and knowledge exchange (i.e., nested and inter-connected studies, comparative studies, fleeting 'policy window' opportunities), basic and applied research, and within and cross-country collaborations. Targeted funding and training and mentorship across career trajectories are additional supports Di Ruggiero believes are necessary to encourage research in this area.

Elizabeth Gyorfi-Dyke continued the session by introducing her innovative PhD research exploring factors that influence International Non-Governmental Organizations' (INGO) implementation of equity principles in their HIV/AIDS work. Gyorfi-Dyke believes a gap exists between the intent of INGOs to ensure equity in their HIV/AIDS work and actual practice. She suggested that global donor funding may be a contributing factor. According to Gyorfi-Dyke there has been a shift from the funding of horizontal programs to vertical programs. Relying on donor funding, INGOs are influenced by the focus of the donors that tend to be disease specific and vertically oriented. Advantageous to vertical funding is targeting of diseases, monitoring successes, (i.e., reduced enteric disease), and enhancing the awareness and thus support to combat diseases. On the other hand, vertical funding

contributes to lack of donor coordination, poses challenges for sustainable programs, and hinders the development of comprehensive approaches required to address wider determinants and social inequity.

For Gyorf-Dyke, the question is how do we integrate vertical or horizontal approaches, or in the case of HIV/AIDS, is one approach better suited than the other? Arguing that HIV/AIDS shares common underlying structural issues with other health concerns such as poverty, gender inequity, and lack of human resources and infrastructure, Gyorf-Dyke believes there needs to be a shift in funding arrangements that allows targeting upstream sources of problems. She suggested that perhaps it is through a 'diagonal approach' that opportunities from vertical approaches can be retained yet address gaps through horizontal approaches.

Adding to the horizontal and vertical integration dialogue, Christine Kurtz-Landy began by introducing her doctoral and post doctoral research interests concerned with health inequities experienced by those in early motherhood. Kurtz-Landy argued that commitments to address inequities and ensure basic human rights for children and mothers living in poverty are not being met. Government policies as well as societal rhetoric and ideologies contribute to the disadvantage of these women who experience poorer health, lack essential supports, and resources and are stigmatized and discriminated by the very service providers put in place to help. Addressing these concerns requires combined vertical hierarchical and horizontal integration and collaboration. Kurtz-Landy cautioned the linear thinking that may accompany vertical and horizontal approaches. She suggested the relationships involved with vertical and horizontal integration are complex and chaotic, requiring communication at every level and across levels.

Discussants: Marjorie MacDonald and Beth Jackson

Discussants Marjorie MacDonald and Beth Jackson provoked additional theoretical and methodological considerations in their responses to the three presentations. MacDonald noted that all presenters identified theoretical and methodological challenges for gaining knowledge about horizontal and vertical integration in MIPs. Pulling together various theoretical perspectives to guide research for programs that focus on multiple aspects of a problem, involve complex interventions, cross sectors and jurisdictions, and play out differently in different contexts remains an important area for investigation and innovation.

Picking up on Kurtz-Landy's idea, MacDonald suggested that moving away from linear ways of thinking and grappling with complexities may be facilitated through network theories. We also need to think very differently about how we research complex interventions within complex systems. MacDonald argued that the kinds of methodologies and designs that get funded and with which we are most familiar will not begin to take us down that path. Methodological development is critical and fortunately, people are now starting to come together to discuss these issues.

Adding to the themes of theoretical and methodological issues, Beth Jackson proposed that feminist epistemologies, science and technology studies, and intersectional analysis are important tools that can help to advance knowledge in health and social justice. Jackson shared ideas from her paper (recently accepted for publication), which describes the complementary and productive cross-fertilization of these approaches in research. Feminist epistemologies and science and technology studies draw attention to the social, political, historical, and material contexts in which knowledge is produced, while intersectional analysis guides inquiry into the production of meaning, systems of inequality, and social justice. Value added through such approaches is the provision of responsible accounts of how and what we know and questioning of the assumptions upon which those knowledge claims are based.

Jackson suggested there is an addiction to developing tools, but we may be well served to shift our thinking to developing critical methods of inquiry. We have lots of work to do in terms of developing and implementing these theoretical and methodological frames. Fortunately we have a rich set of concepts and practices with which to do this work across disciplines. Jackson ended the session by reminding participants that we may not always recognize each other's language but we are all very much engaged in the same project.

Structural Issues in Vertical/Horizontal Integration for Multiple Intervention Programs

Structural Issues in Vertical/Horizontal Integration

Speaker: Jack McCarthy

During the third session of the symposium, Jack McCarthy specifically considered structural issues in vertical and horizontal integration for multiple interventions. McCarthy shared learning about horizontal and vertical integration strategies at the community level gained through his work at a local community health care centre. The centre serves as the hub for a number of comprehensive health and social services, and is engaged in community development and policy work. The centre requires networking, planning, advocacy, and co-ordination with various community groups to meet its vision of building healthy communities and promoting healthy public policy. Integration is believed to improve client care through the provision of timely services, appropriate referrals, delivery of seamless care, and system efficiencies. For McCarthy, the issue is not buy in for integration but how to integrate.

Diverse structural barriers pose challenges for integration. Integration is labour intensive and may overload existing mandates. There is an absence of an overarching framework for health goals and of common data management systems. Different governance and legislative mandates and funding mechanisms represent additional structural challenges for integration. Turf protection and institutional behaviour change that is slow to change are also barriers. Yet, we know integration is possible. McCarthy drew on examples of crisis

and tragedy to illustrate that no perfect process or operational plan is needed to bring people together to solve community problems. Making integration happen requires creating partnerships, developing common missions, taking risks, and remembering to remain passionate and have fun in the process.

Discussants: Tim Hutchinson and Dominique Tremblay

Tim Hutchinson and Dominique Tremblay provided insightful comments in response to McCarthy's presentation. Hutchinson identified a number of questions around vertical and horizontal integration inspired in response to the presentation. From a public policy perspective, Hutchinson asked how we measure the various levels of integration described in these complex programs and how we measure successful networks. Although there is no cookie cutter approach, there are common elements and indicators from which we can learn and avoid reinventing the wheel.

Hutchinson was also struck by the importance of figuring out how to measure context in relation to integration. In addition to addressing the community, cultural, and client contexts, there is a need to deal with the changing context that includes both subtle and dramatic shifts. Building answers to these questions into our evaluation frameworks and research agendas would be an important step forward. Hutchinson also spoke of the need to learn more about the levers that pull people together, not only in times of crisis but also during times of opportunity. Understanding what elements of the structure facilitate creativity and responsiveness is an important area to explore. For Hutchinson, a critical structural piece for systems integration is the development and sharing of data sets to maximize synergies and actualize potentials that are possible because of integration.

For Tremblay, McCarthy's presentation underscored the need for researchers to invest in understanding how successful integration occurs. Tremblay offered a number of observations about how things seem to come together. Building on McCarthy's idea of speaking the language of communities, Tremblay suggested we need to similarly understand the differences in language between policy makers, care providers, and researchers. Integration also requires clear delineation of roles to facilitate mobilization and action. Tremblay argued we should not presume that actors at higher system levels are the only ones capable of leading integration. As McCarthy's example illustrated, actors at local levels have the power to initiate and lead integration across many system levels. For Tremblay, integration is a living laboratory to create new status and roles best suited to meeting the needs of populations. It is a space for innovation and relates to collaboration, coordination, leadership, and community of action.

Tremblay compared the challenges for integration to a game of snakes and ladders – just as you think you are making progress you may find you are set back. We can learn 'where are the snakes' and 'who has the ladders' as we attempt to help make integration work. We have to keep in mind there is no magic bullet. Barriers for integration are related to the

context and so attempting to manage barriers will only be met with other barriers. Key to success is contextualization - learning to adapt projects and maintain objectives in the face of barriers.

From Rhetoric to Reality: Premises and Principles in Vertical/Horizontal Integration for Multiple Intervention Programs

Group Discussions

During the afternoon of Day 1, symposium participants were given the opportunity to discuss premises and develop principles related to vertical and horizontal integration. Participants selected one of four premises to work on in small discussion groups. Based on the group’s premise, each was asked to develop principles for a draft resolution that would be suitable for adoption at, for example, a Canadian Public Health Association Conference. The following table summarizes key comments from these group discussions.

PREMISE	KEY COMMENTS and PRINCIPLES
<p>PREMISE: Distinct and potentially competing goals and accountabilities and structural "silos" and "tunnels" that inhibit communication and trust among sectors and levels inhibit integration and constrain the design and evaluation of multiple intervention programs.</p>	<p>NEW WORDING OF THE PREMISE was suggested: “Distinct and potentially competing goals and separate accountabilities and funding structural silos and tunnels that inhibit communication, interaction, and joint planning among sectors and levels inhibit integration.”</p> <p>DISCUSSION COMMENTS:</p> <ul style="list-style-type: none"> • Re premise, ‘trust’ is a loaded word • Competing goals/different accountabilities • Structure of public health: funded by 3 ministries; accountability separate; diverse Interests; and lack of synergy • Funding structures • Leadership hubs (illustration from program of research funded by International Development Research Centre and led by Edwards, Kaseje and Kawa): structure that can be put in place to mitigate funding structure; formal process/structure; to break down silo issues and get people talking; engage public health practitioners at a local level • Example of multi-sectoral intervention: LHINs- Falls Prevention: <ul style="list-style-type: none"> – LHIN funding has led health units to collaborate with each other and other community partners (community funding lever) – LHINs have no jurisdiction over public health

PREMISE	KEY COMMENTS and PRINCIPLES
	<ul style="list-style-type: none"> - Project meets needs of all partners - Common goals project established <p>PRINCIPLE should include:</p> <ul style="list-style-type: none"> • Translation process • Levers for collaboration • Common goals • Set up formal structures (organic) • Establish same language • Common understanding • Develop strategies to better understand context and meaning around solution
<p>PREMISE:</p> <p>Input from the full range of affected parties is necessary and forms the basis for synergies in integrated program development.</p>	<p>PRINCIPLES:</p> <p>Be it resolved that:</p> <ul style="list-style-type: none"> • Priority will be given to community driven and governed approaches; these need to be used, applied, and investigated. • Affected parties, including service providers, community stakeholders, decision makers, researchers, policy makers, and politicians need to be identified and need to be invited/ encouraged/ supported/ accommodated/ engaged/ acknowledged. • Research needs to include the full range of affected parties in its activities and planning (audience-researchers). • Shared leadership and decision making with jointly-established parameters for decision making. <p>CLARIFICATION COMMENTS:</p> <ul style="list-style-type: none"> • Representation must reflect population heterogeneity (as appropriate to the issue and size of planning group). • Adequate resources (time, money, space, and staff) need to be allocated for full implementation of these principles.
<p>PREMISE:</p> <p>Inequities in power and status, and lack of political will and/or executive buy-in lead naturally to unbalanced participation in integration efforts.</p>	<p>DISCUSSION COMMENTS:</p> <ul style="list-style-type: none"> • Government perspective; strategies and frameworks; enable programs and legislation • How do voices move up? • Whose agenda is put forward? • What is the role of advocacy groups? • Executive buy-in: To a balanced perspective? Whose political will? • Strategies change <p>PRINCIPLES:</p> <ol style="list-style-type: none"> 1. Unbalanced participation* and integration efforts are fostered/promoted by inequalities in power and status. <p>*Participants: those who are most effective by inequities</p>

PREMISE	KEY COMMENTS and PRINCIPLES
	<p>2. Balanced participation requires the following: Be it resolved that:</p> <ul style="list-style-type: none"> • Participatory processes to engage those most affected by inequities be adopted (equity impact, equity analysis homework, resource enablers? reimbursement?). • Participatory processes require new roles and appropriate (e.g., employment, and engagement) and respectful compensation. • Participatory processes must be incorporated in our program planning, delivery, policy development, and research. • Decision-making structure must be based on a power-sharing model. • Environment must be culturally sensitive, safe, and respectful. • Accessibility, timing, and location are important. • Meaningful engagement is required.
<p>PREMISE: Different research, evaluation and knowledge translation practices across sectors create challenges in the integration of existing research findings from different disciplines and the development of program monitoring and evaluation functions for intersectoral programs.</p>	<p>DISCUSSION COMMENTS:</p> <ul style="list-style-type: none"> • There are differences in language across sectors, disciplines, and system levels. • There must be respect/understanding for different disciplines, methods, diversity, processes, and values. • Can't assume understanding of your "language." • Requires resources/infrastructure to understand our own and others' interpretations. • Early engagement and an ongoing process – a true KT model is needed. • Knowledge translation requires cultivating multilingual capacity and critical thinking. • Social construction of knowledge is not a shared standpoint. • Engagement is necessary. • Teach differences/similarities across disciplines; develop elements of a common language. • Disengagement is a challenge. • Different players have different success indicators and priorities. • Synthesizing quantitative/qualitative research is critical. • How to integrate different types of indicators. <p>What PRINCIPLES should guide us?</p> <ul style="list-style-type: none"> • Respect and honour diversity education/training about processes for working across disciplines.

PREMISE	KEY COMMENTS and PRINCIPLES
	<ul style="list-style-type: none"> • Education institutions, professional associations. • Building consensus about language, meanings, approaches. • Infrastructure for engagement (especially time). • Each partner values the collaboration process.

Overall, the groups varied substantially in what they chose to work on and the extent of formulating principles for draft resolutions. This is perhaps somewhat reflective of the challenges facing policy development, research, and implementation of vertical and horizontal integration in multiple intervention programs.

Process Issues in Vertical/Horizontal Integration for Multiple Intervention Programs

Integrated Strategy on Healthy Living and Chronic Disease. Process Issues in Vertical/Horizontal Integration for Multiple Intervention Programs

Speaker: Tim Hutchinson

Day 2 of the Symposium began with a presentation and discussion of process issues related to vertical and horizontal integration for MIPs. The first speaker, Tim Hutchinson provided a comprehensive overview of the *Integrated Strategy on Healthy Living and Chronic Disease* (ISHLCD) of the Public Health Agency of Canada (PHAC), identifying the key areas where integration has played a significant role in the success of the development and implementation of the strategy and the organization put in place to oversee it. He reinforced the notion that defining integration has been a challenging but essential aspect of the success of the ISHLCD – a very ambitious multiple intervention program. He emphasized the need to talk about structure when discussing process, and the importance of context, such as changes in governments and the election environment of a minority government.

The ISHLCD began with public health thinking about multiple intervention programs, with particular attention on how to address issues of meshing common risk factors across a number of public health functions and how to operationalize the strategy using an integrated framework. Hutchinson presented the conceptual framework for the Strategy and pointed to the important aspects of integration represented in it. For example, he talked about integration within and across local, provincial/territorial and national jurisdictions; inter-and intra-sectoral engagement in varied settings; and the interface between public health and health care. Hutchinson discussed the development and operationalization of a Strategy matrix (the blueprint or ‘placemat’) that demonstrated integration across and within program components and functional components. He explained the integration between functional

components and also the synergies that existed between the programs through each of the functional components.

Hutchinson raised many probing questions related to integration, indicating the depth of thinking that has gone into the integrative focus of this Strategy. As an example, he asked: “How do you use your surveillance data that comes together with your KDED (Knowledge Development, Exchange and Dissemination) pieces (that is, emerging best practices) and your program pieces, and how do these work together in a way that your surveillance is informing the other components?” Further challenges associated with integration included the possibility of too much communication; the amount of engagement needed; the costs associated with integration; and the importance of determining and operationalizing roles and responsibilities. Hutchinson also commented that organizations can get lost in the structure when trying to operationalize complex and integrated systems.

The Strategy led to putting a coordination structure in place to ensure congruence and consistency. Hutchinson suggested that it is easier to work across sectors because roles are clearer. However within one’s own sector, interesting dynamic issues exist that pose real challenges in operationalizing integrated ways of working, including determining the degree of interpretation and competition.

He also talked about the Strategy’s logic model and how it provided a sense of how various components ‘meshed’ and demonstrated the development of program elements in an integrated way. Through ongoing monitoring and evaluation and implementation reviews, integration has evolved, building on internal collaboration and working towards broader scale integration. Hutchinson emphasized the importance of having a framework (the matrix) that keeps the Strategy focused on both vertical and horizontal integration, knowledge development and cross-functional work.

Hutchinson concluded by summarizing lessons learned about integration and multiple intervention programs as the ISHLCD has been developed and implemented. Some components have been successfully integrated vertically – the surveillance and KDED functional components and diabetes community-based programming. An example of horizontal integration, the Healthy Living Fund has been successfully implemented across sectors. Overall progress has been made in engagement, reach, and partnerships. “Being true to principles is what ultimately makes for effective integration” was the final message that Hutchinson offered participants.

Discussants: Caroline Andrew and Louise Lemyre

In their comments, discussants Caroline Andrew and Louise Lemyre brought unique but extremely relevant perspectives to the discussion. Andrew organized her remarks around one definition, two perspectives and three lessons. She identified governance (the effective mechanisms of coordination in situations where power, resources, and information are

widely distributed) as particularly relevant to the discussion of process issues of integration and the ISHLCD. She suggested that we don't know enough about coordination mechanisms – which ones work and which ones don't; who should be involved and who decides; and how clear/vague mandates are.

Andrew then provided two perspectives on the Strategy matrix in the context of effective mechanisms of coordination. As she reflected on earlier discussions about approaches to integrative interventions, Andrew's first perspective was on place-based policy, commenting that the Strategy matrix importantly allows for continuous effort of federal capacity building of local governments and communities. However, she questioned how the model coordinates the three distinct community-based programs, commenting that they were each disease specific and did not seem to relate to other broader issues at the local level.

The second perspective reflected Andrew's particular interest in the needs of groups such as immigrant women in the health care system, involving politics, advocacy, open systems, and multiple actors. She asked how that perspective works its way into the ISHLCD matrix, into mental health, and into knowledge. If one thinks of flexible and open systems of integration, how do these political points of view get worked into integration? She suggested that the challenges of intersectionality and the multiplicity of identities require that numerous groups need to understand how to intervene.

Lessons gained from Hutchinson's presentation included the importance of good federal programs for place-based policy making and good federal coordination with key players focussed on capacity building. The second related to the current constraints of Canadian federalism. She suggested that issues of jurisdiction are important, asking what the relationships between communities and municipalities are and should be. There is currently a (provincial) blank space in how we think about place-based vertical and possibly horizontal integration. Lastly, Andrew felt it is important for the federal and provincial governments to think about their evolving roles in place-based policy making. Changes from top down processes to partnering are required. Returning to the issue of immigrant women, Andrew concluded by asking how the priority of mental health of immigrant women could be advanced in the ISHLCD. Are governments thinking about new ways to relate in this vertical and horizontal integration strategy?

Louise Lemyre provided comments from the perspective of 'her context,' that being of developing interventions to integrate psychosocial considerations into planning and managing of risks in areas such as Chemical, Biological, Radiological, and Nuclear Explosive (CBRNE) terrorism, pandemic planning, natural disasters, and major events like the Olympics. Lemyre commented that she is trying to promote an ecology of systems very much like multiple interventions, which includes targeting multiple levels. Other important aspects of the ecology of systems are the ripple effects of one risk or event on others, and thinking ahead of the curve. She is implementing this system in the training of scientists, first responders, health workers, the public, the media, and decision makers. This training is

carried out vertically (by government jurisdictions and by public, private, and NGO levels) and horizontally (by sector, e.g., health, transportation, etc.).

Lemyre emphasized the need to view interventions in context, using a photograph of rain droplets in water as a way of thinking about what multiple interventions and their evaluations look like. She suggested it is like asking “which of the droplets is effective in getting me wet?” If we want to foster an ecological system, we cannot only use the system to structure interventions – the process has to be more organic. There is a tacit biomedical paradigm used in multiple interventions: looking for ‘prescriptive’ doses; looking for fidelity instead of agility of interventions; and an emphasis on top-down, unidirectional approaches where there is little input and some consultation, but not real engagement. Lemyre suggested that we should be implementing multiple *patient* interventions at many levels.

She stated that processes are critical and should be considered the dependent variable in interventions. Interaction and awareness are essential and knowledge must become much more organic. It is in the very engagement of the people to whom one would apply a treatment (or intervention) that the ‘active ingredient’ resides, and it is when stakeholders understand the real factors and pathways (i.e., important experiential knowledge) that things begin to change. Missing processes include co-ownership of issues and solutions; social identity; and experiential processes that are organic.

In reframing intervention processes, Lemyre concluded by proposing the use of the term “circum-vention” rather than intervention. In this way, we pursue engagement and reciprocity and through interaction and shared knowledge, we will learn to share issues and eventually find shared solutions.

Equity Issues in Vertical/Horizontal Integration for Multiple Intervention Programs

Using Ethical Analysis to understand Policy Processes: Implications for Multiple Intervention Programs

Speaker: Colleen Varcoe

The first speaker to discuss equity issues in MIP integration, Colleen Varcoe, clarified that she was neither an ethicist nor a multiple intervention practitioner, but was bringing a different perspective and skill set to the symposium discussions. Varcoe explained that she was looking at ethical analysis and how health policies really work from the perspective of theorists from contextual, relational, and feminist ethics, not from the dominant biomedical paradigm used in health. Her interest in policy is focussed on how research and policy making related to violence against women can have a broad impact on understanding and reducing violence.

Varcoe described a qualitative study that set out to analyze priorities and the policy-making processes of senior government personnel in the BC government. The principal issue was to examine how ethical analysis could enhance socially-just policy. A key aspect of the

research was to understand the relationship between evidence and policy. Although the literature confirms the non-linear nature of this relationship, it is not always well understood in practice. The study found that, while equity might be a priority for the interviewed policy makers, their role was not only to inform policy, but also importantly, to inform and manage public outcry and public understanding, and to inform how problems are framed. There are many places where evidence can be helpful and these policy makers repeatedly said that only when there is intelligent evidence out in the public realm, and when that same evidence informs policy from the researchers' perspective, will things move forward.

Her study also found a diversity of understanding of equity in relation to health care that represented a continuum from distributive to social justice. However, the predominant emphasis on equality of access was reflective of the distributive justice perspective. Varcoe suggested that this was attributable to several factors including the Canada Health Act; the biomedical organization of government (and embedded verticality); an emphasis on economic efficiency; and the "course correction" approach to government (i.e., fix small problems that maintain the status quo but do not attend to the broader social determinants of health).

Varcoe pointed to windows of opportunity for a more equitable approach to public policy, such as whole government/full landscape approaches but emphasized that grass roots commitment is still essential. She commented that there is a recognition of the ineffectiveness of silos; a beginning recognition that inequities are not good for business; and increasing attention to the importance of participatory democracy in policy making. She recommended proactive actions such as: 1) engaging a wide spectrum of stakeholders earlier; 2) early examination of language, values and conceptual meanings; 3) early identification and analysis of policy context, relevant policies and policy questions; 4) early analysis of dominant and competing values in public discourse; and 5) creating and taking advantage of windows of opportunity.

Varcoe concluded her presentation by setting out five important questions that participants should consider:

- How can these understandings inform strong policy interventions?
- How can policy context be treated as enabling structures and conditions?
- Can ethical theory be a useful adjunct to policy change theories?
- Can sustainability anticipate short policy cycles? and
- When does collaboration become collusion, especially as related to economic efficiency?

Economics And Integration: Is There A Choice Between Efficiency And Equity?

Speaker: Stephen Birch

Stephen Birch concluded the Symposium presentations with a discussion about the tradeoffs between efficiency and equity and how that process impacts integration in multiple interventions programs. He began with an overview of the challenges of evidence-based medical research, calling his view “evidence-based medicine unplugged” (Birch, 1997). He then provided a brief explanation of multiple intervention programs. MIPs aim to maximize wellbeing; overcome problems of the traditional medical research approach; provide customized approaches; and respond to reality. Birch went on to present an economic perspective suggesting that MIPs “reflect multiple ‘inputs’ in the production of health, illness, and recovery in populations.”

Birch introduced three economic concepts germane to his presentation – scarcity, choice, and opportunity cost, explaining how they relate to efficiency and equity. Equity is a subjective consideration about fairness, and although all studies involve equity, the equity principle is often hidden or implicit. It can be misused to meet economic, not social justice ends in systematic economic evaluations of health care programs. Birch commented that the opportunity cost of equity is often not considered, leading to the question of whether (or when) equity improvements are warranted.

With respect to equity and efficiency, it is important to identify specific social objectives (that maximize benefits to society) first and then incorporate equity into these objectives. These should be built into evaluations to ensure systematic consideration of alternative programs in terms of precise social values generated from outcomes, thereby “being efficient in producing equitable outcomes.” Birch then discussed access to care, seeing it as an ambiguous concept at best. ‘Reasonable’ access has been a principal objective of many health care systems, with the emphasis being on demand-side problems such as ability to pay and use of service. After 50 years, we still have unequal use of services and access to care, and in some countries, inequalities are increasing under this policy. For example, when national comparisons of high and low income people who needed physician or dental care but didn’t consult a provider due to cost are examined, noticeably more of the low income group do not consult providers.

Birch viewed access not as use, but as empowerment. He defined empowerment as having the freedom to use care when needed, with integration of demand and supply side factors. In addition, empowerment occurs when individual capacity to benefit from health care services is not only based on system funding and delivery capacity, but also on policy-makers’ and managers’ obligations to empower individuals and families. He presented a framework called “The Triple ‘A’ Framework” to explain the factors that access is based on: affordability, availability, and acceptability. *Affordability* is determined by the full cost to

individuals and the ability to pay that cost. Not only the size of payment but also the form (how one pays) and expected time patterns of income impact affordability. *Availability* is determined by location and timing of services and need, and includes transportation infrastructure and services, health care service configurations, and provider willingness to contribute to programs. *Acceptability* is determined by attitudes and expectations of providers and clients. It relates to mutual respect and client autonomy and the perspectives underlying service planning and evaluation. Importantly, it represents a shift from a normative approach, based on what should be expected, to a positive one based on what can be expected.

Birch concluded with his views on single intervention failures and equitable access. He identified impediments related to the Triple A Framework and the multiple factors that make improving equitable access by public funding a challenge. These included prohibitive additional costs to the user (affordability); insufficient fee levels to attract providers (availability); and stigmatizing criteria for eligibility (acceptability). In addition, there is a failure to recognize multiple interacting determinants. What we have instead are “unprecedented public subsidies for the middle class.” Birch left participants with the message that there is no tradeoff between equity and efficiency. Effectiveness based on multiple dimensions (the Three As) means that improving access will require multiple integrated programs.

REFLECTIONS, IMPLICATIONS, and NEXT STEPS

The final undertaking of the Symposium saw the participants contribute to a discussion of “Take Home Messages.” Important messages included:

- The importance of placed-based evaluation and integration.
- Evaluation possibilities (vertical and horizontal, feed-back systems and protocols).
- Possibilities from public out-cry.
- The need to explore mandates.
- Integration is very political, not just rational.
- The need for a plan to determine how to influence decision makers at all different levels.
- The disconnect between policy and public understanding.
- The organic nature of the integration process.
- The need for more theory on how MIP integration fits together.
- The need for tools to help explain MIP integration to community partners.

The use of metaphors was also raised, including:

- A patchwork quilt of ideas, for example, the possibility of public out-cry.
- The complexity of combining vertical and horizontal integration; they are represented as two dimensions, while images presented during the symposium such as rippling water and complex flow charts suggest the need to capture other dimensions.
- The role of public out-cry suggests reframing questions; perhaps getting close to fire with forethought, aim, ready (thanks to Bernard Lamontagne).
- Researchers working outside their usual comfort zones in areas important to interventions.

Symposium Reflections

Speaker: Susan Duncan

Susan Duncan generously provided her reflections to sum up the Symposium deliberations. Her verbatim comments are provided next, with thanks.

It is a privilege to reflect on the insights achieved over the past day and a half – to experience what is possible when committed people with great minds and experiences in community health research come together.

I would like to offer my remarks according how discussions over the past two days inform the state of our body of knowledge for Multiple Intervention Programs and in particular how they inform structural, process, and equity issues in Multiple Intervention Programs. Ultimately we are developing our understanding of what has to happen to create real momentum for maximum health impact by framing our problematic, engaging diverse communities, and evolving research methods and theories.

My first reflection is that we are talking about re-framing the research process, to one that is organic and focuses on engagement as well as intervention; and on the interaction of context, process, and content. To do this, we require new methods to approach the complexity of this interaction as well as new theoretical perspectives on inquiry that are critical and bring the equity lens to our work. The question of how we bring an equity lens to our work is one that we must commit to; I worry that it could become a checklist rather than commitment to values-based inquiry. Stephen Birch reminded us this morning of the importance of social objectives in equity-based decision-making and choices.

Themes emanating from all presentations pertaining to structure, process, and equity as well as reflect on the insights from our cutting edge researchers in MIPs:

Structure:

- *Nancy began the day yesterday with key questions of process: how do we understand and work with the levers of change in other sectors? And of structure: what structures are needed to achieve horizontal and vertical integration? She shared the image of the flat bridge in Jamaica as a metaphor of safety for front line workers sharing their vision.*
- *There is an awareness of the need for new structures for engaging people; diversity and confronting power differentials, such as the Community Health Centre Model which Jack described as a natural integration structure.*

Process:

- *The term organic was used by a couple of presenters to describe how we must work in research and policy; meaning that integration may be too linear and we are instead looking at processes that are evolving and may not be nailed down in ways required by funders and accountability frames.*
- *There was a discussion of how to engage power and decision makers – the momentum of a call to action at all levels – what is this process and the role of the health sector? These are the critical questions of verticality.*
- *Barb gave us the insight of using systems as the lens for viewing situations.*
- *Leadership for change is a key process that must be engaged and researched within MIPs – passion, action and politics and fun (Jack McCarthy) – and Jack indicated the role of a leader in asking critical questions about equity issues, for instance: who was affected by the transit strike? It was a powerful example of how equity issues become invisible in complex systems (e.g., the impact of the Ottawa transit strike on the poor).*

Equity:

- *There is a call for critical research processes and research agendas in MIPs; an ethical framework for policy research. The presentations by our 3 researchers yesterday and Colleen Varcoe today were vibrant illustrations of how engaging the right voices can stimulate needed change.*

Insights from cutting edge researchers – Erica, Elizabeth and Christine:

- *Integration is non-linear and organic. These were excellent examples from Kenya and maternal child programs for families living in poverty in Canada; I think that Christine asked a key question that is pivotal to our discussions here: Is it part of a*

MIP to shift ideology that limits the human rights of mothers and children? And if so, how do we do that and how do we ensure that it is integral to our research and policy processes?

- *Our cutting edge researchers all related the theme of voice of those most affected by health issues within vertical decision-making structures.*

I conclude with a few other questions that I have heard in our discussions and I think will form significant aspects of our inquiry as we move forward:

- *My first question is underpinned by a note of caution and that is: How do we avoid oversimplifying or decontextualizing the concept of integration? I suggest that in all of our discussions and initiatives we must be very clear on the purpose and context of integration – and we must be aware of the potential to diffuse important programs such as public health under the guise of integration (as Marjorie MacDonald has pointed out – this is a problematic for further inquiry in her research program).*

Further Questions:

- *How can we engage our communities, our jurisdictions, and our sectors in deeper awareness and action on the patterns or determinants of our most pressing equity issues in health?*
- *What are the exemplars? The country based equity case studies reviewed for this MIP Symposium point to some of the way forward; but how can we build on these with methods including but not limited to case study approaches?*
- *How do we engage our communities, jurisdictions and sectors in seeing the whole and adopting “a pattern language – a way to visualize and talk about deeper patterns?” (Senge et al., 2008, p.47*

Relating to the proceedings of the previous symposia and the discussions over the past day and half, I see tremendous gains in our understanding of multiple intervention programs and their relationships to context, process, and structure; and likely the next step is to grapple with the interaction of these three elements as they relate to research and change processes in health. I have no doubt that these methods and theoretical perspectives will evolve and make a difference to equity and social justice, and engage communities in multiple intervention programs, making a difference to the health outcomes that matter most.

Thank you for this opportunity to participate in what has been my first multiple intervention program symposium – perhaps a future symposium could engage people from diverse sectors, communities and jurisdictions around a defined issue to further illuminate issues of process, context, structure, equity, and their interaction.

Closing Remarks

Nancy Edwards closed the Symposium with thanks to presenters and participants, commenting on the fruitful and meaningful insights gained over the day and a half of deliberations. She looked forward to all taking away new perspectives on MIPS and integration and finding ways to incorporate this knowledge and understanding into their work in public health research, policy, and practice. She concluded with an invitation to provide additional input and comments as participants thought about integration and multiple intervention programs in relation to their own research or work.

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APPENDICES

Appendix 1: Participants

Appendix 2: Background Reading

Appendix 3: Symposium Agenda and Changes

Appendix 4: Multiple Intervention Program Framework

APPENDIX 1

PARTICIPANTS

Caroline Andrew
Professor
School of Political Studies
University of Ottawa

Lisa Ashley
Nurse Consultant
Nursing Policy
Canadian Nurses Association

Karen Benzies
Assistant Professor
Faculty of Nursing
University of Calgary
Canadian Health Services Research
Foundation Postdoctoral fellowship
CHRU Associate

Stephen Birch
Professor, Department of Clinical
Epidemiology and Biostatistics
McMaster University

Dot Bonnenfant
CHNET-Works! Animator
Community Health Research Unit
University of Ottawa

Ivy Bourgeault
Associate Director
Community Health Research Unit
Professor, University of Ottawa
Canada Research Chair in Comparative
Health Labour Policy

Kathryn Clinton
PhD Candidate
Institute of Population Health
University of Ottawa

Fides Coloma
Team Manager, Health Program Policy
and Standards Branch
Health System Strategy Division
Ministry of Health and Long Term Care

Marie DesMeules
Centre for Chronic Disease Prevention
and Control
Population and Public Health Branch
Health Canada

Erica Di Ruggerio
Assistant Director
Canadian Institutes of Health Research
Institute of Population and Public Health

Susan Duncan
Professor
Thompson Rivers University

Nancy Edwards
Director
Community Health Research Unit
Professor, University of Ottawa
Canada Research CHAIR in Population
Health

Alma Estable
Senior Researcher, Gentium Consulting
Research Consultant
Community Health Research Unit
University of Ottawa

Michelle Giroux
Associate Professor
Faculty of Law, Civil Law
University of Ottawa

Elizabeth Gyorf-Dyke
PhD Candidate
Institute of Population Health
University of Ottawa

Donald Hall
The Tweedsmuir Group
Ottawa

Faiza Hassan
Administrative Coordinator
Community Health Research Unit
University of Ottawa

Tim Hutchinson
Director, Centre for Chronic Disease,
Prevention and Control
Public Health Agency of Canada

Beth Jackson
Manager, Research and Knowledge
Development Strategic Initiatives and
Innovations Directorate
Public Health Agency of Canada

Suzanne Jackson
Director, Centre for Health Promotion
Department of Public Health Sciences
University of Toronto

Beverly Kelley
PhD Candidate
Institute of Population Health
University of Ottawa

Christine Kurtz-Landy
Assistant Professor
School of Nursing
University of McMaster

Bernard Lamontagne
Senior Planner
Champlain LHIN

Ariella Lang
Nurse Scientist
VON Canada

Louise Lemyre
Director - GAP-Santé
McLaughlin Research Chair on
Psychosocial Aspects of Health
Full Professor, Faculty of Social
Sciences, School of Psychology
University of Ottawa

Jo-Anne MacDonald
PhD Candidate
Institute of Population Health
University of Ottawa

Marjorie MacDonald
Associate Professor
School of Nursing
CIHR/PHAC
Public Health Education and Population
Intervention Research

Lynne MacLean
Research Associate
Community Health Research Unit
University of Ottawa

Emily Maddocks
Analyst
Canadian Population Health Initiative

Jack McCarthy
Executive Director
Somerset Community Health Centre

Mechthild Meyer
Senior Researcher, Gentium Consulting
Research Consultant
Community Health Research Unit
University of Ottawa

Judy Mill
PAHO/WHO Collaborating Centre for
Nursing and Mental Health
Associate Professor
University of Alberta

Esther Moghadam
Program Manager
Ottawa Public Health
City of Ottawa

Daina Mueller
Senior Manager, Health Promotion
Programs
Chronic Disease Prevention and Health
Promotion Branch
Ontario Ministry of Health Promotion

Renée Nossal
Research/Project Assistant
Community Health Research Unit
University of Ottawa

Wendy Peterson
Assistant Professor
University of Ottawa

Nancy Porteous
Senior Advisor
Chronic Disease Prevention Division
Public Health Agency of Canada

Barb Riley
Scientist, Centre for Behavioural
Research and Program Evaluation
Assistant Professor
University of Waterloo

Julie Senecal
Assistant Director
Partnerships and Knowledge
Translation
Canadian Institutes of Health Research

Dominique Tremblay
Postdoctoral Fellow
Canadian Health Services Research
Foundation

Colleen Varcoe
Associate Professor
School of Nursing
University of British Columbia

Lynda Zimmerman
Acting Program Development Officer
Education and Research Unit
Ottawa Public Health
City of Ottawa

APPENDIX 2

BACKGROUND READING

Public Health Agency of Canada. (2008). *Health equity through intersectoral action: An analysis of 18 country case studies*. Ottawa, ON: Author.

Riley, B. L., & Edwards. N. (2005). *A primer on Multiple Intervention Programs and some implications for a research agenda*. CHRU & NBPRU Publication No. M05-1. Ottawa, ON: Community Health Research Unit, University of Ottawa.

APPENDIX 3

2009 MIP SYMPOSIUM <i>Achieving vertical and horizontal integration in multiple intervention programs: Issues in structures, processes, and equity</i> April 21 and 22, 2009, Crown Plaza Hotel, 101 Lyon Street, Ottawa	
TUESDAY, APRIL 21 Penthouse Pinnacle Room	
8:30	Arrival, Light Buffet Breakfast
9:00	<u>Symposium Welcome</u> Opening Remarks Welcome and Introduction
9:15	<u>1. Exploring Vertical and Horizontal Integration for Multiple Intervention Programs: An Overview</u> Speaker: Nancy Edwards Discussants: Barb Riley and Bernard Lamontagne
10:30	Break
10:45	<u>2. Cutting Edge Research and Cross-Cutting Themes in Vertical/Horizontal Integration</u> Speakers: Erica DiRuggiero; Elizabeth Gyorfi-Dyke; and Christine Kurtz-Landy. Discussants: Marjorie MacDonald and Beth Jackson
12:00	Lunch
1:00	<u>3. Structural Issues in Vertical/Horizontal Integration for Multiple Intervention Programs</u> Speaker: Jack McCarthy Discussants: Kim Elmslie and Dominique Tremblay
2:30	Break
2:45	<u>4. From Rhetoric to Reality: Premises and Principles in Vertical/Horizontal Integration for Multiple Intervention Programs</u> Group Discussions
4:00	Adjournment
4:00-6:00	Opportunity for informal networking
<i>6:00 pm. Dinner (optional-no activities scheduled- RSVP required)</i>	
WEDNESDAY, APRIL 22 Ballroom B	
8:00	Arrival, Light Buffet Breakfast
8:30	Welcome and Introduction to Day 2
8:45	<u>5. Process Issues in Vertical/Horizontal Integration for Multiple Intervention Programs</u> Speaker: Tim Hutchinson Discussants: Caroline Andrew and Louise Lemyre
10:00	Break
10:15	<u>6. Equity Issues in Vertical/Horizontal Integration for Multiple Intervention Programs</u> Colleen Varcoe Stephen Birch
11:15	<u>Reflections, Implications, Next Steps</u> Discussion: "What are the Take Home Messages?" Symposium Reflections: Susan Duncan Closing Remarks: Nancy Edwards
12:00	Available Lunch

AGENDA CHANGES

One change to symposium discussants is noted. In Session 3 on Structural Issues in Vertical/Horizontal Integration for Multiple Intervention Programs, Kim Elmslie from the Public Health Agency of Canada (PHAC) was unable to be present and Tim Hutchinson, also from PHAC kindly participated instead.

APPENDIX 4

MULTIPLE INTERVENTION PROGRAM FRAMEWORK

Multiple Interventions Framework

(Edwards, Mill & Kothari, 2004)

