Evaluating Community and Organizational Transition to Enhance the Health Status of Residents of Northern Saskatchewan

Shared Paths for Northern Health Project Evaluation
2004-2006

FINAL EVALUATION REPORT

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The Appendices to the Final Evaluation Report are included within a separate document.

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Acronyms

ACN	Associated Counselling Network
AHA	Athabasca Health Authority, Inc.
CD	Community Development
CDTAC	Chronic Disease Technical Advisory Committee
CEO	Chief Executive Officer
CJDM	Cross-Jurisdictional Decision-Making
CJI	Cross-Jurisdictional Issues
CLO	Community Liaison Officer
EHR	Electronic Health Record
FNIHB	First Nations and Inuit Health Branch
FNIHIS	First Nations and Inuit Health Information System
HIM	Health Information Management
HIMTAC	Health Information Management Technical Advisory Committee
HISC	Health Information Solutions Centre
HR	Human Resources
HRTAC	Human Resources Technical Advisory Committee
IT	Information Technology
ITTAC	Information Technology Technical Advisory Committee
KTRHA	Kelsey Trail Regional Health Authority
KYRHA	Keewatin Yatthe Regional Health Authority
LLRIB	Lac La Ronge Indian Band
MCRRHA	Mamawetan Churchill River Regional Health Authority
MFN-CAHR	Manitoba First Nations – Centre for Aboriginal Health Research
MHATAC	Mental Health and Addictions Technical Advisory Committee
MLTC	Meadow Lake Tribal Council
MOU	Memorandum of Understanding
NCCC	Northern Chronic Care Coalition
NITHA	Northern Inter-Tribal Health Authority
OHTAC	Oral Health Technical Advisory Committee
PAGC	Prince Albert Grand Council
PBCN	Peter Ballantyne Cree Nation
PHC	Primary Health Care
PHCTF	Primary Health Care Transition Fund
PHU	Population Health Unit
PIHTAC	Perinatal and Infant Health Technical Advisory Committee
REB	Research Ethics Board
RFP	Request for Proposal
RHA	Regional Health Authority
NHLWG	Northern Health Leadership Working Group
NHS	Northern Health Strategy
NHSWG	Northern Health Strategy Working Group
NLF	Northern Leadership Forum
NMS	Northern Medical Services
SAHO	Saskatchewan Association of Health Organizations
SPHERU	Saskatchewan Population Health and Evaluation Research Unit
TAC	Technical Advisory Committee
TACEQ	Technical Advisory Committee Effectiveness Questionnaire
UofR	University of Regina

Executive Summary

All northern residents have the right to expect a certain level of health services, which presents a challenge for all northern health service delivery organizations given the north's unique history, geography, population, language, and culture. The Northern Health Strategy Working Group (NHSWG) grew out of the need for a Northern Health Strategy (NHS), that is, a unique way of meeting the health needs of northerners. The overall goal of the NHSWG is to improve the health of the residents of northern Saskatchewan through a more wholistic approach to health and health services, and through collaboration.

The Shared Paths for Northern Health project was an initiative of the NHSWG and funded by Health Canada's Primary Health Care Transition Fund (PHCTF), Aboriginal Envelope. The goal of this project was to utilize working relationships among the partners in the NHSWG to move to a primary health care approach, which is: comprehensive, accessible, coordinated, accountable, sustainable, and of good quality. In order to achieve this goal, as well as to enhance the health status of all northerners, the project created and utilized focused working groups known as Technical Advisory Committees (TACs), which consisted of primary health care providers and community residents who understood northern life to address specific areas of concern such as, mental health and addictions, chronic disease, perinatal and infant health, and oral health. These TACs were supported in their activities by various "support TACs" in the areas of human resources, information technology, and health information management. In addition, the project also had components that addressed the areas of communications, cross-jurisdictional issues, and community development. The NHSWG hoped to leave as project legacy: TACs that become models for future groups in other areas of health care; TACs that continue to promote collective relationships, collaboration, and cooperation; sustainable, ongoing improvement supported by organizational change; and shared paths of cooperation that continue to be built and developed across northern Saskatchewan.

The evaluation of the Shared Paths for Northern Health project focused on process, that is, the "how and why" of project implementation. Through a collaborative process, the evaluation coordinator, evaluation team, project staff, and the NHSWG identified the evaluation parameters (e.g., goal and objectives; priority issues to evaluate; intended uses of findings), which together formed the evaluation framework. The goal of this formative evaluation was to evaluate the process undertaken by the partners of the NHS in conducting the primary health care transition project to assess how well the process/project worked, including both the successes and challenges, with the intent to determine where improvements in or changes to the process/project needed to occur to ensure that progress was made towards desired outcomes. The evaluation objectives included:

1) Identify and promote improvements in or changes to both the process and project to ensure that progress is made towards the desired outcomes.
2) Describe both the process and project successes with an examination of why both the process and project are succeeding.
3) Describe both the process and project challenges with an examination of why both the process and project challenges exist and how these are overcome.
4) Establish the progress made towards the desired outcomes and the achievements of the project against the original project goal, objectives, and anticipated outcomes.
5) Provide an assessment of the change in health service delivery in the project areas (e.g., mental health and addictions, chronic disease, perinatal and infant health, oral health).

6) Identify the lessons learned from this process of working together and the next steps to continue to work together on other primary health care or health projects.
7) Provide an assessment of the applicability of this process/transitional model in the north of Saskatchewan and potentially elsewhere (e.g., the south, other northern regions of Canada).
8) Satisfy the evaluation requirements of the funded primary health care transition project.

An evaluation matrix (strategy) for each project component (i.e., cross-jurisdictional issues; community development; communications; human resources, technical advisory committees; information systems) was developed by the evaluation coordinator and presented to the relevant project staff, the NHSWG, and the evaluation team for discussion and feedback, prior to the start of data collection within that component. Each matrix outlined the proposed data collection methods and data sources, as well as relevant indicators and evaluation questions. In addition, ethical approval to conduct this evaluation was received from the University of Regina Research Ethics Board.

The data collection methods were chosen to maximize participation of project stakeholders and participants (e.g., focus groups, project diaries). These participatory methods were complemented by methods intended to gather information and measure progress toward project outputs and outcomes (e.g., document review, observation, semi-structured interviews, questionnaires). Data for the evaluation of all project components was collected: continuously, through document review, observation, and ongoing discussion and feedback with project staff; at intervals, through project diaries, questionnaires, and semi-structured interviews; and at a single-point in time (e.g., interviews with each NHSWG representative). As data or information was collected, it was compiled and analyzed utilizing the evaluation framework and the evaluation matrices for each project component, as well as the appropriate quantitative and qualitative data analysis procedures. Data analysis began early on in the project and continued through to the end of the project. Evaluation progress and findings were continuously fed back and reported, through oral and written means, to the project staff, the TACs, and the NHSWG.

Within this final evaluation report, each project component is discussed in terms of: objectives and anticipated outcomes; activities, outputs, and outcomes; project/TAC recommendations and NHS strategic plan; evaluation findings; a summary statement; and the evaluation's recommendations. This report also discusses overall observations related to the project and its process and these include: networking, information sharing, and increased awareness and understanding; short timeline of project; representation at TAC and NHSWG meetings; participation in meetings and activities; clear direction and regular feedback; partnerships and group development; communications; TAC interaction; staffing and project management/coordination; lessons learned; suggested improvements; sustainability; NHS coordination; NHS strategic plan; community transition; NHS Leadership meetings; and the role of government in support of NHS.

Overall, the Shared Paths for Northern Health project met some of its objectives and anticipated outcomes. The majority of the TACs constructed their work plans, and all TACs developed a current state assessment for their respective areas, which elucidated many of the gaps and weaknesses in services that exist in the north. From these current state assessments and identification of best practices, standards of care, and core services, the TACs developed and submitted recommendations to the NHSWG that aimed to improve health service delivery and ultimately improve the health status of northern residents. In addition, the project's consultants also progressed through their work plans and developed recommendations with respect to cross-jurisdictional decision-making, and developmental relationships as essential to community

development. Due to the fact that many of these recommendations were submitted at the end of the project (March 2006 and beyond), some recommendations have yet to be assessed or approved by the NHSWG. On the other hand, recommendations that were submitted early in the project have been approved, in some cases, and implemented to create change.

Evaluation Recommendations

The recommendations within this final evaluation report are based on: 1) the results of the data collection and analysis; 2) discussions with project staff, TAC representatives, and NHSWG representatives over the course of the evaluation; 3) observation of NHSWG and TAC group development and process; and 4) observation of project activities and progress. For each component of the project, a recommendation(s) has been put forth to ensure sustainability and to improve upon processes from the Shared Paths project. Furthermore, this report concludes with overall recommendations to be implemented by the NHSWG.

Cross-Jurisdictional Issues

It is recommended that the second Memorandum of Understanding (MOU) that formalizes the proposed cross-jurisdictional decision-making mechanism is ratified and signed as soon as possible so that jurisdictional issues which impede access to care or create inefficient care for residents of northern Saskatchewan can be resolved. Once the MOU is signed, resources should be devoted to the implementation of this mechanism (e.g., establish terms of reference; review and prioritize identified issues; determine research opportunities). Each level (i.e., TACs, NHSWG, Northern Health Leadership Working Group, Northern Leadership Forum) within this mechanism should prioritize at least one jurisdictional issue, identify realistic strategies to resolve the issue(s), and advocate for changes to habits and practices, organizational policies, governmental policies, Contribution Agreements, and/or legislation to resolve the particular issue(s). As suggested by the consultants, evaluation of the mechanism's performance should occur after one year.

Community Development

It is recommended that those NHS partners that wish to implement the community development strategy proposed by the Associated Counselling Network do so, and that these partners share the experiences, outcomes, and lessons learned from doing so with all NHS partners. It is also recommended that those NHS partners that do not wish to implement the proposed strategy continue to address the issue of community development, both within each organization and collectively, by:

- ensuring that it is a component of the NHS Strategic Plan and/or next NHS initiative; and
- contracting an organization/individual with expertise to work with those individuals in each NHS partner with community development responsibilities (with respect to health) to identify the internal strengths of each organization or communities within the region, and build upon these principles or best practices to provide additional direction for community development in the north.

It is also recommended that when working with consultants (or project staff) that the NHSWG: clearly identify the expectations of the work to be completed; establish criteria to assist in the

identification of consultants to complete the work; clearly identify the deliverables of the work; provide clear direction in a timely manner; and establish good dialogue and reporting processes in order to appropriately manage the work (of course, with the support of the project coordinator) and to achieve the desired results.

Communications

Considering the achievements of the Communications Coordinator and the project in the area of communications, such as the increased awareness of the NHS in the north, the province, and Canada, it is recommended that the NHSWG give consideration to including a communications position within its Strategic Plan and request for core funding in order to ensure that project gains will not be lost, as well as to ensure the visibility of the NHS. With other funding secured through special projects, such as Shared Paths for Northern Health, consideration should be given to a second communications position, each with their own set of responsibilities. For example, one position would be responsible for planning and decisions; the other production and dissemination; or one position would be responsible for communication to the external stakeholders (e.g., media, general public); the other internal stakeholders (support for organizational communications needs or development of health promotion materials). If finances to support a communications position are not secured through core or special project funding, the NHS partners should give consideration to shared funding of a position.

In addition, the communications position should develop specific strategies to facilitate communications and information flow between the TACs as they continue to meet; between the TACs and the NHSWG; between the NHSWG and the NHS Leadership; and between the NHS and the communities of the north, utilizing the successes of the Shared Paths project (e.g., mini-NHSWG), as well as other innovative ideas.

Human Resources

In an effort to sustain the work of the Human Resources Coordinator, the Human Resources TAC, and the Communications Coordinator, it is recommended that the NHS partners: utilize the job and career fair materials kit at numerous events throughout the north and the province to encourage northern youth and high school students to pursue health careers, and health care professionals to work in the north; examine the findings and recommendations of the total compensation study and implement the suggestions, where possible and desirable to do so, in an attempt to narrow the existing gap between salary grids and recruitment and retention incentives among northern health organizations; and move forward with the next steps in the pursuit of a NHS bursary and scholarship program.

If the area of human resources is one that the NHSWG continues to pursue collaboratively (via core funding or special project support) through the TAC, then consideration should be given to: identifying a clear direction or mandate for the group; supporting the group with a competent leader; and ensuring the proper representation is at the table based on the intended outcomes of the collaboration, for example, a northern health human resource strategy or focused activities such as, creating a casual staff labour pool or collaboration on education and training initiatives.

Mental Health and Addictions TAC

As stated in the Mental Health and Addictions Technical Advisory Committee (MHATAC) Final Report, the TAC representatives are interested in continuing to meet once or twice a year in the future. Given the importance of mental health and addictions in the north, the NHSWG needs to give consideration to the next steps for the MHATAC. For example, will it remain a TAC with a north-wide focus or will the needs be better served with regional partnerships? The NHSWG should also seek input from the MHATAC representatives with respect to this decision. In addition, the NHSWG should formally review, discuss, and approve the recommendations developed and submitted by the MHATAC, in a fashion similar to the other TACs. These recommendations also need to be prioritized by the MHATAC or the NHSWG, and detailed work plans need to be created for the recommendations that are of high priority.

Chronic Disease TAC

The Chronic Disease Technical Advisory Committee (CDTAC) plans to continue its work in the form of the Coalition; however, the formation of this Coalition will require the leadership of CDTAC co-chairs in the absence of a TAC Coordinator, and furthermore, a NHS Coordinator. The work plan, charter, and logic model for the Coalition have already been drafted, along with a budget that identified actions with and without funding. Thus, it is recommended that the CDTAC continue its work under the new banner of the Coalition and that the NHSWG pursue funding for its work plan. Moreover, if funding is not secured, then implementation of its alternate work plan should be supported. In addition, it is recommended that the Coalition fosters the sustainability of the patient self-management training program given that patient self-management is an important component of the model espoused by the Coalition.

Perinatal and Infant Health TAC

Members of the Perinatal and Infant Health Technical Advisory Committee (PIHTAC) were quick to note that their own satisfaction would increase when recommendations are implemented. Evaluation findings, particularly comments from members of the TAC, leads to the recommendation that the TAC recommendations submitted should be followed up and implemented where appropriate. For instance, enhance supportive care for breastfeeding (e.g., lactation consultant for the north); provide training of peer support for breastfeeding; enhancing physician orientation to perinatal programs and services in the north; establishment of a perinatal forum to address quality of care issues. Furthermore, the Northern Breastfeeding Committee has not met recently and this group should be sustained in order to address this issue in northern communities. However, follow-up and implementation of the TAC recommendations and activities is threatened by the lack of a TAC coordinator/co-chairs, as well as a project coordinator past September 30, 2006. Thus, efforts should be made to determine co-chairs from within the TAC.

Oral Health TAC

The Oral Health Technical Advisory Committee (OHTAC) has expressed commitment to continuing their working relationship into the future. Thus, it is recommended that the OHTAC continue to pursue their work plan and the recommendations submitted to the NHSWG. In order to provide direction for the group, the OHTAC should prioritize its recommendations and modify

the current work plan accordingly. Given the success of the OHTAC in developing and distributing resource material for the NHS partners and in providing a joint training session, it is recommended that the group continue these best practices.

Furthermore, it is strongly recommended that the NHSWG bring back to the table the dentist services proposal, confirming partner support for the proposal and direction on how to proceed (i.e., regionally, north-wide) to improve access to dentist services for the residents of northern Saskatchewan, particularly the adult population. Once there is direction on how to proceed, it is recommended that the NHSWG meet with potential funding agencies of this proposal, and formally discuss any and all jurisdictional issues that may impede access to services and identify solutions to these barriers, so that residents of northern Saskatchewan are no longer without access to care.

Information Technology TAC

Sustaining the work of the Information Technology Coordinator and the Information Technology Technical Advisory Committee (ITTAC) will hopefully lead to the development of a northern e-health strategy, which is a requirement for the Health Information Solutions Centre to begin providing services. Thus, it is recommended that consideration be given to the development of a northern information officers forum or task force with the mandate to work collectively to build the information technology and management capacity of northern First Nations partners to that of the northern Regional Health Authorities, as well as to establish a northern e-health strategy (e.g., what does it look like and how to get there). It is recognized that this will require a significant period of time, as well as significant resources (i.e., financial, human, technological), which should be sought from all available sources (e.g., internal and external to the NHS partners, governmental and non-governmental). Given that the website expired on August 31, 2006 (due to the lack of funds to maintain), the NHSWG should continue to pursue and implement the SharePoint web portal as a means to share and disseminate information to the partners without incurring costs.

Health Information Management TAC

The Health Information Management Technical Advisory Committee (HIMTAC) desires to continue meeting, either in its present form or as an amalgamation between the HIMTAC and the ITTAC. In either form, the HIMTAC should continue to pursue its short-term objectives of: a plan for strategic integration of health information and IT applications needed for a sustainable and intra-operative information system between health jurisdictions in northern Saskatchewan, with a streamlined and comprehensive collection of clinical documentation, information, utilization, and management of health information systems. These objectives should be met through the: implementation of the recommendation to establish and implement an electronic tool to capture client demographic, clinical, and nursing utilization information via the modification and utilization of an existing database or the development of a new one; development of a human resources development plan around health information and informatics; and development of the bridging plan with the ultimate goal of creating an electronic health information management system that is interoperable with the eventual pan-Canadian electronic health record.

Overall Recommendations to the NHSWG

These recommendations are not in a prioritized order and equal consideration should be given to all of the recommendations.

1. Given the scope of the Shared Paths project, the NHSWG should prioritize components of the project to move forward, as well as prioritize the recommendations within those components for implementation, and support accordingly.

2. It is strongly recommended that solid planning of all future NHS activities and projects takes place, given the challenges experienced in the Shared Paths project. For example, provide clear direction and expected deliverables to staff, working groups, consultants; clearly define roles and responsibilities; provide formal feedback mechanisms between stakeholders; identify actions in work plans; develop detailed budgets; etc. [Utilize the evaluation findings with respect to lessons learned, suggestions for improvement, and sustainability.]

3. In all NHS activities and projects, ensure that the vision and principles of the NHS are being addressed (e.g., coordination, cooperation, collaboration, communication, wholistic viewpoint, respect for jurisdictional authority, consensus).

4. Explore creative ways to ensure community involvement in the NHS and input into the process.

5. Given that collaboration is a principle of the NHS, the NHSWG is to ensure that links are being made with inter-sectoral partners (i.e., those that do not often view themselves as having a responsibility for health) where essential, for example, to address the underlying determinants of health such as, poverty, housing, and employment.

6. All NHS partners and funding agencies should ensure that there is representation at the table, through the nominated representative or an alternate, and that there is full participation by the representatives in all discussions and activities (NHSWG and TAC levels). Partner representation and participation in the process will help to address the challenges of health service delivery in the north, as well as contribute to the success and sustainability of the NHS.

7. When hiring NHS Coordination and/or project staff, give careful consideration to hiring individuals with the required knowledge and skill set. Often employees are willing to learn and opportunities for professional development and continuing education should be provided.

8. Improving access to services is a fundamental issue addressed by the NHS, as well as intent of the work of the TACs. Progress has been made within the project (e.g., dentist services proposal, CommunityNet), and efforts to improve access to health care services for residents of northern Saskatchewan should be continued by the NHS and supported by the funding agencies. A process or a forum should be established with the federal and provincial governments to address the issue of access to services, as evidenced by the stalling of the dentist services proposal.

9. Given successful advocacy efforts of the NHS (e.g., CommunityNet, Saskatchewan Registered Nurses Association transfer of medical function process; Health Quality Council Chronic Disease Management Collaborative), efforts of advocacy to positively impact health and social policy, through recommendations for changes or implementation of changes to policy should be continued by the NHS. The NHSWG should continue to identify specific areas for advocacy and take steps toward necessary change. As an example, advocate that funding agencies review current practice and guidelines with respect to project funding to allow for greater flexibility or adjustments, particularly with respect to timelines and/or extensions in order that effective and sustainable transition, which is generally the desired outcome, is possible.

10. There should be a concerted effort to document the history of the NHS (i.e., its development, activities, accomplishments, challenges). It is recognized that this will need the support of special project funds and personnel (i.e., contracted service) given the already demanding positions of the NHSWG representatives and NHS Coordinator; however, this should be considered.

11. The NHSWG representatives should give consideration to including a reflective analysis or an evaluation component to all NHS projects, continuing to strengthen the current relationship with SPHERU and/or developing new relationships with other evaluators (i.e., individuals, organizations), which will contribute to continued partnership development, as well as ensure sustainability.

12. Given the baseline data gathered through the Shared Paths project, as well as the project evaluation, it is recommended that another evaluation is conducted in five years to determine the impact of the project on: health service delivery; and community and organizational transition to improve the health of northern residents that is attributable to the project.

1. Northern Health Strategy Overview

All northerners have the right to expect a certain level of health services, which presents a challenge for all northern health service delivery organizations given the north's unique history, geography, population, language, and culture. The Northern Health Strategy Working Group (NHSWG) grew out of the need for a Northern Health Strategy (NHS) – a unique way of meeting the health needs of northerners. The partners of the NHS have a long history of working together and their concerns and ideas for a northern health strategy have been shared with and recognized in *The Action Plan for Saskatchewan Health Care* (December 2001), the Commission on Medicare (Fyke Report, April 2001), and the Commission on the Future of Health Care in Canada (Romanow Report, November 2002). In June 2001, the partners signed a Memorandum of Understanding (MOU) reflecting their commitment to the development of a northern health strategy and in February 2002, a NHS Accord was signed between health authorities responsible for health service delivery in the north, with the NHSWG formed in the spring of 2002. The overall goal of the NHSWG is to improve the health of the residents of northern Saskatchewan through a more wholistic approach to health and health services, and by working together.[1, 2]

The NHSWG is a partnership of senior executives/managers or their representatives from the following jurisdictions and agencies that deliver health services in northern Saskatchewan:

- Federal and First Nations Jurisdictions
    - Lac La Ronge Indian Band (LLRIB)
    - Meadow Lake Tribal Council (MLTC)
    - Peter Ballantyne Cree Nation (PBCN)
    - Prince Albert Grand Council (PAGC)
    - Northern Inter-Tribal Health Authority (NITHA) – a joint creation of the above First Nations and Tribal Councils
    - Health Canada, First Nations and Inuit Health Branch, Saskatchewan Region (FNIHB)
- Provincial Jurisdictions
    - Kelsey Trail Regional Health Authority (KTRHA)
    - Keewatin Yatthe Regional Health Authority (KYRHA)
    - Mamawetan Churchill River Regional Health Authority (MCRRHA)
    - Population Health Unit (PHU) – a joint creation of KYRHA, MCRRHA and the Athabasca Health Authority, Inc.
    - Saskatchewan Health
- Provincial/Federal and First Nations Jurisdictions
    - Athabasca Health Authority, Inc. (AHA)
    - Northern Medical Services (NMS)

The mandate[2] of the NHSWG is to:

- work cooperatively to improve the health status of all residents in northern Saskatchewan;
- work together across jurisdictions with the development of health service delivery and health promotion frameworks;
- increase family, community, and northern region capacity;
- develop partnerships while ensuring diversity; and
- ensure equitable resource allocation.

The partners agree that a Northern Health Strategy[3] must:

- be wholistic;
- place individuals within the appropriate family and community context;
- recognize the North's unique historic, geographic, language, cultural, and demographic situation;
- emphasize prevention and not just treatment;
- recognize and respect the complex jurisdictional issues in the North (First Nations, Métis, health authorities, federal and provincial governments); and
- recognize that the health of northern people requires cooperation and support from departments and agencies that do not view themselves as delivering health services.

The basis for a NHS is the concept of holistic primary health care that considers the physical, mental, emotional, and spiritual health of individuals, families, and communities.[3] Initiatives of the NHS and its working group are governed by the following principles:[4]

- collaboration;
- cooperation;
- a wholistic viewpoint;
- prevention and promotion as well as treatment;
- respect for jurisdictional authority;
- cultural appropriateness;
- client focus;
- a team approach;
- respect for professional responsibilities; and
- partnership and consensus.

The health organizations of Northern Saskatchewan (e.g., AHA, NITHA, KYRHA, MCRRHA) all face similar issues and challenges. For instance, existing health service delivery systems are fragmented and disjointed, services available are inconsistent, duplicated or delivered by overlapping jurisdictions, and gaps in service do exist, all leading to a number of major challenges.[1] The NHS attempts to address some of these challenges, which include: jurisdictional complexities in service delivery; diseconomies of scale; human resource issues (recruitment and retention difficulties); geographic dispersion, small population, and small community size (often remote/isolated).[1]

> These challenges are unique in Saskatchewan but may be shared by many other provinces and territories in their northern jurisdictions. Multiple levels of jurisdictions with overlapping geographical regions and differing funding leads to challenges in the efficient use of limited resources and the provision of comprehensive, accessible services appropriate to the culture and remote setting.[1, p.17]

In addition, a number of health challenges exist in Northern Saskatchewan leading to poor health status of the population (i.e., First Nations, non-Status, Métis, non-Aboriginal) such as mental health and addictions issues (suicide rates are high); the prevalence of chronic health conditions such as diabetes and heart disease; high rates of injury and death from preventable injuries; and high rates of violence (both within families and in communities as a whole).[1] As well, there appears to be little

involvement in the delivery of health services by families and communities, as such families and communities are not empowered to take responsibility for their own health.[1]

There are, however, significant strengths in Northern Saskatchewan that give rise to fertile ground for the development of innovative initiatives such as Shared Paths for Northern Health, which include: a strong tradition of partnerships; a strong sense of unity; a strong sense of community; and the desire for change.[1]

2. Shared Paths for Northern Health – Project Overview

This project originally entitled, "Community and Organizational Transition to Enhance the Health Status of all Northerners," was an initiative of the NHSWG funded by the Primary Health Care Transition Fund (PHCTF), Aboriginal Envelope, Health Canada. Upon project commencement in April 2004, the title was changed to "Shared Paths for Northern Health," reflecting the principles of cooperation, coordination, collaboration, partnership, and a wholistic viewpoint which are adhered to by the NHSWG.

According to the proposal[1] submitted to the PHCTF, the project had as its goal:

> To utilize working relationships among the partners in the Northern Health Strategy Working Group to move to a primary health care approach which is comprehensive (preventive, promotive, curative, supportive, rehabilitative); accessible (culturally, fiscally, timely); coordinated (to enhance integration, effectiveness and efficiency); accountable (through information collaboration); sustainable and of good quality.

In an attempt to achieve this goal, as well as to enhance the health status of all northerners, the project had two distinct approaches – community development and organizational improvement, each with their own set of objectives.[2]

Community Development Objectives:

- promote community and family leadership in finding and implementing solutions;
- empower communities to be more active in their health care and build local capacities;
- support prevention and health promotion;
- look for wholistic, culturally appropriate solutions; and
- build on existing networks and relationships.

Organizational Improvement Objectives:

- strengthen networks and relationships between current structures;
- respect existing networks and cultural traditions;
- reduce access barriers;
- address human resource issues;
- develop an equitable level of health status for all residents along with seamless processes that support community needs; and
- provide a continuum of care.

In order to achieve the project goal and objectives, Shared Paths for Northern Health created and utilized focused working groups known as Technical Advisory Committees (TACs), which consisted of professionals and residents who understood northern life, to address specific areas of concern such as mental health and addictions. Through multi-disciplinary (representatives from a variety of health care professions), inter-jurisdictional (representatives from Tribal Councils, health authorities, and federal and provincial governments), and inter-sectoral (representatives from government agencies and programs outside of health) representation, the TACs identified shared needs throughout the north and worked toward equitable and practical access to health services for all northern residents.[5]

The project had four primary health care (PHC) TACs which focused on community needs as identified by the NHSWG (gleaned from health status indicators and consultations with managers, staff, etc.) and prioritized (consensus among partners was achieved) to include: mental health and addictions, chronic disease, perinatal and infant health, and oral health. These TACs included primary health care providers working in northern Saskatchewan, community members, and others that were reflective of the communities, priorities, and geographic areas represented by the NHSWG, with the intent of developing a working model for improved service delivery.[2] As various health service delivery organizations and communities receive clients from northern Saskatchewan (e.g., Prince Albert Parkland Regional Health Authority), the TACs were encouraged to have representatives from these organizations or communities to act as advisors where appropriate.[2] Each TAC had a coordinator who facilitated the TAC's activities. The objectives or activities[5] of these PHC TACs included:

- develop a description of the current state of health services for their area of health provided to residents within the geography of the NHSWG;
- determine appropriate standards of care and services for their area of health;
- develop lists of core services for their area of health;
- identify and analyze weaknesses and gaps in services;
- build community involvement;
- include other units or agencies of government;
- develop recommendations around prevention, promotion, and treatment services that will improve health outcomes for residents specific to their area of health;
    - These recommendations must include the following (along with others identified by the TAC):
        - program and professional resources development;
        - community development;
        - recognition of jurisdictional responsibilities;
        - reduction of barriers to health care access;
        - consultation; and
        - education.
- seek approval of recommendations from all groups represented by the NHSWG; and
- implement approved recommendations.

Thus, the purpose[4] of these PHC TACs was two-fold: to provide a forum for collective discussion, information sharing, strategizing, and action planning concerning all matters related to the specific area of health (e.g., mental health and addictions); and to develop and implement plans and recommendations that will improve the health outcomes within the specific area of health for residents living in communities represented by the members of the NHSWG.

More specifically, these PHC TACs identified priority areas in which to focus their recommendations for improved health service delivery and ultimately improved health outcomes for residents of northern Saskatchewan. The Mental Health and Addictions Technical Advisory Committee (MHATAC) identified the areas of child and youth services; substance use/abuse; and access to professional services (e.g., psychological or psychiatric services).[2] The Chronic Disease Technical Advisory Committee (CDTAC) identified the areas of diabetes mellitus and cardiovascular disease; and if time permitted, the TAC would address cancer; respiratory illnesses; arthritis and disabilities; and chronic infectious diseases (i.e., Hep C/HIV).[2] The Perinatal and Infant Health

Technical Advisory Committee (PIHTAC) identified the areas of active participation in prenatal care; long-term breastfeeding; and sexual wellness education.[2] Finally, the Oral Health Technical Advisory Committee (OHTAC) identified the areas of access to dentist services; public education campaigns, such as "Drop the Pop," smokeless tobacco cessation, and early childhood tooth decay; workshops for staff and teaching resources; and fluoride varnish program development/expansion.[2]

The PHC TACs were supported in their activities by various "support TACs" in the areas of human resources, information technology, and health information management. These support TACs were similar in structure to the PHC TACs (i.e., each TAC had a coordinator and members representing each jurisdiction); however, they differed slightly in purpose. Each support TAC and its coordinator were to support the PHC TACs with their human resource, information technology or health information management needs. In addition, these support TACs also had area specific objectives to meet. The objectives under human resources[2] included:

- to place and keep the right number of competent people in the right jobs in the north; and
- to develop and implement plans and recommendations that will improve the recruitment, retention, training, and education for the partners of the NHSWG.

The objectives for information technology and health information management[2] were the same and included:

- to share community level information about:
    - current information technology practices and standards
    - current health records practices and standards;
- to identify commonalities, gaps, and jurisdictional issues;
- to work with the other TACs to identify opportunities to collaborate, cooperate, and coordinate information technology services and health information management;
- to provide recommendations to the NHSWG; and
- to provide an implementation plan.

In addition to the above, Shared Paths for Northern Health also had project components which addressed the areas of cross-jurisdictional issues and community development. The Manitoba First Nations – Centre for Aboriginal Health Research (MFN-CAHR), University of Manitoba, was contracted to provide consultant expertise on cross-jurisdictional decision-making. Their work focused on a reflection process with all NHSWG partners, which led to the establishment of a mechanism for cross-jurisdictional decision-making.[6] Associated Counselling Network (ACN) was contracted to provide consultant expertise in the area of community development. Their work focused on the development of an approach to health care that would assist individuals, families, and communities in northern Saskatchewan to become more self-reliant in their own wholistic health.[7]

Finally, the project had additional support through the communications component for which the purpose was to create understanding of and support for Shared Paths for Northern Health, as well as to facilitate internal communications between project groups. The communications objectives[8] included:

- to provide lines of communication between the NHSWG, the TACs, and project staff
    - through circulation of minutes of NHSWG and TAC meetings; monthly TAC reports; web forum; and two-way reporting of activities between TAC and NHSWG representatives;

- to inform all stakeholders and relevant audiences about the project
    - through bi-monthly project newsletters; project website; project updates through fax, mail or email; presentations to staff or inclusion in staff newsletters; presentations or displays at conferences; local radio, newspapers, and community newsletters; and community liaison officers;
- to participate in health education and promotion in northern Saskatchewan
    - through the production and distribution of appropriate materials such as posters, community meetings, or messages on the radio; and
- to relay information about the project to stakeholders and the general public of Saskatchewan
    - through publicity (press releases and press kits) on province-wide radio and television stations and in the daily newspapers; Aboriginal and First Nations' publications and broadcasts; provincial health news publications; Shared Paths for Northern Health project conference; other health and community development conferences; project website; and the Saskatchewan Centennial Canoe Quest.

A senior project coordinator responsible for project management, that is, facilitation and coordination of project activities; human resource management; financial management; reporting; etc., guided Shared Paths for Northern Health with the support of an executive assistant, as well as a clerk typist (for an 8 month term position). The project coordinator received guidance and direction from the NHSWG.

With this project, Shared Paths for Northern Health, the NHSWG hoped to leave as its legacy:[2] TACs that become models for future groups in other areas of health care; TACs that continue to promote collective relationships, collaboration, and cooperation; sustainable, ongoing improvement supported by organizational change; and shared paths of cooperation that continue to be built and developed across northern Saskatchewan.

3. Evaluation Overview

According to the proposal[1] submitted to the Primary Health Care Transition Fund, Aboriginal Envelope (Health Canada), the evaluation was expected to "evaluate the process, review progress on a regular basis, and evaluate the outcomes against the goals…and evaluate how well the project goals and objectives have been achieved." [p. 39] Given this expectation, the focus of the evaluation was primarily on the process, that is, the "how and why" of project implementation, with additional focus on immediate and observable short-term outputs and outcomes in the later stages of the project. Process evaluations focus on "the internal dynamics and actual operations of a program in an attempt to understand its strengths and weaknesses …[and] is developmental, descriptive, continuous, flexible, and inductive."[9, p. 206] By answering questions such as: what is happening and why?; how do the parts of the project fit together?; and how do stakeholders/participants experience and perceive the project?; the evaluation can investigate the formal activities and anticipated outputs and outcomes, as well as informal activities and unanticipated consequences.[9]

The purpose of this evaluation was to utilize the findings to improve the project during the development and implementation stages, address unanticipated problems, and make sure that progress was made towards desired outcomes. Thus, formative evaluations tend to be "more open ended, gathering varieties of data about strengths and weaknesses with the expectation that both will be found and each can be used to inform an ongoing cycle of reflection and innovation."[9, p. 68] Formative evaluation asks the following kinds of questions: To what extent are stakeholders/participants progressing toward the desired outcomes? What kinds of problems have emerged and how are they being addressed? What is happening that was not expected? How are staff and clients interacting? How is the project's context affecting internal operations? What new ideas are emerging that can be tried out and tested?[9]

The evaluation approach and methods were chosen to the maximize participation of stakeholders/ participants within the parameters of the evaluation. Patton and other professional evaluators agree that negotiating the parameters of an evaluation together with stakeholders is key to its success - "intended users are more likely to use evaluations if they understand and feel ownership of the evaluation process and findings."[9, p. 22] The approach chosen here, utilization-focused evaluation with its focus on *intended use by intended users*, is a "process for helping primary intended users select the most appropriate content, model, methods, theory, and uses for their particular situation."[9, p. 22] This can include any kind of evaluative focus (e.g., process, outcome, impact), purpose (e.g., formative, summative), design (e.g., naturalistic, experimental) or data (e.g., qualitative, quantitative, mixed). Utilization-focused evaluation is inherently participatory and collaborative in actively involving intended users in all aspects of the evaluation and thus, this evaluation adhered to principles of participatory evaluation such as: the evaluation process involved participants in learning evaluation logic and skills; participants focused the evaluation on process and outcomes they considered important and to which they were committed; all aspects of the evaluation were understandable and meaningful to participants, etc.[9]

Through a collaborative process involving the project staff and the NHSWG (i.e., the stakeholders), the responsibilities of the evaluation coordinator included:

- to define the project logic model;
- to define and negotiate the parameters of the evaluation which include: the goal and objectives of the evaluation, the intended uses for the evaluation, the priority issues and

aspects of the project to evaluate, as well as the corresponding evaluation questions, data sources, data collection methods, and the timeline;
- to clarify expectations of the level of participation by stakeholders in various aspects of the evaluation (e.g., data collection, data analysis);
- to guide the collection of data utilizing multiple methods for gathering information;
- to guide the analysis of data;
- to prepare and present findings for discussion/feedback on an ongoing basis (e.g., regular meetings with the project staff, progress reports to the NHSWG); and
- to prepare an interim and final report.

In addition, the evaluation coordinator had the support of her supervisor and an evaluation team consisting of members from the NHS partners (i.e., NITHA, PHU) and the Saskatchewan Population Health and Evaluation Research Unit (SPHERU). The evaluation team, through an advisory function, was responsible for providing the following to the evaluation coordinator:

- discussion, feedback, and approval of the evaluation proposal, framework, and timeline;
- individual involvement in particular aspects of the evaluation dependent on members' interest, availability, etc.;
- periodic discussion and feedback of evaluation activities, progress, and findings during the implementation, data collection, data analysis, and writing stages through teleconferences, face-to-face meetings, or individual contact with the evaluation coordinator (e.g., email, telephone, in person);
- discussion, feedback, and approval of the interim and final reports; and
- direction on how to proceed in the event that the evaluation and/or project were not proceeding as envisioned.

Furthermore, opportunities were provided for two research assistants to assist with data analysis and writing; as well as several transcribers to assist with the transcription of interview and focus group data.

4. Evaluation Framework

Given the proposed approach to the evaluation, the initial task of the evaluation coordinator, in collaboration with the stakeholders (i.e., the project staff, NHSWG), was to carefully define the parameters of the evaluation and the stakeholders intended level of participation. The evaluation coordinator developed an evaluation framework through the following methods:

- document review (e.g., project proposal, project work plan, project logic model, minutes of the evaluation team meetings); and
- planning questionnaire for the project staff and the NHSWG.

The planning questionnaire was intended to: define the evaluation goal and objectives (clarifying any assumptions underlying the evaluation); identify key questions for the evaluation to answer; identify and prioritize key issues or aspects of the project to focus on; establish intended uses of the evaluation findings; clarify expectations and requirements of stakeholders; and determine project success and satisfaction indicators.

A participatory prioritization process (i.e., ranking) was used to come to agreement on the intended uses of the evaluation findings and the key issues or aspects for the evaluation to focus on (these were based on, but not limited to uses, issues, and aspects referred to in the project proposal), as well as agreement on the project success and satisfaction indicators.

The information collected through the document review and the planning questionnaire determined the evaluation framework, which includes the evaluation goal, objectives, questions, priority aspects, and intended uses.

4.1 Evaluation Goal

To evaluate the process undertaken by the partners of the NHSWG in conducting the primary health care transition project to assess how well the process/project is working, both the successes and challenges, with the intent to determine where improvements in or changes to the process/project need to occur to ensure that progress is made towards desired outcomes.

4. 2 Evaluation Objectives

1) Identify and promote improvements in or changes to both the process and project to ensure that progress is made towards the desired outcomes.
2) Describe both the process and project successes with an examination of why both the process and project are succeeding.
3) Describe both the process and project challenges with an examination of why both the process and project challenges exist and how these are overcome.
4) Establish the progress made towards the desired outcomes and the achievements of the project against the original project goal, objectives, and anticipated outcomes.
5) Provide an assessment of the change in health service delivery in the project areas (e.g., mental health and addictions, chronic disease, perinatal and infant health, oral health).
6) Identify the lessons learned from this process of working together and the next steps to continue to work together on other primary health care or health projects.

7) Provide an assessment of the applicability of this process/transitional model in the north of Saskatchewan and potentially elsewhere (e.g., the south, other northern regions of Canada).
8) Satisfy the evaluation requirements of the funded primary health care transition project.

4.3 Evaluation Questions

To address the objectives, the following questions were proposed:

1) What changes are occurring or have occurred across jurisdictions with respect to promotion, prevention, and treatment in the areas of mental health and addictions, chronic disease, perinatal and infant health, and oral health?
2) What changes are occurring or have occurred that will lead to increased access to, efficiency in, and effectiveness of primary health care services across jurisdictions in the areas of mental health and addictions, chronic disease, perinatal and infant health, and oral health?
3) What changes are occurring or have occurred with respect to communication, cooperation, coordination, and collaboration across jurisdictions in the project areas (e.g., mental health and addictions, chronic disease, perinatal and infant health, oral health, human resources, information technology, health information management)?
4) Are the changes culturally appropriate as well as relevant to the realities of the north and to wholistic health? How so?
5) What are the levels of commitment to and the participation of NHSWG partners in this process and primary health care transition project?
6) What is different in terms of how the NHSWG partners work together?
7) Is this process of working together sustainable? Why or why not?
8) Are project activities as well as (implemented) recommendations consistent with the principles and vision of the Northern Health Strategy? How so?
9) Are project activities as well as (implemented) recommendations responsive to community needs? How so? How well does the project (NHSWG partners) engage communities and build capacity?
10) How well does the project (NHSWG partners) engage other service providers (from various disciplines, sectors, and jurisdictions) and build capacity?
11) Is this transitional model sustainable? Is it applicable to other areas of primary health care or other service areas? Is it applicable to other areas of Canada (i.e., the south, other northern regions)? Why or why not?
12) Can this transition result in a model that will improve the health status of northern residents of Saskatchewan? How so?

4.4 Priority Aspects of the Project

The evaluation focused on the following aspects of the project, which are listed in order according to the preferences of the NHSWG as determined through the prioritization process (i.e., ranking).

1) Cross-jurisdictional Issues
2) Community Development
3) Communications
4) Human Resources
5) Technical Advisory Committees (i.e., MHATAC, CDTAC, PIHTAC, OHTAC)
6) Information Systems

4.5 Intended Uses of Evaluation Findings

The intended uses of the evaluation findings, listed in order according to the preferences of the NHSWG, included:

1) Ensure progress is made towards desired outcomes
    a. Review the process/project on a regular basis
    b. Inform the process/project
2) Determine project effectiveness (merit or worth)
3) Solve unanticipated problems

The evaluation framework was presented to the NHSWG in December 2004 and consensus was reached to proceed with the evaluation as presented.

4.6 Data Collection

Data collection was initiated early on with a review of relevant documents such as the project proposal, minutes of previous NHSWG meetings, PowerPoint presentation on the project, project brochure, TAC terms of reference, minutes of the first evaluation team meetings, etc., in preparation of the evaluation proposal and framework.

The data collection methods were chosen to maximize participation of stakeholders and project participants (e.g., focus groups, project diaries). These participatory methods were complemented with methods intended to gather information, measure progress toward project outputs and outcomes, etc., (e.g., document review, observation, semi-structured interviews, questionnaires). Using multiple methods of data collection is a way of ensuring trustworthiness of evaluation findings and validity of the data collected by allowing for data triangulation.[10]

Data for the evaluation of all project components was collected:

- continuously (e.g., through document review, observation, ongoing discussion and feedback with project staff);
- at intervals such as every 3 months or at the start, mid-way, and end points of the project (e.g., project diaries, questionnaires, semi-structured interviews); or
- at a single-point in time (e.g., interviews with each NHSWG representative).

An evaluation matrix (see Appendix C) for each project component was developed and presented to the relevant project staff (i.e., consultants, TAC coordinators), the NHSWG, and the evaluation team for discussion and feedback, prior to the start of data collection with respect to each project component. Each matrix outlines the proposed data collection methods and data sources, as well as relevant indicators and evaluation questions.

According to the project proposal,[1] "all evaluation projects will be submitted to the University of Regina Research Ethics Board prior to commencement of data collection." [p. 41] Given the breadth and the nature of this evaluation, ethical approval was sought in phases, according to project components. For example, the first submission to the University of Regina Research Ethics Board (UofR REB) was for the investigation of the four PHC TACs. This ethics application was submitted in November 2004 and ethical approval was received in December 2004. The second submission to the REB was for the investigation of the communications component and it was approved in June

2005. The remaining ethical approvals were as follows: third submission was for the human resources component, approved in June 2005; fourth submission was for the information systems component, approved in May 2005; fifth submission was for the cross-jurisdictional issues component, approved in July 2005; and finally, the sixth submission was for the community development component, also approved in July 2005.

Given that the project was very much a work in progress, the evaluation needed to be flexible in achieving its own goals and objectives. In order to ensure that valid information was collected on issues and aspects important to the stakeholders/participants, and relevant to the overall success of the project, the evaluation coordinator was flexible in the data collection methods utilized, as the evaluation and project progressed. And as such, there were only slight modifications to the data collection process over the course of the evaluation (e.g., the project diaries were discontinued; in some TACs only one focus group was conducted instead of the proposed two).

All project stakeholders (e.g., TAC representatives, Community Liaison Officers, TAC coordinators, consultants, NHSWG representatives) who participated in the project diaries, questionnaires, interviews, and focus groups received a letter of invitation to participate in the evaluation. These evaluation participants also completed a consent form prior to their participation in the activity. With respect to the interviews and focus groups, the participants were offered the opportunity to review the interview or focus group transcript for errors or omissions. In some instances, where the identity of the participant might become known because there was a small number of participants or an n=1 (e.g., project staff, consultants), the participants completed a transcript release form. Samples of all data collection materials, which include: letters of invitation to participate in the evaluation; consent forms; transcript release forms; questionnaires; interview guides; and focus group guides can be found in the Appendices.

In general, data collection consisted of:

- Success and satisfaction indicators
    - Identification and prioritization of the indicators by the stakeholders at the start of the project, with a review of the indicators at the mid- and end-points of the project
    - Completed by the MHATAC, CDTAC, PIHTAC, and the NHSWG;
- Project diaries
    - Completed by PHC TAC representatives and reviewed every 3 months
    - It was anticipated that 3 members per TAC would complete; however, only 2 members in total participated so the diaries were discontinued due to small numbers;
- TAC Effectiveness Questionnaire (TACEQ)
    - Completed by the MHATAC, CDTAC, PIHTAC, and OHTAC (n=98 completed questionnaires over the course of the evaluation)
    - Administered at three intervals (i.e., baseline, mid-point, end-point);
- Questionnaire for the Community Liaison Officers
    - Completed at three intervals (n=5 completed questionnaires);
- Semi-structured interviews (n=43 completed interviews)
    - Cross-jurisdictional issues consultant interviews (n=2 interviews)
    - Community development consultant interviews (n=2 interviews)
    - Communications coordinator interviews (n=2 interviews)
    - Community liaison officer interview (n=1 interview)
    - Human resources coordinator interviews (n=2 interviews)

    - MHATAC, CDTAC, and PIHTAC representatives interviews (n=19 interviews)
        - Completed by 2-3 members per TAC at three intervals (n=8 participants)
    - Health information management consultant interviews (n=2 interviews)
    - Information technology coordinator interviews (n=2 interviews)
    - NHSWG representatives (n=11 interviews; n=11 participants);
- Focus groups
    - Completed by the MHATAC, CDTAC, PIHTAC, OHTAC, HRTAC (n=2 focus groups), HIMTAC, and ITTAC (n=8 completed focus groups);
- Document review
    - NHSWG and TAC minutes; all meeting documents; project progress and final reports; email correspondence, etc.; and
- Observation of meetings and activities (n=118 meetings attended)
    - Attendance at 46 NHSWG meetings (face-to-face and conference call)
    - Attendance at 68 TAC meetings (face-to-face and conference call)
    - Attendance at 4 NHS Leadership meetings (face-to-face)
    - Attendance at weekly project staff meetings (face-to-face).

In addition, detailed process notes were kept on each project component. These notes were compiled from document review and observation of meetings and activities.

Table 1, Data Collection Methods Utilized in each Project Component, summarizes the data collection methods utilized in the evaluation within each project component.

Table 1 – Data Collection Methods Utilized In Each Project Component

	Data Collection Methods													
	Success & Satisfaction Indicators		Diary		Questionnaire		Interview		Focus Group		Document Review		Meeting Observation	
Project Component	**Yes**	**Date**	**Yes**	**Date**	**Yes**	**Date**	**Yes**	**Date**	**Yes**	**Date**	**Yes**	**Date**	**Yes**	**Date**
Cross-Jurisdictional Issues							√	Nov05 May06			√	Sep04 to May06	√	May05 Oct05 Jan06 Apr06
Community Development					√ (CLOs)	Dec05 Mar06	√	Dec05 Apr06			√	Jan05 to Apr06		
Communications					√ (CLOs)	Oct05 Mar06	√	Jul05 Mar06 Jun06			√	Aug04 to Sep06		
Human Resources							√	Jul05 Jun06	√	Nov05 Mar06	√	Nov04 to Jul06	√	May05 to Mar06
Technical Advisory Committees	√	Nov04 Jun05 Mar06	√	Apr05 to Aug05	√	Jan05 Sep05 Feb06	√	Apr05 Oct05 Apr06	√	Jun05 Jan06 Feb06 Mar06	√	Aug04 to Sep06	√	Oct04 to Mar06
Information Systems							√	Jul05 Feb06 Mar06	√	Jan06 Mar06	√	Oct04 to Mar06	√	Jun05 to Mar06
NHSWG	√	Nov04 Oct05 Jun06					√	May06 to Jun06			√	Aug04 to Sep06	√	Aug04 to Sep06
Total (where applicable)			**3**		**103**		**43**		**8**				**118**	

4.7 Data Analysis, Feedback, and Reporting

As data for the evaluation was collected, it was compiled and analyzed utilizing the evaluation framework and the evaluation matrices for each project component. More specifically, interview and focus group participants were given the option to review the corresponding transcript for omissions and errors once it was transcribed (if recorded), after which this qualitative data was coded and analyzed using Atlas-ti 5.0 software. In addition, the qualitative data gathered from the TAC Effectiveness Questionnaire and community liaison officer questionnaires were also analyzed using Atlas-ti 5.0. SPSS 11.5 was used to analyze the quantitative data from the TAC Effectiveness Questionnaire.

Feedback and reporting of evaluation findings and progress to the project stakeholders included: evaluation progress to date; evaluation activities in progress; next steps in the evaluation; data analysis and findings to date; any unexpected results; etc. Evaluation findings and progress were reported continually to the project coordinator and staff through weekly staff meetings, phone calls, email, etc. The evaluation coordinator also provided oral reports of evaluation findings and progress to the TAC participants at TAC meetings. Highlights from the evaluation and regular progress reports were submitted to the NHSWG at monthly face-to-face meetings. Finally, progress reports were submitted monthly to the evaluation team and findings were discussed at quarterly face-to-face meetings.

In addition to this final evaluation report, an interim evaluation report was prepared and submitted to the NHSWG on September 6, 2005.[11]

5. Evaluation Findings by Project Component

The evaluation findings are presented according to the priority aspects of the project, as determined by the NHSWG. Each findings section follows a similar format.

The proposal submitted (October 2003) to the Primary Health Care Transition Fund, Aboriginal Envelope (Health Canada), contained project objectives that were broadly stated. In November 2004, the NHSWG acknowledged that these project objectives as written were somewhat unclear and not well developed. A review and refinement of the project objectives would not only enable financial resources to be spent more appropriately, but also provide more specific and evaluable objectives. In fact, an important component of project evaluation is to continually review, describe, and explain any changes in understanding or implementation of project objectives and related output or outcome expectations. In December 2004, the NHSWG reviewed the proposal and each project objective in detail, reducing the number of objectives within each project component and ensuring that each objective was clear and measurable. Furthermore, as project coordinators and consultants were hired, additional objectives and outcomes were identified for each of the project components. For ease of understanding, these changes and additions to project objectives and anticipated outcomes are reflected in a table at the beginning of each project component discussion.

In addition to the objectives and anticipated outcomes, each project component is explored in terms of:

- its progress, that is, the process or activities undertaken;
- all outputs and outcomes achieved (expected or unexpected);
- proposed recommendations of the consultants, TAC coordinators, TACs;
- its contribution to the NHS strategic plan;
- evaluation findings (for example, successes; challenges);
- sustainability issues;
- summary statement; and
- recommendations from the evaluation.

5.1 Cross-Jurisdictional Issues

The following table (Table 2 – Cross-Jurisdictional Issues Component Objectives and Anticipated Outcomes) reflects the changes and additions to the project objectives and anticipated outcomes from the project proposal to the implementation of this project component.

Table 2 – Cross-Jurisdictional Issues Component Objectives and Anticipated Outcomes

According to Proposal (October 2003) [1]	
Objectives	• Build a framework for the integration of core service delivery for the north that addresses complex jurisdictional issues of the area and associated overlaps and gaps in service delivery, while maximizing limited resources of multiple players; [p. 25] and • Expand and develop new partnerships in health service delivery. [p. 26]
Short-term Outcome	• Northern health authorities will be able to achieve efficiencies through better use of common resources across jurisdictions. [p. 27]
Long-term Outcomes	• Integration of service delivery will ensure access to core services; [p. 20] and • Coordination of seamless service delivery where the client is served without regard to jurisdiction. [p. 20]
According to NHSWG Review (December 2004)	
Objectives	• To develop processes to facilitate cross-jurisdictional decision-making within NHSWG partners; and related to advocacy, • To positively impact health and social policy, through recommendations for changes or implementation of changes to policy.
According to Consultants (October 2005) [12]	
Objective	• To facilitate a reflection process with all NHSWG partners (consensus building), which will lead to the establishment of a mechanism for cross-jurisdictional decision-making (by northerners for northerners).
Short-term Outcome	• To develop a decision-making mechanism(s) to address jurisdictional issues arising from legislation, "P"olicy, "p"olicy, and practice.
Long-term Outcome	• To resolve jurisdictional issues that impedes access to care or create inefficient care for residents of northern Saskatchewan.

5.1.1 Activities, Outputs, and Outcomes

In the fall of 2004, NHSWG members were asked to identify priority cross-jurisdictional issues within the overall context of the project from local, regional, provincial, and federal perspectives. Potential cross-jurisdictional issues identified in the project proposal were also added to this list of priorities. This preliminary list of potential priority cross-jurisdictional issues was intended as a planning tool (for a consultant) with further priorities to be generated from the recommendations of the TACs.

In March 2005, the NHSWG contracted the MFN-CAHR, University of Manitoba, to provide consultant expertise on cross-jurisdictional decision-making. Their work, consisting of three tasks, focused on a reflection process with all NHSWG partners (consensus building), which would lead to the establishment of a mechanism for cross-jurisdictional decision-making (by northerners for northerners) to assist in working together to improve access to quality health services. Task One consisted of the development and validation of a northern health care system map showing each NHS partners' role and responsibilities, derived from official mandates, policies, regulations, and legislation. Task Two consisted of the identification and inclusion of jurisdictional stress points into the northern health care system map including overlaps, gaps, and contested responsibilities. Task Three included the identification of the decision-making levels required to resolve these stressors and the development of a cross-jurisdictional decision-making process to address these jurisdictional stressors.[6]

The MFN-CAHR utilized three processes to gather information on cross-jurisdictional issues in order to map the northern health care system (potentially a strategic plan) and to determine a cross-jurisdictional decision-making process. The processes included: 1) documentation of potential jurisdictional issues emerging from official mandates, policies, regulations, and legislation; 2) engagement of all the TACs (i.e., PHC and support TACs) in an exploration of cross-jurisdictional issues impacting health service delivery; and 3) engagement of the NHS Leadership in an exploration of the broader directions, i.e., relevant for the whole north. Detailed information regarding each process and its particular findings/analysis can be found in the MFN-CAHR final report to the NHSWG.[13]

In terms of outputs, the MFN-CAHR mapped the northern health care system in its current state, with jurisdictional stress points identified, and suggested strategic options for resolving these stressors. The "map" of the northern health care system is presented in the form of tables and physical maps according to: leadership priorities identified through four NHS Leadership meetings; continuum of care issues (e.g., front-line workers and practitioners) identified within the TAC areas (i.e., mental health and addictions; chronic disease; perinatal and infant health; oral health; human resources; health information management; information technology); legislative framework, general service provisions, policies and regulations that impact access to services identified through a detailed review of official documentation.[13, 14]

The MFN-CAHR was also able to achieve consensus among the NHS Leadership and NHSWG with respect to a cross-jurisdictional decision-making mechanism or process, with both governance and strategy options for resolving jurisdictional stressors.[13] At the fourth NHS Leadership meeting in April 2006, the representatives agreed to adopt the proposed mechanism or process for a period of one year, after which it will be evaluated to ensure that it performs as intended. The next step in

formalizing this mechanism or process requires the signature of a second Memorandum of Understanding (MOU). This MOU will build upon the mission, values, principles, and approaches of the NHS, as well as the collaborative effort undertaken within the Shared Paths project, and it creates a Northern Health Leadership Working Group (NHLWG) with two representatives from each NHS partners' Health Board of Directors. This group will discuss recommendations of the NHSWG, set direction, and advocate on legislative issues and priorities received from the NHSWG. In addition, **all** NHS partners will become signatories to this MOU (in the previous MOU, the NITHA partners, that is, LLRIB, MLTC, PAGC, PBCN, and the KTRHA were not signatories). Participants of this process stated that "the resolution of northern grievances would be more readily achieved if northerners could speak with one voice." [p.6] The MFN-CAHR believes that the proposed cross-jurisdictional decision-making process creates an opportunity for this to occur, as well as ensures that a mechanism exists to identify issues and solutions in a timely manner.

5.1.2 Project Recommendations and NHS Strategic Planning

In terms of recommendations to the NHSWG,[13] the MFN-CAHR suggests that some of the cross-jurisdictional issues raised through its work "will have a better chance at being resolved if advocacy is supported with evidence derived from independent yet participatory research." [p.22] As a result, the MFN-CAHR recommends that the NHS, through the proposed cross-jurisdictional decision-making process, "develops long-term partnerships and enlists the assistance of university and other researchers to assist in building the case on key issues." [p.22] Furthermore, the MFN-CAHR suggests that the NHS be recognized as a best practice model across Canada and supported accordingly.

Within the NHS Strategic Plan,[15] there is support for continuing to partner in a common vision to improve access to quality health services for northerners through the broader engagement of leaders, managers, service providers, and community members as proposed in the above cross-jurisdictional decision-making mechanism, as well as for independent yet participatory research to provide the evidence needed for advocacy of key issues (e.g., medical transportation, northern funding formula).

5.1.3 Evaluation Findings

Successes

A notable success of the cross-jurisdictional issues component is the consensus achieved among the NHS Leadership and NHSWG with respect to a cross-jurisdictional decision-making mechanism or process. This consensus was achieved remarkably smoothly perhaps because of the consultant's knowledge, understanding, and respect for northern governance and health issues; her ability to mediate any sensitivity; and the fact that the proposed mechanism retains the current process implemented by the NHSWG (i.e., TACs; partner organizations; communities), with the addition of another working group (NHLWG) and a Northern Leadership Forum (NLF) tasked with addressing legislative issues, as well as issues emerging from federal and provincial policies, through advocacy.[13] The incremental, small step approach to consensus building used by the consultant enabled the participants to trust the process and feel ownership. Each meeting of the NHS Leadership built upon the last, as the consultant guided the participants through the full process each time they met so that they could see their words, their work, and where they had come from.

Furthermore, this cross-jurisdictional issues component built capacity among the NHS partner organizations by identifying cross-jurisdictional issues and stressors from the practitioner level to the leadership level, and by establishing a mechanism to determine the solutions and seek resolutions, removing barriers to accessing care at the habits and practices level through the TACs, at the "p"olicy level through the NHSWG, and at the "P"olicy, Contribution Agreement, and legislative level through the NHLWG and NLF.[13] In the future, additional organizational capacity can be attained through collaboration with university-based and other researchers on needs-based, evidenced-based research to support advocacy efforts that seek resolution to key jurisdictional issues such as medical transportation.

Challenges

Several challenges are to be noted with respect to this project component, one being, distance planning. The consultants contracted were researchers from the University of Manitoba. While planning and conducting their research from a distance was not insurmountable, it did present the following issues: communication with the project coordinator and TAC coordinators was not as extensive or as regular as it perhaps needed to be in terms of coordination of activities, planning agendas, etc.; access to stakeholders (i.e., NHS Leadership; NHSWG; TAC representatives) for input into the process and feedback on findings or reports was limited; and perhaps, a missed opportunity to build local capacity in contracting a Manitoba organization versus a local organization/individual. The NHSWG preferred to hire Saskatchewan based organizations/individuals, particularly from the north, to staff the project; however, with respect to the cross-jurisdictional issues component there was a lack of interested and qualified organizations/individuals that responded to the request for proposal (only three of the five suggested Saskatchewan based organizations/individuals responded). The MFN-CAHR was chosen because of the extensive knowledge, skills, and experience that would be dedicated to the project.

The relatively short project timeline (March 2005 – May 2006) presented additional challenges in terms of engaging and building consensus among the stakeholders, from TAC representatives to NHS Leadership. Northern development tends to be participatory, which takes time, and all project stakeholders are busy individuals with roles and responsibilities that go beyond the project and the NHS. In addition, the start of the cross-jurisdictional issues component or the work of the MFN-CAHR did not coincide with the start of many of the TACs. As a result, the data gathering process utilized by the MFN-CAHR with the TACs essentially became a second "current state assessment" for those TACs that started in 2004 (e.g., mental health and addictions, chronic disease). This lack in coordination of activities (between the MFN-CAHR and the project coordinator) left some TAC Coordinators and TACs concerned for how this exercise would fit together with the TAC work plan or that of the project (i.e., work plan of the MFN-CAHR).

The MFN-CAHR developed several physical maps[13] (e.g., hospitals; health care facilities; nursing stations and health centres; addiction treatment facilities; special care homes), which were useful in data analysis, particularly the TAC data, and which were well received initially. However, the physical mapping exercise was since met with mixed feelings from the NHSWG and Project Coordinator because their use as visual aids in presentations may raise concerns due to the concentration of facilities in certain areas, as well as the lack of First Nations partner representation on the maps (i.e., there was not full NHS partner representation). These concerns were valid and sensing some discomfort, the MFN-CAHR did not pursue: the use of the maps as a discussion tool; the

information needed to fully represent all NHS partners; or the systematic review of the maps by the NHSWG; and therefore, the maps were not fully integrated into the final report.

Finally, the consultant expressed that the request for proposal and the work plan were quite open; however, this lack of clear direction at the onset did not appear to present a big hurdle for the consultant given that she has worked in Northern Saskatchewan for many years.

According to the consultant, these challenges were adaptable and successfully worked through; however, there remain a number of perceived risks to the establishment of the cross-jurisdictional decision-making mechanism which include:

> *that it will lead to a new bureaucracy, paralyzed by a lack of funding; that leaders will see it as a challenge to their leadership; that the autonomy of the partners may be challenged; that reaching consensus may be a long and challenging road; and once consensus is achieved, unyielding bureaucracies will buckle and little tangible benefit will result.*

These concerns were raised and discussed by the leaders at the last NHS Leadership meeting in April 2006. Of the options for a cross-jurisdictional decision-making mechanism presented to them, the leaders opted for a mechanism or model that would address these concerns. Provisions put in place such as, flexibility in the implementation of this mechanism, readjustments over time, and an evaluation of the mechanism's performance after one year will ensure that these concerns are addressed in a suitable manner.

Sustainability

The NHSWG representatives generally thought that there was progress made and success achieved within the cross-jurisdictional issues component. The consultant had the appropriate expertise and skill; there was good discussion about the jurisdictional issues and barriers, as well as some solutions; it provided validation for the process currently in place; the proposed mechanism further engages the NHS leadership in the process (addresses the criticism of some leaders that the NHSWG is setting the direction for the NHS versus the leaders); and it provides a good basis to continue the momentum attained by the NHS and the Shared Paths for Northern Health project. However, this mechanism still requires commitment, time, and small steps to ensure success given the reservations that exist when discussions turn from potential solutions to resolutions, as was the case with the dentist services proposal (see OHTAC page 83).

5.1.4 Summary Statement

Perhaps, there should have been more time dedicated to the cross-jurisdictional issues component, as some NHSWG representatives thought that more could have been done in this area. For example, utilizing the expertise of the consultants to prioritize one or two of the identified jurisdictional issues and do some detailed work on the issue(s) that is, determine options or solutions to resolve the issue(s) and take steps toward its resolution. And while this component provided validation to the NHSWG about the process, it did not take the NHSWG to the next level. What is the next step? Perhaps, that is challenging the various governance structures in place, be it local, regional, provincial or federal, to do things differently, be that in decision-making, access to services, communication, funding, and so on.

The cross-jurisdictional issues component met project objectives and anticipated outcomes. Many jurisdictional issues have been identified and several will need to be defined further as the jurisdictional language is sometimes different depending upon the issue (e.g., issues related to access, issues related to funding formulas). Several strategy options for resolving the jurisdictional stressors have been suggested. There is a need to prioritize the issues already identified, while recognizing the need to re-prioritize as additional jurisdictional issues emerge. Implementation of the proposed cross-jurisdictional decision-making mechanism will require resources such as, a facilitator/ coordinator to initiate the meetings of the NHLWG, to organize meetings, to facilitate prioritizing of the issues, handle communications, as well as financial resources to cover the costs of meeting (i.e., conference call or face-to-face), communications, etc. The proposed mechanism was not tested within the project, although jurisdictional issues had been identified and could have been used as working examples within the TACs or at NHSWG or NHS Leadership meetings.

5.1.5 Evaluation Recommendations

It is recommended that the second MOU that formalizes the proposed cross-jurisdictional decision-making mechanism is ratified and signed as soon as possible so that jurisdictional issues which impede access to care or create inefficient care for residents of northern Saskatchewan can be resolved. Once the MOU is signed, resources should be devoted to the implementation of this mechanism (e.g., establish terms of reference; review and prioritize identified issues; determine research opportunities). Each level (i.e., TACs, NHSWG, NHLWG, NLF) within this mechanism should prioritize at least one jurisdictional issue, identify realistic strategies to resolve the issue(s), and advocate for changes to habits and practices, organizational policies, governmental policies, Contribution Agreements, and/or legislation to resolve the particular issue(s). As suggested by the consultants, evaluation of the mechanism's performance should occur after one year.

5.2 Community Development

The following table (Table 3 – Community Development Component Objectives and Anticipated Outcomes) reflects the changes and additions to the project objectives and anticipated outcomes from the project proposal to the implementation of this project component.

Table 3 – Community Development Component Objectives and Anticipated Outcomes

According to Proposal (October 2003) [1]	
Objective	• Empower individuals, families, and communities to take more appropriate responsibility for their own health issues.[p.21]
Short-term Outcome	• Community consultation mechanisms in northern communities (as agreed to and defined by the communities) [p. 27] which may result in the formation of a community involvement process or structure in communities across northern Saskatchewan to assist in defining core services, assess the existing access to services, and the quality of services; and begin wholistic community initiatives in priority health issues (as defined by the community). [p. 35]
Long-term Outcomes	• Health teams that support families and communities will be in place; [p. 20] and • The health delivery system will be able to include non-health professionals, community leadership, and family representatives on health teams as appropriate. [p. 20]
These outcomes are also facilitated through the work of the four PHC TACs.	
According to NHSWG Review (December 2004)	
Objective	• To re-power individuals, family, leaders, and their community to recognize their responsibility for health and health service delivery.
The refinement of this objective recognizes the health management capacity that currently exists in the north and the importance of building upon that capacity; to "re-power" rather than "empower," and to "recognize" rather than "take" responsibility for more than health issues but specifically health service delivery.	
According to Consultants (October 2005) [12]	
Objective	• To develop an approach to health care that will assist individuals, families, and communities in northern Saskatchewan to become more self-reliant in their own wholistic health.
Short-term Outcomes	• Acceptance of CD principles/process as outlined by the NHSWG and NHS boards/councils; and • Develop funding proposals for implementation.
Long-term Outcomes	• Provide health service delivery staff with adequate orientation and training to implement CD principles/ process; • Revise job descriptions to include CD responsibilities and all performance reviews to include elements of CD activities; • Develop strategies for working with northern families for every relevant occupation in health; and • Health budgets to include continuing funding for CD activities by staff and community.

5.2.1 Activities, Outputs, and Outcomes

In May 2005, the NHSWG contracted the Associated Counselling Network (ACN) to provide consultant expertise in the area of community development. Their work focused on the development of an approach to health care that would assist individuals, families, and communities in northern Saskatchewan to become more self-reliant in their own wholistic health.[7] The specific objectives according to the work plan[7] submitted to the NHSWG included:

- To complete and report on a current state assessment of community development initiatives and programs which are currently functional within the partners of the NHSWG and other northern Saskatchewan organizations and communities;
- To undertake a literature search of current community development models, principles, and standards applicable to communities in northern Saskatchewan;
- To design an evaluation tool to be used in assessing the state of community development initiatives and "best practice" options, and to report on the status of each community development initiative using that tool;
- To develop recommendations of best practices from the current state assessment and literature search;
- To design a model(s) of community development which incorporates best practices and meets the individual, family, community, and organizational needs, as well as the collective needs of the NHS; and
- To propose an implementation process for the resulting community development model(s).

The work of the ACN consisted of four phases: 1) literature review; 2) data gathering; 3) model development; and 4) development of an implementation process to accompany the model(s).[7] In the data gathering phase, which consisted of NHS partner/community consultations through interviews and focus groups with community residents, as well as project stakeholders, the ACN suggested that a change in focus was needed. The original focus was on community development initiatives, i.e., programs or projects, and what was discovered through the consultations was that community development, according to northern residents, was about developmental relationships. As one of the consultants stated, "It wasn't a project or organization that was needed. It was a relationship pattern … [that] needed to be different." This change in focus required the consultants to go back to the literature with a focus on literature relevant to developmental psychology, educational psychology versus literature on community development and community participation in health. The ACN first presented the change in focus to the NHSWG in a progress report in December 2005. In January 2006, the consultants met with the NHSWG, presented the findings to date, and received approval to develop a model/strategy based on the change in focus.

As a result of the change in focus, the consultants did not complete several of the above work plan objectives as had been anticipated. For example, the final report[16] did not include a comprehensive current state assessment or inventory of community development initiatives within the NHS partners or other northern Saskatchewan organizations and communities, although the consultants did provide some examples. Because the focus was then on developmental relationships rather than community development programs or projects, the consultants did not develop an evaluation tool to assess community development initiatives within northern Saskatchewan. Furthermore, the consultants struggled with what an evaluation tool to assess developmental relationships would look like. They suggested that perhaps, the final report was an evaluation framework (tool) to assess the state of community development in northern Saskatchewan, which included a definition and process

for identifying what relationships are developmental. Finally, the consultants also grappled with developing recommendations with respect to best practices in community development. For the consultants, the change in focus from programs/projects to developmental relationships changed what best practice might look like. Unfortunately, they did not elaborate further.

Rather than develop a model(s) for community development initiatives (i.e., programs or projects), the consultants, in the final report[16] submitted to the NHSWG in March 2006, presented various types of models in an attempt to describe what makes a relationship developmental. By integrating principles and "best practices" from these models, the consultants proposed a strategy that they felt would assist individuals, families, and communities in northern Saskatchewan to become more self-reliant in their own wholistic health. The strategy, founded in traditional knowledge and rooted in traditional processes, was to create a culture of developmental relationships in northern Saskatchewan.[16]

The consultants did not have a definitive answer with respect to: what does one do about creating a culture of developmental relationships? However, they suggested that implementation of the strategy had two major components: a personal development component and an institutional development component. The consultants focused the strategy on people who worked in the health care system to begin a change in the culture of the health system in northern Saskatchewan. Briefly, the personal development component[16] involved changes in beliefs and behaviours, that is, the recognition that the responsibility for community development (i.e., developmental relationships) lies with everyone. This component requires a period of intense activity involving workshops, a workbook (which was not developed by the consultants), and supporting activities (e.g., educational activity, community service, family activity, spiritual activity). The institutional development component[16] was described as an effort to adjust the institutional framework of health services so that developmental relationships are encouraged and supported. This component would involve an intense level of participation and cooperation by all levels of management including boards, senior managers, and program managers, and implementation of this component is expected to be complex and lengthy. "Health regions which desire a culture of developmental relationships will need to, over time, review and modify as necessary, their policies, organizational structures, programs, procedures, and reward systems to ensure that developmental relationships are supported and rewarded."[16, p.73] According to the consultants, this strategy is accessible by an individual, as well as by a whole health region, and it is up to each jurisdiction to determine how to implement it.

In addition, the consultants engaged the Community Liaison Officers (CLOs; described on page 36), as well as the community in their work. The ACN interviewed the CLOs with respect to their perceptions of community development, and the CLOs helped organize the community consultations, as well as reviewed and critiqued the findings and the proposed strategy and implementation process. The consultants engaged the community through consultations (e.g., focus groups) and reported participation from a high number of community residents. These residents varied in age and characteristics, such as those who were supporters of community development; those who were critics; those who were community leaders; as well as those who were not and so on.

5.2.2 Project Recommendations and NHS Strategic Planning

In terms of recommendations to the NHSWG, the ACN suggests that a cultural change is required to assist individuals, families, and communities to become more self-reliant in their own wholistic health, whereby health care providers need to see their role as a support to individuals, families, and communities, and that they have a developmental function to nurture the capacity of individuals and families to meet their own wholistic health needs.[16]

> *The cultural change required is for health service providers to recognize that families and individuals have major responsibilities for their own health and act in a way that fosters growth in family and individual capacity to accept and act on that responsibility. As families and individuals grow in their capacity to accept and act on their responsibility for their own health, then health care providers will need to give up some of their decision and action power to these growing families and individuals.*[16, p.91]

Within the NHS Strategic Plan,[15] there is no mention of supporting the implementation of the community development strategy and implementation process proposed by the ACN; however, community development is mentioned as one of the NHS priorities.

5.2.3 Evaluation Findings

Successes

According to the consultants, the change in focus from community development initiatives (i.e., programs and projects) to community development as a culture of developmental relationships was a success, in other words, "a fruitful way to go." The consultants noted that this change in focus did not come from the professionals or the literature but from the people in the communities, which was further validated through a presentation and discussion with the NHS Leadership (also community residents) in January 2006. A further success identified by the consultants was the personal growth experienced through working on the project.

> *We've learned lots and we've changed quite a bit in terms of ourselves … we've challenged our own thinking in a number of areas because we thought we were doing some things pretty well but you start looking at it from a different point of view and maybe there is a whole other area out there that we can explore to do things much better. So, whether it changes anybody else or not, it's changed us and will continue to change us.*

Challenges

While the consultants mentioned the change in focus as a success, they also noted this change as a challenge. Often community development is thought of in terms of projects or programs; however, the findings of the consultants discovered that, according to northern residents of Saskatchewan, community development is about developmental relationships. The consultants noted that this change in focus requires a shift in the way that individuals view community development. The consultants felt that the idea needed to be properly presented and then assimilated by individuals otherwise it would be rejected.

This leads to the second challenge or concern identified by the consultants. The concern was that the consultants did not receive the length of time needed with the NHSWG to discuss the findings,

the strategy, and the implications for the NHSWG representatives so that all would understand what the consultants were proposing. The consultants had suggested a one-day workshop with the NHSWG; however, due to busy schedules the NHSWG only allowed one hour for presentation. Without this understanding, the consultants felt that there would be no implementation of the strategy within the regions' strategic plans, operational plans, and budget projections, nor would there be a developmental relationship between the NHSWG and themselves.

> *What we've done takes a lot of work to assimilate, and I don't think that the members of the NHSWG are prepared - and that could be for a number of reasons - are prepared to do the work in order to really understand and assimilate what we have done. And that's probably our biggest challenge and our biggest concern.*

In addition, the consultants recognized that the proposed implementation process would not be easily implemented, particularly within a whole health region; however, if one individual wanted to do something the strategy was available to them. The idea is to start and progress. While the consultants directed the implementation process towards the health care system and those who work within the system, they claimed that a parallel process could occur within the community directing the strategy towards the family and those individuals that are interested in making change. This parallel process was not presented within the final report due to short timelines.

A third challenge identified by the consultants, and similarly expressed by the MFN-CAHR, related to distance planning. The ACN experienced some difficulty in organizing the interviews and focus groups from their Regina office.

> *You can't sit on the telephone, sit down here and organize all your interviews. It just doesn't work that way. You can do enough to justify a trip and then you go up and you really organize as you wander around the community. And you just find people and sit down and visit and do interviews … in terms of organizing focus groups, it's even been that kind of experience too. It's difficult to organize it ahead of time, and sometimes you can't organize it anyway, even when you get there.*

The consultants also mentioned travel time as a challenge; however, it was not completely unexpected given that their office is located in Regina, and travel is the norm when working in the north.

Furthermore, the consultants regret that there was no opportunity to feedback the findings to the communities and individuals who participated in the interviews and focus groups. The consultants felt that their relationship with the participants was not a developmental relationship because they were not able to share what was done with the information given to them by the participants. In addition, feedback of findings to the participants ensures that researchers, outsiders or whoever is asking the questions has not misinterpreted the findings.

Capacity Building

Based on data collected within the evaluation, the evaluation coordinator believes that there may have been a missed opportunity with respect to capacity building within the community development component of the Shared Paths for Northern Health project. For instance, the NHSWG contracted the ACN to conduct a research study; however, avenues to address any

community development initiatives specific to TAC work plans or NHS partners/communities were not suggested nor provided by either the project stakeholders (i.e., NHSWG, TACs) or the ACN. This represents a potential loss in terms of capacity building, as there was no opportunity to gain from the consultants' expertise in terms of information sharing/ knowledge translation or support for existing or potential community development initiatives within the project or the partners. Of note, following the focus groups with the PHC TACs conducted by the ACN, the TAC Coordinators noted that this exercise should have been part of the TACs' orientation to the project rather than one year later, as it would have provided the context within which to do their work, as well as acted as a team building exercise. Community development is one avenue through which the NHS can support community transition to improve the health status of residents of northern Saskatchewan, for example, assist individuals to recognize their responsibility for health and become more self-reliant in their own wholistic health. It is assumed that the potential for capacity building that exists within the community development component will be borne through the implementation of the strategy proposed by the ACN; and it remains to be seen which organizations will implement the strategy.

NHSWG Representative Thoughts

Community development means different things to different individuals. Among the NHSWG representatives, there was general dissatisfaction with respect to the community development component of the project. Many had hoped for more direction than philosophical discussion; and felt that little new information was presented in the final report.

> *I was looking for something that would pull together ideas from throughout northern Saskatchewan and say, 'these are things that work, and the group might want to consider this, and that, and these partners' … a little more direction out of it rather than a philosophical discussion.*

> *I would have liked some recommendations, or some assessment and recommendations, with respect to processes for accomplishing what the consultants identified as principles and generic practice. So, how do we do this in the north, so as to actively make the connections with community-based [individuals] and their staff, and promote the relevant activities in communities?*

Other NHSWG representatives felt that there was value to this project component.

> *The study by ACN is still valuable because it depicted what the community membership understands to be community development needs, community development make-up, what constitutes community development. Community development is based on social relationships or interactions. For me, community development is core, the integrity of cultural foundation; without it vulnerability exists.*

While for some project stakeholders expectations were not met, and there was not a tight fit between the outcomes of the consultants' work and what was requested in the request for proposal of the NHSWG, the consultants felt they had kept to the core of what was asked of them, and what they thought that they would do, that is, to develop a model(s) for community development that would fit the north, as well as the needs of the NHS.

> *What we've done is put a significant piece in place for [the] Northern Health Strategy. We suggested a significant element of [a northern approach to health issues], probably not anywhere near everything, but it's a*

significant element. And as we've thought about what we proposed, we think that this is a major opportunity for [the] Northern Health Strategy Working Group to have a significant impact on the direction of health in the north.

The evaluation findings would suggest the importance of: clearly laying out the expectations of the work to be completed; establishing criteria to assist in identifying consultant(s) with the ability to meet expectations; identifying clear deliverables of the work; providing clear direction at strategic points; establishing good dialogue and reporting processes in order to appropriately manage the work and achieve the desired results.

5.2.4 Summary Statement

In the view of the evaluation coordinator, the community development component met some of the project objectives and anticipated outcomes. For instance, the consultants provided a general assessment of community development in the north (primarily, focused on developmental relationships; minimally focused on initiatives); conducted a review of the literature with respect to community development and developmental relationships; and developed a community development strategy and implementation process for the north that, according to the findings of their research, would assist individuals, families, and communities to become more self-reliant in their own wholistic health.

Community development is an approach valued and respected by the NHS, evidenced by its inclusion in the Shared Paths for Northern Health project (and the designated number two in terms of priority for project components). Perhaps, there should have been more time dedicated to the community development component given its importance to the NHS and that the expectations of some project stakeholders were not met. For example, this project component was the last to get officially underway, which was in June 2005 (contract signed with the consultants) a full year after project commencement. In addition, there should have been more attention directed at clearly identifying the expectations of this project component; ensuring that work was progressing on schedule (particularly important when working in short timelines); and that work was progressing towards the desired outcomes or deliverables (e.g., current state assessments, recommendations, strategies). In this instance, when stakeholder concerns were identified, it was near completion of the consultants' work and the end of the Shared Paths project, leaving little time for changes or improvements.

5.2.5 Evaluation Recommendations

It is recommended that those NHS partners that wish to implement the community development strategy proposed by the ACN do so, and that these partners share the experiences, outcomes, and lessons learned from doing so with all NHS partners. It is also recommended that those NHS partners that do not wish to implement the proposed strategy continue to address the issue of community development, both within each organization and collectively, by:

- ensuring that it is a component of the NHS Strategic Plan and/or next NHS initiative; and
- contracting an organization/individual with expertise to work with those individuals in each NHS partner with community development responsibilities (with respect to health) to identify the internal strengths of each organization or communities within the region,

and build upon these principles or best practices to provide additional direction for community development in the north.

It is also recommended that when working with consultants (or project staff) that the NHSWG: clearly identify the expectations of the work to be completed; establish criteria to assist in the identification of consultants to complete the work; clearly identify the deliverables of the work; provide clear direction in a timely manner; and establish good dialogue and reporting processes in order to appropriately manage the work (of course, with the support of the project coordinator) and to achieve the desired results.

5.3 Communications

The following table (Table 4 – Communications Component Objectives and Anticipated Outcomes) reflects the changes and additions to the project objectives and anticipated outcomes from the project proposal to the implementation of this project component.

Table 4 – Communications Component Objectives and Anticipated Outcomes

According to Proposal (October 2003) [1]	
Objectives	• Facilitate the flow of information to and from all partners that impact the wholistic health of residents of northern Saskatchewan, including: o NHSWG Partners, NHS Boards and Councils; o Cooperating non-health agencies such as education, justice, social services; o Community and municipal leaders across northern Saskatchewan; o Saskatchewan universities, colleges, and technical institutes that train and support health professionals; o Provincial health department officials and ministers; o Federal health department officials and ministers; o General public of northern Saskatchewan; and [p. 42] • Improve accountability. [p. 26]
Short-term Outcome	• To keep all of the communities informed about initiatives and progress and aid their understanding of the intent of the initiative. [p. 36]
Long-term Outcomes	• None stated
According to NHSWG Review (December 2004)	
Objective	• To identify and implement communications requirements of the project and to monitor the effectiveness of communication from the perspective of all stakeholders.
According to Coordinator (April 2005) [12]	
Objective	• To create understanding of and support for the Shared Paths for Northern Health project, as well as to facilitate internal communications between project groups.
Short-term Outcomes	• To participate in health promotion and education in northern Saskatchewan; and • To support communications needs of the TACs.
Long-term Outcome	• To relay information about the NHS, Shared Paths for Northern Health and its progress to stakeholders and the general public of Saskatchewan.

There were two Communications Coordinators employed over the course of the Shared Paths for Northern Health project. The first coordinator worked with the project from July 2004 to September 2005. Upon resignation, a second coordinator was hired and worked with the project from November 2005 to August 2006. The discussion of the communications component does not make distinctions between the two coordinators in terms of activities, outputs, successes, etc., other than with respect to the communications strategy, which was developed by the first coordinator and adhered to by the second coordinator.

5.3.1 Activities, Outputs, and Outcomes

Communications Strategy and Work Plan

A communications strategy and work plan was developed for the communications component at the start of the project. The communications strategy[17] consisted of three stages. The first stage focused on the NHS partners, with the intent to reach the staff working in the health sector in northern Saskatchewan and provide them with introductory information about the project. Information was released through NHS partner publications, such as web sites, newsletters (e.g., KYRHA Newsletter), and newspapers (e.g., PAGC Tribune). It was anticipated that publication in these mediums would also reach residents and other stakeholders in the north. The first stage was approved by the NHSWG in December 2004 and continued throughout the project with regular updates. The second stage focused on the local community and regional levels. Introductory information about the project was shared with northern communities, radio stations, newsletters, and weekly newspapers serving communities throughout the north via faxed or mailed posters, personal visits, and press releases, all as an attempt to garner publicity for the project. The second stage was approved by the NHSWG in January 2005 and continued throughout the project with regular updates on newsworthy project activities. The Prince Albert media (radio, television, and newspaper) was not contacted until July 2005, at the request of the NHSWG, as they did not want to communicate too widely (i.e., go too far outside of the north) in the early stages of the project. The third stage focused on the provincial and national levels. Information about the project's activities and successes was to be shared with mainstream and specialty media within Saskatchewan, as well as some specialty media across Canada via newsletters, newspapers, radio, and television. This third stage was never formally presented by the Communications Coordinator to the NHSWG and therefore, neither discussed nor approved by the NHSWG.

The work plan activities[8] of the Communications Coordinator included:

- develop all project resources;
- write, design, and produce project materials;
- update all project materials;
- support the communications needs of each TAC (e.g., development of health promotion materials, posters, PowerPoint presentations);
- develop and implement communications strategies with each TAC with respect to approved recommendations (if required);
- support project staff (e.g., edits; print jobs; media monitoring for news stories, articles or health information and resources of interest to the project);
- facilitate orientation sessions for the CLOs and continued support and work with the CLOs throughout the project;

- support the communications needs of each NHS partner, if requested (e.g., newsletters, posters);
- attend NHSWG, NHS Leadership, and TAC meetings;
- plan and support project conference;
- provide stakeholders with updates on project activities, progress, and successes;
- media releases and interviews;
- respond to queries of project stakeholders or the general public;
- attend northern and provincial health events to raise awareness of the NHS and the project (e.g., conferences, workshops, training sessions, strategic planning sessions);
- sponsorship of northern health events (e.g., conferences, healthy physical activities); and
- document the history of the NHS.

Communications Materials

A complete description of the communications materials produced throughout the project can be found in the final report[18] submitted to the NHSWG in August 2006. Briefly, the materials (e.g., outputs) developed for the project included:

- Northern Health Strategy brochure;
- project background document and brochure;
- project logo;
- project letterhead, fax cover, and memo;
- project web site and web forum;
- TAC information sheets;
- TAC resource binders;
- bi-monthly newsletter;
- monthly TAC activity reports (PIHTAC Bulletin);
- project PowerPoint presentations;
- media kit;
- press releases and fax releases;
- communiqués;
- conference, workshop or publicity event resources (i.e., a banner stand (NHS) and table top display (project));
- project promotional materials (e.g., pen, magnet, Frisbee, mug, business cards, posters);
- northern media database;
- northern photo database; and
- project component/TAC specific outputs:
    - CDTAC – Patient Self-Management Training poster and brochures;
    - PIHTAC – prenatal care poster; Mom, Dad and Baby Log Book; Sexual Health Education workshop brochure;
    - OHTAC – Motivational Interviewing Training posters; fluoride varnish manuals (instructor and training); oral health information tear sheets; oral health month promotion materials;
    - HRTAC – career fair materials (i.e., display and package); and

- Community development component – re-design of findings into a user-friendly format.

Over the course of the project, NHSWG representatives, project staff, and the Communications Coordinator made presentations or featured the NHS and the Shared Paths for Northern Health project at numerous conferences, workshops, or meetings.[18] Some examples included:

- Northern Labour Market Committee meeting 2004;
- Northern Medical Services Polypartite meeting 2004;
- Prince Albert Parkland RHA Aboriginal Advisory meeting 2004;
- Canadian Centre for Analysis of Regionalization and Health workshop 2005;
- Health Canada Health Integration Initiative Conference 2005;
- New North Conference 2005 and 2006;
- University of Saskatchewan Health Sciences Faculties workshop 2005;
- Northern Healthy Communities Partnership Media and Promotions Working Group meeting 2005;
- SAHO Conference 2005 and 2006;
- Regina Qu'Appelle RHA meeting in Prince Albert 2005;
- Northern Human Services Partnership meeting 2005;
- Northern Health Promotion Working Group meeting 2005;
- Saskatchewan Health and Health Canada, First Nations and Inuit Health Branch Ministers and Deputy Ministers meeting 2006; and
- numerous meetings across northern Saskatchewan with partner organizations 2004 to 2006 (e.g., Board meetings, Chiefs meetings, senior management meetings, Health Directors meetings, staff meetings, community visits, conferences, workshops, training sessions).

As a result of these presentations and displays, as well as the internal and external activities of the communications strategy or media plan, the awareness of the NHS and the Shared Paths project has increased as evidenced by references in both print and radio. Some examples include:

- Project Coordinator interviewed on Missinipi Broadcasting Corporation (three times), re: overview of the NHS and the project; change in coordinator; and NHS strategic plans and priorities;
- Missinipi Broadcasting Corporation website (follow up to the on-air report), article entitled "Northern Health Project Emphasizes Efficiency";
- The Health Quality Council – Health Clips, article entitled "Northern Health Project Emphasizes Efficiency";
- Meadow Lake Progress, article entitled "Solutions to Address Health Issues in Northern Communities";
- PAGC Tribune, article entitled "Northern Health Care Groups Team Up to Improve Health";
- La Ronge Northerner, article entitled "Shared Paths Improves Resources for Northern Health";
- CBC Morning Edition and CBC website, re: overview of the project and sponsorship of the Centennial Canoe Quest;
- Sask Libraries website, re: overview of the project; and

- several mentions in NHS partner newsletters (e.g., NMS, KYRHA).

In addition, the Communications Coordinator received requests for information on the NHS and the project from community members, students, researchers, universities, and government.

The NHS, through the communications component of the project, worked cooperatively with other organizations in the north and supported local, provincial, and national events. For instance, the Communications Coordinator was a member of the promotions and media working group of the Northern Healthy Communities Partnership, a group of approximately 20 organizations in northern Saskatchewan working wholistically to support and promote healthy communities through: active living; accessible, nutritious foods; the promotion of good mental well-being; and the prevention of substance abuse. Furthermore, the NHS supported: a local breastfeeding walk in La Ronge, through paid advertising in a northern newspaper; the provincial Centennial Canoe Quest 2005 through event and team sponsorship, with team members promoting the NHS and the project, and distributing health packs containing health promotion materials to community residents along the race route; and the 2005 Canada Public Health Day (national) through a participatory healthy living activity game for all staff within NHS partner organizations. All these initiatives demonstrate the NHS's commitment to promoting and improving the health of the residents of northern Saskatchewan through a more wholistic approach and by working together.

Community Liaison Officer

It was originally intended that each TAC representative would act as a liaison between the project and the health care staff in their organizations and the residents in their communities (i.e., jurisdictions); however, it became evident that the TAC representatives did not have the additional capacity to provide this on-going communications support (e.g., provide overview of NHS, project purpose and objectives, project activities and progress). So, the project coordinator developed a Community Liaison Officer (CLO) position, one for each NHS partner, responsible for communications support to all the TAC representatives within the partner. The NHSWG agreed with this new position; however, they wanted to see the CLO role expanded to include support for the community development component as well. Thus, the CLOs were employees of their NHS organization, receiving direction from the organization, and working in collaboration with the communications coordinator and the community development consultants to support project needs.

Essentially, from the communications perspective, the CLOs provided two-way communication between the NHS and Shared Paths project, and the health sector staff and residents in northern communities. The CLOs shared information about the Strategy, project, and the TAC activities with staff and residents (e.g., one-on-one, radio, meetings), as well as gathered information from staff and residents of interest to the TACs (e.g., PIHTAC community consultations). In addition to facilitating orientation sessions for the CLOs, the Communications Coordinator provided the CLOs with assistance in communications planning, communications materials, etc. Over the course of the project, five CLOs were hired; three in the spring/summer of 2005 and two towards the end of the project, winter/spring 2006. A notable activity of one of the CLOs was the formation of a mini-NHSWG within the region (i.e., KYRHA). This group of TAC representatives met approximately every six weeks with the CLO, the CEO of the health region, and at times, Board Members to discuss TAC activities and progress, recommendations that were developed, and how the work of the NHS fit within the strategic plan of the region. In an effort to build regional partnerships, this

group invited the NHS First Nations organization from the west side of the province to meet as well (i.e., MLTC). Project staff was also invited to attend the meetings. Other CLOs tried to emulate this process within their regions; however, they had difficulty getting the TAC representatives together (e.g., due to competing priorities). With respect to many of the CLOs, particularly those hired towards the end of the project, their role or job description included activities within the region that were outside of the project, e.g., communications, health promotion, primary health care team development, etc. It was anticipated that these CLO positions would be sustainable beyond the life of the project, a legacy perhaps, and in the case of one of the NHS partners this is the case.

NHS Gathering – September 2006

A major communications activity of the project (and the NHS) was the NHS Gathering/Shared Paths for Northern Health Project Finale held in September 2006. This two-day event was an opportunity for all of the project participants (i.e., TAC representatives, NHSWG representatives, NHS Leadership, project staff) and invited field experts (e.g., health care system analyst, community development consultant) to: share and learn about all project activities, findings, and recommendations; confirm next steps within the NHS; learn more about collaborative working relationships and community development through key note speakers; and recognize project participants' commitment and contributions to the project. Feedback from Gathering participants indicated that the event met its stated objectives:

> *Excellent speakers who discussed relevant topics. This gathering gave a clear picture to what NHS has done and what still needs to be done.*

5.3.2 Project Recommendations and NHS Strategic Planning

In terms of recommendations[18] to the NHSWG, the Communications Coordinator suggested the following for sustainability and increased awareness of the NHS and the successes of the project (presented to the NHSWG in August 2006):

- Continue to provide awareness and information to both internal and external requests regarding the NHS;
- Continue the gains of the TACs and Working Group to continue producing materials that support and enhance each committee's specific health promotion;
- Maintain a clearinghouse service for the NHS, including the production of materials to support the NHS and its members and to manage the sharing of these tools; and
- Fully represent the communications of the NHS and NHSWG with a focus on increasing the profile and awareness of the NHS members and its partnership.

Within the NHS Strategic Plan,[15] there is support for a communications/media plan as established within the Shared Paths project. The communications plan is essentially to facilitate the flow of information regarding the NHS to and from all partners, including: NHSWG members; NHS Leadership; co-operating non-health agencies (e.g., education, justice, social services); community and municipal leaders; Saskatchewan universities, colleges, and technical institutes; provincial and federal departments of health; and the general public. However, there is no plan to support the staffing of a communications position, and rather dissemination of information will occur through the NHS Executive Assistant and members of the NHSWG and TACs. Communications will be

supported with briefing notes, slide presentations, handouts, and press releases prepared by the Executive Assistant.

5.3.3 Evaluation Findings

Successes

There were several notable successes achieved within the communications component of the project. The outline of NHS and project resources on page 34 of this report speaks to the efforts of the Communications Coordinator to produce the needed materials to establish and promote the project and the NHS within the partners, northern communities, and general public. In addition to these resources, the Communications Coordinator worked with some of the TACs to produce relevant health promotion materials, which benefited all NHS partners. As an example, the Coordinator supported the layout, edits, and production of the Fluoride Varnish Instructor and Training Manuals (2) for the OHTAC and each NHS partner received copies of both manuals. Although met with its own challenges, the Communications Coordinator, with the support of the project staff and NHSWG representatives, was able to disseminate information about the NHS and the Shared Paths project to a wide audience in the north and within Saskatchewan. Northern residents, health sector staff, municipal leaders, provincial and federal ministers of health, and the general public were provided information via the world wide web, newsletters, press releases, event or conference sponsorship, as well as displays and presentations at conferences, workshops, and meetings of health sector staff (e.g., staff meetings) through to leadership (e.g., Board/Tribal Council Authorities). Furthermore, a media database has been established, which identifies the media outlets available in each northern community, and serves to aid future dissemination of information by the NHS.

The production of informational and promotional material and its dissemination has contributed to the identity and increased awareness of the NHS and the Shared Paths project, not only within northern Saskatchewan but also within Canada. The NHS and the project have been featured in both print and radio, for example, on Missinipi Broadcasting Corporation and Canadian Broadcasting Corporation radio and in the PAGC Tribune and the La Ronge Northerner (see page 35). Both the Communications Coordinator and the Project Coordinator have received requests for information and materials from the general public, as well as those that work within the health care system, from front-line staff to ministers of government departments.

> *I thought the Northern Health Strategy has done a good job of getting its message and getting exposure out there and that speaks to successful communications efforts. Certainly, when I hear of any of the possible integration projects across the country, [individuals] mention the Northern Health Strategy in northern Saskatchewan. So, a good job communicating.*

Finally, the Communications Coordinator worked collaboratively with a number of northern organizations to support the efforts and goals of these groups, as well as to increase visibility of the NHS and the project within the north (e.g., Northern Healthy Communities Partnership; New North; KYRHA Communications Advisory Committee).

Challenges

There were several challenges and areas for improvement identified by the Communications Coordinator, CLOs, TAC representatives, and NHSWG representatives with respect to communications.

Communications Infrastructure

Unfortunately, there is little to no communications infrastructure (e.g., systems, human resources) or experience in the NHS partner organizations; with the exceptions being KYRHA, which has a communications position and advisory committee, and MLTC, which recently hired a communications team; however, this team serves all the Tribal Council Departments, not just Health and Social Development. As a result, the Communications Coordinator spent considerable time at the start of the project explaining the intent and uses of communications, as well as the role of a communications officer. This lack of communications infrastructure and experience in the organizations created challenges with respect to the dissemination of information and communication with the NHS partners, and ultimately, with the communities. It was the responsibility of the Communications Coordinator to inform the stakeholders of project activities, progress, successes, etc. The Coordinator did a good job at communicating with the NHSWG and TAC representatives with respect to the project (and NHS), and encouraged these individuals to share the information within their regions. In the absence of an individual responsible for communications in an organization, the responsibility for further disseminating information about the project (and NHS) within the region fell onto the NHSWG and TAC representatives. As CEOs, Health Directors, and senior managers for their respective jurisdictions, the NHSWG and TAC representatives are busy individuals who do not necessarily have the time needed to do effective communications within the organization. Some TAC representatives reported that their NHSWG representatives were consistent in disseminating information on the project (and NHS) to the region, while many were not.

Communications to the Community

The Communications Coordinator, TAC representatives, and NHSWG representatives cited communications to the community as a challenge and as an area that needed more work. The Communications Coordinator felt that communication to the communities to increase awareness of the Shared Paths project and the NHS was a long-term strategy, limited by the resource and time constraints of the project, as well as its focus on communication to the NHS partners. The bi-monthly newsletters and press releases were aimed at reaching the community, which presented the challenges of: access to the newsletters given that further distribution was the responsibility of the organizations; and coverage of the press releases by the media was not guaranteed. The Coordinator had several suggestions for improvement of the communications strategy with the community, thereby increasing the visibility of the NHS and any future projects in the community, which included: travel to the communities to meet with residents and discuss the project and the NHS via display and presentation; increase the mailing list of those who receive project/NHS newsletters; take advantage of community events to showcase the project and the NHS (i.e., increase networking opportunities); and with a larger budget, increase sponsorships of community events (i.e., paid advertising).

Some TAC representatives felt that the NHS via the project was not effective at communications at the community level, which could potentially limit community buy-in to the NHS and its project(s). As mentioned earlier, it was envisioned that the TAC representatives would act as a liaison between the project (and the NHS) and the community residents they serve. However, it soon became evident that the TAC representatives were too busy to act in this role, with communication of the project (and the NHS) low on their list of responsibilities. Furthermore, they were unsure of what to share. As a result, the PIHTAC decided to produce a bulletin (with the support of the Communications Coordinator) following each meeting that the TAC representatives would then share with the staff and community residents within their regions. The idea of a bulletin was not picked up by the other TACs. In addition, some TAC representatives felt that the newsletter was too detailed and targeted towards those who were engaged in the project or Strategy, and the language was too technical for the community. Some felt that the newsletter may not have been the best way to communicate with the community residents; perhaps, face-to-face community meetings would have been better.

Finally, several NHSWG representatives felt that communication to the community was a challenge and needed some work both within the project and within their own organizations. With respect to the project, some NHSWG representatives thought that communication should have included more than the newsletters, for example, there should have been more use of MBC radio to share highlights of the project and the NHS (in all three languages: English, Cree, Dene). According to one NHSWG representative, the project (e.g., communications coordinator) had a secondary role to the NHS partners in communicating with the northern communities. And the project, via the Communications Coordinator and the CLOs, made a reasonably good attempt at reaching the communities, and getting the information out; however, they were limited in success due to the lack of communications infrastructure within the organizations to communicate effectively with their own communities and to receive advice on what would work best within a particular community. With respect to the organizations, there were attempts by some organizations to inform the community about the project and the NHS, and create buy-in. As an example, one First Nations partner communicated to the communities via their CLO, the Health Coordinators, the Community Health Coordinators, and the Board Members.

Community Liaison Officer

As previously mentioned, the CLO position was created to support communications, particularly communications to the community. Of all the positions created within the project, it was this position that experienced the most challenges with respect to recruitment and retention. For example, individuals hired were reassigned within the organization; left the organization; went on maternity leave; and some organizations were never able to recruit to the position. It was intended that all NHS partners would have a CLO position; unfortunately, only five NHS partners were able to fill this position, with two of these partners hiring in 2006 (one post March 31). Several NHSWG representatives felt that this was an important position, which helped to provide additional capacity to share information related to the project and the NHS within the organizations and with the community, as well as to provide a link between the NHSWG representative and TAC representatives in the organization. However, some NHSWG representatives were disappointed in the lack of accountability of some NHS partners to hire for the position.

The CLOs reported that there was little to no knowledge of the NHS and its project amongst the health care staff and residents in many northern communities at the start of their work. After being in the position for several months, the CLOs were asked what the current knowledge of the NHS and its project was amongst staff and residents, as a result of the information that they were sharing. The CLOs responded that knowledge had increased; however, there was still follow-up needed, particularly in the communities. In terms of successes, the CLOs mentioned: information sharing; production of a newsletter (with the support of the Communications Coordinator); and of course, the mini-NHSWG in the KYRHA. One CLO noted that meeting with the health committees and health coordinators within the organization was a challenge due to competing priorities within the organization and busy agendas. Unfortunately, the CLOs did not have much formal interaction amongst themselves via the project; however, they were invited to attend the last project staff meeting of each month (with variable attendance by the CLOs), and were welcome to attend all TAC meetings (with little attendance by the CLOs). Most interaction amongst the CLOs occurred informally, e.g., phone conversations.

The CLOs were an employee of their NHS organization and were to work collaboratively with the communications coordinator and the community development consultants to support project activities in these areas. Thus, their primary direction was to be received from the organization and their secondary direction was to be received through the project. One TAC representative commented that keeping the CLOs informed and engaged must be challenging. And it would appear from the comments of the NHSWG representatives, that the CLO role within the organization was not as well developed as it needed to be; that more direction should have been provided; and perhaps, redefinition of the role to include responsibility for capacity building with community workers. In addition, minimal direction and support was provided to the CLOs from the Communications Coordinator, that is, not much beyond providing an orientation to the project and regularly updated information to share with the staff and residents within their jurisdictions. Furthermore, the community development consultants did not engage the CLOs beyond assistance in setting up community consultations and providing feedback into the findings. Lastly, there was limited involvement with the TACs; only one of the TACs engaged the CLOs in terms of sharing or gathering information in the communities.

NHS/Shared Paths Project Confusion

According to the Communications Coordinator, communications is a gradual process based on repetition. "Studies show that communications within a single corporation can take up to three years to reliably reach that single audience. This project does not have three years and it has a much more complex group of stakeholders."[18, p. 7] At the start of the project, and well into its first year, the efforts of the Communications Coordinator focused on creating an understanding of and support for the project. These efforts were so successful that the NHS itself became lost within the project; meaning TAC representatives were confusing the Strategy for the project and the project for the Strategy. As a result, an un-branding was needed and communications efforts focused on creating an understanding of and support for the Strategy rather than the project. These efforts included changing project resources, such as the letterhead, website, and logos to reflect first, the NHS and second, the project; and making reference to the project as "Shared Paths for Northern Health – A project of the Northern Health Strategy Working Group." According to the NHSWG representatives, these efforts have worked, as there is now less confusion among staff members.

Another challenge mentioned by the Communications Coordinator was timely production and dissemination of communications and health promotional materials. The NHS adheres to the principles of inclusion and consensus, which at times can cause delays in actions when stakeholders are slow to respond with information, resources or feedback. In addition, fact checking takes time and sometimes contributed to delays.

Internal/External Communications

The Shared Paths for Northern Health project was large in scope with only one communications coordinator. At times, the Coordinator felt that the focus on internal communications activities, i.e., the support provided to project/TAC activities (e.g., health promotional materials) may have limited progress with respect to communications to the partners and northern communities, i.e., the external communications activities. This was particularly true for the second Communications Coordinator, as his responsibilities also included the facilitation of the HRTAC given the resignation of that TAC's Coordinator. However, it was noted by the Coordinator that internal communications also served to increase awareness of the project and the NHS, and it was important to find a balance between both internal and external communications activities. And despite feeling stretched thin at various times over the course of the project, the Communications Coordinator felt that the knowledge and skills available to project stakeholders were not fully utilized given the minimal engagement with some TACs (e.g., MHATAC), and the minimal support they provided to the NHS partners with regards to their organizational communications needs.

Many TAC representatives criticized the project for the lack of TAC interaction and stated that a formal process for sharing information and engaging with the other TACs did not exist. As a result, the TAC representatives were not able to share experiences and felt disconnected with respect to what the other TACs were doing. According to the Communications Coordinator, it was expected that the TACs would work independently of one another and that the website, newsletters, and updates on the project provided by the Communications Coordinator and/or Project Coordinator at TAC meetings would facilitate information sharing among the TACs. In response to TAC representative requests for more interaction, the Communications Coordinator produced monthly TAC reports that included information about the activities and progress of the NHSWG and each TAC, as well as the contact information for the TAC Coordinators. The TAC reports were first produced in May 2005 and shared via email with TAC representatives, NHSWG representatives, and the CLOs. Some NHSWG representatives reported that these TAC reports were also useful in reporting to Board Members and sharing with staff the progress of the project. The TAC representatives would have appreciated an opportunity to connect halfway through the project (e.g., workshop, conference), in addition to the NHS Gathering/Project Finale at the end. This lack of TAC interaction may represent a potential loss in opportunities for collaboration on TAC activities or recommendations to the NHSWG.

The TAC representatives were interviewed three times over the course of the project, and in each interview they were asked specifically about the communication that occurs within their organization around the project and the NHS. Communications activities improved very little over the course of the project for many organizations. In several NHS partners, TAC representatives reported that there was little formal communication about the project and the NHS between themselves and their NHSWG representative or the other TAC representatives. Any communication about the project or the NHS occurred through more informal means, such as asking questions in the hall versus

discussion at a staff or management meeting. Throughout the project, the Communications Coordinator encouraged the TAC representatives and their NHSWG representatives to contact one another on a regular basis to provide and receive updates on the project and the NHS (which was also outlined in the TAC Terms of Reference). In some regions, TAC representatives did not even know who was sitting on the other TACs. They recognized that they could determine who was involved in the project from their region; however, they wanted to stress the point that there seemed to be no cohesion at the regional level with respect to the project and the NHS. In other regions, this was not the case. As previously mentioned, the CLO from the KYRHA formed a mini-NHSWG within the region, which provided a venue for the TAC representatives to come together and get to know one another, as well as apply what they learned from the TAC meetings, and have collective input into the developments of the Strategy within the region (i.e., regional cohesion). The NHS partners that did not hire a CLO were at a particular disadvantage, in that there was no one available within the region to facilitate the meeting, information sharing, and strategizing of TAC representatives. However, in these organizations the TAC representatives suggested that even a conference call every three months to share information between the NHSWG and the TAC representatives would have been appreciated and supported.

On the contrary, communication between the NHSWG and the NHS Leadership, as well as among the Leadership themselves, improved through the Shared Paths for Northern Health project. Having last met as a group in June 2003, the Leadership and NHSWG met four times from May 2005 to April 2006 to receive updates on the NHS and progress reports/recommendations from the Shared Paths project. In addition, the Leadership discussed cross-jurisdictional issues and a mechanism or process for decision-making, and received updates on initiatives of relevance to them, for example, the Aboriginal Health Blueprint. One year into the project an attempt was made to address the weak internal communications between the Leadership and the NHSWG (i.e., build capacity in communications). The NHSWG suggested a "TAC" made up of NHS Leadership, i.e., Board and Council Health Authority members that would work with the Communications Coordinator. The objectives of this committee were to: improve communications amongst the NHS Leadership and to the communities; provide ongoing guidance for communications between all levels of the NHS (e.g., communities, Shared Paths, NHSWG, Leadership); and develop the agendas for the proposed Leadership meetings. Unfortunately, this group, which was termed the Communications Advisory Committee, never got off the ground; only three names were submitted to sit on the committee. Potential reasons included: lack of interest in sitting on this committee or yet another committee in the north, as well as it was thought to be a big expectation of a board member by some. One project participant felt that a committee of this nature was needed.

> *So, to me, the definition of the process should have been, let's help the jurisdictions and the partners attempt a capacity process for communication. And if it incorporates, you have a much easier way of sharing what it is that you're doing as your priorities, which include some of the priorities that are being developed and shared and built at Northern Health Strategy/Shared Paths.*

Sustainability

With respect to sustainability, the Communications Coordinator strongly felt that a communications position within the NHS was required to sustain the gains achieved through the Shared Paths project. Without this position, the responsibility for communications falls on the NHSWG representatives and/or the NHS Coordinator (if one exists). The Communications Coordinator

recognized that all are individuals with many responsibilities, which may potentially limit effective communications with the target audiences.

5.3.4 Summary Statement

Despite the many challenges and areas for improvement identified within the project with respect to communications, the component met its objectives and anticipated outcomes. Through the communications foundation established by the project, the NHS can continue to facilitate the flow of information to and from all stakeholders. One NHSWG representative commented that despite the successes of the communications component of the project, there is still a need to do more in terms of promoting the intent and objectives of the NHS, both within the organizations and externally.

The NHS is guided by four key principles, one of them being communication. The findings of this evaluation point to the need for improvements in the communication of the NHS and its initiatives to both the NHS partners and the communities. Perhaps, some ideas within the project, such as the CLOs, the Communications Advisory Committee, and the mini-NHSWG should be explored further or redefined to enhance the communications infrastructure within the NHS partners and in the north (e.g., establish a contact person in the organizations responsible for communications; determine how to better communicate within the organization and with the public). Given the network being established within the NHS, there is the potential for facilitating the flow of information from the resident in the community or patient in the health care system through to the provincial and federal government representatives responsible for health.

5.3.5 Evaluation Recommendations

Considering the achievements of the Communications Coordinator and the project in the area of communications, such as the increased awareness of the NHS in the north, the province, and Canada, it is recommended that the NHSWG give consideration to including a communications position within its Strategic Plan and request for core funding in order to ensure that project gains will not be lost, as well as to ensure the visibility of the NHS. With other funding secured through special projects, such as Shared Paths for Northern Health, consideration should be given to a second communications position, each with their own set of responsibilities. For example, one position would be responsible for planning and decisions; the other production and dissemination; or one position would be responsible for communication to the external stakeholders (e.g., media, general public); the other internal stakeholders (support for organizational communications needs or development of health promotion materials). If finances to support a communications position are not secured through core or special project funding, the NHS partners should give consideration to shared funding of a position.

In addition, the communications position should develop specific strategies to facilitate communications and information flow between the TACs as they continue to meet; between the TACs and the NHSWG; between the NHSWG and the NHS Leadership; and between the NHS and the communities of the north, utilizing the successes of the Shared Paths project (e.g., mini-NHSWG), as well as other innovative ideas.

5.4 Human Resources

The following table (Table 5 – Human Resources Component Objectives and Anticipated Outcomes) reflects the changes and additions to the project objectives and anticipated outcomes from the project proposal to the implementation of this project component.

Table 5 – Human Resources Component Objectives and Anticipated Outcomes

According to Proposal (October 2003) [1]	
Objectives	• Develop cooperative human resource initiatives (e.g., supporting and retaining primary health nurse practitioners working in isolated primary health care sites in the north); p. 25 • Develop cooperative chronic health conditions management initiatives (e.g., the best approach to training multi-skilled individuals to deliver diabetes, cardiovascular, and other prevention programming) (also facilitated through the work of the CDTAC); p. 25 and • Identify opportunities for involving local people in the delivery of primary health care services (also facilitated through the work of the four PHC TACs). p. 25
Short-term Outcomes	• None stated
Long-term Outcomes	• Training of health professionals will change to include components that support wholistic health, working in team environments, working in the north, and working in multi-jurisdictional environments; p. 27 and • Cooperation in staff recruitment and training of managers and staff to work effectively in a new primary health care environment. p. 27 & 35
According to NHSWG Review (December 2004)	
Objectives	• To identify human resource requirements of all NHS partners and develop (recommendations) strategies to improve: recruitment, retention, education, training; and • To create a capacity building plan within NHS partners related to recruitment and retention issues, and education and training of staff.
The refinement of these objectives further defines human resource initiatives to include recruitment, retention, education, and training, as well as underscores the importance of building organizational capacity through project initiatives, which is one of the deliverables of the project (i.e., organizational transition to enhance the health status of residents of northern Saskatchewan).	
According to Facilitator/Coordinator (April 2005) [12]	
Objective	• To develop and implement plans and recommendations for improvement in the areas of recruitment, retention, training, and education for NHS partners.
Short-term Outcomes	• To increase awareness of human resource issues related to recruitment, retention, education, and training within northern Saskatchewan in the health sector; and • To have a sustainable human resource strategy that may be implemented by NHS partners.

Long-term Outcomes	• To develop 'project champions' in the areas of recruitment, retention, education, and training who can lead and assist in the implementation of human resource recommendations developed; and • To have a sustainable partnership (e.g., HRTAC) and utilize this partnership to implement human resource recommendations and develop new human resource initiatives.

5.4.1 Activities, Outputs, and Outcomes

The HR Coordinator worked with the Shared Paths project from January 2005 to his resignation in December 2005. Within that period of time, the HRTAC held six meetings, the first in May. Following the HR Coordinator's resignation, the HRTAC was facilitated and supported by the Communications Coordinator from January to July 2006 due to its focus on the development of a job and career fair materials kit (see recommendation on page 51). Within this period of time, the HRTAC held five meetings, the last in June.

The HR Coordinator's initial task was to develop a work plan for the human resources project component.[19] Following the development of a work plan, the Coordinator contacted the HR and front-line manager contacts within each NHS partner and funding organization to complete a current state assessment with respect to recruitment and retention, as well as education and training issues in northern Saskatchewan. The HR Coordinator gathered the information through interviews and email correspondence with each of the contacts, as well as site visits to each organization. This current state assessment was completed in June 2005 and it identified several key observations, some of which included:[20]

- Recruitment issues:
  - most organizations face difficulties in recruiting staff to the following positions: nursing (licensed practical nurses, registered nurses, nurse practitioners, advanced clinical nurses), public health inspectors, health records practitioners, dental therapists, social workers, speech language pathologists, combined laboratory and x-ray technologists, physiotherapists, occupational therapists, dieticians, environmental health officers, and physicians;
  - most organizations are unable to offer additional incentives to recruit new staff due to the lack of additional financial resources to invest in recruitment, and some organizations are limited by the collective agreements in place;
  - northern organizations are in competition with urban centres and organizations that can pay higher salaries; and
  - shortages of staff results in higher overtime costs paid to existing staff.
- Retention issues:
  - most organizations face difficulties in retaining staff in the following positions: nursing (licensed practical nurses, registered nurses, nurse practitioners, advanced clinical nurses), public health inspectors, health records practitioners, dental therapists, social workers, speech language pathologists, combined laboratory and x-ray technologists, physiotherapists, occupational therapists, dieticians, environmental health officers, and physicians;

    - most organizations are unable to offer additional incentives to retain staff due to the lack of additional financial resources to invest in retention, and some organizations are limited by the collective agreements in place;
    - northern organizations are in competition with urban centres and organizations that can pay higher salaries;
    - shortages of staff results in burnout of existing staff and often staff resign from their positions; and
    - it is difficult for staff and their families to "fit in" in new and remote communities.
- Education issues:
    - northern students are not taking maths and sciences in high schools;
    - northern students do not have enough awareness of health careers; and
    - challenges accessing post-secondary education such as living away from home and receiving financial assistance limit enrollment.
- Training issues:
    - staff cannot get the days off for training because there are not enough staff to backfill the position;
    - it is costly and difficult to find casual staff in the north;
    - there is little or no money to train staff;
    - high turnover rates increase orientation and training costs;
    - distance education does not allow for all types of training; and
    - there are unskilled or low skilled staff providing services in First Nations communities (e.g., addictions workers); however, some positions would remain vacant if a post-secondary education was an absolute requirement.

In addition to the current state assessment, the HR Coordinator and the HRTAC completed a "cross-jurisdictional exercise" to identify the specific jurisdictional issues with respect to human resources, which emphasized: how recruitment and retention impact access to services in the north; opportunities for continuing education and capacity building; and any recommendations based on the findings. This exercise was requested by the MFN-CAHR to aid in their exploration of jurisdictional issues within the NHS partners, and the development of a cross-jurisdictional decision-making mechanism (see page 19).

The HR Coordinator also conducted an industry assessment (i.e., a literature review) of best practices in human resources, as well as appropriate standards of human resource services. Armed with the information from the current state assessment, the cross-jurisdictional exercise, as well as best practices and standards of HR services information, the TAC was able to analyze the gaps in human resources that exist in the north and began to develop recommendations to close these gaps.

During the initial meetings of the HRTAC, the Coordinator presented the TAC with the recruitment, retention, education, and training issues identified from the current state assessment for collective discussion and prioritization of the issues to address within the TAC work plan. The HRTAC identified various priorities under each topic, which included: a common recruitment strategy for the north; standardization of recruitment incentives (monetary and non-monetary); best practice retention strategies; staff surveys; involvement of staff in the community; a northern casual staff labour pool; job shadowing/mentoring; and a representative workforce.[19]

The HR Coordinator suggested that the TAC prepare a strategic planning document for the NHSWG, which would include each of the prioritized issues, and the HRTAC agreed. The document was to include current recruitment, retention, education, and training strategies or initiatives of the NHS partners, as well as new strategies or initiatives identified through industry assessment and analysis of best practices, and the TAC recommendations would emanate from this work. A similar document produced by the Northwest Territories' Allied Health Care Professionals, Nurses, and Social Workers (Recruitment and Retention Plan, 2002) was used as a template. The HRTAC document contained strategies and initiatives such as: a casual staff relief pool for health care workers; exchange programs for nurses; staff surveys; exit interviews; job shadowing, etc. The HR Coordinator and the TAC worked on this document for several months (entitled Northern Saskatchewan Recruitment, Retention, Training and Education Plan – December 2005 – Draft); however, this document was never completed due to a change in focus of the HRTAC. The document is in need of additional information and revisions to ensure relevance to northern Saskatchewan and the NHS partners. Without a coordinator to assist and complete this document, the HRTAC tabled the plan for future discussion and development post Shared Paths project.

In the preparation of the strategic planning document, the HRTAC identified six areas where potential recommendations could be developed and submitted to the NHSWG. In three of these areas, the TAC discussed the issues and potential solutions; however, formal recommendations were not submitted to the NHSWG, again due to the change in focus of the HRTAC. These three "draft" recommendations were included in the TAC final report[20] as reference to TAC activities, and the following is a brief summary of the discussion and activities relevant to each:

- Community involvement for new staff:[20]
    - The TAC discussed the idea of a community orientation binder for new and relief staff that would include information on: community events/holidays, places of interest, key community members, contact information, etc.
    - The HR Coordinator was to develop a template for the binder.
    - The Communications Coordinator was to support the development and production of the binders.
    - Each NHS partner was to adopt and use if desired.
    - The recommendation did not progress further than the initial planning stage (i.e., a template was not developed).
- Formalizing mentorship procedures:[20]
    - The TAC discussed the idea of formalizing existing mentorship procedures or programs in the NHS partners as a key recruitment and retention strategy for nursing and other professions.
    - The HR Coordinator was to develop the recommendation further with respect to implementation, resources needed, etc.
    - The recommendation did not progress further than the initial idea.
- Childcare services for health care staff:[20]
    - The TAC discussed: the perceived need for childcare services, particularly for those doing shift work; the feasibility of providing childcare services in terms of numbers and finances within the regions; and potential collaboration with other sectors also in need of childcare services for its workers.
    - The TAC decided to conduct a needs assessment to determine if it was a perceived need or actually a reality within the health care system.

- The HR Coordinator developed a survey, which was reviewed and revised by the TAC.
- The survey was distributed to health care staff within the regions via the HRTAC representatives and at the discretion of the NHS partners – February 2006.
- The methods of distribution varied and were dependent on a suitable process for that region (e.g., email, website).
- The completed surveys were returned or forwarded to the NHS office for analysis, which was completed by the Communications Coordinator – March 2006.
- The results were presented to the TAC – March 2006.
- The limitations of the survey included: low number of completed surveys (n=47); response rate could not be determined, as it was not known how many people received the survey (anticipated to not be higher than 25%); sample was not representative of the population being studied, therefore, generalizations could not be made from the findings.
- However, results did indicate that of the 74% in need of childcare services, 68% had access to childcare services, with the majority utilizing unlicensed services and in need of childcare services between 8:00 a.m. and 8:00 p.m., Monday through Friday.
- Given the results, the present uncertainty of financial resources to provide childcare services, and the survey's limitations, the TAC did not develop a recommendation with respect to childcare services for the NHSWG.
- The TAC may revisit the issue of childcare services for health care staff in the future.

Over the course of the project, the HRTAC had several discussions with respect to salary grids and recruitment strategies or incentives in an effort to identify options to narrow the gap that currently exists between the NHS organizations; however, some TAC representatives were reluctant to share this information with the HR Coordinator and the TAC. As a result of this reluctance to share information, a briefing note was prepared by the HR Coordinator and submitted to the NHSWG in November 2005, which asked each NHSWG representative to discuss this issue with their TAC representative and encourage them to share this information with the TAC.[20] From the discussion of this briefing note, the NHSWG decided to hire a consultant to do an environmental scan of northern Saskatchewan and other northern regions in Canada with respect to salary and recruitment/retention incentives. The Saskatchewan Association of Health Organizations (SAHO) was contracted in March 2006 to undertake a market survey for the NHS that would encompass the elements of total compensation (i.e., salaries, benefits, and company policies for unionized and management positions), as well as best recruitment and retention practices particular to northern employers.[20] In addition to the NHS partners, other northern health care jurisdictions in Canada were surveyed. Unfortunately, this study is behind schedule due to the late submissions by several NHS partners. The Project Coordinator has worked with these partners to ensure that their information was submitted to the consultants and included in the study. The results of this study and SAHO's recommendations to the NHSWG with respect to: options for competitive pay practices; successful compensation practices; and successful recruitment and retention practices are expected in September 2006.[20]

Part of the mandate of the HR Coordinator and the HRTAC was to support the human resource needs of the four PHC TACs and the two other support TACs. Unfortunately, the only support

provided was to the PIHTAC with respect to salary information, job descriptions, and human resources in northern areas (e.g., itinerant positions, co-managed positions) in regards to lactation consultants or breastfeeding resource persons. The HR Coordinator also provided some support to one of the NHS partners with respect to salary grids, contracts, and job descriptions for addictions workers and mental health therapists at the request of the organization's Mental Health Supervisor. Finally, the HR Coordinator provided support to a Career Pathing Discovery Session[20] held in La Ronge in November 2005; there were no volunteers from the TAC to help with the planning of this session. Unfortunately, the HR Coordinator and the TAC did not work with the OHTAC or the HIMTAC to address the hard to recruit and retain positions of dental therapists and health records practitioners as identified in the HRTAC's current state assessment.

With respect to sustainability of the HRTAC, the TAC representatives felt that there would be value to continued networking, information sharing, and collaboration on certain initiatives if the NHSWG saw the value, and if the NHSWG agreed to commit to continued meetings of the TAC, in terms of the costs involved such as, costs related to travel, time in travel, no backfilling of the position while at meetings, etc. The TAC would like to do more through teleconference/ WebEx, video conferencing, and email; and only meet face-to-face three to four times per year. The TAC also desired to have a focused work plan with only one or two items to address; and recognized the need for co-chairs to sustain the TAC and its work; however, no volunteers have come forward. It has also been suggested that the TAC evolve into the health sector sub-committee of the Northern Labour Market Committee given that many of the participants are the same and it would create a link between the northern health organizations and the academic institutions in the province; however, this sub-committee currently does not involve First Nations organizations and is focused more on education and training than recruitment and retention issues. This suggestion has been presented to the NHSWG for further discussion and direction, with no decision made as of yet.[20]

5.4.2 TAC Recommendations and NHS Strategic Planning

The HR Coordinator and HRTAC developed and submitted two recommendations to the NHSWG over the course of the project. The first recommendation, presented in November 2005, proposed the provision of bursaries and scholarships to northern students through the NHS and its member organizations.[20] These bursaries and scholarships would be in addition to what currently exists within the organizations (e.g., KYRHA, MCRRHA). Several of the NHS partners do not have programs, policies or funds to deliver bursaries and scholarships (e.g., AHA, MLTC, PAGC). This recommendation suggested that the NHS could solicit donations from government and northern businesses or organizations to support this program. The NHSWG or a subcommittee thereof would have discretion over how much to allocate to bursaries, to scholarships, and for which health care positions, with the total donation distributed equitably amongst the partnership. The NHSWG approved this recommendation in principle and asked that the HR Coordinator proceed with the next steps, bringing back the recommendation to the NHSWG for formal approval. The next steps included: the preparation of a concept paper to be presented to government, businesses, and organizations when requesting donations; the development of guidelines for the bursaries and scholarships process; and a list of businesses and organizations to approach for donations. Unfortunately, the HR Coordinator resigned shortly after the presentation of this recommendation to the NHSWG, and there was no follow up by the TAC. Thus, no progress on the next steps was made.

The second recommendation, also presented in November 2005, proposed that all the NHS partners would be represented by one booth at job and career fairs.[20] A job and career fair materials kit, inclusive of all the NHS partners, would enable all partners to have a presence at many job and career fair events throughout the province. Representing all partners at one booth would save time and money within each organization, as the presenter(s) would be representing their own organization as well as the partners of the NHS, providing potential recruits with information on available positions and health care organizations in northern Saskatchewan. This kit would be housed at the NHS office or a willing NHS partner, and would be available for loan to any partner wishing to attend local or provincial job and career fairs. The NHSWG approved this recommendation and the HRTAC, with the support of the Communications Coordinator, focused their efforts in the last half of the project on the development of the materials. The kit targeted three audiences: youth (K-9), high school students, and post-secondary students. The materials developed included: an 8 foot banner display; PowerPoint presentations for each target audience; information binders containing relevant information for each target audience (e.g., organizational information, positions available in the north, scholarship and bursary information, reasons to work in the north, employee profiles, photos of employees in action); a NHS employment opportunity brochure; and a user's guide and checklist of materials. This job and career fair materials kit was completed in July 2006 and is available for use to the NHS partners.

Within the NHS Strategic Plan,[15] there is support for: health careers promotion utilizing the job and career fair materials developed (i.e., NHS Coordinator to coordinate attendance and representation at events, in the absence of HRTAC co-chairs); review of the compensation study and implementation of recommendations; identifying training needs and collaboration on training initiatives (e.g., nursing, addictions); establishing partnerships with academic institutions (re: training and education issues); and linking with federal and provincial health human resource strategies.

5.4.3 Evaluation Findings

Challenges According to HR Coordinators

There were several challenges identified by the HR Coordinator with respect to the job and the project. The Coordinator recognized his own limitations, acknowledging that he had no prior experience in facilitation and that his presentation skills were weak; however, he did solicit advice and feedback on his performance from the Project Coordinator and other staff, and prepared for each meeting to the best of his abilities. In addition, the HR Coordinator found there to be a steep learning curve in terms of: understanding his role within the project; working with numerous stakeholders; and understanding the roles of these stakeholders (e.g., role of the province, RHAs, First Nations, and the federal government in health care delivery). With respect to the project, the HR Coordinator reported that gathering information from the TAC representatives was challenging in that: there was a lot of information being collected and collated; TAC representatives were busy individuals with little time to gather the needed information; and some TAC representatives were reluctant to share certain information with the Coordinator and/or the TAC. Moreover, the HR Coordinator mentioned that the short timeline of the project was challenging in terms of completing the work, as well as personally challenging in that it represented a lack of job security. As a result, the Coordinator resigned from his position to accept a permanent position with another organization.

Following the resignation of the HR Coordinator, the Communications Coordinator was asked to facilitate and support the HRTAC, primarily because of its focus on the development of a job and career fair materials kit, but also because of: the unlikely-hood of recruiting to such a short-term position (i.e., 3 months); the unlikely-hood of seconding from the partners due to limited capacity within their HR departments; and the TAC representatives and Project Coordinator were too busy to chair the meetings. The Communications Coordinator also identified similar challenges with respect to the job and the project. For instance, gathering information was challenging in that the TAC representatives were often slow to respond or did not respond at all to emails or requests for information put forth during the TAC meetings. The Communications Coordinator spent a considerable amount of time following up with the TAC representatives, primarily via email, in an attempt to ensure that all TAC representatives were aware of the activities and progress of the TAC, and that they had an opportunity to provide feedback and input into the process, particularly for those that were unable to attend TAC meetings. In addition, the Communications Coordinator reported that the short time remaining in the project would potentially limit the development of the job and career fair materials kit; and as a result, the project continued to support the meetings of this TAC beyond March 31, 2006, in order to complete the kit with the best possible results. Furthermore, the Communications Coordinator stated that considerable time was spent on the facilitation of the HRTAC and its follow-up activities, which may have limited progress with respect to the communications component of the project; however, the Communications Coordinator considered both roles to be important and to have contributed to the success of the NHS.

> *A lot of time and effort was put in to ensure that each of these roles was successful and [to be] able to provide support to the NHS members (including the TACs and NHSWG). This included a lot of additional hours and commitments outside of the normal work environment and hours; though I feel that the roles are both important and have contributed to the successes of the NHS. Additional commitments were positive, relevant, and appropriate due to the nature of each role and the demands necessary to achieve positive results.*

Successes According to HR Coordinators

According to both the HR Coordinator and the Communications Coordinator, the successes of the HRTAC and the human resources component of the project included: the current state assessment; the recommendations submitted to the NHSWG; the childcare services needs assessment; the job and career fair materials kit; and (potentially) the total compensation study conducted by SAHO.

Challenges According to HRTAC

The HRTAC representatives also identified several challenges to their work and progress as a technical advisory committee. The HRTAC, like many of the other TACs, struggled with an unclear mandate at the start of the project and well into the project.

> *One of my challenges was…not sure where the group was going from the get go? Not in terms of the group being cohesive or anything like that, but being unsure what the Shared Paths group, the supervisor, the senior level group hoped to get from the HRTAC. And that, I found, made it difficult for us at some points to pick a target…to pick a target where we're trying to go. And had that maybe been defined a little more carefully in the initial phases we wouldn't likely or in my opinion, we would be further along than we are now.*

The TAC also suffered from an ill-equipped Coordinator in terms of the knowledge (i.e., of the north, as well as of the federal and provincial health care systems), and the skills (i.e., in facilitation and being able to "think outside the box," see a broader vision) needed to bring about collective discussion, information sharing, strategizing, and action planning concerning matters related to human resources in the north. Furthermore, the TAC struggled with finding a common ground upon which to begin to work collaboratively, likely due to the fact that the individuals at the table were HR managers, responsible for managing payroll, benefits, etc., and not front-line managers such as nurse managers, responsible for coordinating and providing access to services for northern residents. In addition, some TAC representatives had responsibility for only health human resources (e.g., RHAs), while others had responsibility for human resources for the whole organization (e.g., First Nations partners).

The HRTAC representatives also made reference to the short timeline of the project with respect to group development or relationship building. The TAC representatives expressed that a group needs time to gain trust and build confidence in one another, to set its own direction, and to accomplish tasks or activities in the hopes of meeting stakeholder expectations.

The TAC representatives were busy individuals within their organizations and as a result, there were challenges with respect to attendance at meetings. In the HRTAC, there was a core group of representatives who attended the meetings; however, there was a consistent lack of attendance by several of the NHS partners. In addition, turnover of TAC representatives was noted and in some instances, these representatives were not replaced and thus, there was no representation of those organizations at the meetings. One TAC representative expressed the concern that TAC representatives need to gain knowledge (or skills) from attending the meetings, and feel as though they are contributing to the work of the TAC, so that challenges such as, busy schedules, competing priorities, and travel do not limit attendance.

Finally, travel to attend the meetings was identified as a challenge for the TAC representatives. The TAC consensus was to hold the meetings in Prince Albert; however, travel to the meetings meant that their workload increased due to time in travel (i.e., two days out of the office for a 5 hour meeting), and that there was no one available to backfill the position while they were away from the office, which also created a hole in the management team.

Successes According to HRTAC

Like the other TACs, the HRTAC identified networking, information sharing, and an increased knowledge and understanding of the "other" organizations (i.e., federal, provincial, RHA, First Nations) as successes of the TAC and/or project. The TAC representatives felt that meeting their counterparts in the other organizations, and sharing information, experiences, and ideas specific to human resource issues, as well as organizational information was beneficial in and of itself. In fact, in the absence of a Coordinator, the TAC was still committed to working together.

Given that the TAC representatives had concerns with respect to: their limited progress in the project; the ability of the HR Coordinator to facilitate the process; and the short time remaining in the project (December 2005 to March 2006), the HRTAC decided to narrow their focus in the remaining four months to one or two activities, in order to achieve some tangible results. The TAC changed their focus from completing the Northern Saskatchewan Recruitment, Retention, Training

and Education Plan (i.e., the strategic planning document) and developing additional recommendations to completing the childcare services needs assessment and developing the job and career fair materials kit. The NHSWG supported this change in focus and the TAC considered this change a success.

The TAC representatives also recognized the support provided to them through the project as beneficial and contributing to their progress. For example, in recognizing the need for a course correction, the Project Coordinator supported the TAC in narrowing its focus to one or two activities, which the TAC felt was critical and important to its progress. In addition, the support provided by the Communications Coordinator in facilitating the TAC meetings, following up with the TAC representatives for their input and feedback, and completing the job and career fair materials kit also contributed to the TAC's progress. Furthermore, the TAC cited the input and support of the Executive Assistant of the project as important to its progress, and not to be underestimated. Finally, the TAC representatives appreciated having the provincial government representative at the table, listening to the issues, gaining a better understanding of the north, and hopefully, willing and able to be a better advocate for northern health human resource issues.

A potential success identified by the HRTAC was the total compensation study conducted by SAHO, provided that the findings and recommendations of this study were examined by the NHSWG (or the HRTAC) and efforts were made to level the playing field among the northern health organizations with respect to salary grids and recruitment and retention initiatives.

> *I'm thinking about the salary study that they're going to do, to my mind, that's very preliminary steps. And it would be my hope that when that's done, that it doesn't stop there. I mean, we're entirely different work environments, we're unionized; the First Nations aren't. But if there can be anything where we level the playing field, I think you would always compete somewhat for staffing, but so that you're not upping the ante all the time, just sort of compete with each other, that that would be real progress in working together.*

Northern Health Human Resources Strategy

According to the HR Coordinator, a comprehensive recruitment and retention strategy for the north would have the potential to improve the human resources capacity to deliver services, which would then have the potential to improve the quality of services (i.e., provided by skilled workers) and improve access to services for northern residents, and ultimately, improve the health of these residents. In addition, this strategy would have the potential to decrease workloads and burnout of staff, thereby potentially improving the quality of care provided to the northern residents. Unfortunately, there was no northern health human resources strategy or development plan proposed by the HR Coordinator or the HRTAC. The Recruitment, Retention, Education, and Training Plan (or strategic planning document) was a step in this direction; however, the TAC tabled further discussion and development of this document or plan due to a lack of progress and the short time remaining in the project. Nevertheless, the HRTAC did discuss several initiatives or ideas that could be elements of a northern health human resources strategy, some of which were referenced in the draft of the Recruitment, Retention, Education, and Training Plan. The TAC discussions included initiatives or ideas to:

- narrow the gap in salary grids and recruitment incentives amongst the northern health organizations;
- enhance community involvement of new and relief staff in the communities;

- create a casual staff labour pool for the north to support backfilling for vacation, sick time, and professional development opportunities, and to decrease overtime and burnout in staff;
- get youth and high school students interested in health careers and professionals interested in working in the north through increased visibility at job and career fairs;
- increase mentoring of students in many health care professions;
- support existing and create new scholarship and bursary programs to assist northern residents to receive the training and education needed to work in the north in their desired professions;
- share information about education and training opportunities amongst the partners;
- share educational and training resources amongst the partners;
- share any unused training seats amongst the partners;
- collaborate on education and training activities to reduce duplication amongst the partners; and
- collaborate with academic institutions to bring education and training programs (or facilities) to the north (either whole programs or the first one or two years).

It had been recommended in the interim evaluation report[11] that the HRTAC work plan place more emphasis on education and training issues within the north or the TACs, rather than only recruitment and retention issues, in the remainder of the project; however, the TAC did not do more than discuss education and training issues, initiatives, and possibilities (as briefly outlined above) due to the desire to narrow its focus in an effort to achieve a tangible success and to encourage continued involvement in the project (and beyond March 2006).

Support Provided to Other TACs

It was also recommended in the interim evaluation report[11] that the four PHC TACs identify any support needs and/or ways in which collaboration was possible or needed with the support TACs (e.g., HRTAC) as soon as possible. Unfortunately, there was minimal support provided to the four PHC TACs, and in addition, to the other support TACs (i.e., HIMTAC, ITTAC) in addressing any identified human resource needs. This was a missed opportunity given the individuals and resources brought together through the Shared Paths project.

NHSWG Representative Thoughts

With respect to this component of the project, the NHSWG representatives felt that little progress was made, primarily due to an inexperienced Coordinator.

> *Generally, a poor performance, but I think that is simply reflecting the reality of the partners. Nobody has got a strong human resource capacity within their organizations. So, the people representing their organizations are themselves just overwhelmed with the challenges of trying to recruit, retain, develop staff, and that got compounded by not having a strong staff person.*

Some NHSWG representatives thought that while it may have served to have the NHS partners talk about the human resource issues together; it did not result in a comprehensive set of recommendations or an action plan. If this TAC were to continue, then it would be necessary to

bring in a strong individual to facilitate and coordinate the group. One NHSWG representative thought that perhaps the area of human resources was not appropriate for the Shared Paths project to address.

5.4.4 Summary Statement

Within the human resources component, the project objective and anticipated outcomes were partially met. The focus of the component was primarily on recruitment and retention issues in the north, with minimal focus on education and training issues. The short-term outcome of increasing awareness of human resource issues related to recruitment, retention, education, and training within northern Saskatchewan in the health sector was achieved over the course of the project. Both the current state assessment and the draft strategic planning document (i.e., Northern Saskatchewan Recruitment, Retention, Education, and Training Plan) lay a foundation for the future development of a northern health human resources strategy for the NHS partners. Unfortunately, a sustainable strategy was not developed in the project and there is still much work to be done in this area. Fortunately, the members of the HRTAC are interested in continuing to network, share information, and collaborate on focused initiatives; however, if the TAC was asked to develop a northern health human resources strategy, they would need the support of a competent leader. Nevertheless, with or without such a strategy, the NHS through a collective voice has the potential or ability to influence the larger health human resource strategies within the province (e.g., Northern Labour Market Committee, Saskatchewan Health's Health Workforce Action Plan).

5.4.5 Evaluation Recommendations

In an effort to sustain the work of the HR Coordinator, the HRTAC, and the Communications Coordinator, it is recommended that the NHS partners: utilize the job and career fair materials kit at numerous events throughout the north and the province to encourage northern youth and high school students to pursue health careers, and health care professionals to work in the north; examine the findings and recommendations of the total compensation study and implement the suggestions, where possible and desirable to do so, in an attempt to narrow the existing gap between salary grids and recruitment and retention incentives among northern health organizations; and move forward with the next steps in the pursuit of a NHS bursary and scholarship program.

If the area of human resources is one that the NHSWG continues to pursue collaboratively (via core funding or special project support) through the TAC, then consideration should be given to: identifying a clear direction or mandate for the group; supporting the group with a competent leader; and ensuring the proper representation is at the table based on the intended outcomes of the collaboration, for example, a northern health human resource strategy or focused activities such as, creating a casual staff labour pool or collaboration on education and training initiatives.

5.5 Technical Advisory Committees

The following table (Table 6 – Technical Advisory Committees Component Objectives and Anticipated Outcomes) reflects the changes and additions to the project objectives and anticipated outcomes from the project proposal to the implementation of this project component.

Table 6 – Technical Advisory Committees Component Objectives & Anticipated Outcomes

According to Proposal (October 2003) [1]	
Objectives	• Build on the strengths of the partners to create successful primary health care promotion programming; p. 26 and • Improve health services. p. 26
Short-term Outcomes	• Core standards for health services in the north will be identified and applied; p. 20 • Consensus will be reached on health service gaps and a common definition of core wholistic primary health care services (including quality standards and cultural appropriateness) across all jurisdictions and health care delivery agencies in northern Saskatchewan; p. 27 and • Primary health care plans will have components that include provision for the needs of all northerners (i.e., First Nations, Non-Status, Métis, and non-Aboriginal). p. 26
Long-term Outcomes	• wholistic primary health care services will be established, which involve families, communities, and other agencies; p. 20 • Health teams that support families and communities will be in place; p. 20 • Health teams will include family representatives, community leadership, and non-health professionals as appropriate; p. 20 and • From the point of view of the client, service delivery will be: wholistic, culturally relevant, of high quality, have appropriate services, involve community and family, and will be seamless without regard to jurisdiction. p. 27
According to NHSWG Review (December 2004)	
Objectives	• To establish technical advisory committees representative of all NHSWG partners with the mandate to develop and implement recommendations for the improvement of primary health care delivery within northern Saskatchewan in the identified priority areas (i.e., mental health and addictions, chronic disease, perinatal and infant health, oral health); and • To improve access to health care services for residents of northern Saskatchewan within the identified priority areas.
The refinement of these objectives further defines the mandate of the TACs, identifies the priority areas of health for which TACs will be established, and identifies access to health care services as an important issue in the north.	
According to Facilitator/Coordinators (April 2005) [12]	
Objective	• To develop and implement plans and recommendations for the improved cooperation, coordination, and collaboration of primary health care services within four targeted areas of health for the residents of northern Saskatchewan.

Short-term Outcomes	• To have a common definition of culturally appropriate core primary health care services in targeted areas of health for northern Saskatchewan; and • To build a framework for the integration of core health service delivery for the north.
Long-term Outcome	• To have sustainable partnerships within targeted areas of health that are multi-disciplinary, inter-jurisdictional, and inter-sectoral that will continue to support and work together beyond the life of the project.

According to the TAC Terms of Reference, the TAC was established to:

- provide a forum for collective discussion, information sharing, strategizing, and action planning concerning all matters related to mental health and addictions (or chronic disease, perinatal and infant health, oral health); and
- develop and implement plans and recommendations which will improve the mental health and addictions (or chronic disease, perinatal and infant health, oral health) outcomes for residents living in communities represented by the members of the NHSWG.

As such, each TAC was assigned five tasks:

- Develop a description of the current state of mental health and addictions (or chronic disease, perinatal and infant health, oral health) services provided to residents within the geography of the NHSWG.
- Determine appropriate standards of care and services.
- Develop core lists of services.
- Analysis of gaps or weaknesses in service.
- Develop recommendations around prevention, promotion, and treatment services that will improve the mental health and addictions (or chronic disease, perinatal and infant health, oral health) outcomes for residents.

5.5.1 Mental Health and Addictions TAC

5.5.1.1 Activities, Outputs, and Outcomes

The MHATAC Coordinator worked with the Shared Paths project from November 2004 to November 2005 when their position was terminated. A second Coordinator was hired to assist the MHATAC from December 2005 to March 2006. There were sixteen meetings of the MHATAC over the course of the Shared Paths project, with the first meeting facilitated by the Project Coordinator in October 2004. An Elder attended each MHATAC meeting and provided feedback and direction relevant to the meetings' discussions.

It should be noted that the MHATAC struggled with the completion of its tasks under the direction of the first TAC Coordinator. As such, the TAC essentially "started over" with the assistance of the second TAC Coordinator, striving to complete an 18-month project in 4 months.

Priority Areas to Address

In November 2004, the MHATAC identified the areas of: child and youth services; substance abuse; and access to professional services (e.g., psychological or psychiatric services) in which to focus its recommendations for improved health service delivery and ultimately improved health outcomes for residents of northern Saskatchewan.[2] Over the course of the project, the MHATAC engaged in several discussions with respect to the TAC work plan, that is, what will the TAC specifically address within the three priority areas, as well as who will do the work, what are the resources needed, and timeline. Initially, the MHATAC discussed work plan items within the three priority areas; however, the TAC soon began discussing broader work plan items, failing to: align these items specifically within a priority area; concede on which items should be addressed by the TAC; and therefore, failing to make progress within any of the three priority areas. All the work plan items discussed by the MHATAC were important and relevant for one or more of the three identified priorities, and examples included: provide a process for communities to evaluate and implement their ideas for addressing mental health and addictions issues; develop a treatment model that is based on best practices and that is conducive to the needs of the north; develop staffing standards and core competencies for human services professionals in the communities; update policies and procedures manuals; identify professional development plans and training initiatives; clinical supervision; case management; discharge planning; follow-up or aftercare treatment; and community crisis protocol. The MHATAC struggled with the development of their work plan over the course of the project, and in November 2005, the TAC still did not have a definitive work plan identified within each of the three priority areas. Aware of the MHATAC's frustration with the lack of progress, the Project Coordinator attended the November TAC meeting to work with the TAC Coordinator and the MHATAC representatives to determine work plan items in which to focus energies and develop recommendations for the remaining five months of the project. At this meeting, the MHATAC formed three subcommittees, each responsible for determining work plan items and potential recommendations in one of the three priority areas; however, these subcommittees were discontinued in January 2006. As previously mentioned, the TAC "started over" in the remaining four months of the project, and ultimately, their work plan consisted of the five assigned tasks, which included: develop a description of the current state; develop a core list of services; analyze gaps and weaknesses in services; determine appropriate standards of care; and develop recommendations. This work plan was achieved through the collaborative efforts of the second TAC Coordinator and the MHATAC, collating the information previously collected with the new information collected.

Current State Assessment

The first TAC Coordinator completed an environmental scan of mental health and addictions resources and services delivered by the NHS partners in December 2005 (via site visits and interviews with the TAC representatives). This current state assessment included information related to full-time equivalents, caseloads, job descriptions, community services, etc. In addition, the MHATAC completed a spreadsheet prepared by the Saskatchewan Health representative on mental health, mental health services, and addictions, in order to further substantiate the information collected by the TAC Coordinator, as well as the recommendations that the TAC would develop. The MHATAC also collected prospective information on new clients over a period of six months (i.e., April 1 to September 30, 2005). The current state assessment was revisited with the second TAC Coordinator (January to March 2006), utilizing the same spreadsheet due to an inability to

collate the information previously collected. The MHATAC found that there were many gaps in terms of the data that is available on mental health and addictions in the north. For instance, information about service outcomes is totally lacking, and the extent to which information is available refers mostly to the number of staff, number of clients, number of clients served within a time period, etc. Regardless, the key findings of the current state assessment were:[21]

- there are serious mental health and addictions problems in the north, based largely on anecdotal evidence, which include: addictions to alcohol, nicotine, illicit drugs, prescription drugs; trauma related to abuse which occurred in residential schools; relationship problems and violence or (physical, sexual, emotional) abuse of children, women, spouses, elders; and suicide; and
- limited resources exist for individuals working in MHA, particularly in terms of training opportunities, isolation, limited access to specialized consultation and support, limited technology, jurisdictional issues, and communication difficulties.

Standards of Care, Core Services, Analysis of Gaps

The first TAC Coordinator researched best practice information, standards of care and services, and community resources, supports, and services that work well in northern Saskatchewan. From the information collected and the current state assessment, the TAC Coordinator analyzed the gaps and weaknesses in mental health and addictions programs and services in the north. Unfortunately, the identification of core services and the analysis of gaps and weaknesses had to be revisited by the second TAC Coordinator with the MHATAC, again due to an inability to collate the information previously collected. The MHATAC defined core services as, "services which are important, if not essential, to assist the people of northern Saskatchewan to experience good mental health and to live free of addictions."[21, p.10] The MHATAC identified these core services in three levels: those which need to be available in each community; those which need to be available in each region (i.e., each area which is served by a regional health service organization); and those which need to exist within the province and be available to the people of the north. These core services were identified across the continuum of care: promotion, prevention, early intervention, crisis intervention, long-term healing, and rehabilitation. In a similar fashion, the MHATAC provided an analysis of where gaps and weaknesses exist in terms of mental health and addictions services. To see further information regarding core services and gaps in services in northern Saskatchewan refer to the MHATAC Final Report.[21] Finally, the MHATAC discussed and identified three types of standards that would guide the provision of mental health and addictions services: ethical standards, which various groups, including professional regulatory bodies have established for their members to follow; legal standards established in common law and statute law relevant to health services; and administrative standards established by organizations to guide the conduct of staff.[21]

Community Involvement

The MHATAC struggled with how to best involve the community or get community input into its work. The debate within the MHATAC ranged from the TAC representatives being knowledgeable and experts on what is happening and needed in the community, and therefore representing the community, to the need for a process that involves community (e.g., community consultations) and does not impose the "experts' " (i.e., TAC representatives) views of what the community wants or needs. Some TAC representatives felt that a community development philosophy should be integrated into the work of the TAC, while others felt that to work more directly with the

community was not necessary and furthermore, would slow down the process and the project had a short timeline as it was. At a meeting in November 2005, the Project Coordinator explained to the MHATAC that they work in and with the community everyday through their work, and the intent of the TAC was to determine how to collaborate to deliver services that are accessible within the community. As a result, the MHATAC did not involve the community outside of the input and direction provided by the Elder at each TAC meeting.

5.5.1.2 TAC Recommendations and NHS Strategic Planning

The MHATAC originally identified the areas of child and youth services; substance abuse; and access to professional services (e.g., psychological or psychiatric services) in which to focus its recommendations; however, the eight recommendations submitted to the NHSWG in the MHATAC Final Report spanned a broad range of areas. The MHATAC Coordinator presented these recommendations to the NHSWG in June 2006; however, the recommendations have not been formally discussed or approved by the NHSWG, and therefore, no implementation has occurred.

The first recommendation developed by the MHATAC addressed the determinants of health. More specifically, the recommendation was to "develop partnerships involving all sectors – political, economic, health, education, social services – in the north to collaborate in creating healthy environmental, economic, and social conditions in which children are loved, nurtured and protected, young people have opportunities to learn and grow, adults work and are well rewarded for their labour, elders are respected and share their wisdom, friends share each other's happy and sad times, people know and care about each other, there is room for everyone, everyone belongs, has a sense of purpose in life and has hope for the future."[21, p.16] Essentially, this recommendation is cognizant of the fact that many of the communities in northern Saskatchewan face social, environmental, physical constraints in pursuing wholistic health. Some of these constraints include: lack of clean water; contaminated foods; isolation; poverty; inadequate housing; misuse of systems (e.g., medical transportation); the over-use of prescription drugs; high rates of injury; family problems and violence; and rapid urbanization. The ultimate objective of this recommendation was to have all sectors – education, health, justice, etc. – working towards creating/supporting healthy communities that foster positive mental health and a life free of addictions. The implementation strategy proposed by the MHATAC for this recommendation was not well-defined (i.e., no action plan) and needs to be further developed.[21]

The second recommendation developed by the MHATAC was to "strengthen the capacity of families and communities to nurture, care, and support children and youth, and develop an adequate system of mental health and addiction services for children, youth, and families who are experiencing social, emotional, and behavioural problems."[21, p.16] This recommendation was considered quite important, as the proportion of the population that is under 18 is much higher in the north than in the south. Furthermore, due to a lack of opportunities, a large proportion of young people in the north feel hopeless and suffer from emotional and social problems, which often leads to problems with addiction. In addition, most professional mental health and addictions services are directed at adults. The objective of this recommendation was to develop a long-term strategy for children, youth, and families in which available resources were re-oriented to children, youth, and family; capacity was created within existing resources to be responsive to the needs of children, youth, and family; and there was greater coordination of services to children, youth, and family. The

implementation strategy proposed by the MHATAC for this recommendation was not well-defined and needs to be further developed.[21]

The third recommendation developed by the MHATAC addressed human resource development. More specifically, the recommendation was to "prepare a long-term human resource development strategy aimed at enhancing the capacity of people within communities and within local, regional, and provincial agencies to promote wholistic health and well-being, to prevent disorder and distress, to intervene promptly when problems arise, to help people through crises, to facilitate long-term healing, and to rehabilitate persons who suffer from long-term disabling mental disorders and addictions."[21, p.16] The MHATAC determined that qualified and committed human resources are severely lacking in many northern communities. As such, there needs to be committed northern people interested in making their careers in the north to provide leadership, to teach and model wholistic health, and to provide professional assessment and treatment services for individuals suffering from mental disorder, distress, and addiction. The objective of this recommendation was to create a strong capacity to provide core services within the communities, the region, and the province through training more First Nations and Métis people, and developing effective recruitment and retention strategies to attract qualified professionals to the north. The implementation strategy proposed by the MHATAC for this recommendation included the formation of a Human Resource Development Working Group among the NHS partners (offshoot of the HRTAC) mandated to develop and implement a long-term human resource development strategy (some suggested actions provided in the recommendation).[21]

A fourth recommendation developed by the MHATAC addressed access to professional services. More specifically, the recommendation was to "engage all providers of professional mental health and addictions services – RHAs, Tribal Councils, First Nations, community-based non-profit agencies, independent practitioners, others – and regulatory and funding bodies (Saskatchewan Health, Health Canada, professional regulatory organizations) in joint planning and development aimed at providing an adequate array of professional services to the people of the north using telehealth, mobile teams, specialist consultants, and centre-based services."[21, p.16] This recommendation grew out of the fact that residents of northern Saskatchewan are largely underserved by mental health and addictions professionals. In addition, professional personnel in the north generally have less training and experience in their roles than their counterparts in the south. As such, many of the professionals actually based in the north are generalists, and specialists only visit infrequently from the south. The MHATAC encouraged the following principles to be followed when developing professional mental health and addictions services: service based on need; equal access; focus on early childhood, as well as youth and families; multi-disciplinary; and locate professional services as close as possible to the people who need them. The implementation strategy proposed by the MHATAC for this recommendation emphasized the creation of teams; the enhancement of the capacity of professionals based in the north; and the utilization of telehealth and related distance technologies directed at community, regional, and provincial resources.[21]

The fifth recommendation developed by the MHATAC was to "seek commitments from all partners in the NHS to work together: a) in teamwork for clients; and b) in collaborative planning and development of services and systems; by exchanging information, developing protocols and procedures for meaningful coordination, and eliminating barriers wherever possible with due regard for rights and interests of clients, and with due respect for the different jurisdictions of the partner organizations."[21, p.16] This recommendation grew out of the recognition that most of the agencies responsible for health services in the north work in isolation; however, the NHS has brought mental

health and addictions service providers together, providing a unique opportunity to work together and create a synergistic relationship. The implementation strategy proposed by the MHATAC for this recommendation was directed at teamwork for individual clients, which might entail creating teams of professionals or working across jurisdictions; and at collaboration among systems, which might entail developing protocols for inter-agency collaboration and also developing linkages with other sectors such as education, social services, justice, recreation, etc.[21]

The sixth recommendation developed by the MHATAC was to "develop a common standard electronic system to collect, manage, and utilize mental health and addictions information."[21, p.16] As discovered in the current state assessment, most of the information currently available to providers of mental health and addictions services is incomplete, lost, and/or never utilized for quality control, management, planning, or research purposes. Currently, the collection of health information in the north is largely paper-based; however, the RHAs utilize the mental health information system of Saskatchewan Health, an electronic database. There is no common electronic information system for mental health and addictions information in the north. According to the MHATAC Coordinator, this is an opportune time to bring all stakeholders together to develop a system for collecting, managing, and utilizing mental health and addictions information with due respect for the rights of individuals and due regard for legal and ethical standards of confidentiality and the release of information. The implementation strategy proposed for this recommendation consisted of the MHATAC working in conjunction with the HIM and IT Coordinators/TACs to develop the collective requirements for the electronic management tool.[21] Unfortunately, this did not progress beyond an initial needs assessment due to MHATAC representative concerns surrounding privacy and confidentiality of client information, access to information, as well as whether to focus on common data elements between jurisdictions or a common system for the north.

A number of discussions occurred during MHATAC meetings surrounding policies and procedures, which led to the development of the seventh recommendation to "engage all partners in the NHS to work toward a coherent set of program policies and procedures related to mental health and addictions services which involves: a) existing policies and procedures which are common to all member organizations; and b) new policies and procedures which need to be developed to enhance services to northerners."[21, p.16] While most agencies delivering mental health and addictions services have some written policies and procedures, these documents are usually incomplete and/or not comprehensive. The NHS represents an opportunity to share existing policies and procedures among the organizations and to collaborate in the development of new policies and procedures that would raise service standards and enhance inter-agency collaboration.[21]

In collaboration with the CDTAC, the PIHTAC, and the OHTAC, the MHATAC developed and submitted a joint recommendation to engage all of the NHS partners "in developing an action plan to implement an integrated health promotion strategy, both collectively and within each partner organization, as an essential component of primary health care."[21, p.17] Health promotion actions generally encompass: building healthy public policy, creating supportive environments, strengthening community action, and developing personal skills. Furthermore, health promotion is a critical component of primary health care. Currently, there is very little funding allocated to health promotion activities in the north, there is also a lack of educational resources and personnel, and there is a need for broad and active participation in health promotion initiatives, such as the Northern Healthy Communities Partnership. For further elaboration on this recommendation see page 70.

Within the NHS Strategic Plan,[15] there is support for improving mental health and addictions outcomes for residents of northern Saskatchewan through establishing an addiction/mental health strategy which would include: education, professional development, and access to professional services, as well as the further development and implementation of the TAC recommendation on a child, youth, and family strategy.

5.5.1.3 Evaluation Findings

Success and Satisfaction Indicators

The satisfaction indicators determined by the MHATAC in November 2004 included:

- Find an overall strategy of building capacity within the community to address the issue that the community defines as number one.
- The committee identifies a small list of practical areas in mental health and addictions services where a re-distribution of resources can make a positive impact on the quality of services.
- Front-line workers from different jurisdictions can participate in some training or at least some information sharing sessions (e.g., relapse prevention, trauma, sexual abuse, one case management model and process).
- There is mutual respect in the group.
- We are able to identify issues specific to at least 8 communities in the northern service area.

The MHATAC reviewed these satisfaction indicators in July 2005 and then again in March 2006. As of March 2006, the MHATAC had not achieved the first indicator of building capacity within the community. The MHATAC did not create a strategy or process for community development and felt that this was an overly ambitious indicator chosen at the outset of the project. The second indicator of identifying a list of practical areas for redistribution of resources has also not been met as of March 2006. The MHATAC has identified resources, which is a good foundation for determining what resources and how to best redistribute these resources to improve the quality of mental health and addictions services. The recommendations of the MHATAC (e.g., information management and technology; coordination, collaboration, teamwork) may also facilitate an equitable redistribution of resources. The third indicator of front-line workers participating in cross-jurisdictional training has also not been met; however, the groundwork for this indicator has been laid, with the MHATAC engaging in information sharing and posing ideas for collaborative training. Finally, the two indicators of mutual respect and identifying issues specific to communities in the north were met by the MHATAC.

The success indicators determined by the MHATAC in November 2004 included:

- The committee can produce a report which provides a small number of practical recommendations to impact the quality of mental health and addictions services, with work plan (e.g., re-distribution of resources).
- The partners at the table can demonstrate at least two projects where better coordination or delivery of services has occurred in tangible ways (i.e., better case management demonstrated through the use of a similar model of case management; better follow-up

of clients who are discharged from inpatient alcohol/drug treatment; training that gives workers some very practical skills that can be transferred to clients and their families).

- Approaches to mental health are well integrated with approaches to social, economic, and health issues both systematically and for individual clients.
- There is an identified strategy that defines service delivery standards for mental health and addictions services for the north.
- Anyone living anywhere within the north will have clear and timely access to helpers of a mental health nature (counselors, etc.). Access will be to both comprehensive assessment and intervention.

The MHATAC also reviewed these success indicators in July 2005 and then again in March 2006. The first indicator of producing a report with a small number of recommendations was achieved in April 2006 when the MHATAC Final Report was submitted to the NHSWG. The second indicator of demonstrating two projects where better coordination or service delivery has occurred was not achieved, although it could likely be achieved if the MHATAC continues to meet in the future. The third indicator of a well-integrated approach to mental health was not achieved, mainly due to its ambitious nature. The timeline of the project was too short to achieve this all-encompassing indicator, although it could be achieved on a case-by-case basis in a shorter period of time. As for the fourth indicator, the MHATAC has identified ethical standards, legal standards, and administrative standards; however, the TAC has not determined what constitutes appropriate standards. This particular indicator could be a potential work plan item. Finally, the fifth indicator of improving access to services was also quite ambitious, and was not achieved over the course of the project. The intent of improving access to services will need to continue to be a priority for the TACs and the NHS post Shared Paths project.

Successes

The MHATAC representatives agreed that the concept of the Shared Paths project was a positive one. As a result of the project, MHATAC representatives have: met their counterparts in the other northern health service organizations; created and built relationships; shared information, experiences, and ideas; and gained a better understanding of how the "other" systems work (e.g., provincial, RHA, federal, First Nations). The MHATAC representatives also identified as successes the fact that: the TAC was able to identify commonalities and agreed on issues to address as a TAC; the TAC was able to produce a final report with recommendations; and there was some cohesiveness within the group, and a willingness to collaborate outside of the project among some of the NHS partners.

Challenges

Unfortunately, the progress of the MHATAC was often stalled and did not meet expectations. Initially, the MHATAC identified the three priority areas to address within mental health and addictions, and set out to perform the tasks identified in the overall work plan such as, the current state assessment, determining appropriate standards of care, developing core lists of services, and an analysis of gaps and weaknesses in services. The MHATAC was diverted from the tasks at hand on several occasions, mainly due to the fact that the mandate and the process to be followed were unclear to the MHATAC representatives, particularly at the start of the project. This uncertainty persisted as the first TAC Coordinator was unable to provide clear direction and adequate support

to the MHATAC. The MHATAC representatives reported that they sometimes left TAC meetings feeling frustrated with the lack of progress and seemingly no sense of direction. The MHATAC representatives felt that things turned around in the November 2005 meeting with the guidance provided by the Project Coordinator, and that there was some sense of direction with the second TAC Coordinator. Nevertheless, the MHATAC had concerns that they would be able to deliver a quality product to the NHSWG, as now they were trying to accomplish all of the tasks of the project with only four months left. According to a NHSWG representative, the MHATAC struggled with strong personalities, which also stalled its progress; although this is a normal phase of group development. Besides, the (first) TAC Coordinator was not proficient and was unable to overcome these personality issues.

> *It just never went anywhere. But I do know that the group members … I did have calls from a couple of the group members, which I passed on, and they kept talking about how people weren't working on the project. They were just doing their own thing. And it was, 'come hell or high water, you are not going to move me off my topic,' you know. I was disappointed in that and I think it was because of the leadership.*

Similar to the other TACs, the MHATAC faced common challenges such as the regular attendance of TAC representatives at meetings. The MHATAC representatives felt that there was not a consistent level of commitment from some of the NHS partners, which sometimes inhibited progress. In addition, there was also difficulty in getting a large group together consistently due to the workloads of these individuals in their organizations. The MHATAC representatives also thought that the timeline of the project was too short to accomplish anything substantial (e.g., set direction and do solid work or work through the phases of group development). Consistent with findings from the other TACs, members of the MHATAC reported that formal communication within their organizations regarding the NHS and the Shared Paths project was lacking. Furthermore, they were much too busy in their own positions to properly promote the NHS and the project. In addition, MHATAC representatives were dissatisfied that there were no formal means of communicating or interacting with the other TACs.

Sustainability

In terms of sustainability, the evaluation focus group with the MHATAC representatives determined that the MHATAC seemed to agree that they would not continue meeting after the completion of the Shared Paths project. However, one MHATAC representative suggested that this large group could break into smaller groups, perhaps, regional groups to work on the issues; and all the NHS partners could gather once or twice per year to share progress, plans, ideas, etc. Furthermore, the MHATAC felt that if it was to continue meeting there needed to be clarity as to why and it would be beneficial to hold a strategic planning session. Furthermore, there would need to be commitment on behalf of the NHS partners to allocate staff time to meet, and compensation for costs related to attendance. Finally, a qualified coordinator would be needed.

These findings somewhat contradict the discussion on next steps toward a sustainable process of development and "preliminary ideas for possible collaboration" presented by the TAC Coordinator in the MHATAC Final Report. The Final Report states that the MHATAC sees itself as "having key roles to perform in implementation;" and is "prepared to become an action group, instrumental in continuing the dialogue, seeking practical ways of working together in areas in which the NHSWG is prepared to proceed;" and "proposes to embark on the next phase, moving from advice to

action."[21, p.18] The TAC Coordinator also states that: the MHATAC would be interested in meeting once or twice each year to exchange ideas, share reports and plans, and to develop projects for joint action; the NHSWG could name representatives to working groups charged with working towards implementation of the recommendations; and to be practical, the group would need the support of a qualified coordinator.[21]

5.5.1.4 Summary Statement

The progress of the MHATAC was inhibited by a number of challenges, largely poor facilitation and coordination, personality issues within the group itself, and even ideological divides and jurisdictional discussions that result when these two disciplines are brought to the same table. The experiences of this TAC highlight the need to: hire qualified individuals; provide facilitation training at the start of a project; and also the need for performance reviews. Despite the challenges experienced, the MHATAC was able to produce a current state assessment, a list of standards, a list of core services, an analysis of gaps and weaknesses, as well as several recommendations. However, due to the fact that these outputs were produced near the end of the project, implementation of the recommendations has not occurred and will be challenging. Furthermore, the next steps have not been formally determined.

5.5.1.5 Evaluation Recommendations

As stated in the MHATAC Final Report, the TAC representatives are interested in continuing to meet once or twice a year in the future. Given the importance of mental health and addictions in the north, the NHSWG needs to give consideration to the next steps for the MHATAC. For example, will it remain a TAC with a north-wide focus or will the needs be better served with regional partnerships? The NHSWG should also seek input from the MHATAC representatives with respect to this decision. In addition, the NHSWG should formally review, discuss, and approve the recommendations developed and submitted by the MHATAC, in a fashion similar to the other TACs. These recommendations also need to be prioritized by the MHATAC or the NHSWG, and detailed work plans need to be created for the recommendations that are of high priority.

5.5.2 Chronic Disease TAC

5.5.2.1 Activities, Outputs, and Outcomes

The CDTAC met fourteen times over the course of the project and held one meeting following the project's end date of March 31, 2006. The CDTAC identified the areas of diabetes mellitus and cardiovascular disease in which to focus its recommendations for improved health service delivery and ultimately improved health outcomes for residents of northern Saskatchewan.[2] Originally, the TAC also wanted to address: cancer; respiratory illnesses; arthritis and disabilities; and chronic infectious diseases (i.e., Hep C/HIV); however, the short timeline of the project only allowed for the CDTAC to address diabetes mellitus and cardiovascular disease.

Current State Assessment, Core Services, Analysis of Gaps

The CDTAC and its Coordinator completed a current state assessment in June 2005 of both diabetes and cardiovascular disease management practices and services within each NHS partner with respect to various promotion, prevention, and treatment criteria. This current state assessment included information related to: the modifiable risk factors for diabetes and cardiovascular disease, such as healthy eating, active living, and substance use/abuse; health promotion strategies within schools, work places, and confectioners; screening tools; access to diagnostic tests; access to specialist services; management of complications; rehabilitation supports; etc. Furthermore, the TAC Coordinator researched best practice information, as well as standards of care and services with respect to the management of these chronic diseases. In addition, the CDTAC formed a subcommittee to: examine the diabetes clinical practice guidelines; discuss the core services and standards of practice as identified in the clinical practice guidelines in relation to the current services and practices within the NHS partners; as well as develop some preliminary recommendations, and bring all this information back to the CDTAC for further discussion. In September 2005, the CDTAC developed a core list of services and completed a core services mapping exercise, indicating where these core services were available in the north (at the bequest of MFN-CAHR to aid in their exploration of northern cross-jurisdictional issues). These activities revealed that a number of challenges remain in terms of accessing chronic disease services, which included:

- lack of timely access to a diabetes team, which would consist of a Registered Nurse/Diabetes Educator, Registered Dietician/Diabetes Educator, and Physician;
- lack of consistent use of practice guidelines and flow sheets;
- lack of planned screening services;
- minimal patient support and rehabilitation groups;
- current patient registries and planned follow-up care are lacking;
- access to specialists is difficult; and
- ongoing local support for client and professional education is minimal.

For further information regarding the current state assessment, the list of core services, and/or the core services mapping exercise refer to the CDTAC Final Report.[22]

Northern Chronic Care Coalition

Given the results of the current state assessment, the core services mapping exercise, and the work of the subcommittee, the CDTAC suggested to the NHSWG in November 2005 that an efficient

means of addressing chronic disease in the north in the face of human resource constraints would be through the creation of a Northern Chronic Care Coalition (NCCC).[22] A Coalition strategic planning session was held February 28 and March 1, 2006 in Prince Albert. The purpose of the session was to look at options available in creating a network to advance chronic disease management. At this session, a charter, work plan, budget, and logic model were all prepared in draft form. The Coalition is to be structured in two phases and will be in agreement with the components of the 'Expanded Chronic Care Model' (Barr, et al.). During Phase I, the Coalition intends to focus on the Health System components of the Chronic Care Model, involving Elders, clients, and practitioners from northern communities, agencies, and jurisdictions. The components include: self-management and personal skill development; delivery system design; decision support; and information systems. Once the Coalition is more formally established (after 1-2 years), Phase II will occur and membership will expand to include wider community representation. Activities under this phase will encompass the Community components of the Expanded Chronic Care Model, including: strengthening community action; creating supportive environments; and building healthy public policy. The CDTAC views the Coalition as the means by which to continue their work of improving the health status of northern residents. As such, the CDTAC feels that a letter of intent should be prepared and submitted to funding agencies. For further elaboration see TAC recommendations on page 70.

Patient Self-Management Program Training

The CDTAC sought to train lay leaders of peer support groups for a chronic disease patient self-management program (Living a Healthy Life with Chronic Conditions), as patient self-management is an important component of the Expanded Chronic Care Model.[22] In February 2006, the NHSWG approved expenses for this training initiative and identified two individuals from within their region to participate in the four-day training session held in May 2006 in Prince Albert. Each NHS partner is responsible for sustaining this initiative beyond the Shared Paths project and supporting these trained lay leaders who have committed to delivering the chronic disease patient self-management program two times within their regions over the next year. In addition, the Project Coordinator recommended that this program is expanded to others within the regions and in the north, suggesting that a second training session be held.

Linking with other Initiatives/Community Involvement

The CDTAC also felt it was important to be aware of and to be linked to other chronic disease initiatives occurring throughout the province. As such, in April 2005, the CDTAC invited the Health Quality Council to present on their Chronic Disease Management Collaborative.[22] As a result of this presentation, the CDTAC advised the NHSWG that participation of all NHS partners in this collaborative would benefit chronic disease services in the north. Consequently, several of the NHS partners participated in the Health Quality Council's Collaborative (i.e., KYRHA, MCRRHA, KTRHA, AHA) and these partners were supported by the CDTAC Coordinator in their participation, particularly those that did not hire Collaborative Facilitators. Unfortunately, this Collaborative was directed towards the RHAs, although the Health Quality Council encouraged the participation of the First Nations NHS partners via partnerships with the RHAs. In addition, in May 2005, the CDTAC invited Saskatchewan Health to present on the Western Health Information Collaborative Chronic Disease Management Infostructure Project.[22] This project involved the four western provinces in the development of an innovative and sustainable chronic disease management "infostructure," which included the creation of standards for chronic disease data and information

exchange, with the capacity to share this information across systems and jurisdictions in support of clinical decision-making. Unfortunately, there had been no real northern representation in the project in the early phases. The CDTAC, along with the IT Coordinator and the HIM Consultant recognized the importance of this initiative and jointly recommended that the NHSWG seek representation and participation in the project so that the unique needs of the north were met (see next page).

From its earliest meetings, the CDTAC discussed how to involve the community or get community input into its work. As a result, community outreach activities included attendance at the KYRHA Defeat Diabetes Conference in Ile-a-la-Crosse (November 2005) and the MLTC Health Summit (October 2005) to share information on the NHS, Shared Paths project, and the work of the CDTAC.[22] The TAC struggled with securing Elder participation in the TAC meetings to provide feedback and direction relevant to the meetings' discussions; however, towards the end of the project an Elder began attending the TAC meetings.

5.5.2.2 TAC Recommendations and NHS Strategic Planning

The CDTAC developed and submitted three recommendations to the NHSWG over the course of the Shared Paths project. The first recommendation submitted in June 2005, was a joint recommendation between the CDTAC and the IT Coordinator and the HIM Consultant to ensure northern representation and participation on the Western Health Information Collaborative Chronic Disease Management Infostructure Project.[22] The NHSWG approved this recommendation, requested representation, and were successful in achieving representation and participation on two of the project's working groups: functional requirements; and IT and security requirements. For further information regarding this recommendation refer to the ITTAC section on page 100.

As previously discussed, the CDTAC submitted a second recommendation to the NHSWG, in November 2005, which suggested that "the partner organizations of the NHS support the development and implementation of a sustainable, integrated northern Chronic Disease Management Strategy."[22] The CDTAC researched chronic disease management models and they selected the Expanded Chronic Care Model (Barr, et al.) as the most suitable for their purposes in northern Saskatchewan. In addition, the TAC reviewed chronic disease management programs in populations and geographic regions of Canada bearing similarities to northern Saskatchewan. As a result, the CDTAC suggested that an efficient means of addressing chronic disease in the north in the face of human resource constraints would be through the creation of a NCCC. This Coalition of health care providers and key community people would augment current services through the enhancement of planned, integrated chronic care by collaboratively developing, implementing, and coordinating a northern chronic disease management strategy that addresses the most commonly occurring chronic diseases in the north. The CDTAC proposed that a strategic planning session be held to develop a work plan for the northern chronic disease management strategy which included a chronic care network, priority initiatives, meeting times/modes, and optional action plans with and without additional funding. The NHSWG approved this recommendation and a strategic planning session was held on February 28 and March 1, 2006 (see pages 68-9). At the NHS strategic planning session in June 2006, the NHSWG supported the formation of the NCCC. A letter has been sent to each NHSWG representative requesting a nomination to the Coalition committee. The nominee could be the CDTAC representative from the region or another suitable individual. In the Coalition strategic planning session, the participants developed an action plan with and without additional

funding, and once coordination for the NHS has been secured, it is anticipated that funding for the Coalition will be sought.

As part of the CDTAC Final Report, the TAC in collaboration with the MHATAC, the PIHTAC, and the OHTAC developed and submitted a joint recommendation to engage all of the NHS partners "in developing an action plan to implement an integrated health promotion strategy, both collectively and within each partner organization, as an essential component of primary health care."[22] Health promotion actions generally encompass: building healthy public policy, creating supportive environments, strengthening community action, and developing personal skills. Furthermore, health promotion is a critical component of primary health care. Currently, there is very little funding allocated to health promotion activities in the north, there is also a lack of educational resources and personnel, and there is a need for broad and active participation in health promotion initiatives, such as the Northern Healthy Communities Partnership. The proposed implementation strategy of this recommendation included:

- develop a northern cooperative approach of working together to acquire long-term, stable funding for various health promotion programs to improve the sustainability of initiatives and enhance long-term beneficial outcomes;
- develop a northern health resources clearinghouse to provide information and resources suitable for the north to support those working in health promotion;
- partner with Pahkisimon Nuyeah Regional Library to acquire and maintain health resources accessible to the public;
- ensure that each partner organization in the NHS is presented and actively involved in the Northern Health Promotion Working Group and actively supports their work of health promotion in the north;
- ensure that each partner organization in the NHS is represented and actively involved in the Northern Healthy Communities Partnership;
- enhance knowledge-based practice of the Northern Healthy Communities Partnership by supporting access to a best practice knowledge broker and evaluation expert; and
- establish a firm commitment to support and adopt recommended practices into organizational plans for health promotion.

This recommendation has not been formally discussed and/or approved by the NHSWG.

Within the NHS Strategic Plan,[15] there is support for: the formation of the Northern Chronic Care Coalition; continued participation in the Health Quality Council's Chronic Disease Management Collaborative; as well as working collectively to establish a patient self-management program in the north.

5.5.2.3 Evaluation Findings

Success and Satisfaction Indicators

The satisfaction indicators determined by the CDTAC in December 2004 included:

- We clearly identify five priority conditions to focus on.
- The committee makes recommendations based on best practices for management of chronic disease.

- The committee looks at chronic disease prevention in a broad population-based approach.
- Projects are implemented in northern communities to manage chronic disease.
- Feasible recommendations on ways of approaching these conditions are made to the NHSWG and all partners.

The CDTAC reviewed these satisfaction indicators in June 2005 and then again in March 2006. Of note, by March 2006 the CDTAC had met all of their satisfaction indicators. The CDTAC met the first indicator of identifying five priority conditions to address early on in the project, although they were only able to address diabetes and cardiovascular disease in the time frame of the project. The second indicator of making recommendations based on best practices was also met, as all recommendations were based on best practices research conducted by the TAC and its Coordinator. The third indicator of using a broad population-based approach in their work was met through the health promotion recommendation and also aspects of the proposed Coalition. The fourth indicator of implemented projects in northern communities has been met with the patient self-management training program and the proposed implementation of the Coalition. Finally, the fifth indicator of making feasible recommendations on ways of approaching chronic diseases was met by the three recommendations submitted to the NHSWG.

The success indicators determined by the CDTAC in December 2004 included:

- A sustainable model for a team approach to managing chronic disease is developed to be used northern wide and endorsed by the NHSWG.
- A model for risk reduction in the north is developed and endorsed by the NHSWG.
- Communities take an active role in reducing risks for chronic disease through health promotion activities.
- At least 50% of the recommendations made to the partners are implemented by at least 50% of them.
- We are able to put our observations of the processes involved into user friendly applications in as few steps as possible.

The CDTAC also reviewed these success indicators in June 2005 and then again in March 2006. As of March 2006, the CDTAC had met only one of its success indicators, and in many cases, were questioning the wording or objectives of the indicators they originally selected. First, the indicator of a sustainable model for a team approach to managing chronic disease was achieved through the proposed Coalition, which advocates the Expanded Chronic Care Model. According to the TAC representatives, the Coalition provides the guidelines or framework of this model and the management model will flow from this once implemented. The second indicator of developing a model for risk reduction was not met, and the CDTAC does not understand or recall what they originally meant by this indicator. The third indicator of communities taking an active role in reducing risks for chronic disease was not achieved; however, the potential exists for this indicator to be partially met through the patient self-management training program, as well as phase two of the Coalition once implemented. Furthermore, the CDTAC recognized that meeting this indicator was unlikely given the short timeline of the project. With respect to the fourth indicator, it is hoped that there will be 100% participation in the Coalition, as well as implementation of the health promotion recommendation, which remains to be seen at this juncture. The final indicator of putting processes into user friendly applications was partially met through the proposed Coalition

(i.e., charter, work plan); however, the CDTAC does not recall what they actually meant by this indicator.

Successes

Similar to the other TACs, a number of CDTAC representatives were unclear as to the purpose of the TAC when they first met as a group. Despite these uncertain beginnings, the CDTAC representatives seemed to agree that progress was positive and objectives were achieved over the course of the project. Furthermore, CDTAC representatives viewed the TAC Coordinator positively, although one NHSWG representative was concerned that the leadership of this TAC was at times, too directive. Nevertheless, progress over the last six months of the project was considered substantial by most. Several NHSWG representatives commented that this TAC seemed to have the most impact overall.

> *As a group they had a common vision, they were focused on making in-roads into what they know is a problem. The future work in this area has been identified. They didn't only do what they were asked to do; they went above and beyond that. And the fact that the Health Quality Council's Collaborative happened during their tenure assisted in highlighting the area of chronic disease, no question about it in my mind. The physicians were supportive. I think the Diabetes Self-Care Project is a wonderful example of empowering community members, leaving a legacy for future work.*

> *I think they are one of the ones that is the closest to what people were hoping was going to happen, in terms of getting very practical things and some policy issues to move forward.*

A further challenge at the beginning was the numerous perspectives represented at the table; however, this challenge was overcome by subdividing the work and allowing TAC representatives to focus on their areas of expertise in subcommittees (i.e., one committee with a health promotion/prevention focus; another with a treatment focus). At the end of the project the CDTAC representatives reported being a cohesive group with a good working relationship. Similar to the other TACs, the CDTAC representatives identified opportunities for networking and information sharing as successes of the Shared Paths project. For example, the TAC representatives met their counterparts in the other northern health service organizations; created and built relationships; shared information, experiences, and ideas; and gained a better understanding of how the "other" systems work (e.g., provincial, RHA, federal, First Nations), which will make collaboration easier in the future.

The proposed Coalition as a north-wide approach to managing chronic disease is notably one of the significant achievements of the CDTAC. It is hoped that this Coalition will improve access to services for northern residents via the augmentation of existing services, through the enhancement of planned, integrated chronic care by collaboratively developing, implementing, and coordinating a northern chronic disease management strategy. According to one NHSWG representative, the Coalition strategic planning session attracted a good cross-section of people, which speaks to the stature of the initiative. The CDTAC representatives commended the session's facilitator for her efficiency, helpfulness, and ability to facilitate discussions without the presence of jurisdictional issues. The CDTAC representatives also commented that regardless of the fate of the Coalition, the CDTAC was able to raise awareness of some of the needs and issues relevant to chronic diseases and its management that exist in the north.

Another significant success of the CDTAC was the patient self-management training delivered to community members. One TAC representative noted that two community people in their jurisdiction would be taking the patient self-management training, which would not have occurred without the existence of the CDTAC. In the past, a person interested in this type of training would not have had the support or education available to them. As a result of the project, there is the potential for a patient self-management program to be initiated and expanded within the north given the lay leaders that have been trained to date, the suggestion to hold additional training sessions, as well as its inclusion in the NHS Strategic Plan; changing the way chronic disease is managed in the communities.

Challenges

As mentioned earlier, the CDTAC experienced inhibited progress near the beginning partially attributable to a lack in clarity of purpose and mandate. For instance, the CDTAC got off track several times because they were unclear about recommending versus implementing actions, as well as focusing on promoting/preventing versus treating chronic diseases. Many CDTAC representatives commented that it was difficult to come to the TAC meetings and have the same discussions repeatedly. Some personality clashes were also reported for the CDTAC, and individuals who were not assertive had trouble speaking at the meetings. Furthermore, new members joining the CDTAC did not always come prepared and this also impeded initial progress by explaining what the TAC had done to this point and why. Due to these challenges, CDTAC representatives believed that turnover occurred because progress may have been too slow; these individuals did not see, understand or agree with where the TAC was heading; or there was not a match between the work of the TAC and their work within their organization.

One CDTAC member noted that working across jurisdictions is a challenge due to the time that it takes to progress, as well as not being able to devote much time to work outside of their own organization.

> *When you think about partnerships, I think it's an ongoing challenge to keep people involved in cross-jurisdictions. And I think it is a challenge because of time; it's a time factor. I don't believe that it's lack of interest. I think it's lack of time. And so those are difficult challenges to work through any process. So, it's how do you keep the numbers of meetings reasonable so that it's not taking too much time, and yet you've got enough time to develop. But I find that a challenge and I think others do as well.*

Similar to the other TACs, members of the CDTAC found that time constraints, such as the short project timeline, and competing priorities, such as their own full-time positions, presented a challenge to meeting and completing the work of the TAC. Attendance at CDTAC meetings was often low, with a core group of TAC representatives that attended. In addition, several CDTAC representatives felt that an important perspective was missing without a physician attending the TAC meetings.

Communication internally and externally to the Shared Paths project was consistently cited as a challenge by the CDTAC representatives. Some TAC representatives felt that there was disconnect between the CDTAC and the communities; however, it is worth noting that the CDTAC had discussions about involving or engaging the community in its work and recognized the importance

of this. Although the CDTAC determined that they would not involve or engage the community out of concern for raising expectations until there was something specific for the community to address. Of note, community involvement or engagement will be a function of the Coalition in phase two. The CDTAC representatives also reported that awareness of the CLOs and their role was minimal. In addition, most CDTAC representatives did not communicate frequently with their respective NHSWG representative. The TAC representatives were unsure of how much information was going back to the NHSWG regarding the CDTAC activities. Essentially, responsibility for communication was not explicit for CDTAC members. Furthermore, some CDTAC representatives felt disconnected from the other TACs. For instance, one TAC representative was unsure of who from their organization was on which TAC. The CDTAC felt that the TACs worked in silos, which meant many lost opportunities for collaboration. Finally, CDTAC representatives believed that the newsletters produced by the Communications Coordinator were not targeted to an external audience, which was viewed as a weakness. One CDTAC member mentioned that the newsletter would only be useful if you were involved in the project.

5.5.2.4 Summary Statement

Initially, the CDTAC was confronted by an unclear mandate and confusion regarding a focus on promotion/prevention versus treatment of chronic disease, as well as implementation versus recommendation of actions. However, during the later half of the Shared Paths project, the CDTAC was able to clarify their purpose and make marked progress. A subdivision of the work worked remarkably well for this TAC, and possibly increased retention of its members. Furthermore, the outcomes of the CDTAC (i.e., the proposed Coalition; patient self-management training) appear sustainable and have the potential to improve the health status of northern residents with respect to chronic disease.

Similar to the other TACs, the CDTAC faced many challenges in its work; most notably, members of the CDTAC were concerned with communications internal and external to the project. According to these TAC representatives, internal communication was flawed, and there was disconnect between the NHSWG and the TACs. Furthermore, the TAC representatives were disappointed that there was not a formal mechanism for engaging with the others TACs. In terms of external communication, TAC representatives believed that this could be improved, and that newsletters are not the most efficient means of communicating with an external audience, particularly if they are not targeted towards the audience.

5.5.2.5 Evaluation Recommendations

The CDTAC plans to continue its work in the form of the Coalition; however, the formation of this Coalition will require the leadership of CDTAC co-chairs in the absence of a TAC Coordinator, and furthermore, a NHS Coordinator. The work plan, charter, and logic model for the Coalition have already been drafted, along with a budget that identified actions with and without funding. Thus, it is recommended that the CDTAC continue its work under the new banner of the Coalition and that the NHSWG pursue funding for its work plan. Moreover, if funding is not secured, then implementation of its alternate work plan should be supported. In addition, it is recommended that the Coalition fosters the sustainability of the patient self-management training program given that patient self-management is an important component of the model espoused by the Coalition.

5.5.3 Perinatal and Infant Health TAC

5.5.3.1 Activities, Outputs, and Outcomes

The Perinatal and Infant Health TAC identified the areas of active participation in prenatal care; long-term breastfeeding; and sexual wellness education in which to focus its recommendations for improved health service delivery and ultimately improved health outcomes for residents of northern Saskatchewan.[2]

Current State Assessment, Core Services, Analysis of Gaps

The TAC met sixteen times over the course of the project and continued to meet following the project's end date of March 31, 2006. The TAC Coordinator completed a current state assessment in the spring of 2005 of perinatal resources, programs, and services within each NHS partner. The current state assessment found that perinatal care and prenatal classes/education are offered in most northern communities; however, expectant mothers do not always access these services. Another issue is that most northern clients must deliver outside of their home community, which presents its own difficulties such as lack of a support person, transportation, childcare, and translation issues. Furthermore, there are variable rates of breastfeeding across northern communities and there is a need for more than one lactation consultant in the north. There are also relatively high rates of sexually transmitted infections and pregnancy among teenagers in northern communities supporting the need for north-wide sexual wellness education. Currently, sexual health programming is available in the Northern Lights School Division and in LLRIB; however, there is no comprehensive strategy in all of the northern schools.[23] Following the completion of the current state assessment, the TAC Coordinator researched best practice information, as well as standards of care and services related to perinatal and infant health programs and/or services. Armed with the information from the current state assessment, as well as best practice and standards of care and services information, the TAC was able to analyze the gaps in service that exist in the north and develop recommendations to close these gaps.

Northern Breastfeeding Committee

The TAC formed a subcommittee to address long-term breastfeeding, which came to be known as the Northern Breastfeeding Committee. This subcommittee was tasked with the need:

- To develop a northern breastfeeding strategy that is wholistic and culturally appropriate (a complement to the provincial Baby-Friendly Initiative), allowing for community interpretation and implementation of the strategy,
    - Including short and long-term education strategies, education of both health care and community professionals, peer support system for breastfeeding, access to a lactation consultant, breastfeeding kits, etc.; and
- To develop a data collection strategy that accurately reflects northern breastfeeding practices (in an effort to increase the rate of breastfeeding initiation and maintain exclusive breastfeeding for 6 months).

It should be noted that the Northern Breastfeeding Committee struggled with attendance and met infrequently over the course of the project. The last meeting occurred in November 2005. Also, the NHSWG suggested that collecting information only on northern breastfeeding practices was too focused and should be expanded to include broader information on perinatal and infant health

issues, so the development of a data collection strategy became the task of the TAC versus the subcommittee and was not completed.

Community Involvement

The TAC also discussed how to involve the community or get community input into its work. Initially, the TAC discussed holding meetings in Prince Albert, as well as in communities in all the NHS partner regions; however, meetings outside of Prince Albert did not occur. TAC members determined that meeting in Prince Albert, due to its central location, involved the least amount of travel for most partners meaning less time away from the office, and was respectful to the Elders who attended the meetings. These Elders (both female and male) provided feedback and direction relevant to meeting discussions. In addition, the TAC tried to include young mothers in their meetings; however, the involvement of young mothers was minimal due to mobility issues for the mothers (e.g., transportation, childcare), as well as an inability to find women to attend the meetings (e.g., young women were not comfortable public speaking, TAC representatives were too busy). Furthermore, the TAC engaged the CLOs to conduct community consultations (i.e., focus groups) within three of the NHS partners on the supports needed for expectant mothers when they leave their home communities for childbirth. This TAC was one of two within the project to conduct community consultations.

Of particular note, the TAC produced a number of health promotion outputs,[23] including:

- Hosting a breastfeeding telehealth session – The Cost of Not Breastfeeding;
- Developing a poster on the importance of regular prenatal care, with logos of all the NHS partners; and
- Producing a "Mom, Dad and Baby Log Book" – resource for mothers to keep track of their prenatal care.

5.5.3.2 TAC Recommendations and NHS Strategic Planning

The TAC developed and submitted several recommendations to the NHSWG over the course of the project. These recommendations all focused on prevention and promotion goals, and form the basis of a north-wide strategy to increase active participation in prenatal care; to promote breastfeeding; and to assist NHS partners to implement sexual health school programming.[23]

Under the north-wide strategy to increase active participation in prenatal care the TAC submitted four recommendations. The first was a recommendation to include Elders in both the planning and teaching of prenatal programming/classes, including financial support for participation such as travel costs, honorariums, etc. This recommendation was accepted in August 2005 by the NHSWG, with a referral to each partner for implementation. Information from the TAC (evaluation) focus group conducted in January 2006 revealed that at least one of the partners has implemented this recommendation. The second recommendation, presented to the NHSWG in December 2005, encouraged the involvement of northern media in showing videos and delivering cultural and literacy appropriate perinatal messages to northern communities. This recommendation was approved in principle and referred to each partner to decide on implementation. The TAC was also asked to consider videos/messages that would be appropriate, costs for air time, sustainability issues, evaluation, etc. (these discussions still to occur). A third recommendation was also submitted in December 2005. This recommendation suggested the orientation of new physicians in the north to

community perinatal services and support agencies through the creation of a resource binder containing the relevant information. The NHSWG approved the recommendation in principle and asked that the TAC provide an outline of information to be included and then discussions with respect to implementation would take place (e.g., Is a resource binder the best option? What about a web portal?). At this juncture, the physician orientation information/resource binder is still only in the template phase. The fourth recommendation to the NHSWG, presented in April 2006, asked for the establishment of a perinatal forum to address quality of care issues of northern clients delivering at southern or out of province birthing centres (as a result of the information gleaned from the community consultations completed by the CLOs and the TAC). At the April 2006 meeting of the NHSWG, the TAC Coordinator presented the TAC final report and as such, the new recommendations presented were neither approved, nor not approved. Thus, if approved the recommendation would become part of the 2006/07 work plan for the TAC, given that this TAC is interested in continuing its work despite the end of the project. Finally, in June 2006, the TAC recommended that the NHS keep abreast of a Saskatchewan Health midwifery initiative and to become involved (e.g., through representation on the implementation committee) if this issue is considered relevant for the north. This recommendation was premised on the fact there was not a northern or First Nations/Métis perspective on the committee (pilot sites included Regina and Saskatoon).

Under the north-wide strategy to promote breastfeeding, the TAC submitted three recommendations to the NHSWG. First, the continuation of the Northern Breastfeeding Committee (beyond March 2006), with the addition of multi-disciplinary members from each jurisdiction as needed, was originally presented in August 2005 and re-presented in April 2006. This signifies the value in a forum that enables sharing of information and resources, partnering on advocacy efforts or training initiatives, and discussing northern breastfeeding issues (all part of the committee's proposed 2006/07 work plan). The committee is waiting for approval from the NHSWG. The second recommendation, presented in August 2005, proposed a training initiative for peer support counselors for breastfeeding that would take place in each jurisdiction. It also suggested that a network of peer support trainers should be developed and it should include other agencies, such as Kids First North. This recommendation was accepted by the NHSWG, with implementation options requested. The TAC discussed implementation options and prepared a grant application for funding of this initiative, which was presented to the NHSWG as part of the TAC final report and the TAC is waiting further instruction. The third recommendation, accepted in principle in December 2005, suggested that each jurisdiction should have access to a resource person knowledgeable about breastfeeding (i.e., lactation consultant) who would provide consultation to clients and training to staff. The TAC recommended that one full time equivalent be hired, with the position to be shared amongst the NHS partners; and developed a job description outlining duties and responsibilities, as well as funding options. This position would be piloted for one year and then reviewed. The implementation and funding options were presented to the NHSWG as part of the TAC final report in April 2006.

Under the north-wide strategy to assist NHS partners to implement sexual health school programming, the TAC submitted one recommendation to the NHSWG as part of the TAC final report in April 2006. The recommendation was to implement a sexual health education workshop that allows NHS partners with established programs to share their skills and knowledge with workshop participants so that all partners will come away with the tools to implement the curriculum within their respective communities. This recommendation was approved by the

NHSWG at their strategic planning session in June 2006 and the TAC is currently organizing the workshop scheduled for September 27 and 28, 2006.

Of particular note, the TAC also recommended to continue the relationships and collaboration between the TAC members beyond March 2006 or the end of the Shared Paths for Northern Health project. As part of the TAC final report, the TAC included a proposed 2006/07 work plan, administrative structure, and meeting protocol.

Within the NHS Strategic Plan,[15] there is support for improving perinatal and infant health outcomes for residents of northern Saskatchewan through the implementation and further development of the TAC's north-wide strategy to increase active participation in prenatal care; to promote breastfeeding; and to assist NHS partners to implement sexual health school programming.

5.5.3.3 Evaluation Findings

Success and Satisfaction Indicators

At the end of the project (March 2006), the TAC reviewed the success and satisfaction indicators developed in November 2004. At this point, the TAC felt that they had met the majority of their selected indicators. Specifically, in terms of satisfaction indicators, the TAC felt that:

- the TAC was interdisciplinary, inter-jurisdictional, and inter-sectoral to an extent;
- the TAC identified key issues in northern perinatal health and created innovative recommendations;
- TAC members were committed and contributed freely and openly;
- the TAC worked towards goals that were agreed upon by all; and
- the TAC was able to create prenatal/perinatal education materials that were dynamic, interesting, and culturally relevant (e.g. Mom, Dad and Baby Log Book).

As for success indicators, members of the TAC believed that:

- the TAC took the time to gather community members' input both on and off reserve;
- TAC members kept in mind the whole of the northern population;
- partnership continued with ongoing communication; and
- the TAC members were often able to come to the table without preconceived ideas.

One of the success indicators, northern communities understanding and engaging in perinatal health initiatives, is a future objective for the TAC.

Successes

According to TAC members, the group plans to continue meeting via conference call/WebEx and has agreed to pursue next steps such as implementation of the sexual health education workshop, synthesis of the data from the community consultations, establishment of a perinatal forum to discuss quality of care issues, etc. The focus group with the TAC and TAC representative interviews revealed that members generally considered their outputs (e.g., prenatal care poster, telehealth session) and their recommendations as successes achieved by the group. In addition, members of the TAC noted the proficiency of their Coordinator as an asset. Overall, TAC members indicated that the group worked well together as a team and this contributed to their progress.

Challenges

Challenges that may have slightly impeded the progress of the group were quite similar to challenges expressed by the other TACs, including: short timeline of the project; unclear mandate at the start of the project; turnover in committee members; traveling to attend meetings; balancing TAC responsibilities with the roles and responsibilities of their job; and a process for engaging and meeting with the other TACs was not established. Furthermore, some TAC members were concerned that a change in TAC membership in the future may mean that recommendations are not implemented.

5.5.3.4 Summary Statement

The TAC addressed their three priority areas, that is, active participation in prenatal care, long-term breastfeeding, and sexual wellness education through the development of nine recommendations submitted to the NHSWG. In addition, health promotion outputs were also produced (e.g., the breastfeeding telehealth session; Mom, Dad and Baby Log Book; prenatal care poster) to address these areas. Essentially, the TAC was successful in addressing its priority areas; however, follow-up on a number of the recommendations is required. Lines of evidence indicate that most recommendations have not been implemented, with the exception of the sexual health education workshop and the Elder participation in prenatal programming recommendation (only in some partner organizations).

5.5.3.5 Evaluation Recommendations

Members of the PIHTAC were quick to note that their own satisfaction would increase when recommendations are implemented. Evaluation findings, particularly comments from members of the TAC, leads to the recommendation that the TAC recommendations submitted should be followed up and implemented where appropriate. For instance, enhance supportive care for breastfeeding (e.g., lactation consultant for the north); provide training of peer support for breastfeeding; enhancing physician orientation to perinatal programs and services in the north; establishment of a perinatal forum to address quality of care issues. Furthermore, the Northern Breastfeeding Committee has not met recently and this group should be sustained in order to address this issue in northern communities. However, follow-up and implementation of the TAC recommendations and activities is threatened by the lack of a TAC coordinator/co-chairs, as well as a project coordinator past September 30, 2006. Thus, efforts should be made to determine co-chairs from within the TAC.

5.5.4 Oral Health TAC

5.5.4.1 Activities, Outputs, and Outcomes

The origin of the Oral Health TAC is different than the other three PHC TACs. The OHTAC, also known as the Northern Oral Health Working Group (NOHWG), has been in existence since January 2003 and was adopted by the NHSWG as one of its TACs at the start of the Shared Paths project. The OHTAC did not have a Coordinator, but rather was co-chaired by the PHU and NITHA representatives. The Project Coordinator was also heavily involved in this TAC. The TAC met fourteen times over the course of the project and continued to meet following the project's end date of March 31, 2006.

Current State Assessment, Core Services, Analysis of Gaps

As with the other TACs, the OHTAC methodology included: identification of current state, development of standards, gap analysis, recommendations, approval, and implementation. The TAC completed these tasks with the support and guidance of the Project Coordinator. Some of the significant findings from the current state assessment included:[24]

- dental team members working in the dental clinics vary and may include: dental therapists, dental assistants, and dental aides, with the support of a consulting dentist. Additional support may include services provided by a technical consultant and/or dental educator;
- challenges to providing services in the north are the geographic dispersion and the lack of human resources;
- there is only one resident dentist and itinerant dentist services, which vary considerably;
- there are 23 dental therapists and one dental hygienist providing oral health services in the north; and
- the recommended provider to patient ratio is: one dental therapist to 500 children, one dental therapist to 800 adults and children, and one dentist to 1500 adults and children. The population in northern Saskatchewan is ~42,700.

For further information regarding the current state assessment refer to the Final Report.[24]

The OHTAC also spent considerable time discussing and identifying prevention, promotion, and treatment standards of practice for oral health, which form the basis of program delivery for residents of northern Saskatchewan. The TAC noted that the standards of practice have changed since the time that they had their discussions, and an update to the information collated by the TAC is scheduled as part of the TAC 2006/07 work plan.[24]

Work Plan and Outputs/Outcomes

The work plan[24] of the OHTAC consisted of a comprehensive oral health strategy, which had a treatment and a prevention/promotion focus. The work plan contained the following items: a Request for Proposal (RFP) for dentist services and follow-up; fluoride varnish program development/expansion; database development; public education campaigns; education of staff; advocacy for core services and accessibility to comprehensive dental services; and resource sharing/networking. The OHTAC decided to focus on a few items that could be accomplished in

the remainder of the Shared Paths project (e.g., from June 2005 to March 2006). Thus, the OHTAC identified the areas of: access to dentist services; public education campaigns (i.e., "Drop the Pop," smokeless tobacco cessation, and early childhood tooth decay campaigns); workshops for staff (i.e., motivational interviewing); and fluoride varnish program development/expansion in which to focus its activities and recommendations for improved health service delivery and ultimately improved health outcomes for residents of northern Saskatchewan.[2]

When adopted as a TAC by the NHSWG, this group was working on improving access to dentist services for residents of northern Saskatchewan and thus, the group continued its work and developed a RFP[24] for itinerant dentist services to eight communities within the NHS partner communities. This RFP was approved by the NHSWG and issued to the Colleges of Dentistry in three western provinces, plus some private dental practices in Saskatchewan in April 2005, with proposals to be submitted to the NHSWG by August 31, 2005. The University of Saskatchewan, College of Dentistry originally intended to submit a proposal, but was unable to do so due to a lack of capacity. However, the College was still interested in providing clinical support, community outreach programming, etc., and they prepared a submission to this affect for the NHSWG. Only one proposal was submitted to the NSHWG in response to the RFP, which was from the Centre for Community Oral Health, University of Manitoba, Faculty of Dentistry. The OHTAC reviewed this proposal in October 2005 and determined that the criteria of the RFP had been met. The OHTAC recommended to the NHSWG in November 2005 that they pursue a contract with the University of Manitoba. The outcome of this recommendation is described in a later section.

The OHTAC also strove to further develop and expand the fluoride varnish program,[24] targeting children of 0 months to 2 years of age. As a component of this objective, the OHTAC wanted to develop a "Train the Trainers" manual for public health nurses or other support workers who would apply the fluoride varnish with the child's immunization schedule, as well as develop a database system to track the fluoride varnish program. As such, the OHTAC worked on standardizing the fluoride varnish program in the north and adopted the "Generation of Healthy Smiles" Children's Oral Health Initiative (COHI) training and instructors manuals. With permission from Health Canada, these manuals were adapted to fit the needs of the NHS partners into an Oral Health Aide Training Manual and an Oral Health Aide Instructors Manual. The Communications Coordinator produced the manuals in-house. Each of the OHTAC representatives submitted requests as to the number of manuals needed in their organization and the resources were distributed in September 2006. In addition to the manuals, the TAC also produced fluoride varnish information cards; a fluoride varnish protection consent record; fluoride varnish protocol guidelines; and fluoride varnish stickers.

Furthermore, the OHTAC formed a subcommittee to work with the IT Coordinator and the HIM Consultant to develop a database for surveillance and planning; however, this work was not completed within the project timeline and remains as a work plan item for 2006/07.

As mentioned earlier, the OHTAC also identified developing resources as one of their priorities. Over the course of the project, the following resources[24] were developed and then distributed in communities:

- Oral health screening forms;
- Oral health screening referrals;
- Oral health tear sheets;

- NOHWG logo design/development;
- Distribution of dental health month resources; and
- Re-Think Your Drink and Diabetes & Oral Health tips (320 packages were distributed through Northern Health Promotion Working Group).

The OHTAC's "Drop the Pop" campaign was completed in January 2006 and represents a tangible success. In fact, the Northern Healthy Communities Partnership expressed a desire to work the campaign into the nutritional guidelines for all schools in northern Saskatchewan, rather than leaving it as a stand-alone project.

5.5.4.2 TAC Recommendations and NHS Strategic Planning

The OHTAC developed and submitted five recommendations to the NHSWG over the course of the project.

In February 2005, the OHTAC submitted its first recommendation to the NHSWG, which was to improve access to dentist services for northern residents through the provision of regularly scheduled clinics attended by dentists in specified communities in northern Saskatchewan.[23] The OHTAC envisioned dental teams planning clinic times and operations in certain communities to ensure that emergency dental services were available for those who needed it (i.e., treatment services), while at the same time working to inhibit people from relying solely on emergency-only care (i.e., enhancing promotion and preventative services). The proposed implementation strategy included the NHS partners formalizing partnerships/agreements to work together to improve access, with the partners responsible for: scheduling of visits in conjunction with the dentist; booking of patients; providing a community aide; and the physical facility (i.e., fully equipped, two-chair clinic). Furthermore, the current services (and associated funding) provided by the dental team at the facilities would continue. As previously mentioned, the OHTAC prepared a RFP, which was approved by the NHSWG and issued to several potential service providers. One proposal in response to the request was received, and subsequently reviewed by the OHTAC.

In November 2005, the OHTAC submitted a follow-up recommendation to the NHSWG to pursue a contract with the Centre for Community Oral Health, University of Manitoba, Faculty of Dentistry, as their proposal met all of the RFP criteria.[24] The NHSWG approved this recommendation and began to proceed with the next steps, one of which was to secure funding for the proposal. The NHSWG prepared a financial analysis with respect to the current costs of dentist services among the partners (best estimates), as well as a proposal that would be submitted to potential funding agencies (i.e., FNIHB, Saskatchewan Health). Discussions surrounding the dentist services proposal generated concerns among the NHSWG representatives, such as: that the issue of internal equity is addressed by this proposal (i.e., same level of service to AHA and MCRRHA, as each region has a different population base); that this proposal is addressing and not exacerbating the inequalities that currently exist; that organizations may be asked to use funds from within their operational budgets to cover the costs; and most important, that this proposal may jeopardize existing funding and service agreements, particularly for the First Nations partners. As a result, some First Nations partners were hesitant to participate in the proposal process for fear of losing existing programs, such as the dental therapy program. It should be noted that the intent of the NHS was, and is not to jeopardize the programs and services of its partners. Furthermore, since the preparation of the RFP, there have been changes in dentist services in the north (i.e., some

organizations were able to secure their own dentists to come to the communities). Thus, there was a need to confirm among the NHS partners: the sites chosen to receive dentist services in the original RFP; participation in the proposal; and if so, what was their preference for seeking funds (i.e., collectively, individually). The Project Coordinator sent a letter to each NHS partner to this affect in February 2006 and received limited response. The NHSWG plans to discuss the dentist services proposal again in September 2006 to determine support for and how best to proceed, that is, collectively or forming local or regional partnerships across the jurisdictions (e.g., LLRIB and MCRRHA; MLTC and KYRHA). Once or if there is agreement to collaborate, a proposal for funding can be prepared and the partners can enter into service agreements with dentist service providers, such as Centre for Community Oral Health. Unfortunately, due to jurisdictional issues, the NHSWG seems to be "stuck in concrete boots" unable to implement the dentist services proposal and residents of the north are without dental care.

Also in November 2005, the OHTAC submitted a second recommendation to the NHSWG to enhance dental therapists' knowledge and skills in the area of prevention – Shared Paths project to support Motivational Interview training for the northern Dental Therapists.[24] This recommendation grew out of the OHTAC's identification of prevention strategies as a priority in their work plan. This recommendation was approved by the NHSWG in November. Subsequently, the OHTAC held three two-day training sessions (one each in Prince Albert, Meadow Lake, and La Ronge) for northern dental health staff on motivational interviewing, which is technique used by practitioners to promote change in patients/clients' behaviour, in order to facilitate improved oral health.

The third recommendation submitted to the NHSWG, also in November 2005, was to develop a management tool to facilitate the improvement of oral health programs and health outcomes for residents of northern Saskatchewan.[24] Due to a busy agenda, the NHSWG was unable to discuss this recommendation; however, they suggested that the OHTAC continue to work with the IT Coordinator and the HIM Consultant on this recommendation. The OHTAC formed a subcommittee and continued to have discussions regarding the functional requirements for a database and its conceptualization. In March 2006, the OHTAC decided to table this issue and place it on the 2006/07 work plan for further discussion.

As part of the OHTAC Final Report (May 2006), the group submitted a fourth recommendation to the NHSWG, which was to improve access to oral health services by advocating for increased access to care inclusive of health promotion, prevention, and treatment.[24] This recommendation sought to address the lack of core or standard oral health services in the north due to inadequate numbers of service providers. Furthermore, services vary from jurisdiction to jurisdiction, with most communities not receiving comprehensive oral health services. The proposed implementation strategy was that the NHSWG would take a lead role in advocating for increased access to oral health services through lobbying for additional oral health professionals and support staff as per the recommended patient to clinician ratio. This recommendation has not been formally discussed or approved by the NHSWG and therefore, no implementation has occurred.

Also as part of the Final Report, the OHTAC submitted a fifth recommendation to the NHSWG, which was to increase knowledge and understanding of oral health for all health service providers through the integration of oral health education into existing health programs.[24] This recommendation was in recognition of the fact that oral health programs and services are usually separate from other health services. Evidence increasingly supports the association between oral

health and general health outcomes, highlighting the importance of oral health as a component of wholistic health. The proposed implementation strategy of this recommendation would entail:

- Health Authorities to provide opportunities for bi-directional information sharing between health care providers;
- Health Authorities to incorporate oral health knowledge and practices into new and existing programs to influence positive oral health and general health outcomes;
- NHS partners to increase their emphasis on the importance of general health/oral health;
- NHS partners to collaborate with the OHTAC to provide educational sessions for health professionals; and
- NHSWG and the NHS partner organizations mandate curriculum reviews, revising to include an oral health component where needed.

This recommendation has not been formally discussed or approved by the NHSWG and therefore, no implementation has occurred.

Within the NHS Strategic Plan,[15] there is support for the enhancement of oral health services through: collectively advocating for dentist services; collaboration on health promotion and prevention resource material development and distribution, as well as collaboration with other northern health promotion initiatives; and the development and delivery of oral health professional development sessions for other health care providers.

5.5.4.3 Evaluation Findings

Unlike the other TACs, data collection with the OHTAC consisted of the TAC Effectiveness Questionnaire (TACEQ); a focus group held in June 2005; document review; and observation of TAC meetings. This TAC did not complete the success and satisfaction indicator exercise and TAC representatives were not interviewed. Thus, these findings should be read while considering events post-June 2005 such as, the submission of the University of Manitoba in response to the dentist services RFP; the lack of progress on the dentist services proposal; resource development; cross-jurisdictional training, etc.

Successes

The OHTAC plans to continue to meet and to finalize their 2006/07 work plan in September. In the focus group in June 2005, the OHTAC representatives voiced their commitment to sustaining this group beyond the completion of the Shared Paths project. After all, they had been meeting prior to the inception of the project. On the whole, the OHTAC reported satisfaction with the opportunities for networking, innovation, and information sharing. According to TAC representatives, the OHTAC has become a common meeting group for all northern oral health professionals. One of the NHSWG representatives commented:

> *It became a support group for the individuals who pretty much worked in isolation. This was the first predecessor to the TACs. So, everybody was working in isolation, so by bringing them together it became a support group. Which I think holds true for the rest of the TACs during the project itself. So, they were able to discuss issues they faced at their work, thus being able to express their frustration and feel somebody is listening. They talked to one another … and each organization faced different issues.*

Many different perspectives existed among the OHTAC representatives, which was cited as a positive aspect of the group because it allowed for innovation, whereby TAC representatives were able to look beyond their own communities towards solutions that may benefit the north as a whole. Although one representative felt that it was sometimes a challenge that there were so many different and competing perspectives. Information sharing has also increased between the members of the TAC and across jurisdictions, which has led to an increased awareness of the oral health issues in the north, as well as an understanding of the other jurisdictions delivering oral health services. In addition, some noted that the members of the OHTAC were passionate employees with many years of experience. One representative explained that the dynamics of the group have improved over the past couple of years, as they have gotten to know and respect one another.

As per their work plan and objectives, the OHTAC has worked towards improving access to dentist services for residents of northern Saskatchewan. As a result of the current state assessment, the TAC was able to bring to light some of the inadequacies in dental care that exist in the north. The OHTAC representatives also felt that recognition of the importance of oral health has occurred because of the work of the TAC. For instance, the Chief Dental Officer from Health Canada has commended the OHTAC on its work, as it fits well with the Canadian Oral Health Strategy. In addition, he commented that the dentist services proposal demonstrates a best practice model. Furthermore, the OHTAC has garnered some recognition and commendations from its counterparts in southern and central Saskatchewan. Lastly, the other TACs also seemed to be realizing that oral health relates to the general health of an individual, evidenced by the desire to increase collaboration and interaction among the TACs.

There has been a long history between the NHS partners (via the OHTAC representatives), FNIHB, and the College of Dentistry, University of Saskatchewan in the development of an adult dental initiative in the north (initial discussions beginning in 2002). And unfortunately, as evidenced in this report, the adult population in the north still continues to be underserved largely due to barriers of a jurisdictional nature. At any rate, the numerous meetings held over the years have increased the sharing of information between all stakeholders and there have been other benefits. According to OHTAC representatives, the University of Saskatchewan's dental program has become more focused on a public health approach to dentistry, which is partially attributable to discussions with the OHTAC. This was viewed as an achievement because the University of Saskatchewan was one of the few universities without a public health focus. In addition, a few TAC representatives believed that dentistry students were now focusing more on public health and were not as concerned with going into private practice.

The OHTAC representatives considered the development of the dentist services RFP a success, which was also posited as promoting cost-effectiveness. As such, it was suggested that the RFP could be used as a template in the other TACs to also improve access to services.

> *And not only that it was submitted and agreed upon, but we've had very good feedback from it. We've had interested potential clients, I guess you would say, which is good. And it just makes so much sense, the number of dollars that will be saved. I don't know if we'll be able to track that, but it will just be amazing if it works out the way that we are hoping that it will.*

Yet, some of the NHSWG representatives expressed concern that a lot of work went into the RFP, and implementation has been completely stalled by jurisdictional issues. It was hoped that this initiative would be a quick success for the OHTAC and the NHSWG; however, success has not

been fully achieved. Although in terms of advocacy, highlighting the inadequacies of dental care in the north via the RFP process has enabled some NHS partners to improve their dental programs, with dentists now visiting additional communities in the north. This initiative was an example of a specific proposal on the table of the NHSWG for a year, and the NHSWG has not been able to effectively move it forward. According to one NHSWG representative:

> *It's actually an example of where a very specific proposal came forward to the Working Group that I think that our table kind of faltered on this thing because we're not … there hasn't been a consistent expression of support for the idea. In some ways, it's one of the few real tests of how committed people are to working together because I think the reluctance for people to sign off on the proposal is partly because people are concerned about whether the existing arrangements will be at risk or whether this other proposal would be a replacement for existing services or incremental … if it is replacement, for some jurisdictions it would mean less.*

Fortunately, the OHTAC has made progress and found value in the other items of their work plan. The TAC has valued the collective approach to health promotion and prevention resource material development and distribution, reporting cost savings in producing the materials (e.g., fluoride varnish program training and instructor's manuals). Furthermore, the joint planning and delivery of cross-jurisdictional staff education sessions (i.e., motivational interview training) was cited by the OHTAC as a valuable and cost-effective approach to providing professional development opportunities.

Challenges

According to the OHTAC representatives, their mandate was not entirely clear when the OHTAC first began to meet in 2003. The TAC representatives believed that this was largely because their first coordinator did not possess a clear vision as to what the group should be accomplishing. Furthermore, their progress appeared to stagnate following the initial meetings, partially attributable to the absence of a work plan. Fortunately, the mandate of the OHTAC became clearer when they were adopted by the NHSWG to participate as one of the TACs in the Shared Paths project. The TAC has benefited from the support and guidance of the Shared Paths Project Coordinator, in addition to the support provided by the Executive Assistant in terms of organizing meetings, taking minutes, etc.

Jurisdictional issues have also been a consistent challenge and point for discussion for the OHTAC. As an example, there are communities that have both provincial and federal programs and as such, the OHTAC has to consider children that constantly move between on-reserve and off-reserve. In addition, frontline workers are often confused as to whom they may treat or not. However, TAC representatives believed that jurisdictional issues have improved over the past few years. For instance, in some areas, resources have been pooled and networking has occurred.

Similar to the other TACs, members of the OHTAC found that competing priorities, such as their own full-time positions, presented a challenge to meeting and completing the work of the TAC. There was a core group of TAC representatives that attended the meetings; however, there was a consistent lack of attendance from several NHS partners. Furthermore, the short timeline of the project (and hence, funding) limited what could be accomplished and as a result, the OHTAC focused on a few work plan items that would be attainable within the project timeline, while other

work plan items were put on the back burner (e.g., issue of water fluoridation). In addition, the OHTAC representatives felt that greater collaboration between the TACs should be encouraged and that more information sharing should occur between these groups.

5.5.4.4 Summary Statement

The OHTAC had a unique advantage compared to the other TACs due to its history prior to the Shared Paths project. Members of the OHTAC had worked together for a number of years and had formed a strong working relationship through opportunities for networking and information sharing. As a result of this cohesive working relationship, the OHTAC was able to produce a considerable amount of health promotion and educational resources to be distributed to the NHS partners, as well as plan and deliver a cross-jurisdictional staff education session. Also of note, the OHTAC successfully formulated their "Drop the Pop" campaign, with positive responses from the Northern Healthy Communities Partnership. Furthermore, the OHTAC created an extensive work plan, which will continue to be pursued in the future.

Jurisdictional issues challenging the delivery of oral health services to northern residents have been decreasing over the past few years, according to OHTAC representatives; however, the implementation of the dentist services proposal has been stalled in large part due to the existence of jurisdictional issues related to funding for the proposal, and threats to existing programs and services within the north.

5.5.4.5 Evaluation Recommendations

The OHTAC has expressed commitment to continuing their working relationship into the future. Thus, it is recommended that the OHTAC continue to pursue their work plan and the recommendations submitted to the NHSWG. In order to provide direction for the group, the OHTAC should prioritize its recommendations and modify the current work plan accordingly. Given the success of the OHTAC in developing and distributing resource material for the NHS partners and in providing a joint training session, it is recommended that the group continue these best practices.

Furthermore, it is strongly recommended that the NHSWG bring back to the table the dentist services proposal, confirming partner support for the proposal and direction on how to proceed (i.e., regionally, north-wide) to improve access to dentist services for the residents of northern Saskatchewan, particularly the adult population. Once there is direction on how to proceed, it is recommended that the NHSWG meet with potential funding agencies of this proposal, and formally discuss any and all jurisdictional issues that may impede access to services and identify solutions to these barriers, so that residents of northern Saskatchewan are no longer without access to care.

5.5.5 Technical Advisory Committee Effectiveness Questionnaire

The four PHC TACs brought together individual professionals from various disciplines, jurisdictions, and sectors to work towards a common goal: the development and implementation of recommendations for improved health service delivery and ultimately improved health outcomes for residents of northern Saskatchewan. It was anticipated that the specialized knowledge and skills that each TAC representative brought to the group, as well as their commitment to work together, would be an effective way to achieve this common goal. Thus, it was important that the evaluation addressed this teamwork element and each TAC's perceived effectiveness of its work.

Description of the Questionnaire

In order to assess each TAC's effectiveness, the evaluation utilized the Technical Advisory Committee Effectiveness Questionnaire (TACEQ). This questionnaire was a modified version of a Team Effectiveness Tool used by the Primary Health Services Branch of Saskatchewan Health[1] to provide an assessment of key elements of teams, including team purpose and vision, roles, communication, service delivery, team support, and partnerships. Modification of the Saskatchewan Health Tool included the addition of questions that were specific to the NHSWG project and the TAC objectives with respect to primary health care and health service delivery.

The TACEQ, comprised of 40 questions, surveyed six dimensions (or constructs) of teams for which the results, according to each TAC, are reported in Tables 8 to 11. The analysis presented includes a brief description of each TAC's perceived effectiveness and progress with respect to each dimension. The questionnaire contained a likert scale of 1 to 5, with 1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree; and 5 = not applicable at this time. Therefore, a higher rating for the dimension indicates a higher perceived effectiveness and conversely, a lower rating for the dimension indicates a lower perceived effectiveness or an area for improvement.

Administration of the Questionnaire

As the TACEQ was used periodically to assess TAC effectiveness and progress, it was desirable to have baseline data against which to measure and thus, each TAC completed the TACEQ near the start of its work together (i.e., January and February 2005). In addition, the OHTAC, which had been in existence since January 2003, completed the TACEQ in March 2005. The TACEQ was administered two more times within the project timeline, at approximately the project mid-point (i.e., August and September 2005) and the end-point (i.e., February and March 2006).

The Evaluation Coordinator distributed the TACEQ to MHA, CD, PIH, and OH Technical Advisory Committee representatives at a face-to-face meeting, and mailed the questionnaire to those TAC representatives not in attendance with a stamped return envelope addressed to the Evaluation Coordinator. The overall response rate (Table 7) to the first administration of the TACEQ was good at 71.4% (i.e., 35 completed questionnaires out of 49 questionnaires distributed). The overall

[1] The Saskatchewan Health Tool is based on the ideas of Steven Phillips and Robin Elledge, *The Team-Building Source Book,* San Diego, California: University Associates, Inc., 1989, and the work of David Jamieson, "The Team Character Inventory," a widely used tool to assess team functioning, found in Phillips and Elledge, *The Team-Building Source Book*. Permission to use and modify the Saskatchewan Health Tool, based on the work of David Jamieson, was obtained from both Saskatchewan Health and David Jamieson.

response rate to the second administration of the TACEQ was better at 79.2% (i.e., 38 completed questionnaires out of 48 questionnaires distributed). While the overall response rate to the final administration of the TACEQ was again 71.4% (i.e., 25 completed questionnaires out of 35 questionnaires distributed). For the individual response rates for each TAC at each administration see the table on page 93.

Analysis of the Questionnaire

The "not applicable at this time" responses were excluded from data analysis at all three time points. The number of these responses excluded in any given question within the six dimensions varied; however, these responses were considerable for some dimensions (i.e., service delivery, partnerships) at all three time points. This result was expected in the baseline measure where certain areas had not yet been addressed and therefore, perceived as not applicable at this time by respondents. It was anticipated that respondents would provide an assessment of effectiveness in the later administrations of the questionnaire, given TAC progress in its work plan and ultimately progress within each of the dimensions. In fact, the total number of questions in which respondents answered "not applicable at this time" (out of the total number of questions answered) decreased with each administration of the TACEQ. For example, in the baseline measure there were 258 questions that were answered "not applicable at this time" out of a total of 1400 possible questions answered by the respondents (i.e., 40 questions x 35 respondents). At the mid-point, there were 112 questions that were answered "not applicable at this time" out of a total of 1520 possible questions answered by respondents (i.e., 40 questions x 38 respondents). And at the end point, there were 60 questions that were answered "not applicable at this time" out of a total of 1000 possible questions answered by respondents (i.e., 40 questions x 25 respondents). In terms of percentages, the "not applicable at this time" responses were 18.4% (baseline), 7.4% (mid-point), and 6.0% (end-point).

In the event that a respondent did not answer the question, the mode for that question according to the TAC (or the most common response for that question within the TAC) was imputed as that respondent's response. This occurred for only 11 questions out of 1400 possible questions (i.e., 40 questions x 35 respondents), or 0.8% of the questions in the baseline measure. At the mid-point, this occurred for 55 questions out of 1520 possible questions (i.e., 40 questions x 38 respondents), or 3.6% of the questions. And at the end-point, this occurred for 31 questions out of 1000 possible questions (i.e., 40 questions x 25 respondents), or 3.1% of the questions.

The N in the tables below is used to determine the mean for each dimension and is equal to the total number of completed questionnaires in the TAC at that time point or is lower depending upon the exclusion of the "not applicable at this time" responses from the analysis. The individual means for each of the questions within the dimensions were used to determine the overall mean for that dimension. The overall mean for each dimension are the results reported in the tables below. In a questionnaire with a small likert scale such as 1 to 5, it is better to report the median response and the range of responses for each dimension; however, in this report the mean response and the standard deviation are presented in an effort to better illustrate any variance in the dimensions between the three time points. Nevertheless, the reader is cautioned not to place too much emphasis in small changes in the means, for example, from 3.09 to 2.76. A change in the means from 3.52 to 1.76 would be more significant. Unfortunately, tests for statistical significance (e.g., paired t-tests) could not be performed because of an inability to match a respondent's questionnaire between the three time points, as the questionnaires were completed anonymously. Furthermore, due to TAC

representative turnover, some respondent's completed the baseline questionnaire only, or completed only the mid- and end-point questionnaires, or another such combination of responses. This is recognized as a limitation of the study; however, the reader may draw clinical importance or project significance from the findings presented below.

The discussion below (or the TACEQ) is not intended to compare or to contrast between the TACs, rather the analysis is used to assess improvements in perceived effectiveness or progress within each TAC with respect to each dimension from one point in time to another (e.g., from baseline to mid-point; from mid-point to end-point). For the purposes of this analysis, ratings of effectiveness of 3.0 or greater are considered to be high perceived effectiveness by the TAC. Ratings of effectiveness less than 3.0 are considered to be low perceived effectiveness or areas for improvement for the TAC.

Mental Health and Addictions TAC

The MHATAC had good ratings of effectiveness for three of the questionnaire dimensions: purpose and vision, roles, and communication (Table 8). The service delivery, team support, and partnerships dimensions were areas for improvement for the MHATAC. This was not surprising given that the MHATAC struggled with: the development of its work plan; poor facilitation; and personality issues, which all inhibited group cohesiveness to some extent (i.e., the development and strengthening of partnerships within), not to mention the development and strengthening of inter-sectoral partnerships or linkages with the community (both aspects measured within the partnerships dimension of the TACEQ). Furthermore, many TAC representatives felt that they were not meeting to "deliver services" and thus, ratings of effectiveness were lower in this dimension. The TAC representatives were encouraged to think of the service delivery dimension as the mandate from the NHSWG to collaborate on the development of recommendations aimed at improving promotion, prevention, and treatment services to residents of northern Saskatchewan within their particular area of health (e.g., mental health and addictions). It had been anticipated that over the course of the project, as the MHATAC progressed through its work plan, and developed new or strengthened existing partnerships, the ratings of effectiveness for these dimensions would increase at the mid-point and/or end-point; however, the ratings remained the same or decreased.

Chronic Disease TAC

The CDTAC had good ratings of effectiveness for four of the questionnaire dimensions: purpose and vision, roles, communication, and team support (Table 9). The service delivery and partnerships dimensions were areas for improvement for the CDTAC. At the time of the baseline measure, the CDTAC was in the development of its work plan, which might explain a lower rating of effectiveness with respect to the service delivery dimension. It had been anticipated that over the course of the project, as the CDTAC progressed through its work plan, the ratings of effectiveness for this dimension would increase at the mid-point and/or end-point, which was the case and likely due to the development of a charter or strategic plan for a northern chronic care coalition.

Perinatal and Infant Health TAC

The PIHTAC had good ratings of effectiveness for all questionnaire dimensions: purpose and vision, roles, communication, service delivery, team support, and partnerships (Table 10).

Furthermore, the ratings of effectiveness in each dimension increased from time point to time point. The PIHTAC reported good working relationships, strong facilitation, progress in its work plan, and successes such as, resource development and information sharing/training events (e.g., sexual health education workshop), likely all contributing to the high perceived effectiveness in each dimension for this TAC.

Oral Health TAC

The OHTAC had good ratings of effectiveness for five of the questionnaire dimensions: purpose and vision, roles, communication, service delivery, and team support (Table 11). The partnerships dimension was an area for improvement for the OHTAC. The TAC representatives felt that their TAC could be more professionally diverse (i.e., not just dental professionals), and should begin to work more closely with the other TACs (e.g., chronic disease, perinatal and infant health), given the importance of oral health to the overall health of the individual.

Reliability Analysis

A reliability analysis was performed on the TACEQ with good results (Table 12). A reliability analysis is a measure of the internal consistency of the questionnaire or its ability to measure what it claims to measure. A reliability coefficient (i.e., the alpha) of 1.0 is a perfect correlation (between the questions and the dimension the questions are to be measuring), while a coefficient of 0.7 is considered to be acceptable. In all instances except for two, the reliability coefficients for each of the dimensions measured by the TACEQ at all three time points were above 0.7. Thus, the reader can have confidence in the measures of perceived effectiveness in each dimension for the four PHC TACs. The overall reliability coefficient for the questionnaire (i.e., all dimensions combined) for the three time points is also included in Table 12.

Table 7 – Technical Advisory Committee Effectiveness Questionnaire (TACEQ) Response Rates for each Technical Advisory Committee at each Time Point

Response Rates									
	Baseline			Mid-Point			End-Point		
TAC	Distributed	Returned	Percentage	Distributed	Returned	Percentage	Distributed	Returned	Percentage
MHA	13	12	92.3	14	11	78.6	11	10	90.9
CD	11	8	72.7	11	8	72.7	8	4	50.0
PIH	11	6	54.5	12	10	83.3	8	7	87.5
OH	14	9	64.3	11	9	81.8	8	4	50.0
All TACs	49	35	71.4	48	38	79.2	35	25	71.4

Table 8 – Overall Mean for each Dimension at each Time Point for the Mental Health and Addictions Technical Advisory Committee

Mental Health and Addictions Technical Advisory Committee									
	Baseline			Mid-Point			End-Point		
Dimension	N	Mean	SD	N	Mean	SD	N	Mean	SD
Purpose/Vision	12	3.19	0.39	11	3.02	0.55	10	2.96	0.55
Roles	11	3.17	0.44	11	3.05	0.49	10	2.95	0.58
Communication	12	3.12	0.24	11	3.13	0.31	10	2.93	0.36
Service Delivery	12	2.70	0.50	11	2.72	0.55	10	2.68	0.46
Team Support	12	3.09	0.37	11	2.89	0.34	10	2.76	0.33
Partnerships	11	2.74	0.47	11	2.74	0.53	10	2.38	0.38

Table 9 – Overall Mean for each Dimension at each Time Point for the Chronic Disease Technical Advisory Committee

Chronic Disease Technical Advisory Committee									
	Baseline			Mid-Point			End-Point		
Dimension	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**
Purpose/Vision	8	2.82	0.41	8	3.21	0.30	4	3.06	0.30
Roles	8	3.07	0.59	8	3.09	0.53	4	2.96	0.37
Communication	8	3.07	0.47	8	3.17	0.40	4	3.20	0.47
Service Delivery	8	2.64	0.42	8	2.85	0.24	4	2.96	0.30
Team Support	8	2.84	0.58	8	3.05	0.42	4	2.92	0.32
Partnerships	8	2.80	0.24	8	2.50	0.28	4	2.71	0.44

Table 10 – Overall Mean for each Dimension at each Time Point for the Perinatal and Infant Health Technical Advisory Committee

Perinatal and Infant Health Technical Advisory Committee									
	Baseline			Mid-Point			End-Point		
Dimension	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**
Purpose/Vision	6	3.30	0.47	10	3.54	0.33	7	3.69	0.26
Roles	6	3.14	0.54	10	3.42	0.42	7	3.59	0.21
Communication	6	3.04	0.13	10	3.51	0.33	7	3.46	0.24
Service Delivery	6	2.98	0.39	10	3.28	0.44	7	3.42	0.38
Team Support	6	3.17	0.41	10	3.32	0.44	7	3.46	0.30
Partnerships	4	3.13	0.25	10	2.96	0.25	7	3.37	0.39

Table 11 – Overall Mean for each Dimension at each Time Point for the Oral Health Technical Advisory Committee

Oral Health Technical Advisory Committee									
	Baseline			Mid-Point			End-Point		
Dimension	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**
Purpose/Vision	9	3.04	0.48	9	3.24	0.53	4	3.20	0.52
Roles	9	3.00	0.48	9	3.04	0.52	4	3.17	0.56
Communication	9	3.04	0.34	9	3.16	0.46	4	3.16	0.33
Service Delivery	9	2.85	0.22	9	2.94	0.44	4	2.95	0.44
Team Support	9	2.81	0.44	9	2.85	0.67	4	2.88	0.55
Partnerships	9	2.53	0.29	9	2.74	0.65	4	2.65	0.53

Table 12 – Reliability Coefficient for each Dimension at each Time Point

Reliability Analysis									
	Baseline			Mid-Point			End-Point		
Dimension	**N**	**n**	**Alpha**	**N**	**n**	**Alpha**	**N**	**n**	**Alpha**
Purpose/Vision	35	26	0.69	38	35	0.75	25	22	0.81
Roles	35	29	0.88	38	35	0.84	25	25	0.88
Communication	35	23	0.60	38	30	0.83	25	18	0.84
Service Delivery	35	12	0.75	38	24	0.86	25	18	0.88
Team Support	35	21	0.83	38	30	0.89	25	22	0.80
Partnerships	35	16	0.70	38	27	0.72	25	19	0.84
All Dimensions	35	10	0.91	38	18	0.96	25	15	0.96

N = total number of questionnaires completed at baseline, mid-point or end-point (all TACs combined)
n = total number of cases used to determine the alpha coefficient (1 case = 1 completed questionnaire)
Alpha = alpha coefficient (reliability measure)

5.6 Information Systems

The following table (Table 13 – Information Systems Component Objectives and Anticipated Outcomes) reflects the changes and additions to the project objectives and anticipated outcomes from the project proposal to the implementation of this project component. Within the project, the information systems component is composed of two parts: information technology and health information management. Each of these was evaluated separately.

Table 13 – Information Systems Component Objectives and Anticipated Outcomes

According to Proposal (October 2003) [1]	
Objective	• Develop the statistical systems that will monitor and provide surveillance of environmental health, wholistic health indicators, and common data to all partners (especially the community) for planning and evaluation purposes. [p. 35]
Short-term Outcomes	• None stated
Long-term Outcome	• A common statistical collection system that will monitor wholistic health indicators and provide support for wholistic health planning. [p. 27]
According to NHSWG Review (December 2004)	
Objective	• To identify information requirements of NHSWG partners to enable evidence-based decision-making specific to: program planning, program evaluation, and monitoring indicators of health status.
According to the Information Technology Facilitator/Coordinator (April 2005) [12]	
Objective	• To assess the IT infrastructure of the NHS partners and identify opportunities for cooperation, coordination, and collaboration of IT services and practices provided to northern communities in the health sector.
Short-term Outcome	• To increase awareness and understanding of e-health trends, emerging technology standards, and IT commonalities and gaps between the provincial and First Nations systems among ITTAC members.
Long-term Outcomes	• To facilitate a common IT system of at least interoperable systems between health jurisdictions in northern Saskatchewan; and • To facilitate common IT solutions for the TACs.
According to the Health Information Management Consultant (April 2005) [12]	
Objective	• To develop a snapshot of the current health information environment across northern Saskatchewan.
Short-term Outcomes	• To develop long range objectives and a plan for a streamlined and comprehensive collection of clinical documentation, information, utilization, and management of health information systems in northern Saskatchewan; and • To develop a plan for strategic integration of health information and IT applications needed for a sustainable and intra-operative information system between health jurisdictions in northern Saskatchewan.

Long-term Outcome	• To streamline and standardize (where possible) HIM among the NHSWG partners to improve health care and services provided to residents of northern Saskatchewan.

5.6.1 Information Technology TAC

The purpose of the Information Technology TAC was "to provide a forum for collective discussion, information sharing, strategizing and action planning concerning all matters related to IT services; and to develop and implement plans and recommendations that will improve IT services for health delivery in the communities represented by the NHS."[25, p.3]

5.6.1.1 Activities, Outputs, and Outcomes

The IT Coordinator worked with the Shared Paths project from January 2005 to his resignation in February 2006. Within that period of time, the ITTAC held five meetings, the first in June 2005. The IT Coordinator was not able to establish a formal work plan for himself or the TAC for a number of reasons. Information technology is by nature a support service and was dependent on the readiness of the PHC TACs to identify and document their health information management needs (see below for further elaboration). In addition, the gap between the First Nations and provincial IT systems, as well as jurisdictional barriers inhibited the development of a work plan.[25]

Current State Assessment

The first task of the IT Coordinator was to complete an environmental scan with respect to current IT practices and standards, as well as IT projects currently in development that would impact health services in northern Saskatchewan. The Coordinator interviewed each TAC representative within the NHS partners and funding organizations, and individual current state assessments were prepared from the information collected. These assessment were completed in June 2005 and identified several key observations, some of which included:[25]

- FNIHB assumes the IT services for First Nations community health services;
- provincial NHS partners are part of a well planned and structured provincial e-Health Network with the Health Information Solutions Centre (HISC) being an integral IT and information management service provider for the RHAs;
- AHA is a multi-jurisdictional organization and has no local IT support and relies solely on an outside private organization for recommendations and implementation;
- RHAs use the health segment of CommunityNet for their (private) wide area networking. All the provincial TAC representatives identified CommunityNet as making the most significant impact to IT and information management;
- RHAs provide guidance and hands on support for their community level IT services;
- the e-Health Services Unit of FNIHB and the Tribal Councils share support services for the First Nations communities, but this is not coordinated;
- almost all the First Nations health facilities have internet access, but IT has not been standardized nor does IT have the capacity to support video conferencing over the Internet Protocol (IP); and

- there are presently no adequate electronic health information systems to address client management and surveillance systems for the areas of concern identified by the NHSWG: mental health; chronic disease; perinatal and infant health; and oral health.

In addition to the current state assessment, the Coordinator and the TAC completed a "cross-jurisdictional exercise" to identify the specific jurisdictional issues with respect to IT systems, which emphasized: identification of essential IT services and programs required to support community-based care givers; identification of where telehealth and electronic health information systems work well and where they breakdown; and any recommendations based on the findings. This exercise was requested by the MFN-CAHR to aid in their exploration of jurisdictional issues within the NHS partners, and the development of a cross-jurisdictional decision-making mechanism (see page 19). Please refer to the ITTAC final report for a detailed summary of the current state assessment and cross-jurisdictional exercise.[25]

Support Provided to other TACs/Project/NHS Partners

Part of the mandate of the IT Coordinator and the ITTAC was to support the information technology needs of the four PHC TACs. At the start of the project, it was thought that the IT component could provide electronic tools to support the information management needs of the PHC TACs; however, it became evident that the current IT systems did not meet the information management needs of the north. According to the IT Coordinator, the development of an electronic information management tool has four phases: needs assessment; requirements gathering; software strategy; and planning and development. In the later months of the project, the IT Coordinator and the HIM Consultant met with the PHC TACs (i.e., MHATAC, PIHTAC, OHTAC) on several occasions to document their needs and begin the tedious process of collecting specific requirements in an attempt to proceed with software solutions. Unfortunately, once the TACs were ready to engage in a system requirements exercise, the project was nearing completion. Thus, only minimal progress was made with regards to discussing the requirements for a northern electronic information management tool within each TAC. However, the IT Coordinator and the HIM Consultant did begin to look for an external software management service provider because the north did not have the resources or expertise to host or manage software system(s). It became clear that HISC of Saskatchewan Health would be the most appropriate service provider, as software management and support services are components of their mandate. The IT Coordinator and the HIM Consultant met with HISC in January 2006 to explore the idea of HISC providing software solutions and services for the north. The HISC was interested in this idea, although they had a number of concerns, including: a lack of provincial scope for the NHS; would the north's e-health strategy be complementary to the provincial strategy (note: a northern e-health strategy does not currently exist); and the multi-jurisdictional nature of the NHS, particularly the First Nations jurisdictions.[25]

In addition, the IT Coordinator organized the purchasing of video conferencing equipment and advanced network switches (for provision networking 'Quality of Service') for nine partners of the NHS (costs covered through 2004/05 unexpended project funds). The provincial partners were able to apply their units into their network because they are part of an established province-wide virtual private network (CommunityNet) and telehealth system, with support services and training available to them. The First Nations partners struggled, and are still struggling with implementation of the units because: they are excluded from the provincial network (CommunityNet); they do not have standards or a structured approach to telehealth systems; and furthermore, they do not have an

overall IT strategy or funding support. For the First Nations partners, receiving this equipment was their first exposure to video conferencing and therefore, requested assistance and education on equipment setup, telecommunication needs, etc. The IT Coordinator facilitated an education session with the First Nations ITTAC representatives to educate these reps on video conferencing technology and terminology, and also to discuss the technical and jurisdictional issues that could affect performance and interoperability. In addition, the Coordinator made site visits to several partners to assist with equipment setup (e.g., installation and configuration).[25]

The IT Coordinator also suggested the use of WebEx to enhance TAC and NHSWG teleconference meetings. WebEx, a remote on-line electronic tool, improved remote collaboration of the NHS partners; reduced telecommunications costs to the project; and added a visual dimension to standard teleconferencing as participants could view agendas, working documents, PowerPoint presentations, etc., from their office computers.[25]

The IT Coordinator also provided specific IT support or advice to some NHS partners. The Coordinator worked with AHA to provide advice on enabling video conferencing and telehealth capacity in the far north. AHA is at a disadvantage in comparison to the other NHS partners due to its remoteness and limited telecommunications options. For example, video conferencing capabilities would provide a medium for participation in the NHSWG or TAC meetings for which time and costs associated with travel to and from the far north are a barrier. Telehealth capacity (through video conferencing capability) would also provide a medium for administrative, educational, or clinical sessions with other health service providers in the province for the residents and health service providers in the AHA region. Illustrative of this last point, the Coordinator also worked with PBCN to identify the technical requirements needed to deliver mental health services from service providers in Saskatoon to clients in the north via telehealth, utilizing the video conferencing equipment. According to the Project Coordinator, PBCN is currently utilizing telehealth to provide residents with access to professional mental health services. These examples of support, from project to NHS partners, is indicative of the need at times to address barriers to accessing services, and to support individual partner readiness prior to proceeding with broader collaboration.

5.6.1.2 TAC Recommendations and NHS Strategic Planning

The IT Coordinator and/or the ITTAC developed and submitted three recommendations to the NHSWG over the course of the project. From the current state assessment and the video conferencing equipment initiative, a recommendation to include First Nations partner organizations within the health segment of CommunityNet (other segments include government and education) was prepared by the IT Coordinator for the NHSWG in June 2005. Presently, provincial health service providers, including the provincial partners of the NHS, use the health virtual private network for data communications needs, such as internet and email access, telehealth, and centralized health information systems. First Nations health service providers are excluded from CommunityNet through policy, although some (i.e., NITHA, PBCN) have been given limited access on an informal basis to provincially hosted IT services, such as the Integrated Public Health Information System (iPHIS), the Saskatchewan Immunization Management System (SIMS), and telehealth services (e.g., clinical and education sessions). Including First Nations within CommunityNet would lead to common systems within the north (potentially eliminating interoperability problems), improved IT services, lower telecommunications costs, and potentially

improved health outcomes for residents of northern Saskatchewan through the availability of fluent and reliable electronic information exchanges with the province, such as telehealth and health information systems (e.g., electronic health records systems).[26]

The NHSWG approved this recommendation in August, and in September the NHSWG Co-chairs, Project Coordinator, and IT Coordinator met with individuals from the Information Technology Office (ITO) and the HISC (the main stakeholders involved in CommunityNet) to discuss the barriers of First Nations access and to advocate for their inclusion. Both the ITO and HISC were receptive to First Nations access to CommunityNet and verbally agreed to allow access to First Nations; however, they noted that there was much work to do in order to achieve access. Essentially, those second level First Nations health service providers (e.g., LLRIB, MLTC, PAGC, PBCN) interested in accessing CommunityNet would enter into individual discussions and agreements with the HISC/ITO, and would be treated as "customers" much the same way as RHAs are treated. The difference being that the First Nations "customers" would be required to cover the costs of access. The first level First Nations health service providers (e.g., communities) would access the service via their respective second level health service providers and could do so incrementally. This was considered a huge success by the IT Coordinator, Project Coordinator, and the NHSWG, as it represented a change in policy. In January 2006, the IT Coordinator and the HIM Consultant met with HISC as a follow up to the September meeting. At this meeting, HISC raised a potential barrier to access, stating that CommunityNet was not only a province wide virtual private network but also a component of a larger e-health plan, which included services such as electronic health records systems, support services, helpdesk, etc. If First Nations were to gain access to CommunityNet, their strategy should also be to complement the larger provincial e-health plan. As a result, HISC expects the NHS and First Nations to develop a northern e-health strategy that would complement the province's CommunityNet plan. Currently, First Nations are developing their strategies via the NITHA e-health working group, presently chaired by the project's IT Coordinator. According to the IT Coordinator, before substantive ground is made on this recommendation there needs to be information exchange and collaboration between the two jurisdictions.[25]

The IT Coordinator and the HIM Consultant worked with the Chronic Disease Coordinator and TAC to prepare a recommendation to the NHSWG in regards to the Western Health Information Collaborative Chronic Disease Management Infostructure Project. This project involved the four western provinces in the development of an innovative and sustainable chronic disease management "infostructure," which included the creation of standards for chronic disease data and information exchange, with the capacity to share this information across systems and jurisdictions in support of clinical decision-making. Unfortunately, there had been no real northern representation in the project in the early phases and these Coordinators, recognizing the importance of this initiative, recommended that the NHSWG seek representation and participation in the project so that the unique needs of the north were met. The NHSWG approved this recommendation in June 2005, requested representation, and were successful in achieving representation and participation on two of the project's working groups: functional requirements; and IT and security requirements. The Saskatchewan Health representative of the NHSWG was instrumental in ensuring northern representation and participation in this project. Of note, the IT Coordinator was a member of the IT and Security Requirements Committee. However, this project was eventually suspended and the project team was transferred to the Health Quality Council's Chronic Disease Management Collaborative (see page 69) given that the collaborative had the same focus with a deadline of September 2006.[25]

Finally, the ITTAC submitted a recommendation in February 2006 to leverage the HISC's "SharePoint" license and web hosting service in order to facilitate a NHS 'web portal' whereby the partners could post and access information relevant to the Strategy. According to the IT Coordinator, SharePoint is a dissemination tool that is sustainable, has no cost, and is self-managed (i.e., developed and maintained by the user). The NHSWG reached consensus to implement this recommendation, also in February, with the Communications Coordinator responsible for initial setup.[25] This is still in the development phase due to accessibility issues; however, the initial page, a NHS page, with partner information and links has been established. The agreement between HISC and the NHS is expected to be in place in September 2006, and the partners will be given control of their specific pages and authorization to sign up employees for exclusive access.[18]

When presenting the ITTAC final report to the NHSWG in June 2006, the IT Coordinator made the following recommendations to sustain the work of the Coordinator and the TAC post-project:

- implement the SharePoint web portal;
- First Nations partners should build e-health capacity;
- First Nations partners should build relations with Saskatchewan Health and get a seat on the Chief Information Officers (CIO) Forum;
- NHS should formalize a 'northern e-health strategy' and framework to:
  - Address the information needs of the northern health profile;
  - Meet northern health providers needs to deliver services to a common and mobile client base; and
- the IT and HIM TACs should merge to form a northern information officer forum.

The Coordinator also suggested that the ITTAC could not sustain itself given the disparity between the provincial and First Nations partners with respect to information technology; however, the ITTAC representatives felt that the group should continue to meet post-project to develop a northern e-health strategy and would like to see more commitment from FNIHB.[25]

Within the NHS Strategic Plan,[15] there is support for establishing a northern "task force" (made up of individuals with information technology and management responsibilities), with a mandate to establish a northern e-health strategy and to plan, manage, facilitate, support, and sustain health information requirements and advances in the north.

5.6.1.3 Evaluation Findings

Successes

The first and foremost success of the IT component of the project was the HISC's agreement to allow First Nations access to CommunityNet, although this is dependent on the development of a northern e-health strategy. Regardless, the advocacy work of the NHS via the IT Coordinator is important for several reasons: it demonstrates what a collective voice can accomplish; it represents a change in governmental policy; it shows that providers are beginning to acknowledge the continuum of care versus jurisdictions when providing services; and it removes a jurisdictional barrier to accessing service, and also a technical barrier, opening the door for First Nations partners to gain access to the eventual inter-operable electronic health record through the province.

> *[It was] a huge success that the province will permit First Nations onto the provincial health network. Now there won't be any technical barriers such as when you start looking at the applications, information systems*

that are hosted by the province, driven by the province, as well as the telehealth systems. And also, with the province being the proxy to the larger e-health picture, the Canadian inter-operable electronic health record strategy, they're the experts and they could be the gateway [for] First Nations.

In addition, the current state assessment completed by the IT Coordinator was considered a substantial success, as it provided a comprehensive understanding of what exists in the north and where gaps occur in terms of IT. Both the IT Coordinator and the ITTAC identified networking and information sharing as successes of the project. Historically, provincial and federal/First Nations e-health providers have not actively engaged each other on IT issues; however, with the ITTAC some engagement has occurred between the jurisdictions, and both have benefited from meeting their counterparts, discussing the state of IT in the north, and learning about the "other" system. According to the Coordinator, education of the TAC representatives via TAC meetings, educations sessions or one-on-one discussions have led to increased knowledge and understanding of the current state and future of e-health systems (i.e., technology, applications), as well as the importance of and need for common systems in the north. According to TAC representatives, First Nations in northern Saskatchewan now understand the importance of being included in an e-health strategy with both the province and the federal government. The TAC representatives also noted their other recommendations and the receipt of video conferencing units as successes. The TAC representatives were very pleased with the work of their Coordinator and with their progress; however, they wished that they could have met as a TAC earlier in the project (first met in June 2005), potentially accomplishing more and feeling less rushed to complete their tasks.

Challenges

Like the other TACs, the ITTAC experienced some challenges in attendance at meetings. For example, there were two vacant positions on the TAC, which were representative of vacant IT positions in the NHS partners. Furthermore, there was a lack of consistent participation in TAC meetings from several NHS partners. In addition, ITTAC representatives cited travel as a challenge as this took time away from their daily responsibilities as travel time ranged from two to four hours one-way.

A significant challenge to the work of the IT Coordinator (and to the TAC) was the apparent gap that exists between First Nations e-health development and provincial e-health development. There has been a lack of coordination between the federal and First Nations systems to provide the same level of services to northern First Nations that the province is able to provide to the northern RHAs. The First Nations partners have no infrastructure, human resources, management structure or financial resources, and are also faced with jurisdictional barriers to access to provincial systems. Furthermore, the ITTAC cited a lack of capacity among northern First Nations with regards to electronic health information systems. As such, the provincial partners of the TAC were in a better position to discuss and work towards IT innovations. According to the Coordinator, "*without first overcoming these barriers the ITTAC could not focus on common innovative systems.*"

The IT Coordinator also noted a second challenge to his work, the willingness of the provincial and federal governments to engage in a PHC approach to e-health systems, i.e., a public health picture versus discreet data sets. Although the Coordinator did feel that through the project some progress was made in this area, particularly with the NHS partners, as all seem to understand the need and

importance of common systems in the north and to align First Nations e-health development with provincial e-health development.

With respect to this component of the project, the NHSWG representatives reported that: the IT Coordinator was an asset to the project; initial steps have been taken and progress was made; and an important achievement was access to CommunityNet for First Nations, a door has been opened and First Nations partnerships with the province are being built. However, one NHSWG representative felt that this component of the project was focused too much on the First Nations partners and did not address the north as a whole. Another NHSWG representative felt that an overall plan or strategy for moving IT forward in the north was not provided, particularly with respect to building human resource capacity.

> *In their recommendations, there's no overall plan or strategy about moving forward and again, there was no specific human resource development recommendations there. Generally, people are dependent either on expertise in NITHA or from the Federal government offices or the Provincial government offices and not a lot of discussion about how do we improve the resident capacity in the different organizations but I think that there has been some good work done there.*

5.6.1.4 Summary Statement

Similar to other TACs, the completion of a current state assessment regarding IT infrastructure in the north will provide a foundation for future programs, services, and policy. The work of the IT Coordinator furthered understanding of both the current state and the future of e-health systems, and also seemed to create an awareness of the importance of developing inter-operable systems in the north. The short-term outcome of increasing awareness and understanding of e-health trends, emerging technology standards, and IT commonalities and gaps between the provincial and First Nations systems among ITTAC members was achieved over the course of the project.

The recommendations of the IT component of the project were largely premised on the belief that inter-operable systems must be developed and maintained to facilitate information sharing and ultimately improve client care in the north. The most formidable obstacle to achieving the outcome of inter-operable systems will remain jurisdictional issues. However, the agreement to allow First Nations access to CommunityNet represents an important step in achieving this outcome. The second long-term outcome for the ITTAC, to facilitate common IT solutions for the PHC TACs, will be dependent on the continuation of the TACs; further identification of their systems requirements; and identification of a software management service provider.

5.6.1.5 Evaluation Recommendations

Sustaining the work of the IT Coordinator and the TAC will hopefully lead to the development of a northern e-health strategy, which is a requirement for the HISC to begin providing services. Thus, it is recommended that consideration be given to the development of a northern information officers forum or task force with the mandate to work collectively to build the information technology and management capacity of northern First Nations partners to that of the northern RHAs, as well as to establish a northern e-health strategy (e.g., what does it look like and how to get there). It is recognized that this will require a significant period of time, as well as significant resources (i.e., financial, human, technological), which should be sought from all available sources (e.g., internal and

external to the NHS partners, governmental and non-governmental). Given that the website expired on August 31, 2006 (due to the lack of funds to maintain), the NHSWG should continue to pursue and implement the SharePoint web portal as a means to share and disseminate information to the partners without incurring costs.

5.6.2 Health Information Management TAC

5.6.2.1 Activities, Outputs, and Outcomes

The HIM Consultant worked with the Shared Paths project from January 2005 to March 2006. Within that period of time, the HIMTAC met eight times. Unfortunately, the HIMTAC had to cancel its meeting in June 2005 and thus, the first meeting of this TAC occurred in August.

Current State Assessment

The HIM Consultant's first task was to develop a work plan for the health information management component of the project.[27] Following the development of a work plan, the Consultant interviewed the HIM contacts within each NHS partner and funding organization to complete a current state assessment with respect to health information management in northern Saskatchewan. This was a daunting task considering that every health care provider must create a medical or health record for every client visit that occurs, regardless of the service provided (e.g., acute care, outpatient, home care, immunizations). Therefore, it was necessary to determine specific areas to assess in order for the process to be manageable within the timeline of the project. The key information and infrastructure areas identified and assessed were: demographics; databases (paper or electronic); indices; immunizations; communicable diseases; home and community care; mental health and addictions; chronic disease; perinatal and infant health; and oral health. Individual current state assessments were prepared from the information collected from each NHS partner. Drawing from these current state assessments, site visits to communities, and from information provided by HIMTAC representatives, some interesting findings[28] came to light, some of which included:

- health information collection, utilization, and management throughout the north is essentially manually recorded and paper driven, with the exception of the regional acute hospitals, where electronic health record technologies have been introduced;
- there are virtually no electronic (health record) database systems in northern communities, with the exception of the regional acute hospitals;
- few First Nations communities in the north have continued to use the First Nations Inuit Health Information System (FNIHIS) electronic database, largely due to a lack of capacity and the system is not user-friendly (FNIHIS is to be discontinued in 2006);
- due to the lack of health record professionals in the north, nurses are mainly responsible for the processing of records and the development of required statistics, which is extremely time consuming;
- there are no standard, centralized client/patient indices in First Nations' community health care sites, with the exception of a few communities;
- there are no unique patient identifiers in the north, except for at provincial acute cites that utilize WinCis;
- the majority of clinical health information in First Nations communities is underutilized;
- client/patient records are duplicated in some communities to facilitate care and physician's access; and
- patient information is fragmented for all of the jurisdictions, as there are no mechanisms in place to interface client/patient demographic information between the jurisdictions, which has a negative impact on continuity of care.

In addition to the current state assessment, the HIM Consultant and the TAC completed a "cross-jurisdictional exercise" to identify the specific jurisdictional issues with respect to HIM systems, which emphasized: identification of essential health information systems (where are these available and accessible); identification of where the flow of health information systems works well and where it breaks down; confidentiality, security, and privacy issues; and any recommendations based on the findings. This exercise was requested by the MFN-CAHR to aid in their exploration of jurisdictional issues within the NHS partners, and the development of a cross-jurisdictional decision-making mechanism (see page 19).

Electronic Databases – Bridging Plan

Recently, the province mandated an electronic patient demographic registration database, which has been introduced to the northern RHAs for the acute sites, with expansion to other sites within the region at the discretion of the RHA. The database is known as WinCis and it is hosted and supported through the HISC in Saskatchewan Health. The long-term objective is to have the database networked across the province and eventually Canada, producing a pan-demographic registration system, that is, one component of the eventual electronic health record (EHR).[28] Conversely, many First Nations communities in the north currently use a manually-driven, paper-based system for recording patient demographic information.[28] Thus, the HIMTAC discussed the differences between the electronic (i.e., provincial) and the paper-based client demographic systems numerous times over the course of the project. At the third HIMTAC meeting in October 2005, the TAC received a demonstration of the Nurses' Daybook electronic database developed by AHA in conjunction with SPHERU, which tracked client demographics and services provided. This database was specifically designed to eliminate manual recording of client information and reduce the workload for nurses' month end reports (e.g., eliminate the tedium of manual calculations for month end statistics). It should be mentioned that this database was piloted with nurses from the AHA region, was well received, revisions were made based on feedback, and it was hoped to be implemented within the region by June 2006. At the sixth meeting in January 2006, the HIMTAC received a demonstration of the Cypress Hills RHA Public Health Database, which tracked client demographics, appointments, daily statistics, etc.

Following the demonstration of the AHA Nurses' Daybook database, the HIMTAC agreed that a good foundation would be to convert from a manual, paper-based system to an electronic record and developed a recommendation with respect to developing an electronic tool to capture client demographic and nursing service utilization[28] (see pages 108-9 for full explanation). Furthermore, the HIMTAC agreed that the north required a bridging plan or migration strategy to facilitate the implementation of an improved health information system and electronic records capacity (e.g., from paper records to an access database to WinCis to EHR). The ultimate objective of this bridging plan would be the implementation of the EHR in the north, which would be interoperable with the pan-Canadian EHR. The HIMTAC began to discuss and develop a bridging plan,[28] which included five domains: client care; programming and services; data management; communications; and organizational management. Unfortunately, the HIMTAC did not complete this plan during the project and it remains a work plan item for the recommended HIM task force or council (i.e., the HIMTAC post-Shared Paths project).

Due to time constraints, the HIMTAC did not formally address confidentiality, privacy, and security issues, although these are extremely important components of HIM and IT; however, a number of informal discussions occurred in the TAC meetings.[28]

Support Provided to other TACs/Project/NHS Partners

Part of the mandate of the HIM Consultant and the HIMTAC was to support the health information management needs of the four PHC TACs; however, only the Consultant provided support to the PHC TACs. The HIM Consultant sat on the northern breastfeeding subcommittee of the PIHTAC to provide support in the collection of data with respect to northern breastfeeding rates (i.e., initiation rates, maintenance rates). Currently, there is no standardized breastfeeding information collected in the north, with the information that is available often being not timely or comprehensive. Moreover, the NHSWG suggested that collecting information only on northern breastfeeding practices was too focused and should be expanded to include broader information on perinatal and infant health issues, so the development of a data collection strategy became the task of the TAC versus the subcommittee. Accordingly, the HIM Consultant provided support to the TAC to facilitate the process of developing their strategy and recommendations for a breastfeeding survey and an overall Perinatal Information Management System. Recommendations related to a breastfeeding survey and perinatal information management tool were discussed, but not fully developed and formally submitted to the NHSWG.[28]

At the provincial level, there is a Mental Health and Addictions electronic information system, which is a web-based community database. Saskatchewan Health did not involve First Nations in this information system due to cost and also jurisdictional issues. Thus, there are currently no standardized information systems, formats or information collection methodologies in northern First Nations communities. The MHATAC initially wanted to recommend the development of a mental health and addictions information management system, with the aid of the HIM Consultant and IT Coordinator; however, the MHATAC decided not to proceed with this recommendation due to concerns surrounding privacy and confidentiality of client information, access to information, as well as whether to focus on common data elements between jurisdictions or a common system for the north.[28]

In terms of oral health information, the north does not have a common, standardized information system or database. As a result, the OHTAC identified data collection (or database development) as one of their priorities. The TAC requested the support of the HIM Consultant and the IT Coordinator to facilitate the development of a strategy and recommendation to develop an oral health data collection management tool. A subcommittee of OHTAC members was formed to work with the HIM Consultant and the IT Coordinator. The strategy and recommendation was discussed during several OHTAC meetings, but not fully developed and formally submitted to the NHSWG. It remains as a 2006/07 work plan item.[28]

At the start of the project, it was thought that the HIM and IT components of the project could provide electronic tools to support the information management needs of the PHC TACs; however, it became evident that the current IT systems did not meet the information management needs of the north. According to the IT Coordinator, the development of an electronic information management tool has four phases: needs assessment; requirements gathering; software strategy; and planning and development. In the later months of the project, the HIM Consultant and the IT

Coordinator met with the PHC TACs (i.e., MHATAC, PIHTAC, OHTAC) on several occasions to document their needs and begin the tedious process of collecting specific requirements in an attempt to proceed with software solutions. Unfortunately, once the TACs were ready to engage in a system requirements exercise, the project was nearing completion. Thus, only minimal progress was made with regards to discussing the requirements for a northern electronic information management tool within each TAC. However, the HIM Consultant and the IT Coordinator did begin to look for an external software management service provider because the north did not have the resources or expertise to host or manage software system(s). It became clear that HISC of Saskatchewan Health would be the most appropriate service provider, as software management and support services are components of their mandate. The HIM Consultant and the IT Coordinator met with HISC in January 2006 to explore the idea of HISC providing software solutions and services for the north. The HISC was interested in this idea, although they had a number of concerns, including: a lack of provincial scope for the NHS; would the north's e-health strategy be complementary to the provincial strategy (note: a northern e-health strategy does not currently exist); and the multi-jurisdictional nature of the NHS, particularly the First Nations jurisdictions.[25]

The HIM Consultant also worked with AHA in regards to the impact on medical transportation due to the loss of one airline to the north. The HIM Consultant organized a data collection tool for AHA to collect data on Emergency Medical Services Medivac Flight Tracking.[28]

5.6.2.2 TAC Recommendations and NHS Strategic Planning

The HIM Consultant and/or the HIMTAC developed and submitted two recommendations to the NHSWG over the course of the project. The HIM Consultant and the IT Coordinator worked with the Chronic Disease Coordinator and TAC to prepare a recommendation to the NHSWG in regards to the Western Health Information Collaborative Chronic Disease Management Infostructure Project. This project involved the four western provinces in the development of an innovative and sustainable chronic disease management "infostructure," which included the creation of standards for chronic disease data and information exchange, with the capacity to share this information across systems and jurisdictions in support of clinical decision-making. Unfortunately, there had been no real northern representation in the project in the early phases and these Coordinators, recognizing the importance of this initiative, recommended that the NHSWG seek representation and participation in the project so that the unique needs of the north were met. The NHSWG approved this recommendation in June 2005, requested representation, and were successful in achieving representation and participation on two of the project's working groups: functional requirements; and IT and security requirements. The Saskatchewan Health representative of the NHSWG was instrumental in ensuring northern representation and participation in this project. Of note, the IT Coordinator was a member of the IT and Security Requirements Committee. However, this project was eventually suspended and the project team was transferred to the Health Quality Council's Chronic Disease Management Collaborative (see page 69) given that the collaborative had the same focus with a deadline of September 2006.[25]

The second recommendation, submitted to the NHSWG in December 2005, was to develop an electronic tool to capture client demographic and nursing service utilization, which would facilitate comprehensive, standard collection and reporting capability in community health care.[28] As mentioned earlier, the current state assessment found that the majority of patient demographic and health information in the north is manually recorded on paper documents. Furthermore, there is a

lack of comprehensive and complete demographic and clinical information for the north, resulting in an inaccurate picture of the health of northern residents. According to the HIMTAC, the objective of this tool was to improve the collection, management, and utilization of patient demographic information and nursing service. The NHSWG approved this recommendation (December 2005) and asked the HIMTAC to further develop the plan in terms of benefits, costs, sustainability, resources, etc.

The HIMTAC decided that client demographic information was a good place to begin the move from paper to electronic records, utilizing the Nurses' Daybook as it collected client demographic and nursing service utilization information. The TAC received two demonstrations of databases in existence that collected some of the information they were interested in capturing (i.e., AHA Nurses' Daybook database, Cypress Hills RHA Public Health database). The HIMTAC was then faced with the options of: utilizing the AHA database with the desired modifications specific to each health center or nursing station; utilizing the Cypress Hills database with the desired modifications; developing a third database taking the best of both of the demonstrated databases, also with the desired modifications; or acquiring a Saskatchewan Health database. According to the HIM Consultant, the HIMTAC leaned toward the development of a third database and thus, the Consultant felt there was a need to expand on the recommendation submitted to the NHSWG in December. As a result, the HIMTAC prepared another recommendation that was submitted to the NHSWG in the TAC Final Report, which was to establish and implement an electronic tool that captures demographic, clinical, and nursing utilization information to improve community health care.[28] Essentially, this recommendation sought the development and implementation of the tool discussed in the TAC's previous (second) recommendation approved by the NHSWG. Unfortunately, the HIMTAC did not progress in developing the desired database or utilizing and modifying one or the other of the demonstrated databases.

The HIM Consultant and the HIMTAC discussed a number of informal recommendations (i.e., not fully developed and submitted to the NHSWG for discussion and/or approval). For instance, the HIMTAC Final Report briefly mentioned the following recommendations:[28]

- the HIMTAC could continue as a northern "task force" that plans, manages, facilitates, supports, and sustains health information requirements and advances;
- to appoint and/or hire a health information specialist that would develop and facilitate the bridging process discussed previously;
- to educate both consumers and health care professionals in the importance and use of quality health information; and
- to work in collaboration with the province to achieve an effective health care system that will be supported by an infrastructure that is timely, appropriate, secure and accessible when and where northerners enter into the system.

Within the NHS Strategic Plan,[15] there is support for: establishing a northern "task force" (made up of individuals with information management and technology responsibilities), with a mandate to establish a northern e-health strategy and to plan, manage, facilitate, support, and sustain health information requirements and advances in the north; developing and facilitating the migration strategy (bridging plan) from paper to electronic health records; developing an electronic tool to capture client demographic, clinical, and nursing services utilization with the support of a contracted HIM specialist (via special project funding); collaborating to provide education to both consumers and health care professionals in the importance and use of health information; and collaborating

with Saskatchewan Health and FNIHB to achieve an effective health care system supported by the appropriate HIM and IT infrastructures.

5.6.2.3 Evaluation Findings

Successes

According to both the HIMTAC representatives and the HIM Consultant, the completion of the current state assessment was a significant achievement for the TAC. The current state assessment was able to capture a comprehensive picture of HIM in the north, which had not been attempted in the past. Furthermore, the NHSWG representatives also considered the HIM current state assessment a noteworthy accomplishment.

In examining the current state assessment, the TAC representatives soon realized that technology and methodology must be updated in the north. At first, HIMTAC representatives resisted the need for changes to the way they collected information, but they came to understand that changes must occur and these changes will create efficiencies and also ensure greater continuity of care in the north. Essentially, members of the HIMTAC became more aware of the importance of HIM, which may potentially lead to greater advocacy and capacity building in the future. The TAC representatives also recognized the need for qualified health information staff in the north, where there is a marked dearth in HIM capacity. The HIMTAC also developed an appreciation for the need: for a comprehensive identification method utilizing unique patient ID numbers to be able to track, identify, and access patient information across the north; and for index systems to comprehensively collect and aggregate homogenous information such as, grouping of patients, diseases, treatments, immunizations, etc.

The HIMTAC represented the first time a group such as this had met in the north. Similar to other TACs, networking occurred between TAC representatives, often over and above the TAC meetings, which was considered very beneficial. As a result of networking opportunities, information sharing has increased among representatives and the NHS partner organizations. Furthermore, the HIM Consultant and the HIMTAC cited the networking and relationship building between the NHS (via the HIM and IT TACs and their Coordinators) and the HISC as a success of the project. This networking provided an opportunity for advocacy on behalf of the First Nations NHS partners to gain access to CommunityNet (see page 99); and served to raise the profile of HIM in the north, placing it on the agendas of the various stakeholders (e.g., HISC, NHSWG, NHS partners).

The HIMTAC representatives identified a potential success resulting from their discussions of northern health information collection, management, and utilization, and their recommendation to establish and implement an electronic tool to capture client demographic, clinical, and nursing service utilization because it has the potential to reduce workload and to allow the utilization of information in a new and innovative way.

> *The fact that we are going to be able to do electronic daybooks is going to help, not only the nurses' workload but it's going to allow us to be able to look at so much of the information and actually do something with it. In a nutshell, we're going to be able to compile and utilize information that we have never ever been able to use before. Some of the other things that it's going to contribute to is, we've never really seen workload issues in the north for the nurses in the communities, we're going to be able to take a look at that…many, many*

areas. In a nutshell, utilization of information that has always been put down before but never utilized properly.

Challenges

In terms of challenges, representation at TAC meetings was raised, specifically that the members of the HIMTAC lacked a health information and/or an informatics background.

> *The TAC members themselves because of the human resource issue in the north. Of course, if we had been dealing with librarians or informatics, people with degrees in informatics or technical people, from a health information standpoint, things could have progressed. I think things could have and probably would have progressed in a different manner. When I look at the other TACs and they're dealing [with] perinatal, for example, the people that are there are very well versed with perinatal issues and breastfeeding issues, so, of course, things can move much more readily. So, I thought that that was a bit of a weakness on this TAC.*

Furthermore, many of the HIMTAC representatives were nurses and thus, they were particularly interested in nursing data, which meant less time was devoted to discussing other HIM issues such as infrastructure (e.g., demographics, indices, databases). Notably, health human resources recruitment and retention is difficult across the north, particularly with respect to health records practitioners, which explains why some TAC representatives lacked a health informatics background. Given the lack of HIM capacity within the NHS organizations, one of the NHSWG representatives was disappointed that the HIMTAC did not create a human resources development plan around health information and informatics.

Similar to other TACs, meeting attendance was cited as a challenge for the HIMTAC. For example, there were two vacant positions on the TAC and there was a lack of consistent participation in TAC meetings from several NHS partners, with attendance dropping towards the end of the project. Moreover, TAC representatives reported that it was a challenge to find the time to attend meetings and some found traveling to meetings a persistent challenge.

> *We are all busy people no matter what role we're in; we're all busy people. And there were times when it was very challenging to try and get to meetings. Even though, at times I thought, 'Oh, I can't afford the time to get down to this meeting. I really shouldn't be going.' By the time the meeting was done, I was always grateful that I had attended. So, that says something for itself.*

The HIM Consultant found that completing the work within the short timeline of the project, particularly the current state assessment, was challenging due to: its originally broad focus and the need to narrow the scope of the current state assessment to something manageable within the timeline of the project; gathering this information was time-consuming (i.e., a lengthy interview and review process), complicated at times by the inability to connect with knowledgeable individuals within the organizations; and lastly, an inability to spend an appropriate amount of time in each site (i.e., NHS partner) preparing an assessment (generally, comprehensive assessments can last one week; not four hours). In addition, the HIMTAC was the last TAC to begin meeting (its first meeting occurred in August 2005), which was partially due to the fact that a TAC was not originally planned and the lack of TAC representatives able to attend the meeting that was scheduled for June. As a result, the HIM Consultant felt that this TAC was at a particular disadvantage compared to some of the other TACs.

As for future challenges, some HIMTAC representatives felt that results from the work of the TAC will take a long time to materialize, which may be frustrating for some individuals, and this may ultimately affect the commitment and retention of TAC members.

Sustainability

In terms of sustainability, the HIMTAC is interested in continuing the work, through creating a HIM task force or council in the north, which is acknowledgement that health information is an important issue. Furthermore, the TAC representatives identified criteria needed for sustainability such as, commitment and support from the NHSWG; partnership with Saskatchewan Health and FNIHB; a facilitator/coordinator (i.e., HIM specialist); funding; and the need to work within and across jurisdictions to accomplish their goals. However, as one NHSWG representative noted, the HIMTAC failed to develop and submit a formal recommendation concerning the sustainability of the group.

5.6.2.4 Summary Statement

Unfortunately, the HIMTAC did not produce a work plan with the steps in developing a northern electronic health information management system fully identified, in terms of human resource development needs, next steps on how to proceed, etc. However, the current state assessment completed by the HIMTAC was a considerable achievement, representing the first comprehensive, detailed scan of HIM in the north. This assessment will provide a solid foundation for future planning regarding needs, next steps, and policy, with respect to HIM and also IT since these two project components are interrelated.

As for the short-term outcomes identified by the HIM Consultant: to develop long range objectives and a plan for a streamlined and comprehensive collection of clinical documentation, information, utilization, and management of health information systems in northern Saskatchewan; and to develop a plan for strategic integration of health information and IT applications needed for a sustainable and intra-operative information system between health jurisdictions in northern Saskatchewan, these have not been fully achieved within the course of the Shared Paths project. A bridging plan, essentially a strategy to migrate northern health care sites from a manually-driven paper system to an electronic health information system, has yet to be fully developed. There were many discussions around the bridging plan during HIMTAC meetings; however, a concrete work plan on how to proceed was not achieved.

The long-term outcome identified by the HIMTAC Consultant, to streamline and standardize (where possible) HIM among the NHSWG partners to improve health care and services provided to residents of northern Saskatchewan, will have to remain an objective of the northern "task force," which is of course dependent upon its continuation. Fortunately, the current state assessment will serve as a foundational document, which clearly identifies where the gaps and weaknesses lie. This will facilitate planning in the future and determine where resources should be invested.

5.6.2.5 Evaluation Recommendations

The HIMTAC desires to continue meeting, either in its present form or as an amalgamation between the HIMTAC and the ITTAC. In either form, the HIMTAC should continue to pursue its short-term objectives of: a plan for strategic integration of health information and IT applications needed for a sustainable and intra-operative information system between health jurisdictions in northern Saskatchewan, with a streamlined and comprehensive collection of clinical documentation, information, utilization, and management of health information systems. These objectives should be met through the: implementation of the recommendation to establish and implement an electronic tool to capture client demographic, clinical, and nursing utilization information via the modification and utilization of an existing database or the development of a new one; development of a human resources development plan around health information and informatics; and development of the bridging plan with the ultimate goal of creating an electronic HIM system that is interoperable with the eventual pan-Canadian EHR.

6. Overall Observations

The following is a discussion of several overall observations made throughout the course of the evaluation. These observations are based on: 1) the results of data collection and analysis; 2) discussions with project staff, TAC representatives, NHSWG representatives, and evaluation team members over the course of the evaluation; 3) observation of NHSWG and TAC group development and process; and 4) observation of project activities and progress.

6.1 Networking, Information Sharing, and Increased Awareness and Understanding

The TAC representatives identified several benefits to coming together as a TAC. While the partners of the NHS have been meeting for a number of years at the operational (i.e., NHSWG) and governance (i.e., NHS Leadership) levels, the Shared Paths project was the first real opportunity for the service provider level to meet, to work together, and to collaborate with one another. It was an opportunity to network with others in the field, develop relationships where previously none had existed, and strengthen relationships that did exist. A number of TAC representatives believed that the TAC process facilitated a greater commitment to working across jurisdictions. As one TAC representative expressed, "this is an experience that would not have been had in any other health region." The TAC also provided an opportunity for information sharing, with the TAC representatives sharing experiences, ideas, resources, and expertise with one another. According to the Project Coordinator, the TAC meetings provided an avenue for sharing information and knowledge, for example, new ways of doing something or best practices, which the TAC representatives were then able to apply within their own organizations as they saw fit. As a result of sharing information, there was an increased awareness of the issues in the north as they related to the TAC focuses (i.e., mental health and addictions, chronic disease, perinatal and infant health, oral health), as well as an increased understanding of the "other" jurisdictions and its roles and responsibilities for health service delivery (e.g., provincial, RHA, First Nations, federal).

6.2 Short Timeline of the Project

Unfortunately, the Shared Paths for Northern Health project was faced with a short timeline, approximately two years; with the extension, approximately two and a half years. For a project of this nature and magnitude, the short timeline presented a challenge to accomplishing the large project goal and objectives, related to both community and organizational transition to enhance the health status of residents of northern Saskatchewan.

The NHSWG received funding for this project in the spring of 2004, with the first project staff hired in July (i.e., Project Coordinator, Executive Assistant, Communications Coordinator). Prior to the commencement of any project, there are start-up and planning activities that need to occur, for example, recruitment of staff and methodology refinement, the importance of which should not be underestimated. The start-up phase of this project lasted longer than anticipated due to the recruitment process and the lack of a prescribed methodology on how to proceed. For instance, what does community and organizational transition look like? How does one define community or organizational transition? What are the steps necessary to achieve this transition? As well, the inclusion of the NHS partners into every step of the recruitment process was important, in that, it provided the opportunity for each partner to: have input into the process; feel ownership of the

project; build some organizational capacity (i.e., through those project staff seconded from partners into their positions); and further strengthen the partnership by working together.

All start-up and planning activities take time, and this meant that the first PHC TAC meetings were held in the fall of 2004, several months past the "official" project start date. With approximately eighteen months to complete their tasks, both the PHC TAC Coordinators and the TACs felt the time constraint. On more than one occasion, the TAC representatives mentioned the short timeline for the project as a challenge. The TAC representatives expressed concern that the TACs would not be able to complete the work plans or address all priorities, given the amount of time necessary to devote to the project, the expectations placed upon them, and their heavy workloads within the organizations. Furthermore, the timelines of other project components were shorter than the eighteen months of the PHC TACs. For instance, the support TACs had approximately fifteen months to complete their tasks (i.e., human resources, information technology, health information management). As well, the cross-jurisdictional issues and community development components (contracted in the spring of 2005) had approximately one year. These individuals and TACs also experienced similar pressures to complete tasks on time.

While all project components made progress towards objectives and anticipated outcomes and/or achieved successes within the expected timeline of the project, perhaps the lesson learned here is, rather than scramble to spend a considerable amount of money within a certain period of time in the hopes of achieving the objectives and anticipated outcomes, that the organizations in a position to fund complex initiatives such as, Shared Paths for Northern Health, should review current practice and guidelines with respect to funding to allow for greater flexibility or adjustments, particularly with respect to timelines and/or extensions in order that effective and sustainable transition, which is generally the desired outcome, is possible. In the end, there would be improved accountability on both parts, those organizations in receipt of funds and the funding organizations, for the money that was spent.

> *Our message needs to be – We know what works; we're already doing some of it. What we need you guys to do is to tackle the constraints that prevent us from doing this stuff, and support us in doing this.*

6.3 Representation at TAC and NHSWG Meetings

The TAC representatives expressed concern over the lack of representation of all NHS partners and funding agencies at the TAC meetings. This concern was identified in the interim evaluation report and it remained a concern throughout the project. In some instances, there was no representative to sit at the table, and in other instances, representatives attended quite infrequently or not at all. The TAC representatives felt that it was important to have as much representation at the meetings as possible. They also understood that all TAC representatives had busy schedules (e.g., regular job responsibilities, other committee responsibilities) and therefore, were not expected to attend every TAC meeting. Nevertheless, efforts should have been made to ensure that there was partner and funding agency representation at the table through the nominated TAC representative or an alternate representative. Related to the issue of representation, TAC representative turnover was also cited as a challenge for many of the TACs, as this often impeded progress if consistently new members needed an orientation to the group. Furthermore, some instances of turnover did not produce a new representative for the TAC, which meant a lack of representation for some organizations. In addition, some TAC representatives also expressed concern over the lack of

Aboriginal representation on the TACs. While 85% of the northern population is Aboriginal, there were only a handful of Aboriginal representatives on the TACs.

Similar representation issues existed at the NHSWG level. In some instances, the representatives attended meetings quite regularly, and in other instances, the representatives attended infrequently or not at all. Many factors contributed to meeting attendance, for example, all NHSWG representatives had busy schedules as CEOs and Health Directors, and smaller partners did not have the capacity or they lacked the personnel to attend meetings regularly (i.e., not in expertise but were understaffed). It is important to have as much representation at the NHSWG meetings as possible. Therefore, efforts should be made to ensure that there is partner and funding agency representation at the table through the nominated NHSWG representative or an alternate representative. It is the responsibility of the NHSWG representative to stay informed, and the responsibility of the alternate representative to become informed, so that any decisions can be made during the meetings and the process is not slowed down. Representation at the meetings shows partner commitment to the NHS; enables buy-in to the NHS at all levels, from leadership to health sector staff to community residents; and full participation in the meetings' discussions and NHS activities ensures that each NHS partner has a voice and an equal opportunity to shape the health care system in the north.

6.4 Participation in Meetings and Activities

As with any group, some individuals participate while others do not participate very much at all. The participation of the TAC representatives varied during the TAC meetings and in its activities (e.g., resource development, workshop planning). Within the TAC meetings, the Coordinators employed various approaches to involving all TAC representatives and soliciting their input or feedback. For example, some TAC Coordinators utilized roundtable discussions; others had TAC representatives speak to certain issues or agenda items; and all Coordinators kept TAC representatives informed and requested input and feedback via email. Operating by consensus, the TACs discussed, debated, and agreed on: the issues to address, the work plan, activities, recommendations, etc. So, it was important that all TAC representatives felt as though they were informed and had the opportunity to: provide input into the discussions; determine the work plan of the TAC; participate in the activities; inform the recommendations that were developed, etc. Consequently, it was also their responsibility to ensure that they were informed and participating in the TACs' discussions, activities, and meetings.

In addition, while meeting by teleconference/WebEx was beneficial in that it reduced travel time for the TAC representatives, it also limited TAC representatives' participation in the meeting's discussions and activities, particularly for those who joined a face-to-face meeting by teleconference. This being said, there were occasions when meeting or joining by teleconference/WebEx was most appropriate and/or was better than not meeting or joining at all.

Lastly, the TAC representatives identified the importance of having the right individual at the table. Someone committed to the process, with the right level of program/service expertise, and the right level of administrative authority, so that any decisions could be made during the meetings and the process was not slowed down.

6.5 Clear Direction and Regular Feedback

A consistent challenge identified by many TAC representatives was an unclear mandate at the start of the project, with respect to the purpose of the TAC and their specific role within the project; however, this became clearer in some TACs (i.e., CDTAC, PIHTAC, OHTAC) as the project progressed and milestones were achieved (e.g., an approved recommendation). Others TACs (i.e., MHATAC, HRTAC) struggled all the way through the project with respect to their purpose; signifying the importance of and need for: better strategic planning upfront in terms of project objectives, outcomes, and activities; internal evaluations of TAC progress performed by the TAC Coordinators and TAC representatives; timely and clear communication of concerns or difficulties to the appropriate individuals; and timely and appropriate direction provided, particularly in the event that progress is not proceeding as envisioned. It was suggested in the interim evaluation report that the TAC Coordinators periodically review the project purpose, objectives, and TAC mandate with the TAC representatives to keep the TAC focused on its tasks and to achieve the project goal, objectives, and anticipated outcomes; however, only two of the TAC Coordinators did so.

Typically, direction, feedback, and project updates from the NHSWG to the TACs were provided via oral reports (at TAC meetings) by the Project Coordinator. Conversely, progress updates and feedback from the TACs and the TAC Coordinators to the NHSWG were provided via written and oral reports (at NHSWG meetings) by the Project Coordinator. As the project activities progressed, it became more difficult for the NHSWG to provide the needed direction and feedback to the TACs. For example, several NHSWG representatives reported that meeting agendas were full with much information to review prior to the meetings. It should be noted that the Shared Paths project was not the only initiative or focus of the NHSWG; however, given the magnitude of the project it did consume much of each meeting's agenda. As more recommendations were coming to the NHSWG for their review and approval, there was a suggestion by one of the NHSWG representatives to limit the number of recommendations to two that were presented at each meeting. As a result, many recommendations were submitted to the NHSWG as part of the TAC Final Reports and are awaiting formal review and approval to proceed with implementation.

This somewhat informal process for providing updates, feedback, and direction was sufficient until there was a marked increase in project activities and recommendations coming forward. It is important that clear, consistent, and regular feedback and direction is provided along the continuum from the NHSWG to the Project Coordinator to the TAC Coordinators to the TACs. Perhaps, there needs to be a more systematic way of reviewing information and providing feedback and direction, not only to the TACs as/if they continue, but to consultants and others who will be involved in future NHS initiatives. As one example, this could be facilitated through a bi-annual conference whereby all the TAC representatives, NHSWG representatives, and other stakeholders would have the opportunity to network and share information. Furthermore, it is important that the NHSWG representatives stay informed of all NHS initiatives and progress so that feedback and direction can be provided in a timely and appropriate manner.

6.6 Partnerships and Group Development

It is evident that partnerships and collaboration take time and effort, and do not come without risk; however, the benefits can be great. There are several examples of partnerships in the north, for example, the NHSWG, the Northern Healthy Communities Partnership, the Northern Health

Promotion Working Group, and many others. Partnerships are often constrained and tested by many factors such as, tight timelines related to funding, lack of funding, differing viewpoints of participants, hidden agendas, and the list goes on. As a result, partnerships need to be nurtured and supported from within, as well as from the outside (i.e., external stakeholders, funding agencies).

All partnerships go through a group development process, which has been widely studied and goes by variations on the theme of "forming, storming, norming, and performing."[29] Moreover, partnerships go through several cycles within this development process. The TACs experienced these phases of group development. As an illustration, the TAC representatives came to the table, met their counterparts, and developed personal and professional relationships (i.e., forming phase). All TACs worked through a "storming phase" with respect to discussing and debating the issues to address, the work plan items, and TAC activities, achieving consensus among thirteen partners and almost as many differences of opinion. Nevertheless, each TAC worked together as a group, made progress within its work plan (i.e., norming phase), and developed and submitted recommendations to the NHSWG (i.e., performing phase).

6.7 Communications

Communications was a challenge identified in the interim evaluation report and it remained a challenge throughout the project. The findings of this evaluation point to the need for improvements in the communication of the NHS and its initiatives to both the NHS partners and the communities. The intent here is not to reiterate the communications challenges experienced in the project by the Communications Coordinator, the TAC representatives or the NHSWG representatives; rather the intent is to emphasize the importance of communication amongst the stakeholders in the success of any project, organization or partnership. The NHS is guided by four key principles, one of them being communication. Through the communications foundation established by the Shared Paths project, the NHS can continue to facilitate and improve upon the flow of information to and from all stakeholders.

6.8 TAC Interaction

Many TAC representatives criticized the project for the lack of interaction between TACs and stated that a formal process for engaging with the other TACs did not exist. As a result, the TAC representatives were not able to share project experiences or collaborate, and felt disconnected with respect to what the other TACs were doing. Aside from the website, monthly TAC reports, newsletters, and updates from the Project Coordinator and the Communications Coordinator, there were no formal interactions between the TACs within the project. The TAC representatives would have appreciated an opportunity to connect halfway through the project (e.g., workshop, conference), in addition to the NHS Gathering/Project Finale at the end (September 2006). At the time of the interim evaluation report, some TAC representatives had hoped that more interaction would occur and that the TACs would work more closely together in the remainder of the project. This lack of TAC interaction represents a potential loss in opportunities for collaboration on TAC activities or recommendations to the NHSWG.

6.9 Staffing and Project Management/Coordination

The findings of the evaluation, observation of TAC meetings, and the challenges identified by the TAC and NHSWG representatives have illuminated some issues and needs with respect to staffing a project such as Shared Paths for Northern Health. For instance, Coordinators should possess the proper skill set in terms of: knowledge of the field/issue (e.g., mental health and addictions, information technology); knowledge of the north and the NHS (i.e., the environment in which they work); knowledge of federal and/or provincial roles and responsibilities in the health care system; excellent facilitation skills (i.e., ability to drive the process and keep the TAC on task); ability to facilitate group development and address group dynamics (e.g., strong personalities, differences of opinion); ability to visualize what needs to be done and to be able to communicate this vision to the group; ability to initiate and develop initiatives or group activities; and ability to work independently and in a team environment. Conversely, the Coordinator cannot be too strong a leader in that the group interest is lost.

It is important for the Coordinators to be sufficiently prepared and briefed prior to undertaking the position. For example, an orientation process to the NHS and to each NHS partner. Perhaps, consideration should be given to a training period (e.g., 6 months) where staff (even if experienced) is trained in group facilitation, conflict resolution, writing reports, and other professional development opportunities (continuing education should continue throughout the project). In addition, it is important that there is structure within the workplace (e.g., regular staff meetings, office policies, feedback mechanisms), and accountability of staff through monthly activity reports, performance reviews, etc. It is important for the Project Coordinator to provide feedback on progress and work ethic, as well as timely and appropriate direction on how to proceed when progress is not as envisioned.

It should be noted that the NHSWG attempted to fill the coordinator/consultant positions with individuals from the north in an effort to build local capacity, seconding from the NHS partners when possible; however, the majority of the positions were filled with individuals from the south, although some had extensive experience working in the north.

In a project with a short timeline it is particularly difficult to recruit "the cream of the crop" as these individuals tend to not apply to short-term employment opportunities. Furthermore, as experienced in the Shared Paths project, there is staff turnover in short-term positions as the employees tend to search for and often find long(er) term positions prior to the end of their positions, which can create hardships for the project. The project experienced changes in staffing (largely due to a lack of progress in their work, insufficient skills) or early departures in six positions: Communications Coordinator; Human Resources Coordinator; Mental Health and Addictions Coordinator; Perinatal and Infant Health Coordinator; Information Technology Coordinator; and Project Coordinator.

The change in Project Coordinator mid-way through the project was not met without its difficulties; however, transition phases are unavoidable in any project, program or organization. The findings of the evaluation seem to indicate that this change in project management was beneficial for the project staff, TAC representatives, and NHSWG representatives. The second Project Coordinator was seconded from one of the NHS partners and therefore, was well versed in the northern health care system and the NHS itself. Previously leaving an acting CEO position, the Project Coordinator was well suited to the tasks of project management and coordination. The success that the NHSWG has

had with the Shared Paths project is in large part attributable to the coordination and management efforts of the second Project Coordinator. According to one TAC representative:

> *I think this committee really turned around when Angelique became involved. I think she did a really good job of actually taking the whole Northern Health Strategy and developing it further. That's just my view of it. Particularly, this committee, I think we were able to focus on some tangible things when she got involved.*

Furthermore, project staff described the second Project Coordinator as: hands-on; worked to ensure that employees were comfortable in their role and able to maximize their production; provided timely feedback and information as needed throughout the project; provided necessary direction, but also allowed for independent and self-directed work; and practical in setting deadlines and performance expectations.

6.10 Lessons Learned

In the questionnaires, interviews, and focus groups with project stakeholders (i.e., TAC representatives, NHSWG representatives, project staff), the participants were asked to identify the lessons learned in carrying out the Shared Paths project. The following is a compilation of the lessons identified.

- The need for clarity of purpose and clear direction at the start of the project (particularly for the TACs; however, for the consultants as well).
- The importance of a qualified Coordinator to keep the TAC focused on the process and to ensure success.
- The importance of the right people at the table in terms of being committed to the process, with the right program/service expertise and the authority to make decisions.
- The importance of proper and broad representation at the table in terms of community, regional, and northern perspectives, as well as service providers that are not only mid- or senior-level managers.
- The importance of consistency in TAC and NHSWG representation in terms of continuity and commitment to the process.
- Turnover in TAC representatives will occur if/when the group comes upon tough times (e.g., individuals will stop attending meetings).
- Forming subcommittees aided TAC progress in that TAC representatives were dedicated to a task (i.e., an area of expertise), thereby enhancing commitment and potentially decreasing turnover.
- Perhaps, reducing the number of meetings would sustain commitment to the TAC.
- Communication is key.
- Messages need to be clear and consistent.
- Communications materials need to be targeted to the various audiences (e.g., health care staff; community; project stakeholders) in terms of content and readability.
- The need to provide avenues for the TACs to interact with one another, to enhance opportunities for collaboration.
- The TACs should have utilized the CLOs more in their work.
- There should have been (increased) client representation at the TAC meetings.
- The TACs should have involved the community more in their work, for example, conducted community consultations; communication with the residents about the

project and the NHS; and engagement of the community developers within the NHS partners in TAC activities.

- The need for quick/small successes to sustain interest in the work.
- The successes need to be publicized and celebrated.
- The NHS Leadership meetings increased communication between the Leaders and the NHSWG and the meetings should be continued.
- Respect for jurisdiction, different approaches, and differing view points is important when maintaining and nurturing a partnership.
- The value of a collective voice in responding to challenges, addressing policy issues, and trying to affect change.
- The need to maintain the momentum; implement the recommendations; and track the implementation, even without core funding.
- Evaluation is an important tool to encourage change and improve process when needed.

6.11 Suggestions for Improvement

In the questionnaires, interviews, and focus groups with project stakeholders (i.e., TAC representatives, NHSWG representatives, project staff), the participants were asked to identify suggestions for improvement to the Shared Paths project, if they were to do it all over again. The following is a compilation of the suggestions mentioned.

- At the start of each TAC hold a strategic planning session to clarify the purpose and narrow the focus or objectives.
- Each TAC should prepare a team charter to clarify roles and responsibilities.
- TAC Coordinators should receive training in facilitation prior to working with the TAC.
- NHSWG to provide clear deliverables to the TACs, consultants, and project staff.
- Improve communication between the NHSWG representatives and the TAC representatives within an organization.
- Improve communication between the NHSWG and the TACs, particularly at the start of the TAC; perhaps meetings, at least initially.
- Improve communication and more feedback between the NHSWG and the consultants.
- The CLOs to participate more in the TAC meetings and to facilitate interaction between the TACs.
- Each organization to have a mini-NHSWG within the region (like KYRHA).
- More opportunities for the NHS partners to participate in cross-jurisdictional training.
- More engagement of other sectors (i.e., education, recreation, justice, social services) in the work of the NHSWG and the TACs to address the determinants of health.
- Project staff to increase their visibility in the communities.
- Project staff to receive an orientation to the NHS and to each NHS partner.
- Better planning at the start of the project (e.g., SWOT analysis).
- Smaller, more focused projects in the future (e.g., only two PHC TACs versus four).
- Establish a communications position within the coordinating staff of the NHS.
- Improve/increase internal promotion and public relations related to the intent, goals, and objectives of the NHS.

- NHSWG to meet with all Leadership (e.g., New North; northern MLAs) to promote the NHS.
- More regionalization of the NHS process amongst the partners, building local capacities and improving sustainability (e.g., partnerships between MLTC and KYRHA; LLRIB and MCRRHA).
- Document the history of the NHS (e.g., events, presentations, successes, challenges, outcomes).

6.12 Sustainability

In the questionnaires, interviews, and focus groups with project stakeholders (i.e., TAC representatives, NHSWG representatives, project staff), the participants were asked to identify the criteria for sustainability of the process or this model of working together. The following is a compilation of the criteria suggested.

- A core group of TAC representatives that are able to attend meetings and are committed to the process (i.e., consistent representation and participation).
- Support (commitment) for continued meeting and the process from the NHS partners and funding agencies.
- Financial resources to cover the costs of meetings (e.g., travel, accommodation, meals).
- The need for strategic priority setting (i.e., narrow the objectives to those that are attainable).
- The need for clear guidelines (i.e., changes to the terms of reference) and internal evaluation of progress.
- Various modes of meeting (e.g., face-to-face; conference call/WebEx; video conference) to save on travel time and costs.
- Communication.
- Changes to the TAC representatives to ensure that the right person is at the table (i.e., representation, expertise, authority).
- TAC Coordinator with proper skill set (and consistency in the coordinator).
- In absence of a TAC Coordinator, an organization(s) would need to take the lead role (i.e., chair or co-chairs).
- Regular feedback from the NHSWG regarding progress, direction, etc.
- TACs need some decision-making power for consistent buy-in from members.
- Recommendations to be implemented or the TAC to become an action group to garner commitment from the representatives.
- Sufficient time to attend meetings, gel as a group, make progress, and achieve success.
- TAC support personnel are important (i.e., communications, information technology, health information management). Recognize that funding would be needed to provide this support.
- NHS Coordinator to carry out activities of the NHS and support implementation of the recommendations (also administrative support).
- Trust within the partnership needs to be continually nurtured and maintained.
- Open and honest dialogue amongst the NHS partners.
- Regionalization of the NHS process amongst the partners, building local capacities and improving sustainability by fostering the process in future leaders (e.g., partnerships

between MLTC and KYRHA; LLRIB and MCRRHA). Perhaps, meeting as a large group more infrequently.

- Support the NHS partners that are unable to participate effectively at the NHSWG and/or TAC tables due to limited capacity/personnel within the organizations.

6.13 NHS Coordination

The NHSWG has had the support of a Coordinator since the fall of 2002. Through the PHCTF, the NHSWG has had the support of an Executive Assistant, a Communications Coordinator, and a host of other project staff and consultants in working cooperatively towards improvements in the health status of residents of northern Saskatchewan. Considerable time and effort has been put into creating the working relationships and opportunities for collaboration. As the Shared Paths project comes to an end, the NHSWG finds itself in search of special project funding in an effort to maintain the momentum of the Shared Paths project. In order to maintain the momentum and to continue NHS collaboration in on-going and new initiatives, the NHSWG needs at minimum, a Coordinator and an Executive Assistant. Ideally, a partnership or an organization would benefit from retaining the corporate knowledge gained by its staff throughout their tenure and thus, efforts should be taken where feasible to retain current project staff.

6.14 NHS Strategic Plan

Currently, the NHSWG is in the process of developing a strategic plan, that is: determining the aspects of the Shared Paths project to carry forward, ensuring consistency, continuity, and legacy for which support and funding should be sought immediately; determining the aspects of the project that could wait for a period of time for support and funding; and determining the issues beyond the Shared Paths project that also need the collective attention of the NHS (e.g., the broader determinants of health such as poverty, housing, employment). Following the presentations of all final reports, the NHSWG held a strategic planning session in June 2006; however, not all partners were in attendance so the identification of specific actions did not occur, simply the identification of the priority areas to continue to address. It was suggested by several NHSWG representatives that prior to submitting a request for core funding to the federal and provincial governments, a solid plan should be developed, that is, what are the specific actions to move forward, and how does the NHS propose to support those actions. So, a second strategic planning session was held in August 2006; however, again with limited participation by all the NHS partners. The intent is to submit the priority areas to continue to address as the NHS strategic plan for the next year to both governments for shared core funding, as well as to form the beginnings of a proposal for project funding under the Aboriginal Health Transition Fund (Health Canada). It is strongly encouraged and recommended that solid planning of all future NHS activities and projects takes place, given the challenges experienced in the Shared Paths project, particularly the confusion of the TAC representatives with respect to the purpose of the NHS and the Shared Paths project, as well as the mandate of the TACs and the representatives' role within the TACs.

It was suggested in the interim evaluation report[11] that the NHSWG begin the strategic planning discussion prior to the project's end so that proposals could be written with the support of a Coordinator and project staff; and that funding would be secured to continue the work of the project, maintaining any momentum generated, as well as support new initiatives of the NHSWG (i.e., avoid a lapse in funding).

6.15 Community Transition

One of the deliverables of the Shared Paths project was community transition. At the NHS Leadership meeting in May 2005, the project was criticized for the lack of community involvement, as evidenced by no clear contribution to or no tangible evidence of the project in the community (e.g., no funding of programs or changes in services). However, the intent of the project was not to fund programs or services in the community; rather it was to improve access to services for community residents through better coordination and collaboration between the organizations responsible for health service delivery in the north. As a result of this criticism, the project made some attempts to increase the level of community involvement in its activities. For instance, three of the PHC TACs strived to have an Elder attend the TAC meetings. The PIHTAC attempted to have client representation (e.g., young mothers) at the TAC meetings and held community consultations via the CLOs to gather input into a specific work plan item. The CDTAC Coordinator attended various workshops or conferences within the NHS partners/communities in the fall of 2005, in order to receive community input and feedback into the TAC's work. In addition, the Communications Coordinator and the CLOs worked at increasing awareness and understanding of the NHS and its project within the regions, hoping to engage the community in the process. Lastly, the ACN involved the community via interviews and focus groups aimed at determining an approach to health care that would assist individuals, families, and communities to become more self-reliant in their own wholistic health.

Much work still needs to be done, beyond the reaches of the Shared Paths project alone, to enhance the health status of residents of northern Saskatchewan through community transition, that is, empowering individuals, families, and communities to take ownership and responsibility for their own health and health care. And the work that needs to be done within each community will vary depending upon community readiness. Perhaps too, some additional work needs to be done at the organizational level to further identify barriers and opportunities to enabling communities to become more involved in this process and to have a voice in shaping the northern health care system.

6.16 NHS Leadership Meetings

Four NHS Leadership meetings were held over the course of the Shared Paths project (i.e., May and October 2005, January and April 2006). It seems advantageous to continue to hold such meetings, in that it is an opportunity for the NHS Leadership to: remain informed of the activities and progress of the NHSWG; provide direction to the NHSWG on a regular and collective basis versus only on an individual basis through meetings of the Leadership and the NHSWG representative (e.g., at monthly Board or Council meetings); discuss, debate, and review the work and recommendations of the proposed NHLWG, with respect to cross-jurisdictional issues that affect the northern health care system and any potential solutions; and periodically review the NHS vision, mandate of the NHSWG, and partner commitment to the NHS. All of which are important to the long-term sustainability of the NHS. In addition, these meetings maximized the NHS Leadership's participation in the Shared Paths project, and if continued, would also maximize their participation in future projects or initiatives of the NHSWG. Furthermore, interviews with the NHSWG representatives found that many viewed these opportunities to meet with the Leadership as beneficial.

6.17 Role of Government in Support of NHS

Federal and provincial funding agencies (i.e., FNIHB, Saskatchewan Health) sit at the table with the NHS partners at both the NHSWG and TAC levels. According to the government representatives at the NHSWG table, their role is to: support the process and make contributions to successful outcomes; identify opportunities and threats to the work of the NHS (e.g., funding, policy issues); raise awareness of the NHS within the governments; and advocate for the NHS and assist in moving things forward within the governments. Involving these representatives at the TAC level has been an effective way of engaging regional program staff in understanding what the initiative is and what it is trying to accomplish along the way, versus at the end of an initiative when a proposal or report is submitted to the governments. As one TAC representative mentioned, it was good that these representatives were at the table, listening to the issues, gaining a better understanding of the issues, and then hopefully, willing and able to be better advocates for the north; "it's a great way to communicate our voice."

One NHSWG representative commented that when the federal and provincial governments do not collaborate, this invariably leads to gaps in service, with one or the other failing to assume responsibility for services. The NHS is an example of where collaboration across jurisdictions is successful, beneficial, and also somewhat risky. Given that there is not enough financial resources within the health care system to support a fragmented approach to service delivery, as well as the potential benefits for residents of northern Saskatchewan in terms of access to services, improved quality of services, and improved health outcomes when health service organizations collaborate to provide services, perhaps, it is time for the NHSWG representatives, including the FNIHB and Saskatchewan Health representatives, to say:

> *We want to challenge the system, we want to break the mould; just because this is the way [things are] done right now and this is the way decision making happens, doesn't mean it makes any sense or that we are best served by that. So, the challenge is for the individual to say, "Okay, we can do that. We can challenge the system, even though we are part of the provincial or the federal system. We can challenge it from within or from outside."*

> *There are far too many resources and energy that goes to sustaining structures that aren't actually making an active, an effective contribution to services to people in communities. And if they're not then … if you can't roll up your sleeves and figure out what the job is and work with everybody to get it done in northern Saskatchewan, you can't do it anywhere in this country.*

6.18 Project Success and Satisfaction Indicators

As with most of the PHC TACs, prioritized success and satisfaction indicators were identified by the NHSWG to assess their own progress and that of the Shared Paths project, and these were reviewed in October 2005 and June 2006. The prioritized satisfaction indicators for the NHSWG included:

- We can demonstrate that most of the objectives have been met or are on their way to being met.
- Recommendations are applied and prove to be successful, cost-effective, and sustainable.
- We clearly identify some outcomes and have plans for how to proceed.

- It [the project] shows us what works and what does not in terms of working together across health jurisdictions.
- We involve northern communities in a meaningful way and do not just pay lip service.

The first satisfaction indicator of demonstrating the achievement of objectives has been discussed in earlier sections of this report (i.e., under each of the respective project components).

The second satisfaction indicator of recommendations being applied and proving to be successful, cost-effective, and sustainable was achieved in some cases. For instance, the PIHTAC (i.e., with the resources developed), the OHTAC (i.e., with the resources developed and motivational interviewing), and the HRTAC (i.e., with job and career fair materials developed) all developed and applied resources/recommendations that were both successful and cost-effective. The ITTAC's CommunityNet recommendation was applied and in time the success, cost-effectiveness, and sustainability of this recommendation will have to be assessed. In addition, the CDTAC (i.e., with patient self-management training), and the Nursing Scope of Practice Working Group (i.e., their response to the external environment regarding the transfer of medical function process) were considered successful. Many of the recommendations (e.g., Northern Chronic Care Coalition, Sexual Health Education Workshop) were submitted at the end of the project and the application, success, cost-effectiveness, and sustainability of these recommendations will need to be determined in the future.

As for the third satisfaction indicator of clearly identifying some outcomes and planning for how to proceed, it was generally met. Some of the outcomes identified over the course of the project were: the RFP for dentist services; participation in the Health Quality Council's Chronic Disease Management Collaborative; Career Pathing conference; video conferencing units; NHS Leadership engagement; working relationship with the Saskatchewan Registered Nurses Association; input into the Aboriginal Blueprint; meetings with the federal and provincial governments; Saskatchewan Health and FNIHB at the table; some TACs to continue their work; increased understanding of each other's organizations, issues, etc.; multi-disciplinary TACs broadened the knowledge and understanding of PHC in a northern sense. The NHSWG also drew up a preliminary plan for how to proceed at its strategic planning session in June 2006, with the identification of priority areas to focus on. At this juncture, the NHSWG work plan is a work in progress.

The fourth satisfaction indicator of determining what works and what does not work in terms of working together across health jurisdictions provided many lessons learned (see pages 120-21). For instance, with regards to communications, there was often confusion between the NHS and the Shared Paths project, and a 'un-branding' of the Shared Paths project had to occur near the end of the project in order to raise greater understanding of the NHS. Overall, the NHSWG felt what worked was:

- lead by stakeholders, encourages ownership;
- need a good facilitator;
- involve people who know the north;
- commitment of staff to participate;
- in the north, you must first agree on the concept, next you agree to work together, then you develop a strategy, etc.; and
- accountable partner (e.g., funds) gains experience.

According to the NHSWG, what did not work was:

- new TAC members, changing one person can make a difference or impact group dynamics;
- still yet to be seen, but getting the federal and provincial systems (at all levels) to accommodate and deal with a cross-jurisdictional group; and
- not to have policy-makers as involved, as they have the potential to make change.

The fifth satisfaction indicator of involving northern communities in a meaningful way generated the question: what is meaningful? Beyond this definitional question, the NHSWG identified a number of examples of community involvement: partners are at various levels in terms of involving community, although those with CLOs have a distinct advantage; the CLOs were invited to attend the last staff meeting of each month; the PIHTAC engaged in focus groups with community residents, utilizing the CLOs; the ACN conducted community consultations; the CDTAC's patient self-management training involved community residents; the HRTAC's childcare services needs assessment involved community residents; the NHSWG representatives involved community residents through their own connections; the NHS Leadership meetings represents accountability to the communities; and the community is engaged on some level through the health boards and councils. In addition, the First Nations partners and the RHAs already engage the communities in various ways; and there are other initiatives (e.g., the Northern Healthy Communities Partnership) in existence that engage communities.

The prioritized success indicators for the NHSWG included:

- It [the project] gives us a template as to how health services can work, potentially more efficiently and effectively through coordination and collaboration and thus, provide a more comprehensive, accessible, equitable service to northerners.
- It [the project] shows stronger relationships in the north to successfully support improved health of northerners.
- All of the identified teams have been established and are actively working, and if a clearly defined process for continuing sustainability has been identified.
- There is a willingness to sustain 'the good' that has been realized (at all, if not in most areas) and a willingness to proceed onward and upward.
- People in the communities that are included in the project are able to see and able to explain differences in the way services are available and provided to them.

The first success indicator of 'the project providing a template' was still considered a work in progress by NHSWG representatives. Thus far, the template includes: recommendations in ten target areas (the resource binder of final reports); terms of reference of the NHSWG; and the process of the TACs could be applied to the larger system, but this will require buy-in from all stakeholders. According to the NHSWG, the OHTAC has made the most progress (i.e., dentist services proposal), although the CDTAC has also made significant strides with its work plan and charter for the Northern Chronic Care Coalition. Furthermore, the NHSWG representatives believed that the objectives have been identified by the grassroots and this is a model that should be followed in the future.

The second success indicator of demonstrating stronger relationships is still being met at this juncture. However, the NHSWG representatives believed that stronger relationships have occurred

among senior level staff (i.e., TAC representatives), as well as among the NHS Leadership. As an addendum to this indicator, NHSWG representatives felt that the NHS should work towards engaging youth to work with the young population to support improved health.

Establishing teams and ensuring sustainability, the third success indicator, has been met. As such, the TACs have been established and were actively working towards their identified objectives over the course of the Shared Paths project; and some of these TACs will continue to work together beyond the Shared Paths project (i.e., OHTAC). In addition, a process for sustainability has been identified, such as leadership continues to support these groups, and possible funding from the Aboriginal Health Transition Fund. Identified next steps for ensuring sustainability were: finalizing the MOU from the April 2006 Leadership meeting; and there is a need to build consensus around the issues that must be addressed.

The fourth success indicator of a willingness to sustain "the good" and to proceed will be dependent on the direction from the NHS Leadership. However, indicating that there is a willingness to sustain the accomplishments of the Shared Paths project, a cross-jurisdictional decision-making mechanism was identified and agreed upon at the April 2006 NHS Leadership meeting. The NHSWG also engaged in a strategic planning session in June 2006. Furthermore, some of the TACs are still continuing to meet and/or plan to do so in the future.

The fifth success indicator of including people from the communities in the project and then their ability to understand differences in services was partially met. This indicator is difficult to measure, as there was not a formal survey of community participants and their knowledge of the project or changes brought about by the project. But, perfunctorily, it seems as if there is a further understanding of the NHS by community residents. Furthermore, the NHSWG representatives cited the communications materials as useful in getting the word out about the project.

6.19 Primary Health Care Transition Fund and Aboriginal Envelope Objectives

The Primary Health Care Transition Fund was an investment of $800 million (which ended in March 2006) by the Government of Canada intended to "support the transitional costs of implementing sustainable, large-scale, primary health care renewal initiatives. As a result of such initiatives, it is expected that fundamental and sustainable change to the organization, funding, and delivery of primary health care services will result in improved access, accountability, and integration of services."[30, p. 3] The PHCTF had five common objectives, which were agreed to by federal/ provincial/territorial governments. As Shared Paths for Northern Health received funding through this investment it is important to assess the project's progress towards achieving the Fund's objectives that are applicable to the project.

Objective 1 – Increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population.

- There were no new PHC organizations created as a result of the project; however, it is important to note that northern Saskatchewan relies on the availability, access to, and sustainability of the existing PHC organizations, which are the primary service structures.

Objective 2 – Increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases.

- Health promotion was and continues to be a common objective for all PHC TACs.
- Linkages were made with other health promotion groups in the north and health promotion resources were developed and distributed.
- Management of chronic disease was the focus of one of the TACs.

Objective 3 – Expand 24/7 access to essential services.

- The project did not have a specific objective to expand 24/7 access to essential services; however, TAC representatives shared management practices of PHC, and they learned ways in which to expand access to services.

Objective 4 – Establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider.

- The project promoted an interdisciplinary approach and the TACs were composed of a number of disciplines (e.g., physicians, nurses, community health representatives, dieticians).

Objective 5 – Facilitate coordination and integration with other health services, i.e., in institutions and in communities.

- The project established inter-jurisdictional working groups (i.e., TACs) consisting of provincial RHAs, First Nations Health Authorities, FNIHB, and Saskatchewan Health representatives.
- Within the project, managers and service providers came together to: share organizational policies and programs; identify collaborative opportunities; and work collectively on initiatives such as, resource development and training.
- The project also facilitated dialogue with the RHAs where tertiary/specialized care is delivered to residents of the north.

The Primary Health Care Transition Fund had five envelopes: provincial/territorial; multi-jurisdictional; national; aboriginal; and official languages minority communities. The Aboriginal Envelope supported initiatives that were "transitional and promote large-scale, sustainable changes to primary health care services for Aboriginal peoples and provincial/territorial primary health care systems which support Aboriginal health, and are consistent with the common objectives of the Fund."[30, p. 5] Again as Shared Paths for Northern Health received funding through this Envelope it is important to assess the project's progress towards achieving the Envelope's five objectives.

Objective 1 – Promote more productive and cost-effective primary health care service delivery to Aboriginal peoples through integration of existing services and resources.

- NHS partners collaborated on health promotion and prevention activities and resource development, synergizing local efforts.

Objective 2 – Enhance coordination of service delivery between the First Nations and Inuit Health Branch of Health Canada, provincial and territorial governments, and First Nations/Inuit communities and health organizations.

- The project facilitated linkages between these jurisdictions; identified needs and improved understanding of services; identified areas for collaboration (i.e., information technology, chronic disease management); and lobbied for inclusion of northern First Nations in the provincial health information network (i.e., CommunityNet).

Objective 3 – Enhance the ability of provincial/territorial and First Nations and Inuit Health Branch systems to be accountable to each other and to their publics through collaborative information development.

- The project coordinated opportunities for information sharing, joint meetings, and discussions of collaboration between the systems, which is an accomplishment given that the systems did not even dialogue before.
- Project communications activities helped to improve accountability to one another and the public: briefing notes; newsletters; reports; conferences; provincial and national presentations, etc.

Objective 4 – Improve the quality of primary health care services delivered to Aboriginal peoples, including the cultural appropriateness of services.

- The PHC TACs included Elders in their meetings (re: assessment and planning).
- The project facilitated dialogue on First Nations and Métis community-based approaches.

Objective 5 – Improve linkages between primary health care services and social services delivered to Aboriginal peoples.

- The PIHTAC linked with Kids First North (i.e., representation on the TAC) and with the education sector with respect to delivery of their sexual health education workshop.

7. Recommendations

These recommendations are based on: 1) the results of data collection and analysis; 2) discussions with project staff, TAC representatives, NHSWG representatives, and evaluation team members over the course of the evaluation; 3) observation of NHSWG and TAC group development and process; and 4) observation of project activities and progress. The recommendations are not in a prioritized order and equal consideration should be given to all of the recommendations.

1. Given the scope of the Shared Paths project, the NHSWG should prioritize components of the project to move forward, as well as prioritize the recommendations within those components for implementation, and support accordingly.

2. It is strongly recommended that solid planning of all future NHS activities and projects takes place, given the challenges experienced in the Shared Paths project. For example, provide clear direction and expected deliverables to staff, working groups, consultants; clearly define roles and responsibilities; provide formal feedback mechanisms between stakeholders; identify actions in work plans; develop detailed budgets; etc. [Utilize the evaluation findings with respect to lessons learned, suggestions for improvement, and sustainability.]

3. In all NHS activities and projects, ensure that the vision and principles of the NHS are being addressed (e.g., coordination, cooperation, collaboration, communication, wholistic viewpoint, respect for jurisdictional authority, consensus).

4. Explore creative ways to ensure community involvement in the NHS and input into the process.

5. Given that collaboration is a principle of the NHS, the NHSWG is to ensure that links are being made with inter-sectoral partners (i.e., those that do not often view themselves as having a responsibility for health) where essential, for example, to address the underlying determinants of health such as, poverty, housing, and employment.

6. All NHS partners and funding agencies should ensure that there is representation at the table, through the nominated representative or an alternate, and that there is full participation by the representatives in all discussions and activities (NHSWG and TAC levels). Partner representation and participation in the process will help to address the challenges of health service delivery in the north, as well as contribute to the success and sustainability of the NHS.

7. When hiring NHS Coordination and/or project staff, give careful consideration to hiring individuals with the required knowledge and skill set. Often employees are willing to learn and opportunities for professional development and continuing education should be provided.

8. Improving access to services is a fundamental issue addressed by the NHS, as well as intent of the work of the TACs. Progress has been made within the project (e.g., dentist services proposal, CommunityNet), and efforts to improve access to health care services for residents of northern Saskatchewan should be continued by the NHS and supported by the funding

agencies. A process or a forum should be established with the federal and provincial governments to address the issue of access to services, as evidenced by the stalling of the dentist services proposal.

9. Given successful advocacy efforts of the NHS (e.g., CommunityNet, Saskatchewan Registered Nurses Association transfer of medical function process; Health Quality Council Chronic Disease Management Collaborative), efforts of advocacy to positively impact health and social policy, through recommendations for changes or implementation of changes to policy should be continued by the NHS. The NHSWG should continue to identify specific areas for advocacy and take steps toward necessary change. As an example, advocate that funding agencies review current practice and guidelines with respect to project funding to allow for greater flexibility or adjustments, particularly with respect to timelines and/or extensions in order that effective and sustainable transition, which is generally the desired outcome, is possible.

10. There should be a concerted effort to document the history of the NHS (i.e., its development, activities, accomplishments, challenges). It is recognized that this will need the support of special project funds and personnel (i.e., contracted service) given the already demanding positions of the NHSWG representatives and NHS Coordinator; however, this should be considered.

11. The NHSWG representatives should give consideration to including a reflective analysis or an evaluation component to all NHS projects, continuing to strengthen the current relationship with SPHERU and/or developing new relationships with other evaluators (i.e., individuals, organizations), which will contribute to continued partnership development, as well as ensure sustainability.

12. Given the baseline data gathered through the Shared Paths project, as well as the project evaluation, it is recommended that another evaluation is conducted in five years to determine the impact of the project on: health service delivery; and community and organizational transition to improve the health of northern residents that is attributable to the project.

8. Conclusion

Collaboration and partnership are not new concepts in northern Saskatchewan. In a formal sense, the NHS has been in existence since 2001 with the signing of a Memorandum of Understanding between the partners, and the NHSWG in existence since 2002 following the development of the NHS Accord. The NHS is a unique partnership, viewed as a leader and a practical example of collaboration among health service delivery organizations (i.e., provincial, federal, multi-jurisdictional). The Shared Paths for Northern Health project was a significant initiative of the NHSWG and a prime opportunity to identify areas of collaboration that would improve health service delivery in the north, increasing access to services, and enhancing the health status of the northern residents of Saskatchewan.

Overall, the Shared Paths for Northern Health project met some of its objectives and anticipated outcomes. The majority of the TACs constructed their work plans, and all TACs developed a current state assessment for their respective areas, which elucidated many of the gaps and weaknesses in services that exist in the north. From these current state assessments and identification of best practices, standards of care, and core services, the TACs developed and submitted recommendations to the NHSWG that aimed to improve health service delivery and ultimately improve the health status of northern residents. In addition, the project's consultants also progressed through their work plans and developed recommendations with respect to cross-jurisdictional decision-making, and developmental relationships as essential to community development. Due to the fact that many of these recommendations were submitted at the end of the project (March 2006 and beyond), some recommendations have yet to be assessed or approved by the NHSWG. On the other hand, recommendations that were submitted early in the project have been approved, in some cases, and implemented to create change.

The Shared Paths for Northern Health project was time-limited in nature, which inhibited full exploration of all the issues and the solutions, as well as the potential implications of the recommended actions. Consequently, much work remains to be done in terms of further developing and/or nurturing partnerships and sustaining the progress that was achieved. In hopes of sustaining the momentum, a number of the TACs plan to continue meeting in the future, which will fortunately aid the implementation of recommendations and the further achievement of long-term objectives. Furthermore, the Shared Paths project provided many lessons learned and possible improvements for the future, aiding these groups (i.e., the NHSWG, TACs) in their future work and providing a foundation to continue striving to enhance the health status of northern residents.

Through the Shared Paths for Northern Health project, the NHS has taken initial steps towards community and organizational transition to enhance the health status of residents of northern Saskatchewan. The NHS process and its model for working collaboratively across jurisdictions represents best practice in addressing the issues and needs of the northern health care system, and should be supported accordingly by the provincial and federal governments.

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